

8-2009

Changing Paradigms from Empirically Supported Treatment to Evidence-Based Practice: A Cultural Perspective

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Description

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Disciplines

Mental and Social Health | Psychiatry and Psychology | Psychology

Comments

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This is the author-created, peer-reviewed version of the article published in final form in *Professional Psychology: Research & Practice*:

La Roche, M. J., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice*, 40(4), 396-402.

doi: 10.1037/a0015240

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Changing Paradigms from Empirically Supported Treatment to Evidence-Based Practice: A Cultural Perspective

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Abstract

Psychotherapy research guidelines have a profound impact on research, training, and practice, and they also influence reimbursement decisions which can have ethical and legal consequences. Furthermore, research guidelines have implications for the treatment of culturally diverse groups. Unfortunately, these implications have often been overlooked. Therefore, this paper contrasts the impact of two prominent research guidelines on the development of culturally sensitive psychotherapies: (1) empirically supported treatments (ESTs) developed in 1995 by the American Psychological Association's (APA) Division 12 (Society of Clinical Psychology), and (2) evidence-based practice in psychology (EBPP) developed by the APA (2006) Presidential Task Force on Evidence-Based Practice. Although overall we believe that EBPP is more responsive to the needs and characteristics of culturally diverse groups, ESTs also have many strengths. As the cultural implications of research guidelines are better understood, researchers and clinicians will be able to more effectively advance the development of culturally sensitive evidenced-based psychological treatments.

Keywords: culture, psychotherapy research, empirically supported treatment, evidence-based practice, ethnic minorities

The well-documented history of abuse and neglect of ethnic minorities invites skepticism when major policy changes take place (e.g., Jones, 1981; Turner & Kramer, 1995). Those with least power are frequently the most vulnerable to any adverse effects of these policy changes. The recent development of psychotherapy research guidelines presents an opportunity to diminish or avert negative impact on historically marginalized groups through an increased awareness of the cultural ramifications of these guidelines. The goal of this paper is to review the development of two of the most important psychotherapy research guidelines and their implications for culturally diverse groups. To accomplish this goal, empirically supported treatments (ESTs) and evidence-based practice in psychology (EBPP) are first described. We then review the main requirements for developing a culturally sensitive psychotherapy (CSP), followed by how ESTs and EBPP meet each of these CSP criteria. In the conclusion, these points are summarized and we explain why we believe EBPP may be better suited to address the needs of culturally diverse groups in comparison to ESTs.

We will start by exploring distinctions between EST and EBPP research paradigms. We believe that psychology does not merely describe human nature as it exists. Rather, it organizes through implicit or explicit paradigms the limitless number of observations that are conducted towards the ends of understanding, prediction, and control (Kuhn, 1970). The dominant conceptions of each paradigm provide a framework for such perceptions and a coherent structure for scientific thought. At the same time, a paradigm sets unspoken limits on the questions and methods that

are deemed legitimate (Kuhn, 1970). An understanding of the paradigms underlying ESTs and EBPP helps to shed light on their differences with respect to psychotherapy outcome research among culturally diverse groups. The ability to treat patients with diverse diagnoses in a PH setting is paramount, given the high rate of patients who present with comorbid, multi-axial diagnoses. However, given the ubiquity of mood disorders and generic depressive symptomatology among patients with acute mental illness, it is important that the PH be particularly successful in treating these disorders. To date, very few studies have documented the effectiveness of mood disorder treatment in the PH setting. Although Mazza and colleagues³¹ reported a significant reduction in symptoms as well as overall improvements in functioning and social adaptation among patients with a mood disorder being treated in a PH setting, it remains unclear which components of CBT for mood disorders may be more predictive of successful treatment outcome in this context.

Brief History of Psychotherapy Research

The search for evidence to support the efficacy of psychotherapy began largely as a response to Eysenck's (1952) review of the treatment outcome literature, from which he concluded that psychotherapy's rate of success was not greater than spontaneous remission. Beginning in the early 1970's, Luborsky and colleagues (e.g., Luborsky, Singer, & Luborsky, 1976) research suggested that irrespective of theoretical orientation, therapy was generally effective. The advent of meta-analysis (Smith & Glass, 1977) allowed for the computation of effect sizes and ultimately for the definitive determination that psychotherapy's rate of success was in fact greater than spontaneous remission. Relatedly, meta-analysis in general stimulated movement away from demonstrating the generic efficacy of clinical interventions to a more specific approach wherein a particular therapy or component of treatment could be assessed across several studies. The move toward empirically supported treatment was also fueled by the erroneous perception in the healthcare field that psychotherapy is either ineffective or inferior to pharmacological treatments. This misperception persists despite the wealth of research that demonstrates that effect sizes of psychological interventions for a variety of pediatric and adult psychological disorders rival or exceed those of widely accepted pharmacological treatments (Barlow, 2004; Hollon, Stewart, & Strunk, 2006; Walkup et al., 2008).

ESTs

The EST movement galvanized support in 1995 via the APA Division 12 (Society of Clinical Psychology) Task Force on Promotion and Dissemination of Psychological Procedures, which, in an effort to promote evidenced-based treatments, published criteria for identifying empirically validated treatments (subsequently relabeled empirically supported treatments). Although ESTs are comprised of a heterogeneous set of interventions, the requirements for achieving EST status were clearly defined by APA's Division 12 Task Force (1995). In brief, the criteria put forth for a "well-established" EST were that a treatment be manualized and shown to be (a) superior to a placebo or other treatment or (b) 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.

The APA Division 12 Task Force (1995) criteria were initially patterned after the Food and Drug Administration (FDA) guidelines for the approval of new drugs, which is predominantly based on a biological research paradigm (Wampold, Lichtenberg, & Waehler, 2002). Much like the FDA guidelines for the approval of new drugs, ESTs emphasize the need to obtain appropriate estimates of internal validity as means to empirically validate specific treatment interventions that are beneficial to groups of patients with specific disorders (Chambless et al., 1996, 1998). To obtain appropriate levels of internal validity, EST researchers control for extraneous variables and maximize the variance of the outcome variables through rigorous methodological techniques, such as randomized controlled trials (RCTs). EST researchers underscore the importance of RCTs as one of the most effective methods to achieve optimal levels of internal validity, which aims to ensure that a dependent variable (e.g., a reduction in symptoms) is the result of an independent variable (e.g., a specific treatment intervention); however, this level of rigor may compromise the external validity or generalizability of ESTs (see Franklin, DeRubeis, & Westen, 2006 for a debate on the issue).

The promulgation of lists of "well-established" treatments (Chambless et al., 1996, 1998) based on the APA Division 12 Task Force (1995) criteria coalesced with the burgeoning dominance of managed care organizations (MCOs) during the mid-1990's. These lists provided data for MCOs to use in their efforts to control costs by

restricting the practice of psychological health care (Seligman & Levant, 1998). As ESTs became the standard of care encouraged and increasingly required by MCOs, many states followed suit, mandating the use of mental health treatments considered to be evidenced-based within Medicaid programs (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002). As a result of these measures, a growing number of psychologists have become progressively more concerned about the restrictions imposed on their practice by MCOs, as well as the legal ramifications of such standards (Rupert & Baird, 2004).

The weight of the APA Division 12 Task Force (1995) pronouncement is also evidenced by the fact that ESTs continue to be the gold standard that defines psychotherapy research in the U.S. (Sternberg, 2006). The National Institute of Mental Health's funding process, for example, shares many of the standards espoused by ESTs, and these guidelines have often been met with enthusiasm. Indeed there is a great deal of evidence suggesting that ESTs designed to treat specific psychological disorders (particularly anxiety disorders and depression) are quite effective in the laboratory (e.g., Barlow, Gorman, Shear, & Woods, 2000) and in actual practice (e.g., Stuart, Treat, & Wade, 2000). Furthermore, practice-research networks that have recently appeared can further assess the real-world effectiveness of ESTs (Borkovec, Echemendia, Ragusea, & Ruiz, 2001). Emboldened by these findings, EST proponents have advocated for the recognition of demonstrably effective psychological treatments among the public, policymakers, and training programs, and have been largely successful in having psychotherapeutic treatments be reimbursed by MCOs.

However, ESTs have also been met with skepticism, and opponents have raised a number of concerns. These have included an overemphasis on brief manualized treatments and specific effects as opposed to long-term treatment and common therapy effects, as well as the potential lack of applicability to a diverse range of patients varying in comorbidity, personality, race, ethnicity, and culture (Sue et al., 2006; Wampold, 2007; Westen, Novotny, & Thompson-Brenner, 2004). In response to these criticisms, other APA divisions offered additional frameworks for integrating the available research evidence. In 1999, APA Division 29 (Psychotherapy) established a task force to identify, operationalize, and disseminate information on empirically supported therapy relationships, given the powerful association between treatment outcome and aspects of the therapeutic relationship (Norcross, 2001). Similarly, several additional frameworks from other APA (e.g., Division 17) and non-APA (e.g., Society of Behavioral Medicine; Davidson, Trudeau, Ockene, Orleans, & Kaplan, 2004) divisions have been proposed. One of the most recent and promising efforts stemmed from the APA Presidential Task Force on Evidenced-Based Practice (2006) (hereinafter referred to as the Presidential Task Force) that developed the EBPP guidelines.

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, 2006; p. 273). This closely parallels the Institute of Medicine's definition of evidence-based practice, which is based on a socio-constructive paradigm where knowledge is dependent upon the individual and the sociocultural context (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). The Presidential Task Force clearly stated that their objective is 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 the full range of evidence (including ESTs) that psychologists and policy makers consider in choosing effective treatment for each patient.

EBPP guidelines were also developed as a response to the growing concerns that ESTs are being misused as a justification for inappropriately restricting access to care and treatments of choice (Norcross, Koocher, & Garofalo, 2006). Therefore, the goal of EBPP is to provide a model to enhance the delivery of services to patients within an atmosphere of respect, communication, and collaboration amongst all stakeholders of the intervention protocol including clients, practitioners, researchers, and MCOs. However, this was not intended to be a final set of guidelines, but rather a framework to set both an agenda and tone for the next steps in the evolution of psychotherapy research (APA, 2006). As such, the EBPP guidelines acknowledged research and practice dilemmas, and to address these issues, the Presidential Task Force outlined several directions for future research. An important goal highlighted throughout the EBPP guidelines is the need to ensure that psychological practice is culturally sensitive.

Culturally Sensitive Psychotherapy

Culturally sensitive psychotherapy (CSP) is the tailoring of psychotherapy to specific cultural groups, so that persons from one group may benefit more from a specific type of intervention than from interventions designed for another cultural group (Hall, 2001). Similarly, we understand culturally competent psychotherapy as a process in which the therapist develops an awareness of her own or his own culture and clinical expertise, and subsequently enhances this information by allowing each client to express what is important for them about their culture, as well as their treatment preferences (La Roche & Christopher, in press). More specifically, Hall's (2001) conceptualization of CSP highlights three differences from traditional psychotherapy. First, constructs such as race, ethnicity or culture that are used to classify individuals into different groups must be defined. Secondly, there are constellations of characteristics that are unique or more prominent in certain cultural groups relative to others. Thirdly, culturally sensitive interventions are responsive to the specific characteristics or needs of culturally diverse groups. In the sections that follow we contrast how developers of the EST and EBPP guidelines addressed the three aforementioned CSP distinctions. However, before doing so, it is necessary to underscore that ESTs and EBPP are very complex and diverse. Furthermore, ESTs are composed of a growing and diverse body of studies that include studies conducted even before the promulgation of EST guidelines in 1995; however, there is no longer a single organized EST voice. Given ESTs heterogeneity we will be referring mostly to traditional EST guidelines as defined by the APA Division 12 Task Force (1995). In contrast, EBPP is a coherent set of broad-ranging and inclusive guidelines that lack much data, particularly given its recent formulation. However, similarly to ESTs, many studies conducted prior to the development of EBPP guidelines have implemented a number of the research standards espoused by the Presidential Task Force.

Classification System

Individuals are often categorized according to race, ethnicity, and culture. Although many definitions of these constructs abound, we believe that the two most revealing characteristics of a definition is how it is measured (i.e., how it is operationally defined) and how individuals are classified as belonging to one group and not another. For these reasons, we highlight measurement differences between race, ethnicity and culture that are used to classify groups. Race is often defined in terms of selected physical characteristics, criteria, or permanent attributes such as skin color, hair, or facial attributes (Betancourt & Lopez, 1993). Accordingly, researchers often define and document race by observing participants' physical characteristics or by having them select from a set of fixed categories (e.g., Black, Asian). Ethnicity refers to the shared nationality, language, common values, beliefs, and customs of an identifiable group of people (Betancourt & Lopez, 1993; U.S. Department of Health and Human Services [DHHS], 2001). Culture refers to common ways in which individuals construe or make meaning of themselves and their worlds. Although there is clearly much variability within self-defined groups, people may also construe themselves and the world in somewhat more similar ways on some variables compared to individuals from other groups. Multicultural variables are used to assess these meanings that are more frequent within one group than other groups (Hall, 2001).

ESTs have consistently started to categorize individuals according to ethnic and racial constructs; however, this assessment is a fairly recent development. Chambless et al. (1996) identified 22 "well-established" treatments using the APA Division 12 Task Force (1995) criteria described above, and in reviewing the samples used to examine these 22 treatments, Doyle (1998) found that race or ethnicity was assessed in only 15% of the studies, and in these studies, 92% of participants were Euro-Americans. However, the lack of racial and ethnic minority participants in scientific research was partially addressed by the Revitalization Act which mandated that women and members of minority groups be included in all human subject research funded by (National Institute of Health, 1993). Despite these policy changes, members of ethnic and racial minorities continue to be underrepresented in EST research (DHHS, 2001) though increasingly less so. Additionally, some researchers have begun to assess the efficacy of ESTs with culturally defined groups not exclusively using racial or ethnic classifications. For example, some ESTs are being adapted for use with GLBTQ patients (e.g., Martell, Safren, & Prince, 2004) and patients with physical disabilities (e.g., Mona, Romesser-Scehnet, Cameron, & Cardenas, 2006).

The EBPP guidelines explicitly include a cultural classification system that not only addresses race and ethnicity, but also other sociocultural dimensions (e.g., SES, disability, sexual orientation) as well. Accordingly, the Presidential Task Force articulated the following definition of culture:

Culture, in this context, is understood to encompass a broad array of phenomena (e.g., shared values, history, knowledge, rituals, and customs) that often results in a shared sense of identity. Racial and ethnic groups may have shared a culture, but those personal characteristics are not the only characteristics that define cultural groups (e.g., deaf culture, inner-city culture). Culture is a multifaceted construct, and cultural factors cannot be understood in isolation from social, class, and personal characteristics that make each patient unique. (APA, 2006, p. 278)

In the context of this broad conceptualization of culture, the dichotomy between racial minority and majority groups and the corresponding contrast between cross-cultural and traditional psychology starts to fade as cultural meanings--not racial or ethnic characteristics--are emphasized. Nevertheless, the EBPP conceptualization of culture also creates some unanswered conceptual and methodological challenges regarding how complex cultural classification systems will be operationally defined. Although many variables are considered relevant and thus should be measured, specific multidimensional categorization strategies have not yet been developed. Furthermore, we are not aware of any psychotherapy outcome study that has included all of these different measurements.

Assumptions of Unique Group Characteristics

The second distinction between CSP and traditional psychotherapy is the presence of constellations of characteristics that are more prominent or unique in certain cultural groups than others (Hall, 2001). Some psychotherapy outcome research studies have neglected cultural differences and emphasized similarities--often assuming universal and thus comparable attributes--while other studies highlight the presence of specific cultural characteristics within different groups. Researchers who assume higher levels of universalism tend to overlook cultural conceptualizations of differences, particularly if they have not directly measured cultural variables (Carter & Qureshi, 1995).

As race and ethnicity are incorporated in EST research, they are generally conceptualized as providing members of the same group with similar values, beliefs, and customs by virtue of their common geography and history (Sue, 1999). From an EST perspective, behavioral correlates and attributes are usually inferred given a person's race or ethnicity; however, participants' level of identification with a particular race, ethnicity or other multicultural variables are rarely directly assessed. There is much behavioral variability within different races and ethnicities which makes it difficult to test any hypotheses without measuring multicultural variables within these heterogeneous groups. For example, in a landmark study among depressed Puerto Rican adolescents, Rosselló and Bernal (1999) discovered that although both cognitive-behavior therapy (CBT) and interpersonal therapy (IPT) resulted in a greater reduction in depression over a wait-list control group, IPT was associated with improvements in self-concept and social adaptation whereas CBT was not. Rosselló and Bernal (1999) suggested that IPT may be more compatible with the Puerto Rican values of *personalismo* (the preference for personal contacts in social situations) and *familismo* (the tendency to place the interest of the family over the interests of the individual) than CBT. Nevertheless, these cultural variables were not directly assessed but assumed to be present because the sample was Puerto Rican. Almost 10 years later, Rosselló, Bernal, and Rivera-Medina (2008) replicated their study but found that CBT was significantly superior to IPT for most outcome variables, even those that were assumed to be more compatible with Puerto Rican culture. Again, Rosselló et al. (2008) neglected to measure cultural variables and explained the discrepant findings by suggesting that the outcome measures were biased, and/or that CBT was in fact superior to IPT and/or that IPT treatment fidelity measures were flawed. However, could these divergent findings be more clearly explained by samples differing in levels of *familismo* and *personalismo*? In EST studies such as these, it is possible that neglecting to directly measure multicultural variables may explain some divergent findings.

Some EST researchers have begun to explore this possibility by including multicultural variables. For example, in a randomized pilot study La Roche, Koinis-Mitchell, and Gualdrón (2006) found that asthmatic and highly allocentric (the tendency to define oneself in relationship to others and seek group goals) Hispanic and African American

children visited the emergency department significantly less often after they and their family completed a psychoeducational asthma intervention designed from an allocentric perspective in comparison to a similar group that received a standard psychoeducational asthma intervention designed from an idiocentric perspective (the tendency to define oneself in isolation from others in seeking individual goals). However, EST research that includes multicultural variables remains rare.

The EBPP definition of culture acknowledges that a multifaceted set of shared values, history, knowledge, rituals and customs will often result in a shared sense of identity or common meanings. However, these shared meanings or multicultural variables are also personal or unique in that individuals may share these variables at different levels. Thus, the EBPP guidelines seem to highlight the interaction between individual, culture specific, and universal processes. The methodological implication of this is that cultural differences and similarities can not be assumed but must be examined in each individual: "Psychologists must attend to the individual person to make the complex choices necessary to conceptualize, prioritize, and treat multiple symptoms" (APA, 2006, p. 279). Furthermore, EBPP guidelines explicitly explain that cultural variables not only influence the nature and expression of psychopathology but also patients' understanding of psychological and physical health.

The EBPP definition of culture also acknowledges that cultural meanings are inseparable from the sociocultural context. Thus, it is not only important to assess individual meanings (e.g., levels of allocentrism and idiocentrism) but also the context in which these meanings are created. EBPP guidelines underscore the influence of sociocultural factors, economic forces, and situational factors (e.g., unemployment, lack of insurance) on physical and mental health. Even race is understood as a social construct broadly associated with power, status, and privilege. As a result of an increased acknowledgement of the importance of the socioeconomic and cultural dynamics affecting patients, a better understanding of the specific links between context and individual can be ascertained. These links are multileveled (dimensions that can range from the cellular to the sociocultural) and have explanatory power generating a rich gamut of alternative hypotheses. Contrasting findings across studies (e.g., Rosselló & Bernal, 1999; Roselló et al., 2008) may be explained through a closer examination of these cultural differences.

Translations of Culture into Interventions

The third CSP component entails the level of translation of unique or prominent constellations of cultural characteristics into treatment strategies, which can vary from etic (universal) to emic (culture-specific) (Gielen, Fish, & Draguns, 2004; Hall, 2001). Etic psychotherapies are developed assuming that they will be effective with all groups so that a psychotherapy developed in one group can be transferred to another. Although it may be necessary to make some cultural modifications to adapt ESTs to different groups, overall these changes are usually minor and based on theory rather than measured multicultural variables. In contrast, emic psychotherapies stress the need to develop interventions that originate from the characteristics of each group. From the emic perspective, any intervention is believed to be more effective for members of the cultural group from which it was developed. Consistent with an etic approach, most EST research has relied on stringent research methods (e.g., RCTs) to identify the specific treatment effects that are assumed to reduce symptoms, while cultural and contextual variables are generally given less priority. Although researchers are increasingly recognizing the cultural limitations of ESTs (e.g., they are mostly developed using Euro-American, middle-class samples) they continue to be exported to other groups (Hall, 2001). Consequently, some research suggests that racial and ethnic minorities are benefiting less from ESTs than Euro-Americans (e.g., Chambless & Williams, 1995; Wang, Berglund, & Kessler, 2000).

On the other hand, two recent reviews of the literature (Miranda et al., 2005; Voss Horrell, 2008) on the impact of evidence-based mental health care on ethnic minorities provided support for the efficacy and effectiveness of CBT for African American and Hispanic patients suffering primarily from anxiety and depressive disorders. Several recently developed culturally adapted ESTs for the treatment of anxiety disorders among Asian American patients have also demonstrated promising results (e.g., Hinton et al., 2005). Similarly, in a meta-analysis of culturally adapted mental health interventions among various racial and ethnic groups, Griner and Smith (2006) found a medium treatment effect size ($d = .48$) across 76 studies. Nevertheless, the question of whether culturally adapted ESTs are more or less effective than non culturally-adapted ESTs has yet to be answered. Although López, Kopelowicz, and Cañive (2002) proposed a model to compare the effectiveness ESTs to culturally adapted ESTs, few studies appear to have made this comparison. However, in one example, Kohn, Oden, Muñoz, Robinson, and

Leavitt (2002) did not find any outcome differences for African American women of lower SES who self-selected into culturally adapted CBT versus standard CBT. Moreover, cultural adaptations are not risk free; they can compromise the fidelity of the intervention and its effectiveness (Castro, Barrera, & Martinez, 2004). Furthermore, the cultural adaptation process could lead to an endless, costly and inefficient proliferation of culturally adapted interventions; hence there is a need to develop research guidelines to determine when cultural adaptations are in fact warranted, and these guidelines are still a work in progress (Lau, 2006).

The Presidential Task Force noted that the development of psychological treatments is a complex process that requires clinical and research attention to multiple interacting sources of evidence. This can include evidence gleaned from all types of scientific studies ranging from RCTs to clinical observation and qualitative research. This broader set of guidelines allows findings from various types of studies, including emic and etic, to be considered relevant in the development of intervention strategies. Multiple research designs can provide a more complex and complete portrayal of reality than research from only one source and can be used to address different types of questions (Greenberg & Newman, 1996). However, recognizing that different methods can also yield divergent results, EBPP guidelines encourage psychologists to recognize the strengths and limitations of evidence obtained from each methodological approach. For example, RCTs are useful for drawing causal inferences about the effects of interventions, whereas qualitative research can be used to describe the subjective, lived experiences of people, including participants in psychotherapy (APA, 2006).

Along these lines, although often overlooked in psychotherapy outcome research, the Presidential Task Force highlighted culturally competent treatment in which clinicians access and incorporate patients' cultural meanings or models throughout evaluation and treatment (also see Whaley & Davis, 2007). This is congruent with an anthropologically informed conception of culture, in which the integration of perspectives is not based on some presumed cultural difference or factor associated with the client from a specific ethnic or racial group (Lakes, Lopez, & Garro, 2006). Instead it focuses on the process of defining the problem from the therapist's and client's perspective; the identification or construction of a presenting problem is a process that must be informed by both parties.

Although a contextualized and process-oriented conceptualization of culture (e.g., Garro, 2003) can result in more attention being given to patients' specific needs, it may be more unreliable and confusing, while culturally adapted ESTs have the advantage of being easier to teach and disseminate. Nevertheless, the inclusion of multicultural variables and the cultural context in EBPP guidelines have two important clinical implications. First, therapists are encouraged to explore patients' cultural identity in a more complex and dynamic manner instead of assuming more stereotypical and static racial and ethnic characteristics. Second, all of our patients--not only ethnic minorities--have a cultural, historical, and contextual background making these implications applicable to all, not only ethnic minorities.

Conclusions

We have argued that EBPP guidelines offer greater potential in providing quality treatment to culturally diverse groups in comparison to ESTs. This is largely due to a paradigmatic shift from the EST biomedical perspective that deemphasized sociocultural context to the EBPP model in which the impact of sociocultural factors is explicitly addressed. This is not to suggest that the research guidelines put forth by APA's Division 12 Task Force (1995) must be abandoned. Rather, EBPP guidelines incorporate the strengths of ESTs while also recognizing cultural context and the value of diverse methodological approaches. An EBPP research framework can integrate--but is not restricted to--ESTs and culturally adapted ESTs and therefore can be used more effectively to respond to the three requirements to develop a CSP (Hall, 2001). First, the EBPP conceptualization of culture broadens traditional EST racial/ethnic classifications to include multiple dimensions. Secondly, in EBPP cultural and contextual characteristics are directly measured, whereas in ESTs these have largely been assumed. Finally, EBPP guidelines articulate the need to include findings from both emic and etic research, potentially making interventions more responsive to culturally diverse patients' needs. Despite EBPP's broader appeal, several ESTs have been found to be effective with minority groups, while EBPP guidelines still await systematic implementation. Additionally, although the guidelines state that "EBPP requires an appreciation of the value of multiple sources of scientific evidence,"

This is the author-created, peer-reviewed version of the article published in final form in *Professional Psychology: Research & Practice*:

La Roche, M. J., & Christopher, M. S. (2009). Changing paradigms from empirically supported treatment to evidence-based practice: A cultural perspective. *Professional Psychology: Research and Practice*, 40(4), 396-402. doi: **10.1037/a0015240**

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specific decision making processes for dealing with conflicting sources of evidence have not been articulated (APA, 2006, p. 280).

As noted above, research guidelines have important therapeutic, legal, financial and educational ramifications. If a given set of guidelines do not address the needs of culturally diverse groups, these may be less beneficial or even harmful to them. Therefore, a move to adopt EBPP guidelines in which researchers include multicultural variables and cultural contexts may be advantageous not just for ethnic minorities but for all. As multicultural and contextual variables are directly assessed and not assumed because of skin color or ethnic background, psychotherapy research will be better able to address all of our patient's needs. Our ultimate hope is that as psychotherapy research becomes more embedded within a cultural context, the distinction between EBPP and CSP will become obsolete.

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