
Cultural Competence and Evidence-Based Practice in Mental Health Services

A Complementary Perspective

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The need for cultural competence and the need for evidence-based practice in mental health services are major issues in contemporary discourse, especially in the psychological treatment of people of color. Although these 2 paradigms are complementary in nature, there is little cross-fertilization in the psychological literature. The present article illustrates the complementary nature of these 2 paradigms. A main point of convergence is related to the development of culturally adapted interventions in the move from efficacy research to effectiveness studies. The implications of cultural adaptations of empirically supported treatments for mental health services in terms of research and practice with ethnic/racial minority populations are discussed.

Keywords: cultural competence, effectiveness studies, ethnic/racial minority populations, evidence-based practice, mental health services

Two major issues in contemporary discourse on the delivery of mental health services are (a) how to make these services more culturally competent and (b) how to implement evidence-based practices in real-world settings. At first glance, it would appear that these two questions are hardly ever raised in the same discussion. However, close inspection reveals significant scientific and clinical overlap. Failure to recognize this overlap may be due to the lack of research devoted to the development of culturally competent evidence-based practices.

G. Bernal and Scharrón-del-Río (2001) asked the question, "Are empirically supported treatments valid for minorities?" Atkinson, Bui, and Mori (2001) questioned whether the term *multiculturally sensitive empirically supported treatments* is an oxymoron. Both questions were raised, in part, to draw attention to the inadequate representation of members of ethnic/racial minority groups in studies of evidence-based treatments. Moreover, G. Bernal and Scharrón-del-Río pointed out that the qualitative research often used with ethnic/racial minority populations could enhance empirically supported treatments that tend to have a quantitative focus. Atkinson et al. concluded that empirically supported treatment and multicultural counseling have "fairly distinct and somewhat antithetical goals" (p. 570) and called for reconciliation in the new millen-

nium. The rhetoric notwithstanding, however, a close inspection of the challenges, concerns, and recommendations coming out of the ongoing debates about the future of mental health care reveals that both factors are essential to improvements in service delivery, especially for populations of color. Moreover, we believe that critical discussions of cultural competence and evidence-based practice reflect two paradigms that are very complementary.

The purpose of this article is to illustrate the complementary nature of the needs for culturally competent and evidence-based approaches to mental health service provision. First, we briefly review the literature on cultural competence to highlight definitions and guidelines for practice as critical elements. Second, we briefly review the literature on evidence-based practices with emphasis on definitions and variables related to effectiveness research. The brevity of these reviews is to get to the heart of the issues, hopefully without engaging in selection bias in terms of the literature surveyed. We expect these essential issues to be points of convergence in the two paradigms. Third, we discuss these complementary elements of the two paradigms. Finally, in the conclusion we address the implications of the complementary features of cultural competence and evidence-based practice for future mental health services.

Cultural Competence in Mental Health Services

Definitions of Culture and Cultural Competence

We define the concepts of culture and cultural competence to place the discussion in proper perspective. In this brief review of the literature, we focus on those concepts. Guarnaccia and Rodriguez (1996) noted the inadequate attention, both in practice and in the literature, devoted to conceptualizing culture within the development of culturally competent mental health services. We agree that a

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definition of culture is an important first step in planning culturally competent mental health services. Because culture has been defined in various ways, a more efficient approach would be to identify the essentials of the construct. We believe that an apposite model of culture can be derived by assembling these key aspects.

Culture. Most definitions of culture emphasize the intergenerational transmission of traditions, ways of living, coping behaviors, values, norms, and beliefs (H. Betancourt & López, 1993; Guarnaccia & Rodriguez, 1996; Howard, 1991; Miranda, Nakamura, & Bernal, 2003; Thompson, 2005; Whaley, 2003). Guarnaccia and Rodriguez (1996) defined culture as a “dynamic and creative phenomenon, some aspects of which are shared by large groups of people and other aspects which are the creation of small groups and individuals resulting from particular life circumstances and histories” (p. 433). Howard (1991) stated that culture can be thought of as a community of individuals who share a particular view of the world and of interpretations central to the meaning of their lives and actions. López et al. (1989) defined culture as the values, beliefs, and practices often shared by groups identified by variables, such as ethnicity, gender, and sexual orientation. Later, López, Kopelowicz, and Canive (2002) asserted that a

limitation of the values, beliefs, and practices definition of culture is that it depicts culture as static or fixed. . . . Attempts to freeze culture into a set of generalized value orientations or behaviors will continually misrepresent what culture is. Culture is a dynamic and creative process, some aspects of which are shared by large groups or individuals resulting from particular life circumstances and histories. (p. 63)

Another important aspect of culture in modern society is the interconnection between different cultural groups that

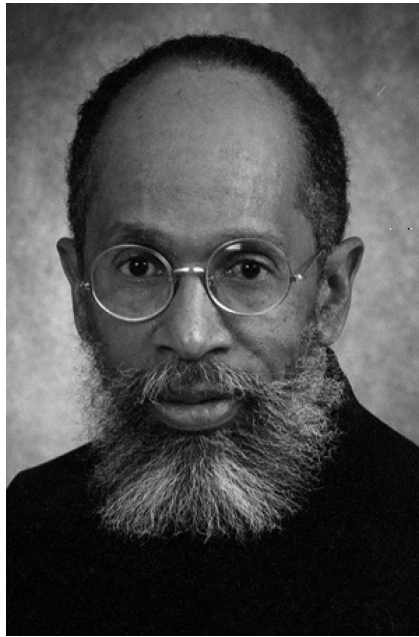
modifies their respective cultures (Guarnaccia & Rodriguez, 1996; Hermans & Kempen, 1998; Howard, 1991; Thompson, 2005). The fact that culture is learned, socially shared, and variable is emphasized in many definitions (H. Betancourt & López, 1993). It is important to recognize that culture is a dynamic process that links the past to the present and is shaped in part by the social, historical, and political context.

Modern definitions of culture acknowledge the globalization of community through technological advancements in communications, media, and transportation, as well as international exchanges fostered by multinational corporations, governments, and nongovernmental world organizations. This reality has led some scholars to suggest that traditional conceptions of culture as dichotomous, geographically based, and internally homogeneous are obsolete (Hermans & Kempen, 1998). This perspective fails to take into consideration factors such as biculturalism, sociopolitical context, and motivation or conviction. All of these factors can result in the maintenance of an internally homogeneous culture in a changing world. Thus, we propose that the cultural dichotomy be replaced with a continuum of interconnection on which the extreme of an internally homogeneous culture, indicating independence, is still a possibility.

In summary, culture can be defined as a dynamic process involving worldviews and ways of living in a physical and social environment shared by groups, which are passed from generation to generation and may be modified by contacts between cultures in a particular social, historical, and political context. Cultures vary on a continuum of interconnection from independence (i.e., internally homogeneous) to interdependence to complete dependence on other cultures. The latter two forms are hybrid cultures, which probably constitute the majority in our global community.

Cultural competence. Several definitions of cultural competence have been offered in the literature. S. Sue (1998) stated, “one is culturally competent when one possesses the cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture” (p. 441). López (1997) considered the essence of cultural competence to be “the ability of the therapist to move between two cultural perspectives in understanding the culturally based meaning of clients from diverse cultural backgrounds” (p. 573). From a broader viewpoint, culturally competent care has been defined as a system that acknowledges the importance of and incorporates culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of interventions to meet culturally unique needs at all levels of service (J. R. Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Finally, D. W. Sue and Torino (2005) defined cultural competence in the following way:

Cultural competence is the ability to engage in actions or create conditions that maximize the optimal development of the client and client systems. Multicultural counseling competence is



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achieved by the counselor's acquisition of awareness, knowledge, and skills needed to function effectively in a pluralistic democratic society (ability to communicate, interact, negotiate, and intervene on behalf of clients from diverse backgrounds) and on an organizational/societal level, advocating effectively to develop new theories, practices, policies, and organizational structures that are more responsive to all groups. (p. 8)

These definitions of cultural competence have points of convergence and divergence. They all agree that knowledge and skills germane to the cultural background of the help seeker are fundamental to a definition of cultural competence. In addition, López (1997) implied that perspective taking, which is a reflection of cognitive flexibility or problem-solving skills, is also a defining characteristic of the culturally competent mental health service provider. The remaining definitions also implicate problem-solving ability but in a different way. For example, J. R. Betancourt et al. (2003) and D. W. Sue and Torino (2005) both expanded the definition of cultural competence to include organizational and system-level activities.

The dynamic processes characterized by the interplay between knowledge and skills, between individuals and systems, and between culture and society resonate with the concept of culture discussed in the previous section. Moreover, a process model of cultural competence has the advantage of being less prone to cultural stereotypes than a content model, which emphasizes the aspects of culture that matter for culturally different groups (López et al., 2002). Thus, we view cultural competence as a set of problem-solving skills that includes (a) the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior; (b) the ability to use the knowledge acquired about an individual's heritage and adaptational chal-

lenges to maximize the effectiveness of assessment, diagnosis, and treatment; and (c) internalization (i.e., incorporation into one's clinical problem-solving repertoire) of this process of recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups. The first stage of recognition of the dynamic interaction between adaptation and heritage dimensions of culture reflects cultural sensitivity as a precursor to cultural competence (Whaley, in press). It should also be noted that the internalization stage of cultural competence proposed here is akin to López's (1997; López et al., 2002) notion of *shifting cultural lenses* in his model of cultural competence.

The Need for Cultural Competence in Mental Health Services

The need for culturally competent mental health services has been expressed over several decades. This need is justified, first and foremost, by increasing sociodemographic shifts toward more cultural diversity in the U.S. population. This growing ethnic/racial diversity necessitates changes in the mental health system to meet the different needs of a multicultural U.S. population (American Psychological Association [APA], 1993, 2003; Atkinson et al., 2001; M. E. Bernal & Castro, 1994; C. C. I. Hall, 1997; Ridley, 1985; D. W. Sue, Arredondo, & McDavis, 1992; D. W. Sue & Torino, 2005; S. Sue, 1998). Another reason offered has been ethnic/racial disparities in the utilization of mental health services. S. Sue's (1977) seminal research showing the underutilization of community mental health services by members of the major ethnic/racial minority groups was a landmark study highlighting the issue. Several more recent national and state-level studies revealed continual problems with mental health services utilization among African Americans, Asian Americans, Latinos, and Native Americans (Breux & Ryuji, 1999). There are instances of overutilization as well as underutilization (e.g., O'Sullivan, Peterson, Cox, & Kirkeby, 1989; Snowden & Cheung, 1990). Underutilization is a case of unmet needs, and overutilization may indicate that some groups are in greater distress or are being given more severe diagnoses (Breux & Ryuji, 1999). Cultural competence is considered a necessary component of the solution to these problems.

Additional arguments for culturally competent mental health services have been made on ethical grounds. Arredondo and Toporek (2004) pointed out the significant overlap between the ethical guidelines of the American Counseling Association and the statement of competencies in their document on multicultural counseling competencies. Similarly, Gil and Bob (1999) indicated common elements in two documents produced by the APA on ethical principles and on the "provision of psychological services to ethnic, linguistic, and culturally diverse populations" (p. 45). Ridley (1985) made an eloquent and compelling argument for cultural competence as an ethical obligation. From an ethical perspective, Ridley (1985) asserted,

The imperative centers around the issue of competence, placing cross-cultural skill on a level of parity with other specialized

therapeutic skills. Acceptance of that perspective means that the acquisition of cross-cultural competence demands a similar depth of training and supervised experience as competence, for example, in treating sexual dysfunction or specific character disorders. Delivering mental health services outside of one's area of competence constitutes an ethical infraction. (p. 613)

Following a similar line of reasoning, C. C. I. Hall (1997) stated that culturally based courses must be viewed as fundamental to the psychology curriculum, as are physiological psychology, sensation and perception, and so forth. These perspectives are rooted in the assumption that cultural diversity is an essential area of human behavior requiring specialized knowledge and skills.

Cultural competence may also satisfy the need for greater attention to the principle of external validity in scientific research. The paucity of scientific knowledge about the multiple cultures that make up American culture is recognized as a problem, because such information serves as the basis for determining which psychotherapeutic treatments are effective with different ethnic/racial groups (Alvidrez, Azocar, & Miranda, 1996; H. Betancourt & López, 1993; G. C. N. Hall, 2001; Hohmann & Parron, 1996; Miranda, Nakamura, & Bernal, 2003; Muñoz & Mendelson, 2005; Rosselló & Bernal, 1999; S. Sue, 1998, 1999). In 1994, responding partly to concerns about the limited external validity of interventions for ethnic/racial minority persons, the National Institutes of Health (NIH) instituted a policy requiring all grant applicants to include women and minorities in all federally funded research or to provide strong justification for not doing so (Hohmann & Parron, 1996). Hohmann and Parron (1996) asserted that this new policy would contribute to the expansion of the scientific knowledge base about what treatments work with a culturally diverse and heterogeneous U.S. population, as well as encouraging researchers to think more about the cultural background of their study participants. As pointed out by some ethnic/racial minority scholars, however, simple inclusion of ethnic/racial minority populations in research funded by the NIH does not ensure production of culturally relevant theories and interventions (G. C. N. Hall, 2001; Miranda et al., 2003). This is a point well taken, but there are other considerations.

For example, the recruitment and retention of ethnic/racial minority groups in such studies to fulfill the mandate may pose a significant challenge to researchers and, consequently, may raise awareness about the need for cultural competence. The likelihood is greater that research by those investigators who are aware of the importance of culture will yield information of greater cultural relevance to theory and intervention, compared with research by investigators who do not have challenges that force them to confront this fact. Although the possibility is greater, it is not a foregone conclusion that attempts to involve ethnic/racial minority individuals in research will lead to an appreciation of the need for, or an increase in, cultural competence. Alvidrez et al. (1996), Gil and Bob (1999), Miranda et al. (2003), Muñoz and Mendelson (2005), Ridley (1985), and S. Sue (1999) among others have all made recommendations to increase the chances of raising aware-

ness and increasing cultural competence in research. A common denominator in the various recommendations is that involvement of communities of color in shaping the research agenda is an important element for culturally competent research. Such a suggestion goes beyond the policy of inclusion of ethnic/racial minorities set forth by the NIH.

A compelling case has been made on sociodemographic, clinical, ethical, and scientific grounds for cultural competence in the delivery of mental health services, so we now discuss this need in more specific terms. Such a discussion of cultural competence should address the current guidelines or standards of cultural competence in the mental health care of an ethnic/racially diverse population.

Current Guidelines and Standards for Cultural Competence

Guidelines and standards have been promoted following the establishment of cultural competence as a service and training goal in the delivery of mental health care. A number of documents exist that delineate competencies or standards for providing mental health services to a culturally diverse population. Most of the guidelines seem to have been developed by individual scholars or groups of scholars who are concerned citizens of their professions. For example, Bean and colleagues developed cultural competence guidelines for family therapists (Bean, Perry, & Bedell, 2001, 2002; Kim, Bean, & Harper, 2004). APA (1993, 2003) is among the few professional organizations that have created guidelines outlining cultural competencies. The Association for Multicultural Counseling and Development (AMCD) is another organization that has produced guidelines (Arredondo et al., 1996; D. W. Sue et al., 1992). It is important to point out that Division 17, Counseling Psychology, of APA and AMCD have overlapping memberships. Despite the overlapping memberships, there are some differences between APA and AMCD with respect to their institutional endorsements of cultural and linguistic competence.

APA's (2003) most recent guidelines on multiculturalism are more encompassing than earlier versions.

Each guideline is . . . presented, with the first two guidelines designed to apply to all psychologists from two primary perspectives: (a) knowledge of self with a cultural heritage and varying social identities and (b) knowledge of other cultures. Guidelines 3–6 address the application of multiculturalism in education, training, research, practice, and organizational change. (p. 378)

Thus, the new guidelines go beyond the provision of psychological services to ethnic, linguistic, and culturally diverse populations (APA, 1993). AMCD organized their guidelines for cultural competency according to a matrix of three characteristics (cultural self-awareness, awareness of other people's culture, and appropriate strategies for intervention) by three dimensions (attitudes and beliefs, knowledge, and skills) to form nine domains of multicultural competencies.

Both APA and AMCD recognize cultural self-awareness and awareness of the cultures of others as important

aspects of cultural competence. It is interesting that the definitions of culture and cultural competence presented in earlier sections do not explicitly address cultural self-awareness. On the other hand, the problem-solving approach inherent in those earlier definitions appears to be very relevant to these guidelines for cultural competency. Another point of connection between definitions and guidelines is the expansion of the purview of cultural competence to organizational change (APA, 2003; Arredondo et al., 1996; J. R. Betancourt et al., 2003; D. W. Sue et al., 1992; D. W. Sue & Torino, 2005). These guidelines and standards are ultimate expressions of a commitment to the operationalization of cultural competence.

The guidelines for cultural competence are not without limitations. The lack of an emic or culturally specific approach has been pointed out as a limitation. Roy Bean and colleagues used the same methodology to derive cultural competence guidelines for African Americans (Bean et al., 2002), Hispanics/Latinos (Bean et al., 2001), and Asian Americans (Kim et al., 2004). In particular, Bean and colleagues conducted a computer assisted review of the family therapy/counseling literature for each ethnic/racial group, used the Social Science Citation Index to create a standardized measure of impact, identified the four or five most influential publications, and conducted content analyses of these sources to generate cultural competence guidelines for family therapy with the respective cultural groups. The guidelines for culturally competent family therapy differed in both quality and quantity across the specific ethnic/racial groups (Bean et al., 2001, 2002; Kim et al., 2004). This culturally specific approach is most useful for mental health service providers who specialize in working with a certain ethnic/racial group. It is impractical for the majority of clinicians whose work involves treating a culturally diverse clientele. This emic perspective also reflects a content model of cultural competence. Thus, the findings of Bean and his colleagues are consistent with the argument of López et al. (2002) concerning the benefits of a process model over a content model of cultural competence.

The framework of cultural competence in the guidelines developed by APA and AMCD is more process than outcome driven. As previously mentioned, López et al. (2002) pointed out the advantages of a process model of cultural competence. This type of model may facilitate the application of these guidelines to different cultural groups, but at this point it is an empirical question. Another limitation is the emphasis on what Lonner (1997) referred to as the *academic and scholarly orientation* to cultural competence: He pointed out that for mental health practitioners, the academic approach is only one of several pathways to cultural competence, including experiential training and formal culture training.

A final limitation is the lack of empirical evidence in support of cultural competence guidelines (Arredondo & Toporek, 2004; S. Sue, 2003). Arredondo and Toporek (2004) responded to this issue by invoking the ethical perspective on cultural competence and stating,

Similar to ethical codes, the Competencies have a consumer-based foundation, often resulting from sociopolitical changes. . . . Ethical statements and guidelines are not developed as empirical models, rather they are based on expertise to serve as a guide for consumer-oriented behavior. (p. 47)

Along similar lines, S. Sue (2003) argued, “policies are often initiated in the absence of solid research justification and are guided by ethical–moral issues, public opinion, cultural practices, and political considerations” (p. 968). S. Sue also asserted that cultural competence cannot be easily defined or tested empirically, especially with efficacy-based research. Miranda et al. (2003) stated that the cultural complexity of the ethnic/racial minority population in the United States today makes it impractical to conduct randomized efficacy trials of established interventions to test their cultural appropriateness. It is important to recognize that this assertion does not detract from the arguments in favor of increasing ethnic/racial minority representation in randomized clinical trials (e.g., Chambless et al., 1996; Hohmann & Parron, 1996). However, there may be other approaches.

López et al. (2002) proposed three strategies for promoting culturally compatible evidence-based interventions: (a) allow basic research, especially studies on the target population of color, to guide the development of an intervention; (b) apply a standard intervention to the specific ethnic/racial group without any cultural modifications to learn which components are useful; and (c) systematically examine a particular intervention from a cultural competence perspective and assess the potential cultural match of the intervention’s components to the group under study. Although López et al. made a compelling case for each strategy, the latter one is most germane to the current thesis. One method of implementing this latter strategy is to put cultural competence to the test in empirical studies of established interventions in effectiveness research. “These interventions may well involve tailoring mental health care so that it coincides more with specific cultural beliefs, providing care in settings that minorities use and feel safe within, providing care in the language of the patient, etc.” (Miranda et al., 2003, p. 478). We define this approach as cultural adaptation and elaborate on this point in a later section.

Evidence-Based Mental Health Services

Defining Evidence-Based Practice

To reiterate, this review is meant not to be exhaustive but simply to highlight some key issues in evidence-based practice debates, starting with definitions. The terms *evidence-based practice*, *empirically validated treatments*, and *empirically supported treatments* have all been used in the literature. The words *treatments* and *therapies* are used interchangeably in the literature, because the difference between them is inconsequential. The terms *empirically validated therapies* and *empirically supported therapies* are variations on the same theme. *Empirically validated therapies* is a phrase coined by the APA Division 12 Task

Force on Promotion and Dissemination of Psychological Procedures (1995) and by its members (Chambless, 1999; Chambless et al., 1996, 1998; Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995). However, Chambless and Hollon (1998) preferred *empirically supported therapies* to *empirically validated therapies*, because the latter term generally connotes that the process of validation is complete and no further research is necessary. Empirical validation of mental health interventions is ongoing, and the criteria for inclusion of a study are somewhat arbitrary (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), so the term may actually be a misnomer.

Empirically supported treatment is therefore a more apt term to describe efficacy research. Chambless and Hollon (1998) defined empirically supported treatments as clearly specified psychological interventions shown to be efficacious in controlled research with a delineated population. They went on to say, “efficacy is best demonstrated in randomized clinical trials (RCTs) in which patients are randomly assigned to the treatment of interest or one or more comparison conditions—or carefully controlled single case experiments and their group analogues” (Chambless & Hollon, 1998, p. 7). This definition is more liberal than the criteria developed by the Task Force on Promotion and Dissemination of Psychological Procedures (1995) to establish treatment efficacy. In their second update of empirically validated treatments, this task force considered well-established treatments to be those that met the following criteria (Chambless et al., 1998, p. 4):

I. Two or more between group design experiments showing efficacy by having a) statistically significant superior effect over pill or psychological placebo or another treatment; or b) an equivalent effect to an established treatment in experiments with adequate sample sizes.

or

II. A large series of single case design experiments ($n > 9$) demonstrating efficacy which a) used good experimental design; and b) compared the treatment to another intervention as in Ia.

In addition to Ia or II

III. Experiments were conducted with treatment manuals.

IV. Sample characteristics were clearly specified.

V. Effects were demonstrated by two different investigators or investigating teams.

The original criteria proposed by the Task Force on Promotion and Dissemination of Psychological Procedures (1995) also differed in that the criteria of Chambless and Hollon (1998) did not require evidence of specificity for a treatment to be considered efficacious. These alterations to criteria for establishing efficacy broaden the definition of empirically supported treatments.

Evidence-based practice is not synonymous with *empirically supported treatments*. Evidence-based practice is the broader category, and empirically supported treatments is one of its subcategories (Messer, 2004; Westen, No-

votny, & Thompson-Brenner, 2005). Messer (2004) suggested that the narrow focus on RCTs precludes clinicians' use of other valuable sources of data to inform their practice. Moreover, evidence-based practice is defined as research inclusive of correlational studies, qualitative research, quasi-experiments, and so forth. Westen et al. (2005) proposed that research on skillful clinicians in the field would be another approach to studying efficacy. What they proposed is research based on deductive reasoning, in contrast to the principles of inductive reasoning underlying RCT methodology, to establish treatment efficacy. In other words, studying successful clinicians in the field (general) yields information about treatment efficacy (specific). On the basis of inductive reasoning, the identification of efficacious psychosocial interventions (specific) improves mental health services (general).

In summary, empirically supported treatment is a subcategory of evidence-based practice that emphasizes internal validity over external validity and utilizes scientific reasoning that is inductive. In evidence-based practice, there is an attempt to balance external validity and internal validity in the promotion of treatments to inform clinical practice, as well as to base science on both deductive and inductive reasoning strategies. It is important to note, however, that adoption of the broader (and more flexible) definition of evidence-based practice does not change the fact that empirically supported treatment using RCT methodology meets the highest standard of causal inference. These different connotations of evidence-based practice versus empirically supported treatment should be kept in mind because these terms are used throughout.

The Need for Evidence-Based Mental Health Services

Ethical, scientific, training, and market arguments have been expressed to justify the need for evidence-based mental health services. Kettlewell (2004) summarized the principal arguments in support of evidence-based treatments as the following: (a) evidence-based treatments give guidance to better serve patients or clients seeking care; (b) using the scientific approach to evaluate treatment is the best way to advance knowledge in order to provide the best mental health services in the future; (c) it is necessary to use limited mental health resources wisely; (d) there are treatments that work that most practitioners do not use; and (e) there may be no better alternative than to use science as the standard for practice. Thus, concerns about the ethical obligation to provide the best treatment possible, the lack of training in these treatments, and cost-effectiveness or efficiency are major themes in Kettlewell's list of arguments. These assertions do not cover all of the issues raised by advocates of evidence-based approaches to mental health services.

Mental health service providers also have an ethical obligation to ensure that their patients or clients know the advantages and disadvantages of the different treatment options available to them, so that they can make an informed choice (Chambless & Hollon, 1998; Chambless et al., 1996). Evidence-based mental health services are more

likely to yield such information. Another argument for evidence-based mental health services is the consumer market. Division 12 (Clinical Psychology) of the APA was concerned that significant advances in the science of psychotherapy were being ignored by the public, third-party payors, and even psychologists, while pharmaceutical companies spent millions of dollars to promote new medications tested in efficacy trials, thereby rapidly impacting psychiatric practice in the community (Chambless, 1999; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Nathan (1998) pointed out that the guidelines for mental health treatment developed by the Agency for Health Care Policy and Research and the American Psychiatric Association emphasized pharmacotherapy over psychotherapy. He attributed this preference partly to the greater weight given to clinicians' judgment about treatment efficacy in the development of these guidelines (Nathan, 1998). Another factor is the growing popularity of health maintenance organizations, which have guidelines favoring pharmacotherapy over psychotherapy, because of a substantial body of evidence demonstrating the efficacy of medications (Atkinson et al., 2001). It is important for proponents of psychological interventions to establish their own treatment guidelines or to be subject to those created by other professions (Nathan, 1998). The successful promotion of evidence-based psychosocial interventions may help to address the preference for pharmacotherapy to treat mental health problems.

The infrequent use of evidence-based approaches can also be linked to the absence of training in graduate schools and internship programs. The Division 12 task force surveyed directors of graduate clinical psychology programs and directors of internships about empirically validated psychological treatments (Chambless & Ollendick, 2001; Crits-Christoph et al., 1995; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). According to Division 12, approximately one in five clinical training programs met their minimum criterion of 25% or fewer of the evidence-based treatments in didactic courses: Also, internship programs were unlikely to require students to be competent in at least one evidence-based treatment by the end of the training year (Chambless & Ollendick, 2001; Crits-Christoph et al., 1995; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). "Task force members reasoned that if psychologists are to be competitive in the current market and efficacious in their provision of services, students need to be trained in treatments of demonstrable efficacy" (Crits-Christoph et al., 1995, p. 515). These gaps in training add to the need for evidence-based approaches to mental health services.

The promotion and dissemination of evidence-based approaches are warranted given these ethical, scientific, training, and public education challenges for advocates of psychotherapeutic interventions. At this point, it is more a question of how instead of when these will happen. A decade has passed since APA accepted the recommendations of the Task Force on Promotion and Dissemination of Psychological Procedures (1995). The list of empirically

supported treatments that qualify grew from 25 in 1995 to 71 in 1998 (Chambless & Ollendick, 2001). One major accomplishment for proponents of evidence-based mental health care is that training in such approaches is now a requirement for APA accreditation of doctoral programs in professional psychology and internship programs (Chambless, 1999). How researchers move from efficacy studies to effectiveness studies is still being debated despite these significant gains.

From Efficacy to Effectiveness in Mental Health Treatment

The evidence-based practice movement has been criticized on a number of fronts. The most comprehensive and piercing commentary is a literature review conducted by Westen, Novotny, and Thompson-Brenner (2004). They took the position that the fundamental assumptions underlying empirically supported treatment methodology are violated or not applicable to the practice of psychotherapy. These assumptions include the following: Psychological processes are highly malleable; most patients have one primary problem; comorbidity is random or additive; psychological symptoms can be understood and treated in isolation from personality disposition; and controlled clinical trials provide the gold standard for assessing therapeutic efficacy (Westen et al., 2004). Advocates of the empirically supported treatment movement challenged this review on the grounds that it selectively reviewed the empirically supported treatment literature, mischaracterized RCT or empirically supported treatment methodology, and espoused untested assumptions (Crits-Christoph, Wilson, & Hollon, 2005; Weisz, Weersing, & Henggeler, 2005). As stated earlier, the counterpoint by Westen et al. is that treatment efficacy should be established by identifying and studying successful clinicians in real-world treatment settings. Westen et al.'s ultimate response to these rejoinders is that evidence-based practice should include research other than RCT studies.

Additional criticisms of the empirically supported treatment movement also addressed the central role of RCT studies in defining it. Southam-Gerow (2004) pointed out that, although a technology metaphor has been used to describe empirically supported treatments because of their focus on the application of rigorous experimental methods to develop specific treatments, this metaphor is not completely appropriate. He explained further that the client (and symptom) focus of treatment development in the case of empirically supported treatment does not consider how provider, agency, and service systems may impact treatment outcome (Southam-Gerow, 2004). Weisz, Chu, and Polo (2004) expressed similar concerns about the adoption of the medical-pharmaceutical model to promote and disseminate evidence-based practices. Medications are first developed in labs. They are then subjected to extensive efficacy testing through RCTs and promoted in community settings through advertisements and free samples to physicians in the community. This model may not be entirely appropriate for psychosocial treatments because the gap between efficacy trials and clinical practice situations may

be much wider for psychotherapies than for “biologically focused treatments” (Weisz, Chu, & Polo, 2004, p. 304). Both of these concerns reflect an awareness of the socio-cultural complexity of mental health service delivery.

Finally, a number of process-related variables have been identified as areas for further improvements of empirically supported treatment. A number of scholars have recommended that the empirically supported treatment movement identify mechanisms of therapeutic change, discriminate among the different manualized treatments, include information on harmful treatments, obtain input from practicing clinicians and clients, use alternatives to diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2000) to identify problems, study processes (e.g., therapeutic alliance) as well as outcomes, and include effectiveness studies in the treatment development stage (Atkinson et al., 2001; Follette & Beitz, 2003; Herbert, 2003; Kettlewell, 2004; Messer, 2004; Southam-Gerow, 2004; Weisz et al., 2004; Westen et al., 2004, 2005). Some of these suggestions have taken hold and are now the subject of empirical study.

For example, O’Donohue, Buchanan, and Fisher (2000) surveyed the authors of the studies included on the list of empirically supported treatments published by the APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (1995) to identify commonalities and differences among the treatments. Another study compared three cognitive and six noncognitive therapies on the therapy process variables of directiveness, emotional arousal, and behavior focus (Malik, Beutler, Alimohamed, Gallagher-Thompson, & Thompson, 2003). Merrill, Tolbert, and Wade (2003) conducted an effectiveness study of cognitive therapy in a community mental health setting. Finally, Schmidt and Taylor (2002) described the implementation of an empirically supported treatment in a children’s mental health center. Chambless and Ollendick (2001) reviewed a few other effectiveness studies of panic disorder, depression, and oppositional-defiant disorder, but they also acknowledged that effectiveness research is in its infancy.

One theme that emerges from the various criticisms of the empirically supported treatment movement is the need to move from efficacy studies to effectiveness studies. The call for expansion of evidence-based practice to include field studies of clinicians in applied settings is consistent with this claim. The medical–pharmaceutical model and the technology metaphor are inapplicable largely because mental health treatments in clinical settings are more complex and confounded than those in controlled laboratory studies. Therefore, dissemination of empirically supported treatments in communities will not necessarily follow a process similar to the one for medications or medical technologies. Thus, the use of empirically supported treatments by mental health clinicians in applied settings takes on greater significance. Concerns about the influence of process variables in therapeutic efficacy can be traced to the importance of these factors in the provision of mental health services in community settings. Presumably, the

motivation and incentives for treatment adherence are lower in community practice compared with laboratory or academic settings, causing therapists’ ability to engage and establish a working alliance with the client to become paramount.

The need for effectiveness studies is also a scientific matter. Efficacy studies tend to emphasize internal validity, and effectiveness studies address issues of external validity (Chambless & Ollendick, 2001; Hohmann & Parron, 1996). Viewed in this manner, proponents of the empirically supported treatment movement also acknowledge the importance of effectiveness studies (e.g., Chambless et al., 1996; Weisz et al., 2005). Another point of agreement between advocates and critics of empirically supported treatment is recognition of the inadequate representation of ethnic/racial minority groups in efficacy studies (Atkinson et al., 2001; G. Bernal & Scharrón-del-Río, 2001; Chambless & Ollendick, 2001; Chambless et al., 1996; G. C. N. Hall, 2001; Hohmann & Parron, 1996; Miranda et al., 2003, 2005; Muñoz & Mendelson, 2005; Vera, Vila, & Alegría, 2003). Chambless et al. (1996) could not find a single study that included tests of empirically supported treatments with ethnic/racial minority populations. Miranda et al. (2003) reported that 10,000 participants have been included in RCTs for major psychiatric disorders since 1986 with only 561 African Americans, 99 Latinos, 11 Asian Americans, and 0 Native Americans. In addition, Vera et al.’s (2003) review of the cognitive–behavior therapy (CBT) literature showed an underrepresentation of ethnic/racial minority participants in study samples. Research also indicates that most efficacy studies do not analyze the data by ethnicity/race, even if people of color are included (Chambless & Ollendick, 2001; Iwamasa, 1996; Miranda et al., 2003). External validation of empirically supported treatments would also require efficacy and effectiveness research with ethnic/racial minority populations. Adaptation of empirically supported treatments for use with people of color is likely to lead to more culturally competent services.

Cultural Adaptations of Evidence-Based Practices

Although there is agreement that inclusion of ethnic/racial minority populations in empirically supported treatment studies is important for the establishment of external validity, a variety of opinions exist regarding the extent to which modifications are necessary to accomplish this goal. On the one hand, it has been suggested that simply including more ethnic/racial minority patients or clients in efficacy studies is an adequate form of cultural adaptation (e.g., Chambless et al., 1996; Hohmann & Parron, 1996). On the other hand, some scholars contend that significant adaptations are needed in terms of delivery, therapeutic process, and inclusion of cultural knowledge, attitudes, and behaviors to make empirically supported treatments more culturally appropriate (e.g., Atkinson et al., 2001; Miranda et al., 2003; Muñoz & Mendelson, 2005; Vera et al., 2003). We define *cultural adaptation* as any modification to an

evidence-based treatment that involves changes in the approach to service delivery, in the nature of the therapeutic relationship, or in components of the treatment itself to accommodate the cultural beliefs, attitudes, and behaviors of the target population. Under this definition, the translation of a treatment protocol into the native language of a non-English speaking population would fall under the rubric of changing the approach to service. Most cultural competence guidelines (e.g., APA, 1993, 2003) would describe this type of translational research as linguistic competence, which is a necessary but not sufficient condition for cultural competence. For the purposes of this discussion, linguistic competence, cultural competence, and cultural adaptation are related but not synonymous concepts. A description of the differences among these concepts is beyond the scope of this article.

The study of depression treatment by Miranda et al. (2006) is a good example of the various types of cultural adaptations. They modified service delivery by providing child care and transportation to enable low-income minority women to participate in their empirically supported treatment intervention. They also changed the nature of the therapeutic relationship by having providers give the participants a number of educational sessions about depression and its treatment prior to delivering the intervention. Finally, they used a manualized form of culturally adapted CBT developed by Muñoz and his colleagues (see Muñoz & Mendelson, 2005, for a description). Components of the CBT were adapted linguistically and by using culturally relevant examples in techniques, as well as by acknowledging the values and experiences particular to the ethnic/racial group. Muñoz and Mendelson (2005) gave the culturally relevant example from Latino culture of using the saying *la gota de agua labra la piedra* [a drop of water carves a rock] to illustrate how thoughts, though transient, can gradually influence one's view of life and cause and maintain depression.

The argument is that culturally adapted therapy approaches may be more compatible with ethnic/racial minority patients' cultural experiences compared with standard therapeutic approaches and, therefore, may be better at treating their psychological problems (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002). Still another perspective is that both of these strategies should be considered, along with a third approach that advocates treatment development guided by basic research (López et al., 2002). The merit of these different views can be examined, to some extent, by the literature that connects ethnic/racial minority populations and evidence-based practice. Studies that have included and analyzed the effects of ethnic/racial minority participation in empirically supported treatment are particularly informative.

To date, Miranda et al. (2005) have provided the most comprehensive review of the research on psychosocial interventions with ethnic/racial minority populations. They found that both traditional empirically supported treatments and adapted interventions are effective with ethnic/racial minority populations. However, they pointed out that standard and culturally adapted psychosocial interventions

have not been compared in an RCT (Miranda et al., 2005). Approaches to such comparisons include the following: (a) testing two identical evidence-based practices with one having cultural adaptations, (b) applying a culturally adapted evidence-based practice to the target ethnic/racial group and another ethnic/racial group, and (c) administering the evidence-based practice with cultural adaptations to members of the ethnic/racial group at different levels of acculturation (López et al., 2002). López et al. (2002) discussed how to address the scientific and ethical challenges posed by these various approaches. It is widely known that CBT is the most common form of empirically supported treatment in the empirical literature, as well as on the list of treatments provided by the APA Division 12 task force (Atkinson et al., 2001; G. C. N. Hall, 2001; Malik et al., 2003; Rosselló & Bernal, 1999). The experiences of ethnic/racial minority clinicians using CBTs with ethnic/racial minority populations in efficacy and effectiveness studies may shed some light on the issue.

Similar to the treatment of participants, the ethnicity/race of the therapist in treatment outcome studies is usually treated as a demographic variable only (Iwamasa, 1996). A number of CBT studies, including some RCTs, conducted by ethnic/racial minority clinicians have demonstrated efficacy or effectiveness of the intervention (e.g., Comas-Díaz, 1981; Miranda et al., 2006; Organista, Muñoz, & Gonzalez, 1994; Pina, Silverman, Fuentes, Kurtines, & Weems, 2003; Rosselló & Bernal, 1999). All of these studies reported some type of cultural adaptation to the CBT. In general, the findings of these studies suggest that culturally adapted CBT is just as effective as traditional CBT. Only a couple of these studies contained designs that yielded information about the relative importance of cultural adaptations. Kohn et al. (2002) did not find any significant differences in terms of treatment outcome for African American women of lower socioeconomic status who self-selected into culturally adapted CBT versus standard CBT. An important note is that over 80% of the women chose the culturally adapted CBT (Kohn et al., 2002). It is important to note that interventions may appear standard on the surface and cultural nuances may go undetected. A case in point is the finding by Rosselló and Bernal (1999) that both CBT and interpersonal therapy, another empirically supported treatment, were efficacious in the treatment of depression among Puerto Rican adolescents, but interpersonal therapy yielded superior outcomes on measures consonant with Puerto Rican cultural values.

Finally, the impact of culture may occur in the process of therapy rather than the outcome. Organista et al. (1994) found that ethnic/minority patients receiving CBT in a primary care setting dropped out of treatment more frequently than their nonminority counterparts. Similarly, despite their outreach efforts, Miranda et al. (2005) found that only 36% of low-income women randomly assigned to CBT attended six or more sessions. These latter results, in conjunction with Kohn et al.'s (2002) preference finding, suggest that culture may be important during the process of therapeutic engagement. Hatch, Friedman, and Paradis (1996) found that Black patients with obsessive-compul-

sive disorder were very resistant to the standard practice of involving family members in the treatment process. These clinical researchers had to depart from the recommendations in the treatment manual to accommodate this cultural attitude. Hatch et al. used a broader definition of *significant other* and allowed patients to designate a person with whom they felt comfortable. Such findings suggest that a broader definition of evidence-based practice is necessary to address adaptation issues with people of color.

Conclusion

The two critical issues for the future of mental health service delivery, especially to persons of color, are the need for cultural competence and the need for evidence-based practice. The debates surrounding the two issues have made it clear that an integration of these two areas would enhance both. The question of how much to culturally adapt evidence-based practice has been raised in discussions about such integration. Findings that standard empirically supported treatments are efficacious with persons of color suggest that modifications to service delivery may be sufficient cultural adaptations in many cases. Indeed, advocates of cultural competence and empirically supported treatment agree that treatments that have been shown to work with predominantly European American populations should be tried with ethnic/racial minority individuals (Chambless et al., 1996; G. C. N. Hall, 2001; López et al., 2002; S. Sue, 2003). Ethnic/racial minorities in the United States do share some cultural characteristics with the mainstream of society, so it is reasonable to assume that standard treatments will work (G. C. N. Hall, 2001; S. Sue, 1998). For the same reason, it may be the case that culturally specific interventions developed for ethnic/racial minority groups are effective with other cultural groups, including European Americans (Atkinson et al., 2001; López et al., 2002). Another possible reason illustrated by López et al. (2002) is that components of standard treatments may be congruent with the cultural background of the study population.

Common elements of empirically supported treatment are the following: Treatment is short term; the emphasis is present focused and problem focused; skills training is stressed; the therapeutic relationship is considered to be important; and homework is assigned (O'Donohue et al., 2000). The use of treatment manuals is also an essential aspect of empirically supported treatment, but it is a point of contention in the debate (see, e.g., Chambless & Hollon, 1998; Chambless & Ollendick, 2001; Malik et al., 2003; Messer, 2004; Westen et al., 2004). Organista and Muñoz (1996) stated, "The common use of therapy manuals, homework assignments, . . . help[s] Latinos to think of therapy as more of a classroom experience that further alleviates the stigma attached to therapy" (p. 259). Along the same lines, Vera et al. (2003) stated that the action-oriented approach inherent in empirically supported treatment such as CBT is compatible with the cultural expectations of some ethnic/racial minority groups. Muñoz and Mendelson (2005), for instance, helped their clients of

color develop strategies to challenge stereotypic beliefs about their ethnic/racial group as a way of addressing experiences of racism and discrimination. The emphasis on behavior change through skills training and practical exercises may address the need for personal and group empowerment expressed by many populations of color.

Nevertheless, the movement from efficacy studies to effectiveness research may be enhanced by including cultural adaptations. Efficacy studies have clearly demonstrated that therapeutic engagement and treatment retention are major challenges in the delivery of evidence-based practices (Miranda et al., 2006; Organista et al., 1994). Cultural competence has been prescribed as a solution to the problem of low utilization of traditional mental health services (e.g., Ridley, 1985; S. Sue, 1977, 1998). Thus, this recommendation is also apt for the delivery of evidence-based practices. Cultural adaptation is one method of making mental health services more culturally competent (López et al., 2002; Muñoz & Mendelson, 2005). Moreover, cultural adaptations are consistent with the need to expand the definition of evidence-based practice to maximize external validity (S. Sue, 1999). An expanded definition of evidence-based practice supports the inclusion of discovery-oriented methodologies along with hypothesis testing in research on ethnic/racial minority populations (see G. Bernal & Scharrón-del-Río, 2001; S. Sue, 2003). G. Bernal and Scharrón-del-Río (2001) described discovery-oriented research as exploratory, phenomenological, often qualitative or naturalistic, and highly characteristic of ethnic/racial minority research. Consistent with our view, G. Bernal and Scharrón-del-Río also considered the two forms of scientific inquiry to be complementary.

APA has acknowledged the need to expand the definition of evidence-based practice and related methodologies in an article by a newly established task force (APA Presidential Task Force on Evidence-Based Practice, 2006). They also broadened the definition of *intervention* to include assessment, diagnosis, prevention, treatment, psychotherapy, and consultation. Although we agree with this broader definition of intervention, for the sake of parsimony, we focused on treatment and psychotherapy, because they are the most popular topics of the evidence-based practice debate. Finally, this 2006 APA task force indicated that a priority for future research is efficacy and effectiveness of psychological practice with underrepresented groups characterized by ethnicity, race, and other individual or sociodemographic characteristics. Thus, in addition to being a critical step toward the integration of cultural competence and evidence-based practice, cultural adaptations are consistent with the future directions of professional psychology with regard to mental health service delivery using evidence-based practices. The fact that the call for more evidence-based practice research on people of color continues to be made a decade after the report of the first APA task force indicates that greater attention to the complementary nature of cultural competence and evidence-based practice is inevitable.

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