

The Contribution of Cultural Competence to Evidence-Based Care for Ethnically Diverse Populations

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cultural competence, cultural tailoring, ethnic diversity, ethnic minority,
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Abstract

Despite compelling arguments for the dissemination of evidence-based treatments (EBTs), questions regarding their relevance to ethnically diverse populations remain. This review summarizes what is known about psychotherapy effects with ethnic minorities, with a particular focus on the role of cultural competence when implementing EBTs. Specifically, we address three questions: (a) does psychotherapy work with ethnic minorities, (b) do psychotherapy effects differ by ethnicity, and (c) does cultural tailoring enhance treatment effects? The evidence suggests that psychotherapy is generally effective with ethnic minorities, and treatment effects are fairly robust across cultural groups and problem areas. However, evidence for cultural competence is mixed. Ethnic minority-focused treatments frequently incorporate culturally tailored strategies, and these tailored treatments are mostly efficacious; yet support for cultural competence as a useful supplement to standard treatment remains equivocal at best. We also discuss research limitations, areas for future research, and clinical implications.

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INTRODUCTION

Despite compelling arguments for the wide-scale dissemination of evidence-based treatments (EBTs),¹ questions regarding their relevance to culturally diverse clients remain (Hall 2001, Miranda et al. 2005, Sue et al. 2009). One of the main concerns is the noninclusion or underreporting of ethnic minority participants in treatment efficacy studies (Bernal & Scharrón-del-Río 2001, Huey & Polo 2008, Miranda et al. 2005). For example, Chambless et al. (1996, p. 2) noted that they were unable to find “a single study that included tests of efficacy of treatment for ethnic minority populations” in the updated report on empirically validated treatments published by the Division 12 Task Force on Promotion and Dissemination of Psychological Procedures (1995). In addition, out of the 41 studies cited in the report, only a handful specified participant ethnicity (Task Force Promot. Dissem. Psychol. Proced. 1995). Similarly, the US Surgeon General’s supplemental report on mental health (US Dep. Health Human Serv. 2001) acknowledged difficulty determining treatment efficacy for ethnic minorities because of an absence of diverse samples in existing randomized controlled trials (RCTs).

These concerns are particularly acute given demographic shifts in the United States (Passel & Cohn 2008) and evidence of ethnic disparities in mental health utilization and service retention (Chen & Rizzo 2010, Dobalian & Rivers 2008). Numerous culture-related barriers to engaging minorities in treatment have been identified (e.g., Gray-Little & Kaplan 2000, Snowden & Yamada 2005), including differences in help-seeking attitudes and behaviors (Abdullah & Brown 2011),

¹The terms evidence-based treatment (i.e., empirically developed interventions that are based on randomized trials) and evidence-based practice (i.e., the integration of available research with clinical expertise in the context of patient characteristics, culture, and preferences) have somewhat different meanings but tend to be used interchangeably by mental health researchers (Drake et al. 2001, Tanenbaum 2005, Whaley & Davis 2007). In this review we use the former term because EBTs are more easily operationalized and the bulk of the relevant literature addresses EBTs in particular.

clinician bias in the diagnosis and evaluation of mental health problems (Lopez & Hernandez 1986, Malgady 2011), and disparities between clinicians and clients in terms of treatment expectations and preferences (Bernal et al. 1995, Cabral & Smith 2011, Sue 1998). Although the extent to which these barriers account for disparities is unclear, the findings highlight the need to consider cultural factors in the development and adaptation of EBTs (Betancourt et al. 2003, Hall 2001, Ridley et al. 2001).

In this review we summarize what is known about psychotherapy effects with ethnic minorities, with a particular focus on the role of cultural competence when implementing EBTs. Specifically, this review addresses three major questions. (a) Are psychotherapies effective for ethnic minorities, and if so, how robust are treatment effects? (b) Are standard therapies differentially effective for ethnic minority versus white clients? (c) Does culturally competent care enhance the effectiveness of mental health practice for ethnic minorities? We also discuss research limitations, areas for future research, and clinical implications.

WHAT IS CULTURAL COMPETENCE?

Despite ongoing efforts to integrate a cultural perspective in evidence-based care, definitional issues have hampered conceptual and empirical progress in the field (Fuertes & Gretchen 2001, Lakes et al. 2006). Although there is general consensus that cultural competence broadly requires an awareness of culture and the application of this knowledge to diverse clients (Betancourt et al. 2003, Whaley & Davis 2007), the literature still lacks a clear, uniform definition, and key terms continue to be used interchangeably. For example, scholars have referred to interventions that are modified to accommodate the beliefs, attitudes, and behaviors of culturally diverse clients as culturally adapted, culturally competent, culturally responsive, culturally sensitive, and culturally tailored, without much distinction (Whaley & Davis 2007). In addition, cultural competence frameworks differ in their assumptions (Betancourt et al. 2003, Lopez 1997), level of analysis (e.g., provider/treatment versus systems level; Resnicow et al. 1999, Sue & Torino 2005, Whaley & Davis 2007), and emphasis (e.g., content versus process oriented; Lopez 1997, Lopez et al. 2002, Sue et al. 2009). Such variations, though subtle, make operationalizing and evaluating the impact of cultural competence on EBTs challenging.

Numerous cultural competence models have been proposed over the past 30 years, and most assume that treatments must be compatible with a client's cultural needs to be effective (Fuertes & Gretchen 2001, Hwang et al. 2008, Tharp 1991). As such, considering the sociocultural context is considered to be important for clinicians who seek to maximize treatment success among ethnic minority clients (Bernal & Scharrón-del-Río 2001, Hall 2001). In addition, most models tend to focus on cultural competence at the provider or treatment level and are less concerned with cultural competence at the systemic or institutional level (Betancourt et al. 2003, Sue & Torino 2005). Where frameworks tend to diverge is in their emphasis, which can be broadly categorized in terms of therapist characteristics (i.e., skills-based or kind-of-person models), treatment characteristics (i.e., cultural adaptation models), and therapeutic processes (i.e., process-oriented models) (Sue et al. 2009, Whaley & Davis 2007). However, these distinctions are not mutually exclusive, as there is often overlap in the various components that constitute the models. For example, a predominantly skills-based model may include various process-oriented elements.

Skills-Based Models

In skills-based models, cultural competence is generally reflected in the provider's cultural self-awareness and knowledge of other cultures, and the ability to recognize how these values and

perspectives impact the therapeutic relationship (Sue et al. 1982). These models focus on the therapists' ability to evaluate their clients' needs in the context of their cultural background and to intervene appropriately (e.g., Pedersen 1978). For example, Sue and colleagues (1992) developed a matrix model representing dimensions that they viewed as most critical to cultural competence. They argued that culturally competent counselors would have three primary characteristics: (a) an awareness of their own assumptions, values, and biases; (b) an understanding of the worldview of the culturally different client; and (c) an ability to develop culturally appropriate interventions and techniques. In theory, these cultural competencies should allow therapists to work effectively across diverse populations, in part by enhancing the clients' perceptions of the clinician's credibility. Skills-based models posit that all therapists should be encouraged to develop such basic proficiencies and receive training in cultural competency (Am. Psychol. Assoc. 2003, Arredondo et al. 1996). To our knowledge, only a handful of controlled outcome studies have tested the efficacy of therapies that adopt a skills-based approach to cultural competence (e.g., Miranda et al. 2003, Ngo et al. 2009). For example, Ngo et al. (2009) compared a quality-improvement intervention to usual care for depressed youths of diverse backgrounds, with quality-improvement staff trained in cultural sensitivity issues (e.g., tailoring to fit the cultural context of each youth and family). They found that culturally enhanced quality improvement showed superior effects for black youths, although no significant treatment effects were found for Latino or white youths (Ngo et al. 2009).

Adaptation Models

Of the three cultural competence models, adaptation models have received the greatest attention in the literature. Models of cultural adaptation involve systematic modifications to service delivery, therapeutic process, or treatment components to make interventions more congruent with a client's cultural beliefs, attitudes, or behaviors (Benish et al. 2011, Bernal et al. 2009, Castro et al. 2010). One popular framework was proposed by Bernal and colleagues (1995) as a guide for developing culturally sensitive interventions for specific ethnic groups. They suggested eight major dimensions to guide the adaptation of existing interventions, including language (e.g., linguistic match), persons (e.g., ethnic matching or discussion of racial issues), metaphors (e.g., use of culturally familiar symbols and concepts), content (e.g., incorporation and application of cultural knowledge), concepts (e.g., presenting the problem in a manner that is consistent with the client's belief system), goals (e.g., ensuring congruence between therapist and client goals), methods (e.g., ensuring compatibility of treatment methods/procedures with the client's culture), and context (e.g., considering the impact of contextual processes). Rosselló & Bernal (1999) used this framework to adapt CBT and interpersonal therapy for Puerto Rican adolescents with depression and found that participants in the adapted therapies showed significant symptom improvement compared to a wait-list control.

Cultural adaptations have also been classified as either "surface" structure or "deep" structure in nature (Resnicow et al. 1999). Surface structure adaptations are used to increase intervention acceptability by modifying superficial characteristics to better fit the client's cultural preferences. Examples include translating treatment materials to match the client's native language (e.g., Burge et al. 1997) or using ethnically matched staff to deliver interventions (e.g., Hudley & Graham 1993). In contrast, deep structure adaptations target cultural values and traditions that affect the clients' perceptions of a disorder's etiology or treatment. Examples include integrating common ethnospecific explanatory models of illness and traditional healing practices into psychotherapy sessions (e.g., Bradley et al. 2006) or selecting psychotherapeutic approaches that emphasize the clients' values, such as the importance of family (e.g., Borrelli et al. 2010). Although the

psychotherapy literature is replete with cultural adaptations that can be classified as surface or deep structure, as an explicit organizing framework this model of adaptation has been applied primarily to behavioral health interventions, such as nicotine cessation and obesity interventions for ethnic minorities (Robinson et al. 2010, Webb 2009).

More recent models have gone beyond the identification of different adaptations by attempting to explain when modifications to an existing intervention are warranted or most beneficial (Castro et al. 2010). For example, Lau (2006) proposes that cultural adaptations be made selectively and applied only to problem areas when there is empirical evidence of poor fit between existing EBTs and the client population. Thus, cultural tailoring of an intervention may be justified if a particular problem emerges within a set of risk or resilience factors specifically associated with a given cultural group, or if a cultural group is known to engage poorly with certain EBTs or techniques. Lau et al. (2011) applied this “selective and directed” approach to a parent training program for high-risk Chinese immigrant families by targeting previously established, group-specific risk factors associated with physical discipline. They found that relative to those in the delayed treatment condition, Chinese American families who received the culturally adapted intervention showed greater gains in parent involvement, discipline, and child behavior (Lau et al. 2011).

Process-Oriented Models

In contrast to models that focus on therapist and treatment characteristics, process-oriented models emphasize the dynamic mechanisms underlying treatment, such as client-therapist interactions. Process-oriented models consider how cultural meaning is ascribed to specific behaviors or treatment contexts rather than what about culture matters for different cultural groups (González et al. 1994, Lopez 1997, Lopez et al. 2002). For example, Lopez’s (1997) “shifting cultural lenses” model argues that cultural competence involves “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). By accessing the client’s cultural perspective and integrating it with the clinician’s perspective throughout the evaluation and treatment process, the clinician may be able to better engage the client in treatment. Sue (1998) also advocates for a more process-oriented conceptualization of cultural competence. His triadic model of cultural competence highlights the importance of dynamic sizing, or the therapist’s ability to appropriately generalize or individualize treatment in the context of the client’s and therapist’s experiences. Because process-oriented approaches often take a broader view of culture based on individual needs and perspectives, they may be more adept at capturing the nuances of culture within specific ethnocultural groups than are models that do not necessarily account for within-group heterogeneity (Lakes et al. 2006, Whaley & Davis 2007).

Process-oriented models have generally been illustrated through case studies (e.g., Lakes et al. 2006), and psychotherapy researchers rarely integrate this form of cultural competence into clinical trials. One of the few was carried out by Dansereau et al. (1996) nearly two decades ago. They evaluated the efficacy of node-link mapping, a visual communication tool that allows the counselor and client to collaboratively develop a pictorial representation of the client’s issues, in the context of methadone maintenance treatment for opiate-addicted individuals. Relative to patients undergoing standard drug abuse counseling, those exposed to mapping-enhanced counseling showed greater treatment retention and drug abstinence. The data also indicated that mapping was generally more effective for ethnic minorities than for whites (Dansereau et al. 1996).

Table 1 gives a brief description of the three broad models of cultural competence in addition to key dimensions that help clarify the validity of each model. The table reveals several things about the literature that raise concerns about the evidence base for most cultural competence models.

Table 1 Summary of the three general models of cultural competence

	Skills-based model	Adaptation model	Process-oriented model
What are the core features of the model?	Emphasize therapists' ability to (a) evaluate clients' needs in the context of their cultural background and (b) recognize how their values and perspectives impact the therapeutic relationship (e.g., Sue et al. 1982)	Emphasize systematic modifications to treatment to make these approaches more congruent with a client's cultural beliefs, attitudes, and/or behaviors (e.g., Bernal et al. 1995, Lau 2006)	Emphasize the dynamic processes underlying treatment, such as client-therapist interactions, and how cultural meaning is ascribed to specific behavior and treatment contexts (e.g., González et al. 1994, Lopez 1997)
Is this approach to cultural competence tested in one or more randomized controlled trials?	Yes, but few (Miranda et al. 2003, Ngo et al. 2009)	Yes, many (e.g., Bradley et al. 2006, Hinton et al. 2005, Rosselló & Bernal 1999)	Yes, but few (Dansereau et al. 1996, Kopelowicz et al. 2012, Yeung et al. 2010)
Are there studies showing that clinicians can reliably utilize or adopt this approach to cultural competence or implement with fidelity?	No	Yes, but few (Pan et al. 2011, Szapocznik et al. 1986)	No
Do tests of specificity exist for this approach to cultural competence (e.g., impact beyond standard treatment effects; stronger effects for minorities or immigrants than for whites or those born in the United States)?	Yes, but few (Ngo et al. 2009) ^a	Yes, but few (Lau et al. 2011, Pan et al. 2011) ^b	Yes, but few (Dansereau et al. 1996) ^c

^aFor Ngo et al. (2009), culturally enhanced treatment (versus usual care) was superior for black youths but not for white or Latino youths.

^bFor Lau et al. (2011), low- and high-acculturation Asian Americans benefited equally from culturally adapted parent-child interaction therapy (versus a wait-list condition). For Pan et al. (2011), culturally adapted one-session treatment (OST-CA) was superior to standard OST (OST-S). Also, less-acculturated Asian Americans benefited more from OST-CA than OST-S, whereas no differences were found for highly acculturated clients.

^cFor Dansereau et al. (1996), the superiority of culturally adapted drug counseling (versus standard counseling) was greater for Mexican Americans and African Americans than for white Americans.

First, despite the large number of skills-based models discussed in the literature (e.g., Fuentes & Gretchen 2001), virtually none have been tested in controlled trials with clinical samples. This limitation applies to process-oriented models as well. Second, when focused primarily on findings from the EBT literature, there is a dearth of data indicating whether clinicians can actually use the skills advanced by cultural competence models. Third, evidence of model specificity is rare, with only a handful of studies showing that cultural elements contribute uniquely to outcomes or that cultural competence is more relevant for indicated groups (e.g., ethnic minorities, immigrants) than for nonindicated groups (e.g., white Americans, nonimmigrants). In short, despite the significant attention given to improving psychotherapy for ethnic minorities, there are few rigorous tests supporting the validity of any particular model of cultural competence. This issue is addressed in greater detail later in the review.

DOES PSYCHOTHERAPY WORK WITH ETHNIC MINORITIES?

Despite initial skepticism, recent reviews show that psychotherapy is generally effective with culturally diverse youth and adults, and the pool of efficacious treatments is growing rapidly

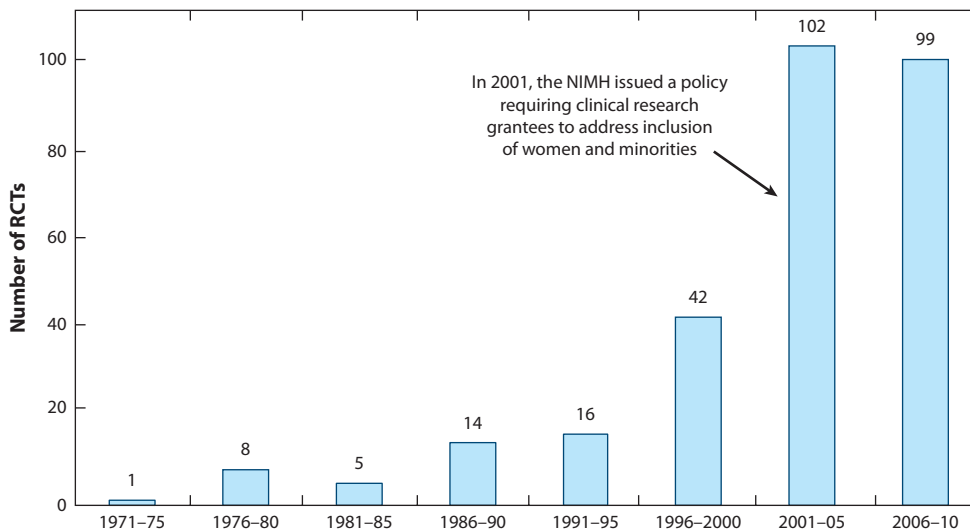


Figure 1

Number of randomized trials of psychosocial interventions with an ethnic minority focus, in five-year intervals.

(Bernal et al. 2009, Carter et al. 2012, Ho et al. 2010, Horrell 2008, Huey & Polo 2008, S.J. Huey Jr. & J.L. Tilley, unpublished manuscript; Miranda et al. 2005). Indeed, in the youth area alone, more than 30 distinct treatments can be classified as probably or possibly efficacious for ethnic minority children and adolescents (Huey & Jones 2013). Moreover, many of these interventions are culturally tailored to some degree. Recent meta-analytic reviews suggest that half of the EBTs for ethnic minority youths, 61% of treatments for externalizing minority youths, and 83% of psychosocial interventions for Asian Americans include some form of cultural tailoring (Gillespie & Huey 2013; Huey & Polo 2008; S.J. Huey Jr. & J.L. Tilley, unpublished manuscript).

However, existing reviews address only a fraction of the total number of treatment outcome studies that target ethnic minorities. Thus, to supplement these reviews, we summarize evidence from an existing database of more than 300 randomized trials of mental health treatments that (a) include predominantly ethnic minority participants, (b) assess how client ethnicity affects treatment outcomes, or (c) evaluate separate treatment effects for ethnic minority participants.² Many of these minority-focused trials include sufficient information for effect size calculation, and results from approximately half of these are discussed below.

Several trends are notable. First, **Figure 1** shows that the number of minority-focused randomized trials increased steadily and dramatically over the past 40 years. For example, only one trial was published over the five-year period from 1971 to 1975, whereas 99 trials were published or written between 2006 and 2010. These data are consistent with other work showing that the inclusion of ethnic minorities in clinical research funded by the National Institute of Mental Health has improved substantially in recent years (Mak et al. 2007, US Dep. Health Human Serv. 2011).

Second, minority-focused therapies appear to be effective across a broad range of mental health problems. **Figure 2** shows effect sizes for problems related to anxiety, depression, externalizing problems, schizophrenia, substance use problems, smoking, trauma, and miscellaneous or other

²These trials were retrieved from a database maintained by the first author.

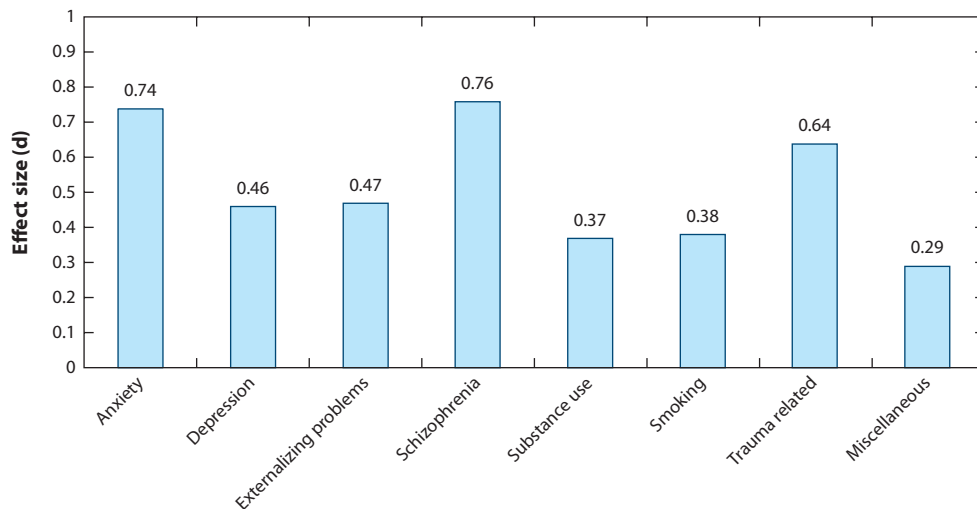


Figure 2

Mental health treatment effects for ethnic minorities across 140 randomized trials.

mental health concerns. Effect sizes range from $d = 0.29$ to 0.76 , which represent small-to-large treatment effects.³ The diversity of possible treatments is further apparent in **Table 2**, which lists nine syndrome categories along with representative EBTs for distinct ethnic minority groups in the United States.

Third, the bulk of the literature focuses primarily on African Americans and Latinos in the United States, with a small but growing number of trials targeting Asian Americans, Native Hawaiians, and Native Americans. Despite this narrow focus on the United States, a significant number of trials have targeted ethnic minorities in other Western nations as well, including Australia and New Zealand (e.g., Kypri et al. 2013, Turner et al. 2007) and a number of European countries (e.g., Adenauer et al. 2011, Afuwape et al. 2010).

Fourth, evidence from the subset of studies using treatment-as-usual or placebo controls ($N = 16$) shows that minority-focused treatments are effective at both reducing clinical symptoms at posttreatment ($d = 0.27, p < 0.001$) and improving treatment engagement ($d = 0.40, p < 0.001$). Thus, psychosocial interventions appear to show promise in attracting ethnic minorities into treatment, keeping them involved in therapeutic activities, improving the client-therapist relationship, and preventing minorities from terminating treatment prematurely.

Although these findings speak to the breadth of support for minority-focused EBTs, several limitations should be noted. Importantly, this brief analysis is based on a convenience sample of RCTs and should not be considered a systematic meta-analysis of treatment outcomes. Also, because these studies have not been coded for potential moderators and mediators, they shed minimal light on the parameters of treatment effects with ethnic minorities, including the role of cultural competence or the possibility of ethnic differences in treatment outcomes. These issues are addressed in the next two sections.

³According to Cohen (1988), effect size coefficients of around 0.20, 0.50, and 0.80 represent small, medium, and large effects, respectively.

Table 2 Examples of EBTs for US ethnic minorities with mental health problems

Target problem	Client ethnicity	Representative EBTs
ADHD	African American	Behavioral treatment + stimulant medication (Arnold et al. 2003)
	Latino	Parent-child interaction therapy (Matos et al. 2009)
Anxiety-related problems	African American	Panic control therapy (Carter et al. 2003)
	Asian American	One-session treatment (Pan et al. 2011)
	Latino	CBT (Silverman et al. 1999)
Conduct problems	African American	MST (Borduin et al. 1995)
	Latino	Brief strategic family therapy (Santisteban et al. 2003)
Depression	African American	Collaborative care for depression (Arean et al. 2005)
	Asian American	Culturally sensitive collaborative care management (Yeung et al. 2010)
	Latino	CBT and interpersonal psychotherapy (Rosselló & Bernal 1999)
	Native American	Coping with Depression course (Manson & Brennehan 1995)
Schizophrenia	African American	Assertive community treatment (Kenny et al. 2004)
	Asian American	Psychoeducational group treatment (Shin & Lukens 2002)
	Latino	Skills training (Lieberman & Kopelowicz 2009)
Smoking	African American	CBT plus nicotine replacement therapy (Murray et al. 2001)
	Asian American	Internet-based CBT (McDonnell et al. 2011)
	Latino	Multicomponent behavior treatment (Nevid & Javier 1997)
Substance use problems	African American	Contingency management (Milby et al. 1996)
	Latino	Structural ecosystems therapy (Robbins et al. 2011)
	Native American	Motivational enhancement therapy (Villanueva et al. 2007)
Trauma-related problems	African American	Prolonged exposure (Feske 2008)
	Asian American	CBT (Otto et al. 2003)
	Latino	CBT for trauma in schools (Stein et al. 2003)
	Multiracial Hawaiian	Eye movement desensitization and reprocessing (Chemtob et al. 2002)
Mixed/comorbid problems	African American	Seeking safety (Boden et al. 2011)
	Asian American	CBT (Hinton et al. 2009)
	Latino	Child-parent relationship therapy (Ceballos & Bratton 2010)
	Multiracial Hawaiian	MST (Rowland et al. 2005)

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; CBT, cognitive-behavioral therapy; EBT, evidence-based treatment; MST, multisystemic therapy.

DO PSYCHOTHERAPY EFFECTS DIFFER BY ETHNICITY?

Although ethnic minorities appear to show significant benefit from psychotherapy, there might still be ethnic disparities in the robustness of treatments. A frequent assumption is that treatment outcomes for ethnic minorities will be inferior to those of whites because cultural issues are mostly ignored or addressed superficially. To test this assumption, several reviews have assessed whether the literature shows greater support for ethnic invariance (i.e., treatment outcomes are similar for whites and ethnic minorities) or ethnic disparity (i.e., treatment outcomes for whites are superior to those for ethnic minorities). Evidence of ethnic disparity would strongly suggest the need for cultural tailoring of treatments.

An early review by Miller et al. (2007) summarized ethnic differences in therapy effects for 13 evaluations of motivational interviewing and other drug-focused treatments. They found that the majority of studies (69%) reported no ethnic differences in outcomes, 15% reported stronger

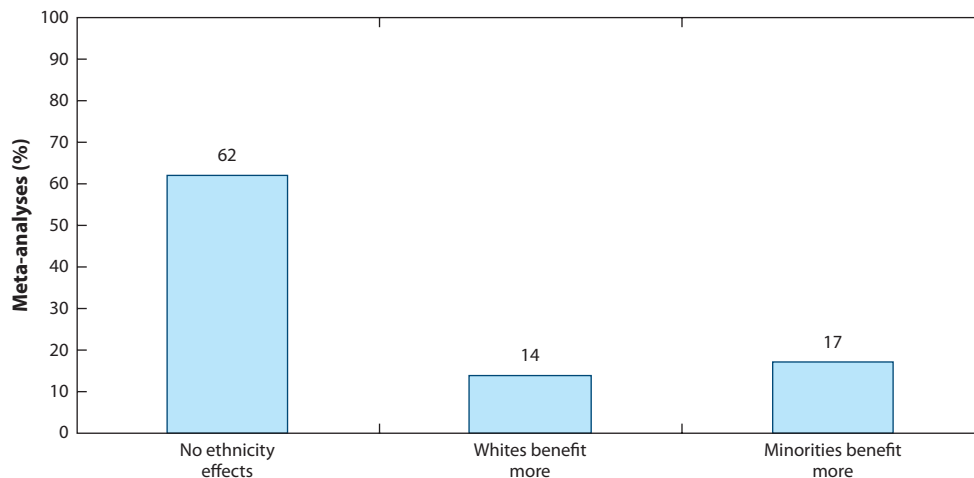


Figure 3

Percentage of treatment outcome meta-analyses ($N = 29$) showing no ethnicity effects, white advantage, or ethnic minority advantage (adapted from S.J. Huey Jr. & C. Smith, unpublished manuscript).

effects for whites, and 15% showed outcomes favoring ethnic minorities. Similarly, Huey & Polo (2008) reviewed outcomes from 13 child/adolescent randomized trials that tested ethnicity as a moderator of treatment effects. Most studies (62%) showed no ethnicity effects, 15% reported stronger effects for white youths, and 23% reported superior outcomes for ethnic minority youth. Huey & Jones (2013) took a different approach by summarizing effects from five meta-analyses testing whether ethnicity (white versus ethnic minority) moderated youth psychotherapy effects. No significant ethnicity effects were found for any of the meta-analyses, although one did show larger effects for studies conducted in North America versus other regions.

S.J. Huey Jr. & C. Smith (unpublished manuscript) synthesized a much larger pool of 29 meta-analyses that evaluated ethnicity as a treatment moderator. Approximately 38% focused on externalizing problems, 34% on substance use problems, 7% on comorbid problems, and 21% on other or mixed problems (e.g., anxiety, depression, and mental health problems). The majority focused primarily on youths (66%), whereas the remainder included predominantly adults (34%). **Figure 3** shows that 62% of meta-analyses reported no significant ethnicity effects, 14% reported outcomes favoring whites, 17% showed superior outcomes for ethnic minorities, and 7% showed mixed or indeterminate outcomes. Curiously, when substance use meta-analyses ($N = 12$) were examined separately, ethnic disparities were more apparent; 33% showed no ethnicity effects, 25% showed superior outcomes for whites, and 42% reported better outcomes for ethnic minorities (S.J. Huey Jr. & C. Smith, unpublished manuscript).

A related question is whether some ethnic minority groups benefit more from psychotherapy than others. To assess this possibility, we reviewed four additional meta-analyses that compared outcomes across two or more ethnic minority groups. Two compared outcomes across four groups (Griner & Smith 2006, Smith et al. 2011), and the others compared outcomes for black and Latino participants (Hodge et al. 2010a; Huey & Polo 2008). Generally, no ethnic differences in treatment outcomes were found, although one meta-analysis (Smith et al. 2011) showed that Asian Americans benefited more from psychotherapy than did African Americans, Latinos, and Native Americans (**Figure 4**).

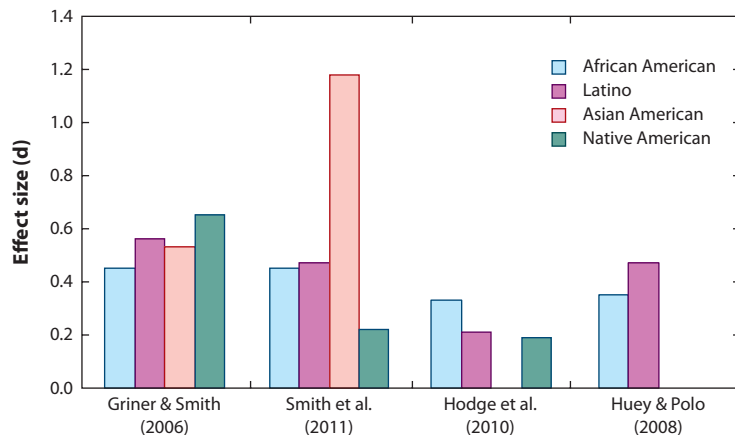


Figure 4

Results from four treatment outcome meta-analyses testing ethnicity as a moderator of treatment effects.

Thus, on average, psychotherapies appear to work equally well for whites and ethnic minorities. Approximately 60–70% of randomized trials or meta-analyses that examined ethnic differences found no significant moderator effects. Moreover, when ethnic differences did arise, results favored ethnic minorities as often as they favored whites. Overall, these results appear to support an “ethnic invariance” perspective, with the caveat that certain treatments may favor white participants under some circumstances but ethnic minorities under others. In addition, treatment outcomes across ethnic minority groups were quite similar, with one notable exception.

One important limitation of these “ethnicity-as-moderator” studies is that the role of cultural competence is mostly obscured. Although the majority of reviews suggest ethnic invariance in outcomes, the invariance could be because many minority-focused RCTs include cultural elements of one sort or another. The next section summarizes research evaluating the potential impact of cultural tailoring on treatment outcomes.

DOES CULTURAL TAILORING ENHANCE TREATMENT EFFECTS?

To evaluate whether cultural tailoring⁴ enhances treatment outcomes, we summarize results from 10 recent meta-analyses evaluating culturally tailored interventions for ethnic minority youths and adults. The meta-analyses differed in their inclusion criteria, but all focused on emotional, behavioral, or behavioral health outcomes for ethnic minorities. Although all 10 meta-analyses showed that culturally tailored interventions were efficacious for ethnic minorities, they diverged in their conclusions regarding the specific benefits of tailoring (see **Table 3**).

Yuen (2004) conducted a meta-analysis of studies evaluating culturally tailored primary prevention, secondary prevention, and positive youth development interventions. Studies included youths ranging from infancy to 25 years of age and compared culturally tailored treatments to a variety of control conditions (e.g., no treatment, placebo, and treatment as usual). Results yielded

⁴The overwhelming majority of relevant studies utilize cultural adaptations, with very few controlled trials evaluating skills-based or process-oriented approaches to cultural competence. For this reason, the authors of the meta-analyses in this section mostly make reference to culturally adapted, culturally sensitive, or culturally tailored treatments. Although we generally adopt the terminology used by these investigators, we also use cultural tailoring as an overarching term.

Table 3 Summary of meta-analyses evaluating culturally tailored treatments

Study	Focus	N	Design	Overall effect size	Moderators
Benish et al. (2011)	Culturally adapted versus bona fide psychotherapies for mental health problems	21	Direct-comparison experimental and quasi-experimental studies only	$d = 0.32$	Myth adaptation moderated treatment effects for culturally adapted treatments ($d = 0.21$).
Griner & Smith (2006)	Culturally tailored prevention programs and mental health treatments	76	Single-group, quasi-experimental, and experimental studies	$d = 0.45$	Three significant treatment moderators: (a) Older participants benefited more from treatment than did younger participants ($r = 0.29$). (b) Treatments delivered to ethnically homogeneous clients showed larger effect sizes ($d = 0.45$) than those delivered to ethnically mixed groups ($d = 0.12$). (c) Treatments that matched clients with therapists who spoke their native (non-English) language produced larger effects ($d = 0.49$) than those that did not ($d = 0.31$).
Hodge et al. (2010a)	CSIs for ethnic minority youths with behavioral problems or behavioral health problems	21	Single-group, quasi-experimental, and experimental studies	$g = 0.24$	None significant
Hodge et al. (2010b)	CSIs for Latino youths with behavioral health problems	11	Single-group, quasi-experimental, and experimental studies	$g = 0.18$ externalizing behaviors $g = 0.20$ physical health outcomes	None tested
Hodge et al. (2012)	CSIs for ethnic minority youths with substance use problems	10	Single-group, quasi-experimental, and experimental studies	$g = 0.12$	Treatment effects significant for recent alcohol use ($g = 0.23$) but not for recent marijuana use ($g = 0.61, p = 0.168$).
Huey (2013)	Culturally adapted versus generic treatments for mental health problems	10	Direct-comparison experimental studies only	$d = 0.01$	Two significant treatment moderators: (a) Treatments with implicit cultural tailoring had greater effects ($d = 0.24$) than those with explicit tailoring ($d = -0.42$). (b) Published studies had greater effects ($d = 0.28$) than unpublished studies ($d = -0.28$).

(Continued)

Table 3 (Continued)

Huey & Polo (2008)	EBTs for ethnic minority youths with behavioral and/or emotional problems (70% were culture responsive)	25	Experimental studies only	$d = 0.44$	Effects were greater when EBTs were compared to no treatment ($d = 0.58$) or psychological placebos ($d = 0.51$) versus TAU ($d = 0.22$).
Jackson et al. (2010)	CSIs for high-risk behaviors among African American youths	7	Single-group, quasi-experimental, and experimental studies	$g = 0.35$	None tested
Smith et al. (2011)	Culturally adapted treatments for psychological and family problems	65	Single-group, quasi-experimental, and experimental studies	$d = 0.46$	Five significant treatment moderators: (a) Older participants benefited more from treatment than younger participants ($r = 0.39$). (b) Treatments delivered to ethnically homogeneous clients showed larger effects ($d = 0.45$) than those delivered to ethnically mixed groups ($d = 0.12$). (c) Treatments for Asian Americans were more effective ($d = 1.18$) than those for African Americans ($d = 0.45$), Latinos ($d = 0.47$), or Native Americans ($d = 0.22$). (d) More cultural adaptations in eight domains were associated with larger effects ($r = 0.28$). (e) Descriptions of therapeutic goals ($b = 0.29$) and use of metaphors/symbols ($b = 0.37$) were associated with positive outcomes.
Yuen (2004)	Culturally tailored primary prevention, secondary prevention, and positive competency development studies	87	Single-group, quasi-experimental, and experimental studies	$d = 0.31$	More cultural adaptations ($b = -0.21$) and incorporation of cultural values into treatment were associated with poorer outcomes ($b = -0.40$).

Abbreviations: CSI, culturally sensitive intervention; EBT, evidence-based treatment; RCT, randomized controlled trial; TAU, treatment as usual.

a small effect supporting culturally tailored treatments ($g = 0.28$; $n = 87$).⁵ Moderator analyses revealed an unexpected result: The degree of cultural tailoring and the inclusion of cultural values were associated with poorer treatment outcomes. This pattern of results suggests circumstances in which cultural tailoring may attenuate treatment effects. However, given the focus on prevention and positive youth development, many study participants did not have preexisting behavioral or emotional problems, thus limiting the relevance for youth psychotherapy.

⁵Hedges's g is an unbiased or corrected version of Cohen's d . However, unless sample sizes are extremely small, the difference between d and g is typically trivial (Borenstein et al. 2009).

Hodge and colleagues conducted a series of meta-analyses examining the efficacy of culturally sensitive interventions (CSIs) for ethnic minority youths and found significant effects favoring culturally tailored treatments. One meta-analysis examined the effectiveness of CSIs in treating ethnic minority youths with behavioral health problems and found a small effect size ($g = 0.24$, $n = 21$; Hodge et al. 2010a). A second meta-analysis focused on CSI studies targeting health-related behaviors (e.g., substance use, dietary behaviors) for Latino youths and found a small effect size as well ($g = 0.18$; $n = 11$; Hodge et al. 2010b). A third meta-analysis of studies aimed at reducing high-risk behaviors among African American youths resulted in a small-to-medium effect size for CSIs ($g = 0.35$; $n = 7$; Jackson et al. 2010). Finally, a fourth meta-analysis focused on CSIs for substance use problems among ethnic minority youths found a very small but significant effect ($g = 0.12$, $n = 10$; Hodge et al. 2012). These meta-analyses provide consistent support for the efficacy of CSIs with ethnic minority youth, although they did not assess the relative benefits of the culturally sensitive elements in relation to EBTs.

Huey & Polo (2008) conducted a meta-analysis of RCTs evaluating EBTs for ethnic minority youths with preexisting behavioral and emotional problems. Overall, effect sizes were of medium magnitude ($d = 0.44$, $n = 25$), with effects larger when EBTs were compared to no treatment ($d = 0.58$) or placebos ($d = 0.51$) versus treatment as usual ($d = 0.22$). They also evaluated whether categorization as a “culture-responsive” or “standard” treatment moderated EBT effects using both conservative (i.e., cultural elements were explicitly described in the RCT) and liberal (i.e., cultural elements could also be described in treatment manuals or other supplementary sources) criteria. Regardless of the criterion used, no significant effects emerged, suggesting that cultural tailoring may not be necessary for interventions to be effective with ethnic minority youths. One limitation of the meta-analysis by Huey & Polo (2008) is that included treatments were all empirically supported, and ineffective treatments were excluded. Also, because the focus was exclusively on children, the relevance of these findings to adults is unclear.

To assess the efficacy of cultural tailoring for ethnic minority youths and adults, Smith and colleagues conducted two meta-analyses with predominantly adult ethnic minority participants and found results favoring culturally adapted treatments (Griner & Smith 2006, Smith et al. 2011). The first meta-analysis included 76 studies with disparate designs (e.g., single-group, quasi-experimental, and experimental designs) and both symptomatic and nonsymptomatic clients (Griner & Smith 2006). Overall they found medium effects favoring culturally adapted treatments ($d = 0.45$). Moderator analyses yielded three relevant findings: (a) Effect sizes were greater when participants were matched with a therapist who spoke their primary (non-English) language ($d = 0.58$) than when language match was absent ($d = 0.31$); (b) interventions aimed at a specific ethnocultural group were more efficacious ($d = 0.49$) than those provided to ethnically mixed groups ($d = 0.12$); and (c) treatment effect and age were positively correlated ($r = 0.29$), with older participants showing greater benefit.

A second meta-analysis by Smith et al. (2011) narrowed its scope to include studies with (a) quasi-experimental and experimental designs and (b) ethnic minority participants with preexisting psychosocial problems. Overall, medium effects were found for culturally adapted interventions ($d = 0.46$), and moderator analyses revealed that the number of adaptations made according to eight cultural dimensions (Bernal et al. 1995) was positively associated with larger effects ($r = 0.28$). Of these dimensions, the two that reached statistical significance were the use of “therapeutic goals that explicitly matched the clients’ goals” and the use of “metaphors/symbols in therapy that matched client cultural worldviews” (Smith et al. 2011, p. 171). Also, treatments aimed at a specific ethnocultural group ($d = 0.51$) were more effective than those delivered to ethnically mixed groups ($d = 0.18$). Finally, age was again a moderator of treatment effects ($r = 0.39$). **Figure 5** shows a consistent pattern of age effects from the Griner & Smith (2006) and

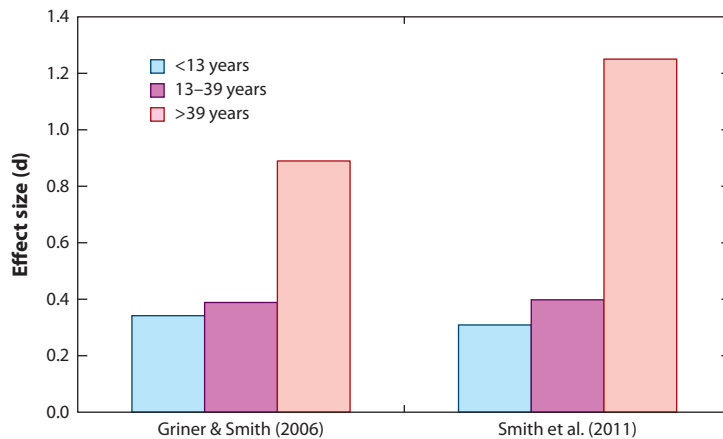


Figure 5

Treatment effect size by age across two meta-analyses of culturally adapted treatments (T.B. Smith, personal communication).

Smith et al. (2011) meta-analyses, suggesting that older adults benefit most from culturally adapted treatments.⁶

The meta-analyses summarized above uniformly support the use of culturally tailored interventions with ethnic minorities across the lifespan but are equivocal about whether cultural tailoring per se enhances treatment effects. Yuen (2004) found the number of cultural adaptations to be negatively associated with treatment outcomes, Smith and colleagues (2011) found a positive relationship, and Huey & Polo (2008) found that culturally tailored and standard treatments were equally effective. However, many of the included studies in these meta-analyses did not involve direct comparisons of adapted with unadapted treatments, leaving open the possibility that other factors were responsible for tailoring effects (or the lack thereof).

To disentangle the effects of cultural adaptation, Benish and colleagues (Benish 2010, Benish et al. 2011) conducted a multilevel, direct-comparison meta-analysis of culturally adapted treatments versus unadapted bona fide therapies. Bona fide treatments included a relationship with a therapist that was tailored to participants and met two of four criteria: (*a*) referenced an established approach, (*b*) included discussion of psychological processes, (*c*) included a manual or training, and (*d*) described essential treatment ingredients. Using these criteria, the authors identified 21 direct-comparison studies and found a medium effect on psychological functioning favoring culturally adapted treatments over standard treatments ($d = 0.32$). This indicates that 62% of participants who received culturally adapted treatment were better off at posttreatment compared to the average recipient of standard treatment. However, treatment retention was similar for culturally adapted (86%) and bona fide (88%) therapies, suggesting no differential effects on engagement (Benish 2010).

In interpreting their findings, the authors hypothesized that adaptation of the “illness myth,” rather than the addition of specific cultural ingredients (e.g., cultural values), was responsible for the improved efficacy of culturally adapted treatments above and beyond bona fide therapy. The illness

⁶Differences in treatment effects associated with age may be confounded with acculturation and clinical diagnoses. When the average age was 40 years or older (versus below age 40), participants tended to show lower levels of acculturation and more clinical diagnoses (T.B. Smith, personal communication).

myth refers to Frank & Frank's (1993) notion that psychotherapy theories are analogous to ancient myths via a shared lack of scientific falsifiability. Frank & Frank (1993) posited that psychotherapy is effective, in part, because it provides a plausible explanation for the client's symptoms along with a prescribed set of rituals intended to help alleviate the client's suffering. Accordingly, tailoring treatment to fit with the client's worldview should aid the therapist in providing an acceptable and adaptive explanatory model regarding client difficulties, thus mobilizing positive treatment expectancies and facilitating positive treatment outcomes (Wampold 2007).

To assess whether myth adaptation helped explain the superiority of adapted treatments, Benish et al. (2011) coded studies for evidence of treatment adaptations that accommodated clients' beliefs about the manifestation of illness symptoms, etiology, course, consequences, and expectations about the appropriate treatment. Moderator analyses found that culturally adapted treatments with myth adaptation showed superior effects on psychological functioning compared to treatments without myth adaptation ($d = 0.21$). Moreover, when myth adaptation effects were statistically controlled, culturally adapted treatments were comparable to bona fide treatments, and differences were nonsignificant. Other moderating variables were nonsignificant (Benish 2010, Benish et al. 2011), including the eight cultural dimensions outlined by Bernal et al. (1995). From this perspective, psychotherapy's contextual elements (i.e., nonspecific factors), as opposed to specific ingredients or mechanisms, are hypothesized to drive change. A limitation of this study is that culturally adapted treatments were not necessarily compared to unadapted treatments of the same length and format, making it difficult to determine whether the cultural adaptations (i.e., myth adaptation) were truly responsible for improved outcomes (Huey & Jones 2013).

Huey (2013) attempted to isolate the effects of cultural tailoring by conducting a direct-comparison meta-analysis of 10 RCTs in which the only differences between the experimental and control treatments were specific adaptations outlined by the investigators. Results showed that the overall effects of culturally tailored treatments on symptom reduction ($d = 0.01$) and treatment engagement ($d = -0.02$) were nonsignificant. However, moderator analysis revealed that cultural tailoring was indeed effective when adaptations implicitly addressed cultural factors ($d = 0.24, p = 0.02$) but potentially detrimental when adaptations were explicit in addressing race, ethnicity, or culture ($d = -0.42, p = 0.03$). Huey (2013) speculated that explicit reference to cultural values may in some cases have iatrogenic effects by eliciting reactance or stigma in ethnic minority clients.

Overall, these findings present a mixed picture of the benefits of cultural tailoring. Although culturally adapted treatments are clearly efficacious with ethnic minorities when compared to conventional control groups, it is less evident whether culturally adapted interventions are more efficacious than unadapted interventions. Some meta-analyses suggest that cultural tailoring may be a powerful tool for enhancing treatment effectiveness for ethnically diverse groups (Benish et al. 2011, Smith et al. 2011). However, other meta-analytic evidence suggests that some forms of cultural tailoring may provide little added benefit to ethnic minorities compared to standard treatments and, in some cases, may even reduce treatment effectiveness (Huey 2013, Yuen 2004). Further research is needed to understand the effects of cultural tailoring and determine what forms are effective and for whom.

Despite ambiguous findings on the treatment-enhancing effects of cultural tailoring, results from moderator analyses provide some clues as to which types of cultural tailoring might be most efficacious. First, available evidence suggests that cultural tailoring aimed at a specific ethnocultural group is more effective than tailoring targeting a mixed group (Griner & Smith 2006, Smith et al. 2011). Second, some evidence suggests that matching clients with therapists who speak their preferred (non-English) language may improve treatment outcomes (Griner & Smith 2006). Indeed, it is difficult to envision psychotherapy being effective when the client and therapist cannot

communicate with one another. Third, client variables such as age and acculturation may be particularly important to assess before implementing cultural adaptations. Meta-analytic evidence suggests that cultural tailoring may be most effective for older, less acculturated clients (Griner & Smith 2006, Smith et al. 2011). Fourth, some evidence suggests that therapist-client congruence on therapeutic goals and using metaphors/symbols that match the clients' cultural worldview may strengthen treatment efficacy (Smith et al. 2011). Fifth, myth adaptation that incorporates the clients' beliefs about symptoms, etiology, course, consequences, and appropriate treatment may improve treatment outcomes (Benish et al. 2011). Finally, addressing cultural factors implicitly rather than explicitly may be one promising way to capture the benefits of cultural tailoring without the risk of iatrogenic effects (Huey 2013). These results provide some preliminary guidance to researchers and therapists when deciding what types of cultural tailoring are likely to be most beneficial; however, additional research is necessary to replicate these findings in well-controlled trials before causality can be inferred.

IMPROVING THE RESEARCH ON CULTURAL COMPETENCE

In summary, psychotherapy is generally effective with ethnic minorities, and treatment effects are fairly robust across cultural groups and problem areas. However, the evidence for cultural competence is mixed. Minority-focused treatments frequently incorporate culturally tailored strategies, and these tailored treatments are mostly efficacious; however, support for cultural tailoring as a useful supplement to standard treatment remains equivocal at best.

Given our limited understanding of effective culturally competent practice, what steps should be taken to improve the research? In this section, we highlight some of the major challenges in the field and make recommendations for future research.

Maximize Internal Validity

A persistent critique of this literature is the abundance of cultural competence models in the absence of well-controlled research to isolate cultural effects (Kumpfer et al. 2002, Price et al. 2005). In assessing the efficacy of minority-focused treatments, the typical RCT involves comparing a culturally tailored treatment to no-treatment, placebo, or treatment-as-usual controls; however, this design evaluates the efficacy of the overall intervention rather than specific effects of cultural tailoring.

To assess the validity of any particular cultural competence model, we propose a “strong inference” (Platt 1964) approach that includes six critical elements. First, using cultural features specified by the theoretical model, a culturally tailored treatment should be compared to a generic treatment in an RCT. Second, the generic and tailored treatments should be alternate versions of the same core treatment and not differ substantially in length or intensity (i.e., they should differ only in the inclusion or absence of key cultural features). Third, tailored treatment should lead to significantly greater symptom reduction (or treatment engagement) than generic treatment. These first three elements are necessary to demonstrate that the added cultural features, and not other extraneous factors, are causally related to symptom reduction.

A fourth requirement is that trials have appropriate statistical power to detect significant tailoring effects. If medium effects (e.g., $d = 0.50$) are expected, then a modest sample size (approximately 60 per condition) would be required (Kazdin & Bass 1989). However, because some argue that cultural tailoring effects are likely in the small range (e.g., $d = 0.20$) (e.g., Cardemil 2010), sample sizes needed to detect significant effects might exceed 400 participants per condition in some cases, which is prohibitively large for most randomized trials. Fifth, there should be

evidence of differential impact; culturally focused interventions should benefit indicated populations to a greater extent than those who are not the intended beneficiaries. For example, many models implicitly assume that cultural tailoring will be most effective for ethnic minorities, immigrants, and low-acculturation individuals but least effective for whites, nonimmigrants, and highly acculturated individuals (Hall 2001). Thus, if ethnic minority and white clients were to benefit equally from a cultural tailoring strategy, parsimony might suggest that the strategy be considered a universal change approach rather than a culturally specific one. Finally, the mechanisms hypothesized to account for cultural tailoring effects should be specified, tested, and confirmed (Hinshaw 2002, Kazdin 2007). Elucidation of mechanisms is important because cultural tailoring may enhance treatment effects, but not necessarily for the reasons theorized by investigators. Many skills-based models argue that culturally focused clinical competencies (e.g., discerning the worldviews of clients) should lead to greater clinician credibility, which in turn should contribute to client improvement (Sue & Zane 1987, Sue et al. 2009, Wade & Bernstein 1991), yet we know of no studies that have tested this mediating causal sequence.

Table 4 provides a summary of 12 RCTs that evaluate culturally tailored versus generic mental health interventions, with each study evaluated in terms of the six criteria. Note that only two of 12 studies were adequately powered (assuming a medium effect), four detected significant tailoring effects, two showed evidence of differential impact, and none confirmed the mechanisms underlying the model. Studies by Dansereau et al. (1996) and Pan et al. (2011) provide the strongest evidence for their respective approaches to cultural competence. As described previously, Dansereau et al. (1996) found that mapping-enhanced counseling led to greater treatment retention and drug abstinence than standard counseling, but only for ethnic minority addicts. Similarly, Pan and colleagues (Huey & Pan 2006, Pan et al. 2011) found that culturally adapted one-session treatment was more effective than standard one-session treatment at reducing symptoms in phobic Asian Americans. Moreover, less-acculturated Asian Americans benefited most from adapted one-session treatment, and culture-related treatment content predicted greater symptom reduction (Pan et al. 2011). Clearly there is a need for additional experimental research that attempts to disaggregate cultural tailoring from standard intervention effects.

Concerns over internal validity also extend to research on cultural competence training. Literature reviews mostly agree that there is little in terms of rigorous evaluation to guide policy decisions about the utility of training clinicians in cultural competence (Anderson et al. 2003, Bhui et al. 2007, Good et al. 2006, Price et al. 2005). The use of appropriate control groups is rare, client samples are analogue rather than clinical, cultural competence evaluations are based almost exclusively on therapist self-report, and evidence linking therapist cultural competencies to client outcomes is sparse. Despite several decades of research, we know very little about (a) the threshold for adequate cultural competence among clinicians, (b) which training approaches increase cultural competence in clinicians, and (c) whether cultural competence can be reliably differentiated from generic clinical competence (Imel et al. 2011).

Consider Research from Other Fields when Developing and Evaluating Cultural Competence Models

Three recent meta-analyses found that most minority-focused therapies include cultural tailoring of one sort or another (Gillespie & Huey 2013; Huey & Polo 2008; S.J. Huey Jr. & J.L. Tilley, unpublished manuscript). Moreover, the majority of adaptations were arrived at systematically through focus groups with cultural agents, expert consultation, reference to existing cultural competence theories, knowledge concerning culturally relevant risk factors, or some combination of these. However, a potential limitation is that adaptations were derived fairly narrowly from the

Table 4 Cultural tailoring RCTs judged on six criteria for a strong test of cultural competence effects

Study	Randomized controlled trial of tailored versus generic	Tailored and generic are equivalent	Appropriate power ^a	Tailored > generic	Differential impact	Cultural mechanisms confirmed
Acosta et al. (1987)	Yes	Yes	Yes	No	— ^b	—
Burrow-Sanchez & Wrona (2012)	Yes	Yes	No	No	—	—
Dansereau et al. (1996)	Yes	Yes	Yes	Yes	Yes. Tailored > generic for ethnic minorities, but not whites	—
Groditzky (1993)	Yes	Yes	No	No	No. Tailoring has same effects for Puerto Rican and Anglo youths	—
Kopelowicz et al. (2012)	Yes	No. Content differed	No	Yes	—	—
McCabe & Yeh (2009)	Yes	Yes	No	No	—	—
Pan et al. (2011)	Yes	Yes	No	Yes	Yes. Tailoring > generic for less-acculturated Asians	Partially. Cultural engagement correlated with treatment condition and outcomes but did not mediate treatment effects
Pan (2011)	Yes	Yes	No	No	No. Tailored = generic for Asian Americans and whites	—
Perez (2006)	Yes	Yes	No	No	—	—
Santisteban et al. (2011)	Yes	No. Content and length differed	No	Yes	—	—
Schwarz (1989)	Yes	Yes	No	No	—	—
Szapocznik et al. (1986)	Yes	Yes	No	No	—	Partially. Youth biculturalism increased more in culturally adapted condition

^aEstimated at 60 participants per condition, assuming a medium ($d = 0.50$) treatment effect (Kazdin & Bass 1989).

^bIndicates that the study did not assess support for this criterion.

clinical or counseling psychology literature. Drawing from other literatures that isolate culturally relevant processes could expand the range of treatment options for ethnic minorities.

For example, experimental research in the field of cultural psychology suggests that cultural differences in basic psychological processes could have profound implications for how psychotherapy is practiced with some ethnic groups. Work by Heine et al. (2001) shows that when North Americans receive positive feedback on their performance, they tend to be motivated to work harder on tasks, whereas East Asians persist longer when they are made aware of their weaknesses or failures. Why is this? The authors argue that compared to white Americans and Canadians, East Asians have a greater self-improvement motivation, which promotes a greater orientation toward identifying weaknesses and correcting them. Because many existing mental health interventions emphasize providing clients with positive evaluations to motivate healthy behaviors, this differential response to feedback could have important implications for the optimal delivery of mental health services to East Asians and Asian Americans. One possibility is that critical feedback that identifies remediable behaviors could improve treatment compliance and engagement for Asian American clients when compared to uniformly positive feedback.

Other work suggests that talking might generally be a less efficient method for processing emotional content for East Asians than for white Americans. In conventional forms of psychotherapy, the standard medium for processing emotional content is talk or speech. However, in East Asian cultural traditions, there is generally less emphasis on talking as an optimal way to communicate one's thoughts and emotions (Kim 2002). In a series of studies, Kim (2002, 2008) examined the differential effects of talking on thinking and performance for Asian Americans and white Americans. Results showed that verbalization of thoughts predictably enhanced problem solving in white Americans but impaired performance for Asian Americans (Kim 2002). Moreover, using cortisol measures of stress response, Kim (2008) found talking out one's thoughts was significantly more stressful for Asian Americans than for white Americans. These findings suggest that the vocalization of thoughts and feelings is more complicated, stressful, and cognitively taxing for Asian Americans than for white Americans. One implication is that East Asians might expend greater effort in treatment and process treatment content more efficiently when a nonverbal medium is used, such as writing or thinking to oneself.

These are merely two examples showing how basic research beyond the confines of clinical and counseling psychology might inform clinical practice with ethnic minorities. Notably, they raise the possibility that optimal treatments for some cultural groups could involve radical departures from current norms of clinical practice. Given the potential for significant contributions to clinical research, we encourage clinical investigators to consider such interdisciplinary sources when developing and refining clinical interventions for ethnic minorities.

Investigate How Cultural Competence Is Actually Practiced

A frequent rationale for cultural competence training is that clinicians poorly attend to cultural issues when treating ethnic minorities. However, therapist survey data over the past 25 years appear to challenge this assumption. In general, the majority of therapists report that they feel competent to work with ethnic minorities, discuss race/ethnicity-related issues when relevant to the presenting problem, feel reasonably comfortable discussing issues of ethnic difference with clients, consider race/ethnicity when constructing case formulations, and pursue additional resources when they are unfamiliar with the client's culture (Allison et al. 1996, Hansen et al. 2006, Harper & Iwamasa 2000, Holcomb-McCoy & Myers 1999, Lopez & Hernandez 1986, Maxie et al. 2006). **Figure 6** summarizes findings from five studies showing that the majority of mental health clinicians (predominantly white) perceive themselves as multiculturally competent

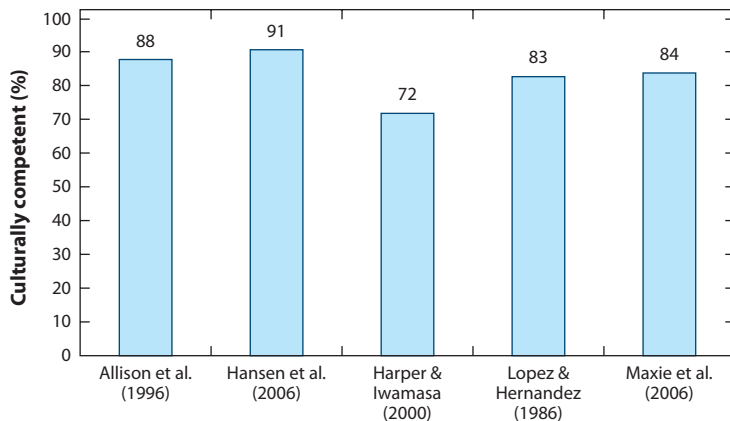


Figure 6

Percentage of clinicians who self-report competence in working with ethnic minority (or diverse) clients. For Allison et al. (1996), percentage reflects those reporting some level of competence in serving diverse clients; for Hansen et al. (2006), percentage reflects those who consider themselves “somewhat” or “very” multiculturally competent; for Harper & Iwamasa (2000), percentage reflects those who address ethnicity-related issues “frequently” or “always” when relevant; for Lopez & Hernandez (1986), percentage reflects those who take culture into account for “most” or “all” “culturally different patients”; and for Maxie et al. (2006), percentage reflects those who discussed ethnic/racial differences with a client at least once in the past two years.

or engage in practices (e.g., discussing ethnic/racial differences with clients) that many regard as culturally competent. Thus, some threshold level of cultural competence may be the norm among clinicians rather than the exception to the rule (Benish 2010).

However, some argue that information derived from therapist self-report may not reveal the true level of attention afforded to cultural issues in typical therapy sessions with ethnic minorities; survey data could simply reflect the therapist’s orientation toward multicultural competencies rather than culturally competent practice per se (Owen et al. 2011). To better determine how cultural competence emerges in both analog and real-world treatment contexts, observational research focused on therapist in-session behavior is needed (Constantine 2001, Owen et al. 2011). A small number of studies do show limited evidence that (a) cultural competence (in various forms) can be measured reliably by trained observers, (b) cultural competence is more prevalent in some groups than in others, and (c) in-session cultural content predicts client engagement or symptom reduction for ethnic minority clients (Constantine 2001, Jackson-Gilfort et al. 2001, Pan et al. 2011, Worthington et al. 2000). Yet current process research says little about the diversity of culturally competent behavior practiced by clinicians (e.g., what practices are rare versus normative), whether culturally competent behaviors vary as a function of client characteristics, or what threshold level of cultural engagement by therapists is needed to achieve true cultural “competence.” Clearly more process-oriented research is needed to address these and other critical issues.

Rethink How Cultural Competence Is Conceptualized and Defined

At a general level, most experts view cultural competence as the application of cultural knowledge to clinical work with ethnically diverse clients. A skilled application of cultural knowledge should improve therapist credibility, increase client engagement, and ultimately improve client functioning. One problem with this definitional approach is the assumption that cultural

competence necessarily leads to efficacious outcomes when applied to minorities. Also problematic is the assumption that cultural competence can be readily distinguished from the therapist's general competence. As we noted previously, neither assumption has strong support as yet.

An alternative framing would essentially reverse engineer the cultural competence construct. Rather than assuming a priori that particular approaches are necessarily optimal for ethnic minorities, cultural competence would instead be defined by its relative impact on ethnic minority clients. As an example, culturally competent therapists could first be defined as those who are comparatively more effective with ethnic minority clients than with white clients, whereas culturally "incompetent" therapists might be those who are less effective with minority clients than with white clients (Imel et al. 2011). Next, additional survey and treatment process research would be required to identify the personal characteristics and clinical skills that differentiate these two groups of therapists. One advantage is that treatment effectiveness would essentially be the starting point with this approach; one would begin by identifying those therapists who are optimally effective with minorities and then try to specify and distill those ingredients that make them effective. Another advantage is that this approach is mostly exploratory and atheoretical, and thus it creates the potential for unanticipated discoveries that might challenge (or support) existing paradigms. However, a major disadvantage relates to feasibility; this method would require a large sample of clinicians treating an ethnically diverse array of clients, as well as access to therapy sessions for process coding.

Studies that examine cultural competence in this way are quite rare, and we know of only one example to date. Imel et al. (2011) used data from a randomized trial for cannabis use to assess whether client ethnicity explained variability in therapist effectiveness. Although posttreatment cannabis outcomes were similar for white and ethnic minority clients, Imel and colleagues found that some therapists were indeed more effective with ethnic minority clients than with white clients, whereas others were relatively more effective with white clients. However, given the limited number of therapists and lack of process data, Imel et al. (2011) were unable to assess whether personal or clinical factors differentiated these therapists. We encourage investigators with access to sufficiently large data sets to explore such possibilities in future research.

Investigate Potential Risks and Harms of Cultural Competence Efforts

Another concern is the relative lack of attention to the potential pitfalls of attending to cultural issues in clinical practice. A frequent critique is that cultural competence efforts are often ideologically driven, without a balanced view of the benefits and costs of culturally focused practice (O'Donohue & Benuto 2010, Weinrach & Thomas 2004).

One pitfall is the possibility of iatrogenesis when it comes to culturally competent practice, with several studies indicating that cultural tailoring can sometimes diminish the effects of standard practice. Indeed, an unpublished meta-analysis of culturally tailored versus generic treatments found that tailoring effects were negative nearly as often as they were positive (Huey 2013; **Figure 7**). Several examples are illustrative. Schwarz (1989) assigned clinic-referred Puerto Rican adults to either a culturally focused orientation video plus clinical services condition or to a placebo video plus clinical services condition. Although no significant treatment effects were found for client symptoms or functioning, surprisingly, orientation clients attended significantly fewer scheduled appointments than did comparison clients. Perez (2006) randomly assigned bilingual, speech-phobic Mexican American undergraduates to one of four video-feedback conditions that differed in terms of (*a*) whether exposure speeches were given in English only versus in both English and Spanish, and (*b*) whether the speech was conducted in front of a perceived white versus Latino audience. Phobics in the three conditions that were adapted for language, audience ethnicity, or

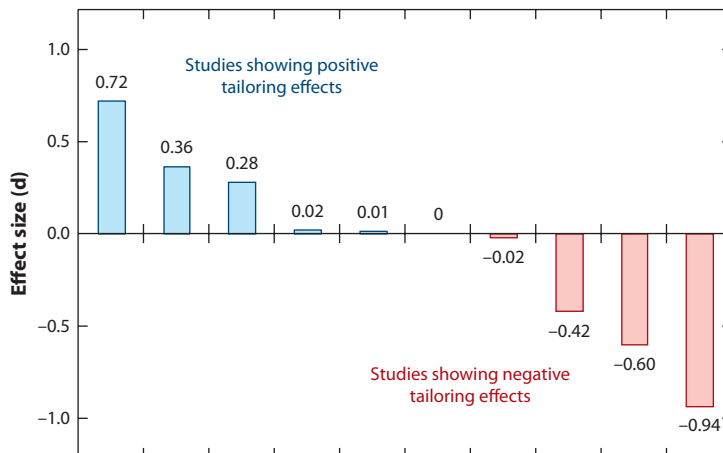


Figure 7

Individual effect sizes for 10 randomized trials comparing culturally tailored with generic treatments for ethnic minorities (adapted from Huey 2013). A positive effect size means that outcomes favor the culturally tailored condition; a negative effect size means that results favor the generic condition.

both, generally showed less clinical improvement than those in the standard condition (English feedback/white audience). Finally, Kliever et al. (2011) tested the effects of standard expressive writing, enhanced expressive writing, or nonemotional writing with violence-exposed African American youth. To fit the oral tradition within African American culture and the popularity of rap/spoken word among African American youths, enhanced writing was adapted by giving youths the option to write stories, skits, songs, or poetry about violence and to share their work with classroom peers. Unexpectedly, enhanced writing was significantly less effective than standard writing at reducing teacher-rated aggression/lability at two months postintervention. Thus, conventional wisdom notwithstanding, it appears that some forms of cultural tailoring have the potential to weaken previously effective treatments.

Why might cultural tailoring sometimes impede treatment progress? Some argue that an excessive and unstructured focus on cultural adaptations could lead to inefficiencies in the conduct of treatment, particularly if they interfere with or replace core intervention components (Castro & Alarcon 2002, Kumpfer et al. 2002). For example, in explaining their counterintuitive findings, Kliever et al. (2011) speculated that youths in the culturally enhanced writing intervention may have focused their efforts on generating a creative product, which interfered with their ability to effectively process their thoughts and feelings concerning violence. Another possibility is that ethnic-specific tailoring might elicit negative reactance in some minority individuals who prefer to receive generic treatments that generally avoid allusions to race or ethnicity (Huey 2013). Although such explanations are purely speculative, investigators who tailor existing interventions for ethnic minorities should consider the possibility that tailoring might be unintentionally harmful and perhaps should build explanatory mechanisms into study designs.

CLINICAL IMPLICATIONS

Given the ambiguous findings concerning the role of cultural competence in evidence-based care and the possibility that tailoring could inadvertently weaken existing treatments, how should clinicians proceed? Our overarching recommendation is to use EBTs as first-line treatments. One

Table 5 Four possible approaches to integrating cultural context into evidence-based care

Strategy	Possible advantages	Possible disadvantages
Adopt cultural elements only when embedded within an existing evidence-based treatment protocol	Cultural elements already vetted by prior therapists or investigators	Constrains clinician to adopt specific cultural elements Within-group heterogeneity is often not considered Some elements may not make sense for cultural groups that were not included in the validation studies
Adopt a well-specified, empirically based cultural adaptation model	Several models have good support	New adaptations may be required for each client demographic encountered by a clinician or clinic Depending on the model, cultural knowledge or familiarity with current research may be necessary
Adopt an empirically supported skills-based or process-oriented cultural competence model	Flexible Several models have good empirical support	Requires specific training in that model
Individualize treatment to match the client or client population	Maximum flexibility Most consistent with current practice Many treatment models and evidence-based treatments claim to facilitate this already	Unstructured emphasis on cultural elements could distract from core treatment elements Evidence for treatment individualization is mixed

advantage of this approach is the range of options available, with distinct EBTs existing for diverse ethnic groups exhibiting a broad array of mental health problems (see **Table 2**). Although most EBTs are cognitive-behavioral in orientation, interpersonal therapies, systems therapies, and a number of other approaches are also represented. There is also increasing evidence that EBTs can be successful with ethnic minorities when used by practicing therapists in real-world clinical settings (e.g., Foa et al. 2005, Henggeler et al. 1997, Miranda et al. 2003, Ngo et al. 2009).

Yet, how does one decide when and how to address cultural issues? On the basis of the limited evidence to date, we offer four possible approaches to considering culture when providing mental health services to culturally diverse populations. **Table 5** lists each approach, along with possible advantages and disadvantages to adopting each. We should note, however, that these approaches are not mutually exclusive.

The first approach involves adopting EBTs in their original form and incorporating cultural content only if it is already part of the treatment protocol. For example, in a recent randomized trial, Kaslow et al. (2010) successfully evaluated a culturally specific treatment (named Nia) for suicidal African American women that (a) included Afrocentric concepts, (b) utilized African proverbs and culturally relevant role models, and (c) encouraged clients to build on African American strengths, including strong kinship bonds and high religious involvement. Subsequent efforts to disseminate this approach might consider retaining all cultural elements as specified by the treatment developers. One advantage of this general approach is that therapists and clinical investigators have presumably scrutinized the cultural elements, given their prior use in clinical trials. The drawback, however, is that most adaptations are poorly specified in extant RCTs (Huey & Polo 2008) and frequently are not described in treatment manuals. Also, this approach (a) limits flexibility because it constrains therapists to use prescribed cultural elements that may not necessarily fit the needs of other demographic groups (e.g., because Nia was specifically designed for African Americans, it may be inappropriate for Asian American or Latino women), and (b) may not

account for within-group heterogeneity (e.g., many African American women might not relate to Nia's Afrocentric content).

The second approach uses cultural adaptation models with clear implementation protocols and acceptable levels of empirical support. Few models meet this threshold, but the adaptation framework by Bernal et al. (1995) is one viable approach. Although strong inference tests of the framework are lacking, the adaptation methods are well specified (Rosselló & Bernal 1996), some model components are supported by meta-analytic research (Smith et al. 2011), and several investigators have successfully adopted the model in treatment outcome studies (e.g., Matos et al. 2009, Rosselló & Bernal 1999). The adaptation models by Pan et al. (2011) and McCabe & Yeh (2009) are also promising in that (a) cultural elements appear to enhance the effects of standard treatment,⁷ and (b) both include guides that specify how cultural adaptations should be implemented (S.J. Huey Jr & D. Pan, unpublished treatment manual; McCabe et al. 2005). However, the primary challenge with this approach is pragmatic—numerous adaptations might be required to match the cultural variations encountered in clinical settings (O'Donohue & Benuto 2010). For example, if a particular clinic serves a predominantly Latino clientele that differs by country of origin (e.g., Dominican, Honduran, Mexican, Salvadoran) and acculturation level, then distinct adaptations might be required for each identifiable subgroup. This could pose an even greater challenge for those adaptation models designed explicitly with one cultural group in mind.

A third approach involves the use of empirically supported skills-based or process-oriented approaches to cultural competence. At least two models seem relevant here—Pedersen's (1977) triad model of cross-cultural counseling (a skills-based approach) and Dansereau et al.'s (1996) node-link mapping (a process-based approach). Regarding the former, Wade & Bernstein (1991) randomly assigned black female clients either to counselors who had received cultural sensitivity training based on Pedersen's (1977) model or to counselors who did not receive such training. They found that clients in the cultural sensitivity condition reported more satisfaction with counseling and stayed in treatment longer than did control clients. However, because Wade & Bernstein's (1991) approach was an analogue study focused on nonsymptomatic women in brief treatment (three sessions maximum), generalizability may be limited. In contrast, Dansereau et al. (1996) focused on clinic-referred drug abusers treated by full-time clinicians; they found that mapping-enhanced treatment was more effective than standard treatment in retaining clients and promoting drug abstinence. The primary advantage of both approaches is the greater flexibility they afford clinicians. A potential drawback, however, is that specific training in the models is required, and it is unclear how well therapists are able to adhere to these models. For example, Dansereau et al. (1996) found that trained therapists used node-link mapping in only 50% of cases.

A fourth approach involves individualizing treatment to match the specific needs of ethnic minority clients. Rather than adapting treatment on the basis of ethnic affiliation, clinicians would attend (implicitly or explicitly) to ethnocultural factors primarily when they seemed relevant to treatment goals or clinical concerns. Although most cultural competence theories presume that clinicians will tailor therapy to match the client's needs, many mainstream psychotherapy models also make this assumption. For example, a number of clinical scientists have argued that particular treatments are intrinsically responsive to cultural considerations given their focus on (a) identifying and targeting the client's personal goals, (b) using functional or "fit" analysis to assess unique determinants of client behavior, or (c) developing individualized treatment plans that address the

⁷Note that cultural adaptation effects for the McCabe & Yeh (2009) model are more tenuous. Effect size coefficients were consistently higher for culturally adapted treatment, but no significant differences were found between culturally adapted and standard parent-child interaction therapy.

client's sociocultural context (e.g., Hayes et al. 2011, Henggeler et al. 1992, Reid et al. 2001). The flexibility afforded by this approach gives it the greatest potential for success as well as failure with ethnic minority clients when compared with other approaches. On the one hand, individualization is a favored therapeutic strategy that maps onto routine clinical practice; individualization also allows clinicians to flexibly consider the cultural worldviews and experiences of diverse clients. On the other hand, the evidence that treatment individualization improves therapy outcomes is mixed at best, with several studies showing negative effects (e.g., Schulte 1996). Moreover, some scholars express concerns that allowing therapists to informally tailor without the benefit of established guidelines could dilute core interventions and thus erode treatment effects (Castro & Alarcon 2002, Kumpfer et al. 2002).

Thus, there may be no optimal approach to cultural competence because of the potential advantages and risks that each presents. For this reason, we are reluctant to endorse or prioritize any particular approach to cultural competence beyond our recommendation to consider EBTs as a first step. However, we expect that the latter two of the approaches described above will be the most amenable to practicing clinicians given the flexibility they afford.

With regard to engaging ethnic minorities in treatment, what part should cultural competence play? It appears that some role is warranted since limited evidence shows that some cultural tailoring approaches may increase session attendance and treatment retention among ethnic minorities (Dansereau et al. 1996, Wade & Bernstein 1991). That said, the literature also shows that mainstream engagement strategies can be effective with ethnically diverse populations. These include letter and phone prompting (McKay et al. 1998, Planos & Glenwick 1986), addressing practical and family-related barriers to treatment attendance (McKay et al. 1998, Santisteban et al. 1996, Szapocznik et al. 1988), role induction (e.g., Katz et al. 2004), and motivational interviewing (e.g., Carlini et al. 2008, Kemp et al. 1998). Although these approaches are ostensibly culture neutral, some argue that motivational interviewing is implicitly culturally sensitive in that it is person centered and nonjudgmental, mindful of the client's own assumptions and experiences, and attentive to the client's intrinsic beliefs and goals (Tomlin et al. 2013).

FINAL THOUGHTS

Elsewhere, we offered various recommendations for improving the quality of treatment outcome research with ethnic minorities (Huey & Jones 2013; Huey & Polo 2008, 2010). These include (a) expanding the number of clinical trials with ethnically diverse populations, (b) describing whether treatments incorporate culture-related elements (particularly in treatment manuals), (c) tapping culturally appropriate outcomes and utilizing culturally valid measures, (d) ensuring that sample sizes allow for adequate power to evaluate key research questions, and (e) assessing potential moderators of treatment effects, such as nativity and acculturation status. Here we offer two additional agenda items to help identify those strategies with potential for maximum treatment benefit and wide-scale use.

First, we encourage the use of rigorous study designs that test the basic tenets of cultural competence theories. Randomized trials that compare culturally tailored treatments to conventional controls (e.g., wait list) may help identify the efficacy of broad treatment packages, but they tell us little about the utility of specific tailoring approaches. A cursory review of the literature suggests hundreds of potential strategies when working with ethnically diverse populations. Unfortunately, the dearth of well-designed studies precludes efforts to separate the wheat from the chaff with regard to cultural competence. If our ultimate goal is to promote effective mental health care for ethnic minorities while discouraging inert or harmful practices, then rigorous evaluation of cultural competence models and strategies is needed to truly assess their worth.

Conceivably, future cultural competence protocols could emerge as highly effective in well-controlled studies but still gain little traction in treatment settings because providers find them unappealing or inconvenient. Approaches that involve considerable training, complex protocols, extensive monitoring, substantial costs, and applicability only to narrow demographics are less likely to be adopted and maintained by clinicians and agencies. Thus, we also encourage the development of inexpensive, easy-to-adopt cultural competence protocols that can overcome the barriers that prevent dissemination to real-world treatment contexts. Given the increased cultural diversity in industrialized nations and the growth in mental health care use worldwide, a major challenge for clinical scientists is to find approaches to cultural competence that are highly effective yet create minimal burden to mental health professionals.

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