Making the Case for Selective and Directed Cultural Adaptations of Evidence-Based Treatments: Examples From Parent Training

Anna S. Lau, University of California, Los Angeles

With prevailing concerns about the generalizability of evidence-based treatments (EBTs) in real-world practice settings, there has been increased attention to the potential of cultural adaptations of treatments to ensure fit with diverse consumer populations. However, it could also be argued that there has been insufficient dissemination and evaluation of our existing EBTs with minority populations to warrant and guide adaptation efforts. This article discusses a framework (a) for identifying instances where cultural adaptation of EBTs may be most indicated, and (b) for using research to direct the development of treatment adaptations to ensure community engagement and the contextual relevance of treatment content. Ongoing work in the area of parent training is highlighted to illustrate key issues and recommendations.

Key words: cultural adaptation, evidence-based treatments, minority children and families, parent training.

With increasing urgency, the field of children's mental health is focused on the task of ensuring the transportability of evidence-based treatments (EBTs) into real-world service settings (e.g., Hoagwood, Burns, Kiser, Ringeisen, & Scheonwald, 2001; Stirman, Crits-Christoph, & DeRubeis, 2004). Since Weisz and colleagues (1992, 1995) reported that effects of treatment in usual practice settings fall well below the effects observed in controlled trials, investigators have begun to identify and address the barriers to the implementation of EBTs (e.g., Addis, 2002; Herschell, McNeil, & McNeil, 2004; Hoagwood et al., 2001). At the same time, there is a paucity of data supporting the efficacy of EBTs for minority communities (Chambless et al., 1996; Hall, 2001). Indeed, some have argued that the usual practice–laboratory efficacy gap may be due, in part, to differences between patients in real-world settings and subjects in laboratory trials. One important discrepancy is the limited inclusion of minority youth and multiproblem families in the latter (Burns, Hoagwood, & Mrazek, 1999; Southam-Gerow, Weisz, & Kendall, 2003; Weisz & Hawley, 1998). Without assurances of the external validity and generalizability of our EBTs, some have questioned the wisdom of the rapid and wholesale transport of EBTs to an increasingly diverse consumer population (e.g., Bernal & Scharron-del-Rio, 2001; Hall, 2001; Shirk, 2004).

Although current approaches to dissemination call for the adaptation of EBTs to optimize compatibility with parameters of the receiving service system (e.g., Weisz, Jensen, & McLeod, in press), there has been little empirical research addressing the adaptation of EBTs to ensure their fit for specific ethnic communities. Scholars concerned with matters of cultural diversity have advocated the strategy of modifying evidence-based psychotherapies that have been developed and evaluated with homogeneous majority group samples in such a way to ensure cultural sensitivity. For example, Hall (2001) recommended a
process by which EBT experts collaborate with investigators invested in promoting the cultural sensitivity of therapies toward the goal of tailoring EBTs for specific groups. In their framework for cultural adaptation, Bernal, Bonilla, and Bellido (1995) presented key dimensions of interventions and the corresponding cultural sensitivity elements that may be considered in treatments adapted for Hispanics. Insightful recommendations for overcoming challenges in pertinent treatment outcome research have also been outlined (Bernal & Scharron-del-Rio, 2001; Hall, 2001). However, there has been less discussion about how research could be employed to direct the development of such treatment adaptations for ethnic minorities (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Thus, there is little in the extant literature to guide systematic translational research to inform adaptation.

There are also a number of concerns about forging ahead with culturally focused adaptations of EBTs. First, although there is as yet limited evidence supporting the effectiveness of EBTs with minorities, evidence that they are less effective with minorities is likewise limited (Miranda et al., 2005; Weisz, Huey, & Weersing, 1998). In the recent child treatment literature, scattered findings prompt some concern about possible disparities in EBT outcome for treatment of depression (Cardemil, Reivich, & Seligman, 2002; Weersing & Weisz, 2002) and attention deficit hyperactivity disorder (Arnold et al., 2003); however, response to treatment by ethnicity analyses is still rarely reported in the literature. Perhaps the first priority is to proceed with deployment to ensure minorities have access to evidence-based care and evaluate parity within inclusive effectiveness trials. Second, a focus on adapting EBTs to be culturally responsive may prompt haphazard or inappropriate adaptations that may actually compromise the fidelity of the interventions and their effectiveness (Castro, Barrera, & Martinez, 2004; Elliot & Mihalic, 2004). Third, the potentially endless proliferation of adapted variants of EBTs for various clinical problems for various target communities seems inefficient and unwarranted.

Certainly, there is an indisputable need to proceed with inclusive effectiveness trials to evaluate the generalizability of our EBTs to diverse groups (U.S. Department of Health and Human Services [USDHHS], 2001). In fact, much can be learned from such trials to determine what types of modifications may be required to ensure robust effects across diverse settings and groups (Shirk, 2004). At the same time, a compelling case can and should be made for treatment adaptation prior to the conduct of costly trials of standard EBTs. The demographic landscape is clear. With few exceptions, most of our existing well-researched EBTs for children have been developed and tested in research settings, largely with homogeneous samples of majority group families (Southam-Gerow et al., 2003; Weisz et al., 1998). Yet nationally, White children and families comprise only half of those served in public sector community mental health practice settings (Center for Mental Health Services, 1999). This proportion drops in systems of care in more diverse states, with Whites comprising only 37% of children in California's system of care (California Department of Mental Health, 2005). The gap between the samples benefiting from the efficacy of extant EBTs, and the representative youth in usual practice settings stands only to widen given current demographic shifts. In 1990, 31% of children in the United States were from racial and ethnic minority groups; this proportion is expected to increase to 48% by 2015 (USDHHS, 2001). Between 1995 and 2015, the population of White youth is projected to increase by 3%, whereas the numbers of African American youth are expected to increase by 19%, American Indian and Alaska Native youth by 17%, Hispanic youth by 59%, and Asian and Pacific Islander youth by 74% (Snyder & Sickmund, 1999).

It is not difficult to imagine that the specific treatment needs of ethnic minority children and families may differ from their majority group counterparts for a variety of reasons. EBTs developed based on work with mainstream samples “may not take into account the language, values, customs, child-rearing traditions, expectancies for child and parent behavior, and distinctive stressors and resources associated with different cultural groups” (Weisz et al., 1998, p. 70), thus compromising both engagement and outcomes. It is plausible that certain EBTs with established efficacy will not generalize to improve certain presenting problems in certain ethnic communities. A lack of generalization might be characterized by inequity in clinical outcomes when the EBT is administered with fidelity and at the optimal dose. Alternately, generalization may fail when there is differential engagement of ethnic groups in
treatment such that it becomes difficult to deliver what would otherwise be an effective dose of the EBT. Thus, cultural adaptation of treatments is warranted in either of these situations. The impact of adaptation efforts will be greatest when focused on those presenting problem–intervention–target community combinations that are most likely to yield generalization failures. However, a framework for identifying these junctures and deriving promising adaptations has yet to be articulated.

In this article, I propose an approach to the selective adaptation of EBTs for targeted communities that is systematically guided by evidence. This approach to adaptation prioritizes the use of data to (a) selectively identify target problems and communities that would most benefit from an adapted intervention approach and (b) direct the design of treatment adaptations. By advocating a selective and directed approach to treatment adaptation, I assume a fairly conservative approach to EBT adaptation. A selective approach suggests that adaptation efforts be focused judiciously on those presenting problem–intervention–target community constellations for which evidence suggests the likelihood of EBT generalization failure. The following discussion presents categories of evidence that may be considered in making this determination. A selective approach based on evidence of poor fit between particular EBTs and particular communities is meant to focus treatment adaptation efforts where they are most needed, while safeguarding against less defensible, improvised drifts away from EBT fidelity in the name of cultural competence. Striving toward the ethical imperative of cultural competence in mental health practice can instead inspire the scientific mindedness needed to form hypotheses about how best to treat clinical problems in culturally distinct groups (Sue, 1998). A directed approach to cultural adaptation likewise emphasizes reliance on data, in this case to derive specific modifications to EBT procedures or content. The interventionist should proceed with adaptation design in an a posteriori manner, guided by empirical findings on just how the fit of the EBT may be improved for the target cultural group. This article discusses the types of research evidence that may be of value in selecting adaptation targets and directing adaptation design. Examples from the parent training literature are presented to illustrate facets of this approach.

**SELECTIVE ADAPTATION: IDENTIFICATION OF TARGET PROBLEMS AND TARGET COMMUNITIES**

Toward the goal of selective adaptation, community-specific treatment adaptation may be warranted when there is evidence pointing to important variability across groups in (a) contextual processes influencing vulnerability to and protection from target problems and/or (b) response to common EBT strategies for the target problem. Broadly speaking, there are two types of research findings that can help to isolate target problems in target communities that would benefit from adapted treatment approaches.

**Distinctive Sociocultural Context of Risk and Resilience**

First, and perhaps most compelling, are data suggesting the existence of community-specific processes that contextualize the presentation of a given mental health problem. That is, treatment adaptation may be warranted when translational research suggests that a particular clinical problem emerges within a distinct set of risk and resilience factors in a given community. In influential models of treatment specification, positive outcomes are thought to be achieved when core intervention procedures impact theoretically and empirically important mechanisms that cause or maintain problem behavior (Rosen & Proctor, 1981; Schoenwald, Henggeler, Brondino, & Rowland, 2000). Translational research can serve to identify important instrumental treatment goals, which when achieved, produce the desired ultimate treatment outcomes. Therefore, if there is evidence to suggest that a clinical problem emerges within a distinctive sociocultural context in a given group, treatment adaptation may be indicated to address culturally specific risk processes.

Research on cultural processes in developmental psychopathology represents a nascent area of inquiry. While ecological context is centrally important in the study of the emergence of disorder and problem behavior, empirical study of cultural influences has been lagging (Garcia-Coll, Akerman, & Cicchetti, 2000). The idea of equifinality, there being multiple pathways to psychopathology, is well accepted. Yet, limited progress has been made toward understanding how cultural context may pattern the processes leading to disordered or healthy development. This line of inquiry, however, would represent a major inroad toward identifying fruitful avenues for culturally responsive interventions. For example, translational research is underway to identify the key
sociocultural risk factors responsible for the high rate of suicide attempts among adolescent Latinas (Canino & Roberts, 2001). Zayas, Lester, Cabassa, and Fortuna (2005) theorize that these attempts are catalyzed by family conflict around Latina teen behavior that exposes the clash between competing models of relatedness—*familismo* versus autonomy. Struggling to make developmental strides toward autonomy, while still committed to cultural ideals of family unity, emotionally vulnerable Latinas faced with unremitting familial disapproval may see suicide attempt as a reasonable escape response. The National Institute of Mental Health is currently funding these investigators to empirically test this emic formulation of suicide risk in order to inform the development of culturally adapted family-based treatments.

A culturally specific model of risk and resilience factors for alcohol abuse among American Indians has already received empirical support. Whitbeck, Chen, Hoyt, and Adams (2004) situate the problem of alcohol misuse and dependence in the context of the legacy of genocide as well as the continued stressful experiences of everyday discrimination against American Indians. They demonstrate that perceptions of discrimination lead to increased alcohol abuse among American Indians, and that this link is mediated by feelings of “historical loss”—exemplified by experiences of disintegration of family and community ties and tradition: language, cultural, and spiritual loss. These investigators reason that alcohol abuse may represent a reaction to anger resulting from discrimination and historical loss, perhaps as a means of self-medication to numb reminders of all that has been lost. Conversely, “enculturation” or being embedded and strongly identified with American Indian traditional culture exerts a protective effect against alcohol abuse. A stated purpose of this research is to use the findings to guide the development of culturally based interventions.

Indeed, evidence for the existence of unique processes that protect against the development of clinical problems in specific communities is of key relevance to treatment adaptation. In this case, adaptation would focus on mobilizing or exploiting naturally occurring community-specific protective factors (Bernal et al., 1995), such as the potential potency of enculturation practices in prevention of alcohol abuse among native populations (cf., Brady, 1995). While much of this work has yet to be translated into treatment design, Lopez, Kopelowicz, and Cañive (2002) describe cross-cultural research on family processes and schizophrenia that has served to inform the design of a culturally adapted intervention. Lopez et al. (2004) found that criticism was a risk factor for schizophrenic relapse in Anglo-American families but not in Mexican American families. Conversely, family warmth functioned as a protective factor for Mexican Americans, but did not protect against relapse among Anglo-American families. The authors reason that family interventions for schizophrenia, which focus on reducing family conflict through psychoeducation, communication training, and problem solving (e.g., Falloon et al., 1982), may be adapted for Mexican Americans by fortifying family unity through the enhancement of positive affective family ties (Weisman, 2005). A randomized trial is now ongoing to evaluate this hypothesis. These examples exemplify the idea that if the processes of risk and resilience for a given presenting problem differ across cultural and ecological contexts, well-reasoned cultural adaptations may target culturally informed instrumental treatment goals (e.g., enhancing positive family affect) to achieve ultimate treatment goals (e.g., reducing psychotic relapse).

Thus far, the discussion of treatment adaptation to accommodate the sociocultural context of presenting problems has been limited to considerations of intergroup differences in risk and protective factors for problems. Cultural context may also have a deterministic role in symptom presentation and phenomenology that may also have been instructive for directing treatment adaptation. For example, recent work suggests that posttraumatic stress appears to have a unique presentation in Southeast Asian refugees. Hinton and colleagues have identified culturally specific panic attack subtypes (e.g., neck-focused and orthostatic panic attacks) comorbid with posttraumatic stress disorder in these communities. Detailed accounts suggest a cultural ontogeny of symptoms whereby trauma cues tend to elicit somatically focused panic rather than fears of external threats to safety. Ethnotheories about physiology (e.g., beliefs about “wind overload” and “heart weakness”) are linked to culturally specific catastrophic appraisals of sensations that may be triggered by trauma associations. Data from controlled trials indicate that culturally adapted cognitive-behavioral therapy is efficacious for improving panic attacks and flashbacks among previously treatment-resistant
Cambodian refugee victims of trauma (Hinton et al., 2004). Cultural adaptation involved modification of several core elements, including (a) incorporation of mindfulness exercises during relaxation; (b) cognitive restructuring and psychoeducation tailored to aspects of ethnophysiology and refugee trauma characteristics; and (c) interoceptive exposures specific to key trigger sensations for this group (orthostatic and neck-focused panic).

**Threats to the Social Validity of Interventions**

A second compelling rationale for adaptation would be provided by evidence suggesting that certain communities may respond poorly to certain EBT approaches. In this case, I refer to factors that constrain community engagement in the intervention, rather than factors that would limit effectiveness when adequate treatment dose is received. Shirk (2004) observed that a major threat to the successful dissemination of EBTs is the potential for dilution of treatment strength owing to increased attrition or marginal participation in usual practice contexts. In this regard, the assessment of the social validity of interventions in target communities is informative. Foster and Mash (1999) discuss social validity in terms of the acceptability and viability of the intervention when implemented in a community setting. Treatment procedures that are viewed as acceptable by potential consumers are more likely to be sought out and adhered to when they are offered (Cross Calvert & McMahon, 1987).

Methods are needed to determine if indeed ethnic communities vary reliably in their receptiveness to treatments, necessitating efforts to overcome barriers to engagement. Ample evidence suggests that ethnic minorities are less likely to receive mental health treatment compared to Whites even after need and financial factors are controlled (USDHHS, 2001; Garland et al., 2005). Furthermore, when minorities do receive care, it is less likely to be consistent with evidence-based practice (Wang, Berglund, & Kessler, 2000). Clearly, there is a broad array of barriers to accessing mental health treatment among minority communities. Recent evidence points to racial variation in psychological factors, including etiologic beliefs about child problems, and perceptions of the acceptability of treatment options, as factors that help to explain underutilization among minority families prospectively (Krain, Kendall, & Power, 2005; Yeh et al., 2005). However, more specific data would be useful in understanding patterns of acceptability for particular interventions and elements of evidence-based practice among ethnic communities.

Direct and indirect evidence regarding the social validity of a psychosocial intervention can be obtained in a variety of ways. Data from inclusive effectiveness trials may demonstrate differential attrition or participation among certain groups of consumers, making tangible problems with social validity. In addition, attitudes toward therapeutic procedures can be assessed among current or past consumers of an EBT. Analog studies of attitudes among nonclinical samples can be helpful when the cultural community of interest is understudied and not generally included in effectiveness trials. These studies may be qualitative or based on survey research methods, and can guide the development of culturally responsive programs (Coard, Wallace, Stevenson, & Brotman, 2004; McCabe, Yeh, Garland, Lau, & Chavez, 2005; Powell, Zambrana, & Silva-Palacios, 1990). Generally, treatment procedures associated with an EBT are evaluated for their acceptability (i.e., do potential consumers view the procedures as palatable, feasible, relevant, or helpful?). Individuals’ perceptions of the social validity of EBTs have important implications for engagement and outcomes. For example, Kazdin and colleagues have demonstrated that parents’ perceptions of the acceptability, relevance, effectiveness, and demandingness of treatment procedures and goals are related to both persistence in treatment and therapeutic change (Kazdin, 2000; Kazdin, Holland, & Crowley, 1997; Kazdin & Wassell, 1999). Therefore, treatment adaptation may be indicated when there is evidence of low social validity of an EBT for a given community; that is, when members view component treatment strategies as irrelevant, unhelpful, or unacceptable.

While attitudinal barriers stemming from stigma and cultural mistrust certainly contribute to greater initial reticence to seeking mental health treatment among ethnic minorities, problems with the perceived acceptability and credibility of treatments offered in initial clinical encounters may better account for elevated levels of early attrition from care (Sue & Zane, 1987). Indeed, compared to Whites, ethnic minorities have been noted to have higher rates of premature termination from
treatment within randomized controlled trials of EBTs (Kazdin & Whitley, 2003; Kendall & Sugarman, 1997), as well as from mental health service systems at large (Bui & Takeuchi, 1992; Sue et al., 1991). More detailed study of barriers to engagement in specific interventions may be helpful in directing specific efforts to adapt EBTs. Thus far, efforts to enhance treatment engagement have focused on general strategies for promoting participation, such as pretreatment preparation interventions (e.g., videotaped orientation materials) or use of incentives for attendance. However, engagement-enhancement strategies have generally not been informed by theoretical or empirical work on the specific barriers to the acceptability of interventions or their component elements (Nock & Ferriter, 2005).

**DUAL APPROACHES FOR DIRECTED TREATMENT ADAPTATION**

Within a research-based approach to treatment adaptation, work may proceed along two parallel lines. Two types of treatment adaptations may be contemplated to ensure fit with the needs of the target community, while attending to the needs of ensuring fidelity to the EBT model. The first arm of adaptation involves **Contextualizing Content**, such that the adapted intervention accommodates the distinctive contextual factors related to the presenting problem in the target community. This may involve the addition of novel treatment components to target these group-specific risk processes, or the addition of components to mobilize group-specific protective factors. Alternately, treatment content may be altered to target symptom presentation patterns that require distinctive intervention elements. The second thrust of adaptation involves **Enhancing Engagement** in EBT strategies with demonstrably low social validity. The main challenge is to design adaptations that increase engagement in a standard EBT approach without undermining the therapeutic value of the original intervention (Castro et al., 2004).

The approach outlined above is reliant on basic behavioral research that addresses distinctive socio-cultural patterns of risk, resilience, and presentation of mental health problems, and attitudes toward common EBT practices in diverse communities. This translational work may either capitalize upon existing research, or (especially likely in the case of understudied communities) may necessitate original research. While this process may be labor intensive, it may have valuable long-term returns in the efficient allocation of resources while also installing safeguards in the enterprise of treatment adaptation. Such an approach ensures some rigor by advancing an empirically guided approach to adapting EBTs. It is conceivable that well-intentioned adaptation efforts that are not informed by data may fall into a category of being “culturally appealing” but scientifically indefensible (Castro et al., 2004). If preliminary or extant research provides little support for community-specific differences in problem presentation or treatment-related attitudes, then a program of effectiveness and dissemination research may be more advisable than proceeding toward the design of community-specific treatment adaptations. Pragmatically, this “triage” approach serves to help identify empirically indicated priorities for cultural adaptation of EBTs.

**EMERGING EXAMPLES IN PARENT MANAGEMENT TRAINING**

Parent management training (PMT) interventions represent a class of interventions with a long history and well-established evidence base (Brestan & Eyberg, 1998). Although PMT programs were initially designed to teach parents behavioral strategies to reduce child conduct problems, they also have demonstrated efficacy in reducing the target problem of abusive parenting (e.g., Chaffin et al., 2004; Hughes & Gottlieb, 2004). In contrast to most other EBT categories, the generalizability of PMT treatment effects has enjoyed some empirical support from studies which have included large, diverse samples. For example, the effects of parent–child interaction therapy (PCIT) in reducing abusive parenting appeared to generalize across groups including Caucasians, Latinos, and African Americans, with no apparent intervention by ethnicity interactions (Chaffin et al., 2004). In prevention samples, the Incredible Years program has reduced child behavior conduct problems among Caucasian, Latino, African American, and Asian American families, and the number of ethnic differences in attrition and outcomes did not exceed that expected by chance (Reid, Webster-Stratton, & Beauchaine, 2001).

Still, there have been some documented racial/ethnic disparities in outcomes of PMT. Minority families have shown less improvement in parent discipline strategies in the Healthy Steps program (Caughy et al., 2003), and in teacher-rated child aggression in the Fast Track intervention (Conduct Problems Prevention Research Group, 2002). There are also some indications that engagement
in PMT may be problematic for some ethnic minority families. For example, in controlled trials immigrant and minority parents appear to be less likely to enroll in parent training programs (Cunningham et al., 2000; Reid et al., 2001) and more likely to drop out when compared to Caucasians (Holden, LaVigne, & Cameron, 1990; Kazdin & Whitley, 2003). Furthermore, even when the rate of attendance is similar across groups, levels of active engagement and participation in PMT therapy process may still be lower among minority parents compared to Caucasians (Orrell-Valente, Pinderhughes, Valente, & Laird, 1999).

Concerns are growing about the fit of traditional PMT strategies for families from diverse cultural backgrounds (Forehand & Kotchick, 1996, 2002). The target of change in PMT may be especially sensitive to cultural differences, since there is wide variation in parenting practices and family values across ethnic groups that may influence receptivity to prescribed changes in parent–child interaction patterns (Kazdin et al., 1997). Preventionists appear to be leading the charge in attempts to adapt PMT to accommodate these cultural differences (e.g., Roosa, Dumka, Gonzales, & Knight, 2002). Data are emerging to suggest that culturally adapted versions of PMT, which make surface-level (e.g., including community-relevant examples, modifying graphic material to depict ethnically similar families, and acknowledging and respecting cultural values) and structural changes (e.g., community network recruitment, ethnic match in provider, conducting groups in churches and other community locations, and addressing basic living needs), result in marked improvements in recruitment and retention (Harachi, Catalano, & Hawkins, 1997; Kumpfer et al., 2002).

However, outcomes associated with these adaptations are typically equivalent or only slightly better than standard versions. A vital observation is that adaptations that effectively reduce dosage of the standard behavioral strategies or eliminate critical content can reduce positive outcomes (Castro et al., 2004; Kumpfer et al., 2002). For example, versions of the Strengthening Families program adapted for Asian Pacific Islanders and Hispanic families have included material on cultural family values, but displaced behavioral skills content. The culturally adapted Strengthening Families program resulted in less improvement in parenting skills, parental depression, and child behavior problems than the original version, which focused on behavioral skills only (Kumpfer et al., 2002). Kumpfer observed that cultural adaptation has been largely driven by clinical observations and an ethical imperative to be respectful of diverse cultural values and competencies. Adapted programs are often based more on practitioners’ perceptions of ethnic community needs rather than on empirical data. Given that these previous adaptation efforts have not appeared to improve clinical outcomes among target groups, the need for a systematic and evidence-based approach to adaptation is apparent.

**SELECTIVE AND DIRECTED ADAPTATION OF PMT: EXAMPLES IN THE FIELD**

**Contextualizing Content: Black Parenting Strength & Strategies**

Stephanie Coard has developed the Black Parenting Strengths & Strategies (BPSS) program, a cultural adaptation of the Parenting the Strong-Willed Child program (Forehand & Long, 2002). BPSS teaches key behavioral parent management skills, while also mobilizing unique cultural processes found in earlier investigations to be protective among African American families. Coard’s work was informed by theoretical perspectives suggesting that parents socialize their children to develop the skills needed for adult competence within the relevant cultural context (Ogbu, 1981). For African American youth, developmental competence requires the ability to make sense of and cope with pervasive and open hostility, prejudice, and discrimination (Ward, 2000). Racial socialization practices are employed by African American parents to teach children how to navigate their environments and promote adjustment in the face of race-related ecological challenges. Coard and colleagues reviewed the research suggesting that parental use of racial socialization practices is associated with better emotional, behavioral, and academic outcomes among African American children (Coard et al., 2004). She reasoned that evidence-based parenting programs for African American families could be augmented by the promotion of racial socialization practices, which lead to positive parent–child interactions, higher academic performance, and reduced depression and anger problems.

Coard utilized qualitative research methods to inform the development of program components to enhance traditional PMT approaches for use with African American families (Coard et al., 2004). In-depth semistructured
interviews were conducted to gain a richer understanding of the socialization messages commonly emphasized by mothers of young African American children living in low-income, inner-city neighborhoods. Consistent with influential models of racial socialization, Coard’s work revealed that African American parents commonly focus on transmitting messages related to racial achievement, preparation for bias, racial equality, and racial pride. Parents’ narratives also revealed four modes of communicating race-related content to children, including oral communication, modeling, role playing, and exposure. The richness of the obtained narratives describing specific message content areas and teaching techniques enabled the investigators to translate the broad literature on the protective nature of racial socialization into the design of specific program components in a cultural adaptation of an evidence-based parent training program.

In this way, Coard’s approach to tailoring PMT exemplifies the approach of contextualizing intervention content to mobilize culturally salient protective factors that have demonstrated potential for achieving targeted outcomes. Moreover, Coard argues that including culturally relevant “adaptations to content may be necessary to engage families of color, promote interest, participation and satisfaction with the intervention.” Indeed, contextualizing treatment content may serve a complementary role of enhancing treatment engagement among diverse consumers of EBTs.

ENHANCING ENGAGEMENT: GUIANDO A NINOS ACTIVOS

Kristen McCabe has developed a culturally adapted version of PCIT for use with Mexican Americans. PCIT is designed to help parents manage child behavior more effectively by building warm and responsive relationships. Parents are taught skills to improve their interaction with their children, and live coaching is used to guide parents as they practice new skills with their child in session. McCabe suggests that the core elements of parent training can be valuable across diverse cultures, with many aspects of PCIT being well suited to Mexican Americans (i.e., hands-on teaching, inclusion of both parents, structured, time-limited). However, she argues that cultural responsiveness could be augmented by attending to engagement in an individualized manner. Through her integration of the clinical literature on Mexican Americans, empirical studies of treatment barriers among Latino families, and original qualitative research, McCabe generated a set of adaptations designed to reduce cultural barriers to engagement in PCIT (McCabe et al., 2005).

Drawing upon their previous work with Mexican American families, McCabe and colleagues noted that cultural and attitudinal barriers discourage treatment seeking for child behavior problems over and above practical barriers such as transportation and finances. In a large survey of Latino parents of children with mental health needs, almost two-thirds reported fears about negative consequences of treatment (e.g., breaches of confidentiality) and over half doubted the effectiveness of treatment for meeting their specific needs (Yeh, Hough, McCabe, Lau, & Garland, 2004). In a qualitative study of 30 Mexican American parents who had sought child treatment, the majority had experienced disapproval from family members who believed treatment would be ineffective and that the act of seeking treatment reflected parental failure (McCabe, 2002). Specific parental attitudes and expectations were related to dropout after the initial treatment session. Parents who believed increased discipline was the appropriate response to child behavior problems, and who expected rapid recovery, were more likely to drop out (McCabe, 2002). These findings pointed to general considerations in treatment engagement among Mexican American parents, but specific directions for adaptation of PCIT required additional research.

Focus groups and interviews were conducted with Mexican American parents of youth with behavior disorders to evaluate the social validity of PCIT. PCIT was described and participants were invited to comment on the features that they found appealing or unappealing and to suggest improvements to the program. There was a great deal of variability in attitudes among respondents, suggesting that the adapted program must flexibly accommodate differences in familial attitudes and acculturation levels. Nonetheless, some clear themes emerged as requiring attention. Given concerns about blame, stigma, and labeling of children, mothers preferred the program to be framed as educational rather than therapeutic. They wanted interventions focused on changing parent behaviors to be presented in a nonblaming manner, as guilt reactions are already commonplace. Mothers highlighted the need to make clear how activities, such as play, can reduce behavior problems. They requested
support for enlisting the involvement of fathers and extended family. Fathers recognized the likely difficulty in engaging fathers in PCIT, given traditional gender roles, and suggested the use of testimonials from other similar fathers and providing information on the consequences of paternal inaction. Fathers and mothers also believed that Mexican Americans’ preference for strict discipline would make time-out and ignoring procedures appear too mild. Parents also suggested a stronger focus on building communication skills.

Based on the analyses of information gathered, a theoretical approach and a list of specific modifications to PCIT were derived and reviewed by expert panels. The resulting program called Guiando a Ninos Activos (GANA) adopts a public health approach that recognizes that individuals who are most in need of treatment are also likely to face the most barriers to engaging in treatment. The onus is on the interventionist to address barriers to participation and prevent dropout. Consistent with this approach, and given the potential of family members to support or undermine treatment in the Mexican American context, a major adaptation in GANA is the inclusion of an engagement protocol for mothers, fathers, and extended family. From the initial telephone contact, problem solving commences to address potential barriers. The goals include increasing investment and efficacy for help-seeking, assessing familial support for treatment and creating an engagement plan for other family members, eliciting attitudes about previous treatment experiences, and overcoming practical obstacles to initial treatment attendance. Beyond the initial engagement plan, unlimited phone contacts and limited home visits are incorporated to facilitate treatment persistence. Engagement of other family members may include calling fathers or grandparents directly, sending materials designed to address common concerns about the program, or providing them with videotapes of treatment sessions.

To address stigma concerns, GANA is framed as an educational program for building skills, and the therapist is referred to as a GANA teacher (maestro). The treatment components of PCIT are reframed to emphasize valued objectives noted by the key informants. The child-directed interaction and parent-directed interaction phases of treatment are framed as modules teaching communication skills (Ejercicios de Comunicacion [ECO]) and consistent discipline (Disciplina Consistente [DISCO]). An extended orientation to treatment serves to explain the roles of the GANA teacher, parents, and the child, and to inform the parent about what will happen in treatment. Videotaped examples of families in PCIT sessions are presented and narrated to illustrate the main techniques. Misconceptions about treatment and goals are addressed immediately, since inappropriate treatment expectations are linked to dropout.

Given the considerable heterogeneity in attitudes, cultural beliefs, and preferences among Mexican American parents, McCabe adopted a tailoring approach to enhancing engagement whereby an initial assessment of key constructs directs the delivery of treatment components. A comprehensive assessment protocol is administered at intake. Attitudes toward PCIT elements are assessed in a self-report questionnaire, so that GANA teachers are alerted to elements that may require additional explanation or reframing to fit the parents’ beliefs. GANA teachers are provided with a computer-generated report that summarizes parents’ responses and provides specific recommendations for addressing potentially problematic issues (e.g., unrealistic expectations for treatment, discomfort with particular strategies). For example, among parents who feel committed to a strict discipline approach, time-out may appear to be a weak intervention. McCabe suggests that time-out can be framed as a punitive practice, invoking a term such as “punishment chair” (silla de castigo). However, this might alienate parents who disavow punitive strategies with young children, who may prefer framing time-out in other terms, a “thinking chair” (silla de pensativa). Thus, GANA modifications aim to sensitively accommodate cultural differences to enhance the social validity of the interventions offered.

CONCLUDING REMARKS: PRESSING QUESTIONS AND THE POTENTIAL PAYOFF

Thus far, wait-list–controlled trials have demonstrated that culturally adapted EBTs are feasible and efficacious (e.g., Roselló & Bernal, 1999; Martinez & Eddy, 2005). Effect sizes obtained in controlled trials of culturally adapted interventions with youth are in the same range as those found in studies of their standard counterparts evaluated with primarily majority group samples. For example, Martinez and Eddy (2005) evaluated a culturally adapted PMT program designed to address the
developmental challenges of differential acculturation that often characterizes Latino families. Results revealed high rates of retention, reported satisfaction, and numerous improvements in parenting practices and youth adjustment. This and other early work suggests that cultural adaptation research promotes community-interventionist collaboration, adherence, and sustainability of programs (e.g., Spoth & Redmond, 2002). For many, however, the bottom-line question remains whether the additional costs of cultural adaptation are justified by superior clinical outcomes of adapted EBTs over standard versions delivered with fidelity (Kazdin, 1993). Controlled trials are ongoing to determine whether the BPSS and GANA adaptations will result in improved engagement or clinical outcomes relative to their standard evidence-based versions. We await findings to learn whether adaptation holds promise as an essential strategy in narrowing the efficacy–effectiveness gap in children’s mental health. Yet prevailing concerns about EBT adaptation suggest that such undertakings should be embarked upon judiciously and thoughtfully. Critics argue that the need for cultural adaptation is often exaggerated. Elliot and Mihalic (2004) cite instances when adapted versions of interventions have not yielded differential treatment outcomes, and list a number of prevention trials in which effects were robust across race. They state that “the a priori assumption that [cultural] effects are always present and that every program must have a separate treatment or curriculum for each sex and racial/ethnic group is unwarranted. Pressure for this form of adaptation is more a political issue than a scientific effectiveness issue.” The authors contrast the evidence-linking fidelity to outcomes to the lack of experimental evidence on the impact of local adaptations on treatment effects, cautioning that cultural adaptation may bargain away fidelity at the cost of effectiveness. In consideration of these concerns, it is vital that adaptation efforts be scientifically defensible and mounted under circumstances indicating substantive reasons to be concerned about the application of standard treatments.

The current discussion aims to provide guidelines to help identify instances where adaptation could prove advantageous by either increasing the relevance of treatment content or mitigating threats to treatment engagement. Yet lingering questions require further consideration. It may be a good start to rely on empirical evidence of intergroup differences in treatment response or problem etiology to direct efforts for EBT adaptation. However, some judgment is still required to determine what standards of evidence are required to justify EBT modification. For example, how much smaller should treatment effects from unmodified EBTs be for a given minority before adaptation is considered necessary (Franklin, DeRubeis, & Westen, 2006)? When statistical differences are found in vulnerability factors for a given problem across groups, how can we decide if these differences are clinically significant, meriting specialized treatment specification? These difficult questions deserve further attention.

Few would argue that contextual and cultural factors should be ignored in the delivery of our well-specified EBTs. Indeed, it is easy to argue that best clinical practice must always attend to “principles of patient-centered care, including exploration, empathy, and responsiveness to patients’ needs, values, and preferences” (Betancourt, 2004, p. 953). Learning about particular communities may be helpful, but interventions or techniques broadly prescribed for specific communities run the risk of making stereotyped assumptions about individuals on the basis of their membership in a sociocultural group (Lopez, 1997; Miranda, Nakamura, & Bernal, 2003; Sue & Zane, 1987). Ethnicity is clearly limited as a meaningful marker of the local relevant cultural context within which an individual functions and adapts. The expectation that a one-size-fits-all EBT adaptation will maximally benefit all members of a heterogeneous ethnic group will more than likely be disappointed. As such, adaptation efforts and their sensitive application should attend to factors that are likely to be more proximal to presenting problems and treatment response than ethnic group membership per se. These factors may include processes associated with acculturation and acculturative stress, minority status and discrimination experiences, immigration experiences and premigration trauma, and so on (Alvidrez, Azocar, & Miranda, 1996). McCabe’s GANA model anticipates concerns about within-group heterogeneity by relying on individualized assessment to tailor the implementation protocol family by family.

A natural question stemming from this discussion is whether “culture” is the singular dimension along which treatment adaptation may be indicated to narrow the efficacy–effectiveness gap. As observed by many, patients in usual practice settings differ from patients in efficacy
trials on dimensions including culture, social class, comorbidity, trauma history, and so on, pointing to an unlimited proliferation of adaptations that could be contemplated (Franklin et al., 2006). Certainly, if different manuals were needed for every difference between efficacy samples and representative clinical patients, then the task of manualizing treatment in clinical settings would be untenable. However, consistent with the formulation presented in this article, whether any of these dimensions should drive treatment adaptation efforts should depend on whether they covary with demonstrable differences in problem presentation, vulnerability and protective factors, or critical treatment-related attitudes that can direct well-reasoned modifications to treatment content or engagement processes. Thus, the considerations for adaptation presented herein are not necessarily unique to concerns about ethnic or cultural variation.

The idea that EBTs may require various types of adaptation to meet the needs of the relevant consumer base has prompted many to question the approach of transporting evidence-based practice through the dissemination of discrete manualized intervention packages. Critics reason that the transportation of theory-driven principles of treatment could be more thoughtfully and flexibly applied to diverse and complex cases (Rosen & Davison, 2003; Westen, Novotny, & Thompson-Brenner, 2004). Similarly, others suggest that knowledge about the core intervention components that are responsible for EBT outcomes is essential to answering questions about what must be preserved and what local adaptations may be permissible (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

Broadly speaking, a central challenge in EBT is how one can take data generated from a nomothetic context (controlled trials) and apply the results in an idiographic practice context (treatment of an individual patient). Clinicians must decide if a given EBT is relevant to their patient and, further, how to ensure implementation is responsive to the patient’s unique set of circumstances. Along these lines, Chorpita et al. have proposed a database distillation and matching model (DMM) to help select and integrate core components from across EBTs to generate treatments that maximize the fit of the intervention to the individual’s problem and context (Chorpita, Daleiden, & Weisz, 2005). Rather than taking intact manuals as the unit of analysis, Chorpita recommends distilling information at the level of practice elements, discrete clinical techniques (e.g., “time-out” or “relaxation”) used as a part of a larger intervention plan. Outcome studies are cross-tabulated with component practice elements yielding a matrix indicating protocol overlap. In the matching process, efficacy and effectiveness data are further mined to generate information about what practice elements have been demonstrated to work for whom under what circumstances. DMM analysis of the outcome literature is meant to yield a decision tree for matching clients to treatments, along with profile of practice elements that can be assembled in a modular fashion to match specific targets and contexts. For example, the approach could be used to aggregate information across successful clinical trials to tell us what has worked for African American preschool-aged girls with PTSD.

The DMM approach holds promise as an empirical approach to assembling treatments for specific target groups, but unfortunately the requisite demands of the evidence base are as yet unmet. After all, this discussion began with concerns about the large amounts of missing data about treatment response among minority groups. Furthermore, while the approach can point to sets of practice elements that have demonstrated positive effects in the context of interest, it cannot inform innovations that improve the fit of common practice elements for specific target groups. In contrast, empirically guided adaptation of evidence-based practice capitalizes on additional data sources to generate strategies for enhancing the cultural responsiveness of interventions, while also taking advantage of the extensive research that has gone into developing EBTs.

The potential of cultural adaptation for improving clinical outcomes among minorities awaits experimental evidence. Given the inherent difficulties in demonstrating differential treatment effects among active psychotherapies in general (Wampold et al., 1997) and evidence suggesting that nonspecific therapist factors can account for more variance in psychotherapy outcomes than specific techniques (Norcross, 2001), some may also question whether there is more promise in training clinicians to be culturally competent in general (Sue, 2001) than in the cultural adaptation of specific EBTs. Therefore, an additional question to examine empirically is the extent to which culturally adapted EBTs can result in better outcomes than standard EBT protocols when they are
applied flexibly and sensitively by culturally competent clinicians. Indeed, practice-based evidence in cultural responsiveness could also be a matter of focus. While the present framework presents a strategy for adaptation guided by research evidence, it may also be instructive to empirically examine how effective clinicians spontaneously adapt standard interventions based on clinical judgment and experience in ways that promote outcomes for diverse patients (Garland, Hurlburt, & Hawley, 2006). Research examining these related questions may help identify the most efficient solutions yet for getting quality mental health treatment to ethnic minorities in need.

As of this writing, Hall’s (2001) article calling for the evaluation of relative efficacy of standard EBTs versus culturally adapted treatments has not acted as a major catalyst to action among clinical scientists. It remains to be seen whether this charge will be taken up by interventionists in the effort to narrow the efficacy–effectiveness gap. While conclusions about the effectiveness of standard EBTs with minority groups are pending, many may question whether the tailoring of interventions for specific minority communities should be a top priority. This prospect may be contentious given concerns about maintaining fidelity, doubts about the incremental value of cultural enhancements over standard versions, and allocation of scarce resources for treatment development, evaluation, and dissemination. Even when the spirit is willing, there are many practical barriers to diversification of EBT research that may serve as disincentives to investigators. These include daunting challenges in recruitment of minorities into clinical trials (Swanson & Ward, 1995), added costs of conducting psychotherapy research in languages other than English, and the limited availability of ethnic and linguistic minority clinicians (USDHHS, 2001; Vega & Lopez, 2001), to name a few. Motivation of EBT investigators to take up the challenges posed by intervention adaptation research may be spurred by focused requests for proposals, special initiatives for interventionists to partner with community agencies already serving specific ethnic communities, and supplemental budgetary support for the added costs of inclusive controlled trials.

It is possible that such support may be seen as diverting already limited resources to fewer special populations. However, it is also possible that well-grounded adaptations based on solid translational research may quicken the pace of treatment innovation more generally for all. Novel interventions often arise from refinements of existing treatments that have been tailored for specific subgroups (Hollon et al., 2002), with their broader utility being recognized only later with subsequent applications to additional groups. Working toward adaptations to make EBTs more relevant and engaging for certain groups with noted barriers to treatment participation may eventually result in better standard treatments with greater potential for generalizability. In the end, the argument that there is limited variability between contemporary ethnic groups may ironically provide support to the enterprise of investing time and effort to systematically study the needs of particular underserved groups to the potential benefit of others.

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