National Hispanic and Latino
ATTC Addiction Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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EBP 101: Toward a Better Understanding of Evidence-Based Treatments, Evidence-Based Practice, and Alternative Approaches

- We will begin the webinar promptly at 02:00 PM (ET)
- Please post your questions by clicking the Q&A icon on your screen. We will answer questions at the end of the webinar, and we will try to answer as many as we possible.
- The webinar is being recorded and we will email all attendees once its ready. Also, a PDF copy of the presentation will be distributed at the same time. We will send an email to all attendees once these materials are ready. In order to view it, you must sign up (provided via link later) to our Juntos/ATTC list.

This webinar was made possible through funding from Grant Number 1H79TI081174-01 and Grant Number 6U79SP023012-01M001.

National Latino Behavioral Health Association NLBHA

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Substance Abuse and Mental Health Services Administration

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EBP 101: Toward a Better Understanding of Evidence-Based Treatments, Evidence-Based Practice, and Alternative Approaches

Presented by: Luis A. Vargas, PhD

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Our Mission

The Mission and Goal of The National Latino Behavioral Health Association is to influence national behavioral health policy, eliminate disparities in funding and access to services, and improve the quality of services and treatment outcomes for Latino populations.

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Our Objective is to provide national leadership on mental health and substance abuse concerns of the Latino community in five major areas of focus:

- Policy Issues in Mental Health and Substance Abuse
- Education and Workforce issues
- Mental Health and Substance Abuse Service Delivery
- Latino Focused Behavioral Health Research
- Latino Family Focused Interventions

Fredrick Sandoval, MPA
NLBHA Executive Director

National Latino Behavioral Health Association NLBHA

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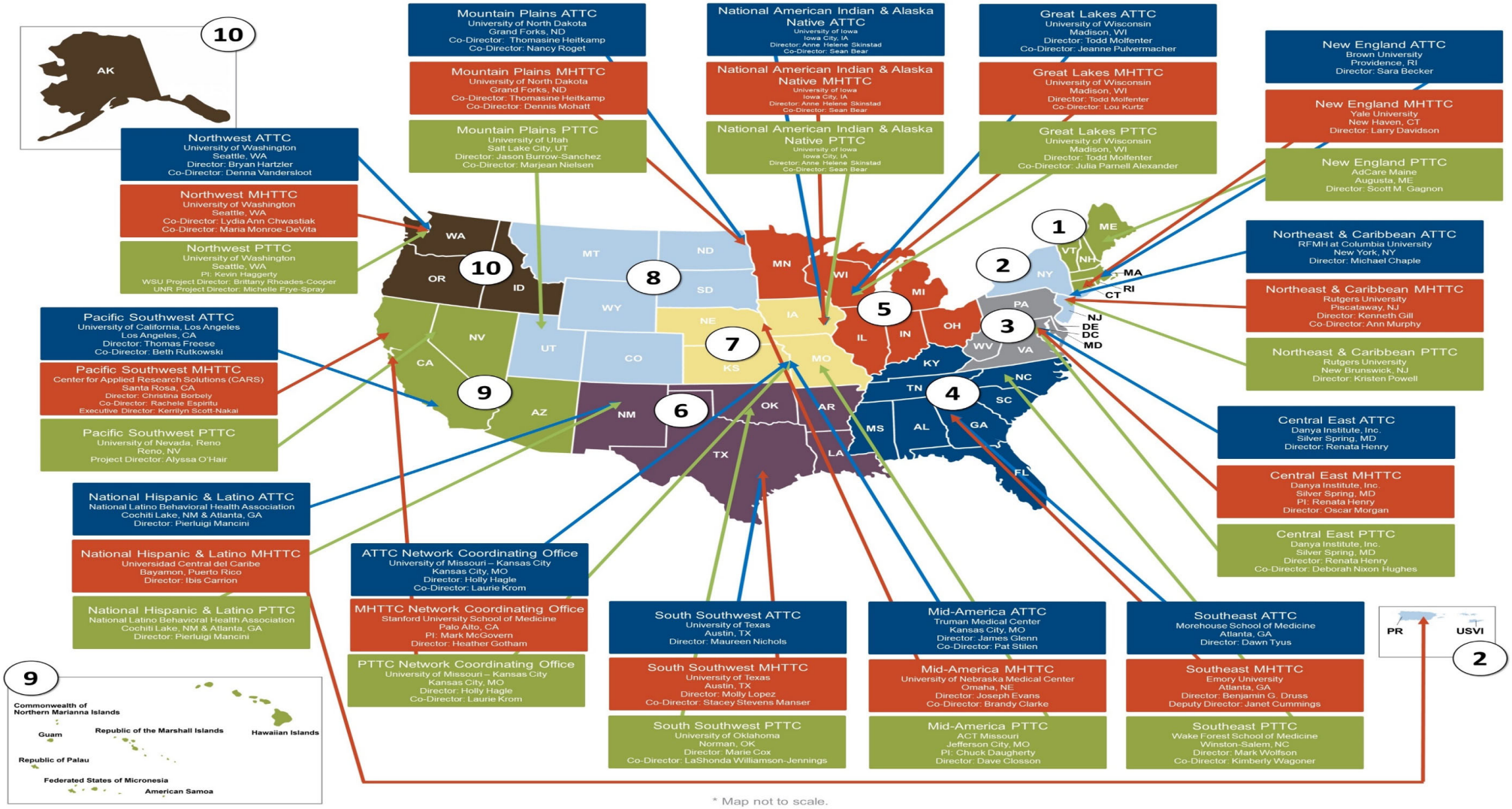

* Map not to scale.

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Today's presenter:

Luis A. Vargas, PhD

EBP 101: Toward a Better Understanding of Evidence-Based Treatments, Evidence-Based Practice, and Alternative Approaches

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Learning Objectives

- Understand the difference between EBTs and EBP and efficacy and effectiveness
- Identify the major concepts underlying EBTs
- Understand the contributions of meta-analyses of EBT studies, the components that contribute to behavioral change, the advantages of EBTs, and the limitations of EBTs
- Recognize the main factors related to the application of EBTs to culturally diverse populations
- Appreciate the importance of the counselor/client relationship and processual issues in implementing EBTs/EBP
- Identify alternative strategies to enhance EBTs/EPB
- Recognize the role of politics, power, and privilege in the scientific study of treatment outcome

Evidence-Based Treatments vs. Evidence-Based Practice

Evidence-based treatment (EBT)

- Refers to a treatment that is supported by empirical research studies and has been shown to be efficacious in a sample or samples of a population.

Evidence-based practice (EBP)

- Is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences (American Psychological Association policy statement, 2005).
- Is the integration of best research evidence with clinical expertise and patient values (Institute of Medicine, 2001).

Evidence-Based Practice

- Its purpose is “to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention” (IOM, 2001).

- A much broader concept that includes (a) the context of the service delivery system and the communities it serves, (b) the composition and structures of the organizations within which the services are delivered, and (c) the processual and cultural aspects pertaining to the delivery of services, including EBTs.

Evidence-Based Practice

- Emphasizes psychometrically sound assessments and evidence-based interventions that are culturally responsive to the communities in which they are implemented.
- Matching of treatments to needs identified during assessment is considered alongside clinical expertise and contextual and demographic characteristics.
- A scientifically minded, culturally responsive approach, characterized by continual monitoring of (a) interventions provided, (b) the client's response, and (c) events and conditions that impact treatment, can contextualize EBP.

Other Important Evidence When Making Decisions About Evidence-Based Treatments

- **Experiential Evidence:** Based on professional insight, understanding, skill, and experience that is accumulated over time and is often referred to as intuitive or tacit knowledge.

- **Contextual Evidence:** Based on factors that address whether a strategy is useful, feasible to implement, and accepted by a particular community.

Puddy, R. W. & Witkins, N., Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence Effectiveness. Atlanta, GS: Centers for Disease Control and Prevention, 2011

Framework for Evidence-Based Practice

- Puddy, R. W. & Witkins, N., Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence Effectiveness. Atlanta, GS: Centers for Disease Control and Prevention, 2011

Which is true of an Evidence-Based Practice?

1. It can include an EBT.
2. It includes clinical expertise/experience.
3. It takes into consideration client values, culture, and preferences.
4. It takes into consideration context.
5. It takes into consideration client-counselor relationship.
6. All of the above.

Definitions

- **Efficacy**: the extent to which an intervention/prevention program achieves its intended effect under ideal, controlled ("lab") circumstances, such as in a randomized clinical trial.
- **Effectiveness**: the extent to which an intervention achieves its intended effect in the "real world" (e.g., in a clinical setting or community-based agency).
- **Internal Validity**: the extent to which differences between the intervention/prevention program and control group in a clinical study can be confidently attributed to the intervention/prevention program and not to an alternative explanation. This requires constraints to reduce confounding factors and bias to a minimum.
- **External Validity**: the extent to which an intervention/prevention program can demonstrate the same desired effects in a wide range of populations and contexts (**generalization**).
- **Ecological Validity**: the extent to which an intervention/prevention program can demonstrate the desired effects in a particular setting with a particular population. This is not the typical definition and is more akin to M. M. Wolf's concept of "social validity" (1978).

Definitions

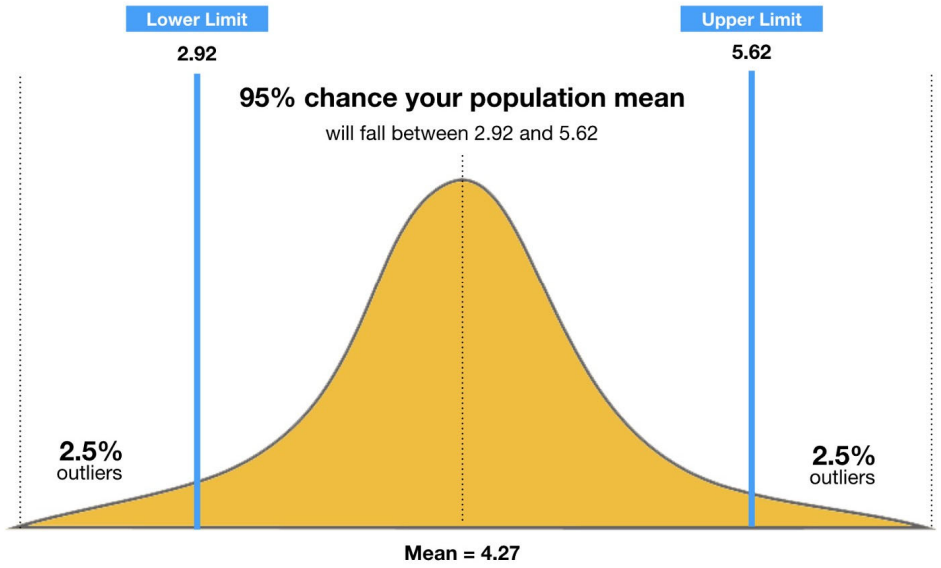
- **Random Control Trials:** Experiments in which the participants are **randomly assigned** to an intervention/prevention program or a control group. RCTs have strict inclusion and exclusion criteria (e.g., as pertains to age, diagnosis or problem behavior, co-morbidity, multiple drug use, etc.). Considered the strongest research designs for establishing cause-effect relationships.
- **Quasi-Experimental Designs**: Use of multiple groups **without random assignment**; **full experimental control is lacking**. Considered to be rigorous designs but not as rigorous as RCTs.
- **Meta-Analysis:** A type of systematic review of scientific studies using statistical analyses to combine and analyze the data from each of these studies on a specific topic (e.g., substance abuse treatments) and using these combined findings to generate a single estimate or effect size to make statements about the topic with a higher degree of certainty.
- **Treatment Fidelity/Integrity:** Degree to which a treatment or prevention program was **implemented as it was designed** (according to its protocol or manual). It is an important aspect of validity.

Definitions

- **Effect Size:** A way of quantifying the difference between two groups (e.g., the one receiving the treatment of interest and the other receiving the usual treatment) that emphasizes the size of the difference; in other words, **how much of an effect the treatment had**). Effect size is independent of sample size. For studies using a standardized mean difference, an effect size of d=0.2 is considered "small"; d=0.5 is considered "medium"; d=0.8 is considered "large" (d is the difference in the two groups' means divided by the average of their standard deviations). An effect size of 0.2 or less is trivial, even if the difference is statistically significant.
- **Statistical Significance**: The determination that the results in comparing two groups are **not due to chance alone**. Usually represented by a p-value ≤ 0.05, which is the probability that the observed difference between two groups is due to the treatment because there is an equal to or less than 5% chance that there is no difference between the groups. It is affected by sample size and does not address the size of the effect of the treatment.
- **Clinical Significance**: The **practical importance** of a treatment effect. It is a subjective interpretation as to whether the effect a treatment had is meaningful in clinical practice.

Definitions

- **Confidence Interval:** The range of values that is likely to include a population value with a certain degree of confidence. Often expressed as a percentage in which a population means lies between an upper or lower interval.



Definitions

- **Generic EBTs:** Evidence-based treatments developed on and for the dominant ethnic/racial society; the evidence for these EBTs is based on studies that have used participants primarily or only from the dominant ethnic/racial society. These EBT studies may or may not include representative samples of different minority ethnic/racial groups.
- **Culturally Adapted EBTs:** Generic evidence-based treatments that have been adapted for use with the particular cultural groups to which they will be applied. These EBTs have limits on how far the cultural adaptation can go due to treatment fidelity requirements.
- **Culture-Specific EBTs**: Evidence-based treatments developed on and for specific cultural groups. These EBTs fully reflect the cultural values, beliefs, and norms of the cultural groups to which the EBTs will be applied.

Statistical significance is superior to clinical significance because it is empirically based.

___True

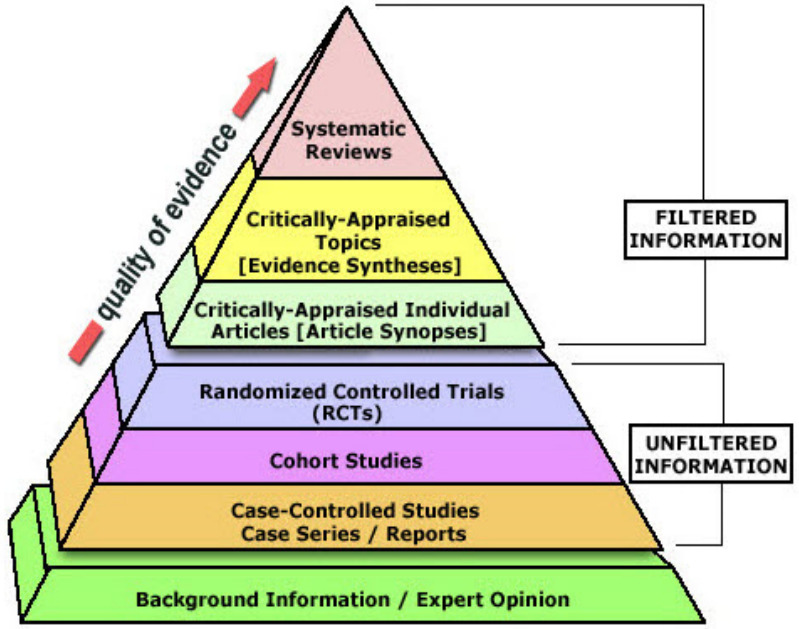
___False

In a study comparing a specific treatment or prevention program to "usual care," effect size is the subjective estimate of the "real world" effect that the treatment or prevention program had compared to "usual care."

___True

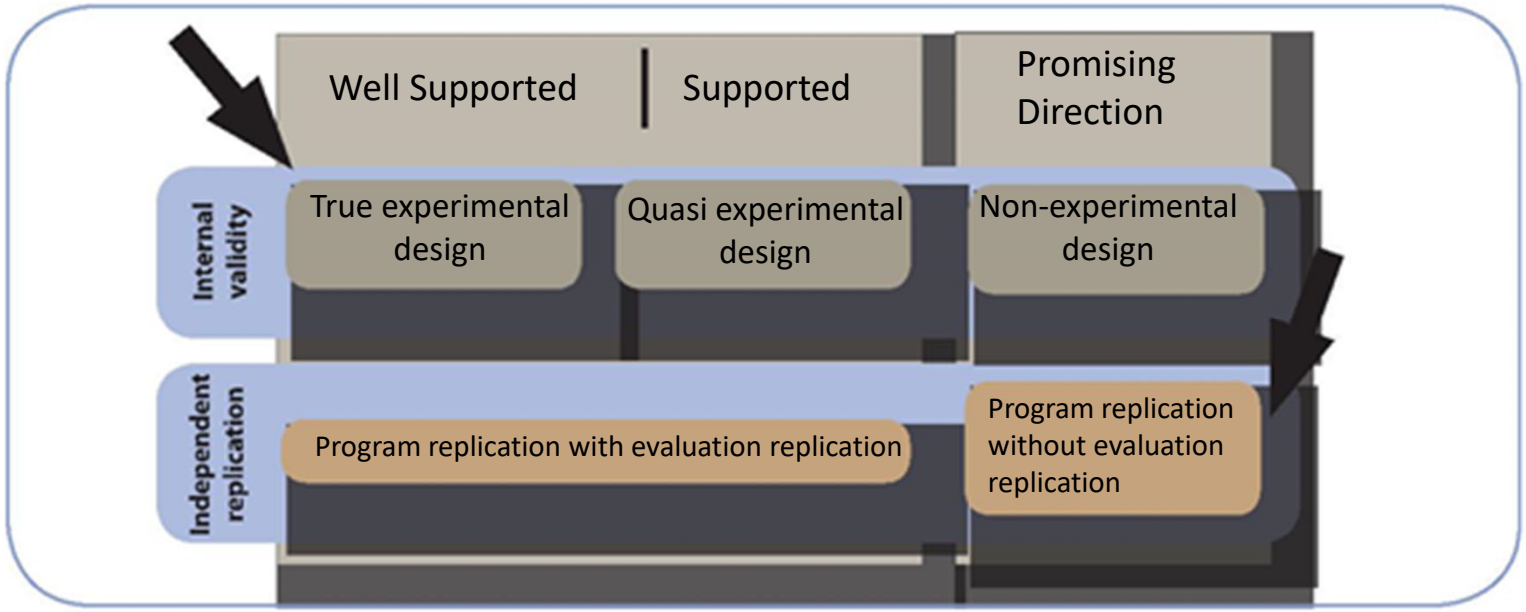
___False

Evidence-Based Medicine
(Best Available Research Evidence)



Continuum of Evidence

Puddy, R. W. & Witkins, N., Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continnuum of Evidence Effectiveness. Atlanta, GS: Centers for Disease Control and Prevention, 2011



American Psychological Association Task Force Criteria for Evidence-Based Treatments

Criteria 1: Well-Established Treatments

- There must be at least two good group-design experiments, conducted in at least two independent research settings and by independent investigatory teams, demonstrating efficacy by showing the treatment to be
  - superior to pill or psychological placebo or to another treatment

OR

  - equivalent to, or not significantly different from, an already established treatment in experiments with statistical power being sufficient to detect moderate differences

AND

  - treatment manuals or logical equivalent were used for the treatment
  - treatment was conducted with a population, treated for specified problems, for whom inclusion criteria have been delineated in a reliable, valid manner
  - reliable and valid outcome assessment measures were used, at minimum tapping the problems targeted for change
  - appropriate data analyses

American Psychological Association Task Force Criteria for Evidence-Based Treatments

Criteria 2: Probably Efficacious Treatments

- There must be at least two experiments showing the treatment is superior (statistically significantly so) to a wait-list or no treatment control group

OR

- One or more experiments meeting the Well-Established Treatment Criteria with the one exception of having been conducted in at least two independent research settings and by independent investigatory teams

Criterion 3: Possibly Efficacious Treatments

- There must be at one study showing the treatment to be efficacious in the absence of conflicting evidencleaste

Criteria adapted from Division 12 Task Force on Psychological Interventions (Chambless et al., 1998, Chambless et al., 1996) and from Chambless and Hollon (1998)

So What Does All This Information Have to Do with EBTs? Some Questions to Ask When Selecting an EBT

- Are the studies providing the evidence on the substance abuse treatment/prevention program that you are considering published in peer-reviewed journals?
- Do the studies report effect sizes and/or confidence intervals? If so, are they clinically meaningful?
- If the studies report only statistical significance, does the difference in means between the treatment in which you are interested and the control or comparison group clinically meaningful?
- Are the samples of participants used to show the efficacy of the treatment or prevention program similar to the populations to which you will be applying it (e.g., cultural group, education, age, socioeconomic status, etc.)?
- Was the treatment/prevention program tested in an RCT (experiment) or in a quasi-experimental design? If so, given the restrictions used in the sample selection and the conditions and the context in which the treatment/prevention program was delivered, do you think it can be delivered in a practical, real-life setting like your clinic or agency?

Limitations of Current Approaches to EBTs

- Nonspecific factors are usually not incorporated into theories (esp., in CBT) and are more often referred to as good clinical practice (e.g., be respectful and warm) in treatment manuals (Bjornsson, 2011).
- Many controls are often not credible; control conditions should be matched as closely as possible with the therapy that is being tested on nonspecific factors like empathy, therapeutic alliance, etc. (Bjornsson, 2011).
- Therapists are likely adapting EBTs on their own, although these adaptations are not being measured.
- EBTs focus on average response of patients (Nagayama Hall, 2001).

Limitations of Current Approaches to EBTs

- EBTs in psychology are based on efficacy studies, not effectiveness studies (Cook, 2007).
- EBTs neglect 3 essential elements of psychotherapy (Norcross, 2003)
  - the person of the therapist
  - the therapy relationship
  - the patient's non-diagnostic characteristics
- "Research suggests that effective therapists have a sophisticated set of interpersonal skills, including verbal fluency, warmth, acceptance, empathy, and an ability to identify how a patient is feeling. They can also form strong therapeutic alliances with a range of patients" (Novotney, 2013).

Limitations of Current Approaches to EBTs

- Random Clinical Trials (RCTs) de-emphasize processual aspects of therapy (Elliott, 1998).
- Most RCTs represent one version of the intervention and one version of outcome in one setting at one time with one population—problems with representation and extrapolation (Cook, 2007).
- RCTs are still too dependent on traditional statistical significance and often do not include statistics designed to reflect the practical value of results, although this is gradually changing.
- Efficacy study results are often overgeneralized (Cook, 2007).

Limitations of Current Approaches to EBTs

- Study of 193 RCTs showed that 84% discussed clinical significance, 46% considered statistical power, 31% interpreted effect size, and 2% interpreted confidence intervals (Faulkner, et al., 2008).
- However, focus on statistical power, effect sizes, confidence intervals, as well as alternative approaches that are more applicable to the “real world,” are being increasingly used.

When Is Cultural Adaptation Necessary?

- When the studies that provide the evidence for the EBT are based primarily on samples of the majority ethnic/racial population.
- When the studies that provide the evidence for the EBT are based on ethnic populations (e.g., participants who are 2nd and 3rd generation of Puerto Rican descent) that are very different from the population on which the EBT will be applied (e.g., immigrants from small villages in Northern Mexican states).
- When ecological validity has primacy over external validity. In other words, we want the treatment or prevention program to work (i.e., show efficacy) in a particular community with a particular cultural group.

Culture vs. Ethnicity

- Ethnic groupings more typical in studies examining “generic” Evidence-Based Treatment (EBT) for ethnic groups.
- Representative numbers of ethnic minorities in efficacy studies not a solution (Miranda et al., 2003).
- Cultural adaptation of EBTs usually focus on “culture” rather than “ethnicity” but is limited by treatment fidelity.
- Treatment and prevention programs developed specifically for a cultural group may work well for that group (high ecological validity) but not as well for other cultural groups (low external validity).

Culture vs. Ethnicity

- Ethnic groupings more typical in studies examining “generic” Evidence-Based Treatment (EBT) for ethnic groups
- Culture-specific EBTs typically have the greatest focus on culture compared to the other two types of EBTs
- Representative numbers of ethnic minorities in efficacy studies not a solution (Miranda et al., 2003)
- Few studies address levels of acculturation

  Example of a study that does:

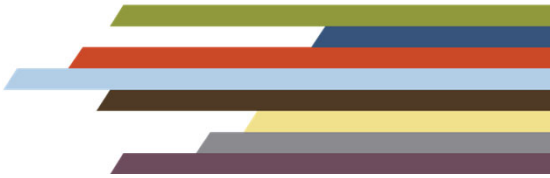
  Substance Use and Treatment Outcomes among Spanish-Speaking Latino/as from Four Acculturation Types (Serafini, et al., Psychology of Addictive Behaviors, 2017, 31 (2), 180-188)

Examples of Culturally Adapted EBTs for Latinos/as

- Balance between treatment fidelity and adaptation
- Examples of culturally adapted EBTs
  - Culturally Adapted, Web-Based Cognitive Behavioral Therapy for Spanish-Speaking Individuals with Substance Use Disorders (Paris, et al., American Journal of Public Health, 2018, 108 (11), 1535-1542)
  - Culturally Adapted Motivational Interviewing Tailored for Heavy Drinking Latinx (Lee, C. S. et al., A randomized control trial of motivational interviewing tailored for heavy-drinking Latinx, Journal of Clinical and Consulting Psychology, 2019, 87 (9), 815-830)
  - Promotora-Delivered, Spanish Language, Counseling Intervention for Heavy Drinking among Male, Latino, Day Laborers (Moore, A. A. et al, Development of preliminary testing of a promotora-delivered, Spanish language, counseling intervention for heavy drinking among male, Latino, day laborers, Journal of Substance Abuse Treatment, 2016, 62, 96-101)

Problems in Developing Culturally Adapted Treatments

- “Adaptation of treatments” loosely used (Hwang, 2006)
- Use of ethnic groups as proxies for cultural groups
- Lack of measures of culture
- Lack of guidelines for what “culturally adapted” means in research
- Length of time and amount of effort to adequately culturally adapt an EBT and measure its efficacy



Examples of Culture-Specific EBTs for Latinos/as

- **Brief Strategic Family Therapy –** a systemic family therapy for Latinos/as for families with adolescents with behavior and substance abuse problems (Szapocznik, J. & Williams, R. A., Brief strategic family therapy: Twenty-five years of interplay among theory, research, and practice in adolescent behavior problems and drug abuse. Clinical Child and Family Psychology, 2000, Rev. 3, 117-134)
- **Proyecto Juventud Intervention** – a community-based intervention for families with children at risk for substance abuse (Crunkilton, D. et al., Culturally Competent Intervention with Families of Latino Youth at Risk for Drug Abuse, Journal of Social Work Practice in the Addictions, 2005, 5 (1-2), 113-131)
- **Familia Adelante –** a family-oriented, psych-educational, module-based curriculum to enhance communication and psychological coping, increase substance abuse and HIV knowledge and perception of harm, and improve school behavior in Mexican-American youth (Cervantes, R. et al, Familia Adelante: A Multi-Risk Prevention Intervention for Latino Families, Journal of Primary Prevention, 2011, 32, 225-234)

Advantages of Meta-Analysis

- It can be superior to narrative systematic reviews of the literature if the meta-analysis is done well.
- It focuses on effect sizes.
- It provides a better estimate of the effects of the variable of interest (e.g., the effect of a treatment or prevention program) that exists in the population than single studies because it pools results of many studies.
- It is quantitative; the estimates are more precise because there is an increased amount of data and statistical power.
- It overcomes the limitations of small sample sizes.
- It follows a defined criteria established by the researcher(s) conducting the meta-analysis.
- Hypothesis testing and biases associated with publications can be examined.
- It helps resolve inconsistencies in research, and identifies potential moderating or mediating variables.

Potential Biases in Meta-Analyses

- It may have a publication bias because studies that report positive findings are much more likely to go to print (i.e., hard to get reports of studies with negative findings).
- It may have a search bias, as a result of, for example, using an incomplete set of keywords, a flawed strategy to search databases, or a search engine with limit access to studies, resulting in an incomplete set of studies.
- It may have a selection bias due to the criteria established by the researcher(s) conducting the meta-analysis.
- The criteria used to select studies might not be strict enough; e.g., allowing for studies that lack internal or construct validity, use unreliable measures, or use studies that vary considerably in the methods used to study the variable of interest (i.e., the treatment or prevention program).

Examples of Meta-Analyses

Meta-Analysis of RTCs of group treatment for substance use disorders in adults – 33 RCT studies including 34 treatment conditions and 3951 patients (Lo Coco, G. et al., Group treatment for substance use disorder in adults: A systematic and meta-analysis of random-controlled studies, Journal of Substance Abuse Treatment, 2019, 99, 104-116)

- Found small effects of group therapy (wide range of types of therapy) on abstinence compared to no treatment, individual therapy, and other treatments
- Effects on substance use frequency and substance use disorder symptoms not significant
- Significant moderately sized effects found for mental state when group therapy compared to no treatment
- No differences in attrition rates between group therapy and comparison treatments
- Robust sensitivity analyses results; no indication of publication bias

Examples of Meta-Analyses

Meta-Analysis of Family Interventions in Preventing Adolescent Illicit Drug – 39 RCT studies representing 18 different intervention programs (Vermeulen-Smit, et al., The Effectiveness of Family Interventions in Preventing Adolescent Illicit Drug Use: A systematic review and meta-analysis of randomized controlled trials, Clinical Child and Family Psychological Review, 2015, 18, 218-239)

- No clear evidence for the efficacy of family interventions in preventing or reducing illicit drug use and drug disorders among high-risk groups
- 3 small RCTs showed some indication that family interventions might reduce the frequency of illicit drug use among substance-using adolescents
  - Two RTCs based on motivational interviewing focused on improving parental monitoring and increasing parent-caring behaviors
  - Third RTC: A parent coping skills training program aimed at helping parents to respond more effectively to their adolescents' substance use using group discussion and role-play of frequently encountered situations
- Family intervention targeting parent-child dyads showed a small effect size suggesting that these programs are likely to be efficacious in preventing and reducing adolescent marijuana use in the general populations but not for other illicit drug use
- No evidence of publication bias

Examples of Meta-Analyses of Culturally Responsive Interventions

Meta-Analysis of Culturally Sensitive Substance Use Treatment for Racial/Ethnic Minority Youth– 7 studies composed of at least 90% racial/ethnic minority youth for a total of 723 participants (Steinka-Fry et al, Culturally sensitive substance use treatment for racial/ethnic minority youth: A meta-ethnic review, Journal of Substance Use Treatment, 2017, 75, 22-37)

- Culturally sensitive treatments were associated with significantly larger reductions in post-treatment substance use levels relative to comparison conditions (i.e., no treatment or alternative treatment)
- Used RCT studies or studies using controlled quasi-experimental designs
- Results limited by the small number of studies

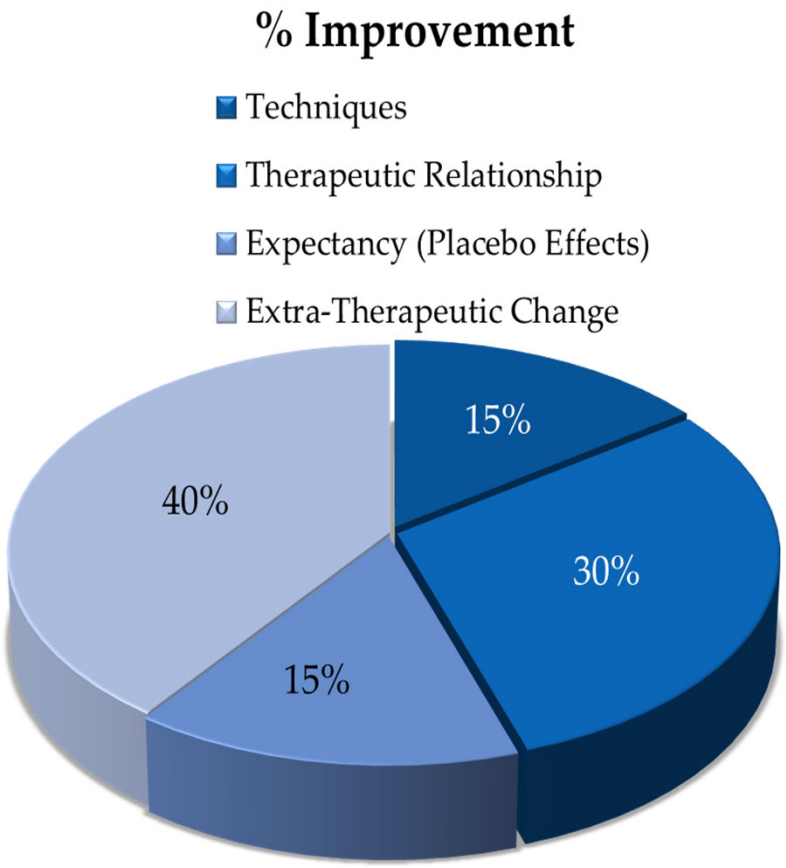
Additional Questions to Ask When Selecting an EBT

- Are there cultural adaptations for the EBT that I am interested in, and are the cultural adaptations appropriate to the client population to which the EBT will be applied?
- Are there any culture-specific EBTs that more closely match the client population to which the EBT will be applied?
- Are there any meta-analyses or systematic narrative reviews that can help me select the EBT best suited to the client population to which the EBT will be applied?
- Are the studies used in the meta-analysis of interest too broad? (E.g., I am interested in the efficacy of motivational-interview-based individual counseling for alcohol-abusing Latinos but the studies included in the meta-analysis includes many other individual therapies like mindfulness-based counseling and CBT.)

Improvement in Psychotherapy

- 40%: client and extra-therapeutic factors (such as ego strength, social support, etc.)
- 30%: therapeutic relationship (such as empathy, warmth, and encouragement of risk-taking)
- 15%: expectancy and placebo effects
- 15%: techniques unique to specific therapies

From: The Handbook of Psychology Integration by M.J. Lambert, 1992, p. 97



Incorporating Aspects of the Counselor-Client Relationship into Evidence-Based Practice

Some of the Conclusions of the American Psychological Association Task Force on Evidence-Based Relationships and Responsiveness:

- The psychotherapy relationship makes substantial and consistent contributions to patient outcome independent of the specific type of psychological treatment.
- The therapy relationship accounts for client improvement (or lack of improvement) as much as, and probably more than, the particular treatment method.
- Efforts to promulgate best practices and EBTs without including the relationship and responsiveness are seriously incomplete and potentially misleading.

Norcross, J.C. & Lambert, M.J., Psychotherapy Relationships That Work III, Psychotherapy, 2018, 55 (4), 305-315

Table 2

Task Force Conclusions Regarding the Evidentiary Strength of Elements of the Therapy Relationship and Methods of Adapting Psychotherapy

Evidentiary strength	Elements of the relationship	Methods of adapting
Demonstrably effective	Alliance in individual psychotherapy Alliance in child and adolescent psychotherapy Alliances in couple and family therapy Collaboration Goal consensus Cohesion in group therapy Empathy Positive regard and affirmation Collecting and delivering client feedback	Culture (race/ethnicity) Religion/spirituality Patient preferences
Probably effective	Congruence/genuineness Real relationship Emotional expression Cultivating positive expectations Promoting treatment credibility Managing countertransference Repairing alliance ruptures	Reactance level Stages of change Coping style
Promising but insufficient research	Self-disclosure and immediacy	Attachment style
Important but not yet investigated		Sexual orientation Gender identity

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. Psychotherapy, 55(4), 303-315. http://dx.doi.org/10.1037/pst0000193

What does <u>not</u> contribute to improvement in treatment?

1. The client-counselor relationship
2. Placebo effect
3. Client characteristics (e.g., diagnosis, client's openness)
4. The social support the client has
5. The treatment method
6. Client feedback
7. None of the above

Processual Considerations in Implementing an Evidence-Based Practices in Clinics or Agencies

- Strategies to ensure the “buy in” to the treatment or prevention program
- Capacity of the clinic or agency to deliver the EBP (e.g., supervision is often necessary to ensure treatment fidelity)
- Attention to contextual aspects (e.g., where is the clinic/agency situated, where will the treatment/prevention program be delivered, who are the administrative, provider, and clerical staff, how is the clinic/agency decorated, is help available to provide travel to the clinic/agency or child care during the delivery of the treatment?)
- Is the treatment or prevention program linguistically adapted (e.g., variations of Spanish)?
- How will the treatment/prevention program be assessed for its efficacy?

Alternative Enhancements to the Design and Implementation of Evidence-Based Treatments

- **Ecological Validity vs. External Validity (Generalization)**
  - Treatments or programs developed from the ground up within the cultural communities for which they are intended maximize ecological validity.
  - Cultural adaptation of generic treatments or programs attempt to address ecological validity but are limited due to the primacy of external validity.
  - Generic treatments or programs that show efficacy across diverse communities and cultural groups might be most cost-effective but may not yield optimal results for all cultural groups.
- **Potential Biases in Generic EBTs**
  - The treatment is often based on the theories and methods of the dominant ethnic/racial group and these theories and methods are culturally based.
  - The researchers, often from the dominant ethnic/racial group and/or trained in U.S. universities, decide what treatments should be developed, and how the effect of these treatment will be measured (e.g., assessing mental state using measures developed and standardized on participants largely from the dominant group).

Alternative Enhancements to the Design and Implementation of Evidence-Based Treatments

- **Practice-Based Evidence** (Issacs, M. R., et al., Services for youth and their families in culturally diverse communities. In B. A. Stroul & G. M. Blau (Eds.), The System of Care Handbook: Transforming Mental Health Services for Children, Youth, and Families (pp 619-642). Baltimore, MD: Paul H. Brookes)
  - "A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions"
  - Common example: traditional healing practices
  - Lack empirical support through formal research
  - Created and improved through the experiences of an organization actually offering the practice or treatment to the community
  - Has come to mean a "practice-to-science" complement to the "science-to-practice" paradigm

Alternative Enhancements to the Design and Implementation of Evidence-Based Treatments

- **Community-Based Evidence (CBE)** (Martinez, K, et al., Community-Defined Evidence: A Bottom-Up Behavioral Health Approach to Measure What Works in Communities of Color, Emotional & Behavioral Disorders in Youth, 2010, 10 (1), 11-16)
  - A refinement of PBE emphasizing "the inherent knowledge, experience, and expertise of communities themselves, based on their history, prior success, and community-sanctioned use of certain practices, including those considered culturally related or not."
  - "a set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community." (Martinez, K., Culturally defined evidence: What is it? And what can it do for Latinos/as? El Boletin (Newsletter for the National Latino/a Psychological Association, Fall/Winter, 2008)
  - Based on the premise that "people in the service-user community have knowledge based on their life experiences and learned expertise that is rarely tapped to inform scientific study, especially in developing behavioral health practices."

Alternative Enhancements to the Design and Implementation of Evidence-Based Treatments

- **Community-Based Participatory Research (CBPR)**
  - "a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities." (Kellogg Community Health Scholars Program, 2001)
  - Recognizes community as a unit of identity.
  - Builds on strengths and resources within the community.
  - Facilitates a collaborative, equitable partnership in all phases of research, involving an empowering and power-sharing process that attends to social inequalities.
  - Fosters co-learning and capacity building among all partners.
  - Integrates and achieves a balance between knowledge generation and intervention for the mutual benefit of all partners.

Alternative Enhancements to the Design and Implementation of Evidence-Based Treatments

- **Community-Based Participatory Approach (CBPA) (cont.)**
  - Focuses on the local relevance of public health problems and on ecological perspectives that attend to the multiple determinants of health.
  - Involves systems development using a cyclical and iterative process.
  - Disseminates results to all partners and involves them in the wider dissemination of results.
  - Involves a long-term process and commitment to sustainability.
  - Openly addresses issues of race, ethnicity, racism, and social class, and embodies “cultural humility.”
  - Works to ensure research rigor and validity but also seeks to ”broaden the bandwidth of validity” with respect to research relevance.

Sources: 1-9 bullets, Israel et al., 1998 and 2005; 10-11 bullets, Minkler and Wallerstein, 2008

Additional Questions to Ask When Selecting an EBT

- How can I ensure that the EBT I select, either to use myself or to have it implemented clinic or agency wide, will adequately incorporate client-relationship aspects to maximize the effect of the EBT?
- If the EBT is to be implemented clinic or agency wide, how can I ensure that the counselors are giving as much attention to the client-relationship aspects as they are to the treatment method?
- Is the EBT I select based on research studies that use any of the alternative enhancement approaches discussed above?
- If selecting an EBT for an agency or clinic, does the clinic or agency have the financial, structural, and manpower resources to implement and sustain the EBT?

Do Politics, Power, and Privilege Play a Role in the Scientific Study of Treatment Outcome?

The current Western thinking of the science of psychology in its prototypical form, despite being local and indigenous, assumes a global relevance and is treated as a universal mode of generating knowledge. Its dominant voice subscribes to a decontextualized vision with an extraordinary emphasis of individualism, mechanism, and objectivity. This peculiarly Western mode of thinking is fabricated, projected, and institutionalized through representation technologies and scientific rituals and transported on a large scale to the non-Western societies under political-economic domination.

Misra, 1996, as quoted in Marsella, 1998, p. 1285

Do Politics, Power, and Privilege Play a Role in the Scientific Study of Treatment Outcome?

- "Generic" EBTs are actually culturally based, usually on the dominant society from which participants in the study samples largely come
- RCTs and meta-analytic studies are not immune from unintentional biases
- Every treatment has an underlying, culturally based epistemology (e.g., American cognitive behavioral therapy, Navajo healing ceremonies, Mexican curanderismo)
- Exportation of EBTs is another form of cultural imperialism (Bernal & Scharrón-del-Río, 2003)
- Ethical considerations in the selection of EBTs (e.g., Does the theory on which the EBT is based incorporate specific cultural values, beliefs, preferences, and norms that are very different from those of the population that comprises the community you serve that could lead to the inadvertent imposition of that culture via the EBT?)

Thank You.

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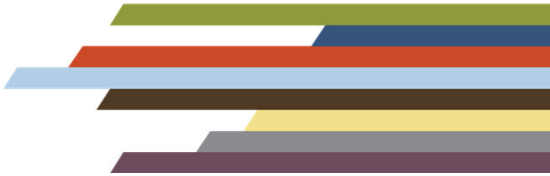

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Obrigado por participar desta apresentação.