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Changing Multicultural Guidelines: Clinical and Research Implications for Evidence-Based Psychotherapies

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The American Psychological Association's (APA) release of the multicultural guidelines (*APA Multicultural guidelines: An ecological approach to context, identity and intersectionality*, 2017, http://www.apa.org/about/policy/multicultural-guidelines.pdf; *APA guidelines on race and ethnicity in psychology: Promoting responsiveness and equity*, 2019, http://www.apa.org/about/policy/race-and-ethnicity-in-psychology.pdf) is a welcome advance to the conceptualization and practice of culture in psychology. These guidelines mark a significant expansion of the previous Multicultural Guidelines (*APA Guidelines on multicultural education, training, research, practice and organizational change for psychologists*, 2002). It is argued that changes in these guidelines are substantial enough to constitute a paradigmatic shift with significant implications and challenges for the development of evidence-based psychotherapies (EBPs). Furthermore, these guidelines are particularly timely and applicable to cope with the spread of the COVID-19 pandemic, social/racial unrest, and in promoting international collaborations. However, in the process of broadening cultural approaches, confusion is created in already contested, imperfect, and evolving cultural concepts. The goal of this article is to clarify and examine this emerging paradigm that is herein called cultural EBPs and is differentiated from its two predecessors, universal EBPs and racial and ethnic minority EBPs. Each paradigm is distinguished by describing APA multicultural guidelines and contrasting two dimensions extended from the treatment match model that underlies EBPs. These two dimensions are (a) main cultural assumptions and (b) methods and evidence.

Public Significance Statement
This article suggests that the APA release of the multicultural guidelines (*APA Multicultural guidelines: An ecological approach to context, identity and intersectionality*, 2017, http://www.apa.org/about/policy/multicultural-guidelines.pdf; APA guidelines on race and ethnicity in psychology: Promoting responsiveness and equity, 2019, http://www.apa.org/about/policy/race-and-ethnicity-in-psychology.pdf) is a welcome advance to the conceptualization and practice of culture with significant implications and challenges for the development of EBPs. This article clarifies and examines these implications as it suggests that these changes are indicative of an emerging paradigm herein called cultural EBPs that are differentiated from previous understandings.

Keywords: evidence-based psychotherapies, multicultural guidelines, cultural adaptation treatments, cultural match and global co-operation

The idea that culture is a fundamental feature of human experience dates to the beginning of psychology as a science. In 1879, Wilhelm Wundt, considered the founder of psychology, introduced the experimental method to the study of human behavior (Boring, 1957). Countless psychological advances owe their existence to this inclusion. Wundt (Wundt & Schaub, 1921) also proposed a second research path, the *Volkerpsychologie*, that highlighted the influence of culture on human behavior. Ten copious volumes are the result of Wundt's cultural studies (Cole, 1998). Nevertheless, like most cultural studies, these continue to be overlooked in the field of psychology. Culture has particularly been neglected in the psychotherapy literature American Psychological Association [APA] (2002, 2017, 2019). Similarly, Zane et al. (2016) noted how many of the first research projects using evidence-based psychotherapies (EBPs) overlooked or confused race, ethnicity, and culture. However, EBP researchers have gradually refined their conceptualizations of culture which have grown in complexity and can be differentiated into three distinct paradigms: (a) universal EBPs; (b) racial/ethnic minority EBPs; and (c) cultural EBPs. The first term is abbreviated to "universal psychotherapies," racial and ethnic minority EBPs to "racial/ethnic psychotherapies," and the last to "cultural psychotherapies." The term *psychotherapies*, in contrast

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to the singular *psychotherapy*, is used to indicate the heterogeneity of interventions included within each of these three categories. The aim of this article is to describe and differentiate recommendations in research and clinical practice, as well as the challenges of each paradigm for EBPs. These clarifications may help psychologists understand the growing diversity of multicultural studies that at times make the field seem fragmented and disorganized (Smith & Trimble, 2016).

Paradigms are herein defined as the foundational principles of what knowledge/evidence is and their accepted methods to glean evidence, truth, or knowledge (Kuhn, 1970). Theories, hypotheses, and methods are shaped, though often inadvertently, by unspoken assumptions within paradigms that often mirror sociocultural values. For example, many definitions of race reflect American cultural biases rather than evidence. The race is often conceptualized as a fixed and biological attribute, even though findings of the Human Genome Project demonstrated that racial and ethnic distinctions have no biological basis (Bonham et al., 2005). Unfortunately, this racial bias has been used to justify the neglect and oppression of marginalized communities. For example, authors have questioned the need for investing in educational efforts for African Americans, who were described as inherently less capable of learning than White Americans because of their genetic predispositions (e.g., Herrnstein & Murray, 1994).

In this article, psychological paradigms are identified using APA's Multicultural Guidelines (APA, 2002, 2017, 2019). Guidelines are central because they explicitly provide psychologists with a set of parameters for the provision of services, as well as operationalize psychological knowledge (APA, 2017). Furthermore, the ideas articulated within the guidelines reflect salient sociopolitical beliefs and scientific breakthroughs as well as ideas that had already been circulating for some time in different fields. Consequently, guidelines are living documents that need to be updated every so often to reflect sociopolitical changes and/or new and scientific knowledge.

In understanding cultural understandings, it is argued that three paradigms have developed in the practice of EBPs. The absence of any such guidelines prior to 2002 suggests the lack of cultural considerations and prevalence of universal premises. Racial/ethnic psychotherapies are clarified through the 2002 Guidelines (APA, 2002). Finally, the Multicultural Guidelines (APA, 2017, 2019) are employed to identify the emerging characteristics of cultural psychotherapies' paradigm. However, before outlining these three paradigms it is necessary to define EBPs, race, ethnicity, and culture.

History of EBPs

During the last three decades, the number and importance of EBPs have grown exponentially within and outside the United States. Currently, there is a large, growing, and diverse number of EBP studies (David et al., 2018). Even though there are many types of EBPs, in this article they are broadly referred to as any intervention that is substantially informed by empirical evidence (Barlow, 2004; Weisz et al., 2013). In general, EBPs share the assumption that it is necessary to utilize research findings to inform what works best in psychotherapy and to directly apply these findings to treatment selection (Weisz et al., 2013). The treatment match model, which means that interventions are more effective as they fit clients' individual characteristics underlies much of the EBP literature (Barlow, 2004). Treatment efficacy is augmented as psychologists tailor interventions to the specific characteristic of clients (Barlow, 2004).

EBPs were initially a response to Eysenck (1952) review of the treatment outcome literature, from which he concluded that the rate of success for psychotherapy was not greater than spontaneous remission. However, it was not until the early 1970s, that Luborsky and colleagues found that irrespective of theoretical orientation, therapy is "remarkably efficacious" (Luborsky et al., 1975). The advent of meta-analysis (Smith & Glass, 1977) further solidified these findings by allowing the definitive determination of effect sizes (Wampold & Imel, 2015) and stimulating movement away from demonstrating the generic efficacy of clinical interventions to a more specific approach wherein a particular therapy or component of treatment is assessed across several studies. Psychotherapy outcome studies have consistently supported the efficacy of psychotherapy even in comparison to psychopharmacological treatments (Spielmans et al., 2011; Wampold & Imel, 2015). Additionally, meta-analyses have found that EBPs often outperform traditional treatments that are not systematized through evidence (Weisz et al., 2013).

Before 1996, during the pioneering years of EBPs, outcome studies were often characterized by the use of diverse methodologies that yielded a maze of findings that made the literature seem daunting and fragmented (David et al., 2018). A clear framework was required to inform clinicians about the best available strategies. One of the first and most significant efforts to systematize EBPs was the development of Empirically Validated Treatment guidelines—subsequently called Empirically Supported Treatments. Empirically Supported Treatments guidelines galvanized support in 1995 via the APA Division 12 (Society of Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1996; Task Force Division 12, 1995). Although empirically supported treatments are comprised of a heterogeneous set of interventions (Chambless et al., 1996), they are all required to obtain a significant level of internal validity to ensure that clearly defined treatments are in fact responsible for ameliorating-specific symptoms (Hersen et al., 1984). In addition, empirically supported treatments need to be shown to be either superior to a placebo or other treatments or equivalent to an already established treatment, in at least two "good" group design studies or in a series of single-case design experiments conducted by different investigators (Chambless et al., 1996; Task Force Division 12, 1995).

A more comprehensive effort to systematize EBPs was spearheaded by APA's Presidential Task Force on Evidence-Based Practices in Psychotherapy (APA, 2006). These guidelines are from here on called the task force guidelines, which are defined as "the integration of the best available research with clinical expertise in the context of client characteristics, culture, and preferences" (APA, 2006; p. 273). The task force noted that their objective was to promote effective psychological practice and to enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention by taking into account multiple types of evidence (e.g., randomized control trials and qualitative research). Although the task force and empirically supported treatments guidelines are both EBPs they also differ significantly. In contrast to empirically supported treatment guidelines, the task force attempted to balance internal validity requirements with external validity or the

need to generalize findings to different groups (Hersen et al., 1984) with the overall hope that by underscoring the importance of external validity, more diverse participants would be sampled (APA, 2006).

Defining Race, Ethnicity, and Culture

Although the terms "race," "ethnicity," and "culture" are very distinct, within social sciences they are often used interchangeably, particularly in the psychotherapeutic literature, generating confusion, and misunderstanding (Betancourt & Lopez, 1993; Causadias et al., 2018). This confusion is concerning because the ways in which race, ethnicity, and culture are defined have significant clinical implications (Bernal & Domenech Rodriguez, 2012). Although conceptualizations of each term abound, perhaps the most revealing characteristic of each definition is how they are measured or operationally defined.

The race is often defined in terms of phenotypic characteristics or permanent attributes such as skin color or facial characteristics (Betancourt & Lopez, 1993). Historically physical or phenotypical characteristics determine racial groupings, which suggests underlying biological or genetic commonalities (Landrine & Klonoff, 1996). Accordingly, clinicians and researchers often ascertain and document the race of clients or research participants by observing their physical characteristics. Researchers who use these methods argue that these are fast and reliable. However, although different observers may quickly agree upon participants' race, they may not agree on the meaning of any racial difference. Not only are there significant variations within racial groups, but the race is a sociocultural construct that does not explain psychological or cognitive attributes.

Ethnicity is a broader term than race, as it involves the shared nationality, language, common values, beliefs, and customs of an identifiable group of people (Betancourt & Lopez, 1993). It entails a person's identification with an ethnic group, which is determined by genealogical ties or other socially related factors (Causadias et al., 2018). Ethnicity is measured by inquiring about peoples' backgrounds using a handful of questions, such as, "Are you Hispanic/Latino/a?" Similar to race, it yields quick and reliable results but unclear meanings. Furthermore, the meaning given to participants' responses is often assigned by society's dominant groups. Many individuals have limited power in defining their race and ethnicity. This also connotes a homogeneous, static, and stereotypical understanding of their cultural experience that does not capture the complexity and vitality of any experience.

Numerous authors define culture differently (Betancourt & Lopez, 1993; Causadias et al., 2018). In this article, culture refers to the shared meanings that people interacting within specific contexts/groups have of themselves and their world (La Roche, 2020). This definition mirrors culture's dual nature, on the one hand it highlights individuals' cultural meanings and on the other, contexts. People create and share meanings within-groups and complex ecologies. Although culture has a powerful impact on everyday life it has repeatedly been overlooked from much of the EBP literature.

In contrast and in response to this neglect, the EBP literature is herein organized employing three paradigms that emphasize the way in which race, ethnicity, and culture are defined or neglected (La Roche, 2013). Paradigms are differentiated using the following two dimensions: (a) main cultural assumptions, which describes the central cultural premise of each paradigm; (b) methods and evidence, which depict the commonly used research strategies and evidence, refer to the main findings yielded through these methods.

Universal EBPs or Universal Psychotherapies

Main Cultural Assumptions

Universal psychotherapies refer to EBPs in which the mechanisms of change in psychotherapy are the same for all clients who are viewed as sharing similar core psychological characteristics irrespective of race, ethnicity, and culture. Although people differ in language, symbols used, or phenotypes, all share similar psychological qualities, such as self-esteem, personal schemas, or a desire to self-regulate that are prioritized over any ethnic or racial difference (Shweder, 1995). Cultural differences are considered superficial or derivative expressions of deeper, universal, and more relevant attributes, such as the "Big Five"—openness, conscientiousness, extraversion, agreeableness, and neuroticism (Heine & Buchtel, 2009).

Most universal psychotherapies underscore individualistic therapeutic factors that reside within an individual such as insight, biological factors, self-coping, and self-regulation thus minimizing the impact of the psychotherapeutic relationship and cultural contexts. Although race and ethnicity are at times examined, they are mostly used as moderating variables (Baron & Kenny, 1986) that need to be controlled or factored out to ascertain more relevant, individualistic, and universal variables (La Roche & Christopher, 2009). Consistent with this individualistic accent universal psychotherapies share an understanding of clients as independent, separate, and autonomous. Clients have well-defined boundaries between observers and social contexts. Furthermore, treatment aims often underscore individual goals such as clients' symptom reduction and self-awareness.

Methods and Evidence

Universal psychotherapies are crafted through findings gleaned by research methods specified in empirically supported treatment guidelines (Chambless et al., 1996). Interventions to ameliorate clients' symptoms are manualized after rigorous testing and do not differ because of race and or ethnicity. Manualized treatments often underscore the need to follow interventions with fidelity across cultural contexts. Given universal psychotherapies' emphasis on shared and similar characteristics, it has not been a priority to include samples from different cultural and international groups nor is it critical to test their efficacy with diverse samples. Universal psychotherapies have seemed to assume that an efficacious intervention developed for use with one group (e.g., White Americans) is easily transferable to others. As a result of this overgeneralization, many non-White clients have not benefited as much from universal psychotherapies as White Americans (Marrast et al., 2016; Maura & de Mamani, 2017). Furthermore, some clients whose cultural differences were disregarded have been harmed by treatments' indiscriminate use (Sue, 1999). Similarly, an overgeneralization of the efficacy of some psychotherapies in one country can lead them to be harmful in other parts of the globe (Bernal & Domenech Rodriguez, 2012).

It is important, however, to highlight that even during the early stages of empirically supported treatments the need to include racial/ethnic minority samples was acknowledged (e.g., Chambless et al., 1996).

Unfortunately, these calls were not prioritized and did not translate into many interventions for diverse clients. Additionally, research with racial/ethnic minorities has traditionally lacked funding, which has challenged their ability to afford the rigorous internal validity requirements endorsed by empirically supported treatment guidelines (Sue, 1999). As a result, they have often lacked the same methodological rigor that those using predominantly larger White American samples have, which in turn undermined their scientific credibility and prospects for subsequent funding (Sue, 1999). Despite significant funding limitations, outstanding rigorous research has been conducted with racial/ethnic minorities (Zane et al., 2016). Furthermore, to date there is a dearth of systematic research assessing the efficacy of empirically supported treatments with international groups (Hoffmann, 2018).

Racial/Ethnic Minority EBPs or Racial/Ethnic Psychotherapies

Main Cultural Assumptions

Racial/ethnic psychotherapies assume that each demographic group has unique constellations of cultural characteristics that require the development of entirely new treatments and that universal psychotherapies developed with White Americans are not as effective with racial/ethnic minorities. One of the earliest and most influential studies that highlighted the influence of race and ethnicity on the psychotherapeutic process was Sue (1977) landmark article, in which he reported that almost 70% of White Americans returned to a second appointment with a White American clinician as compared to 50% of racial/ethnic minorities. A growing number of investigations followed that identified additional minority health disparities. Studies have repeatedly documented how racial/ethnic minorities have not benefited and continue to not fare well within the American mental health system (e.g., Smith & Trimble, 2016; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015).

The 2020 COVID-19 pandemic has exposed and exacerbated alarming racial/ethnic health disparities that persist within the United States. As a result of deeply entrenched socioeconomic inequities and experiences of hostility and discrimination against racial/ethnic minorities in the United States, they are being infected and dying at almost twice the rates of White Americans (Center for Disease Control and Preventions [CDC], 2020). Similarly, racial/ethnic minorities are experiencing significantly more socioeconomic challenges (e.g., unemployment and limited access to health services) as well as emotional hardship than White Americans (CDC, 2020). At the same time growing awareness of racial/ethnic inequities has fueled social/racial unrest that has spread throughout many American cities, in which many citizens/groups are demanding social/racial justice. Similarly, mental health disparities are extremely pronounced outside the United States, particularly in the least developed countries (Patel & Unutzer, 2018; World Health Organization [WHO], 2011). Mental health services in many countries are scarce and almost nonexistent for marginalized groups (Patel & Unutzer, 2018; WHO, 2011).

An enhanced awareness of racial/ethnic disparities and biases within different psychological practices led (Sue et al., 1998) to elaborate the tripartite model of multicultural competencies (MCCs), which remains a central pillar of the multicultural literature. MCCs are based on three core skills. First, clinicians need to continuously examine their own cultural views, biases, and assumptions to ensure that they are kept at bay or effectively used in engaging clients. A second competency underscores the importance of learning the typical characteristics, assets, norms, and values of clients' racial/ethnic group. A third competency highlights the need to translate the specific cultural characteristics of clients into effective skills to assess, understand, engage, and treat them (APA, 2002; Sue et al., 1998).

A more demographically diverse America, as well as sociopolitical changes and an enhanced knowledge of the contribution of race and ethnicity within different psychological practices, propelled the APA to elaborate on the "Guidelines on Multicultural Education, Training, Research and Practice" (APA, 2002) with the goal to prepare psychologists to work with racially and ethnically diverse populations. The 2002 Guidelines remain a groundbreaking document in which APA finally recognized the profound power of race and ethnicity in the practice of psychology. In contrast to universal psychotherapies, the 2002 Guidelines focused on race and ethnicity as salient variables in multicultural practice particularly grounded on MCCs (Sue et al., 1998), and as such they constitute a paradigmatic shift from universal psychotherapies that had neglected cultural differences. More specifically, the 2002 Guidelines focus on the well-being of racial and ethnic groups within the United States and state:

> We are defining "multicultural" in these Guidelines narrowly, to refer to the interactions between individuals from minority ethnic and racial groups in the United States . . . Ethnic and racial minority group membership includes individuals of Asian and Pacific Islander, Sub-Saharan Black African, Latino/Hispanic and Native American/American Indian descent, although there is great heterogeneity within these groups. (APA, 2002, p. 2)

A significant shift of the 2002 Guidelines was consistent with interpersonal approaches—and in contrast to universalist's individualistic frame—they acknowledged the contribution of clinicians' attributes within treatments. Sue (1977) demonstrated that clinicians' race, ethnicity, and MCCs impacted clients' dropout rates and therefore psychologists are a significant part of the psychotherapeutic equation. As a result of this finding, the relevant treatment question is not only what interventions ameliorate which symptoms as underscored by universalistic psychotherapies, but also "by whom" (Wampold & Imel, 2015). Racial/ethnic psychotherapies underscored the influence of the psychologist on treatments. Consistent with this view the 2002 Guidelines explicitly acknowledge that multicultural treatments do not occur independently of psychologists who are in fact

> A part of the multicultural equation: Therefore, on-going development of one's personal and cross-cultural awareness, knowledge, and skills is recommended. (APA, 2002, p. 24)

The 2002 Guidelines were a consensus of the prevalent knowledge and skills assumed necessary to effectively address the needs of racial/ethnic minorities within the United States (APA, 2002). Prior to the 2002 Guidelines, different institutions had already started to highlight the importance of race and ethnicity within their theories and methods. For example, the National Institutes of Health (NIH) through its Revitalization Act of 1993 had already mandated the appropriate inclusion of racial and ethnic minorities in

all National Institutes of Health-funded research which passed into law in 1994 (National Institutes of Health Revitalization Act of 1993 [NIH], 1994). However, over 25 years after this Act, the proportion of racial and ethnic minority clients enrolled in clinical trials remains alarmingly low (APA, 2019).

Methods and Evidence

A growing awareness of the influence of race and ethnicity within the psychotherapeutic process led to the development of cultural adaptation treatments (CATs). CATs are an example of racial/ethnic psychotherapies that involve systematic modifications to consider language, culture, and context in such a way that it is compatible with the clients' cultural patterns, meanings, and values (Bernal & Domenech Rodriguez, 2012). CATs are methodically informed by empirical evidence that defines them as EBPs. Furthermore, the development of CATs broadens the treatment match model (Barlow, 2004) noting that for interventions to effectively work they need to be consistent with the typical characteristics of target racial/ethnic groups. More specifically when clinicians are trained in MCCs they are better prepared to deliver interventions that are aligned with racial/ethnic minority clients' needs. Some studies have in fact documented that training clinicians with MCCs does enhance psychotherapy outcomes for racial and ethnic minority clients (Cabassa & Baumann, 2013). Furthermore, highlighting diversity issues has allowed psychotherapy to acknowledge the toxic power of racism within society and therapeutic sessions. Consistent with this emphasis, growing efforts have been invested in addressing racial/ethnic minority health disparities and in refining CATs (Zane et al., 2016).

In contrast to empirically supported treatments that prioritized data obtained by quantitative research methods, CATs encouraged the utilization of qualitative and mixed-method strategies (Zane et al., 2016). Unfortunately, qualitative studies have rarely been employed to test CATs' efficacy (Levitt et al., 2017). Only a limited but growing number of CATS have been tested during the last decades. (Zane et al., 2016) with racially/ethnic diverse samples. Overall, meta-analyses have consistently found that CATs significantly outperform interventions that are not culturally adapted in terms of symptom reduction (Hall et al., 2016; Griner & Smith, 2006; Smith & Trimble, 2016; Soto et al., 2018). Furthermore, research has found that many racial/ethnic groups prefer clinicians of their same racial/ethnic background (Smith & Trimble, 2016), highlighting the need to increase the diversity of psychologists (DeCarlo & Miranda, 2014).

However, a closer inspection of CATs' reported cultural modifications reveals that most include one or two cultural modifications (Bernal & Domenech Rodriguez, 2012; Smith & Trimble, 2016). The most common being language, specifically delivering the intervention in the client's first language, and clinicians' race and/or ethnicity, specifically employing racial/ethnic minority clinicians over White American clinicians. Instead of employing White American clinicians, CATs use minority clinicians that match clients' race and/or ethnicity. The underlying assumption seems to be that if interventions are delivered in the clients' dominant language and by racial/ethnic clinicians irrespective of their level of clinical skills, cultural values, or MCCs, then these are considered CATs. However, this operationalization of CATs not only simplifies MCC guidelines but also the vast diversity within racial/ethnic groups. It suggests that being of a particular race/ethnicity determines which CAT is applicable-irrespective of clients' unique characteristics. However, this reduction does not represent the aims of MCC guidelines that emphasize complex cultural characteristics. Furthermore, in most clinical settings racial/ethnic matches are not feasible nor do these matches ensure treatment efficacy. In support of this view, recent and complex meta-analyses have found that treatment outcomes for racial/ethnic matches when controlled for with other variables were weakly associated with symptom reduction (Hall et al., 2016; Smith & Trimble, 2016). Thus, the amelioration of symptoms observed on racial/ethnic matches could be explained by other variables (Smith & Trimble, 2016).

Furthermore, when categorical, simplistic, and ahistorical definitions of race and ethnicity are solely used to classify groups they increase the likelihood that stereotypes be generalized to entire racial or ethnic groups. Paradoxically, racial/ethnic psychotherapies' efforts to be inclusive have led to separate interventions for each racial and ethnic group, just as American society has frequently encouraged racial/ethnic groups to remain segregated. Enhanced awareness of these limitations and a growing number of studies and changes within American society have led to a richer and more inclusive reconceptualization of culture that moves beyond a sole emphasis on race and ethnicity. This shift is significant enough to entail the development of a new paradigm, which is herein called "cultural psychotherapies."

Cultural EBPs or Cultural Psychotherapies

Main Cultural Assumptions

Cultural psychotherapies, similar to racial/ethnic psychotherapies, highlight the influence of race and ethnicity within the psychotherapy process. However, in contrast to racial/ethnic psychotherapies that in practice infer psychological characteristics because of participants' race or ethnicity, cultural psychotherapies examine the way clients' construe meanings (e.g., racial and ethnic identity) and highlight additional intersecting factors such as gender orientation, religion, socioeconomic status (SES), and political affiliation (Heine, 2008). Cultural psychotherapies explore clients' meanings linked to their personal experiences, relationship with clinicians, and cultural/global influence(s). If these relationships and contexts are not examined, much is missed within the psychotherapeutic process (Wampold & Imel, 2015). In addition, cultural psychotherapies more than racial/ethnic psychotherapies, highlight the need to work with White Americans in the United States and international communities.

The release of two complementary sets of Multicultural APA Guidelines are helpful to recognize the emerging characteristics of cultural psychotherapies: The "Multicultural Guidelines: An Ecological Approach to Context, Identity and Intersectionality" (APA, 2017) and "APA Guidelines on Race and Ethnicity in Psychology: Promoting Responsiveness and Equity" (APA, 2019). The first set of guidelines are herein referred to as the 2017 Guidelines, which are an umbrella set of aspirations to assist psychologists in engaging in a fuller understanding of diversity within the practice, research, consultation, and education of psychology (APA, 2017). The second set of guidelines are from herein called the 2019 Guidelines and accentuated the influence of race and ethnicity within the practice, research, consultation, and education in more detail than the 2017

Guidelines. For example, in the 2017 Guidelines (APA, 2017) the importance of culture is evident in Guideline 2 that underscored how "humans are cultural beings." In turn, the 2019 Guidelines highlighted race and ethnicity as noted in the Fundamental Guideline 1 that states "Psychologists strive to recognize and engage the influence of race and ethnicity in all aspects of professional activities as an ongoing process." Just as the 2002 guidelines reflected the systematization of racial/ethnic psychotherapies framework, so do the 2017 and 2019 Guidelines crystalize the development of cultural psychotherapies. The emergence of cultural psychotherapies marks a paradigmatic shift from racial/ethnic psychotherapies' conceptual framework and practice as detailed below.

A central characteristic of the 2017 and 2019 Guidelines (APA, 2017, 2019) is an enhanced reliance on an intersectional framework, which aims to incorporate the vast array of cultural, structural, sociobiological, economic, and social contexts by which individuals are shaped and with which they identify (Crenshaw, 1989). Individuals are located within a range of social groups whose structural inequalities can result in marginalized identities. A focus on intersectionality is expected to increase psychologists' capacity to consider a multitude of complex and fluid components of identity and personhood, including their own. An intersectional approach not only stresses clinicians' contributions to treatment more thoroughly than racial/ethnic psychotherapies, but also encourages clinicians to examine the ways in which theoretical models are shaped by social, economic, and political contexts. For example, research has found that individualistic biases reflective of dominant American values within the relaxation (Dominguez et al., 2020) literature limited its efficacy with some diverse and more relational communities (La Roche, 2013). Enhanced cultural knowledge can further psychologists' sensitivity to cultural biases within treatments, theories, and interactions. Today, as the devastation of COVID-19 spreads through every community, it is crucial for psychologists to be vigilant about how science may again be used to justify the disproportionate allocation of resources to the most privileged groups, while marginalized groups (e.g., undocumented immigrants, incarcerated communities, and ethnic minorities) continue to lack access to mental health services. Clarity about cultural assumptions may allow psychologists to make more informed recommendations and decisions. Nevertheless, it is imperative that psychologists have a seat at the table when health care groups discuss advocacy and policy initiatives to address the inequeties of the current behavioral health system (Dominguez et al., 2020). Health care workers cannot work in isolation because health inequeties are to profound and complex to tackle alone (Dominguez et al., 2020).

In addition, the 2017 Guidelines were more detailed in incorporating Bronfenbrenner's (1979) ecological model, which proposed five concentric circles or contexts that influence peoples' behavior. A more thorough conceptualization of context(s) encourages psychologists to address the ongoing and changing influence of specific ecological forces on psychological treatments. As a result, in cultural psychotherapies, meanings of race or ethnicity are explored during multiple times rather than during baseline solely as universal and racial/ethnic psychotherapies frequently do. Similarly, prevalent sociocultural values (e.g., consumerism, materialism, and competition) that can be detrimental to individuals' well-being but more harmful for overall communities and the global welfare can be addressed. Unfortunately, not many EBPs have examined these considerations.

Bronfenbrenner's (1979) theory not only underscored the impact of context on behavior but also peoples' potential to influence contexts, a bidirectional process that is highlighted in the 2017 and 2019 Guidelines (APA, 2017, 2019). Consequently, in treatment clients can be empowered to target contextual factors that diminish their psychological health and well-being such as economic inequities or institutionalized racism. Empowerment is defined as peoples' ability to transform themselves, their relationships, and context(s) (Toporek et al., 2006). As social unrest spreads throughout the country, it becomes increasingly necessary for psychologists to develop and use effective strategies to empower people struggle for social and economic justice. If psychotherapy is to remain meaningful and credible it needs to be inclusive of the needs and characteristics of all, not just of a privileged few.

Consistent with Bronfenbrenner's (1979) model the need to include macro- and international contexts were stressed in the 2017 and 2019 Guidelines (APA, 2017, 2019), while the 2002 Guidelines (APA, 2002) narrowly focused on racial and ethnic minorities within the United States. For example, the 2002 Guidelines and the 2017 and 2019 Guidelines shared an emphasis on the need to pursue social justice. Nevertheless, for cultural psychotherapies social justice extends beyond racial/ethnic inequities within the United States to include oppressed and marginalized communities throughout the world. Efforts are therefore aimed at not only combating local injustices but also global ones. This broader international focus is for example expressed in Guideline 7:

> Psychologists endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on the psychologist's self-definition, purpose, role, and function. (APA, 2017 p. 2)

The inclusion of globalization within these guidelines is an acknowledgment of peoples' interconnectedness within international geopolitics. Globalization refers to the complex links of cultural elements across distance, transcending national states, and cultural borders. Social media plays an important role in global communication. Although globalization and social media are a strong presence in everyday life, they are almost completely omitted from the EBP literature. In addition, as psychologists gain more knowledge about global influences they may more frequently collaborate with international and interdisciplinary communities. Significant advances in social media platforms/video conferencing and psychologists' increasing familiarity with these technologies, particularly during the COVID-19 pandemic, could facilitate these exchanges. It is likely that as psychologists work within international teams they will enhance their abilities to recognize how theories and interventions are embedded within sociocultural, economic, and political contexts and develop additional strategies that are culturally sensitive. International collaborations are particularly urgent as the most critical challenges that humankind faces (e.g., pandemics, global warming, poverty, and global conflicts) are only addressable through global co-ordination. Not only is international co-operation crucial to effectively rebuild communities in a post-COVID-19 world but psychologists versed in cultural competence could play a central role in this process. For example. cultural psychological information could be used to foster effective group

communication among interdisciplinary and international collaborations. Clearer dialogues with diverse teams could help them to work more effectively and be instrumental in preventing future pandemics, global warming, and poverty (La Roche, 2020).

The 2017 and 2019 Guidelines (APA, 2017; 2019) underscored unconscious/implicit variables even further than the 2002 Guidelines (APA, 2002). Research has found that much of peoples' experience in society and culture remains implicit or automatic (Bargh & Morsella, 2008; Greenwald & Banaji, 2017). Many behaviors are better predicted using implicit meanings of race and ethnicity than explicit (Greenwald & Banaji, 2017). For example, racist comments are more accurately predicted by peoples' implicit views of race than their self-reports (Greenwald & Banaji, 2017). Within this field of research, important concepts such as microaggressions and implicit biases are not only informing health disparities (Dovidio, 2009; Sue et al., 2007), but also countless additional social processes such as the disproportionate rate of racial/ethnic minority men who are incarcerated. The examination of implicit variables can potentially encourage psychologists to work in multidisciplinary teams and expand the field. Unfortunately, measurements of implicit variables have been significantly absent from the EBP literature (La Roche, 2020).

Methods and Evidence

Cultural psychotherapies, in addition to language and racial/ethnic match and consistent with intersectional and ecological frames have stressed the need to measure diverse cultural (e.g., racial identity and acculturation levels) and contextual variables (e.g., SES and levels of neighborhood violence) to develop effective CATs (Bernal & Domenech Rodriguez, 2012; Hall et al., 2020; La Roche, 2013, 2019; Sue & Zane, 1987; Zane et al., 2005). Findings from recent meta-analyses are supporting the view that CATs are more effective when they involve a greater number of clearly defined cultural modifications that match clients' characteristics (Smith et al., 2011; Smith & Trimble, 2016; Soto et al., 2018). Unfortunately, EBPs that have included several cultural modifications (Smith & Trimble, 2016; Zane et al., 2016) have been slow to come.

Cultural psychotherapies extend the cultural match further than racial/ethnic psychotherapies by specifying three basic assumptions: (a) experiences are shaped by intersecting cultural characteristics and significantly differ within racial/ethnic groups; (b) EBPs are influenced by cultural assumptions; (c) treatment outcomes are improved when EBPs' cultural assumptions are aligned with clients' cultural characteristics (Bernal & Domenech Rodriguez, 2012; La Roche, 2013; Soto et al., 2018; Sue & Zane, 1987).

Just as empirically supported treatments (Chambless et al., 1996) are central in shaping the methods of universal psychotherapies, so are the Task Force's (APA, 2006) guidelines for cultural psychotherapies. Consistent with the Task Forces' guidelines, cultural psychotherapies assume that a more complete picture of the psychotherapeutic process is obtained through the use of quantitative, qualitative, and mixed research methods (Creswell, 2015). Unfortunately, even though qualitative strategies are particularly positioned to examine the psychotherapeutic process embedded within cultural contexts and relationships, and excellent guidelines for their use have been developed (Levitt et al., 2017), they have repeatedly been neglected from the EBP literature. Nevertheless, it remains challenging to design EBPs when divergent findings are obtained. For example, questions remain about which sets of evidence to prioritize or discard when findings differ using different research methods (La Roche, 2020).

Furthermore, subscribing to ecological and intersectional frameworks underscored cultural psychotherapies' goal to transform unjust and inhumane contexts, not only to pursue individualistic treatment goals such as self-actualization, insight, self-coherence, or individuation (Comas-Díaz et al., 2019, Ivey, 1999; Roysicar, 2011). If in treatment socioeconomic and political injustices are not addressed, these are perpetuated (Albee, 1986). This empowerment approach has its theoretical roots in radical and liberation psychology (Freire, 1970; Martín-Baró, 1994; Prilleltensky, 1997) and seems particularly appropriate during 2020, as many demand increased socioeconomic and structural change not only individual benefits. Although promising therapeutic approaches to empower clients have been proposed (Chavez-Dueñas et al., 2019; Comas-Díaz & Torres, 2020; Ivey, 1999; La Roche, 2013), empirical research is needed to document their efficacy.

Cultural psychotherapies' use of intersectional and ecological frame encourages a more thorough examination of cultural and contextual variables. For example, rather than presuming characteristics because of race and ethnicity, cultural psychotherapies directly assess clients' singular meanings. Measuring a broader set of cultural variables accounts for additional sources of variance that more comprehensively describe clients and explain psychotherapeutic processes. Consequently, the cultural psychotherapies research approach leads to a more accurate determination of which interventions are effective, with whom, and in which contexts. Furthermore, this complexity diminishes the risk of generalizing cultural characteristics to entire racial/ethnic groups. Nevertheless, the challenge to achieve this increased level of precision is in selecting the most effective intervention for each client, diagnosis, and set of circumstances (Wampold & Imel, 2015). Clearly, what cultural psychotherapies need is an evidence-based approach that systematically guides efforts to flexibly adapt and personalize interventions to clients' meanings and contexts (Bernal & Domenech Rodriguez, 2012; Hall et al., 2020). To accomplish this goal, cultural psychotherapies encourage a direct assessment of clients' characteristics using tools such as the Cultural Formulation Interview (Lewis-Fernandez et al., 2016) and an examination of the cultural assumptions of different EBPs. However, more research is needed to elaborate additional cultural measures and the development of interventions tailored according to cultural characteristics.

Conclusions

In the midst of the COVID-19 and 2020 social unrest pandemics, cultural psychotherapies offer specific tools to help address these crises. Cultural psychotherapies move beyond universal, color-blind interventions and treatments designed for racial/ethnic minorities to a more inclusive type of EBP that in fact measures and systematically benefits from multiple, changing, and intersecting characteristics (e.g., race, gender orientation, and political orientation). Changes in cultural psychotherapies are not only substantial enough to constitute a paradigmatic shift, but also to raise significant questions that are in need of further study. Some of their main research/clinical implications and challenges are summarized and differentiated from universal and racial/ethnic psychotherapies using the three basic components (below described in **bold**) of

the cultural match model (La Roche & Lustig, 2010; La Roche, 2013). These clarifications are intended to assist psychologists to conduct more innovative research and effective clinical work not only with cultural minorities and international communities but with and for all.

1. **Experiences are shaped by intersecting cultural characteristics that differ significantly within racial/ethnic groups**.

    1.1. In contrast to universal psychotherapies that are color blind, racial/ethnic psychotherapies stress the centrality of race and ethnicity, while cultural psychotherapies measure both cultural commonalities and differences.

    1.2. Cultural psychotherapies highlight the heterogeneity of individuals within racial/ethnic groups and the need to directly examine clients' cultural characteristics rather than presuming them because of race or ethnicity. Consequently, they highlight the need for additional and more sophisticated cultural measures.

    1.3. Universal psychotherapies underline clients' individual behavior in isolation from therapeutic relationships and contexts, while racial/ethnic psychotherapies start including the contribution of the therapeutic relationship on clients' behaviors and cultural psychotherapies further emphasize the impact of the therapeutic relationship and contexts.

    1.4. Cultural psychotherapies note the effect of global influences upon clients' behaviors, while universal and racial/ethnic psychotherapies rarely consider them. Substantial research, however, is necessary to determine the extent of global influences on treatments.

    1.5. Cultural psychotherapies are more informed by the power of implicit variables than universal and racial/ethnic psychotherapies. Nevertheless, to date not many EBPs have measured implicit variables.

2. **Culture influences the methods and evidence used to design EBPs**.

    2.1. Universal psychotherapies underscore the importance of objective evidence to design interventions while cultural psychotherapies add that evidence is also influenced by societies' prevalent assumptions. Therefore, it is necessary to identify the cultural assumptions of EBPs and society to clarify these influences.

    2.2. Although mixed research methods are useful to identify how cultural and contextual influences shape evidence, to date not many EBPs have benefited from qualitative studies. In addition, it is unclear how divergent findings are prioritized in the design of an intervention. Current EBP guidelines need to be reviewed and updated to address these questions.

    2.3. Cultural psychotherapies underscore the use of international collaborations within multidisciplinary and culturally diverse teams to recognize EBPs' cultural assumptions.

    2.4. Universal psychotherapies are mostly crafted using White American samples, while racial/ethnic psychotherapies focus on racial/ethnic minorities in the United States and cultural psychotherapies are also starting to invite international communities.

    2.5. Future EBP research may question the utility of ecological, intersectional, and international approaches and explain their current rise to prominence as the result of current sociopolitical, cultural, and economic forces.

    2.6. As the COVID-19 pandemic spreads havoc in 2020 and 2021 exacerbating social unrest and exposing racial inequities it is critical that psychologists learn from these crises to expand psychotherapy's access and efficacy for all.

3. **Treatment outcomes are improved when EBPs' cultural assumptions are aligned with clients' cultural characteristics**.

    3.1. Matching interventions to clients' cultural characteristics can make interventions more meaningful, relevant, credible, and improve treatment outcomes which, underscores the need to refine approaches that maximize cultural fits.

    3.2. As psychologists widen their cultural views, enhance their MCCs, and distill their experiences with EBTs they can design more effective interventions for each client. This requires that psychologists be trained more fully on how to optimize cultural matches.

    3.3. The ongoing and changing influence of culture has different effects on clients and treatments, which requires that it be measured throughout the therapeutic relationship or clinical project, rather than solely during baseline.

    3.4. Cultural psychotherapies should foster international and multidisciplinary collaborations, which are crucial to promote effective systems of global cooperation to struggle against pandemics, global warming, and address social unrest.

    3.5. For cultural psychotherapies social justice not only entails advocating for people within the United States but also across the globe.

    3.6. As cultural psychotherapies tailor their interventions according to clients' cultural characteristics, the burdensome differentiations between CATs and EBPs become less relevant. Effective EBPs will become CATs and useful CATs will be EBPs.

References

American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice and organizational change for psychologists*. Washington, DC: Author.

American Psychological Association. (2017). *Multicultural Guidelines: An Ecological Approach to context, identity and intersectionality*. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2019). *APA guidelines on race and ethnicity in psychology: Promoting responsiveness and equity*. http://www.apa.org/about/policy/race-and-ethnicity-in-psychology.pdf

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-Based practice in psychology. *American Psychologist*, *61*, 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Albee, G. (1986). Towards a just society: Lessons from observations on the primary preventions of psychopathology. *American Psychologist*, *41*, 891–898. https://doi.org/10.1037/0003-066X.41.8.891

Bargh, J., & Morsella, E. (2008). The unconscious mind. *Perspectives on Psychological Science*, *3*, 73–79. https://doi.org/10.1111/j.1745-6916.2008.00064.x

Barlow, D. (2004). Psychological treatments. *American Psychologist*, *59*, 869–878. https://doi.org/10.1037/0003-066X.59.9.869

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategies, and statistical considerations. *Journal of Personality and Social Psychology*, *51*, 1173–1182. https://doi.org/10.1037/0022-3514.51.6.1173

Bernal, G., & Domenech Rodriguez, M. (Eds.). (2012). *Cultural adaptations: Tools for evidence-based practice with diverse populations*. APA Press. https://doi.org/10.1037/13752-000

Betancourt, H., & Lopez, S. (1993). The study of culture, ethnicity and race in American psychology. *American Psychologist*, *48*, 629–637. https://doi.org/10.1037/0003-066X.48.6.629

Bonham, V., Warshauer-Baker, E., & Collins, F. (2005). Race and ethnicity in the genome era: The complexity of the constructs. *American Psychologist*, *60*, 9–15. https://doi.org/10.1037/0003-066X.60.1.9

Boring, E. G. (1957). *A history of experimental psychology* (2nd ed.). Appleton-Century Crofts.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Cabassa, L., & Baumann, A. (2013). A two-way street: Bridging implementation science and cultural adaptations of mental health treatments. *Implementation Science*, *8*, 90. https://doi.org/10.1186/1748-5908-8-90

Causadias, J., Vitriol, J., & Atkin, A. (2018). Do we overemphasize the role of culture in the behavior of racial/ethnic minorities? Evidence of a cultural (mis)attribution bias in American psychology. *American Psychologist*, *73*, 243–255. https://doi.org/10.1037/amp0000099

Center for the Disease Control and Prevention. (2020). *Provisional death counts for coronavirus disease (COVID-19): Data updates by select demographic and geographic characteristics*. https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/retrieved10/09/2020

Chambless, D. L., Sanderson, W. C., Shoham, V., Bennett Johnson, S., Pope, K. S., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S. R., Sue, S., Beutler, L., Williams, D. A., & McCurry, S. (1996). An update on empirically validated therapies. *Clinical Psychologist*, *49*, 5–18.

Chavez-Dueñas, N., Adames, H., Perez-Chavez, J., & Salas, S. (2019). Healing ethno-racial trauma in Latinx immigrant communities: Cultivating hope, resistance and action. *American Psychologist*, *74*, 49–62. https://doi.org/10.1037/amp0000289

Cole, M. (1998). *Cultural Psychology: A once and future discipline*. Harvard University Press.

Comas-Díaz, L., Hall, G., & Neville, H. (2019). Racial trauma: Theory, research, and healing: Introduction to the special issue. *American Psychologist*, *74*, 1–5. https://doi.org/10.1037/amp0000442

Comas-Díaz, L., & Torres, E. (Eds.). (2020). *Liberation psychology: Theory, method, practice and social justice*. APA Press. https://doi.org/10.1037/0000198-000

Crenshaw, K. W. (1989). Demarginalizing the intersections of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, *140*, 139–167.

Creswell, J. W. (2015). *A concise introduction to mixed methods research*. Sage Publications.

David, D., Lynn, S., & Montgomerry, G. H.. (2018). *Evidence-based psychotherapies: The state of the science and practice*. Wiley Blackwell.

DeCarlo, C., & Miranda, J. (2014). Progress in improving mental health services for racial–ethnic minority groups: A ten-year perspective. *Psychiatric Services*, *65*, 180–185. https://doi.org/10.1176/appi.ps.201200517

Dominguez, D., Garcia, D., Martinez, D., & Hernandez-Arriaga, B. (2020). Leveraging the power of mutual aid, Leadership, and advocacy during COVID-19. *American Psychologist*, *75*, 909–918.

Dovidio, J. (2009). Racial bias, unspoken but heard. *Science*, *326*, 1641–1642. https://doi.org/10.1126/science.1184231

Eysenck, H. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, *16*, 319–324. https://doi.org/10.1037/h0063633

Freire, P. (1970). *Pedagogy of the oppressed*. Seabury.

Greenwald, A., & Banaji, M. (2017). The implicit revolution: Reconceiving the relations between conscious and unconscious. *American Psychologist*, *72*, 861–871. https://doi.org/10.1037/amp0000238

Griner, D., & Smith, T. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, & Practice*, *43*, 531–548. https://doi.org/10.1037/0033-3204.43.4.531

Hall, G., Ibaraki, A., Huang, E., Marti, C., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*, 993–1014. https://doi.org/10.1016/j.beth.2016.09.005

Hall, G. C. N., Berkman, E. T., Zane, N. W., Leong, F. T. L., Hwang, W.-C., Nezu, A. M., Nezu, C. M., Hong, J. J., Chu, J. P., & Huang, E. R. (2020). Reducing mental health disparities by increasing the personal relevance of interventions. *American Psychologist*. Advance online publication. https://doi.org/10.1037/amp0000616

Heine, S. (2008). *Cultural Psychology*. Norton.

Heine, S., & Buchtel, E. (2009). Personality: The universal and the culturally specific. *Annual Review of Psychology*, *60*, 369–394. https://doi.org/10.1146/annurev.psych.60.110707.163655

Herrnstein, R., & Murray, C. (1994). *The curve belle: Intelligence and class structure in American life*. Free Press.

Hersen, M., Michelson, L., & Bellack, A. (Eds.). (1984). *Issues in psychotherapy research*. Plenum Press. https://doi.org/10.1007/978-1-4899-2283-0

Hoffmann, S. (2018). *Clinical psychology: A global perspective*. Wiley.

Ivey, A. (1999). Psychotherapy as liberation: Towards a specific skills and strategies in multicultural counseling and therapy. In J. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling*. Sage Publications.

Kuhn, T. S. (1970). *The structure of scientific revolutions*. University of Chicago Press.

La Roche, M. (2013). *Cultural psychotherapy: Theory, methods and practice*. Sage Publications.

La Roche, M. (2020). *Towards a global and cultural psychology: Theoretical foundations and clinical implications*. Cognella.

La Roche, M., & Christopher, M. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology, Research and Practice*, *40*, 396–402. https://doi.org/10.1037/a0015240

La Roche, M., & Lustig, K. (2010). Cultural adaptations: Unpacking the meaning of culture. *The Scientific Review of Mental Health Practice*, *72*, 26–30.

Landrine, H., & Klonoff, E. (1996). *African American acculturation*. Sage Publications.

Levitt, H., Motulsky, S., Wertz, F., Morrow, S., & Ponterotto, J. (2017). Recommendations for designing and reviewing qualitative research in psychology: Promoting methodological integrity. *Qualitative Psychology*, *4*, 2–22. https://doi.org/10.1037/qup0000082

Lewis-Fernandez, R., Aggarawal, N., Hinton, L., Hinton, D., & Kirmayer, L. (2016). *DSM-5 handbook on the cultural formulation interview*. American Psychiatric Publishing.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes?". *Archives of General Psychiatry*, *32*, 995–1008. https://doi.org/10.1001/archpsyc.1975.01760260059004

Marrast, L., Himmelstein, D. U., & Woolhandler, S. (2016). Racial and ethnic disparities in mental health care for children and young adults: A national study. *International Journal of Health Services*, *46*(4), 810–824. https://doi.org/10.1177/0020731416662736

Martín-Baró, I. (1994). *Writings for a liberation psychology*. Harvard University Press.

Maura, J., & de Mamani, A. W. (2017). Mental health disparities, treatment engagement, and attrition among racial/ethnic minorities with severe mental illness: A review. *Journal of Clinical Psychology in Medical Settings*, *24*(3–4), 187–210.

National Institutes of Health Revitalization Act of 1993. (1994). *National Institute of Health NIH Guidelines on the Inclusion of Women and Minorities as Subjects in Clinical Research*, *59*. Federal Register 14,508.

Patel, V., & Unutzer, J. (2018). The Lancet commission on global mental health and sustainable development. *Lancet*, *392*, 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Prilleltensky, I. (1997). Values, assumptions, and practices: Assessing the moral implications of psychological discourse and action. *American Psychologist*, *52*(5), 517–535. https://doi.org/10.1037/0003-066X.52.5.517

Roysicar, G. (2011). The big picture of advocacy: Counselor, heal society and thyself. *Journal of Counseling and Development*, *87*, 288–294. https://doi.org/10.1002/j.1556-6678.2009.tb00109.x

Shweder, R. (1995). Cultural Psychology: What is it?. In N. Rule-Goldberger & J. Bennet Veroff (Eds.), *The culture and psychology reader* (pp. 41–86). New York University Press.

Smith, M., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, *32*, 752–760. https://doi.org/10.1037/0003-066X.32.9.752

Smith, T., Rodriguez, M., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*. *67*, 166–175. https://doi.org/10.1002/jclp.20757

Smith, T., & Trimble, J. (2016). *Foundations of multicultural psychology: Research to inform effective practice*. American Psychological Association. https://doi.org/10.1037/14733-000

Soto, A., Smith, T. B., Griner, D., Domenech Rodríguez, M., & Bernal, G. (2018). Cultural adaptations and therapists of multicultural competence: Two meta-analytic reviews. *Journal of Clinical Psychology*, *74*, 1907–1923. https://doi.org/10.1002/jclp.22679

Spielmans, G., Berman, M., & Usitalo, A. (2011). Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. *Journal of Nervous and Mental Disease*, *199*, 142–149. https://doi.org/10.1097/NMD.0b013e31820caefb

Substance Abuse and Mental Health Services Administration. (2015). *Racial/ Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906.

Sue, D. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist*, *54*, 1070–1077. https://doi.org/10.1037/0003-066x.54.12.1070

Sue, D., Capodilupo, C., Torino, G., Bucceri, J., Holder, A., Nadal, K., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*(4), 271–286. https://doi.org/10.1037/0003-066X.62.4.271

Sue, D., Carter, R., Casas, J., Fouad, N., Ivey, A., Jensen, M., ... Vasquez-Nutall, E. (1998). *Multicultural counseling: Individual, professional and organizational development*. Sage Publications.

Sue, S. (1977). Community mental health services to minority groups. Some optimism, some pessimism. *American Psychologist*, *32*, 616–624. https://doi.org/10.1037/0003-066X.32.8.616

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy. *American Psychologist*, *42*, 37–45. https://doi.org/10.1037/0003-066X.42.1.37

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in dissemination of empirically validated treatments: Report and recommendations. *Clinical Psychologist*, *48*, 3–23.

Toporek, R., Gerstein, L., Fouad, N., Roysircar, G., & Israel, T. (2006). *Handbook for social justice in counseling psychology: Leadership, vision and action*. Sage Publications.

Wampold, B., & Imel, Z. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). Routledge. https://doi.org/10.4324/9780203582015

Weisz, J., Kuppens, S., Eckshtain, D., Ugueto, A., Hawley, K., & Jensen-Doss, A. (2013). Performance of evidence-based youth psychotherapies compared with usual care: A multilevel meta-analysis. *JAMA Psychiatry*, *70*, 750–761. https://doi.org/10.1001/jamapsychiatry.2013.1176

World Health Organization. (2011). *Fact file on health inequities*. Retrieved December 15, 2018, from http://www.who.int/sdhconference/background/new/facts/en/

Wundt, W., & Schaub, L. (1921). *Elements of folk psychology: Outlines of a psychological history of the development of mankind*. G. Allen and Unwin Ltd.

Zane, N., Bernal, G., & Leong, F. (Eds.). (2016). *Evidence-Based psychological practice with ethnic minorities: Culturally informed research and clinical strategies*. American Psychological Press. https://doi.org/10.1037/14940-000

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., Srinivasan, S., Chun, K., Kurasaki, K., & Lee, L. (2005). Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology*, *33*, 569–585. https://doi.org/10.1002/jcop.20067

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