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I. INTRODUCTION

Given the persistent racial disparities in access, utilization, and quality of mental health services in the United States (USDHHS, 2001), it is imperative to identify and engage in culturally sensitive, evidence-based efforts that prevent the development of mental health disorders within racially diverse communities. A disconnection exists, however, between evidence-based prevention efforts and culturally sensitive approaches in the prevention of mental disorders within racially diverse communities. This chapter defines and reviews evidence-based prevention programs (EBPP) and introduces a framework to understand the different ways prevention programs address cultural context. We specifically call for greater attention to collaborative preventive efforts between researchers, practitioners, and communities, and present two collaborative approaches to incorporating culture in EBPP. This chapter further reviews research on culturally sensitive approaches to evidence-based interventions and concludes by outlining implementation challenges to culturally sensitive EBPP.

II. EVIDENCE-BASED PREVENTION PROGRAMS

Prevention science broadly refers to interdisciplinary, basic, and applied research on the etiology, development, and prevention of health, mental health, and other social problems. A key feature of prevention science is the translation of scientific research into practical preventive interventions. Most
evidence-based prevention programs develop according to a prescribed prevention research cycle, outlined by the Institute of Medicine (IOM) Committee on Prevention of Mental Disorder:

The first step is to identify and define operationally and reliably the mental disorder(s) or problem. The second step is to consider relevant information from the core biological and behavioral sciences and from research on the treatment of mental disorders, and to review risk and protective factors associated with the onset of the disorder(s) or problem, as well as prior physical and mental disorder prevention intervention research. The investigator then embarks on designing and testing the preventive intervention, by conducting rigorous pilot studies and confirmatory and replication trials (the third step) and extending the initial positive findings in large-scale field trials (the fourth step). If the trials are successful, the researcher facilitates the dissemination and adoption of the program into community service settings (the fifth step). (Mrazek & Haggerty, 1994, p. 360)

The IOM Committee on Prevention of Mental Disorders additionally identified four broad types of promotion and prevention programs. The promotion and positive development program targets a whole population with the goal of enhancing individual, family, and community strengths. The universal prevention program targets a whole population to reduce risk for developing a disorder without regard to individual levels of risk. The selective prevention program targets a subpopulation with a known risk factor for developing a particular disorder. Finally, the indicated prevention program targets individuals with elevated but nonclinical symptoms of a particular disorder and are therefore at greatest clinical risk. Accordingly, prevention programs are most effective when appropriately matched to the level of risk within the defined population.

The IOM prevention typology provides a basic framework to organize prevention programs based on levels of risk. This approach, however, does not catalog whether a prevention program works to prevent or reduce mental health disorders. Fortunately, several national registries of EBPPs that have demonstrated efficacy and effectiveness, including among them SAMHSA’s National Registry of Evidence-based Programs and Practices [NREPP]; US Office of Juvenile Justice and Delinquency Prevention’s Model Programs Guide [MPG]; and US Department of Education’s Exemplary and Promising Safe, Disciplined, and Drug-Free Schools Programs. Although the criteria for a successful EBPP do vary somewhat by registry, these independent registries share a core set of characteristics: The prevention program must be tested using a well-designed, methodologically sound study; there must be a demonstrated reduction in the symptoms or risks associated with the identified disorder; and the empirical evidence underlying the program must be peer reviewed. Across registries, additional study criteria to ensure scientific rigor include the use of a randomized controlled trial, replication by an independent investigator, and proven effectiveness in real-world settings. These
latter criteria reflect the standards set forth by Chambless and colleagues (1996) to establish psychotherapy efficacy.

The growth in EBPP over the past two decades is quite impressive. Excluding evidence-based treatment programs, SAMHSA’s NREPP currently lists 144 EBPPs in its online database registry. The US Office of Juvenile Justice and Delinquency Prevention’s MPG lists 188 EBPPs, with 33 of these programs rated exemplary. All these programs span the IOM prevention spectrum from promotion and positive development to indicated prevention. They also address a wide range of targeted outcomes (e.g., life skills, mental health promotion, substance abuse prevention, and mental health and substance abuse treatment) across the lifespan. Approximately half of the NREPP programs, for instance, target adults over 25 years old. Despite the proliferation of programs developed within the scientific community, EBPPs remain inaccessible to most members of society (Weisz, Sandler, Durlak, & Aton, 2005).

The transfer of EBPP from tightly controlled trials to community-based settings has largely been limited (Miller & Shinn, 2005). Recent studies, however, suggest that the transferring of experimentally tested EBPPs into community-based settings is increasing. For example, in a 2005 survey of 1,721 middle schools, 43% of schools reported using an EBPP to reduce and prevent drug use, up from 34% in 1999 (Ringwalt et al., 2009). Despite these findings, less than a quarter of the schools involved in that study currently utilize an EBPP, opting instead for convenient, untested, locally developed programs. Similarly, training community-based professionals to implement EBPP with fidelity remains a challenge. In one study (Fox, Duffy, & Keller, 2006), 44 practitioners were trained in a parenting program but only 23 successfully implemented the program with a targeted family. In another study, among 342 providers who implemented EBPP, only one-quarter adhered with fidelity to the prescribed content and delivery strategies (Ennett, et al., 2011). Not surprisingly, participant enrollment rates in EBPP also remain consistently low, in the 30 to 35% range (Baker, Arnold, & Meagher, 2011; Heinrichs, Bertram, Kuschel, & Hahlweg, 2005). In short, these findings are not surprising given that evidence-based interventions often take 15 to 20 years before incorporation into treatment as usual (Proctor, Landsverk, Aarons, Chambers, Glisson, & Mittman, 2009).

### III. CULTURE AND EBPP

Although implementation of EBPP is a persistent problem with the general population, it is even more difficult with racially/ethnically diverse populations (USDHHS, 2001). For example, Baker et al. (2011) found modest rates of enrollment in parent management training among invited African American and Puerto Rican families (30–41%) but these rates are half of the proportion
of enrollment by invited White families (78%). Unfortunately, these utilization trends in prevention mirror the underutilization of mental health services in general and, importantly, suggest the need to identify strategies to improve dissemination and implementation, in ways that increase the recruitment, enrollment, and retention of populations who are less likely to seek treatment later when problems and disorders disrupt everyday functioning.

Rodríguez Domenech and Bernal (2012) note that the future of prevention and treatment research will involve tailoring programs and services to the cultural characteristics, needs, and preferences of the target community. Specifically, a prevention program is considered culturally sensitive to the extent to which “the experiences, norms, values, behavioral patterns, and beliefs of a target population, as well as relevant historical, environmental, and social forces are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs” (Resnicow, Soler, Braithwaite, Ahluwalia, and Butler, 2000, p. 272). Toward this end, numerous recommendations have been made for culturally sensitive approaches to EBPP for use with specific populations over the past decade (e.g., Castro, Barrera, & Martinez, 2004).

Barrera, Castro, and Steiker (2011) summarized the four common approaches to addressing culture in prevention: (a) prevention research cycle, (b) cultural adaptation, (c) culturally grounded approach, and (d) indigenous approach. In the prevention research cycle approach (Mrazek & Haggerty, 1994), interventions are developed based on available research evidence for a particular problem or disorder and undergo clinical trials to establish efficacy and eventually effectiveness. There often is little to no consideration of racial and ethnic issues, particularly in the initial phases of the cycle. Although, as Barrera et al. noted, there is no reason why cultural issues and underrepresented communities cannot be involved from the beginning. In the cultural adaptation approach, established EBPP—developed using the prevention research cycle approach—are reevaluated and modified when there is a perceived mismatch between the program and the cultural context in which it is now being implemented. In the culturally grounded approach, researchers work collaboratively with members of the target community from program inception to implementation, beginning with a community needs assessment to identify priorities for prevention. In the indigenous approach, the community has independently developed a program that demonstrates feasibility and acceptability within the target community but may lack empirical evidence of effectiveness.

We organize these four culturally sensitive approaches to prevention along the dimensions of knowledge base and effort orientation (see Figure 27.1). In this context, knowledge base refers to the source of information about a particular problem that forms the foundation of the prevention program. Top-down knowledge refers to investigator-driven research guided by scholarship and theory about a particular problem and cultural group.
University-affiliated researchers typically drive this approach. Bottom-up knowledge refers to a contextual, cultural understanding of a particular problem and population shared by in-group members. Correspondingly, community-based individuals and organizations drive this approach. Effort orientation refers to the approach taken to develop, evaluate, and implement prevention programs. Individual effort involves one party taking charge and responsibility for the development of the prevention program. It can be an individual researcher (or investigation team) or a local community, but it does not involve both parties. Collaborative effort involves two or more parties that mutually work together on the development of a prevention program. However, the extent of the collaboration (i.e., partnership vs participatory) varies by type of knowledge base.

This two-dimensional framework (knowledge base and effort orientation) illustrates the potential for underlying tensions and gaps between researchers and communities as both parties grapple with how best to prevent mental health problems. The prevention research cycle and cultural adaptation approaches highlight top-down models in which theory and research—whether explicitly focused on cultural factors or not—guide the development of the prevention program. The indigenous and culturally grounded approaches highlight bottom-up models in which members of the target community individually or collaboratively with researchers contribute to the development of the prevention program. Thus, while top-down models emphasize programs that demonstrate prevention effects from controlled trials, the bottom-up models underscore programs that take into account community specific needs and preferences and are adopted in communities (Barrera et al., 2011; Wandersman, 2003).

These divisions between knowledge base and effort orientation are not inherently impermeable (Wandersman, 2003). Hwang (2012) recently
articulated a model of cultural adaptation for psychotherapy that integrates both top-down and bottom-up approaches. The *Psychotherapy Adaptation and Modification Framework* (PAMF; Hwang, 2006) is a top-down approach in which researchers and practitioners adapt therapy for use with diverse populations using a three-tiered approach that consists of domains, principles, and rationales for adaptation. The *Formative Method for Adapting Psychotherapy* (FMAP; Hwang, 2009) is a bottom-up approach in which consumers generate ideas and provide input for cultural adaptation. However, the FMAP is more reflective of a collaborative effort orientation than a bottom-up, culturally grounded approach. Nevertheless, the PAMF and FMAP are designed to work in conjunction with each other to bring researchers, practitioners, and community members together to inform evidence-based interventions.

A few EBPPs have been developed that reflect the collaborative involvement between researchers and communities to meet the specific cultural needs and preferences of diverse communities. For example, the *Strong African American Families* program (SAAF; Brody, Murry, Gerrard et al., 2006) was developed according to the prevention research cycle principles, but explicitly addresses the cultural and community context through community involvement in all stages and levels of decision-making with SAAF. Miller and Shin (2005) also advocated that researchers should collaborate with practitioners who have already developed indigenous prevention programs to study and disseminate those programs that work. They highlighted the *Pathways to Housing* program, which was developed indigenously to address problems of homelessness and later evaluated by researchers to demonstrate its effectiveness (Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). These culturally sensitive EBPP examples illustrate how to traverse between individual and collaborative effort orientation, as well as top-down and bottom-up approaches.

The remainder of this chapter highlights culturally sensitive approaches to prevention that employ a collaborative effort orientation (i.e., cultural adaptation and culturally grounded) rather than individual effort models. The collaborative effort orientation approach is emphasized for several reasons, including the recognition that addressing the needs of historically marginalized and underserved communities without their primary involvement in decision-making is problematic from a social justice perspective. Building relationships with the target community and having its members as key stakeholders in EBPP development or adaptation ensures greater relevance, reach, and effectiveness as the community’s needs and preferences evolve over time. Among the many benefits of a collaborative approach, community involvement provides a means of empowerment, increasing awareness of EBPP, opens pathways toward engagement and enrollment, and can lift the stigma of program utilization and collaborating with researchers. Researchers also benefit from working hand-in-hand with community stakeholders as these cultural insiders are experts in their cultural worldviews and provide insight otherwise overlooked.
Moreover, interventions derived from the prevention research cycle approach are well documented in the literature, but may lack in cultural sensitivity for applications to diverse groups. Cultural adaptation of these existing EBPPs eventually requires collaboration with communities. There also is scant efficacy and effectiveness research available on most culturally sensitive programs developed from an indigenous approach, and empirical evaluation of these indigenous programs would necessitate collaboration with researchers. Such evaluation data may be increasingly necessary for sustainment and funding of prevention efforts in the public sector. Thus, a central argument in this chapter is that culturally sensitive EBPP requires collaborative effort, whether initiated by the researcher or the community. The aforementioned programs (i.e., SAAF and Pathways to Housing) reflect such collaborative efforts to establishing these EBPP.

IV. CULTURAL ADAPTATION OF EBPPS

The cultural adaptation of existing EBPPs is a common approach to address culture in EBPP. As a top-down approach, the heart of cultural adaptation is the need to balance between fidelity and cultural/ecological validity (Castro et al., 2004). Fidelity refers to the accurate implementation of a program as intended by the program developers. It requires a precise definition and understanding of the mechanisms of change, adequate user training, treatment manuals, supervision, and adherence to treatment protocol (Moncher & Prinz, 1991). Cultural/ecological validity (or fit) refers to the extent to which a program is generalizable beyond the initial target population to other populations and cultural contexts. If there is an identified mismatch between the original EBPP and new population or cultural context, then cultural adaptation can improve program fit. Adaptation requires an understanding of the ecological milieu in which a program is adopted and implemented, as well as an understanding of necessary standards for EBPP fidelity. Prevention researchers and practitioners then are able to tailor a program according to the relevant ecological factors within this context. Cultural adaptation thus aims to transport an existing EBPP to a new cultural context by resolving any mismatches and enhancing overall fit between program and context. The goals of cultural adaptation are (a) to increase participant engagement, as reflected in better recruitment and retention, and (b) to enhance impact on desired outcomes without compromising the core principles and effectiveness of the program.

Numerous models for cultural adaptation have been proposed over the past two decades (Ferrer-Wreder, Sundell, & Mansoory, 2012). These models share many characteristics, but they also emphasize different features and approaches to adaptation. Some models address the key features or components of cultural adaptation (e.g., August, Gewirtz, & Realmuto, 2009; Bernal, Bonilla, & Bellido, 1995; Lau, 2006; Resnicow, Soler, Braithwaite,
Ahluwalia, & Butler, 2000). Other models articulate the approach or sequence to cultural adaptation (e.g., Barrera & Castro, 2006; Domenech Rodriguez & Wieling, 2005).

The first type of cultural adaptation involves modifications to service delivery (e.g., adapted, accommodation, surface structure, cultural attunement, enhanced engagement). These adjustments to EBPP ensure feasibility by fitting the program to the particular culture or community. Common service delivery modifications include matching the language and ethnicity of the client and identifying the best context and setting to deliver services. Other modifications might include using intervention materials that depict images representative of the targeted cultural group. More fundamental service delivery modifications may focus on the problem of increasing the reach of the program to individuals who otherwise might not enroll. Specifically, recruitment and engagement practices need to be reexamined to meet the needs and preferences of the target community (Harachi, Catalano, Hawkins, 1997; Bjorknes, Jakobsen, Naerde, 2011). For example, community outreach activities, psychoeducational programs, and interventions that target motivational processes need to be taken into consideration. Importantly, “the active (core) ingredients or causal mechanisms of a program are preserved but flexibility is available to users around implementation elements that do not detract from the integrity of the designed program” (August et al., 2009, p. 9).

The second type of cultural adaptation involves modifications to content, structure, and practice (e.g., adaptive, adaptation, deep structure, culturally informed, contextualizing content). These substantive alterations or augmentations to EBPP determine the impact of the program by capitalizing on salient cultural values, beliefs, customs, and histories that influence mental health. Common content, structure, and practice modifications include cultural reframing of a behavioral or mental health problem, promotion of cultural assets and strengths (e.g., ethnic identity and coping with discrimination), and use of cultural metaphors and healers. Whereas modifications to service delivery ostensibly enhance the core components and mechanisms of change of EBPP, modifications to content, structure, and practices target “group-specific risk processes, or...mobilize group-specific protective factors. Alternatively, treatment content may be altered to target symptom presentation patterns that require distinctive intervention elements” (Lau, 2006, p. 300).

The remaining forms of adaptation appear to address efforts to improve only service delivery. The approach or sequence by which these two types of EBPP cultural adaptation occur varies greatly (McKleroy et al., 2006). In the passive approach, modifications to service delivery or structure and practices occur informally by the service provider or agency during the implementation of the standard EBPP protocol. Changes may be made in anticipation of a predicted client/community response or in direct response to observed reactions by client/community members during implementation. The program
developers and researchers are typically not consulted or involved in the adaptation. While agencies and providers clearly have good intentions when making these informal changes, this passive approach to cultural adaptation is less likely to be planned, organized, and systematic. Program fidelity and effectiveness consequently may be enhanced in some instances and compromised in other instances (Elliott & Mihalic, 2004). Moreover, replication over time and across contexts may be difficult to achieve unless the process and content of adaptations are well documented and disseminated.

In the active approach, cultural adaptation occurs in a sequence that begins with an identified gap or mismatch between an EBPP and the target community. This is followed by a review of the literature and acquisition of new culture-specific knowledge about the EBPP and community and then an iterative, evaluative process of adaptation and refinement. To facilitate this process, prevention researchers and practitioners usually form a university—community partnership to collaboratively plan, organize, and systematically engage in cultural adaptation prior to implementation. Lau (2006), for example, emphasizes the selective and directed adaptation of EBPP for targeted communities that is guided systematically by data. Her approach prioritizes research to identify group-specific risk factors for the focal problem in the target community that ultimately may moderate program effectiveness, but that are not addressed by the standard EBPP. Taking a broader, all-encompassing approach, the Center for Disease Control (CDC) recently articulated a map of the adaptation process (MAP; McKleroy et al., 2006), which consists of three sequential phases to adaptation: assessment, preparation, and implementation. Each adaptation phase details specific action steps to guide program developers and implementers. However, Wingood and DiClemente (2008) argued that the CDC-MAP is overly complex and may overwhelm community organizations and agencies seeking to implement EBPP. Therefore, they proposed a simplified adaptation model known as ADAPT-ITT. Both CDC-MAP and ADAPT-ITT models, alongside other models (e.g., Kumpfer et al., 2008), complement the IOM’s (1994) preventive research cycle by taking the community context more fully and systematically into consideration in EBPP implementation.

Although many prevention researchers, such as Barrera et al. (2011), view cultural adaptation as the best approach to addressing culture in prevention, four specific limitations remain. First, cultural adaptation is an additive approach to addressing culture in prevention programming. Second, cultural adaptation runs the risk of marginalizing racial “minority” groups and failing to take dynamic sizing—that is, taking cultural knowledge and testing to what extent it fits or does not fit the group—into account (Sue & Zane, 2006). As a result, cultural adaptation may have unintended negative cultural consequences (Fisher & Ball, 2005). It may reinforce a deficit model that presumes members of a minority community cannot resolve problems through standard evidence-based approaches. Cultural adaptation also may
discount the historical, contextual forces that contribute to the presenting problem and inadvertently promote assimilation processes as the only way for communities to succeed in society. Third, cultural adaptation may compromise the integrity and effectiveness of the EBPP by not maintaining fidelity, such as reducing dosage, cutting core ingredients of a program, and focusing on affective rather than behavioral change (Kumpfer, Alvarado, Smith, & Bellamy, 2002). Last, cultural adaptation does not guarantee the likelihood of implementation of EBPP within culturally diverse communities. For example, in a study of 17 facilitators of SafeCare, an evidence-based parent training program for the prevention of child maltreatment, the majority of the facilitators felt there was no need to develop an explicit culturally adapted program for Latino or African American families. Yet, the majority of the facilitators disclosed in interviews that they did make adjustments to the program based on the family (such as spending more time socializing during home visits for Latino families). Importantly, facilitators expressed the need to have opportunities to discuss, share, and compare their experiences with program implementation, such as annual statewide conferences. (Self-Brown, Frederick, Binder, Whitaker, Lutzker, Edwards, & Blankenship, 2011). In other words, communities must still buy into the value of such preventive interventions but may be hesitant if not viewed as equal partners.

V. CULTURALLY GROUNDED EBPP

Culturally grounded EBPP is a less common but increasingly popular approach to addressing culture. As a bottom-up approach, the perspective of cultural group members living within the target community is prioritized and cultural/ecological validity is valued over widespread generalizability and diffusion of EBPP. Cultural grounding requires individuals and/or organizations from the target community to identify a need, risk, or problem and play a principal, active role in the development, empirical validation, and implementation to scale of the prevention program. Cultural grounding thus aims to develop a culture-centric EBPP in which all facets of the prevention program reflect the lives and realities of members of the target community (Hecht & Raup Krieger, 2006). The goals of cultural grounding are (a) to empower individuals and communities through all phases of the research process and (b) to achieve successful outcomes through collaboration and a coconstruction of meaning by community group members and researchers.

Cultural grounding adopts an emic approach to culture and EBPP in which cultural group members come to consensus on indigenous theories of etiology, healing practices, and research methodology. This culturally grounded knowledge serves as a legitimate and valued form of inquiry and knowledge that informs the development and implementation of EBPP (Wallerstein & Duan, 2006). Pang (1994), for example, described Korean older adult immigrants’ understanding of depression from the Korean folk
illness perspective of han (feeling sorry and regret, manifest as a lump in the throat), hwabyung (an anger syndrome with somatic features), and shing-gyongshaeyak (neurasthenia), as well as the ways in which these folk illnesses were treated using Korean and Western medicines and home remedies. Choi and Lee (2007) piloted a culturally tailored nursing intervention for hospital female employees who had previously or currently experienced hwabyung. This program consisted of music therapy, drama, and group therapy. Their pilot study found symptom reduction in the treatment group compared to the no treatment group. A randomized controlled trial of a similar intervention—Oriental Medicine Music Therapy—for patients with hwa-byung is currently underway in Korea (Park et al., 2012). In short, researchers and practitioners can utilize these emic-derived narratives about etiology and healing practices to shape the content, structure, and practices of a prevention program, as well as the methods of service delivery.

Narrative theory and methodology is a useful strategy to assess culturally grounded knowledge (Larkey & Hecht, 2010). Narratives are stories of connected events and characters that contain messages about a given topic (Kreuter et al., 2007). Storytelling, contextual imagery, and writing of personal narratives, in turn, help people to organize thoughts and emotions; make sense of their lives and experiences; establish identities; and express these identities and experiences through conversations, nonverbal responses, and rituals, customs, and practices. Beyond reflecting the content of one’s life experiences, narratives serve as the process by which cultural norms and behaviors are established, maintained, and strengthened. Fisher and Ball (2005), for instance, used storytelling about tribal legends as a positive parenting approach in American Indian and Alaska Native communities. As Larkey and Hecht (2010) state, “Narratives enact identities and weave a set of beliefs, norms, and values that reflect the culture in which they reside...Cultural narratives intrinsically shape behavior” (pp. 117–118).

Culturally grounded narratives have consequently served as the basis for the development and implementation of EBPP. The Keepin’ it REAL program (Hecht et al., 2003) is an excellent example of a culturally grounded EBPP. Keepin’ it REAL used youth narratives to understand how this cultural group resists offers to drug use, adopted evidence-based practices (e.g., life skills training; Botvin et al., 2001) into the curriculum that are congruent with the narratives, and incorporated narrative practices into the curriculum. The American Indian (or Zuni) Life Skills Development Curriculum (LaFromboise & Howard-Pitney, 1995) for American Indian adolescents is another good illustration of a culturally grounded approach to prevention. In these examples, narratives about an identified preventable problem and solutions are more meaningful when they reflect the cultural values and norms of the target community. Participants also are more likely to listen and respond to the accompanied prevention messages that are congruent with the cultural practices of the community. In other words, culturally grounded narratives can
shape the surface and deep structure content and the process of the EBPP; however, more research is needed to demonstrate the utility and efficacy/effectiveness of a narrative approach to EBPP.

Community-based participatory research (CBPR) is the preferred prevention science paradigm to develop a culturally grounded EBPP (Psarsei, Catro, Marsigila, Harthun, & Valdez, 2011). This active, collaborative approach 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. (Minkler & Wallerstein, 2006, pp. 4)

Israel and colleagues (2005) further posit nine key principles to CBPR that highlight the identity and strengths of the community, equitable partnership and colearning between community and research, historical and ecological considerations, and the long-term cyclical and iterative process of generating, disseminating, and sustaining knowledge and prevention. By adopting and enacting these CBPR principles, researchers “become part of the community, and community members become part of the research team,” (Horowitz, Robinson, & Seifer, 2009, p. 2635). Moreover, it is important to note that the strong emphasis on the collaborative process does not mean less scientific rigor using a CBPR approach as university—community research teams can still follow the IOM prevention research cycle to establish an EBPP (Mrazek & Haggerty, 1994). For example, Nagel, Robinson, Condon, and Trauer (2009) reported on the development of a culturally grounded brief clinical intervention for indigenous communities in Australia guided by CBPR principles and practices in a mixed-method, randomized controlled trial study.

The culturally grounded approach to EBPP using CBPR is not without its limitations and challenges. First, culturally grounded EBPP is a high-risk—high-reward endeavor, more so than the cultural adaptation of EBPP. It requires a significant early investment without any assurance that the program will be effective. Second, unlike the cultural adaptation approach, culturally ground EBPP does not build upon an existing intervention. Instead, evidence-based components or principles are introduced relatively late in the process and efficacy and effectiveness studies occur after cultural/ ecological validity is established (Chen, 2010; National Research Council and Institute of Medicine, 2009). There also is the potential that the program will be ineffective or will have iatrogenic effects. Third, the emic-based, idiographic nature of culturally grounded EBPP can make it difficult to transport beyond the target community. However, it is possible to overcome this limit to generalizability, as demonstrated by the Keepin’ it REAL program (Hecht et al., 2003), which has been delivered to Mexican American, African American, European American, and multicultural populations. Fourth, the long-term capacity and sustainability of such efforts remain
unknown. Culturally grounded EBPP requires an extensive amount of sustained time and energy to ensure a working, equitable partnership that may be difficult to maintain due to burnout, shifting interests and priorities, and lack of organizational stability. The slow progress and lack of immediate results also may dishearten or disappoint researchers and community partners. Additionally, project authority, control and ownership among researchers and community members—often manifest in terms of participation, involvement, and decision-making—need to be monitored and adjusted throughout the process to ensure mutuality and equity (Wallerstein & Duran, 2006). Last, the role of power and privilege in terms of race and social class is a constant, conscious, and unconscious specter in culturally grounded EBPP. Researchers and community partners must be willing to critically and openly examine the potential for historical and current racism and classism in all facets of the project development and implementation.

VI. EMPIRICAL SUPPORT FOR CULTURALLY SENSITIVE EBPP

Given the additional time, effort, and resources necessary to incorporate culture into EBPP, it is worth asking if there is empirical support for culturally sensitive approaches to prevention and treatment. A decade ago, Kumpfer et al. (2002) concluded that culturally sensitive EBPPs can improve acceptance, engagement, and retention of racial “minority” participants but only slightly improve outcomes. After the publication of the Kumpfer et al. (2002) paper, five meta-analyses on culturally sensitive/adapted mental health interventions have been published (Benish, Quintana, & Wampold, 2011; Griner & Smith, 2006; Hodge, Jackson, & Vaughn, 2010; Huey & Polo, 2008; Smith, Domenech Rodríguez, & Bernal, 2011). We highlight key findings from the two most recent meta-analyses by Benish et al. (2011) and Smith et al. (2011).

Smith, Domenech Rodríguez, and Bernal (2011) reviewed 65 quantitative studies that met similar inclusion/exclusion criteria established previously by Griner and Smith (2006). However, Smith et al. restricted their meta-analysis to only studies that employed quasi-experimental and experimental designs. Thirty-two of the 65 studies overlapped with the original Griner and Smith meta-analysis; seven overlapped with Huey and Polo (2008); and four overlapped with Hodge et al. (2010). The random effects weighted average effect size was $d = 0.46$ (CI = 0.36–0.56), suggesting participants in culturally sensitive treatments had moderately better outcomes than participants in control groups. Participants’ average age was associated with stronger effect sizes. Studies with Asian Americans also demonstrated larger effect sizes compared to studies with African Americans, Latino/as, and Native Americans. Similar to past meta-analyses, culturally sensitive treatments delivered to a specific racial group were more effective than those delivered to a mixed group. Last and perhaps most important, the more cultural
adaptations made to treatments resulted in larger effect sizes. In particular, cultural adaptations in which therapeutic goals were explicitly matched with clients’ goals and use of metaphors or symbols that matched the clients’ cultural worldviews accounted for the most variance in effect sizes.

Benish, Quintana, and Wampold (2011) reviewed 59 quantitative studies that compared a culturally adapted psychotherapy with a control and 21 studies that directly compared culturally adapted psychotherapy with a bona fide psychotherapy. They established bona fide status when two out of four criteria set forth by Wampold et al. (1997) were met, including reference to an established approach, use of psychological processes, a manual or training for therapists, and a description of core treatment ingredients. Thus, bona fide status was a more liberal evidence-based treatment criteria than the criteria used by Huey and Polo (2008). Eleven of the 59 studies and nine of the 21 studies overlapped with Smith et al. (2011). Benish et al. found an aggregated effect size of \( d = 0.41 \), favoring culturally adapted psychotherapy over a control group. More importantly, in direct-comparison analysis of culturally adapted versus nonadapted bona fide psychotherapies, there was an aggregated effect size of \( d = 0.32 \), again favoring the culturally adapted version. In particular, they found that cultural adaptation of the *illness myth*, in which the therapist explains the etiology, symptoms, course of illness, and client expectations in terms congruent with the clients’ cultural worldviews, moderated the treatment effects.

In summary, the meta-analytic findings support the treatment benefits of culturally adapted treatment and prevention for children and adults, and to a less clear extent of other culturally sensitive approaches (e.g., cultural grounding) for which there are fewer available efficacy studies. Culture-specific moderator variables were identified that support key features of both cultural adaptation and cultural grounding. In terms of modifications to service delivery, for instance, there is good support for language and ethnic matching between therapist and client. There also is some support for the use of culturally sensitive EBPP with clients with low levels of acculturation. Additionally, culturally sensitive EBPP should target a specific racial group rather than a racially mixed group of participants. In terms of modifications to content, structure, and practice, it is clearly important to incorporate culture into how the mental health risk or problem is understood, acknowledged, and communicated (i.e., illness myth; Benish et al. 2011). Similarly, practitioners must work to contextualize content to match the clients’ worldviews, from therapeutic goals and plans to the use of culturally congruent metaphors/symbols to convey important messages and practices. Culturally grounded narratives also can easily accommodate the use of appropriate illness myths and metaphors or symbols that match the clients’ worldviews. Importantly, the more culture is incorporated into different aspects of the curriculum, the more effective the treatment and prevention.
Despite the empirical support for culturally sensitive EBPPs, dissemination and implementation challenges remain in racially or ethnically diverse communities (National Research Council and Institute of Medicine, 2009; Wandersman & Florin, 2003). Most EBPP never reach local communities, and this research-to-practice gap is most significant in racially or ethnically diverse communities. Prevention researchers are often more interested in the science behind the development of EBPPs, and are less invested in the long-term sustainability of EBPP in communities. Prevention researchers also do not always have the necessary knowledge, training, or competence to work effectively within communities. Simultaneously, there is a persistent misbelief within racially or ethnically diverse communities that EBPP, even when tailored to be culturally sensitive, may not meet the needs and concerns of the community (Lee, Altschul, & Mowbray, 2008). Practitioners similarly maintain a healthy skepticism of research-based strategies that do not necessarily correspond with their clinical experiences. Consequently, they are not likely to learn or utilize culturally sensitive EBPP despite available training (Ringwalt et al., 2009). Moreover, once research funding to conduct efficacy and effectiveness studies are depleted, there is often a lack of organizational capacity and commitment to monitor and support the long-term implementation and maintenance of EBPP, even when developed to be culturally sensitive.

Lomas (1993) noted that most scientific knowledge—in this instance, the availability and appropriateness of culturally sensitive EBPP—is passively, if not haphazardly, communicated through professional journal outlets and scientific conferences. This diffuse (or not targeted) form of communication is largely inaccessible to the general population and requires practitioners and community organizations to be highly motivated to seek out this information. It no doubt plays a substantial role in the persistent research-to-practice gap (Backer, 2000). By contrast, dissemination refers to active methods by which the public gains awareness of scientific knowledge through tailored or targeted communication. It may involve training seminars, community presentations, press coverage, targeted mailings, and other forms of outreach and advertising. Implementation goes a step further than dissemination and refers to strategies and approaches to introduce, adapt, or practically apply scientific knowledge within a target community. It involves actively identifying and overcoming barriers to successful application and utilization of the research. Unfortunately, thoughtful and thorough dissemination and implementation of EBPP continues to elude university researchers and practitioners working in the community (Backer, 2000).

As a best practice, dissemination and implementation of EBPP is a community-centered, iterative process in which the prevention program constantly considers and incorporates the best ways of working with a
community or population (Wandersman, 2003). Being community-centered also means local practitioners and community members play an active, collaborative role in the planning and tailoring of all facets of the prevention programs, including the framing of research questions and methodology (Parsai et al., 2011). Practitioners and community members additionally need to develop capacity to monitor and evaluate the EBPP at the local level, thus promoting a sense of empowerment and ensuring continued program refinement. Finally, implementation necessarily entails a collaborative approach to research on the needs and preferences of the target community to best tailor the prevention program to ensure cultural and ecological validity (August et al., 2009).

VIII. CONCLUSION

The development, dissemination, and implementation of EBPP is a necessary step to close the racial disparities in mental health problems and services by reaching out and providing effective services to racially diverse communities who may otherwise not seek care until mental health problems become severe and persistent. However, as outlined in this chapter, the provision of EBPP to racially diverse populations requires researchers, practitioners, and communities to work together to ensure the programs are responsive to the culture-specific needs and preferences of the population. It will be necessary for all invested parties to cross borders to acknowledge the knowledge expertise of each other. We specifically believe these collaborative approaches to developing culturally sensitive EBPPs, if disseminated and implemented appropriately, can help close the racial disparities in access, utilization, and quality of mental health prevention and treatment-focused services.

REFERENCES


center and a supported housing program. *American Journal of Community Psychology, 32*, 305–317.


