

Evidence-Based Practices in Mental Health

*Debate and
Dialogue on the
Fundamental
Questions*

Editors

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and Ronald F. Levant**

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8

HOW WELL DO BOTH EVIDENCE-BASED PRACTICES AND TREATMENT AS USUAL SATISFACTORILY ADDRESS THE VARIOUS DIMENSIONS OF DIVERSITY?

Ethnic Minority Populations Have Been Neglected by Evidence-Based Practices

Stanley Sue and Nolan Zane

From the time of the 1978 President's Commission on Mental Health to the Surgeon General's (2001) and the President's New Freedom Commission (2003) reports, ethnic disparities in mental health have been nationally publicized. The disparities concerned the unmet mental health needs of members of ethnic minority groups (i.e., African Americans, American Indians, Asian Americans, and Latino[a]s). The reports concluded that the

disparities were not so much due to racial and ethnic differences in rates of psychopathology but were due to inaccessible and ineffective treatment. Ethnic minority clients often saw psychotherapists or were administered treatments that did not consider the clients' lifestyles, cultural and linguistic backgrounds, and life circumstances. Thus, one critical task is to improve therapeutic effectiveness and quality of care for these clients.

The evidence-based practice (EBP) movement promises to reduce disparities by using those treatments that are effective according to controlled research studies. It uses research to provide the best evidence of what works and then directly applies those findings to treatment selection. How can anyone disagree with such a movement?

In this position paper, we examine the extent to which EBPs have been helpful in reducing disparities and in improving treatment effectiveness. In many ways, we do not have the luxury of debating controversies identified by others (Beutler, 2004; Levant, 2004), such as whether research priority should be directed to treatment or context, whether external validity should be sacrificed for internal validity, or whether efficacy or effectiveness research is more valuable. Rather, we need to emphasize that more ethnic research must be conducted.

From the outset, our position is that psychological treatment should be guided by research evidence. However, we believe that EBPs have not been very helpful in reducing treatment disparities or improving effectiveness for minorities, primarily for three reasons. First, little research has been conducted on EBPs with clients from ethnic minority groups. Second, a need exists to broaden the current definition of "evidence." Third, research that tests if existing interventions are effective is limiting. Research into culturally competent interventions is needed, and this kind of research is relatively new. Consequently, the conclusions regarding mental health disparities reached by the President's Commission on Mental Health in 1978 have not changed a quarter of a century later (President's New Freedom Commission, 2003; U.S. Surgeon General, 2001).

LACK OF RESEARCH

One major problem in trying to use the EBP model to guide treatments with ethnic minority clients is that relatively little research has been conducted on these clients, especially research that satisfies rigorous research criteria such as those involved in randomized clinical trials (RCTs) or empirically supported treatments (ESTs). Both attempt to convincingly demonstrate via scientific methods the effects of an intervention so that alternative explanations for treatment effects can be eliminated. RCTs involve random assignment of clients to an intervention of interest or to a control group of some kind. Because of random assignment, systematic dif-

ferences between clients are minimized so that outcome differences can be attributed to treatment differences. In the case of ESTs (formerly named as EVTs or empirically validated treatments), Chambless and associates (1996) could not find a single rigorous study that examined the efficacy of treatment for any ethnic minority population. Others have also observed a lack of ESTs for ethnic minority populations (Bernal & Scharrón-Del Río, 2001; Zane, Hall, Sue, Young, & Nunez, 2003).

The U.S. Surgeon General (2001) reported that the gap between research and practice is particularly acute for racial and ethnic minorities. Research involving controlled clinical trials used to generate professional treatment guidelines did not conduct specific analyses for any minority group. Since 1986, about 10,000 participants have been included in RCTs evaluating the efficacy of treatments for certain disorders. For nearly half of these participants ($N = 4,991$), no information on race or ethnicity was given. For another 7% of participants ($N = 656$), studies only reported the general designation "non-white." For the remaining 47% of participants ($N = 4,335$), very few minorities were included; not a single study analyzed the efficacy of the treatment by ethnicity or race.

This sad state of affairs reveals the past history of ethnic mental health research. What portends for the future? Here we have mixed developments. On the one hand, disparities are being recognized, and funding agencies such as the National Institute of Mental Health (NIMH) and the Substance Abuse and Mental Health Services Administration are encouraging ethnic research or requiring research to include diverse groups.

On the other hand, ethnic research has been lacking because of systemic reasons. First, such research is often costly because of population sizes and difficulties in recruiting research participants. For example, African Americans and Latinos each represent less than 15% of the U.S. population, with Asian Americans at 5% and American Indians at 1%. Sampling ethnic clients from mental clinics and hospitals often yields samples that are too small to analyze, many ethnic clients may not want to participate, and convenience rather than representative samples often have to be used. Time for the research may have to be extended or special incentives may have to be given to secure participation. Second, the research is difficult to conduct. In addition to finding adequate clinical samples, tasks such as devising culturally valid measures, selecting appropriate samples that represent a particular ethnic group, deciding on whether to use interethnic versus intraethnic comparison designs, reducing cultural response sets, ensuring adequate English proficiency or translations for participants with limited English proficiency, controlling for potential confounds with ethnicity or cultural variables, and so on are daunting tasks. Third, psychology traditionally has been interested in achieving internal validity. It strives to make causal inferences so that rigorous experimental studies are the gold standard. In such a situation, external validity, or the extent to which research findings can be generalized to

other populations or situations, is of secondary interest. The overwhelming majority of research has been conducted on mainstream Americans. Therefore, if empirical support for the effectiveness of a treatment is found, there seems to be little interest in determining the extent to which the findings can be generalized to other populations (Sue, 1999). Finally, ethnic research is often controversial. Because much of the research touches on topics such as disparities, inequities, differential treatment, prejudice, and values, investigators may be uncomfortable in initiating studies that systematically examine important ethnic and cultural variations. These problems involving sampling, research difficulties, deemphasis on external validity, and focus on controversial topics reveal both the major challenges to conducting such research and the complexities in achieving rigorous research designs.

TWO QUESTIONS

The paucity of ethnic treatment outcome research has raised two important questions: (a) If so little research has been done, particularly research that is rigorously conducted, how can we be sure that disparities in treatment actually exist? (b) If treatment effectiveness and efficacy have not gained empirical support with these populations, should we refrain from using ESTs when they have not been studied in ethnic populations?

In regard to the first question, ample evidence of treatment disparities shows that the quality of care for ethnic minority clients has often been inferior. Although few rigorous outcome studies have been done, the preponderance of research of varying degrees of rigor has pointed to service disparities. With respect to the second question, the U.S. Surgeon General (2001) emphasized that ethnic clients with mental health problems should seek treatment and be given treatments that are generally found to be effective. That is, treatments should be administered on the basis of the best available evidence. This position assumes that the best course of action is to rely on research findings, even if research has been conducted on mainstream populations rather than ethnic populations. One can assume the generality of treatment outcomes, unless proven otherwise by research. However, this is hardly "good science" where assumptions should not be made; rather, they must be tested.

The problem we see is that assuming generalization reduces the pressure to conduct research on ethnic minority populations and to study the external validity and generality of research findings. In other words, the assumption of generalization is made for convenience and necessity rather than for science and client welfare, which would demand that treatment outcomes be studied for all major populations. Gyll and Madon (2000) noted that it is practically impossible to study all groups to see if findings can be generalized. This may be true, but science and skepticism demand that generality be convincingly demonstrated in some manner. Furthermore, that treatment prac-

tices show differential validities for different populations has been demonstrated by findings showing, for example, that recommended dosages for psychotropic medications vary according to ethnicity. Asians who are given psychotropic medication at dosage levels found to be clinically effective for Caucasians may be overdosed, even after controlling for body weight (Lin, Cheung, Smith, & Poland, 1997).

RESEARCH METHODOLOGY

In ethnic minority issues, it is easy to complain or to engage in social criticism because of the history of inequities. We wish to turn now to a discussion of what can be done to increase the value of the EBP movement to ethnic minority groups. We offer some suggestions as to research in general and cultural competency in particular.

The criteria to establish ESTs are rigorous and experimental, strongly intended to allow causal inferences to be made. They help to establish the extent to which treatments work. On the other hand, EBPs are a broader class of research, treatments, and practices. ESTs are one type of EBP.

The important question is the intent of the research. In the long term, the goal is to identify and implement the use of effective treatments. EST criteria are especially helpful in testing the efficacy or outcome of identified treatments. However, the value of EST criteria is more limited in the absence of identified treatments to test. That is, in situations where one does not have a clear intervention or is uncertain about treatment processes, an intermediate goal of research may be to examine psychotherapeutic processes and phenomena. Bernal and Scharrón-DelRío (2001) called this discovery-oriented research. This type of research is not intended to test hypotheses or well-developed treatments. Rather, discovery-oriented research attempts to understand the dynamics of the treatment process to identify important variables that may lead to the formulation of treatment strategies to test. Discovery research can be conducted using all types of methodology, ranging from quantitative to qualitative approaches, experimental to correlations studies, and laboratory to naturalistic settings. This is important particularly in ethnic research where the interest is not only in whether certain treatments used with mainstream Americans work with ethnic clients but also in whether certain culture variables should be taken into consideration.

Hall (2001) made a similar observation in distinguishing between ESTs and culturally sensitive therapies (CSTs). He defined CSTs as involving the tailoring of psychotherapy to specific cultural contexts. People from one cultural group may require a form of psychotherapy that differs from psychotherapy for another cultural group (in addition to cultural variations among people within a cultural group that require additional modification). In fact, it can be argued that currently identified ESTs are really CSTs for

mainstream Americans because they work for mainstream populations and have been largely untested for ethnic minority populations. There is, of course, no intrinsic reason why ESTs and CSTs cannot be the same.

This immediate discussion also shows why the simple inclusion of ethnic minorities as research subjects is inadequate. A 1994 National Institute of Health (NIH) policy required researchers to include ethnic minorities in their samples. Minority groups are defined by NIH as American Indian—Alaska Native, Asian—Pacific Islander, Black—African American not of Hispanic origin, and Hispanic (Hohmann & Parron, 1996). The exclusion of ethnic minority groups must be justified on scientific grounds. Only recruiting and including ethnic minorities in a research sample would fulfill the letter of the NIH policy and enable us to find out if research findings generalize from one group to another. But simple inclusion does not necessarily lead to new knowledge about ethnic minority populations (Hall, 2001). Thus, we believe that the full array of research methodologies and philosophies should be brought to bear in research on ethnic minority populations. Otherwise, research will not be of much benefit in responding to the observed ethnic disparities in mental health.

Furthermore, we should not be oblivious to the fact that research may not lead to improvements because policies and programs are influenced by political considerations. One disconcerting example of political influence and the manipulation of science findings occurred over a report entitled “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (Smedley, Stith, & Nelson, 2003). The report documented racial and ethnic disparities in health care and presented recommendations made by the National Institute of Medicine to reduce these disparities. However, before the report was released, some staff at the Department of Health and Human Services (HHS) attempted to modify the conclusions of the report to downplay the extent of disparities. For example, one draft conclusion was that significant inequalities were found in health care in the United States and health care disparities constituted national problems. After the modifications by HHS staff, none of these conclusions appeared. Protests were made over the modifications made by HHS staff and over the Bush Administration’s attempt to “whitewash” and hide disparities uncovered by scientists:

“Just like a tumor cannot be healed by covering it with a bandage, healthcare disparities cannot be eliminated with misrepresented facts,” said Rep. Elijah E. Cummings, Chair of the Congressional Black Caucus. “I urge the Bush Administration to stand by its commitment to eliminating racially-defined healthcare disparities by 2010. Disparities do not disappear by concealing information.”

“Instead of leading the fight against healthcare disparities, HHS is downplaying the serious inequities faced by racial and ethnic minorities,” said Rep. Michael M. Honda, Chair of the Congressional Asian Pacific American Caucus. “By tampering with the conclusions of its own scien-

tists, HHS is placing politics before social justice.” (Press release concerning letter sent to Tommy G. Thompson, U.S. Secretary of Health and Human Services by Waxman et al., 2004)

Only after such protests were sent to HHS Secretary Tommy Thompson did he say that his department had erred in rewriting the report on racial and socioeconomic health disparities and that he planned to release the report as originally written. This incident involving HHS as well as others altering research conclusions for political purposes, political litmus tests for grant reviewers, and ignoring scientific findings contrary to certain political thoughts (House Committee on Political Reform, 2004; Sluzki, 2003) should be of serious concern to psychological scientists. Manipulations of the scientific process and of research conclusions to achieve political ends are of great threat to science and society.

CULTURAL COMPETENCY RESEARCH

Cultural competency can be defined as having the cultural knowledge or skills to deliver effective interventions to members of a particular culture. At times, some skills may be effectively applied to many different cultures; at other times, some skills may be effective only with particular cultures. What are these skills? Are traditional treatments universally effective? Do traditional treatments need modification to be culturally competent? Can culturally competent skills be scripted and manualized? Do treatment processes differ according to ethnicity? What kind of cultural competency research should be conducted?

Four points are important to consider. First, culture is important in all phases of research and the treatment process. In terms of research, cultural considerations must be taken into account from the formulation of hypotheses, the selection of measures, the collection of data, and the analysis of data to the interpretation of findings. Second, at this stage in our research progress, most of the questions raised earlier cannot be meaningfully answered. We simply have a paucity of research. Third, in trying to ascertain the effectiveness of interventions on the outcomes of ethnic clients, serious complications exist that may impact the intervention used. The therapist may subtly and without awareness change the intervention to accommodate the ethnic client. For example, a therapist who is conducting therapy in English may not interpret literally what a limited English-speaking client is saying or may try to verify what the client is trying to convey. A therapist may engage in a “mental shift” in assessing a client from a different culture and be more cautious about making inferences. All these changes may occur without awareness. These may also help to increase cultural competency, but the intervention may be altered in important ways that are undetected in the

research. Thus, if researchers are interested in studying whether psychodynamic approaches are effective with ethnic minority clients, care must be taken to control for, or consider, subtle changes in the intervention.

Fourth, in studying cultural competency, we often attempt to see if a type of treatment is effective. Such an approach focuses on the intervention and not on the context of the intervention. Norcross and Goldfried (1992) found that therapist and relationship factors accounted for 30% of the improvement in psychotherapy patients, whereas client, family, and other environmental factors accounted for 40%. Specific treatment techniques, when combined with the expectancy factors commonly associated with placebo effects, accounted for the other 30% of improvement. The emphasis on ESTs has often led to calls for standardizing these treatments to minimize "procedural slippage" on the part of the therapist or client. However, this effort to optimize the effect of ESTs tends to cancel out important therapist and client variations, and it does not capitalize on the major patterns found in outcome research. In view of the substantial amount of outcome variance accounted for by therapist and client factors, it seems wise instead to account systematically for and examine these sources of variation to determine how they can moderate the effects of evidence-based interventions. Attempts to see if different types of treatment are effective or to operationally define cultural competency simply as a technique cannot provide a meaningful test of treatment impact. Norcross (2003) argued that decision rules to determine evidence-based psychotherapies neglect three essential elements of psychotherapy: the therapist, the therapy relationship, and the client's nondiagnostic characteristics. Likewise, cultural competency depends on contextual factors such as client characteristics, therapist characteristics, the type of intervention or treatment, and the treatment setting. To study and understand cultural competency, we need to deconstruct the treatment process into various components.

Client factors such as the level of acculturation are crucial. For example, in empirically testing the value of ethnic match between therapist and client, the client's acculturation level interacts with the match. Ethnic match was particularly valuable for Mexican American and Asian American clients who were low in acculturation (Sue, 1998). This means that culture-specific interventions may or may not need to be used, depending on certain client factors. *Therapist factors*, including experience in working with members of a particular ethnic group and a proficiency in the ethnic language, may be very important to consider in cultural competency. After all, if therapists and clients are unable to communicate or must do so with an interpreter, treatment may be seriously affected. Very critical are the racial attitudes and biases that therapists may have. The vast majority of therapists are non-Hispanic Whites. Many may hold stereotypic views of ethnic minority clients or fail to appreciate the "White privilege" that they possess. These attitudes and beliefs can detrimentally influence their perceptions of and interactions with

individuals who are ethnically and racially different from themselves (American Psychological Association, 2003b).

Treatment factors should also be examined. For instance, one criticism often made about treatment is that the interventions do not take culture into account or therapists interact with clients using stereotypes or inappropriate statements. Some intervention strategies may be less susceptible to these problems. Finally, *treatment setting* is likely to influence the use of cultural interventions. An Asian American client who has a great deal of shame and stigma over psychotherapy may not require much initial attention over them if the treatment is conducted in a prevention or educational setting rather than in a mental clinic or hospital. These factors help to determine whether certain cultural interventions are necessary; they also point to the complicated task of operationally defining and measuring cultural competency.

More recently, some attention has turned to another source of outcome variance: the treatment itself (e.g., Bracero, 1994; Chen, 1995; Yi, 1995). For example, Yi (1995) argued that psychoanalytic treatments often were ineffective with Asian clients because of the indiscriminate application of psychoanalytic concepts such as individuation separation. She recommended that therapists reconceptualize such concepts to accommodate nonindividualistic worldviews and use a sustained empathic-introspective approach to better access the experiential events of these clients. These conceptual advances notwithstanding, no sustained research effort has investigated how the life experiences of ethnic minority clients and their families, the attitudes and behaviors of their care providers, and the features of the treatment approaches affect the effectiveness of the intervention. As a result, we still have a rudimentary understanding of how mental health services can effectively respond to the needs of the severely mentally ill in ethnic minority communities.

CONCLUSIONS

EBPs can be of great benefit in cultural competency. However, the problem is that researchers and funding agencies have not paid much attention to ethnic and cultural research that determines if these treatments are effective, in other words, culturally competent. The conclusions reached by the President's Commission on Mental Health in the late 1970s are echoed today, some 35 years later, in the U.S. Surgeon General's supplement (2001) and the President's New Freedom Commission (2003). Research is needed that is inclusive of ethnic minority populations but also explanatory in nature about the effects of cultural variables. In particular, we point to the need to use a variety of methodologies, to examine the complexities in achieving cultural competency, and to resist political intrusions into science that undermine the significance of ethnic and cultural variations when the research indicates these should be considered.