

Development of the Cultural Adaptations Content Checklist: Measuring Cultural Adaptations to Evidence-Based Psychological Interventions for Racial and Ethnic Minoritized Youth

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Disparities in mental health need and service use among racial and ethnic minoritized (REM) youth remain a pervasive public health concern in the United States. Cultural adaptations (CAs) have been put forth as a way to increase the cultural and contextual relevance of evidence-based psychological interventions (EBIs) to improve treatment outcomes among REM youth. Currently, no measure of CAs to EBIs for REM youth in the United States exists in the literature. Using a multistage method, this study sought to develop such a tool, the Cultural Adaptations Content Checklist (CACC). In a previous foundational study conducted via a systematic literature review, authors identified a comprehensive list of existing CAs. In the first two stages, we used a modified Delphi method as a part of which expert practice and research stakeholders ($N = 17$) provided feedback on CA types, definitions, and groupings via survey methodology. In the third stage, we conducted cognitive interviews with a subset of participants ($n = 10$) to assess participant comprehension of the CACC. The final CACC was developed and consists of 36 CA types organized into eight groups. Implications for use of the CACC in research and practice are presented.

Impact and Implications

This research aims to promote the use of cultural adaptations to evidence-based psychological interventions for racial and ethnic minoritized youth with the goal of addressing mental health disparities. Using a multistage method, the present study advances research by developing a tool to measure cultural adaptations.

Keywords: cultural adaptations, racial and ethnic minoritized youth, measure development, evidence-based psychological interventions

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Disparities in mental health symptomatology and service use among racial and ethnic minoritized (REM) youth remain a pervasive public health concern in the United States (U.S.; Alegria et al., 2015). When compared to their White peers, REM youth are at greater risk for developing mental health problems due to a variety of stressors, including higher rates of socioeconomic disadvantage (Williams, 2018), repeated experiences of racism (Castro-Ramirez et al., 2021), and increased exposure to community violence (Santacrose et al., 2021). Such stressors have been linked with higher rates of mental health concerns, including depressive symptoms (e.g., Barry et al., 2022; Tynes et al., 2019), traumatic symptoms (Hatch & Dohrenwend, 2007),

and suicidality (Centers for Disease Control and Prevention, 2021) among REM youth.

Despite this increased risk and high need, REM youth are less likely to access mental health services in comparison to White youth (Lu et al., 2021). Further, when they do access services, REM youth are more likely to drop out of treatment prematurely (de Haan et al., 2018) or to receive inadequate mental health services in comparison to White counterparts (Castro-Ramirez et al., 2021). In addition, despite the promise of schools in reducing barriers to seeking and obtaining mental health services, research has demonstrated that REM youth also tend to underutilize mental health services in school settings (Locke et al., 2017; Whitaker et al., 2018). Current literature has highlighted various barriers to mental health service use among REM youth. These include: (a) adolescent-related barriers, such as severity of impairment; (b) parent-related barriers, such as perceived stigma; (c) provider-related barriers, such as quality of therapeutic relationship; (d) contextual/structural barriers, such as household income and insurance status; and (e) social/cultural related barriers, such as acculturation (Lu et al., 2021).

Many have underscored the importance of considering cultural and contextual factors when addressing disparities in mental health

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problems among REM youth (Cauce et al., 2002; Yasui et al., 2017). Thus, scholars have proposed cultural adaptations (CAs) to evidence-based interventions (EBIs) as one way to make treatment more culturally and contextually relevant and thus more effective for REM populations (Griner & Smith, 2006). In the following, we first review literature on the relevance of EBIs with REM youth, followed by a discussion of CAs to EBIs, including their effectiveness and measurement.

Relevance of EBIs for REM Youth

EBIs targeting a range of mental health problems among children and adolescents have been developed and systematically evaluated (Weisz et al., 2013). Despite their perceived benefits, some have questioned the generalizability and relevance of EBIs to REM youth (Bernal et al., 2009). Specifically, as the majority of research supporting the effectiveness of EBIs has been conducted with White and middle-class populations (La Roche & Christopher, 2008), intervention effectiveness is believed to not have been adequately tested with historically minoritized individuals (Pina et al., 2019). Even when explicitly and purposefully including REM youth, past studies often exclude those who are particularly disenfranchised (i.e., youth experiencing the most severe stressors or facing the most barriers to care; Arora et al., 2017). Further, EBIs have generally embraced Western principles (Huey & Polo, 2008), with insufficient attention to unique barriers to treatment faced by REM youth or limited integration of culturally specific risk and resilience factors and cultural beliefs about mental health and treatment (Castro-Ramirez et al., 2021). Consequently, proponents of the ethnic disparity perspective have underscored the need for culturally informed interventions to more effectively address mental health disparities among REM youth (Bernal et al., 2009).

CAs: A Tool for Improving Outcomes

CAs are defined as “the systematic modification of an evidence-based treatment 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 et al., 2009; pp. 361–362). While promoted as a beneficial method of furthering cultural fit of EBIs, the use of CAs is not without controversy. Arguments for the need for fidelity to EBIs as designed have conflicted with those favoring the need for consideration of culture and context, resulting in a “fidelity-adaptation dilemma” (Castro et al., 2010). Barrera et al. (2017) discussed the CA of EBIs as both a planned (i.e., CAs incorporated during intervention development) and dynamic (i.e., local adaptations made by practitioners during intervention implementation) process to respond to the needs of specific REM populations. Culturally adapted and culturally grounded interventions (i.e., new intervention is designed from the ground up) have been underscored as a way to provide effective care for REM youth populations. While culturally adapted interventions can be developed and implemented to scale more quickly and cost effectively (Holleran Steiker et al., 2008; Okamoto et al., 2014), culturally grounded interventions eliminate the issue of intervention “fit” by purposefully capturing the needs and worldviews of the target population (Castro et al., 2004). Despite potential benefits, critics of culturally adapted interventions highlight the lack of information in the existing literature to guide the adaptation process (Lau, 2006). Given the time and cost intensive nature of

culturally grounded interventions, and the growing disparity in service delivery among REM youth, additional research regarding effective implementation of CAs is warranted.

Meta-analyses examining the effectiveness of culturally adapted interventions suggest that they are more effective than un-adapted versions of the same intervention, other un-adapted interventions, or no interventions (e.g., Benish et al., 2011; Hall et al., 2016). Effect sizes in these studies have ranged from small (Huey & Polo, 2008) to large (Chowdhary et al., 2014), with the majority of culturally adapted interventions reporting moderate to large effect sizes (Rathod et al., 2018). Findings point to differences in effect size based on degree of acculturation, English language ability, age, and homogeneity of treatment groups (Griner & Smith, 2006). Fewer studies have limited their focus to examinations of culturally adapted interventions among youth samples (e.g., Hodge et al., 2010; Jackson et al., 2010; Pina et al., 2019). Among studies with REM youth, culturally adapted interventions have garnered small to medium effect sizes. For instance, Hodge et al. (2010) found that culturally sensitive interventions achieved small effects in the areas of externalizing behaviors among Latino youth. Results from their subsequent meta-analysis revealed small effects for culturally sensitive interventions on substance use among REM youth (Hodge et al., 2012). In their 2010 meta-analysis, Jackson and colleagues found medium effects of culturally sensitive interventions in reducing high-risk behaviors in Black youth. However, the literature indicates mixed findings regarding the effectiveness of culturally adapted interventions when compared to un-adapted EBIs among REM youth populations (Castro et al., 2010; Huey & Polo, 2008). Additional research on CAs for REM youth is thus needed.

CA Types

Scholars have proposed several frameworks guiding the content, or “what” is being adapted (i.e., CA types) of culturally adapted interventions. Bernal et al.’s (1995) ecological validity model (EVM) contends that EBIs can more adequately address the needs of target populations when adapted across the following eight dimensions: (a) language, (b) persons, (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context. Bernal’s EVM model is arguably the most common framework implemented by researchers and practitioners. The psychotherapy adaptation and modification framework, originally created to support CA with newly immigrated Asian American populations, delineates six domains to guide intervention adaptation: (a) awareness of dynamic issues and cultural complexity, (b) inclusion of treatment orientation, (c) integration of cultural beliefs, (d) intentionality of client–therapist relationship, (e) understanding of cultural differences in expression and communication, and (f) awareness of cultural issues of salience (Hwang, 2006). Podorefsky et al.’s (2001) model of essential elements, specifically developed for adapting a preventive intervention for a high-risk urban population, highlights four critical elements to consider in the process of intervention adaptation: (a) expanding the definition of key terms for greater cultural and contextual relevance, (b) improving the flexibility of clinicians, (c) incorporating an ecological approach and building partnerships with caregiver, family, and community, and (d) creating greater awareness of and emphasis on cultural issues. Further, the targeted and tailored approach model outlines five strategies for culturally tailoring interventions: (a) peripheral

strategies (i.e., program and materials appear culturally appropriate and appealing to target populations), (b) evidential strategies (i.e., evidence of the impact of health issue on target population is presented), (c) linguistic strategies (i.e., program and materials provided in native or dominant language of target population), (d) constituent-involving strategies (i.e., staff members share identity characteristics and experiences with the target population), and (e) social-cultural strategies (i.e., discussions of health-related issues are contextualized in the social and/or cultural values of the target population; Kreuter et al., 2003). Last, the surface and deep structure intervention framework asserts that adaptations ought to consider (a) surface structure (i.e., lifestyle elements familiar to the target population, such as places, language, food, etc.) and (b) deep structure (i.e., the impact of cultural, historical, environmental, and psychological factors on presenting problems and help-seeking) factors to make an intervention more acceptable to the target population (Resnicow et al., 1999).

Studies have examined moderation of CAs on outcomes by CA type, with the majority evaluating CA content as defined by Bernal's model (e.g., Smith & Trimble, 2016). Soto et al.'s (2018) analysis indicated that adaptations to the spoken or written language of the intervention resulted in larger (i.e., from small to medium) effect sizes than when that CA was not made. Larger effect size differences were also noted for interventions that were adapted to include goals based on cultural values or cultural metaphors (Smith & Trimble, 2016). Overall, research has found greater impact of interventions on outcomes when there are more (as opposed to fewer) CAs (as defined by Bernal's EVM model; Griner & Smith, 2006; Smith & Trimble, 2016; Soto et al., 2018). Fewer studies have examined the impact of CA types as defined by other frameworks. For example, using Resnicow's model, Escobar and Gorey (2018) found that "deep structure" CAs were more effective than "surface structure" CAs for interventions for depressed Hispanic adults. Thus, research has begun to examine the impact of CA types on intervention outcomes; however, these studies have been restricted by their definitions of CA types and/or the guiding frameworks used.

Measurement of CAs

There is a lack of standardization in how researchers define CA types, as well as a high degree of variability in how they practically apply the aforementioned frameworks when developing culturally adapted interventions (Rathod et al., 2018). In response, a recent systematic review of the literature on CAs to youth mental health interventions in the United States sought to create a list of CA types (i.e., including a name, definition, and examples) used in culturally adapted interventions for REM youth (Arora et al., 2021). Notably, only 50% of studies reported using a CA framework to guide the content of intervention adaptation, with Bernal et al.'s (1995) EVM cited as the most commonly used framework (i.e., 26.9% of studies). Across all studies included in the review, Arora et al. (2021) identified 43 unique CA types via a coding procedure. Further, studies ranged in using between 2 and 19 distinct types of CAs, often with limited details about the content of and the rationale for particular adaptations. This review examined the content of CAs with the highest degree of specificity to date. However, the lack of standardization in reporting culturally adaptations contributes to challenges in evaluating the impact of culturally adapted interventions.

To date, no guidance exists on the quantity of CAs required for "adequate" and effective adaptation. Further, researchers have yet

to standardize how CA types are labeled and defined, as well as how to report the features of and rationale for CA types (Arora et al., 2021), which has presented challenges with evaluating the quality of CAs in a standardized manner (Rathod et al., 2018). Accordingly, guidance is needed in applying CA types in practice when developing, evaluating, and improving the implementation fidelity of culturally adapted interventions in response to the changing needs and heterogeneity of REM populations (Gonzales, 2017).

The Present Study

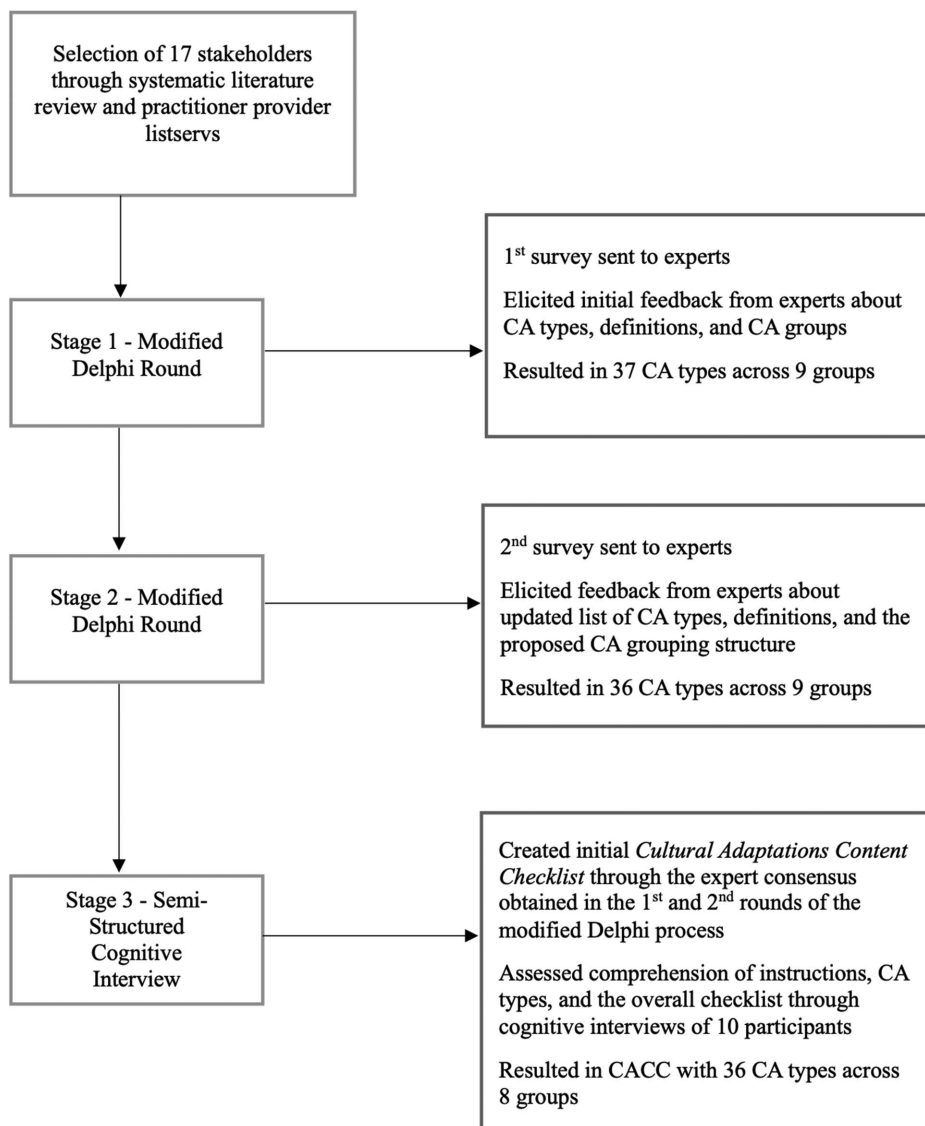
Despite the proliferation of theory to guide the adaptation of mental health interventions for REM youth, *no measure of cultural adaptation exists* in the literature. Such a tool could be applied proactively to determine the types of CAs an intervention may require, while also being used retrospectively to determine whether a program has been sufficiently adapted to a target population. Thus, researchers and practitioners need a tool that can bridge the gap between the rich conceptual foundation in the literature and the practical steps researchers and practitioners must take to culturally adapt EBIs for REM children and families. Accordingly, the goal of the present study was to develop a checklist to serve as a blueprint for future consensus-building research projects related to the CA of EBIs, as well as guide the development and implementation of culturally adapted EBIs within the field of youth psychological interventions.

Method

This study employed a multistage process to develop the Cultural Adaptations Content Checklist (CACC) measure. First, in a previous foundational study (Arora et al., 2021), the research team, including the principal investigator and three graduate student research assistants, conducted a systematic literature review to create a comprehensive list of existing CA types and definitions. Next, in the present study, the research team used the Delphi method, a consensus-building approach that gathers input from expert practice and research stakeholders, for Stages 1 and 2 (McMillan et al., 2016). Stages 1 and 2 involved data collection via surveys to obtain feedback from expert stakeholders, with data analyzed between each stage to inform the generation of the next round of data collection. The third stage involved cognitive interviewing, a technique that incorporates "think-aloud" procedures to assess participant comprehension of the developed measure (Willis, 2005). The Delphi method incorporated in Stages 1 and 2 was used to guide consensus building around the CA content types, while the cognitive interviewing procedure in Stage 3 was used to evaluate and improve the clarity of the items and the overall use of the measure; see Figure 1. Approval was obtained from all relevant institutional review boards.

Positionality Statement

The intersectional identities and personal and professional experiences of the research team have informed the research process. The first author self-identifies as a cisgender female of South Asian descent. Her perspectives as a scholar are informed by her immigration history, as well as those of her multilingual background. The second author identifies as a cisgender female of South Asian and European descent. Her perspectives as a researcher are informed by her upbringing in a multicultural context with limited mental health literacy, as well as

Figure 1*Flow Diagram of Delphi Process and Checklist Creation*

Note. CA = cultural adaptation; CACC = Cultural Adaptations Content Checklist.

experiences as an educator and school psychology doctoral student providing services to REM youth and families. The third author identifies as a White, cisgender female of European descent. Her research is informed by her lived experience growing up in an environment with a limited understanding of mental health, coupled with her training as a doctoral student in a school psychology program. The fourth author identifies as a multiracial, cisgender, male immigrant specializing in psychological and educational research. He was born and raised in an area with limited access to mental health resources and substantial stigma surrounding mental health treatment. The fifth author identifies as a Black and Puerto Rican cisgender female. Her research interests are driven by her experiences growing up in a densely populated urban environment where there was significant stigma surrounding mental health treatment as well as a lack of mental

health services that adequately addressed the needs of children and families of color. The sixth author identifies as a White, cisgender female of European descent. Her research interests, which focus on equity, disparities, mental health, and system-level change, are informed by her experience growing up in a working poor family. The intersectional identities and personal and professional experiences of the research team informed the research process.

The research team aimed to be cognizant of their subjectivity by conferring with and offering feedback to one another in collaborative discussions throughout the research process. While working with data, the team remained mindful of their intersectional identities to reduce potential biases when discussing the inclusion, exclusion, and/or explanation of different CAs. The team's positionalities allowed for nuanced perspectives in discussions. However, it is critical to

acknowledge that there is a lack of representation from certain REM backgrounds on the research team.

Stages 1 and 2

Participants

Stakeholders ($N = 17$), with expertise in the CA of mental health interventions for youth, participated in Stages 1 and 2 of the study. Stakeholders included practitioners ($n = 10$) and researchers ($n = 7$). Participants were primarily female ($n = 13$; 76.47%) and White ($n = 11$, 64.70%); smaller number of participants identified as African American/Black ($n = 2$, 11.76%), Latinx ($n = 1$, 5.88%), Asian/Pacific Islander ($n = 2$, 11.76%), and Native American/American Indian/Alaskan Native ($n = 1$, 5.88%). See Table 1 for additional demographics collected via the demographic survey. One practitioner opted not to complete Stage 2.

Procedure

Practitioners were recruited via email through national provider listservs. Inclusion criteria for practitioners included having at least 3 years of clinical experience as a mental health provider involved in the implementation of evidence-based psychological interventions with client/patient groups not originally or overtly included in the development and testing of those interventions. The team identified researchers who had published articles included in a previous comprehensive systematic literature review of culturally adapted psychological interventions for minoritized youth (Arora et al., 2021), as well as through a google scholar search using relevant key terms. Inclusion criteria for researchers included having published, as the first author, at least two peer reviewed articles, book chapters, or books on CAs of psychological interventions for youth. Efforts were made to diversify the sample, though in the end a convenience sample was used. Prospective participants completed an eligibility survey to

Table 1
Demographic Characteristics of Participants

Demographic variable	Stages 1 and 2		Stage 3	
	Researcher <i>n</i> (%)	Practitioner <i>n</i> (%)	Researcher <i>n</i> (%)	Practitioner <i>n</i> (%)
Gender				
Female	6 (85.71%)	7 (70%)	4 (80%)	5 (100%)
Male	1 (14.29%)	3 (30%)	1 (20%)	0 (0%)
Race/ethnicity				
African American/Black	1 (14.29%)	1 (10%)	1 (20%)	0 (0%)
Latinx/Hispanic	1 (14.29%)	0 (0%)	1 (20%)	0 (0%)
Asian/Pacific Islander	2 (28.57%)	0 (0%)	0 (0%)	0 (0%)
Native American/American Indian/Alaskan Native	0 (0%)	1 (10%)	0 (0%)	0 (0%)
White	3 (42.86%)	8 (80%)	3 (60%)	5 (100%)
Years of experience				
0–5 years	0 (0%)	4 (40%)	0 (0%)	2 (40%)
6–10 years	0 (0%)	4 (40%)	0 (0%)	2 (40%)
11–15 years	0 (0%)	0 (0%)	0 (0%)	0 (0%)
15+ years	7 (100%)	2 (20%)	5 (100%)	1 (20%)
Speaks additional language				
Yes ^a	4 (57.14%)	1 (10%)	3 (60%)	0 (0%)
No	3 (42.86%)	9 (90%)	2 (40%)	5 (100%)
Practitioner location ^b				
University		1 (10%)		1 (20%)
Hospital		1 (10%)		0 (0%)
Inpatient services		0 (0%)		0 (0%)
Outpatient services		6 (60%)		3 (60%)
School		5 (50%)		4 (80%)
Private practice		3 (30%)		1 (20%)
Other ^c		2 (20%)		1 (20%)
Practitioner degree				
PhD		3 (30%)		1 (20%)
PsyD		1 (10%)		0 (0%)
MSW		5 (50%)		3 (60%)
Other ^d		1 (10%)		1 (20%)
Practitioner field				
Psychology		5 (50%)		2 (40%)
Social work		5 (50%)		3 (60%)

Note. Percentages may not add up to 100 due to rounding.

^a Additional languages spoken include Spanish, French, Italian, Mandarin, Taiwanese, Cantonese, and Haitian Kreyol. ^b Participants selected multiple options for this characteristic. Percentages may not add up to 100. ^c The “other” classification represents two practitioners who reported working in “nonprofit agencies.” ^d The “other” classification represents a practitioner who reported having a masters’ level practitioner degree with an expected PhD in the near future.

confirm they met the inclusion criteria and to express interest in participating in the study. We collected informed consent at the beginning of Stage 1.

Stage 1

Step 1

Stage 1 consisted of five steps. In Step 1, an initial survey was sent to participants via email. The survey included a consent form, a demographic form, and a questionnaire eliciting feedback on a comprehensive list of 42 CA types gathered from a systematic literature review (Arora et al., 2021). Participants reviewed and provided feedback on the initial list of CA types by (a) indicating whether the type was a CA (response options: yes, no); and (b) evaluating the definition of the CA type (response options: well defined; definition needs revision), with an option to edit the definition. Participants also had the option of (c) adding, as needed, extra CA types that were missing from the original list of 42 CA types. Participants then (d) grouped the CA types into categories, forming a maximum of 10 groups.

Step 2

Following the dissemination and collection of Stage 1 survey responses, the research team engaged in the data analysis process. The research team utilized a consensus criterion established from prior literature reviews, defined as participants reaching 70% agreement on a survey type (Cadorin et al., 2016). Thus, in Step 2, the research team analyzed part (a) of the survey, retaining all CA types if the listed type was confirmed to be a CA type by at least 70% of participants. Next, all CA types for which there was at least 70% agreement that the listed type was not a CA type, or where there was no consensus reached (<70% agreement), were reviewed by the research team. The team reviewed discrepancies between researchers' and practitioners' decisions regarding these CA types. When all of one participant group reached consensus while the other participant group did not reach consensus (e.g., 100% of researchers selected "Yes" while only 60% of practitioners selected "Yes"), the team retained the CA type. Otherwise, CA types with discrepant ratings (<70% agreement) or with participants reaching consensus selecting "No," were excluded from subsequent rounds.

Step 3

Following the analysis of the list of CA types, in Step 3, the research team analyzed part (b) of the survey, retaining definitions of CAs (with minor edits as needed) for all CA types that were rated as "well defined" by at least 70% of participants (Cadorin et al., 2016). The research team reviewed all other CA types whose definitions did not meet consensus for being "well defined." Using a consensus-building process (McMillan et al., 2016), and addressing one CA at a time, the research team discussed all participant comments and engaged in a round-robin process of sharing ideas and feedback until 100% agreement was met concerning a revised CA definition.

Step 4

Next, the research team analyzed part (c) of the survey by examining the new CA types proposed by stakeholders. The research

team engaged in a similar consensus-building process as described above (McMillan et al., 2016), discussing all participant suggestions for extra CA types and their definitions and engaging in a round-robin process of sharing ideas and feedback until 100% agreement was met. Further, the research team created definitions in this same manner if the participant did not propose a definition.

Step 5

Following the inclusion or exclusion of newly proposed CA types, the research team engaged in Step 5, evaluating the grouping of the CA types in part (d) of the survey. To analyze the grouping of the CA types, the research team examined the frequency that participants paired CAs together. Using a consensus-building process (McMillan et al., 2016), the research team analyzed all themes of the groupings (by, e.g., discussing CAs that were grouped together over 50% of the time by stakeholders), proposed their own CA groups and group names, and engaged in a round-robin process of sharing ideas and feedback until 100% agreement was met on a proposed grouping structure.

Stage 2

Stage 2 consisted of six essential steps. In Step 1, an updated survey was sent to participants via email. The survey elicited feedback on an updated list of 37 CA types. Participants were asked to review and provide feedback on the updated list of CA types by (a) indicating whether the listed type was a CA (response options: yes, no); and (b) evaluating the definition of the CA type (response options: well defined; definition needs revision), with an option to edit the definition. Participants also had the option of (c) adding, as needed, extra CA types that were missing from the original list of 37 CA types. Participants then (d) provided feedback on the research team's proposed groups by indicating if they agreed with the grouping (response options: yes, no), and, if not, to edit the proposed groups and the group name as needed.

In Stage 2, the research team utilized the same data analysis procedures as Stage 1 for examining, retaining, and/or revising the (a) CA types in Step 2 and (b) definitions in Step 3. Further, the process for analyzing extra CA types (c) in Stage 1 was also utilized in Step 4. Subsequently, in Step 5, the research team examined the percentage of participant agreement with the proposed groups in order to analyze (d) the grouping of the CA types. The team discussed all groups, though focusing particularly on groups with <70% agreement. Using a consensus-building process (McMillan et al., 2016), the research team analyzed the proposed changes to the CA groupings and/or group names, proposed their ideas for modifications of CA groups, and engaged in a round-robin process of sharing ideas and feedback until 100% agreement was met on a grouping structure.

Based on these analyses, in Step 6, the research team developed an initial draft of the CACC. The CACC included 36 CA types and their definitions in nine groups. During this step, the research team also prepared the CACC for dissemination, including adding instructions and formatting the instrument. The initial CACC proposed a 3-point Likert scale for participants to take note of the inclusion of a CA (response options: yes, no, N/A). The N/A option was included as not every CA is relevant to every intervention or target population.

Stage 3

Participants

Participants included 10 randomly selected stakeholders ($n = 5$ practitioners, $n = 5$ researchers) from Stages 1 and 2. Participants were primarily female ($n = 9$; 90%) and White ($n = 8$, 80%). See Table 1 for demographics.

Procedure

Based on Willis (2005), the research team developed a cognitive interview protocol with guiding questions about the CACC instructions and CA types. Members of the research team piloted the protocol with graduate students in counseling fields and practiced coding example responses from these respondents. (See Supplemental Material for cognitive interview protocol.) Stage 3 consisted of four steps. In Step 1, participants were prompted to complete the measure by thinking of an existing culturally adapted intervention and verbalizing their thought process aloud as they responded to each CA type. During this process, a research team member evaluated the participant's comprehension of each CA type (i.e., 1 = poor/different, 2 = partial, 3 = full) and the logic of their response (i.e., 1 = poor logic, 2 = satisfactory, 3 = good logic). The team member included CA-specific prompts as needed to gather additional participant feedback. Interrater reliability was not collected due to the small sample size and that the resulting information would not be as practically meaningful. Instead, data were analyzed qualitatively, evaluating data in terms of benchmarks and looking for patterns in the ratings (Peterson et al., 2017). Furthermore, in Step 2, the research team prompted the participant for their feedback on the overall utility of the CACC at the conclusion of the interview.

Following the conclusion of the cognitive interviews, the research team engaged in Step 3, in which descriptive data on the CAs were qualitatively reviewed. Any CAs having a comprehension or logic score below 2.5 were discussed. This cutoff was chosen as a conservative option after visual inspection of a scree plot indicating a gap between scores below and above a cut point of 2.5. Specifically, in a similar consensus-building process as was described above (McMillan et al., 2016), the research team reviewed all participant comments and engaged in a round-robin process to finalize CA type wording until 100% agreement was met among the research team. Finally, in Step 4, the research team analyzed participant responses to overall questions regarding the CACC organization, presentation, and utility. The team engaged in a round-robin discussion to come to a 100% agreement on incorporating further enhancements to the CACC overall.

Results

Stage 1

Of the 42 CA types included in Stage 1, six received less than the 70% threshold for consensus as a CA type and were thus removed from the measure. For three, experts expressed that the CA types were more reflective of "good clinical work." The team removed two additional CA types as participants remarked that there were overlapping similarities to other CA types incorporated in the survey. Finally, two CA types were combined as they both referred to matching clinicians and clients on some personal characteristics. Ultimately, 32 of the 42 (76.19%) CA types were retained.

Of the 32 CA types retained following the Stage 1 analysis, only one CA type's definition scored below the 70% threshold used for consensus. The team edited this CA type's definition as per participant suggestions, to specify that employment of the CA should be based on the need, interest, or preference of the client. Revisions to the remaining definitions consisted primarily of minor structural edits to improve clarity, and the addition of terms to emphasize that any changes made to the intervention, such as the translation of an assessment measure, should be done appropriately to maintain the validity of the intervention component. For example, the team edited the definition, "Refers to translating the verbal components of the original treatment from English to the clients' language. Includes the use of a translator" to avoid assuming that the original treatment was written in English and to specify that the translator should be qualified.

Participants proposed 15 additional CA types for inclusion during Stage 1. Five (33.33%) participant-suggested CA types were rejected as they either overlapped with an existing CA type or were not considered CAs to mental health interventions, as defined by the research team. Of the remaining 10 participant-suggested CA types, four were directly included in the Stage 2 survey, with appropriate edits made to the CA phrase and definition, while the remaining six were integrated into original Stage 1 CA types through examples and specific phrases.

With regards to grouping, nine unique groups arose from the data. Group names included "language," "culturally relevant risk, protective factors, and goals," "culturally familiar elements," "cultural values, traditions, and beliefs," "logistics," "culturally informed treatment," "family and community supports," "therapeutic relationships," and "evaluation." The Stage 2 survey thus included a total of 37 CA types across nine groups.

Stage 2

Of the 37 CA types included in Stage 2, three (9.38%) received less than the 70% threshold for consensus as a CA type. Two of the three CAs (one pertaining to the length of the intervention and the other pertaining to the format) were removed from the measure, while the remaining one, "incorporated traditional healing approaches or local remedies," was retained. This was due to agreement among the research team that the literature provided sufficient evidence that this type should be regarded as a CA (Baker-Ericzen et al., 2012; BigFoot & Schmidt, 2010). Further, this CA type reached consensus among researchers (85.71%).

Of the 35 CA types retained, only one CA type's definition scored below the 70% threshold used to obtain consensus. The definition of this CA type, "translated written materials of the intervention" was edited, per participant suggestions, to specify additional examples and that the changes to the original materials should be valid. As in Stage 1, the remaining revisions consisted primarily of minor edits to the structure or syntax of the definition to improve clarity.

Participants suggested nine additional CA types during Stage 2. Six (66.67%) participant-suggested CA types were rejected as they either overlapped with an existing CA type or were not considered CAs to mental health interventions, as defined by the research team. Of the remaining three participant-suggested CA types, one was directly included in the checklist, with appropriate edits made to the CA phrase and definition, and two were integrated into original CA types to clarify their definitions and examples.

Of the nine groups presented to participants in Stage 2, only one (11.11%) received less than the 70% threshold for consensus. Per participant suggestions, this CA group, previously referred to as “culturally informed treatment,” was edited by removing one CA type, “enhanced dosage or intensity of skills training for unfamiliar, novel skills,” and placing it into the group previously referred to as “logistics.” The team further edited the “logistics” group by removing the two CA types that failed to meet the threshold for consensus as a CA type. Finally, the “culturally relevant risk, protective factors, and goals” group was edited by adding the participant-suggested CA type, “addressed the social and/or political context.”

Finally, while all group names obtained consensus, the team edited five names (55.56%) in line with participant suggestions to better reflect the CAs included in the group. For example, the group name “therapeutic relationships” was changed to “therapeutic relationships and interpersonal processes” as participants characterized the initial group name as too narrow and insufficiently descriptive. Altogether, at the end of Stage 2, the draft checklist contained 36 CA types organized into nine groups.

Stage 3

Of the 36 CA types included in the checklist in Stage 3, four (11.11%) had comprehension and/or logic scores below the cut point. The research team made minor edits guided by participant comments to these four CA types; these edits consisted primarily of grammatical changes to improve clarity of the CA type or the provision of more examples of the CA type. See Table 2 for a summary of the comprehension and logic scores for each CA type.

In response to direct queries during the cognitive interviews, participants expressed approval of the order of the CA groups and the nine group names, with minimal suggestions offered. The team ordered CA types within each group based on the sequence the CAs might occur in during the delivery of an intervention. In addition, a group referred to as “treatment engagement” during the cognitive interviews was combined with the group “tailoring intervention delivery to target population needs.” The research team elected to combine these two groups as they contained related CA types that could be represented under the latter’s group name. Thus, at the

Table 2
Average Comprehension and Logic Scores From Semistructured Cognitive Interviews

Cultural adaptation type	Comprehension score	Logic score
	<i>M (SD)</i>	<i>M (SD)</i>
CA1: Translate the spoken language of the intervention	2.9 (0.3)	2.9 (0.3)
CA2: Translate written materials of the intervention	2.8 (0.6)	2.9 (0.3)
CA3: Adjust literacy level	2.7 (0.7)	2.7 (0.7)
CA4: Reduce the focus on tasks requiring literacy	2.8 (0.4)	2.7 (0.5)
CA5: Translate assessment measures	2.9 (0.3)	2.8 (0.6)
CA6: Request clients’ language preferences	3.0 (0.0)	3.0 (0.0)
CA7: Use culturally appropriate and syntonic language	2.8 (0.4)	2.6 (0.8)
CA8: Incorporate culturally relevant risk factors	2.9 (0.3)	2.8 (0.4)
CA9: Incorporate culturally relevant strengths or protective factors	3.0 (0.0)	3.0 (0.0)
CA10: Address culturally relevant goals	2.1 (0.6)	2.1 (0.7)
CA11: Address the social and/or political context	2.8 (0.4)	2.6 (0.7)
CA12: Incorporate culturally relevant examples, scenarios, and/or stories	2.9 (0.3)	2.8 (0.4)
CA13: Use culturally relevant symbols and/or images	2.6 (0.7)	2.6 (0.7)
CA14: Adapt materials to visually represent clients and their communities	3.0 (0.0)	3.0 (0.0)
CA15: Use culturally familiar formats and activities	2.8 (0.4)	2.7 (0.7)
CA16: Incorporate cultural lifestyle elements	2.9 (0.3)	3.0 (0.0)
CA17: Incorporate cultural values and traditions	2.8 (0.4)	2.7 (0.7)
CA18: Incorporate traditional healing approaches or local remedies ^a	2.9 (0.3)	2.6 (0.7)
CA19: Incorporate religious or spiritual elements	3.0 (0.0)	2.9 (0.3)
CA20: Change the delivery setting	2.9 (0.3)	2.4 (0.8)
CA21: Provide extra services	3.0 (0.0)	3.0 (0.0)
CA22: Provide additional psychoeducation about mental health treatment	2.5 (0.5)	2.5 (0.7)
CA23: Enhance dosage or intensity of skills training for unfamiliar, novel skills	2.5 (0.8)	2.6 (0.7)
CA24: Select intervention components	2.7 (0.7)	2.7 (0.5)
CA25: Address shame and/or stigma related to mental health or treatment	2.9 (0.3)	2.8 (0.4)
CA26: Involve family in the intervention	2.9 (0.3)	2.8 (0.6)
CA27: Involve community supports/networks in the intervention	2.8 (0.4)	2.9 (0.3)
CA28: Add culturally relevant training for clinicians	2.9 (0.3)	2.9 (0.3)
CA29: Incorporate culturally informed therapeutic relationship techniques ^a	2.8 (0.4)	2.6 (0.7)
CA30: Match clinician and clients based on aspect(s) of identity	2.8 (0.6)	2.7 (0.7)
CA31: Address differences in aspect(s) of identity among group members	2.3 (0.8)	2.5 (0.8)
CA32: Use culturally informed assessment measures in the evaluation	2.6 (0.7)	2.7 (0.7)
CA33: Adapt the format of the evaluation	2.6 (0.5)	2.5 (0.5)
CA34: Assess clients’ pretreatment values, attitudes, and beliefs	2.9 (0.3)	2.6 (0.7)
CA35: Change targets of the evaluation	2.6 (0.7)	2.7 (0.7)
CA36: Adapted definition of treatment progress or success	2.6 (0.5)	2.4 (0.7)

Note. This table demonstrates the average comprehension and logic scores for each of the CA types, on a scale of one to three.
CA = cultural adaptation.

^a One participant did not receive a logic score for this CA type due to lack of information.

conclusion of the CA type and grouping analyses, the checklist contained 36 CA types organized into eight groups.

Next, participants commented on the CACC's organization and presentation. The average comprehension score for the checklist instructions was relatively high ($M = 2.7$, $SD = 0.5$). The research team made minor edits to the instructions as per participant feedback. In particular, instructions were modified to clarify the term "target population" and to define the term "Delphi technique." In addition to obtaining input regarding the instructions, wording of the CA types, definitions, and group names, the research team asked participants about certain elements of interest to the researchers. This included the use of the word "client" in the checklist, which the majority of respondents preferred (over participant or patient for example), and was ultimately retained. This also included feedback on the response choices. Six participants (60%) suggested the inclusion of additional response options to allow participants to indicate that a CA was implemented to different degrees. Based on this feedback, as well as that utilizing a five-point Likert scale would allow for stronger statistical analysis in future research, a five-point Likert scale was incorporated with response options: not at all, a little, somewhat, a lot, completely, N/A. The research team kept the original 3-point scale (response options: yes, no, N/A) for CA6 and CA20 since those adaptations cannot be partially implemented. Given that not every CA applies to every intervention or target population, the N/A response option remained for every item to signify that if selected, the item should be removed from the total number of CAs measured for a culturally adapted intervention. The team edited the instructions appropriately to reflect the new response options.

Finally, in order to obtain a comprehensive understanding of the potential implementation of this tool in research and clinical practice, participant feedback on the overall utility of the checklist was sought and resulted in the following additional potential uses: (a) in assisting intervention developers/adapters in considering the variety of potential CA types for an EBI; (b) in training developing practitioners/trainees learning how to implement culturally adapted interventions; and (c) in generally promoting greater awareness of culturally informed care and racial equity in treatment. Altogether, the final checklist, following Stage 3, contained 36 CA types across eight groups. See the [Supplemental Material Tables S1–S3](#) for a list of all CAs at the various stages. Also see the final checklist in the [Supplemental Material](#) linked at the end of this publication.

Discussion

With the goal of supporting the increased standardization of CA types and guiding the adaptation of EBIs to better address the needs of REM youth and families, this study sought to develop a checklist to measure CA types to culturally adapted EBIs for REM youth populations in the United States. Building on our previous systematic literature review (e.g., [Arora et al., 2021](#)), we used a multiphase approach to obtain consensus on a comprehensive list of CA types. The final measure, the CACC, includes 36 CA types grouped into eight categories, with detailed instructions on its potential uses.

With this checklist, we sought to address gaps in the existing literature. In particular, the CACC contributes to efforts to provide common language across theoretical frameworks guiding the CA of EBI for REM youth and families. Further, we sought to guide intervention developers and researchers to consider the breadth of

CA types that may be integrated into a treatment based on need with the CACC. The CACC adds to the existing literature on CAs to EBIs, which has provided detailed justification for the need for CAs, frameworks guiding their application, meta-analyses evaluating their use, and calls for additional research supporting their thoughtful and scientifically valid application.

As outlined above and in the CACC itself, various potential uses of the CACC exist. Specifically, the CACC could be used in the process of intervention adaptation and applied proactively to determine the CA types to make to an EBI. The use of the CACC in this manner might encourage the developer to consider the inclusion of CAs that may have previously been overlooked or not considered for a variety of reasons. Further, the CACC may also be used retrospectively to determine whether a program's adaptations are sufficient for a target population. This may involve determining which individual or combination of CAs are most linked to outcomes, thus encouraging more intentionality and specificity in the process of culturally adapting EBIs. Indeed, in light of the complex relationship between treatment fidelity and adaptation ([Anyon et al., 2019](#)), the CACC may prove beneficial in clarifying whether some CAs potentially improve the effectiveness of an intervention for certain REM youth, while others potentially reduce this effectiveness. Critically, the adoption of CACC language and definitions may support a greater standardization in reporting of CA types and allows for increased systematized evaluation of culturally adapted interventions in the future. Such an effort may also improve training in the practice of CAs to EBIs. Future efforts to achieve the above goals will involve additional research on the CACC, including evaluating the psychometric properties of the checklist. This includes the calculation of item-level descriptive statistics, interitem and subscale correlations, internal consistency reliabilities, and a confirmation of the factor structure. Despite this, the CACC contributes to literature within the field of CA research while also providing a strong example of the measure development process. In our efforts to address mental health disparities among REM youth, we aspire for the CACC to contribute to efforts in highlighting the critical need to consider culture and context in the delivery of psychological interventions.

Limitations and Constraints to Generalizability

Despite the contributions of the CACC, several limitations exist. First, despite efforts to recruit participants with diverse identities, participants in the Delphi process were predominantly White and female. A recent analysis of the demographics of the psychology workforce reported that 86% of the clinical child and adolescent practitioners were White, thus illustrating the challenge of recruiting diverse practitioners in a field lacking diversity ([University of Michigan Behavioral Health Workforce Research Center, 2020](#)). Further, both the fields of school and clinical child psychology have noted limited diversity among U.S.-based researchers within their profession ([American Psychological Association, 2022](#)). In addition, while this study aimed to include equivalent groups of expert stakeholders, the sample consisted of more practitioners than researchers. It should be noted that recruitment occurred during the summer of 2020, which overlapped both with the COVID-19 pandemic and call to action for racial justice following the murders of several unarmed Black individuals. Researchers of color were noted to be facing disproportionate levels of burden (e.g., unequal

workload expectations from the invisible labor of leading diversity, equity, and inclusion related projects at their institutions; Melaku & Beeman, 2023), which may have limited their ability to participate in additional research activities. Future studies may seek to use stratified purposeful sampling to ensure that that appropriate numbers of individuals from various groups are represented. Further, while researchers gathered data on the representativeness of CA types and the accuracy of their definitions, the relative importance of each CA type is not currently known. Using the CACC, future research might seek to analyze the relative importance of CA types as linked to improvements in outcomes. In addition, this research team developed the CACC for use from a broader range of culturally adapted psychological interventions, including within the context of schools. Considering the critical role of school-based interventions delivering mental health treatment to youth populations, data on its use within schools in particular should be gathered. Further, a lack of consensus on guidelines for using the Delphi method exists. Though our efforts fall in line with reports of recommended use of this methodology (Diamond et al., 2014), additional rounds of consensus-building or a larger group of expert stakeholders may have resulted in increased consensus around the final measure CA types, definitions, and groupings. Relatedly, interrater reliability for quantitative items on the cognitive interview protocol were not calculated; instead, a qualitative analysis of responses (as described above) was calculated. Finally, we observed that it was easier for researchers to conceptualize the potential use of the measure, with practitioners requiring more guidance throughout the data collection before responding to prompts. This may have impacted the quality of responses provided and may reflect our background as primarily scholars in the field of culturally adapted interventions with REM youth.

Conclusion

With an awareness of the value of CA, we present here efforts to further the use of CAs to EBIs for REM youth. With current evidence being limited in offering an answer to the question of which types of CAs are most effective (for whom and under which circumstances), we seek to provide improved clarity in defining CA types and supporting standardization in their use. Overall, we seek to support efforts to address mental health disparities among REM youth and families in the United States. We anticipate that the CACC will provide one approach to achieving this goal. Further, we hope that our efforts may serve as a blueprint for future consensus-building research projects within the field of youth psychological interventions.

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