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Are Cultural Adaptations of ESTs an Appropriate Response to Unfavorable Treatment Outcomes of Ethnic/Cultural minorities? An Appraisal of the Response

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Abstract

The highest standards of care for mental healthcare and psychotherapeutic services in the United States is of seminal focus by the national government, insurance agencies, educational institutions, healthcare systems, and greater communities. Included with the emphasis of the highest standards of care; the incorporation of the best practices labeled is the gold standard. However, in the context of the United States, best practices and their required research, are often exclusive diverse populations. This review of the literature and subsequent discussion delve into specific interventions implemented by the counseling field to address best practice inclusion with ethnic and cultural minorities guided by the question: What measures have been taken to promote inclusion of best practices for an increasingly diverse population?

Keywords: evidence-based interventions, culturally adapted interventions, cultural responsiveness, best practices, cultural adaptions for empirically supported treatments

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Introduction

The overall goals of many individual clients utilizing mental healthcare treatments in the United States are generally involving favorable outcomes. While the notion of favorable outcomes is ambiguous, positive reports on outcome questionnaires provide empirical data. Generally, institutions and agencies employ best practices supported by empirical evidence as a protocol to ensure favorable treatment outcomes (Marquis, Douthit & Elliot, 2011). There is an inherent oversight of best practice research in that research populations are representative of the cultural majority, however with the changing demographic in the United States is contraindicative to best practice research.

Cultural adaptation of best practices is the progression and response by best practice research to contraindications. Cultural adaptions are specific measures taken to address problems derived from best practice research. Cultural adaptations are an aspect of larger research initiatives to promote inclusion, however the question of efficacy and adequacy of the inclusive measures presents itself.

Literature Review

The following literature review examines the purpose and importance of evidence within counseling and psychotherapy, the influence empirical data has had onto treatment protocols, and the status of future research regarding specific empirically supported treatments. Literature regarding empirically supported treatments and their relationship to best practices is reviewed; best practice interventions as they relate to specific cultural groups and their effectiveness are also reviewed.

Literature reviewed included published and unpublished research and manuscripts. Topics reviewed were specific culturally adapted psychotherapies and treatment modalities,

culturally adapted treatment effectiveness research, origins culturally adapted treatments, origins of evidence-based and empirically-supported interventions emphasis, and the combination of empirically supported treatments with cultural adaptations. Literature searches utilized the following data bases: PsychINFO, PsycNet EBSCO Host, ProQuest, PubMed, and ResearchGate. Research was conducted using the Winona State Darrell W. Krueger Library online database and the Mayo Clinic Plummer Library online database. A research librarian at Mayo Clinic Plummer Library was utilized.

Efficacy of Evidence-Based Interventions

Continual an ongoing research is being conducted on the broad topic of evidence-based practice (EBPs) initiatives, empirically-supported treatments (ESTs), and best practices within counseling (Marquis, Douthit, & Elliot, 2011)

The origin of the EBP movement in the counseling profession was influenced by the medical model of healthcare treatment preceding psychology and the subsequent counseling disciplines (Marquis et al., 2011). The American Psychological Association, (APA) began an initiative to identify treatments that will earn their created label of "empirically validated treatment", or "empirically supported treatments" (Marquis et al., 2011, p. 398). The terms evidence-based practice or treatments and empirically-supported treatments are often used interchangeably; to promote continuity, the phrase empirically-supported treatments will be used in the remainder of this literature review. The "empirically-supported treatment" label provided by the APA implies an essential standard that allows for the development of treatment manuals and the standardization of care (APA Presidential Task Force, 2006). Further, the movement toward the medicalization of the counseling profession, that is, the adaptation of the medical model, emphasizes the importance of diagnosis and treatment planning for specific disorders and

the validation of treatments (Hansen, 2006). This standardization effort is a continued comparison measure and subsequent effort to align counseling practice with traditional medicine practices (Marquis et al., 2011). Western society has idealized and embraced the traditional medical model of healthcare (Klerman, 1977).

Gaining EST status, standardization, and the use of treatment manuals for specific disorders by practitioners and the implementation of specific treatment modalities is not without criticism by researchers and practitioners alike. Citing influencing factors regarding monetary gain and health insurance corporate involvement; the selection of specific treatment modalities is influenced by length of treatment in comparison to treatment goals (Edwards, Daitillo, & Bromley, 2005). Edwards et al., (2005) highlight that health insurance companies often pursue multiple avenues of treatment including the use of psychopharmacological interventions and they support psychotherapies that promote the use of pharmacological interventions.

Consequently, other therapeutic factors, often outside of empirical consideration, are negated by the implementation of treatment manuals and the standardization movement (Edwards et al., 2005; Marquis et al., 2011). Accordingly, it is these other therapeutic factors that are most efficacious in determining successful outcomes of treatment (Seligman, 1995). Of further concern, government policy and insurance providers are beginning to support ESTs as rationale for reimbursement (Marquis, & Douthit, 2006).

The trend toward the medicalization of the counseling profession includes the emphasis on external validity of research (Hansen, 2006). That is to raise the question; are specific diagnoses generalizable? Moreover, are the conditions and symptoms representative of a diagnosis repeatable between individuals? *The Diagnostic and Statistical Manual of Mental Disorders* (5^{th} ed.) (American Psychological Association, 2013) provides the basis for diagnosis

for the counseling profession. Hansen (2006) argues the *DSM*, in which diagnostic criteria and treatment manuals are presented, has questionable reliability and validity. Thus, the *DSM's* generalizability into the counseling field should be reviewed (Hansen, 2006).

Considerations regarding the premises adopted by the counseling profession's best practice research should be called into question according to Hansen (2006). Medical research regarding treatment modalities for specific disorders displays psychometric properties that best practice research cannot duplicate (Hansen, 2006; Marquis et al., 2011).

Cultural Adaptation: Historical Precedent

Why is cultural competence an essential component for a stance of cultural adaptation in counseling and psychotherapy? Cultural adaptation refers to the tailoring of psychotherapies toward specific cultural values and mores of various ethnic and cultural groups (Sue et al., 1991). The adaptation is not limited to the perspective of the entire cultural group and can be further adapted to individual within the group to correct for variability among individuals (Nagayama Hall, 2001). This further adaptation increases the overall effectiveness of treatments (Miranda, et al., 2005). Cultural competence refers to the application of the responsibility of mental health clinician's and practitioner's obligation to provide effective interventions to their clients and patients with the purpose of providing the best care and best outcomes for client populations (Griner & Smith, 2006; Sue, Arredondo, & McDavis, 1992). From a culturally competent perspective, the application of the clinician's responsibility in an inclusive manor, that is, the promotion of consistency across diverse client populations, is the highest altruistic priority (Sue et al., 1992).

The mental healthcare discipline, both in education and practice, has taken steps to raise awareness with counseling and focus on the improvement and accessibility of services for

historically oppressed racial and ethnic groups (Sue, 1998). Improvements in professional awareness and standards is relation to the cultural blind spot of the profession and movement toward mental health interventions be adapted toward individual client's cultural context and values (Castro & Alarcon, 2002); despite the belief held by professionals and scholars regarding emphasis on the lack of empirical data supporting adapted interventions (Griner & Smith, 2006; Nagayama Hall, 2001) For many disorders, there have been empirically supported psychotherapies developed for treatment however, there is not enough empirical evidence to effectively employ ESTs for ethnic minority populations (Nagayama Hall, 2001).

In 2001, ethnic minorities represented 30% of the population in the United States (Nagayama Hall, 2001); the United States census projects that ethnic minorities will represent approximately 50% of the population within the next 50 years (Nagayama Hall, 2001). These same ethnic minority groups have expressed a desire for culturally adapted psychotherapy services (Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Conversely, there is a measure of reluctance and resistance from professionals in the field to develop culturally adapted services due to the belief that cultural adaptation may negatively influence access for ethnic minorities (Sue et al., 1991). Counterintuitively, the purpose of cultural adaptation is a derivative of low access and is intended as a direct response to the identified barriers influencing access to mental health services presented to ethnic minorities (Sue et al., 1991). These problems identified by Sue et al., (1991) include: problems associated with psychological assessment (Jones & Thorne, 1987; Sue et al., 1991), discriminatory forms of treatment (Sue et.,1991; Yamamoto, James, & Palley, 1968), therapist preference (Schofield, 1964), and the premature termination rates influenced by ineffective healthcare (Gorb, 2005; Sue et al., 1991). Conclusions derived from the research completed by Sue (1977) were that ethnic minority groups varied in utilization

pattern of services and prematurely terminated services. There was a large disparity between ethnic minorities and dominate Caucasian ethnic groups in regard to prematurely terminating services. Ethnicity was found to be a reliable predictor of termination of services. Sue (1977) concluded with recommendations in response to the identified barriers presented to ethnic minorities. Sue (1977) endorsed paradigm shifts in clinician training focusing on curriculum catered to counseling services for ethnic minority clients, emphasis on the employment of bilingual and bicultural clinicians, and the creation of concurrent support services for ethnic minorities.

Implicit Biases. Schofield (1964) indicated that therapist preferences have an influence onto access of mental health services for the cultural and ethnic minority. Therapist preference refers to the hypothesis regarding clinicians offering preferential treatment toward individuals exhibiting specific characteristics. Characteristics include: young, attractive, verbal, intelligent, and successful (YAVIS). Preferential approaches toward YAVIS clients share similarities to the concept of implicit bias. Implicit biases are "actions or judgments that are under the control of automatically activated evaluation, without the performer's awareness ofthat causation" (Greenwald, McGhee, & Schwartz, 1998 p. 1464). Adoption of cultural competency standards outlined by Sue et al., (1992) make considerations for the potential of implicit biases by the practitioner.

Cultural Adaptation in Behavioral Health

The current response from the mental healthcare field in response to the barriers identified by Sue (1991) involves a multifaceted approach involving cultural adaptation of existing ESTs and the promotion of cultural competence within the counseling profession (Dinos, 2015; Sue et al., 1992). These are in alignment with two of the three postulates outlined

by Sue (1977) highlighting the cultural responsiveness hypothesis. The cultural responsive hypothesis attempts to provide framework for addressing the unique phenomenological experiences clients of minority cultural and ethnic groups are bringing to the counseling experience that potentially negatively influence treatment outcomes (Sue, 1977). Emphasis has been placed on the cultural competence of mental health practices (Dinos, 2015; Sue et al., 1992). Current culturally adaptive considerations have been taken to address shared thoughts, schemas, beliefs, and norms that are unique to cultural groups (Dinos, 2015). Empirical data, including multiple meta-analyses, (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Huey Jr. & Polo, 2008) have revealed statistically insignificant results highlighted by negligible effect sizes in regard to the effectiveness of current cultural adapted psychotherapy treatment modalities. Contraindications of culturally adapted treatments included possible alienation of ethnic minorities due to potential damaging assumptions made by researchers and clinicians encompassing cultural groups. The most common assumption being there is a shared common cultural characteristic among cultural groups (Dinos, 2015). This heterogeneity assumption disregards any potential of the existence and influence of subcultures within ethnic minority cultures (Barrera Jr., Castro, Strycker, & Toobert, 2013; Dinos, 2015). This oversight of subcultures within cultural groups, when adjusted, confounds data interpretation (Dinos, 2015). Conversely, cultural adaptations when adjusted for subcultural groups are found to be effective; with favorable treatment outcomes for ethnic and cultural minorities across general healthcare disciplines, however they remain to be inconclusive in the behavioral health disciplines (Barrera Jr. et al., 2013).

There is an apparent gap in the literature and research regarding conclusive evidence supporting or refuting the effectiveness of culturally adapted behavioral health interventions.

Conscience considerations made for specific culturally adapted mental health interventions increase their effectiveness calculated by favorable outcomes of targeted populations (Griner & Smith, 2006). Culturally adapted interventions were found to be most effective if the following considerations were made: (a) the explicit incorporation of the client's cultural values into therapy; (b) the racial, ethnic, and linguistic matching of client and therapist, (c) therapy is provided in the client's native language, (d) the explicit cultural or multicultural paradigm of the agency or clinic providing services consults with individuals who are familiar with the client's culture, (e) outreach efforts to recruit underserved clientele, (f) the provision of support services such as childcare to promote client retention, oral administration of materials for illiterate clients, and cultural sensitivity training for professional staff, (g) the provision of referrals to outside agencies for additional services (Griner & Smith, 2006). Following these guidelines may positive influence specific cultural adaption protocols.

Intersection of Cultural Adaptation and ESTs

Cultural adaptation includes the adjustment of psychotherapeutic interventions to address different metacultural influences of ethnic and cultural minority groups (Dinos, 2015). Contrary to cultural adaptation, ESTs emphasize similarities in human behavior across cultural delineations (Roysircar, 2009). Though there is an emphasis on universal behavioral patterns of human beings, there is little evidence to support effectiveness with all ethnic minorities in the United States when being treated with a manualized treatment modality. Culturally adapted therapies are an attempt to address the concerns regarding the effectiveness of ESTs through measures taken to account for the heterogeneity and diversity within client populations (Roysircar, 2009). ESTs do not consider the heterogeneity or diversity subcultures possess when compared to minority ethnic and culture groups (Roysircar, 2009).

Practicing professionals and scholars agree that ethnic and cultural inclusion in EST research is the preferred model for study, however there are conflicting opinions regarding the extent and depth of such inclusion (Whaley & Davis, 2007). The comprehensive study completed by Miranda, et al., (2005) concluded that ESTs and culturally adapted interventions are effective with ethnic, cultural, and racial minority clients though have not been examined through randomized controlled trials (RCTs).

It is clear from the literature that some level of evidence supports the combination of ESTs and cultural adaptation to promote favorable treatment outcomes with ethnic, cultural, and racial minorities. However, minimal supporting evidence can be cultivated through the completion of future research; specifically, data generated from RCTs. In response to the available literature; the conclusions generated from future research is crucial to the inclusion of cultural adaptation for psychotherapy and best practice standards.

Discussion

Despite the conclusions of literature to support further RCT research, there are barriers and obstacles existing that confound the completion and design of RCTs as it relates to mental health research (Bothwell, Greene, Podolsky, & Jones, 2016). RCT research design is most effective when clear cause and effect relationships can be identified, treatment applications can be standardized and controlled, and outcome data is generalizable to all participants. Disadvantages include the oversight of the idiographic nature or phenomenological experience of counseling (Shean, 2014).

With considerations made for limitations of RCT research for culturally adapted ESTs, perhaps an examination of the cultural responsiveness hypothesis developed by Sue (1977) previously outlined will provide clarification.

Implications on Current Practice

Sue (1977) identified three postulates which represent a culturally responsive or culturally appropriate and competent paradigm; an edict and movement of which the counseling profession and education programs must follow to promote inclusion. The three postulates are: training should include training initiatives addressing dissimilar clients, representative employment (inclusion of bilingual and bicultural mental health workers), and the establishment of parallel support services for specifically for ethnic and cultural minority groups.

Postulate One. The first postulate, counselor training, should include training initiatives addressing dissimilar clients, is intended for education and training programs. Accreditation bureaus including the Council for Accreditation of Counseling & Related Educational Programs (CACREP), and the American Psychological Association (APA), created initiatives for multicultural counseling competency standards. These standards are a component of the larger response to the first postulate identified by Sue (1977). Counselor education curriculum is plagued by indecision and the inability to generate consensus across counselor training programs on appropriate implementation of measures to address the first postulate (Dinsmore & England, 1996). Thus, a systemic universal evaluation of attempts to align with the first postulate by current counselor education training programs proves to be problematic. However, within CACREP accredited counselor education programs, the educational curriculum must be in compliance with various standard listed by the 2016 CACREP standards (Council for Accreditation of Counseling and Related Educational Programs 2015). The APA has similar compliance requirements for their accredited training programs (American Psychological Association, 2017; Council for Accreditation of Counseling and Related Educational Programs 2015, 2015) Research models have been created and implemented to evaluate the specific

measures in curriculum addressing the emphasis of the potential multicultural client (Dinsmore & England, 1996). Research is ongoing.

Postulate Two. The second postulate highlights the importance of an ethnically representative mental health counseling professional population (Sue, 1977). Increased emphasis on the recruitment and development of minority counselor educators and clinicians is a direct response to underrepresentation and low rates of hire in the hiring process (Cargill, 2009). Minority underrepresentation in the applied psychology disciplines has been previously documented in the literature (American Psychological Association, 2008; Dinsmore & England, 1996). Concurrent underrepresentation exists in education and training programs (Dinsmore & England, 1996). Within counselor education training programs hiring rates have been historically at a lower rate than that of the national average hiring rate of ethnic minorities (Dinsmore & England, 1996). In 1990, the rate of hiring further perpetuates underrepresentation in counselor education (Dinsmore & England, 1996). Progress has been made toward correcting the underrepresentation statistics.

As current hiring statistics are closely guarded secrets of the individual agencies an examination of initiatives developed to address concerns regarding hiring practices would be prudent. There has been an increase of federal oversight and an implementation of specific federal initiatives have generated reports examining ethnic minority training and retention within training programs and employment agencies (The National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and, 2001). Data collection is currently in its infancy in tracking the effectiveness of the developed enterprises addressing underrepresentation. Specifically, national data will be analyzed to generate an understanding of the source of ethnic minority underrepresentation and examine the effectiveness of strategies that

are most likely to increase representation and inclusion (The National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research, 2001)

The overall objective of federal oversight is to develop theory and technology of minority recruitment and retention. At an institutional level, the creation and integration of multicultural counseling standards by professional organizations highlighted by CACREP and the APA (Dinsmore & England, 1996); attempts to address concerns of underrepresentation and retention of minorities by means of the creation of mentorship opportunities and recruitment initiatives have been created at the agency level (Cargill, 2009).

Postulate Three. The third postulate indicates a culturally responsive philosophy would include the development of parallel services, that is, services that would be specifically generated for ethnic and cultural minorities (Center of Substance Abuse Treatment, 2006). This includes the specialization of treatment programs and agencies. Specialization encompasses the development of ethnocentric treatment programs for the cultural and ethnic minority, disabled, and populations deemed to benefit from ethnocentric approaches. Components of the specialized treatment programs include: the inclusion of culturally representative providers, training and supervision adjusted for specialization, tools adjusted for specialization, and adjusted programming (Center of Substance Abuse Treatment, 2006). Cultural adaptation of EST initiatives is analogous to the development of parallel services and a facet of the development of specialized treatment programs.

Indigenous Psychology

Indigenous psychotherapies are the manifested application of indigenous psychology of which therapeutic interventions and treatment modalities are designed in consideration of the

parent culture and indigenous population of a region (Allwood & Berry, 2006). Indigenous psychotherapies exhibit the values and ideals of culturally adapted psychotherapies. Therapists are incorporating indigenous psychotherapy interventions into their practice relevant to the counseling situation. Clinicians proficient in the surrounding culture of which they practice are more likely to introduce specific indigenous interventions appropriate to the counseling situation (Clay, 2002). Indigenous psychotherapies are specific examples of specific cultural adaptations by clinicians however, qualities of the clinician may influence the proficiency and implementation of interventions.

Implications for Future Practice

Where will further development of the cultural responsive hypothesis shift the paradigm of the counseling fields? The cultural responsive hypothesis was intended to address the high rates of dropout of minority clients and the addressing of multifaceted influences onto ineffective therapeutic outcomes of minority clients (Sue, 1977). The influences were found to be both inherent to the client and externally attributable, that is, experiential based on the clinician delivering services (Sue et al., 1991). The cultural responsive hypothesis is a corrective measure to standardize delivery systems and negate the clinician's influence onto unfavorable treatment outcomes (Sue, 1977).

The cultural responsiveness hypothesis has been generalized across systems and professional disciplines influencing the pedagogy of education, organizational hiring practices, federal policy, and healthcare delivery (Ladson-Billings, 2009; Cargill, 2009; The National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparity Research, 2001; Center of Substance Abuse Treatment, 2006). As healthcare systems continually develop; the individualization of medicine may be an expression

of and analogous to the cultural responsive hypothesis. Examples of the individualization of medicine include: targeted therapies of specific treatments, the expansion of genetic medicine, and the development of holistic medicine perspectives. These are direct effects of a shift of medicine toward the individual experiences of patients. Within mental healthcare, the cultural responsiveness hypothesis serves as a catalyst for shifting the paradigm toward inclusion (Sue, 1977). The marriage of cultural adaptation and ESTs is an aspect and expression of the shifting paradigm initially driven by an attempt to address virtually ineffective treatment measures endured by ethnic and cultural minorities. Consider the original premise highlighting the apparent medicalization of counseling influencing the adoption and development of ESTs into counseling; Western healthcare is implementing an inclusive vision of patients with the individualization of medicine. Cultural adaptation of ESTs is the analog for the individualized medicine movement in healthcare.

Expression of the cultural responsiveness hypothesis movement in educational institutions are in the recruitment and retention measures taken by institutions aligning with Sue's (1977) first postulate. Culturally diverse and representative faculty members and the promotion of internship placements that provide clinical experience with culturally diverse clients are measures implemented by accrediting bodies to incorporate the cultural responsive hypothesis (Council for Accreditation of Counseling and Related Educational Programs 2015). The original intent of the culturally responsive hypotheis is the promotion of inclusive hiring processes to address underrepresentation and its subsequent consequences (Sue et al., 1991). The response from the counseling field is an increase in ethnic minority and bilingual therapists across genders with a favorable counseling relaitonshp betweeen client and counselor being the primary indicator of favorable client outcomes. The favorable outcome is indicative of

correction for high drop out rates of minorities and supporting data from outcome questionnaires (Sue et al., 1991).

Conclusion

Is cultural adaptation effective? Intuitively, yes. The adaptation of an EST to consider the individual patient experience and their cultural characteristics should positively influence the effectiveness of an already operative EST. The delivery of ESTs does not often allow for considerations of the individual client. For example; manualized treatment programs have restrictions negating the patient experiences, thus standardizing the treatment experiences causing outcomes to be generalizable to the greater client population. Integrating a cultural adaptation allows for some level of consideration to be made for a specific cultural group and eventually, client experiences.

Literature suggests that cultural adaptations integrated into EST are inconclusive in terms of positive influence of treatment outcomes for the respective client and client population (Dinos, 2015). If there were a hypothetical formula for favorable treatment outcomes; other therapeutic factors combined with effective treatment program delivery will result in favorable outcomes. If the formula is true, then the error seems to be in the identified factors; that is, cultural adaptation is an insufficient measure for addressing and quantifying other therapeutic factors.

As a new practicing clinician, supporting a treatment program specifically tailored for a client group is an exciting and enticing prospect. However, without an agency adopting the value of cultural responsiveness while employing a culturally adapted EST is worrisome and potentially problematic. Culturally adapted ESTs are incomplete without the direction and influence of an agency embracing cultural responsive values.

Questions for Reflection

Through the literature review and subsequent disccussion; questions for future research and discussion were intimated though were ultimately unanswered by the the available literature. What is the motivatation behind the cultural responsiveness hypothesis? That is, why adjust current practices for segmented populations of potential clients? Fear of the lack of awareness regarding potential implicit biases suggests that there may have been an overcompensation with the inclusion of cultural adaptation and cultural responsiveness hypothesis. Is the inclusion of cultural adaptation and the cultural responsiveness hypothesis derived from a stance of altruistic philosophies of counseling and mental health helping professions or fear and overcompensation from implicit bias awareness?

The intent of these questions are to drive future research and catalyze further discussion of scholars, professionals, and prospective professionals.

References

Allwood, C. M., & Berry, J. W. (2006). Origins and development of indigenous psychologies: An international Anaylsis. *International Journal of Psychology, 41*(4), 243-268.

American Psychological Association . (2017, January). *Standards of Accreditation for Health Service Psychology* . Retrieved from: http://www.apa.org/ed/accreditation/about/policies/standards-of-accreditation.pdf

American Psychological Association. (2008). *CEMRRAT2 Task Force Progress Report.* American Psychological Association . Washington D.C.: American Psychological Association. Retrieved from: http://www.apa.org/pi/oema/programs/recruitment/draft-report-2007.aspx

APA Presidential Task Force . (2006). Evidence-Based Practice in Psychology . *American Psychologist 61*(4), 271-285.

Barrera Jr., M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural Adaptations of Behavioral Health Interventions: A Progress Report. *Journal of Counseling and Clinical Psychology, 81*(2), 196-205.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally Adapted Psychotherapy and the Legitmacy of Myth: A Direct-Comparison Meta-Analysis. *Journal of Counseling Psychology, 58*(3), 279-289.

Bothwell, L. E., Greene, J. A., Podolsky, S. H., & Jones, D. S. (2016). Assessing the Gold Standard- Lessons from the History of RCTs. *The New England Journal of Medicine, 374*(22), 2175-2181.

Cargill, V. A. (2009, April). Recruiting, Retaining, and Maintaining Racial and Ethnic Minority Investigators: Why We Should Bother, Why We Should Care. *American Journal of Public Health, 99*, S5-S7.

Castro, F., & Alarcon, E. (2002). Integrating Cultural Variables into Drug Abuse Prevention and Treatment with Racial/Ethnic Minorities. *Journal of Drug Issues*, *32*(3), 783-810.

Center of Substance Abuse Treatment. (2006). *Substance Abuse: Administrative Issues in Outpatient Treatment. Treatment Improvement Protocol (TIP)* (Vol. 46). Rockville, Maryland: Substance Abuse and Mental Health Services Administration. Retrieved From: https://www.ncbi.nlm.nih.gov/books/NBK64075/pdf/Bookshelf_NBK64075.pdf

Clay, R. A. (2002). Psychology Around the World. *Monitor on Psychology, 33*(5).

Council for Accreditation of Counseling and Related Educational Programs 2015. (2015). *2016 CACREP Standards.* Retrieved from: http://www.cacrep.org/wp-content/uploads/2012/10/2016-CACREP-Standards.pdf

Dinos, S. (2015). Culturally adapted mental healthcare: evidence, problems and recommendations. *BJPsych Bulletin, 39*, 153-155. doi:10.1192/pb.bp.115.050872

Dinsmore, J. A., & England, J. T. (1996). A study of multicultural counseling training at CACREP-accredited counselor education programs. *Counselor Education & Supervision, 36*(1), 58-76.

Edwards, D. J., Daitillo, F. M., & Bromley, D. B. (2005). Development of Evidence-Based Practice: The Role of Case-Based Research . *Professional Psychology: Research and Practice* , 589-597.

Gorb, G. N. (2005). Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health. *Milbank Quarterly, 3*, 425-456.

Greenwald, A. G., McGhee, D. E., & Schwartz, J. L. (1998). Measuring Individual Differences In Implicit Cognition: The Implicit Association Test. *Journal of Personality and Social Psychlogy, 74*(6), 1464-1480.

Griner, D., & Smith, T. B. (2006). Culturally Adpated Mental Health Intervetions: A Meta-Analysis. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531-548.

Hansen, J. T. (2006). Is the Best Practices Movement Consistent With the Values of the Counseling Profession? A Critical Analysis of Best Practices Ideaology . *Counseling and Values* , 154-160.

Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural Competence and Counselor Training: A National Survey. *Journal of Counseling and Development, 77*, 294-302.

Huey Jr., S., & Polo, A. J. (2008). Evidence-Based Psychosocial Treatments forethnic Minority Youth. *Journal of Adolescent & Child Psychotherapy, 37*(1), 262-301.

Jones, E. E., & Thorne, A. (1987). Rediscovery of the Subject: Intercultural Approaches to Clinical Assessment. *Journal Counseling and Clinical Psychology, 55*(4), 488-495.

Klerman, G. L. (1977). Mental Illness, the Medical Model, and Psychiatry. *Journal of Medicine and Philosophy*, *2*(3), 220-243.

Ladson-Billings, G. (2009). *The Dreamkeepers.* San Francisco: Jossey-Bass

Marquis, A., & Douthit, K. Z. (2006). The hegemony of "empirically supported treatment": Validating or Violating? *Constructivism in the Human Sciences* , 108-141.

Marquis, A., Douthit, K. Z., & Elliot, A. J. (2011). Best Practices: A Critical Yet Inclusive Visoin for the Counseling Profession. *Journal of Counseling & Development*, 397-405.

Miranda, J., Bernal, G., Lau, A., Kohn, L., Hwang, W.-C., & LaFromboise, T. (2005). State of the Science on Psychosocial Interventions for Ethnic Minorities. *Annual Review Clinical Psychology*, 113-142. doi:10.1146/annurev.clinpsy.1.102803.143822

Nagayama Hall, G. C. (2001). Psychotherapy Research With Ethnic Minorities: Empirical, Ethical, and Conceptual Issues. *Journal of Counseling and Clinical Psychology, 69*(3), 502-510.

Roysircar, G. (2009). Evidence-Based Practice and it's Implications for Culturally Sensitive Treatment. *Journal of Multicultural Counseling and Developmet, 37*, 66-82.

Schofield, W. (1964). *Psychotherapy: The Purchase of Friendship.* Piscataway, New Jersey : Transaction Publishers.

Seligman, M. E. (1995). The Effectiveness of Psychotherapy: The Consumer Reports Study . *American Psychologist, 50*(12), 965-974.

Shean, G. (2014, November). Limitations of Randomized Control Designs in Psychotherapy Research. *Advances in Psychiatry*, 1-5. doi:10.1155/2014/561452

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural Counseling Competencies and Standards: A Call to the Profession. *Journal of Counseling and Development, 70*, 477-486.

Sue, S. (1977). Community Mental Health Services to Minority Groups: Some Optimism, Some Pessimism. *American Psychologist, 32*, 616-624.

Sue, S. (1998). In Search of Cultural Competence in Psychotherapy and Counseling. *American Psychologist, 53*(4), 440-448.

Sue, S., Fujino, D. C., Hu, L.-t., Takeuchi, D. T., & Zane, N. W. (1991). Community Mental Health Services for Ethnic Minority Groups: A Test of the Cultural Responsiveness Hypothesis. *Journal of Counseling and Clinical Psychology, 59*(4), 533-540.

The National Advisory Mental Health Council Workgroup on Racial/Ethnic Diversity in Research Training and Health Disparities Research. (2001). *An Investment in America's Future, Racial and Ethnic Diversity in Mental Health Research Careers.* Washington D.C.: National Institutue of Mental Health. Retrieved From: https://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/nimh-diversity_33865.pdf

Whaley, A. L., & Davis, K. E. (2007). Cultural Competence and Evidence-Based Practice in Mental Health Services. *American Psychologist, 62*(6), 563-574.

Yamamoto, J., James, Q. C., & Palley, N. (1968). Cultural problems in Psychiatric Therapy. *Archives of General Psychiatry, 19*(1), 45.