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Introduction

Reconciling evidence-based practice and cultural competence in mental health services: Introduction to a special issue

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Abstract
The calls for evidence-based practice (EBP) and cultural competence (CC) represent two increasingly influential mandates within the mental health professions. Advocates of EBP seek to *standardize* clinical practice by ensuring that only treatment techniques that have demonstrated therapeutic outcomes under scientifically controlled conditions would be adopted and promoted in mental health services. Advocates of CC seek to *diversify* clinical practice by ensuring that treatment approaches are designed and refined for a multicultural clientele that reflects a wide variety of psychological orientations and life experiences. As these two powerful mandates collide, the fundamental challenge becomes how to accommodate *substantive cultural divergences* in psychosocial experience using *narrowly prescriptive clinical practices and approaches*, without trivializing either professional knowledge or cultural difference. In this Introduction to a special issue of *Transcultural Psychiatry*, the virtue of an interdisciplinary conversation between and among anthropologists, psychologists, psychiatrists, and social work researchers in addressing these tensions is extolled.

Keywords
evidence based practice, cultural competence, mental health services, interdisciplinary dialogue

In recent decades, the rigorous scientific evaluation of efficacy for healthcare services offered to the public in industrialized nations—and especially in the United States—has been increasingly prioritized (Iglehart, 2005; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). As just one domain of healthcare service

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delivery, mental health programs and interventions have been similarly called to account (APA Presidential Task Force on Evidence-Based Practice, 2006; Drake et al., 2001). This press for professional adoption of *evidence-based practice* (EBP) is premised on the commitment to a scientifically vetted clinical practice that will afford access to the most effective services for the greatest number of patients in need (Kazdin, 2008). EBP has been described as a "three-legged stool" comprised of research evidence, clinician expertise, and patient preference (Spring, 2007). Clearly, it is the first leg—research evidence—as expressed through the identification of structured treatment approaches targeting specific psychiatric disorders and symptoms that have demonstrated favorable outcomes under scientifically controlled conditions that most characterizes and distinguishes the EBP endeavor. Thus, those interventions that consistently produce improvement or recovery in randomized clinical trials—including effectiveness trials—are then deemed ready for dissemination and implementation by mental health professionals around the globe. Such efforts express the emerging professional consensus that the ethical and effective practice of mental health treatment must be guided by the best available outcome evidence (Baker, McFall, & Shoham, 2009). So compelling has been the call for EBP in the mental health field within the US that government agencies and managed health care organizations have in certain instances agreed to fund or reimburse *only* those approaches and interventions that have been researched in this fashion and supported by robust outcome evidence (Tanenbaum, 2005). Nevertheless, the procuring of such robust outcome evidence is both complex and costly, thereby ensuring that only a subset of mental health interventions will ever be studied in this manner.

In juxtaposition to the EBP movement in the mental health professions, multiculturalist advocates have registered critiques of the "monocultural" bias of mental health knowledge and practice, especially as expressed through psychosocial and counseling interventions (D. W. Sue, 2001; D. W. Sue, Arredondo, & McDavis, 1992). Given that populations of color are staggeringly underrepresented in clinical trials (Miranda et al., 2005), policy mandates for implementation of EBP with multicultural clienteles may be premature because the degree to which demonstrated outcomes of tested interventions might generalize to ethnoracial and cultural minorities remains an open empirical question (Bernal & Scharrón-del-Río, 2001; Hall, 2001). Nevertheless, greater inclusion of ethnoracially diverse samples within clinical trials is unlikely in itself to neutralize the multiculturalist critique. A principal concern expressed by multiculturalist advocates is that mainstream mental health practices have typically originated out of the life experiences of Europeans and Euro-Americans (Kirmayer, 2007), and therefore harbor the potential for alienation, assimilation, or other associated harms for culturally distinctive ethnoracial minority populations (Hall & Malony, 1983; Wendt, Gone, & Nagata, 2014). Thus, beyond the pragmatic concern for rendering effective treatments acceptable to the diverse individuals who might benefit from them (Kirmayer, 2011), the multiculturalist critique of EBP proposes that the danger of mainstream therapeutic approaches often extends well beyond the relatively superficial trappings of "cultural packaging" to questions of power, politics, and even

epistemology (Gone, 2007, 2008). As a consequence, according to multiculturalist professionals, practitioners must demonstrate *cultural competence* (CC) in providing services that are appropriately developed, designed, or tailored for diverse ethnoracial clienteles with due consideration of these complex factors (Cross, Bazron, Dennis, & Isaacs, 1989; S. Sue, Zane, Hall, & Berger, 2009).

Two burgeoning professional mandates thus collide (LaRoche & Christopher, 2008). On the one hand, the EBP movement has emphasized the routine need for a *standardization* of clinical practice that might ensure that only empirically supported treatments are adopted and promoted to address the mental health needs of the world. On the other hand, the multiculturalism movement has emphasized the routine need for a *diversification* of clinical practice that might accommodate the increasing ethnoracial and cultural heterogeneity within the U.S. population as well as retain relevance for a globalized world. The fundamental challenge that remains is how to accommodate *nontrivial cultural divergences* in psychosocial experience using *narrowly prescriptive clinical practices and approaches*. Interdisciplinary conversations among and between mental health professionals, health researchers, and social scientists can help to chart innovative terrain for identifying and redressing psychological distress and disability beyond the cultural mainstream of Western societies. Additionally, fascinating intellectual tensions inhere at the intersection of these professional mandates with regard to: enculturated notions of distress, illness, and well-being; group-based preferences for desirable therapists and therapies; alternatives for training therapists about the significance of culture; and competing conceptions of evidence for gauging treatment efficacy and designing optimal services. To put it another way, the challenge is to take *cultural variety* very seriously as *actively and substantively constituting human experience* (Gone & Kirmayer, 2010; Kirschner & Martin, 2010; Ryder, Ban, & Chentsova-Dutton, 2011) without either requiring a complete abandonment of clinical expertise (a trivialization of professional knowledge), or embracing merely superficial alterations in professional conventions toward otherwise familiar therapeutic objectives (a trivialization of cultural difference).

An interdisciplinary conversation

The emerging professional commitments to EBP and CC, respectively, were born of necessity insofar as service delivery systems maintain a stake in ensuring high quality treatment for the vulnerable mentally ill as well as meeting the mental health needs of culturally diverse national populations. Both movements represent important advances in mental health services, even as both remain subject to specific limitations (Kirmayer, 2012a; Whitley, 2007).

The need for EBP is perhaps most usefully illustrated with a historical vignette. Although premised on various forms of "credentialed knowledge" (Meehl, 1997), the clinical activities of psychologists, psychiatrists, social workers, and other mental health professionals have routinely (and perhaps necessarily) included approaches, conventions, and techniques born of pragmatic exigency more so

than proven efficacy. For example, during the 1990s, well-intentioned psychotherapists unwittingly cocreated with their clients a near epidemic of "recovered" traumatic memories of childhood incest, alien abductions, and Satanic ritual abuse (Ofshe & Watters, 1994; Wright, 1994); it was not until research psychologists marshaled contrary evidence concerning the workings of memory that the general public became aware of this professional folly and the clinical practice of so-called repressed memory therapies began to wane (Loftus & Ketchum, 1994). Thus, one consequence of such historical blunders has been the growing professional commitment to anchoring clinical mental health practice within the extant scientific evidence pertaining to basic psychological processes, as well as to therapeutic process and treatment outcome.

Despite this contribution, it is fair to acknowledge that the EBP movement is strikingly dependent on narrow forms of evidence (Goldenberg, 2006; Kirmayer, 2012a) that privilege outcome results from experimental designs with inadequate attention to questions of external validity (or generalizability). This leads in some instances to premature foreclosure on alternative methodological and therapeutic possibilities for identifying a greater diversity of effective interventions (Cartwright, Goldfinch, & Howick, 2009). A critique of such narrow foreclosure might draw on emerging awareness within the health sciences that *most* published research findings within these realms are probably "false," and that even some of the most influential findings pertaining to seemingly effective health interventions have been attenuated or overturned on replication (Ioannidis, 2005a, 2005b). Such a critique would further serve to remind the field that humility in the face of the sobering challenges of knowledge production may ultimately serve us better than arrogance (Gone, 2011). A reconstrual of the empirical project at hand might prescribe a wider range of methods and projects for adoption to better address a circumscribed set of pressing outcome questions (Gone, 2009; Weisner & Hay, 2015).

As previously described, the potent critique embedded within the call to CC has for good reason found professional traction, but this movement is not itself immune from critical appraisal (Kirmayer, 2012b). Indeed, multiculturalist advocates in the US have been prone to adopting and promoting "essentialist" (i.e., definitively characteristic and highly overgeneralized) accounts of race, ethnicity, culture, and discrimination that serve to efficiently advance political agendas more so than to afford insightful analytic attention to the nuances of group-based cultural orientations and practices (Eller, 1997; Fowers & Richardson, 1996; Hollinger, 2005). A critical assessment of these essentialist accounts would do well to draw on the misgivings of anthropologists (Abu-Lughod, 1991) and other social theorists about the way in which the term *culture* is constructed and deployed in the discourses of health and mental health professionals (Kleinman & Benson, 2006). Such a critique would further serve to remind the field that outdated notions of shared and bounded values, beliefs, and behaviors are greatly complicated in a globalized age. An effective reconstrual of the therapeutic dilemma presented by cultural diversity may require articulation of novel metaphors for representing cultural difference that better represent and appreciate fluency, dexterity,

and hybridity across multiple cultural domains (Good & Hannah, 2015; Kirmayer, 2011).

Beyond this, cultural analysts can assist in important ways by elucidating the historical moments in which broader cultural forces converge to enable clinicians and clients together to take up, craft, and reproduce specific notions of health and well-being, distress and dysfunction, and therapeutic processes and practices (Cushman, 1990; Furedi, 2004; Rieff, 1987). The resultant accounts, to return to our earlier vignette as an example, might reveal both how and why *childhood* and *trauma* became such important tropes in the psychic life of Americans, during the second half of the twentieth century, so as to give rise to the "memory wars" surrounding the iatrogenic psychotherapy of the 1990s (Crews, 1995; Hacking, 1998). Thus, traditions of inquiry associated with both intervention science and cultural analysis—the former grounded primarily in variable-analytic methodologies (in which observations are analyzed quantitatively) and the latter grounded primarily in interpretive methodologies (in which observations are analyzed qualitatively)—would appear to offer concrete and compelling opportunities to inform the clinical practice of mental health professionals (Gone, 2011). One implication is that there may be promising but untapped possibilities that could result from a broader interdisciplinary conversation about these matters.

The Special Issue

The five articles that appear in this special issue of *Transcultural Psychiatry* originated from a conference dedicated to just such an interdisciplinary conversation about the tensions at the intersection of EBP and CC in mental health services (Kirmayer, 2012a). More specifically, in October of 2011, my colleagues and I at the University of Michigan convened 21 distinguished anthropologists, psychologists, psychiatrists, and social work researchers from the US and Canada for a structured, interdisciplinary dialogue devoted to elucidating and recasting basic professional assumptions about the delivery of evidence-based mental health services to culturally diverse populations. Participants were invited to address the following questions with respect to the establishment of culturally attuned, demonstrably effective mental health interventions: (a) In what ways do dominant professional conceptions of *ethnoracial* and *cultural difference* presently influence clinical practice?; (b) In what ways do dominant professional conceptions of *efficacy and outcome evidence* presently influence clinical practice?; (c) In what ways do dominant professional conceptions of *psychopathology and disabling distress* presently influence clinical practice?; and (d) In what ways do dominant professional conceptions of *therapeutic processes and activities* presently influence clinical practice? The articles included in this collection were authored by only a subset of the conference participants, of course, but they retain the multidisciplinary voices and perspectives that distinguished the conference from the outset.

As a social work practitioner and trainer, Jackson (2015) recognizes the independent contributions of both EBP and CC, and thus seeks to identify a composite understanding of treatment that harnesses the value of each. For Jackson, the constituents of this composite form of treatment include an evidence-informed and culturally appropriate intervention, delivered by a practitioner who recognizes the implications of her cultural embedding, within a particular organizational setting, as all of this interacts with a client in distress, who is influenced by his social network within a broader societal context. By way of illustrating the power of this expanded conceptualization of treatment, Jackson focuses on two of its most undertheorized components, the cultural embedding of the practitioner (as a "cultural being"), and the organizational context (inclusive of both culture and climate that together create an "atmosphere" for performance) for service delivery. In sum, Jackson offers several recommendations that stem from this recognition of multiple factors that contribute to a complex helping relationship.

As a counseling psychologist and researcher, Helms (2015) critically examines the methodological quality of the most currently visible research at the intersection of EBP and CC, namely outcome studies of culturally adapted forms of empirically supported treatments. Drawing on three influential meta-analyses of mental health treatments adapted for ethnoracial minority clients, and selecting one study from each for closer scrutiny, Helms determined that the reported findings from these studies remain of dubious quality, primarily because researchers have failed to account for the lived experience of race, ethnicity, and culture in the design, implementation, and especially assessment of treatment effects. More specifically, she illuminates how inattention to any nuanced experiential aspects of the clinical encounter or the need to expand and tailor standard measures toward a more encompassing and valid assessment of therapeutic harm or benefit bedevils research in this important domain of inquiry. She proposes that four types of cultural equivalence—functional, conceptual, linguistic, and psychometric—guide future investigation of adapted treatment research to better account for the impacts of lived ethnicity and internalized racial disadvantage.

As a collaborating medical anthropologist and sociologist respectively, Good and Hannah (2015) take up the messaging of two influential reports from the U.S. federal government—that *culture counts*, and that U.S. ethnoracial health disparities reflect *unequal treatment*—to reflect on culture, evidence, and the clinical encounter. They note that, with increasing globalization, conditions of *hyperdiversity* prevail in many settings such that the traditional categories of social identity (e.g., race, ethnicity) cannot possibly reflect patient preferences or practices in any reliable manner. This "shattering" of culture introduces new dynamics that undermine the certainty with which mental health professionals might provide evidence-based treatments to clients in a culturally appropriate manner. Instead of orienting clinicians to group-based cultural attributes in ways that risk an untenable essentialism, these authors promote a case-based approach that is simultaneously more universal, individualized, and process-oriented by identifying clinical dilemmas and

solutions from a spectrum of relevant cultural information in the treatment of a hyperdiverse clientele.

Also as medical anthropologists, Weisner and Hay (2015) propose that attention to the *settings* in which clinical routines and practices intersect with the everyday lives of patients holds the key to integrating EBP and CC in the form of "context-examined, EBP-informed best practices." Drawing on partnership research models, these authors identify "evidence farming" as one means of recognizing, systematizing, and sharing the locally embedded and contextually tailored practice-based evidence accrued by experienced service providers for the benefit of patients. A second means of integrating EBP and CC proposed by these authors is to frame settings as "cultural learning environments" comprised by activities, routines, relationships, and resources, and to track the accommodations (i.e., functional adjustments) made by families grappling with disability in ways that could be informed by EBP. Finally, these authors remind us that much of culture is as tacit as it is influential—such as the American cultural mandate for individuals to remain active, busy, and productive—often eluding critical awareness and scrutiny at the intersection of EBP and CC.

As representatives of a research team in psychiatry, Vargas et al. (2015) report findings from qualitatively analyzed interviews with Latino patients who were diagnosed with major depression. These interviews revealed striking cultural barriers to psychopharmacological treatment for depression. More specifically, Latino/as in this depressed sample not only appeared to grapple with stigma about their condition from intimate and associate others, but also with culturally patterned personal concerns about the meaning of medication relative to the severity and chronicity of their depression as well as the risk of runaway addiction to their medication. This study memorably expands professional consideration of cultural barriers to evidence-based treatment beyond psychotherapy and other designated psychosocial interventions to remind us that even psychopharmacological treatments remain embedded within variable psychosocial processes requiring clinical awareness and sensitive management.

Future directions

In sum, the authors who have contributed to this special issue offer abundant insights, approaches, and recommendations for improving the quality and effectiveness of mental health services for increasingly diverse populations. Each article usefully expands conventions, challenges assumptions, or promotes innovations in research and practice at the intersection of EBP and CC. As the lead conference organizer and editor of this resultant collection, I have been privileged to witness the generative effects of presented ideas, responsive reflections, and mutual exchange over time as these articles have taken shape through various revisions in the long wake of a structured interdisciplinary dialogue of the kind that remains all-too-infrequent in the mental health field. Beyond wider circulation and further dissemination of the intriguing perspectives represented in this collection, it is my

sincere hope that additional conversations by theorists, researchers, and practitioners across the spectrum of academic disciplines and professional identities will characterize future efforts to advance the helpfulness and relevance of effective mental health treatments for a more inclusive swath of so many rapidly diversifying national populations.

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