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INTRODUCTION

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Ethnic and racial diversity in the United States is becoming an important and dynamic societal reality. By 2043, census officials indicate that ethnic/racial minorities will outnumber Whites. Minority populations now account for 37.5% of the population and are continuing to grow. In contrast, those who identified as White alone experienced the slowest rate of population growth (U.S. Census Bureau, 2011). The ethnic/racial minority population will account for nearly 90% of the total growth in the U.S. population from 1995 to 2050. More than half of the growth in the U.S. population between 2000 and 2010 was due to the increase in the Latino population. During this period, the Asian American population grew 4 times faster than the general population and faster than any other minority group (U.S. Census Bureau, 2011). The two groups will more than triple their 1995 population sizes, reaching 97 million and 34 million people, respectively, in 2050 (Minority Development Business

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Agency, 1999). Between 2000 and 2010, Texas joined California, the District of Columbia, Hawaii, and New Mexico in having a "majority minority" population, where more than 50% of the population was part of an ethnic or racial minority group. By 2025, 13 more states will be one third or more racial/ethnic minority, and these include the populous states of Florida, New York, Illinois, Georgia, New Jersey, and Virginia (U.S. Census Bureau, 2011).

This growing diversity has significant social, political, economic, and human services ramifications. By 2020, Hispanics (18.6%), Blacks (12.0%), Asians (5.7%), and all those belonging to the "all other groups" category (2.9%) will make up nearly 40% of the civilian labor force (U.S. Bureau of Labor Statistics, 2012). The ethnic minority marketplace in the United States now exceeds the gross national product of Canada. Moreover, in 2012, the $1.2 trillion Latino market was larger than the entire economies of all but 13 countries in the world (Selig Center for Economic Growth, 2012). Demographers predict that by the time the so-called baby boomers retire, the majority of those contributing to the Social Security and pension plans of primarily White workers will be racial/ethnic minorities. In California, White students in public schools now constitute the minority, with many other states of the country expected to follow suit by 2043 (Institute of Education Sciences, 2014). Clearly, the mental health field, as with other human services, must address and be responsive to this diversity.

With respect to best practices in mental health care, the American Psychological Association (APA) has adopted a policy that defines evidence-based practice in psychology (EBPP), affirms the importance and usefulness of using EBPP to enhance health, and delineates the various principles that guide EBPP. EBPP is defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Essentially, effective psychological treatment involves three critical processes: (a) applying the best available research evidence in the selection and application of treatments, (b) using clinical expertise that encompasses a number of competencies that have been found to promote positive therapeutic outcomes, and (c) being responsive to the patient's characteristics, culture, and personal preferences (APA Presidential Task Force on Evidence-Based Practice, 2006). The first process is the focus of most clinical research. It involves using treatments that are effective according to randomized controlled trials (RCTs). However, the generalizability of such research to ethnic minority clients must be considered. The second and third processes involve—among other things—cultural competence. *Cultural competence* is the ability of the clinician to work with a client and provide treatment in a manner that is culturally meaningful and ecologically valid. Clinicians must have relevant skill sets as well as substantial cultural knowledge to deliver

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effective interventions to members of a particular culture. Given the aforementioned increase in diversity nationwide, mental health providers need cultural competence to work effectively with ethnic minority clients. This volume considers how all three EBPP processes relate to ethnic minority clients, with a particular emphasis on cultural competence.

THE NEED FOR CULTURAL COMPETENCE

From a multicultural perspective, it is clear that psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences. Thus, attending to ethnocultural aspects of the patient is a critical and essential component of EBPP. However, since 1978, various presidential commissions have documented ethnic disparities in mental health in terms of the unmet mental health needs of members of ethnic minority groups such as African Americans, American Indians, Asian Americans, and Latino/as (President's Commission on Mental Health, 1978; President's New Freedom Commission on Mental Health, 2003). These commissions concluded that the disparities were not so much due to racial and ethnic differences in rates of psychopathology but rather were due to inaccessible and ineffective treatment. Ethnic minority clients often saw therapists or were administered treatments that did not provide consideration of the clients' lifestyles, cultural and linguistic backgrounds, and life circumstances. In view of the policy adopted by the APA on EBPP, those very considerations involving the patient's culture and race are essential to effective psychological practice. Clearly, this is a major priority for EBPP and the mental health profession.

The EBPP movement appears to provide some impetus to reduce ethnic and racial disparities in mental health. EBPP uses the best available evidence on patient characteristics, culture, and personal preferences to adapt the treatment to best serve a particular client. Nevertheless, the substantial promise of EBPP for addressing cultural diversity issues is largely tempered by the reality that there is little of this "best available evidence" with respect to ethnic minority populations.

THE NEED FOR RELEVANT RESEARCH ADDRESSING ETHNIC MINORITY ISSUES

The major problem in trying to use the EBPP model to guide treatment interventions with ethnic minority clients is that relatively little research has been conducted on these clients, especially research that satisfies rigorous

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research criteria such as those involved in RCTs or empirically supported treatments (ESTs). In the case of ESTs (also referred to as empirically validated treatments), Chambless et al. (1996) could not find a single rigorous study that examined the efficacy of treatment for any ethnic minority population. The U.S. Department of Health and Human Services (2001) reported that the gap between research and practice is particularly acute for racial and ethnic minorities. Research involving controlled clinical trials that were used to generate professional treatment guidelines did not conduct specific analyses for any minority group. From 1986 to 2001, about 10,000 participants were included in RCTs evaluating the efficacy of treatments for certain disorders. For nearly half of these participants ($n = 4{,}991$), no information on race or ethnicity was given. For another 7% of participants ($n = 656$), studies reported only the general designation "non-White." For the remaining 47% of participants ($n = 4{,}335$), very few minorities were included; not a single study analyzed the efficacy of the treatment by ethnicity or race.

These earlier reviews did not include outcome studies conducted since the National Institutes of Health mandated that grant applicants include adequate samples of minorities, women, and children, nor did they explain why such samples could not be obtained. Some believe this mandate may have significantly increased treatment research on underserved populations, especially ethnic minorities. Findings from a study seem to indicate that even the most current treatment research programs are not producing "best available evidence" on minority populations or issues. The study involved a review of 379 National Institute of Mental Health-funded clinical trials published between 1995 and 2004 in the five leading mental health journals (Mak, Law, Alvidrez, & Perez-Stable, 2007). The investigators found that fewer than half of the studies provided information on the specific ethnic composition of their samples. Among those that specified their ethnic composition, most ethnic minority groups were underrepresented, notably Asian Americans, Hispanics, and Native Americans. White Americans continued to dominate as participants in clinical trials (61% in studies that provided specific ethnic information). Moreover, few studies analyzed for ethnic or cultural effects. This lack of research on culturally diverse populations is not confined to empirical work in the mental health field. Recently, Chen, Lara, Dang, Paterniti, and Kelly (2014) conducted a review of samples used in clinical trial studies funded by the National Cancer Institute. Of the research institutes at the National Institutes of Health, the National Cancer Institute has one of the largest annual budgets. Chen and colleagues (2014) found that of the 75,215 trial participants in studies of breast, colorectal, lung, and prostate cancer from 2000 to 2002, the proportion of African American trial participants declined from 3.7% to 3% of this total and the proportion of Hispanic trial participants decreased from 11% to 7.9%. Moreover, only 20%

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of studies published in high-impact oncology journals examined race and/or ethnic variations in their results.

Cultural competence is an important and necessary condition of EBPP and, as such, EBPP can be a great catalyst for addressing ethnic and racial disparities in mental health treatment and services. However, researchers and funding agencies have not paid much attention to ethnic and cultural research that determines if these treatments are effective or, in other words, culturally and ecologically valid. The conclusions reached by the President's Commission on Mental Health in the late 1970s are echoed today, some 35 years later, in the U.S. Department of Health and Human Services Surgeon General's Supplement (U.S. Department of Health and Human Services, 2001) and the President's New Freedom Commission on Mental Health (2003). Research is needed that is inclusive of ethnic minority populations but also explanatory in nature about the effects of cultural variables.

PURPOSE AND OVERVIEW OF THE VOLUME

Developing and generating this type of meaningful research involves many challenges. The overall purpose of this volume is to inform and stimulate research and evaluation efforts that lead to the development of evidence-based practices for ethnic minority populations. Experts in the field of ethnic minority mental health treatment examine the reasons why research on culturally informed psychological practices has not progressed as much as some had hoped as well as present tangible ways and substantive strategies for conducting more meaningful and effectual research in this area.

The volume is divided into four parts. Part I (Chapters 1 and 2) discusses general challenges confronting research on cultural factors in EBPP. Part II (Chapters 3–6) discusses critical measurement issues, such as the use of culturally valid and acceptable measures, measurement equivalence, assessment of change in treatment, test translation and adaptation, and major statistical challenges (e.g., power and sample heterogeneity, moderated mediation, and testing for equivalence vs. differences). Part III (Chapters 7–9) covers important design and methodological issues, such as the use of meta-analytic strategies, mixed-method approaches, and participatory research in underserved communities. Finally, Part IV (Chapters 10–13) covers approaches to culturally adapting treatments. In short, the volume consists of chapters that discuss the challenges and highlight specific recommendations for conducting culturally informed EBPP. Below is a brief overview of individual chapters.

Levant and Sperry (Chapter 1) provide an overview of EBPP and a summary of the report of the APA Presidential Task Force on Evidence-Based Practice (2006). The three integral components of EBPP are best available

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research evidence, clinical expertise, and patient characteristics, including cultural values and treatment preferences. The authors emphasize how EBPP involves an integration of these multiple aspects of best practices in psychological treatment.

Lau, Chang, Okazaki, and Bernal (Chapter 2) provide a critical and selective review of the treatment outcome research with ethnocultural groups. Because ethnic minorities are underrepresented in clinical trials, questions remain about the applicability of EBTs for ethnic minority groups and the best strategies for improving their outcomes in care. The authors present three distinct lines of investigation, focusing on generalizability of EBTs for ethnic minorities, cultural adaptation of EBTs, and innovation with culturally sensitive therapies. To parse the priorities for continued research, the authors review emerging research within each area with attention to both methodological and epistemological issues.

Leong and Kalibatseva (Chapter 3) propose a conceptual model to evaluate threats to cultural validity in clinical diagnosis and assessment among racial and ethnic minorities and exemplify it with Asian Americans. Minimizing threats to cultural validity in clinical diagnosis and assessment is essential for culturally informed EBPP. *Cultural validity* refers to the efficacy of an instrument or the accuracy of a diagnosis to incorporate important cultural factors. The authors examine five threats to cultural validity: pathoplasticity of psychological disorders, cultural factors influencing symptom expression, therapist bias in clinical judgment, language capability of the client, and inappropriate use of diagnostic and personality tests.

Rivera-Medina and Caraballo (Chapter 4) discuss statistical and methodological issues that investigators need to consider in planning an RCT. They focus on the type of variables to be used as outcomes (dimensional vs. dichotomous), sample size and its impact on the power to detect the effectiveness of the intervention, handling of missing data, and consequences of adding secondary outcomes or conducting multiple testing. Key methodological concerns and analytic strategies that impact the results from an RCT with ethnic minority groups are examined. For example, they discuss the limitations of the intent-to-treat analytic strategy in clinical trials within ethnic minority communities.

Rios and Hambleton (Chapter 5) discuss the statistical methods for validating test adaptations, which are used in cross-cultural research. Because unresolved methodological issues can lead to invalid references from data in cross-cultural research, the authors of this chapter seek to provide researchers with a basic knowledge of the statistical procedures that can be implemented to evaluate measurement equivalence within a cross-cultural context. The authors examine three potential sources of measurement bias in cross-cultural and cross-ethnic assessment: construct bias, method bias, and item bias. They

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also discuss the specific conditions or circumstances that result in these types of bias (e.g., method bias can occur from sample, administration, or test bias).

Byrne (Chapter 6) focuses on the testing of instrument equivalence across cultures. She provides an overview of the basic concepts associated with both the measurement and structural equivalence of a measuring instrument. Multigroup comparisons of mean scores assume that both the instrument and the construct being measured operate the same across the populations of interest, and this assumption must be tested. She also discusses methods for testing instrument equivalence. Finally, she discusses the complexities in testing for instrument equivalence across cultural groups. For example, she notes that the issue of bias does not necessarily relate to the intrinsic properties of an instrument but rather to the characteristics of the respondents from each cultural group.

Doucerain, Vargas, and Ryder (Chapter 7) discuss mixed-methods research, which involves integrating qualitative and quantitative approaches to the psychological study of culture. They first define mixed-methods research and then explain its philosophical underpinnings. They then discuss the reasons for using mixed methods in research, focusing on five main rationales: triangulation, complementarity, development, initiation, and expansion. They also present a typology of mixed-methods research designs involving three dimensions: level of mixing, time orientation, and emphasis of approaches. The design chosen should be governed primarily by the research question at hand and by which integration would ensure optimizing the benefits of both qualitative and quantitative methods.

Zane, Kim, Bernal, and Gotuaco (Chapter 8) critically review the work done to culturally adapt psychotherapies for culturally diverse populations. They examine efforts to culturally adapt ESTs for use with culturally diverse populations. They focus only on adaptations made to ESTs or empirically validated treatments because these interventions are often considered as the treatments of choice for clients, including ethnic minority clients. They also conduct a content analysis to determine what domains have been addressed by these adaptations and what other domains may need to be addressed to advance culturally competent treatment. Finally, they propose an alternative approach that may be especially helpful in advancing this work.

Belone and colleagues (Chapter 9) focus on the implementation of community-based participatory research (CBPR) with American Indian/Alaska Native (AI/AN) communities. Because of historic genocide and federal institutional policies perpetuated against AI/AN communities, CBPR is a particularly appropriate approach. Based on a 13-year tribal–academic partnership, indigenous and Western theory were blended to cocreate and implement a culturally centered prevention curriculum, the Family Listening Program. This program integrated three perspectives: cultural centeredness

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and indigenous theory, a public health model of risk and protective factors, and empowerment theory based on the educational philosophy of Paulo Freire. CBPR partnering processes provide needed data on culturally centered interventions in improving access and quality care for ethnocultural groups.

LaFromboise and Malik (Chapter 10) provide a compelling example of the highly delicate balance between maintaining scientific rigor and preserving culture and tradition within an intervention. They have developed the American Indian Life Skills program, which is a suicide prevention intervention for AI/AN youth. AI/AN youth have the highest rates of suicide among all ethnic minority adolescents; culturally unique risk factors for suicide include historical trauma, stress from acculturation, community violence, and substance abuse. These factors are addressed in the development of the prevention intervention. Furthermore, the authors emphasize that it is necessary to use a community-driven approach that actively engages members in intervention design, evaluation, and implementation.

Aguilera and colleagues (Chapter 11) demonstrate how a training program located in a public-sector hospital can contribute to the dissemination of culturally appropriate evidence-based practices. The Clinical Psychology Training Program of the University of California, San Francisco, sponsors 12 programs that involve innovative prevention or treatment interventions to manage specific mental health conditions such as depression and alcohol abuse. Within all of these projects, data are gathered to allow for treatments or interventions to be enhanced. For example, in light of the information that there is lower rate of adherence in disadvantaged populations, the text messaging study used text messages to complement cognitive–behavioral therapy. In essence, it is important to note that these types of training programs are appealing to many researchers who are committed to conducting research with these populations in their workplaces.

Milburn and Lightfoot (Chapter 12) note how family-based interventions can reduce high-risk behaviors in vulnerable adolescent populations such as homeless youth and substance-using youth. However, a major challenge in implementing family-based interventions centers on overcoming obstacles to family involvement in these interventions. Using a case example of an evidence-based family-based intervention for delinquent African American adolescents and their parents or guardians, the authors provide specific strategies for increasing family participation. They also discuss using formative research to develop a more tailored strategy for enhancing family involvement. They distinguish between recruitment, retention, and engagement issues when designing and evaluating the effectiveness of family-based interventions for culturally diverse communities.

In the final chapter, Hwang (Chapter 13) discusses a strategy to culturally adapt an empirically supported treatment using two approaches. The

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psychotherapy adaptation and modification framework (PAMF) is a theory-driven and top-down approach, whereas the formative method for adapting psychotherapy (FMAP) represents a community-based and bottom-up approach. He outlines the five major phases of the community-based FMAP approach, of which the theory-driven PAMF constitutes one particular phase. These approaches were used to guide the cultural adaptations to cognitive–behavioral therapy for Chinese Americans with depression. This project demonstrates how salient cultural issues can be systematically addressed to tailor the intervention to the needs of ethnic minority and immigrant communities.

It is our hope that this volume will provide a rough but instructive road map for conducting more systematic and high-yield research on culturally informed interventions. Like most maps, this one will eventually become outdated and obsolete as more "roads" and "pathways" (in this case, to culturally competent mental health care) are built. We eagerly look forward to when this occurs.

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