
Culturally Adapted Cognitive-Behavioral Therapy: Integrating Sexual, Spiritual, and Family Identities in an Evidence-Based Treatment of a Depressed Latino Adolescent



Yovanska Duarté-Vélez, Guillermo Bernal,
and Karen Bonilla

University of Puerto Rico

The article described and illustrated how a culturally adapted cognitive-behavioral therapy (CBT) can maintain fidelity to a treatment protocol while allowing for considerable flexibility to address a patient's values, preferences, and context. A manual-based CBT was used with a gay Latino adolescent regarding his sexual identity, family values, and spiritual ideas. The adolescent suffered from a major depression disorder and identified himself as gay and Christian within a conservative and *machista* Puerto Rican family. CBT promoted personal acceptance and active questioning of homophobic thoughts in a climate of family respect. CBT enabled identity formation and integration, central to the development of a sexual identity for lesbian, gay, bisexual, and transgender youth, with remission of the patient's depression and better family outcomes. © 2010 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 66:895–906, 2010.

Keywords: cultural adaptation; evidence-based treatment; sexual minority youth; Latino adolescent; CBT

Culturally informed, evidence-based treatment (EBT) is fundamental to sound clinical work. We live in a multicultural world. The changing contexts of practice mean that culture, language, ethnicity, race, sexual orientation, disabilities, and a

Work on this article was supported by NIH Research Grant R01-MH67893 funded by the National Institute on Mental Health to Guillermo Bernal.

We thank Lorenzo Lorenzo-Luaces and Julio Santana Mariño for their technical support with graphics and references and Amy Fontenot for her editorial comments.

The content is solely the responsibility of the authors and does not represent the official views of the NIMH or the NIH.

Correspondence concerning this article should be addressed to: Yovanska Duarté-Vélez, Institute for Psychological Research, University of Puerto Rico, 55 University Avenue, Rivera Building, Suite 304, San Juan, Puerto Rico 00925; e-mail: ymduarte@ipsi.uprrp.edu

host of other characteristics must be considered in treatment. The debate as to the utility of EBTs and evidence-based psychological practice (EBPP) continues, and some have culturally adapted EBT protocols with specific patient populations (Bernal, Jimenez-Chaffey & Domenech Rodriguez, 2009). An important aspect of this debate is the degree to which, even with culturally adapted treatments, protocols are clinically rigid or inapplicable when fidelity to a manual-based treatment is considered to trump flexibility (Castro, Barrera, & Martinez, 2004; Kendall & Beidas, 2007).

This article focuses on culturally adapted cognitive-behavioral therapy (CBT) in the case of a Puerto Rican adolescent, who participated in a randomized clinical trial for the treatment of major depression disorder (MDD). We maintained fidelity to the treatment protocol, but flexibly addressed cultural values about sexual orientation, spirituality, family, and identity development as a central part of the treatment. The complexity and sensitivity of the case illustrate how within the so-called constraints of a "treatment manual" there is considerable flexibility to consider salient issues that arise in the course of psychotherapy. First, a brief description of the culturally adapted CBT is presented, followed by a review of developmental considerations on sexual identity, spirituality, and family values that informed the CBT treatment. Next, the specific case is presented to illustrate the process of attending to emerging conflicting identities for a young, gay Latino from a conservative Christian family in the CBT treatment for depression.

Cultural Adaptation of CBT

CBT was culturally adapted using the ecological validity framework developed by Bernal and Sáez-Santiago (2006). The CBT was based on a manual developed by Muñoz and Miranda (1986) for the treatment of depression in adults, using a group format. The manual was adapted to an individual therapy format, taking into consideration both developmental and cultural elements of Puerto Rican adolescents.

The ecological validity model for cultural adaptation posits eight dimensions to increase the ecological and external validity of a treatment (Bernal, Bonilla, & Bellido, 1995). These dimensions include language, persons, metaphors, content, concepts, goals, methods, and context that may be relevant to increase the congruence between the client's experience of a treatment and the properties of the treatment assumed by the therapist. To date, two clinical trials have been published that support the efficacy of this culturally adapted CBT for adolescents with symptoms of depression (Rossello, Bernal, & Rivera-Medina, 2008). Both studies were conducted in San Juan, Puerto Rico, the therapy was delivered in Spanish, and the therapists and the participants were predominantly Puerto Rican, thus augmenting the ecological validity through ethnicity and language match (Griner & Smith, 2006; Sue, 1998).

The CBT used in this case was further modified for another randomized clinical trial that studied the impact of adding a parent psychoeducation intervention to CBT for the treatment of MDD. The study randomized 121 patients to either CBT alone or CBT with the parent intervention. Patients with a variety of comorbid conditions were included to increase generalizability. The CBT manuals are available in both English and Spanish online at <http://ipsi.uprrp.edu/recursos.html>.

The culturally adapted CBT is a short-term, individual intervention that comprises 12 weekly sessions with the option to add four additional sessions as needed.

Sessions are divided into three major modules: (a) thoughts module: how thoughts influence mood (sessions 1–4); (b) activities module: how activities influence mood (sessions 5–8); and (c) interpersonal module: how interactions with other people affect mood (sessions 9–12). Sessions 1–4 target cognition and introduce exercises to identify dysfunctional attitudes and how to change them. During the first session, depression is explained and a rationale is offered for CBT as an alternative way to develop more control over one's life, specifically over depressive feelings. In the following sessions the focus is on identification of thinking patterns and on teaching strategies for challenging dysfunctional thoughts. Sessions 5–8 introduce the concept that the fewer pleasant activities people do, the more depressed they feel, and that it is possible to break the pattern of depression by engaging in activities that are pleasant, rewarding, and inspiring. Sessions 9–12 center on how interactions with people affect mood. The adolescent's support system is identified, including family, friends, teachers, peers, and acquaintances. If the support system is weak, steps are taken to strengthen or enlarge it. The notion here is that the stronger the system of support, the easier it will be to face difficult situations.

Cultural Values: Sexual Orientation, Identity, Spirituality, and Family

For adolescents with same-sex attraction, the developmental milestone of integrating a healthy identity is usually complex and difficult because of the challenge of defining oneself positively within a homophobic society (McDaniel, Purcell, & D'Augelli, 2001). Societal heterocentrism promotes negative messages about homosexuality. Thus, given this context, it is not surprising that many sexual minority youth are at higher risk of developing psychological symptoms, disorders, and suicidality (Russell, 2003; Toro-Alfonso, Varas-Díaz, Andújar-Bello, & Rosa, 2006).

Social prescriptions about homosexuality are perpetuated within the basic unit of society: the family. In some cases, the immediate family context can become a place of intimidation, criticism, and rejection, instead of support and acceptance (Goldfried & Goldfried, 2001). Various parent reactions to a child's "coming out" have been documented (Goldfried & Goldfried, 2001; Savin-Williams & Dube, 1998). Relationships after disclosure may vary from acceptance to tolerance, intolerance, and rejection. The sexual identity development of lesbian, gay, bisexual, and transgender (LGBT) youth implies a process of identity formation and integration, which includes a progression of increased acceptance of one's self and continued identity disclosure to others (Halpin & Allen, 2004). Identity formation is characterized by starting with an awareness of same-sex feelings, questioning, and explorations with the emerging identity. The identity integration is the part of the coming out process, in which an individual accepts his or her LGBT identity (including self-labeling), gains a more positive attitude toward homosexuality (increased resolution of internalized homophobia), discloses his or her identity to others, and begins to participate in LGBT social activities (popularly referred to as coming out).

The Latino cultural value of *familism* privileges the central role of the family. Familism is considered a key cultural value among Latinos/as (Bernal, Cumba-Avilés, & Sáez Santiago, 2006) and may be defined as a value for establishing and maintaining close-knit relationships with immediate and extended family members. For many Latinos/as, the ideal is to have physical and emotional closeness to family members, particularly to parents (Falicov, 1998).

Several core Latino values may conflict with a LGBT identity. *Machismo*, which is rooted in the worldview of a patriarch, emphasizes the leadership role and power of men in society, and the stereotype of a "strong" masculinity (Falicov, 1998). Spirituality or religion is another important value in many Latino families, the Judeo-Christian tradition being the most prominent. Conservative interpretations of traditional religion views same-sex relationships as wrong or evil. To develop a healthy sexual identity, sexual minorities within a conservative religious tradition may need to resolve a cognitive dissonance between two seemingly contradictory identities, integrating LGBT with Christianity or rejecting one or the other. For LGBT Latino youth these conflicts may be more complicated because of the multiple cultural values of spirituality, familismo and machismo, and the possible integration of multiple minority identities (e.g. racial, ethnic, gender, spiritual, sexual; Duarté-Vélez & Bernal, 2008; Rosario, Hunter, Maguen, Gwadz, & Smith, 2001).

For most LGBT youth, seeking congruency between one's views on sexuality and those of family members and religious groups is a particular challenge. For Latino youth who highly value family acceptance and conventional religion, this incongruence is particularly critical. Latinos in their coming out process may fear hurting family members by coming out. Being silent about their sexual orientation could be a way of protecting parents and other family members, which, for men, is congruent with the values of manhood. This process may be different for LGBTs from other cultural groups.

Case Illustration

Presenting Problem and Client Description

"Leonardo" was a 16-year-old Puerto Rican referred to treatment by his mother for symptoms of depression. Leonardo participated in a treatment trial to evaluate the effects of adding a parent psychoeducational intervention to CBT for depression on Puerto Rican adolescents. According to his mother, as a child he was diagnosed with attention deficit disorder and hyperactivity, and during early adolescence, he was diagnosed with MDD.

Leonardo lived with his parents and two younger brothers. He attended a public high school at the time of the study. He was recently moved from school because of bullying. The family was Christian and attended church regularly. During the initial interview, Leonardo's concerns were clearly associated with recognizing himself as gay. He also considered himself Christian, within a conservative family that viewed homosexuality as sinful. He reported that his family would be intolerant of a gay son. He was confronting a great deal of distress as he tried to integrate conflicting aspects of his sexual orientation. Leonardo was not sexually active, but he wished to have a boyfriend.

He wanted his parents to know about his sexuality but was afraid to tell them and be rejected. He described his father as *machista* and as a person who criticizes his clothes, hair, and activities. His mother, Leonardo said, was overly protective of him, and he perceived her as not having enough time and not understanding him enough. He explained that most of his new friends at school, their respective mothers, and extended family members, already knew about his sexual orientation. Most of his relatives advised him to not talk to his parents about this topic. Yet, discussing his sexual orientation with his parents was a critical goal because he wanted acceptance from his parents.

His parents did not present any history of mental health problems. As part of the treatment, Leonardo's mother participated in eight psychoeducational modules designed for parents to enhance understanding of their adolescent's depression and

to increase parental coping strategies. The parents' complaints were related to their son's low self-esteem and his difficulties with organizing his time, establishing priorities, and coping with conflicts. Measures completed by his mother during the intervention are presented in Table 1.

Leonardo's case was chosen for this study because of the particular challenges faced by the psychotherapist, the treatment complexities raised by his sexual orientation, and specific needs as gay Christian within a conservative Latino family. The case illustrates how a culturally adapted CBT can be delivered in ways that honor the patient's values while adhering to a treatment protocol.

As part of the randomized clinical trial, Leonardo and his mother completed self-report questionnaires and face-to-face interviews at pretreatment, during treatment, at post-treatment, and in follow-up interviews. Symptoms of depression (Children's Depression Inventory [CDI]; Kovacs, 1992), self-concept (Piers-Harris Children's Self Concept Scale [PHSCS]; Piers & Herzberg, 2002), dysfunctional attitudes (Dysfunctional Attitude Scale [DAS]; Weissman, 1979), negative criticism by the family, and family emotional involvement (Family Emotional Involvement and Criticism Scale [FEICS]; Shields, Franks, Harp, McDaniel, & Campbell, 1992), and the Psychotherapy Alliance Scale (PAS; Bernal, Padilla, Pérez-Prado, & Bonilla, 1999) were assessed for the adolescent patient. The Child Depression Rating Scale-Revised (CDRS-R; Poznanski & Mokros, 1996) was used to evaluate the severity of the adolescent's depression according to a trained interviewer. The mother completed questionnaires on the relationship between the parents as a couple (Dyadic Adjustment Scale [Dyads]; Spanier, 1976), the mother's feelings of burden because of her son's depression (Burden of Illness Scale [BIS]; Coyne et al., 1987), the mother's coping skills, and perceived family harmony (Coping Skills and Family Harmony Scale; Rodríguez-Soto, Rivera-Medina, & Bernal, 2007).

Case Formulation

Pretreatment assessments confirmed that Leonardo met criteria for MDD, as well as criteria for anxiety disorder not specified and attention deficit disorder and

Table 1
Patient's and Mother's Outcome Measures During Treatment and Follow-Up

	Base	4 Week	7 Week	Post	3 Month	6 Month	9 Month	1 Year
Patient								
PHSCS	20	19	23	21	—	23	—	24
FEICS I	28	24	27	28	30	33	30	31
FEICS II ^a	17	17	22	22	20	24	26	26
Mother								
BDI [†]	13	—	—	4	8	12	11	2
EDMAF	68	—	—	67	—	67	—	75
BAS ^a	55	—	—	44	—	45	—	42
DyAS	17	—	—	25	—	25	—	25

Note. Base = baseline measure; post = posttreatment; PHSCS = Piers-Harris Children's Self-Concept Scale; FEICS = Family Emotional Involvements and Criticism Scale; FEICS I = Perceived Emotional Involvement Intensity subscale; FEICS II = Perceived Criticism subscale; BDI = Beck Depression Inventory; EDMAF = Family Coping Skills and Harmony Scale; BAS = Burden of Illness Scale; DyAS = Dyadic Adjustment Scale.

^aDecreased scores indicate improvements.

hyperactivity, predominantly inattentive. The results of his pretreatment assessments are presented in Figure 1; at baseline his scores indicated severe symptoms of depression and elevated levels of dysfunctional thoughts (DAS = 39).

From a cognitive-behavioral perspective, Leonardo's stress as a sexual minority from early life experiences, such as rejection from peers at school since childhood, shaped, in part, his core beliefs and dysfunctional attitudes about himself, his world, and future. Bullying in the school resulted in his parents transferring him to a new school and may have activated his depressive schemas. Another source of environmental stress was conflict with his spiritual identification and family cultural values, namely, strict gender roles regarding masculinity and rigid values against homosexuality.

In the cognitive domain, Leonardo was struggling with internalized homophobia. He perceived homosexuality as a problem similar to a drug addiction or a mental health disorder. He experienced low self-concept and felt rejected by his parents, God, and others. One of his central thoughts was, "I don't know if people will accept me as who I am." Dysfunctional thoughts related to himself were, "I don't like how I am," "I am a bad son," "I am ugly"; to his world, "Nothing is worthy," and his view of the future was associated with thoughts that he would never have a boyfriend. His negative attributional style was discounting the positive and anticipating negative reactions. In the emotional domain, he felt sad, lonely, and angry. In the behavioral domain, he cried often, reported negative attitudes toward parents and constant conflicts with them, difficulty sleeping, and being distant from others when feeling sad.

From a developmental perspective, Leonardo was moving through an identity crisis centered on his sexuality "I feel bad, I feel false because they believe things about me that I am not. They have expectations about me that I cannot fulfill." His dilemma was whether to accept his sexuality with satisfaction and dignity or whether to hold on to family values of machismo and heterosexism. Leonardo's stress as a sexual minority and fear of rejection, especially by his parents, was considered realistic. Leonardo was at the midpoint of the coming out process, according to the identity acceptance stage (Halpin & Allen, 2004). Our clinical formulation was that

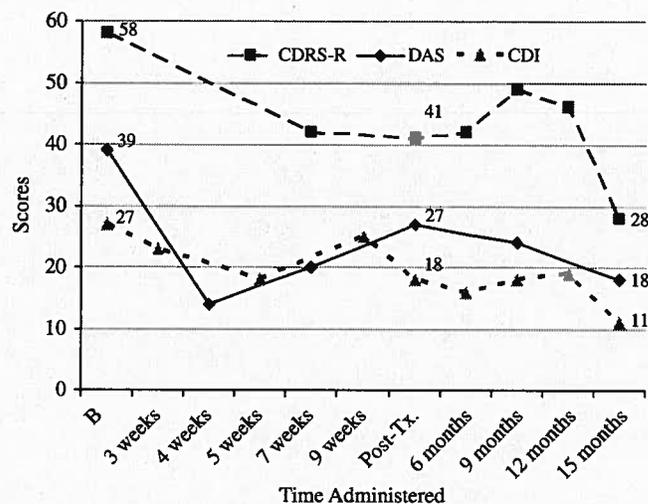


Figure 1. Patient's self-reported and clinician-rated symptoms of depression and dysfunctional thoughts during treatment and at follow-up. Note. CDRS-R = Children's Depression Rating Scale-Revised; DAS = Dysfunctional Attitudes Scale; CDI = Children's Depression Inventory.

helping the adolescent to lessen his cognitive dissonance and changing his negative thinking patterns would alleviate symptoms and improve his long-term functioning. The CBT protocol had strong empirical support for the treatment of adolescents with depression and had been culturally adapted and tested with Puerto Rican youth. Nevertheless, the protocol required considerable flexibility so that the therapist could simultaneously and sensitively center on reducing the depression and addressing the cultural conflicts of an LGBT; for example, the therapist paid particular attention to: recognizing colliding identities; forming an empathic, nonjudgmental approach; identifying specific thoughts or beliefs related to the identity crisis; to sharing information to provide support and clarification on LGBT issues; and discussing social, spiritual, and cultural biases against sexual minority youth within an atmosphere of respect for family and religious values.

Course of Treatment

The focus of treatment was on cognitions during the first four sessions. This permitted the identification of specific beliefs within the three areas of conflict—sexuality, family, and spirituality—that were producing distress.

Sexuality. Leonardo presented internalized homophobia when talking about situations and problems at school. He experienced harassment and rejection from peers at school. He reported that he'd been called "pato" (a term similar to faggot) or homosexual since the first grade. When asked how he felt about it, he said: "I was furious. The thing is, I am (meaning gay), but my mother doesn't know." "I cannot tell them because there have been comments that if something like that happens ... my father is machista and once he told me and my brothers, 'If you turned out to be like that, I would throw you out of this house. I don't care, I don't want my sons to be that way.'"

Family. Leonardo was facing difficulties with both parents. He defined his mother as protective; every time there was a problem with peers at school, she would talk with their mothers and with the teachers to find a solution to the situation. However, he complained that she didn't spend enough time with him and that she was constantly in a bad mood. "I used to cry, I would clam up and not tell her things. I wouldn't talk to her because she would never go out with us; she was always working and that affected me a lot as a child." This expression involved a traditional sociocultural expectation from the mother as the main child caretaker, which does not necessarily fit with current social and economic realities of working mothers in Puerto Rico.

The father was described as antagonistic: "If I wore tight clothes, he criticizes me. He doesn't allow me to shave my legs or change my hair color ... My father doesn't want me to look provocative." The father also has openly expressed his intolerance toward homosexuality and the actions he will take if found that one of his children is homosexual. These have resulted in Leonardo's realistic fear of being rejected if he were to come out. Yet, Leonardo reported that almost all his extended family was aware of his sexual orientation, supported him, and were willing to defend him.

Spirituality. Leonardo came to therapy with rigid religious views and a definition of spirituality that was difficult to integrate with his developing sexual identity "And I cannot tell her (his mother) in front of my father because we are Christians and they don't believe in that (being homosexual).... The thing is, I am also a Christian ... and I know it is not accepted by God. Homosexuals cannot enter Heaven ... I am scared and I say, 'Please God get me out of here.'" The therapist's approach was to facilitate Leonardo's identification of the conflicting aspects of his

self-identity. During the first four sessions, these cognitions were discussed and challenged. For example, we conducted an exercise in which irrational thoughts are discussed and changed; this gave Leonardo the opportunity to evaluate different points of view about homosexuality. An irrational thought was that nothing will change. He used himself as an example to "discuss" the idea: "I want to change; I don't want to be homosexual. Well, I have tried to change, but this is me. I am like this since very young." The therapist introduced different theories on the etiology of homosexuality. They discussed the negative social perceptions toward homosexuality and evidence-based information in this area. This conversation provided Leonardo further validation and acceptance toward his sexual orientation.

Leonardo found particularly helpful the therapist openly acknowledging and congratulating him for discussing his sexual orientation and for deciding to use therapy sessions to focus on "coming out" to his parents. This gave him permission to voice all conflicting aspects without censorship. Gains within this module were that Leonardo received validation and support as he talked about topics that were embarrassing to share. His self-concept seemed to improve as he gained acceptance of his sexuality, and he felt accepted by the therapist. Leonardo was beginning to understand that homosexuality was as valid as heterosexuality. Dysfunctional thoughts decreased markedly (see Fig. 1), which was the goal of the thought module, and symptoms of depression decreased.

The therapy then moved to the activities module, which targeted symptoms of depression by increasing pleasant activities. The patient was asked to identify short-term, medium-term, and long-term goals. Specific activities that supported these goals were structured. Leonardo was encouraged to identify his own goals versus the parents' goals, especially in terms of career options. Leonardo's career goals vividly illustrated the conflict between his values and those of his parents. The family wanted him to pursue a business career, but he wanted to be a dancer. The family was disappointed with his career choice, expressing their judgment as "that is the work of homosexuals." At this point, he felt more empowered and comfortable with himself. He was sure that he wanted to communicate his sexual orientation to his parents to affirm who he was and what he wanted. He said, "I want to tell him, 'Dad, I am gay and I like doing those things (dancing) and that is what I want to do ... I want to be me. I don't want to continue acting, being something I'm not, because I am tired.'"

His extended family played an important role throughout his therapy through their acceptance and support of his sexual identity. Leonardo explained that a family member would argue with his parents, saying, "You have to accept your son as he is, no matter if he is Christian. He is your son." With this statement, Leonardo began to cognitively bridge the gap between Christianity and homosexuality. Family members were validating the notion Leonardo previously perceived to be impossible; that he could be both Christian and gay.

Leonardo's thoughts at this point in therapy evidenced a gain in self-image. He countered perceived rejection from his parents: "I don't care anymore what my mother says. Before, I would say, 'Damn, my mother doesn't like my voice, the way I speak, the way I walk, the way I dress [even though he wanted to be accepted].' If she doesn't want to accept me, it's her decision, but I am her son. It would be very immature of her not to accept me, because she birthed me."

Leonardo appraised the activities that he enjoyed—singing, dancing, modeling—and simultaneously reaffirmed his sexual identity. The therapist facilitated this process through open questions that explored his preferences and priorities as opposed to his parents' expectations. As he was moving closer to the possibility of

“coming out” to his parents, the therapist facilitated the decision-making process by assessing pros and cons, planning the timing, discussing the possible consequences, modeling assertive communication, and providing psychoeducation.

The therapy then moved to the interpersonal module, which was designed to evaluate interpersonal relationships and to explore how they affect mood. Leonardo began to actively differentiate himself from his parents. He was also recognizing difficulties in their communication, particularly because of the underlying “secret” of his sexual identity. His mother approached him constantly regarding his sexual identity until he finally came out to her. As expected, he felt rejected by his mother.

Leonardo asked for a joint therapy session with his mother. In this session, the therapist tried to inspire comprehension and respect, emphasizing that the two had different personalities and different opinions toward homosexuality. The therapist shared with them information on viewing homosexuality as valid as heterosexuality. They worked on problem-solving and negotiation strategies. It was a difficult time for his mother, but during the next weeks, Leonardo reported that “she acted as if nothing had happened.”

Gradually, Leonardo became more secure with the prospect of communicating his sexual orientation to his father. “Finally, I will be myself ... They said, ‘That’s for girls.’ Well, I like boys.” He affirmed his sexuality and understood that coming out to his parents was being more honest with himself and others. In the last session, Leonardo reported that he believed his father knew: “My father tells me, ‘I am afraid that you’ll mix up modeling with other things, you know, in that world there is a lot of homosexuality. You know that’s bad. You know that’s a sin.’ And I tell him, ‘I know. That’s why I don’t talk to you, because you always reject me.’” Immediately, Leonardo expressed ambivalence, saying, “I want to, but I don’t want to, talk to him.”

Once more, the therapist supported him in evaluating the expectations of his father’s reaction and discussed the pros and cons of coming out. As an example, they evaluated his mother’s response. At first, he believed that she would be hostile, but, in actuality, she did not react with hostility, although she said things that bothered him. His greatest wish was to be accepted by both parents, but he acknowledged, “I don’t know how he will accept me as gay.” Finally, Leonardo confronted his major fear: talking to his father in a closing session about his sexual orientation.

Outcome and Evaluation

Leonardo presented to psychotherapy already accepting his sexual orientation but struggled with heterosexual and gender roles demanded by his parents, his religion, and his culture. At the middle of therapy, he began to differentiate his orientation from that of his parents. He evidenced more personal acceptance and less internalized homophobia. At the same time, identity integration was growing (spiritual, family, and sexual). He decided to talk to his parents, although he feared their reactions. The last therapy session showed a greater integration of his sexual identity—“Finally, I will be me.” Leonardo continued participating in church activities, felt more comfortable with his sexual identity, and was accepted by significant persons in his life.

In the final session, he reported feeling more relaxed, more secure, and happier as a result of therapy. He explained, “I am more open than before.” A structural clinical interview showed that he no longer met criteria for MDD, but he continued to meet criteria for a nonspecified anxiety disorder and for attention deficit disorder

and hyperactivity, predominantly inattentive. Figure 1 summarizes Leonardo's outcomes on symptom scores for depression (CDI and CDRS-R) and dysfunctional thoughts (DAS) from baseline to a year after treatment. Leonardo reported a notable decrease in depression on both measures from baseline to post-treatment. His DAS scores also decreased substantially from baseline to the 1-year follow-up. On a measure of therapeutic alliance (PAS), Leonardo had the highest possible score (70) for all three time-points (weeks 3, 5, and 9), suggesting a high level of agreement between the adolescent and the therapist in relation to therapeutic goals, tasks, and bonds.

Leonardo's perception of family criticism (FEISC-criticism) increased from baseline to a year after treatment. These scores may be indicative of his parents maintaining a disapproving view of his sexual orientation. However, Leonardo improved his self concept during that same time period, suggesting that he was able to accept himself better (as shown in the PHSCS) and that he was capable of demonstrating more involvement in family activities (FEISC-involvement). Additional gains obtained from the CBT included a reduction in his mother's symptoms of depression. Moreover, the marital relationship improved at post-treatment and these gains were maintained at the 1-year follow-up. Overall, these results demonstrate considerable symptomatic relief and improved functioning for the adolescent patient as well as durable benefits for his family members.

Clinical Practices and Summary

The case of Leonardo illustrates how a culturally adapted CBT can maintain fidelity to the protocol while allowing for considerable flexibility in addressing the patient's values, preferences, and contexts. Indeed, a number of efficacy studies now build-in flexibility and some have used the term of "living manuals" (Kendall & Beidas, 2007) to denote the fluidity of the therapeutic process. For example, in the case presented, the thought module was scheduled for four sessions but was delivered in six. Extra sessions were required to handle thoughts and feeling after coming out to his mother, and another joint session with her during treatment. Completing the manual content occurred within 18 sessions, because the patient needed more practice on problem solving skills and communication skills; yet, flexibility of extending the number of session was part of the protocol.

Beyond the content and number of sessions, certain aspects of the CBT merit discussion. A host of factors are obviously associated with positive outcomes in therapy, including the method, the therapist, the relationship, the client, and their optimal combination (e.g., Norcross, 2010). In the case presented, Leonardo's MDD symptoms were associated with his emerging and conflicted gay identity within a conservative Latino Christian family. The therapist confronted this clinical challenge from an ethical perspective. A key issue was awareness and respect for cultural and individual differences, including aspects related to gender identity, ethnicity, religion, and sexual orientation (Trimble, Sharron-del-Rio, & Bernal, 2010). In addition, the therapist's expertise and skill in handling spiritual, family, and sexual minority issues also contributed to a positive outcome. The adolescent's capacity to develop skills in identifying and modifying cognitive distortions, increasing pleasant activities, and improving interpersonal problem-solving strategies certainly contributed to a positive outcome. Nevertheless, these skills are acquired in an interpersonal therapeutic context. Thus, the therapy relationship in which the unspeakable can be voiced without censure and honesty is fundamental.

To conclude, an EBT's can be applied with integrity to the core components of the treatment and also with flexibility to the uniqueness of client characteristics. At times, the use of EBTs and the consideration of the culture, context, and singularity of the person are framed as antagonistic positions. Indeed, these seemingly opposing views can be brought together in the interest of providing optimal care. This case represents an integration of these two positions within the context of a clinical trial where it was possible to individualize the treatment and yet maintain fidelity to the protocol. In this case, the particular manual had been culturally adapted and tested. Yet, beyond the consideration of cultural issues related to the manual, it was possible to individualize the treatment to the special needs of the client. In this regard, the treatment offered exemplified the model of evidence-based psychological practice (APA, 2006), which calls for an integration of the "best available evidence" (p. 272) with clinician expertise and in consideration of individual needs, culture, and characteristics of the client.

Selected References and Recommended Readings

- APA Task Force on Evidence Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.
- Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of Abnormal Child Psychology*, 23, 67–82.
- Bernal, G., Cumba-Avilés, E., & Sáez Santiago, E. (2006). Cultural and relational processes in depressed Latino adolescents. In S. Beach & N. Kaslow (Eds.), *Relational Processes and Mental Health*. Washington, DC: American Psychiatric Press.
- Bernal, G., Jimenez-Chafey, M.I., & Domenech Rodriguez, M.M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice*, 40, 361–368.
- Bernal, G., Padilla, L., Pérez-Prado, E., & Bonilla, J. (1999). La alianza terapéutica: Evaluación y desarrollo de instrumentos [The therapeutic alliance: Assessment and instrument development]. *Revista Argentina de Clínica Psicológica*, 8(1), 69–80.
- Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, 34, 121–131.
- Castro, F.G.I., Barrera, M., & Martinez, C.R. (2004). The cultural adaptation of prevention interventions: Resolving tensions between fidelity and fit. *Prevention Science*, 5(1), 41–45.
- Coyne, J.C., Kessler, R.C., Tal, M., Turnbull, J., Wortman, C.B., & Greden, J.F. (1987). Living with a depressed person. *Journal of Consulting & Clinical Psychology*, 55, 347–352.
- Duarté-Vélez, Y., & Bernal, G. (2008). Suicide risk in Latino and Latina adolescents. In F.T. Leong & M.M. Leach (Eds.), *Suicide among racial and ethnic minority groups: Theory, research, and practice* (pp. 81–115). New York: Routledge.
- Falicov, C.J. (1998). *Latino families in therapy: A guide to multicultural practice*. New York: Guilford Press.
- Goldfried, M.R., & Goldfried, A.P. (2001). The importance of parental support in the lives of lesbian, gay, and bisexual individuals. *Journal of Clinical Psychology*, 57, 681–693.
- Griner, D., & Smith, T.B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 531–548.
- Halpin, S.A., & Allen, M.W. (2004). Changes in psychosocial well-being during stages of gay identity development. *Journal of Homosexuality*, 47(2), 109–126.
- Kendall, P.C., & Beidas, R.S. (2007). Smoothing the trial for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology Research and Practice*, 38(1), 13–20.

- Kovacs, M. (1992). *Children's depression inventory manual*. New York: Multi-Health Systems, Inc.
- McDaniel, J.S., Purcell, D., & D'Augelli, A.R. (2001). The relationship between sexual orientation and risk for suicide: Research findings and future directions for research and prevention. *Suicide & Life-Threatening Behavior*, 31(suppl), 84–105.
- Muñoz, R., & Miranda, J. (1986). *Group therapy manual for cognitive-behavioral treatment of depression*. San Francisco: University of California, San Francisco.
- Piers, E.V., & Herzberg, D.S. (2002). *Piers-Harris Children's Self-Concept Scale (2nd ed.)*. Los Angeles: Western Psychological Services.
- Poznanski, E.O., & Mokros, H.B. (1996). *Manual for the Children's Depression Rating Scale-Revised*. Los Angeles: Western Psychological Services.
- Rodríguez-Soto, N.C., Rivera-Medina, C.L., & Bernal, G. (2007). Development of a scale for family harmony and management skills for parents of Puerto Rican adolescents with depression. Paper presented at the 26th National Institute of Mental Health (NIMH) COR Colloquium in Albuquerque, Nuevo México.
- Rosario, M., Hunter, J., Maguen, S., Gwadz, M., & Smith, R. (2001). The coming-out process and its adaptational and health-related associations among gay, lesbian, and bisexual youths: stipulation and exploration of a model. *American Journal of Community Psychology*, 29(1), 133–160.
- Rossello, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology*, 14(3), 234–245.
- Russell, S.T. (2003). Sexual minority youth and suicide risk. *American Behavioral Scientist*, 46(9), 1241–1257.
- Savin-Williams, R., & Dube, E. (1998). Parental reactions to their child's disclosure of a gay/lesbian identity. *National Council on Family Relations*, 47(1), 7–13.
- Shields, C., Franks, P., Harp, J., McDaniel, S., & Campbell, T. (1992). Development of the family emotional involvement and criticism scale (FEICS): A self-report scale to measure expressed emotion. *Journal of Marital and Family Therapy*, 18, 395–407.
- Spanier, G.B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15–28.
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53, 440–448.
- Toro-Alfonso, J., Varas-Díaz, N., Andújar-Bello, I., & Rosa, L. (2006). Strengths and vulnerabilities of a sample of gay and bisexual male adolescents in Puerto Rico. *Revista Interamericana de Psicología*, 40(1), 55–64.
- Trimble, J., Sharron-del-Rio, M., & Bernal, G. (2010). The itinerant researcher: Ethical and methodological issues in conducting cross-cultural mental health research. In D. Jack & A. Ali (Eds.), *Cultural perspectives on women's depression: Self-silencing, psychological distress and movement to voice* (pp. 73–97). New York & London: Oxford London: Oxford University Press.
- Weissman, A. (1979). The Dysfunctional Attitude Scale. A validation study: A validation study. *Dissertation Abstracts International*, 40, 1389B–1390B. (University Microfilm No. 79-19, 533).