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Enhancing the Cultural Relevance of Empirically-Supported Mental Health Interventions

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Abstract

Evidence-based practice (EBP) has become a hot topic in clinical social work and other mental health disciplines. Mental health professionals have called attention to the need for clinical decision-making to be based on the best available empirically supported treatments integrated with client preferences, values, and circumstances. This movement has greatly stimulated mental health professionals to develop, test, and adopt efficacious treatments for clients with psychological problems, but what is missing in the literature is the cultural context in which these treatments must be implemented to be effective with racial/ethnic minority populations. Herein, we utilize the culturally centered framework of Bernal, Bonilla and Bellido (1995) to examine its utility in assessing to what extent empirically supported mental health treatments incorporate culturally relevant components.

Evidenced-Based Practice and its Relevance to Social Work

Evidence-based practice (EBP) has become a hot topic in clinical social work and other mental health professions, such as psychiatry, psychology, and nursing. The academic movement towards evidence-based mental health practice has greatly influenced the social work profession, which is now the largest group of providers employed in the mental health and psychotherapy arena in the country (Insel, 2004; Thyer, 2002). This new paradigm is based upon the belief that providing research evidence for clinical decisionmaking and interventions in mental health treatment ensures accountability to the populations served (McMurray, 2004), and that individuals and families facing mental health disorders deserve access to the best available treatments and services (Hardiman, Theriot, & Hodges, 2005).

The President's New Freedom Commission on Mental Health (Azrin, Moran, & Myers, 2003), The World Health Organization Report on Mental Health (WHO, 2001), and the Report of the Surgeon General (DHHS, 1999) all emphasized the need for mental health research and practice to be evidence-based. These efforts have been part of a worldwide movement towards evidence-based practice, and the desire to base clinical mental health interventions on the same evidentiary guidelines used to identify medical treatments (Norcross, Beutler, & Levant, 2006). It is generally accepted that intervention research that focuses on the efficacy and effectiveness of interventions is the basis of professional

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knowledge (Rubin, 2000; Thyer, 2000). However, there are various definitions of what constitutes evidence-based practice (EBP). What are the commonly accepted criteria?

A commonly cited definition of EBP, provided by The Institute of Medicine (2001), identifies EBP as the "integration of best research evidence with clinical expertise and patient values" (Sackett, Straus, Richardson, Rosenburg, & Haynes, 2000, p. 1). Consistent with this definition, EBP in the social work field is typically described as involving three main components (Rosen & Proctor, 2002) or six critical steps (Gibbs, 2003). Rosen and Proctor (2002) describe EBP as having three components: (a) intervention decisions based on empirical, research-based support; (b) critical assessment of empirically supported interventions to determine their fit to and appropriateness for the practice situation at hand; and (c) regular monitoring and revision of the course of treatment based on outcome evaluation. Similarly, Gibbs (2003) presents an EBP model that includes six steps: (a) formulating a question, (b) searching for the best available evidence, (c) critically appraising the evidence for its validity, impact, and utility, (d) determining which empirically supported intervention is most appropriate for a particular client, (e) applying the intervention and evaluating its effectiveness and efficiency, and (f) teaching others to follow the same process. In essence, EBP in social work is conceptualized as an evolving process (Gambrill, 2006), starting with gathering and evaluating the best evidence available with respect to a specific problem area, such as clinical depression. After locating and evaluating the validity and utility of the empirical evidence about a mental health intervention for depression, for example, the social work practitioner needs to apply the intervention strategies in an ethical fashion (Gambrill, 2003) and combine knowledge of the relevant research, clinical expertise, and client preferences to identify and create individualized, client-centered intervention plans (Gambrill, 2006). In order to effectively implement the components of EBP, the social work practitioner must first recognize the vital role research findings play in guiding the selection and implementation of clinical interventions (Howard, McMillen, & Pollio, 2003), as well as the importance of staying up to date with the evolving mental health research database.

Empirically supported interventions (ESIs) are those that have a reasonable degree of empirical evidence supporting their effectiveness and/or efficacy as a treatment option (Mullen, Bellamy, & Bledsoe, 2007). ESIs are distinct from, but complimentary to EBP. Inasmuch as EBP is a process that includes finding the best available empirical evidence relevant to client conditions, preferences, and circumstances, the EBP search process should identify those ESIs that exist for a particular problem area (Mullen, Bledsoe, & Bellamy, 2008). When ESIs are presented as options, they are typically ranked hierarchically in terms of their level of evidentiary strength. Briefly, the highest level of evidence may consist of systematic reviews, meta-analyses, or replicated randomized controlled trials (RCTs), preferably from two or more sites; the next level may involve at least one RCT or evidence from multiple time series studies or from quasi-experiments; the next level may include uncontrolled open trials with at least 10 or more subjects; and the lowest level of evidence may consist of anecdotal case reports, descriptive studies, and single-subject designs (Barkham & Mellor-Clark, 2003; Concato, Shah, & Horwitz, 2000; Roberts, Yeager, & Regehr, 2006; Singh & Oswald, 2004). The gold standard for mental health intervention evidence for a particular disorder has historically been the conduct of a number of RCTs (Barkham & Mellor-Clark, 2003; Hollon, 2006), which typically include random assignment to experimental, control, and/or other treatment conditions (Chambliss et al., 2001), standardized treatment manuals, and specific exclusion and inclusion criteria (American Psychological Association, 1995). The RCT constitutes the most rigorous type of investigation that is reliable and replicable, and tests explicit and potentially falsifiable hypothesized relationships between variables while making an effort to control for potential sources of bias and confounding (Thyer, 2002). However, the best evidence for treating a

particular disorder derived from a series of RCTs may not be available so we must move down the hierarchy of evidence. In that case, uncontrolled open trials with limitations are better than no evidence at all.

Kazdin (1998) has pointed out that, although not a substitute for experimentation, an uncontrolled open trial or "case study approach" that uses multiple assessments over time serves an important place in exploring innovative clinical treatments and can rule out specific threats to internal validity in a manner approaching that of true experiments. As the number and heterogeneity of clients increase and receive treatments at different points in time, history and maturation become less plausible as alternative rival hypotheses. Problems associated with testing are not likely to influence the pattern of data over a large number of occasions. In addition, the less rigorous sampling strategies of open trials better approximate the heterogeneity of clients encountered in routine clinical practice, giving their results more generalizability than most RCTs (Kazdin, 1998). Initial data obtained from an open trial might well provide important information for the design of an RCT to more rigorously test the effectiveness of the intervention. In brief, a useful strategy for looking for the best evidence in support of an intervention might involve examining the hierarchy to find out what type of evidence exists. As such, best evidence could refer to a number of different studies, other than a randomized controlled trial, which vary in their rigor and ability to critically test interventions (Roberts, Yeager, & Regehr, 2006).

Given that clinical social workers are now the leading mental health providers in the country (Insel, 2004; Thyer, 2002), it is imperative that social work practitioners recognize the importance and utility of EBP. Hardiman, Theriot, and Hodges (2005) identify four commonly cited rationales for EBP that are applicable to the field of social work. First, EBP has the ability to provide practitioners with comprehensive and explicit tools to utilize when making critical practice decisions. Second, EBP is the vehicle that drives mental health programming, policy, and planning decisions. Third, the utilization of EBP aids in the promotion of accountability in the implementation and fidelity of services. Fourth, the use of EBP in mental health can increase the cost-effectiveness of services. Whereas these components are obviously beneficial to the social work profession, and most social work practitioners have supported the movement toward EBP, there are significant barriers to implementing EBP in the field. Evidence-based practice has been criticized for its time-consuming nature, in that practitioners who are already over burdened must additionally read and synthesize a large and complex body of literature (Hardiman, Theriot, & Hodges, 2005). Despite this, social workers and other mental health practitioners have continued to make advances in mental health interventions with a number of social work researchers receiving national recognition for their significant contributions to the EBP literature (Thyer, 2002). However, for clinical social workers and other mental health professionals, a dearth of information still exists specifically in the area of *culturally competent*, empirically-supported mental health intervention research.

Culturally Competent, Empirically-Supported Mental Health Interventions

Cultural competence is the provision of effective and respectful care that is compatible with the cultural health and mental health beliefs, practices, and languages of the people receiving services (Castro & Alarcon, 2002; Cunningham, Foster, & Henggeler, 2002; Sue, 2006). Culturally competent care is a major objective of mental health care and social justice. It happens when cultural knowledge about individuals and populations is integrated and transformed into clinical standards, skills, and approaches (Sue, 2006). Culturally competent practice encompasses holistic considerations of the individual—among them culture, customs, attitudes, beliefs, and treatment preferences—within the context of family and community (McMurray, 2004; Sue, 2006). Whereas a theoretically driven accumulation and

integration of empirical results provides the foundation of knowledge, we must acknowledge that research without attention to cultural context can never fully inform practice. Recognizing and understanding the local and cultural contextual bases of problems presented by clients must be included as essential enhancements of empirically-supported mental health interventions. That is, ESIs that do not take into account the diversity of client lifestyles and circumstances, cultural history and resources, and linguistic backgrounds cannot be considered culturally relevant. Within the current EBP model, most empirically supported treatments have been tested on White populations and thus there is a blindness to differences, impeding the ability to improve the quality of care for racial/ethnic minority clients (Sue & Zane, 2006).

Racial/ethnic disparities in mental health care, particularly the large amount of unmet mental health needs among members of racial/ethnic minority groups, have been consistently described in the academic literature (Sue & Zane, 2006). Indeed, Sue and Zane (2006) are pessimistic about the ability of empirically supported treatments to work effectively in diverse populations and to reduce treatment disparities for a number of reasons. First, they emphasize that little research has been conducted on empirically-supported interventions with racial/ethnic minority clients. Second, they argue that our current definition of "evidence" needs to be broadened to include information provided from a wider range of methodologies and study designs, such as uncontrolled open trial designs or qualitative studies. On the other hand, one of the goals of the evidence-based practice model in social work (Gibbs, 2003; Gambrill, 2003) is to reduce treatment disparities by searching the evidentiary hierarchy to find the best empirically supported interventions *available*. Sometimes this search may reveal that it is more judicious to use an intervention that matches the client's clinical and cultural context even though this treatment may have been tested using only quasiexperimental methods, not a randomized controlled trial (Mullen, Bellamy, & Bledsoe, 2007).

A major concern in attempting to utilize the EBP model in social work to guide treatments with racial/ethnic minority clients is that relatively little intervention research has been conducted with these clients in the social work literature (Reid & Fortune, 2000) or in the general professional literature, particularly research that satisfies rigorous research criteria as in randomized controlled clinical trials (Sue & Zane, 2006). The ability to effectively develop and conduct randomized controlled trials to test mental health interventions in racial/ethnic minority populations has proven to be particularly challenging. Given that the population sizes of racial/ethnic minorities in America are relatively small when compared to Whites, it is not uncommon for racial/ethnic minorities to be concentrated in particular geographic regions in the United States. Thus, it may take additional resources to gain access to these communities in order to engage them in research. Without such efforts, sample sizes can often be too small to analyze (Sue & Zane, 2006).

In addition, many racial/ethnic minorities might choose not to be involved in research. Further, tasks such as creating culturally valid measures, reducing cultural response sets, ensuring adequate English proficiency or translations for participants who speak limited English, and controlling for potential confounds with ethnicity or cultural variables are complicated and time consuming (Sue & Zane, 2006). Due to the nature of their sampling strategies (e.g. convenient or purposive sampling), open trials or qualitative studies may be more effective at attaining adequate enough samples of racial/ethnic minority groups to assess mental health interventions with these hard-to-reach populations.

The lack of racial/ethnic minorities in mental health intervention research is a significant concern, but simply including more racial/ethnic minorities as research subjects in randomized controlled trials is an inadequate solution to the problem (Sue & Zane, 2006). In

1994, the National Institute of Health (NIH) developed a research policy that required a significant number of racial/ethnic minorities in ongoing and future research studies. Although mandating the recruitment and inclusion of racial/ethnic minorities in research studies is a positive step forward, it does not necessarily provide us with new information about racial/ethnic minority populations and what treatments work best for which groups (Hall, 2001; Sue & Zane, 2006). In addition, this research does not help us understand what cultural variables may be important in the treatment of racial/ethnic minority clients (Castro & Alarcon, 2002).

Further research is needed that comprehensively examines the culturally competent skills, tools, and variables that need to be imbedded within all stages of development, implementation, and evaluation of mental health interventions with racial/ethnic minorities. In addition, research must identify and address the cultural factors that may have an impact on the therapeutic process. These values include specific beliefs, values, norms, and behaviors that capture the core life experiences of racial/ethnic minority populations (Castro & Alarcon, 2002). In the next section, a useful framework is described for incorporating cultural components to enhance the effectiveness and relevance of mental health intervention research.

Enhancing Cultural Relevance of Empirically-Supported Mental Health Interventions

Bernal, Bonilla, & Bellido (1995) proposed a culturally sensitive framework for enhancing mental health interventions with racial/ethnic minority clients. Their contextual framework centers the client and the therapeutic intervention within the context of the client's culture (Pedersen, 2003). Bernal and colleagues have utilized this mechanism to adapt psychosocial interventions for their work with depression in Puerto Ricans. However, this framework is relevant for adapting empirically supported treatments for other racial/ethnic minorities as well. The framework incorporates eight culturally relevant components: (a) language, (b) persons, (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context. In the following section we discuss these eight components and highlight their relevance for Latinos, and also for African Americans, Asian Americans, and American Indians.

Language-appropriate interventions add to the cultural relevance of mental health treatments. Bernal and colleagues (2006) state language is related to both cultural and emotional experiences. Barona and Santos de Barona (2003) point out that if a mental health provider is unfamiliar with cultural norms in terms of the expression of language and verbal style, he or she may misinterpret expressions, which can affect the course of treatment. This component is also true for clients whose first language is English. For example, a therapist should be familiar with the subculture of African American youth who may use slang language to represent certain cultural expressions. The language used in mental health interventions should be culturally appropriate and take into account these regional or sub-cultural differences (Bernal et al., 1995, 2006). We argue, along with several others, that bilingual clinicians should be utilized as opposed to interpreters when providing mental health interventions to clients whose first language is not English.

The component of *persons* refers to the client-therapist dyad. Bernal et al. (1995; 2006) stress that a culturally competent intervention takes into account the role of racial/ethnic similarities and differences between the client and therapist during an intervention. This includes issues of racial and/or ethnic match or mismatch between the client and therapist, as well as discussing issues relating to the client's expectations of the therapist at the beginning of the therapeutic process. Results have been mostly non-significant when determining whether racial match impacts the outcomes of therapy (Sue, 1998), but discussing concerns

or expectations about racial or ethnic differences between therapist and client before treatment starts is likely to facilitate the implementation of mental health interventions with racially/ethnically diverse clients (Thompson, Bazile, & Akbar, 2004). Therapists who work with racial/ethnic minority clients also need extensive experience working with diverse minority groups, and should receive cultural competence training throughout their tenure to remain up to date on current best practice evidence.

Metaphors refer to the symbols and concepts that are shared by individuals within diverse cultural groups (Bernal et al., 1995; 2006). Incorporating metaphors into mental health interventions can include having symbols reflective of the Asian culture, such as artwork or music, in the office in which clients will receive their treatment, or incorporating common Spanish sayings or idioms into treatments with Latinos. It is important for these metaphors, sayings, or "dichos," which are common to the ethnic group with which you are working, to become part of the therapeutic intervention.

The component *content* refers to cultural knowledge about values, customs, and traditions shared by different racial/ethnic groups (Bernal et al., 1995, 2006). Bernal and colleagues (2006) suggest the unique aspects of diverse cultures should be incorporated into all aspects of the treatment process. This could include the importance of tribal medicines and healers in Native American cultures and the significant value of family or *familismo* in Latino cultures. Another important value that should be incorporated into therapeutic interventions is the value of religion and spirituality among African American clients (Boyd-Franklin, 1989). Content relates to Sue's (1998) concept of "dynamic sizing," in that mental health practitioners must learn to skillfully incorporate aspects of client culture into the therapeutic intervention without assuming their relevance for every member of a particular racial/ethnic group.

The component *concepts* refers to the way in which the therapist conceptualizes and communicates information about the presenting problem of a client, taking into account how the client views the problem (Bernal et al., 1995, 2006). Different racial/ethnic groups may have different conceptualizations of mental health problems relative to the standard, established views of mental health professionals. For example, some individuals within a particular racial/ethnic group may not acknowledge they are depressed and prefer to call themselves "stressed." It is important for the client to feel understood by the therapist. Having the therapist respect client preferences enhances his or her credibility, thus facilitating the therapeutic process (Grote et al., 2007). It is also important for the client to be in agreement with the definition of the problem and with the treatment that is being provided, and for the treatment to be framed within the client's cultural values (Bernal et al., 1995, 2006).

The creation of *goals* is an important part of mental health treatment, but just as important is that the clinician and client collaboratively establish these goals, taking into account the specific values, customs, and traditions of the client's culture (Bernal et al., 1995, 2006). In other words, therapeutic goals will be culturally meaningful to clients only if they have taken a significant role in determining what they want their goals to be. Goals should also be realistic, meaning that they are small and specific enough to be attained within the cultural context of the client's life (Bernal et al., 1995).

The component *methods* refers to the procedures followed during the intervention to achieve treatment goals. The format and strategies of mental health interventions should be congruent with the values of a client's culture (Bernal et al., 1995, 2006). For example, culturally relevant strategies may include utilizing group interventions for African American women, who tend to endorse the value of community (Thompson et al., 2004) or shortening

the length of treatment to lift the treatment burden of minority women experiencing multiple stressors (Grote et al., 2004). The use of psychoeducation before beginning treatment is another culturally competent method utilized to help educate the client about their mental health problems and treatment options, allowing them to make informed, culturally appropriate treatment decisions (Miranda et al., 2003).

The last component, *context*, refers to the therapeutic consideration of the broader socio-economic-political context in which the client lives (Bernal et al., 1995, 2006). An acknowledgement of client processes such as acculturation, immigration, and relationship to and identification with country of origin (such as Afrocentrism) are important aspects of some client cultural backgrounds that should be assessed and incorporated into the therapeutic intervention. Clinicians should also be prepared to assess socioeconomic stressors that contribute to the client's presenting problems and evaluate their basic needs (such as an adequate food supply, childcare, and transportation) which may prevent access to treatment if not addressed.

To illustrate how some of these eight culturally relevant components identified by Bernal and colleagues (1995) may be incorporated into the design of mental health intervention research, we next present two studies that occupy different levels of the strength of evidence hierarchy: the Women Entering Care Study (Miranda et al., 2003; 2006), a randomized controlled trial; and the Promoting Healthy Families Study (Grote et al., 2004), an uncontrolled open trial. Table 1 illustrates the Women Entering Care Study research design, degree of methodological rigor, and extent of cultural competence.

First Case Illustration—The Women Entering Care Study

The Women Entering Care study (Miranda et al., 2003; 2006) was a randomized controlled trial designed to test the effectiveness of cognitive behavioral therapy and pharmacotherapy, both evidence-based treatments for depression, compared to a referral to community mental health services, to reduce depressive symptoms in a sample of 267 racial/ethnic minority women suffering from major depression, living on low incomes, and receiving food subsidy and family planning services in Washington, DC. The sample of 117 African American women, 134 Latina women, and 16 White women were randomly assigned to one of three groups: (a) anti-depressant medication, (b) eight weeks of manual-guided cognitive behavioral therapy (CBT), and (c) referral to community mental health services. In addition to using established procedures to protect internal validity (randomization, treatment manual, inclusion and exclusion criteria), these authors incorporated a number of culturally relevant enhancements into their intervention, which map onto six of the eight culturally relevant components identified by Bernal et al. (1995). See Table 1.

To address the *language* component, bilingual providers treated all Spanish-speaking women. This ensured that the mental health providers would be familiar with cultural norms of expression and verbal style to reduce the risk of the practitioner misinterpreting expressions, which can negatively affect the course of treatment (Barona & Santos de Barona, 2003). Further, all written materials, including psychotherapy manuals, were available in Spanish.

To address the importance of *persons*, the researchers attempted to include diverse treatment providers. Out of the six providers, one was African American and three spoke Spanish fluently. In addition, all practitioners had extensive experience with African American and Latina participants and were committed to treating low-income and minority clients. They utilized *metaphors* by incorporating Spanish sayings and images into written materials given to the Latina participants. Miranda and colleagues attempted to explain depression to their

participants in a way that was congruent with their cultures and validated their experiences to deal with *concepts*.

To emphasize the importance of *methods*, participants were able to choose whether they received CBT treatment individually or in a group setting. Giving participants this choice represented an attempt to be sensitive to the importance of communal perspective and interdependence valued in African American and Latino communities. Further, the CBT manual for this intervention was modified to be more sensitive to the issues of young minority women with histories of interpersonal trauma and was shortened from a 12-week version to an 8-week version. Offering fewer weeks of treatment makes completion more feasible for racial/ethnic minorities, who are more likely to drop out of treatment than their White counterparts (Miranda et al., 2003). Before treatment began, participants who were randomly assigned to receive CBT intervention or medication intervention and who were not comfortable beginning treatment at that time were offered up to four psychoeducational sessions about depression and depression treatment. During these pre-treatment psychoeducational sessions, participants were able to discuss their depression and treatment options with a clinician, giving these women an opportunity to build trust with their provider before accepting treatment.

To address the final component of *context*, issues related to the personal histories of these women and their experiences of interpersonal trauma were consistently acknowledged to address the larger socio-environmental context of the study's participants. To minimize transportation challenges, sessions were conducted at county clinics, Women Entering Care offices, and in the participant homes. Additionally, transportation and childcare assistance were available to help participants engage with and remain in treatment.

Results of the intent-to-treat analyses showed that at 6-month and 12-month follow-ups both medication intervention and CBT reduced depressive symptoms more so than community referral. At 6-month and 12-month follow-ups, medication intervention resulted in improved instrumental role and social functioning relative to the community referral condition. CBT improved social functioning relative to the community referral group only at the 6-month follow-up. There were no racial/ethnic differences found in response to treatment. It is possible that the cultural adaptations observable in the Women Entering Care study helped to remove barriers to treatment engagement and retention and made the utilization of CBT more culturally relevant for this group of African American and Latina young women with low incomes. Whether the results would have been the same without these cultural adaptations is unknown.

In addition to incorporating six out of eight possible components of cultural competence as outlined by Bernal et al. (2005), this study is also methodologically sound and rigorous as determined by the Methodological Quality Rating Scale (MQRS). The MQRS (Vaughn & Howard, 2004) was created to evaluate the methodological quality and rigor of studies across dimensions including study design, replicability, baseline data, quality control, follow-up rate, collaterals, objective verification, dropouts, independent analyses, and multi-site information. A score on the MQRS can range from 0 (poor quality) to 17 (high quality). Utilizing the MQRS, both authors rigorously evaluated the quality of the Women Entering Care study and gave it a total score of 13. Thus, it is apparent that a mental health intervention study can be both methodologically sound and culturally competent.

Second Case Illustration—The Promoting Healthy Families Study

Grote and colleagues (2004) used an open trial design to gather preliminary evidence on the effectiveness of an innovative, brief form of an established, empirically supported mental health intervention—brief interpersonal psychotherapy, designed to reduce depression

symptoms in a sample of pregnant, low-income, racially/ethnically diverse women. There were 12 women in the study sample: 9 African Americans, 2 Whites, and 1 Latina. In addition to providing manual-guided brief interpersonal psychotherapy, these researchers incorporated seven culturally relevant components into their model to make their intervention more sensitive to the needs of pregnant minority and White women who were depressed and economically disadvantaged. The researchers addressed the component of *persons* by employing therapists who were trained in cultural competence and had considerable experience working with racial/ethnic minorities. Although all therapists in this study were White, therapists addressed the issue of race (and other issues) in a pre-treatment engagement and psychoeducational session to explore participant concerns about racial/ethnic match and to help clarify participant expectations of the therapist. The researchers also utilized the component of *metaphors* by displaying culturally relevant pictures of racially and ethnically diverse infants in the therapist's office.

To address the component of *concepts*, therapists elicited participant views about their depression during the pre-treatment engagement and psychoeducation session. Therapists also attempted to educate participants about depression in a way that was congruent with their cultures and used the word "stressed" instead of "depressed" if participants so desired, to minimize the client's perceived stigma of depression. The component *content* was addressed by exploring coping mechanisms and cultural resources, such as spirituality, that had helped participants through adversity in the past and by building on these resources during treatment. Therapists also helped clients develop treatment *goals* that were personally and culturally relevant to them (Grote, personal communication).

Methods were also addressed in this study. The brief interpersonal psychotherapy utilized in this study was an 8-week version adapted from a 12-week version. This version was developed specifically to address the needs of women who had a hard time adhering to long courses of psychotherapy. Therapists in this study also utilized a flexible approach to treatment delivery by holding sessions at the public care obstetrics/gynecological clinic following the mother's pre-natal visits. During times when a client could not come in for treatment, sessions were conducted by phone. These adaptations helped to accommodate the stressful reality faced by these women and made the treatment more culturally sensitive. Finally, these researchers recognized the impact of the challenging socio-economic and environmental circumstances on their mental health and well being. Therefore, they integrated the cultural component of *context* by providing childcare services in the clinic and free bus passes for transportation, as well as facilitating access to a broad range of social services including job training and housing assistance.

Results of the intent-to-treat analyses revealed women who received culturally relevant brief interpersonal psychotherapy during pregnancy experienced a significant reduction in their depressive symptoms and an improvement in their social functioning after treatment and at 6 months postpartum. These findings suggest that brief interpersonal psychotherapy enhanced by seven culturally relevant components may be an effective treatment for antenatal depression in this sample. Utilizing the MQRS, both authors evaluated the quality of the Promoting Healthy Families Study and gave it a score of 9.

Conclusions and Future Research Directions

Over the past few decades, many investigators and clinicians have called for incorporating culture into empirically-supported mental health interventions. Presently, there exists a dearth of information about culturally competent, empirically-supported mental health interventions for various psychological disorders (Roberts, Yeager, & Regehr, 2006). This article has utilized the framework of Bernal et al. (1995) to examine two case illustrations—

the Women Entering Care Study (Miranda et al., 2003, 2006) and the Promoting Health Families Study (Grote et al., 2004), both of which adapted evidence-based psychotherapies and/or pharmacotherapy to be culturally relevant to racial/ethnic minority clients with depression. Bernal et al.'s framework describes eight culturally relevant components: (a) language, (b) persons, (c) metaphors, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context.

The presentation of the two case illustrations incorporating many of these aforementioned components into empirically-supported mental health interventions suggests that these cultural enhancements *may* help to effectively reduce depressive symptoms and improve social functioning in racial/ethnic minority clients, over and above what is provided in mental health treatments by themselves. Adding these cultural adaptations may have improved treatment outcomes, in part, by increasing client engagement and retention in treatment. More empirical work is needed, however, to examine whether empirically-supported interventions with culturally relevant components are more effective than the same empirically-supported interventions without these cultural adaptations. This is a matter for future research. A good example of an initial investigation into this question may be found in the work of Kohn and colleagues (2002). These researchers utilized a non-randomized comparison group design to examine the degree to which culturally enhanced cognitive behavioral therapy would be superior to standard CBT in reducing depressive symptoms in economically disadvantaged African American women with depression. Results suggested African American women in both treatment groups had improved depression scores, but the African American women who received the culturally adapted CBT had a more significant drop in their depressive symptoms than those in the standard CBT group. This suggests CBT may be an empirically-supported intervention for African Americans who are depressed, and it may be more effective when culturally relevant components are integrated, consistent with the EBP model in social work.

In sum, we suggest that mental health researchers may find it beneficial to utilize the Bernal et al. (1995) framework to conduct culturally relevant intervention research with racial/ethnic minority clients. To this end, it is essential that researchers be explicit about how they integrated culturally relevant components into empirically-supported interventions to provide clinicians and researchers a comprehensive guide for practice and future research. Further, we hope social work and other mental health practitioners can employ this framework to evaluate the extent to which an empirically-supported intervention for racial/ethnic minority clients is culturally sensitive.

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TABLE 1

Overview of Characteristics of the Women Entering Care Study

Author/Study	**Miranda et al. (2006)** **Women Entering Care**
Design and Intervention	RCT Pharmacotherapy or Cognitive-Behavioral Therapy (CBT)
Control Group	Referral to community care
Sample	267= 6% White, 51% Latinas, 44% African Americans
Outcome Measures	Depressive symptoms (HDRS-Hamilton Depression Rating Scale)
	Instrumental role and social functioning (Social Adjustment Scale - SAS)
	Social Functioning (short-form 36-item health survey)
Follow-up	6-months, 12 months
MQRS Score	13
No. of Cultural Components	6 out of 8