Evidence-Based Practices With Ethnic Minorities: Strange Bedfellows No More

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Multiculturalism and evidence-based practice (EBP) in psychotherapy hailed from disparate sources and rarely interacted. These strange bedfellows have become fast friends in recent years as they recognize their crucial interdependence: multiculturalism without strong research risks becoming an empty political value and EBP without cultural sensitivity risks irrelevancy. In this article, the authors reviewed various incarnations and recent manifestations of their overdue intersection, including several conferences, federal initiatives, and organizational accomplishments. They introduced the subsequent 6 articles in this special issue of the *Journal of Clinical Psychology: In Session*, which described and illustrated cultural-sensitive evidence-based practices. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 66:821–829, 2010.

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In psychotherapy today, we are witnessing the convergence of two inexorable, initially separate forces: multiculturalism and evidence-based practice (EBP). They originated in different places and were traditionally associated with disparate advocates. The interdisciplinary origins of multicultural psychotherapies involved psychological anthropology, ethnopsychology, cultural anthropology, psychoanalytic...
anthropology, and folk healing (Comas-Diaz, 2011), largely outside of empirical research and primarily associated with sociocultural forces. Critics of multiculturalism have frequently complained that the movement has been historically indifferent to the results of scientific research and unduly influenced by identity politics (e.g., O’Donohue, 2005). By contrast, EBP in health care originated in medicine in the United Kingdom and gradually migrated to Canada and the United States, largely outside of cultural considerations and primarily associated with clinical science (Norcross, Hogan, & Koocher, 2008). Critics of EBP have frequently complained that the movement has been historically indifferent to the clinical needs of minority populations and unduly influenced by narrow reliance on randomized clinical trials (e.g., Sue & Zane, 2006).

The confluence of these two movements represents enormous progress for psychotherapy, even as it introduces the early awkwardness of strange bedfellows. Culturally sensitive EBP may sound incongruent to some, but its time has arrived. This issue of the Journal of Clinical Psychology: In Session proudly features several exemplars of EBPs with ethnic minorities.

In this article, we address the heretofore disconnected forces of multiculturalism and EBPs in psychotherapy by reviewing various incarnations and manifestations of their overdue intersection, including several conferences, federal initiatives, and organizational accomplishments. We conclude by introducing the six articles in this Journal issue describing and illustrating culturally sensitive EBPs.

Multiculturalism and EBPs: Never the Twain Met

The demographic avalanche in the United States is incontrovertible. The most populous states will transform from majority White/Euro-Caucasian to mostly people of color, Latino and African American. Using U.S. Census data from 2005 to 2025, increases among Asian, Blacks, American Indian/Eskimo, and Latinas/Hispanics are expected in all states except Mississippi where the proportions remain the same (www.census.gov/population/www/projections/natproj.html). By 2015, over 50% of the residents of New Mexico will be Latinos, by 2028 over 50% of the residents of Texas will be Latinos, and by 2042 over 50% of the residents of California will be Latinos.

And yet, both the research base and clinical training for working with ethnic minorities are, by all standards, inadequate for what is coming (U.S. Surgeon General, 2001). The development of psychotherapy was imbedded in a controversial history, in which mental health professionals lacked appreciation for diversity and did not sufficiently value research concerning ethnic minority groups (Pickren, 2009; Sue, 2009). Over several generations, this institutionalized devaluation resulted in few funded research activities and only scattered publication in peer-reviewed journals, which serve as the foundations for determining and identifying evidence-based treatments. The vast majority of published studies lacked consideration of multicultural context, as well as representative samples of ethnic minority groups. Additionally, practically all psychotherapies developed in the United States were done so for English speakers, while only a handful have been adapted and translated into Spanish, and almost none in other languages. The paucity of evidence-based treatments validated on minority populations or developed specifically for minority populations threatened the relevance of EBPs for almost half the country.

According to the National Institute on Health, it takes an estimated 17 years for research findings to be replicated and introduced into practice (Clark, 2008). Given
this historical context, how are psychotherapists expected to provide research-supported treatments for populations not included in research samples or for treatments not developed with these populations in mind?

Similarly, the historical neglect of psychotherapy training for diverse client populations, including racial and ethnic minorities, has resulted in a skewed perspective. Among training programs for behavioral health careers, only three psychology training programs in the United States provide training to conduct interventions in Spanish as part of their academic program (Massachusetts School of Professional Psychology, Chicago School of Professional Psychology, and Our Lady of the Lake University), and one offers a 5-week summer immersion program in Mexico City for Marriage Family Therapist (MFT) and psychology graduate students (Mexico City Campus of Alliant International University). Trainings provided in practicum and internship sites typically lack the standards and formal structures to ensure clinical competence in Spanish. There are, to our knowledge, no programs in the United States for practitioners to learn how to provide clinical services in Spanish. Without cultural competence established in clinical training, psychotherapists risk becoming irrelevant at best, guilty of cultural malpractice at worst (Hall, 1997).

Strange Bedfellows Become Fast Friends

Over the past 20 or so years, these gnawing voids in psychotherapy training and research have been critically challenged and gradually addressed. The strange bedfellows of multiculturalism and EBP have become fast friends as they recognize their crucial interdependence and mutual interests. Multiculturalism without strong research risks becoming an empty political value, and EBP without cultural sensitivity risks irrelevancy. Here, we trace a handful of governmental and organizational initiatives that both reflect and reinforce their maturing, interdependent relationship.

Multicultural Guidelines

In 2002, the American Psychological Association (APA) approved the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists (www.apa.org/practice/guidelines/multicultural.pdf). The guidelines addressing practice and research enjoin psychologists to:

- Recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from them.
- Recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.
- Recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.
- Apply culturally appropriate skills in clinical and other applied psychological practices.
- Use organizational change processes to support culturally informed organizational (policy) development and practices.

Culturally Inclusive Definition of EBP

In 2006, the APA published its definition of EBP, a definition that intentionally enlarged earlier definitions to include the patient’s culture as part of the decision
process. The Institute of Medicine (2001, p. 147) defined evidence-based medicine as “the integration of best research evidence with clinical expertise and patient values.” Beginning with this foundation and expanding it to mental health, the APA Task Force on Evidence-Based Practice (2006, p. 273) defined EBP as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.”

Several core features of EBP in mental health are manifest in this definition (Norcross, Hogan et al., 2008). First, as shown in Figure 1, EBPs rest on three pillars: best available research, clinical expertise, and patient characteristics, culture, and preferences. By definition, the wholesale imposition of research without attending to the clinician or patient is not EBP; conversely, the indiscriminate disregard of available research is not EBP. Second, the definition requires integrating these three evidentiary sources. The integration flows seamlessly and uncontested when the three evidentiary sources agree; the integration becomes flawed and contested when the three sources disagree. Third, not all three pillars are equal: Research assumes priority in EBP. Clinicians begin with research and then integrate it with their expertise and patients’ values. Fourth, the patient assumes a more active, prominent position in that “patient values” were elevated to “patient characteristics, culture, and preferences.” The APA definition deliberately invoked cultural sensitivity. Put bluntly, clinical practice without attending to culture cannot be characterized as EBP.

Samhsa Registry

The Substance Abuse and Mental Health Services Administration (SAMHSA) has created a National Registry of Evidence-Based Programs and Practices (NREPP; www.nrepp.samhsa.gov) designed to provide the public with reliable information on the scientific value and practicality of interventions that prevent and/or treat mental and substance abuse disorders. The NREPP database provides intervention summaries, which describe each intervention and its targeted outcomes, comment on the research on which the intervention is based, report the intervention’s

Figure 1. The three pillars of evidence-based practices.
references, and identify the individuals who developed the intervention. Two ratings are provided for each intervention: a quality of research rating and a readiness for dissemination rating. One of the valuable features of the Registry is its ability to search by keyword with the option of limiting to various topics, areas of interest, evaluations/study designs, or population groups. Cultural groups were privileged along with other parameters as essential components of the research base.

Federal Initiatives

Governmental agencies are increasingly demanding the use of EBPs for federal and state funding of health care services. One such example entails the requirement to use evidence-based interventions (EBIs) by the Centers for Disease Control (CDC) in their 2009 request for proposals for HIV prevention interventions for ethnic minorities. In the funding announcement CDC-RFA-PS10-1003, instructions stipulated, “Grantees must implement at least one and no more than two of the (CDC) EBIs…” (p. 11). Although adaptations were allowed, they must maintain the core elements of the EBI. Failure to use one of the 23 interventions would disqualify the applicant for funding. Based on information on the CDC Web site, only one intervention was adapted and translated into Spanish, a few were for African American women, while most were designed using Euro-Caucasian samples.

National Conferences

One of the first conferences that brought together researchers, program evaluators, and practitioners to develop and implement culture-sensitive EBPs was held in 2008 in Bethesda Maryland. Most of the articles in this issue, in fact, hail from that landmark conference: Culturally Informed Evidence Based Practices: Translating Research and Policy for the Real World. Its purpose was to stimulate activity in generating development and research in EBPs for ethnic minority populations. The conference was initiated and lead by the Society for the Psychological Study of Ethnic Minorities (APA Division 45) in collaboration with four other APA Divisions: Society of Clinical Psychology (Division 12), Society of Counseling Psychology (17), Society for Child and Family Policy and Practice (Division 37), and Psychologists in Independent Practice (Division 42). SAMSHA contributed a significant level of funding with additional funding received from NIMH, AAPA, APA, and 25 APA Divisions. Information and presentation materials from this conference are available online (http://psychology.ucdavis.edu/aacdr/ciebp08.html). This Journal issue was developed in collaboration with Division 45 as part of the planned outcomes of that conference.

Fidelity, Fit, or Both?

In practice, determining the optimal treatment plan for a given patient constitutes a recursive process. After asking, “What does the research tell us?” we must inquire, “What does the patient desire? What is available and realistic? What fits this cultural context? What about the cost-benefit ratio?” and a host of related questions. Then, we ask “Given these circumstances and contexts, what does the research tell us now?” And so on, until we secure a seamless blend, a practical integration of best research, clinical expertise, and patient characteristics (Norcross, Hogan et al., 2008).

In working with racial and ethnic minority patients, psychotherapists frequently confront a clinical dilemma. Should I use a research-supported treatment even if it
has not been validated on patients of the same race or ethnicity as my patient? Fidelity to a research-supported treatment offers the promise that it “works” but not necessarily with that population. Should I use a treatment preferred by the patient and in accord with her cultural conviction even if it has not been extensively tested in randomized clinical trials? Flexibility to the patient’s preferences and culture offers the promise that it “fits” but not necessarily of research support. Errors in either direction can portend failure: Practitioners can become overly cautious in protecting fidelity by adhering rigidly to the protocol and minimizing cultural differences, or can become overly flexible in readily adapting a treatment without or in disregard of the research evidence.

Of course, the easiest cases are those in which EBP trinity—research support, clinical expertise, and patient characteristics, culture, and preferences—converge, as in the overlapping center of Figure 1. But the dearth of controlled research on many psychological (and pharmacological) treatments with ethnic minority patients complicates these decisions.

Practitioners possess three basic options for a particular patient with regard to a research-supported treatment: adopt it, adapt it, or abandon it (Norcross, Hogan et al., 2008). We adopt the research-supported EBP when we believe it is a “good enough” fit for this particular patient and context. Providing the EBP in its original form affords several benefits (Ruscio & Holohan, 2006):

- The treatment has been tested and shown to be efficacious for alleviating the target problem, thus maximizing the probability of client success.
- The clinician will probably feel more confident in using an EBP and communicate that confidence to the patient.
- The client, as a part of informed consent, will learn that she is receiving a demonstrably effective, scientifically supported treatment.

In our experience, the majority of mental health and addiction patients make a good enough match with at least one EBP for one or more of their presenting problems. The percentage of racial or ethnic minority patients who make a good enough match with at least one EBP is probably lower, but perhaps worse, empirically unknown.

We adapt an EBP when we believe it has utility but does not seem adequate for this particular patient, problem, and context. Adaptations can entail modifying, supplementing, or sequencing the treatment, in ways not studied in the research trials, to accommodate the needs of the patient. Adaptation assumes that the practitioner is competent in the cultural and linguistic aspects of the client and has experience in integrating these variables in a culturally competent and congruent manner.

The obvious advantages of adaptation include our hope that the treatment aligns better with the patient’s needs and that the proven efficacy of the research-supported treatment will generalize to this case. The disadvantages include the unknown impact of the adaptation on the efficacy of treatment and the possibility that the modified EBP loses its curative ingredients. However, adapting EBPs may mean the difference between some treatment gains by engaging the patient versus no treatment gains at all by imposing a treatment deemed “unacceptable” by the patient.

Dynamic tension occurs in resolving the conflict between fidelity and fit, both essential elements of EBP. We seek fidelity of implementation in the delivery of the manualized treatment as found effective in controlled research. At the same time, we
seek fit in adapting the service to accommodate the needs of the specific patient (Castro et al., 2004).

Of course, research evidence must systematically guide adaptation of EBPs to cultural contexts and other patient characteristics. Data can selectively identify target problems and communities that would most benefit from an adaptation and then direct the design of the treatment adaptation (Lau, 2006). We also need to factor in the bottom-line question of whether the outcomes justify the additional costs of cultural adaptation. The consensus in the field points to selective adaptations: balancing fidelity with fit.

Numerous studies have now carefully evaluated culturally adapted therapies: traditional psychotherapies modified to improve the treatment utilization, retention, and outcomes of ethnic minority clients. As Duarte-Vélez, Bernal, and Bonilla (this issue) note, therapies can be culturally adapted along multiple dimensions—language, persons, metaphors, content, concepts, goals, methods, and context—to increase the congruence between the client’s experience and the treatment properties. A meta-analysis of 76 cultural adaptation studies found a medium effect ($d = .45$), indicating a moderately strong benefit (Griner & Smith, 2006). What is not yet clear is how such culturally adapted therapies would fare in comparison to the traditional, unadapted therapies offered to the same patient populations.

We abandon a research-supported treatment either before it commences, because we believe it does not apply to the particular patient and cultural context, or during treatment when it does not produce the desired results. Before treatment, clinicians may decide that the research-supported therapy lacks applicability and generalizability. During treatment, clinicians may decide to abandon the research-supported option because the patient shows signs of deteriorating, is not making any progress with it, refuses to continue it, threatens to drop out, or insists on an alternative (Norcross, Beutler, & Levant, 2006).

The decision to adopt, adapt, or abandon a research-supported psychotherapy for a particular patient falls entirely on the practitioner. The uncertainty of outcomes, the dynamic tension between fidelity and fit, and the dearth of research on these decision-making processes exacerbate the burden. And sadly, the risks of harm and malpractice fall completely on the shoulders of the practitioner, not on the policy makers nor on the developers of the research-supported treatments.

This Journal Issue

In this context, the current issue of the Journal of Clinical Psychology: In Session features six prominent examples of culturally adapted research-supported psychological treatments. Authors of all seven articles sensitively balance fidelity with fit, protocol adherence with patient flexibility, in the truest spirit of EBP.

The following articles traverse a range of mental disorders, patient populations, and therapy formats. The disorders addressed or treated with culturally sensitive therapies in these articles entail depression, trauma, delinquency, substance abuse, family dysfunction, and probable child abuse. The patient populations receiving services are all people of color—Latinos/Hispanic, American Indians, African Americans, and Chinese Americans—along with the intersections of their multiple identities (Gallardo & McNeill, 2009). The underserved, minority clientele in these case illustrations are defined by not solely their color or ethnicity but also their immigrant experience, disability status, financial impoverishment, and minority sexual orientation. The treatment formats involve individual therapy, family
sessions, healing networks, group therapy, psychoeducational modules, pharmaco-therapy, and preventive interventions. These cases remind us that cultural sensitivity can and should be developed and implemented for virtually every clinical encounter.

To begin, Phillippe B. Cunningham, Sharon L. Foster, and Sarah E. Warner describe family multisystemic treatment with African Americans. They employ an Afrocentric coding system for monitoring therapist-client interactions. They offer strategies for cultural-sensitive interventions grounded in careful process research and illustrated with in-session clinical examples with families.

Dolores Subia BigFoot and Susan R. Schmidt present an adaptation of trauma-focused cognitive-behavioral therapy with American Indians and Alaska Native children. They introduce the Honoring Children-Mending the Circle model and describe a number of its practical therapeutic tools.

In the next article, Adrian Aguilera, Monica J. Garza, and Ricardo F. Muñoz apply the Healthy Management of Reality (HMOR) treatment manuals with underserved, impoverished populations in the Bay Area. Their 16-week group treatment at San Francisco General Hospital comprises four 4-week modules that integrate Latino value systems.

Alfiee M. Breland-Noble, Antoinette Burriss, and H. Kathy Poole present their African American Knowledge Optimized for Mindfully Healthy Adolescents Project for African American adolescent youth and families suffering from depression. Their investigative work yields culturally specific themes that can facilitate treatment engagement and improve outcomes.

Anna S. Lau, Joey J. Fung, and Vanda Yung present culturally adapted parent training for Chinese immigrant families. Two case examples demonstrate how their approach can engage and treat such families even when psychotherapy is court mandated. Their adaptation of an evidence-based treatment increased its relevance and potency for families struggling with acculturation stress and bicultural family transitions.

Finally, Yovanska Duarte Velez, Guillermo Bernal, and Karen Bonilla adapt cognitive-behavioral therapy to the treatment of a depressed, gay Puerto Rican adolescent. They vividly demonstrate that both treatment fidelity and clinical flexibility can be achieved in the same complex, sensitive case. These scientist-practitioners begin with the most researched psychotherapy of our age—CBT for depression—and apply it to the intersection of the patient’s multiple, marginalized identities—a gay Latino in a Spanish speaking context.

Our overarching goal for this Journal issue is the same as the original conference: to stimulate the development, research, and implementation of EBPs for ethnic minority populations. Each of the following articles describes trailblazing work on integrating cultural sensitivity and EBP, once strange bedfellows and now fast friends.

Selected References and Recommended Readings


