

# Practitioner characteristics and organizational contexts as essential elements in the evidence-based practice versus cultural competence debate

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## Abstract

The different pathways chosen to efficiently and effectively provide relief to those struggling with mental health challenges reflect different assumptions about the human condition and have led to disagreements over which intervention strategies are best suited to particular individuals or populations. Evidence-based practice and culturally competent services, as discussed within the United States, have been characterized as opposites. However, neither approach captures all of the elements that embody the full treatment experience. This article offers a framework that includes the personal identity of the practitioner and the organizational context as two elements that serve as active agents in the helping relationship, although they have rarely been included in the discourse about evidence-based practice or cultural competence. Suggestions for practice, education, and research are included based on this analysis.

## Keywords

cultural competence, evidence-based practice, organizational culture, practitioner characteristics

## Introduction

The different pathways chosen to effectively and efficiently provide relief to those struggling with mental health challenges reflect different assumptions about the human condition and have led to debates as to what intervention strategy is the best for whom and under what conditions (Glasby & Beresford, 2006; Gray, Joy,

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Plath, & Webb, 2013; Petersén & Olsson, 2014; Webb, 2001). Evidence-based practice (EBP) and culturally competent (CC) services are two approaches to promoting healing that have been characterized as opposites (Hall, 2001).

Those who promote EBP assert that use of scientifically vetted interventions, along with clinical expertise of the practitioner and the input of the client,<sup>1</sup> will lead to effective treatment. (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006; Drake et al., 2001; Wampold, Goodheart, & Levant, 2007; Weisz, Ugueto, Cheron, & Herren, 2013); they contend that it is poor practice to rely solely on clinical judgment, or even prevailing conventions, without documentation of efficacy or effectiveness (Kazdin, 2008).

Those who promote culturally competent services challenge the behavioral health system to use interventions that attend to the client's social and cultural context, which informs the meaning attached to the emotional distress, characteristics of an appropriate helping relationship, and delineation of an appropriate outcome. The impact of context is especially important for those who have experienced marginalization and related disparities based on such factors as race and ethnicity (S. Sue & Zane, 2006), sexual orientation and/or gender identity (Brown, 2006), national origin, disability status (Olkin & Taliaferro, 2006), primary language spoken, or geography. The dilemma is bound up with the question of how to apply "probabilistic generalizations to individuals and situations that do not correspond to the circumstances from which the generalizations were derived" (Rosen, 2003, p. 201). One can question the degree to which the design and testing of interventions have accounted for clients' worldviews, traditions, practices, and belief systems—as well as whether the interventions account for the influence of societal oppression and differential power relationships in the development of distress, the process of accessing and engaging in a helping relationship, and the presence or absence of beneficial resources.

EBP proponents and CC proponents alike problematize the practitioner's bias in the therapeutic encounter (S. Sue & Zane, 2006), but neither emphasizes the concept of practitioners as "cultural beings" who bring their whole selves into the encounter. Further, practitioners are influenced by the organizational context in which they conduct their work, just as persons in emotional distress are influenced by their immediate network and sociocultural context (Adler School of Professional Psychology, Institute on Social Exclusion, 2012; Todman, Hricisak, Fay, & Taylor, 2012). The interaction of all these features comprises the treatment experience.

In this article, the author (a) provides an overview of contrasting perspectives in the evidence-based practice literature and the cultural competence literature; (b) presents a framework depicting interacting factors in the treatment experience; (c) examines two particular factors—practitioner characteristics and organizational context—in greater depth; and (d) closes with recommendations towards creating, sustaining, developing, and implementing culturally attuned, demonstrably effective behavioral health interventions.

### *Terminology for evidence-based and culturally competent practice*

**EBP and EBT.** The term “evidence-based practice” was introduced by the Evidence-Based Medicine Working Group in the early 1990s within the medical school of McMaster University, Toronto, to describe a process to apply research knowledge in the practice of medicine (EBMWG, 1992). Other disciplines, such as psychiatry, psychology, and social work, have incorporated this perspective in their practice decisions (Gilgun, 2005; Rosen, 2003; Thyer, 2002). Sackett, Rosenberg, Muir Gray, Haynes, and Richardson (1996) describe evidence-based medicine as the “conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (p. 71).

However, the terminology to describe practice that employs interventions scientifically demonstrated to improve client outcomes varies (American Psychological Association, Presidential Task Force on Evidence-Based Practice, 2006; American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents, 2008; Drake et al., 2001; Kazdin, 2008). The American Psychological Association, Presidential Task Force on Evidence-Based Practice (2006) defines “evidence-based practice” as “the integration of best available research with clinical expertise in the context of patient characteristics, culture and preferences” (p. 273). In this definition, EBP is a *process* that incorporates the perspective of the practitioner, the influence of culture, and consumer choice as active factors in decision-making about the course of intervention. In contrast, some use “evidence-based practice,” “evidence-based treatment,” and “empirically supported intervention” to describe specific interventions that have been examined with scientific rigor (Drake et al., 2001; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Kazden, 2008; Mullen, Bledsoe, & Bellamy, 2008). For the purposes of this paper, I will use “EBP” to reference the broader process conceptualization and “evidence-based treatment” (EBT) to reference specific interventions.

**Cultural competence.** Several terms are used to express the nature of helping relationships that explicitly incorporate “culture” as a factor. For this discussion, at the organizational level, “cultural competence” refers to organizations that value diversity, conduct self-assessment, manage the dynamics of difference, clarify their vision, institutionalize cultural knowledge, and adapt policies, procedures, structures, and practices as indicated (Cross, Bazron, Dennis, & Isaacs, 1989; National Center for Cultural Competence, n.d.; D. W. Sue et al., 1998).

At the practitioner level, cultural competence refers to a practitioner who possesses cultural awareness, cultural knowledge and effective cross-cultural skills, has engaged in self-assessment for biases and stereotypes, and views all behavior in a cultural context (Cross et al., 1989; S. Sue, Zane, Hall, & Berger, 2009).

### *Critiques of the EBT approach*

From a modernist, positivist perspective, EBTs represent standardized, replicable, tested intervention approaches that will achieve better outcomes universally as compared to usual practice (Hoagwood et al., 2001; Whitley, 2007). Their merit rests on being both theory-driven and empirically tested, in contrast to interventions with no, or limited, documented measures of clinical or functional impact. EBTs are generally developed within an academic environment with different levels of research rigor, with randomized controlled trials as the “gold standard” (Drake et al., 2001). To achieve proficiency and maintain fidelity, practitioners receive instruction, supervision, coaching, monitoring and sometimes certification, along with guiding manuals and protocols (Addis & Waltz, 2002).

Proponents of cultural competence are basically concerned about whether the scientific evidence provided to support EBTs applies to historically and currently marginalized groups, posing the questions: how can EBTs be presented as scientifically supported interventions if there is limited inclusion of such populations in the studies used to develop them (Aisenberg, 2008; Bernal & Scharron-del-Rio, 2001; Burns, Hoagwood, & Mrazek, 1999; Weisz & Hawley, 1998; Southam-Gerow, Weisz, & Kendall, 2003), if the world views of such populations are not included in the theoretical conceptualization of the interventions, and if there is limited documentation of the efficacy and/or effectiveness of the interventions with such populations (Drake et al., 2001; Isaacs, Huang, Hernandez, & Echo-Hawk, 2005; S. Sue & Zane, 2006)?

As EBTs become incorporated into public policy, there is a risk that policy makers and funders will rely on an invalid “scientific” hierarchy that would rigidly limit treatment options and stifle clinical decision-making, practitioner flexibility, and consumer choice—all important features in service provision to a culturally diverse client population. The Oregon Revised Statute 182.525 (Senate Bill 267, see <http://www.oregonlaws.org/ors/182.525>) is just one example of a state policy linking allocation of funds to the use of state agency-approved EBTs (Tanenbaum, 2005).

The lack of standing of interventions that have not been tested through randomized clinical trials is particularly troublesome because research institutions are not immune to the values, norms, and biases embedded in society at large. Hofstede and Peterson (2000) and Trompenaars and Hampden-Turner (1998, 2012) provide a glimpse of the developing knowledge of relationships between national cultures and organizational life. Decisions concerning funding, questions for exploration, populations to engage, and methods to employ are made by persons who may not understand or be vested in the unique issues of marginalized populations. Indeed, the very concepts of “science” and “therapy” have a cultural basis, both coming from a European tradition which may not be in alignment with other cultural groups (Wendt & Gone, 2011).

Approaches to the cultural adaptation of EBTs range from surface-level modifications to deep conceptual considerations (Bernal & Domenech Rodriguez, 2012;

Lau, 2006). Researchers involved in cultural adaptations deliberately and intentionally consider such elements as language, metaphors, concepts, values, and patterns of interacting in the content, process, and form of the intervention (Domenech Rodriguez & Bernal, 2012). Interventions may focus on a culturally based understanding of the cause and expression of distress and/or issues related to engagement (Lau, 2006). One critique holds that adaptations can negatively affect the fidelity of the EBT (Lau, 2006). It has also been suggested that cultural adaptations can actually contribute to the misperception of homogeneity within cultural groups (Wendt & Gone, 2011).

### *Cultural competence*

Cultural competence requires that interventions begin from the perspective of the person who is served, with a comprehensive understanding of his or her sociocultural context. Cultural competence sits more naturally in a postmodernistic view of science that is critical of standardization and the notion of a single “truth” (Whitley, 2007). In contrast to the EBT perspective, cultural competence expects flexibility in the approach to services. Indeed, it requires the practitioner to be ever mindful of the role of culture in various aspects of the therapeutic experience, including: (a) cultural beliefs and norms that define the role of gender, parents, elders, and children in the development, maintenance, and resolution of the issue; (b) the role of societal oppression and privilege in the development, maintenance, and resolution of the issue; (c) implications of cultural identity in the process of gaining access to quality care; (d) the structure and process of the helping encounter; and (e) implications for transference and countertransference in the helping relationship (Comas-Diaz, 2012; Comas-Diaz & Jacobsen, 1991; Kirmayer, 2012; Willen, 2013). Advocates of culturally competent services call upon practitioners to adapt to the needs and preferences of the client, including the implications of the client’s cultural identity. The practitioner is expected to be attentive to the impact of societal factors such as racism, sexism, heterosexism, ageism, etc., on the client, and to the role of social determinants of mental health and mental illness (Adler School of Professional Psychology, Institute on Social Exclusion, 2012). This attention requires preparation including self-assessment; the building of cultural knowledge and cross-cultural communication skills; and work to address any and all attitudinal barriers such as bias and stereotypes (Dyche & Zayas, 2001; S. Sue et al., 2009).

The lack of consensus on definitions and indicators makes it difficult to discern and test how cultural competence affects clinical outcomes (Lau, 2006; S. Sue et al., 2009). Cultural competence is more reliant on qualitative research and thereby not perceived in the same manner as treatment approaches based on quantitative research such as randomized clinical trials. In addition, much of the existing research uses racial and ethnic labels in a manner that oversimplifies the complexities that arise with a robust understanding of culture (Epstein, 2007). As such, the sheer complexity of culture makes it difficult to research, leading practitioners to

create interventions strictly on a client-by-client basis (S. Sue et al., 2009; Whitley, 2007).

### *The EBT–CC intersection*

Not all EBTs are alike (see websites for the SAMHSA’s National Registry of Evidence Based Programs and Practices [www.nrepp.samhsa.gov], as well as the National Child Traumatic Stress Network [www.nctsn.org/resources/topics/treatments-that-work/promising-practices]) There are differences among EBTs in the assumptions behind theory of change; nature of the intervention unit (e.g., an individual practitioner or a treatment team); type of interventionist (e.g., mental health professional or classroom teacher); location (e.g., practitioner’s office, client’s home or school); types of equipment required (e.g., none for motivational interviewing, a one-way mirror and phone for parent–child interaction therapy); and preparation (e.g., training, supervision, manuals, certification, etc.). Each of these factors influences the degree to which variation in culture and language can be naturally incorporated into the intervention. A highly scripted intervention may require significant adaptation; a less scripted intervention is more dependent on the practitioner’s cultural knowledge and cross-cultural skills. Consider the following continuum of types of EBTs in relationship to culture (Evans, 2009): (a) *Transcultural*—constructs and processes appropriate across all cultures; (b) *Multicultural*—constructs and processes appropriate for a variety of cultural groups that have similar world views, belief systems, practices, and traditions; (c) *Culturally adapted*—changes made to address meanings and interpretations for a designated cultural group; and (d) *Culture-specific*—developed specifically to address issues of distress as experienced by a specific group.

This continuum implies, among other things, that compatibility between the intervention and the cultural world of the client raises the likelihood of engagement and participation in a process that addresses the right questions and yields positive results (Hernandez, Nesman, Mowery, Acevedo-Polakovich, & Callejas, 2009; Jackson, 2008; Lau, 2006; Littell, 2001). Bigfoot and Schmidt’s (2010) description of the approach of the Indian Country Child Trauma Center to adaptation is instructive in considering how interventions may be selected and modified to foster such compatibility: they first identify interventions that share elements with American Indian and Alaska Native cultural beliefs and practices, and then pursue adaptations that increase the usefulness of these interventions.

Practice-based evidence and community-defined evidence offer additional pathways to the discovery of that which works (Addis & Waltz, 2002; Duncan & Miller, 2006; Isaacs et al., 2005; Martínez, Callejas, & Hernandez, 2010). This area of inquiry recognizes hosts of existing interventions that may have clinical benefit which the academy has not explored. It also recognizes that some interventions are effective for some, but not transferable to others because of the circumstances of the population of focus (Isaacs et al., 2005). As the scientific community comes to understand these interventions better, it might distill the transcultural attributes

of various healing practices. For example, Wendt and Gone (2011) describe “talking cure” as a transcultural element of “psychotherapy,” a cultural approach to healing psychic distress that emanates from Western cultural concepts of the self.

### *Limitations in the literature at the EBP–CC intersection*

The literature related to evidence-based treatment, evidence-based practice, and cultural competence tends to focus on the “intervention” and the knowledge, skills, and attitudes that the practitioner needs to implement that intervention effectively. While the broad process definition of EBP tries to bridge the concepts, the EBT perspective expects fidelity: the implementation of the intervention within the clear framework established by the EBT. The cultural competence perspective expects the practitioner to collaborate with the client and be flexible according to cultural factors and client preferences.

These conversations overlook the role of the personal identity of the practitioner and the organizational context of the practice. The following framework incorporates the influence of these factors in the treatment experience.

## **Building a framework that depicts interacting factors in the treatment experience**

### *Existing frameworks*

The current perspectives on EBT can be presented in a formula-style model. The EBT approach can be described as follows:

$$I \rightarrow Dx = T$$

This equation represents a process in which an *Intervention* acts on the *Diagnosis*, resulting in the *Treatment*. It conforms with Norcross’s (2002) description of EBT lists, which, he states, are written as if “disembodied therapists apply manualized treatments to discrete Axis I diagnoses” (p. 4). In individually delivered EBTs (e.g., cognitive based treatment) and team-delivered psychosocial EBTs (e.g., assertive community treatment and multisystemic therapy) the process may be perceived as unidirectional, acting on the “diagnosis” or “problem,” without consideration of the variables introduced by the practitioner(s), client, and sociocultural context.

The next level is embodied by the APA definition of EBP, which includes the practitioner, client, and social context:

$$(I_{EBT}+P) \leftrightarrow [(CxD) + N]SC = T$$

In this scenario, the *Intervention* is an evidence-based treatment implemented by a *Practitioner* who engages in a bidirectional relationship with a *Client*, a person who is in *Distress* and is influenced by the nature of his or her family and social

*Network* within the larger *Societal Context* that includes the social determinants of health and illness. This entire process comprises the *Treatment* experience. The emphasis is on how the client describes his/her distress, rather than an abstract “diagnosis.” Further, the positive and negative roles of the client’s family and friend network and societal forces are acknowledged.

The *interactive or bidirectional exchange* is the locus of the relationship within the therapeutic encounter. Within this space, therapeutic alliance, empathy, goal consensus, and collaboration are all factors that Norcross (2002) identifies as demonstrably effective relationship attributes. Although evidence-based treatments are important, the quality of the relationship between practitioner and client remains crucial in achieving positive outcomes. Characteristics of positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretation are promising, and probably effective, attributes in the relationship (Lambert & Barley, 2002).

As people are social beings, a *Network*, positive or negative, has an influence on the interpretation and perceptions of the distress, the pathways towards help and the role of helpers. Members of the network can serve as facilitators and/or barriers to recovery (Cauce et al., 2002).

Finally, the client lives within a community with social supports and hazards that influence positively and/or negatively the development and resolution of distress. *Social Determinants* of mental health include the conditions of where one lives, works, studies, or plays, as well as access to clean air and water, appropriate sanitation, public safety, adequate housing, and health care services. Social determinants also include societal factors such as institutional racism, sexism, heterosexism, bias against immigrants, poor housing, environmental hazards, and inability to speak the predominant language in the community (Adler School of Professional Psychology, Institute on Social Exclusion, 2012). The exact mechanisms of these influences are still under study, but research points to an impact even at the level of gene expression, brain development, and neuroendocrine structure and functioning (Rutter, 2005). *Treatment* in this equation reflects the convergence of all of these factors that can promote or prevent positive outcomes.

The cultural competence equation is very similar:

$$(I_{CA} + P_{CC}) \leftrightarrow [(CXD) + N]SC = T$$

This formula puts greater emphasis on an *Intervention* that is *Culturally Appropriate* and a *Practitioner* who is on the journey of *Cultural Competence*. The interaction between the client and the practitioner is bidirectional and, along with the relationship issues noted in the previous section, includes considerations of literacy, preferred language of service, location of service, goals of service, the nature of the intervention, who the practitioner should be, the role of the practitioner, and the role of client’s network in the treatment (Goode & Jones, 2006; Tsang & Bogo, 1997). Further, the practitioner would ideally have an understanding of the historical journey influencing both the emotional and attitudinal

perspectives of the client and family and the impact of history on the social determinants of mental health or mental illness (Bordewich, 2005). This understanding deepens the practitioner's awareness of the societal forces that produce inequity and the ways these types of oppression—exploitation, marginalization, powerlessness, cultural imperialism, and violence—link to both the client's circumstances and perception of the practitioner in a helper role (Garcia & VanSoest, 2006; Young, 1990).

Cultural concordance by race, ethnicity, national origin, religion, sexual orientation, or gender identity can facilitate engagement and participation and increase the likelihood of success (Halliday-Boykins, Schoewald, & Letourneau, 2005). But cultural concordance on one dimension does not guarantee success. The practitioner and the client will always have some type of cross-cultural difference; therefore, the onus is on the practitioner to develop the knowledge, skills, and attitudes that promote effective cross-cultural work.

Two more dimensions influence successful outcomes, namely, the personal identity or "cultural being" of the practitioner and the organizational context in which the work takes place:

$$[(I_{EIP+CA} + P_{CA} P)O] \leftrightarrow [(CxD) + N]SC = T$$

This equation represents an *Intervention* that is *Evidence Informed* and *Culturally Appropriate*, administered by a *Practitioner* who is a *Person* who operates within the context of an *Organization* in *Interaction* with a *Client* who is a person in *Distress*, influenced by a family and social *Network* (that may participate in the service delivery) within a *Social Context* that contributes to the social determinants of health and illness, which ultimately yields the *Treatment* experience. This equation includes space for a range of interventions reflecting a continuum of levels and types of evidence of efficacy and effectiveness, including EBTs based on randomized clinical trials or culture-specific indigenous interventions. The following sections explore more explicitly the role of the *person* of the practitioner and *organizational context* in the EBP–CC discussion.

## A closer look at practitioner and organizational factors

### *Practitioner characteristics*

There is a "person" behind the role of helper, therapist, peer counselor, care manager, clinician, or practitioner. That person enters into the helping relationship shaped by the prescribed role of his or her profession and job function, as well as a cultural identity influenced by such factors as race, ethnicity, sex, gender, marital status, age, parental status, legal status, primary language, religious status, geographic status, disability status, military status, educational status, socioeconomic class, and more. Mainstream and other cultural communities influence the interpretations of the meaning of each of these cultural factors.

The practitioner must respond to these culturally assigned meanings in some fashion, ranging from full embrace to ambivalence to rejection. The person of the practitioner influences attitudes and behaviors exhibited in the process of delivery of an intervention, as well as the nature of investment in the intervention and the nature of the relationship with the client and any members of the client's network. These dynamics can serve as facilitators or as barriers to successful outcomes for the client.

*Attitudes, beliefs, stereotypes.* There is no culture-neutral way of delivering EBTs. EBTs are reflections of cultural beliefs about how people get better and about the nature of relationships between helpers and "helppees." Training, coaching, and supervision do not convert practitioners into culture-neutral tools; therefore, one step towards quality is to make more explicit the ways in which culture affects practice. Similarly, exhortations to be attentive to bias and admonitions to refrain from imposing one's own beliefs and values onto clients—promulgated through professional training and ethical standards of the helping professions—do not always work (Constantine & Sue, 2008; Cross et al., 1989; National Center for Cultural Competence, n.d.; Simmons, Diaz, Jackson, & Takahashi, 2008; D. W. Sue et al., 1998). Two particularly challenging elements are countertransference and unconscious bias.

*Countertransference.* Practitioners need to be mindful of potential countertransference issues that could emerge from both inter- and intraethnic helping relationships. In cross-cultural relationships, the practitioner might act as if there were no relevant cultural differences, be overly curious about the culture of the client, feel ambivalent about the client and client's culture, feel guilty about his or her privilege in contrast to the client, or even pity the client's status. When they share a cultural identity, the practitioner might overidentify with the client, engage the client in an "us versus them" mentality, or experience an alternating sense of hope and despair. Conversely, the practitioner may engage in distancing, or even feel a sense of anger, comparing the practitioner's relative "success" to the client's relative "failure" (Comas-Diaz, 2012; Comas-Diaz & Jacobsen, 1991). Each reaction influences the nature and quality of the practitioner-client interaction and the content of the intervention.

*Conscious and unconscious bias.* The discussion related to countertransference overlaps with that of conscious and unconscious bias. Sue (1998) notes that

[A]lthough we tend to view prejudice, discrimination, racism, and sexism as overt and intentional acts of unfairness and violence, it is the unintentional and covert forms of bias that may be the greater enemy because it is unseen and more pervasive. (p. 36)

The Institute of Medicine's report on disparities (Smedley, Stith, & Nelson, 2003) propelled the consideration of bias—conscious and unconscious—into

greater awareness and acceptance in the health professions. Unconscious bias is an inevitable consequence of living in a society like the United States which has promulgated racial stereotypes since its inception. Even well-meaning people with good intentions can express unconscious bias (Sue, 1998; van Ryn & Fu, 2003). In these cases, the impact can be more dangerous, and efforts to correct more challenging, because the perpetrators' self-image is of "good people" and indeed they have no intention to do harm. Still, this very subtle form of bias can powerfully and negatively shape the practitioner's expectations of the client, limiting: (a) the amount of information that is given to the client, (b) the amount of effort given to understanding the particulars about the person's life circumstances, (c) choices made available to the client and, (d) hope for participation and recovery. Bias can reinforce the power differential between practitioner and client and magnify differences in social status or position (Amodio, 2008; Dovidio & Fiske, 2012; Smedley et al., 2003).

*Practitioner as a cultural being.* The previous sections focus on the hazards that the practitioner can bring into the interaction, especially with a client culturally different from him/herself. The reality is that practitioners, as human beings, will never fully remove all biases. As one begins to understand oneself as a cultural being, one can discern potential positive and negative cultural forces in the therapeutic encounter; these forces are unique to each relationship with a client or family. Hays (2008) offers an analytical tool, called ADDRESSING, that can help elicit multiple cultural dimensions for both the practitioner and the client. ADDRESSING stands for: Age and generational influences; Developmental disabilities; Disabilities acquired later in life; Religious and spiritual orientation; Ethnic and racial identity; Socioeconomic status; Sexual orientation; Indigenous heritage; National origin; Gender. The use of this tool may enhance the practitioner's understanding of him/herself in the relationship and enrich the understanding of the client.

Hays (2008) suggests that the practitioner use this tool by describing him/herself in each of these domains and eliciting information from the client to do the same for him/her. The comparison and analysis of the two profiles are then used to enhance relationship-building, alert for countertransference risks, and enrich understanding of both the client and the practitioner. A practitioner can add to this list to include such factors as military status, political party affiliation, region of the country (e.g., Northeast, Midwest, South), geographic characteristics (e.g., urban, suburban, rural, or frontier) of the community of birth and current residence, nature of work in community of origin and so forth. This approach is particularly useful because it delineates and makes transparent cultural attributes that the practitioner *brings into* the therapeutic relationship. It signals to the client that it is "safe" to talk about cultural factors related to his/her own challenges. It also invites the practitioner to admit to him/herself the positive and negative cultural factors that enter the therapeutic encounter and to be thoughtful as to how to incorporate that awareness in work with the client (Comas-Diaz, 2005; Hays, 2008).

*Attitudes about culture.* The practitioner's views of general cultural matters form another area of exploration. Carter and Querish (1995) examined preprofessional counseling training and noted that five stances were applied to the interface between culture and service provision: (a) as human beings, all people are the same—our commonalities are more important than our differences and intragroup differences are greater than intergroup differences; (b) all identities or shared circumstances reflect culture and all humans are members of multiple cultures; (c) culture is bound by country, language, history, values, beliefs, rituals, etcetera, determined first by birth and then by subsequent socialization; (d) culture is bound by race first, such that it transcends all other experiences and is a function of the values of the racial group and its interaction with the larger society; (e) all people are members of racial groups that transcend national boundaries and as such embody cultural perspectives of that global group.

Similarly, in *The 10 Lenses*, a book written for the general public, Mark Williams (2001) describes 10 types of perspectives that individuals may take about cultural differences: *assimilationists, the colorblind, cultural centrists, elitists, integrationists, multiculturalists, meritocrats, seclusionists, transcendents, and victim/caretakers*. The lenses through which a practitioner views the subject of culture and cross-cultural relations are part of the person that enters into and influences the therapeutic relationship.

*Attitudes about the intervention.* Some practitioners may be strong advocates of evidence-based interventions (D'Arc, Cortese, Pinabel, & Purper-Ouakil, 2013; Ghaemi, 2008), while others may exhibit an ambivalence about EBTs, possibly caused by simple resistance to change. For others, the EBT does not provide guidance that will help with the types of clients they are serving (e.g., comorbidities, multiple concurrent problems, complicating social and family circumstances, and/or sociocultural contexts). Some practitioners resist due to a fundamental opposition to the assumptions inherent in a particular intervention, especially if there is lack of clarity on a diagnosis and/or the etiology of the malady. Others believe that clinical expertise is undervalued (Drake et al., 2001; Gomory, 2013; Hannes, Pieters, Goedjuys, & Aertgeerts, 2010; Haynes, Devereaus, & Guyatt, 2002; Levine & Fink, 2008; Rosen, 2003).

The author has previously noted the differences in perspectives by staff regarding a specific intervention in her study of Africentric practice in kinship care and family preservation services (Jackson, 2008). The agency, composed of predominantly African American, Caribbean, and African staff for a demographically similar client population, used a therapeutic intervention named NTU, pronounced "en-too," a Bantu word meaning "essence" (Phillips, 1990). The founder of the agency and senior colleagues created this intervention in the belief that an Africentric approach would be more useful than mainstream interventions for the population being served. Although the agency used training, certification, and supervision strategies, and conducted all agency staff and client activities within the framework of NTU, implementation at the practitioner level was

uneven, with four types of staff responses. Some staff embraced Africentrism as a way of life and experienced NTU as totally congruent with their belief system. Others appreciated the values and techniques inherent in the intervention, but distanced themselves from the African-oriented themes. A third group struggled with the intervention because of differences in beliefs about “spirituality” and “religion.” The fourth had no investment in the beliefs or values of the intervention, but complied with instruction. The variance in the staff’s attitudes was reflected in the variance in their application of the NTU approach with fidelity and echoes the observation by Glisson (2002) that successful implementation of innovations depends on the commitment by practitioners to make the innovation successful.

*Summary.* The practitioner as a person is a cultural being with a story. That story is reflected in the choice of profession, location of work, and choice of clientele. The practitioner has attitudes about EBTs, culture, and the work. He or she enters into the helping relationship with the potential for positive or negative countertransference and conscious and unconscious bias. The person behind the practitioner is one of the factors in the effectiveness of the intervention—not only by virtue of what he/she knows, is capable of doing, or believes about the client, but also by who he/she is. The following section will explore another mediating factor relevant to the effectiveness of an intervention, namely, the organizational context in which the practitioner or intervention team works.

### *Organizational context*

The practitioner operates within a context that influences his or her capacity to effectively help the client or family unit. Both cultural competence and evidence-based practice need an infrastructure in place to support the practitioner. Not only is the infrastructure critical, but the right culture and climate of the organization is needed to support positive practice.

*Organizational cultural competence.* Organizational cultural and linguistic competence requires organizations to value diversity, conduct self-assessment, manage the dynamics of difference, clarify their vision, institutionalize cultural knowledge, and adapt policies, procedures, structures, and practices as indicated (Cross et al., 1989; National Center for Cultural Competence, n.d.; D. W. Sue et al., 1998). The goal is an environment in which the policies, structures, and programs of the organization and the attitudes and behaviors of the workforce foster culturally competent practice. The organization should support a knowledgeable, welcoming workforce, skilled in connecting to the cultural aspects of the client’s distress, and capable of addressing practical needs for healing and recovery. Hernandez et al. (2009) describes organizational cultural competence as “the degree of compatibility between cultural and linguistic characteristics of a community and the manner in which the combined policies, structures, and processes underlying local mental health services seek to make these services available,

accessible, and utilized” (p. 1047). An effective infrastructure is made evident through organizational values, principles, commitment, and leadership. Specific components include: communication and language assistance; community engagement; supportive governance; and planning, evaluation, and continuous improvement processes. Human resource policies and practices should establish a diverse, trained, accountable, celebrated workforce. An infrastructure that supports organizational cultural competence includes financial and personnel resource allocation, data collection and analysis, a transparent strategy to address staff and client grievances, culture-specific practices as indicated, and expectation of cultural competence for all contractors (Comas-Diaz, 2012; Delphin-Rittmon, Andres-Hymer, Flanagan, & Davidson, 2012; Fung, Hung-Tat, Srivastava, & Andermann, 2012; Hernandez et al., 2009; National Center for Cultural Competence, 2004; Office of Minority Health, Department of Health and Human Services, 2013).

The structural component must be accompanied by a degree of intentionality at all levels of the organization that reflects: (a) the importance of culture and language; (b) the acknowledgement of the role of oppression, privilege, and power; and (c) the need for continuous learning for the benefit of the workforce and the clients (Applegate, 2009, St. Onge, Applegate, Asakura, Moss, Vergara-Lobo, & Rouson, 2009).

Organizations will vary greatly in the degree to which they embed these elements. A disconnect between an intervention and the client group may not be due to the intervention itself but to problems with the host setting. Since facilitation of engagement is one of the rationales for using a culturally adapted EBT, it is possible that an organization that has done well with organizational cultural competence will be perceived as so welcoming that a nonadapted EBT may be sufficient. Conversely, a culture-specific or culturally adapted intervention may not have traction within an organization that is not welcoming to the client. The practitioner cannot act in isolation from the infrastructure and organizational intent regarding culturally competent practice. Similarly, the practitioner cannot operate in isolation from the organization’s infrastructure to support the implementation of EBTs.

**Organizational readiness for EBTs.** Implementation science examines the processes and structures by which an organization integrates an intervention into ongoing practice. In addition to examining the effectiveness of interventions in practice settings, diffusion or spread of interventions across settings, and dissemination or targeted distribution of materials to promote the adoption of interventions (Schoenwald & Hoagwood, 2001; Silverman, Kurtines, & Hoagwood, 2004), implementation science considers the different types of actions related to embedding the intervention itself in an organizational context. The National Implementation Science Network (Fixsen, Blasé, Naoom, & Duda, 2013; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005) identified several factors influencing the ability of an organization to implement innovation: *organizational drivers*, such as a decision-support data system, a facilitative administration, and a systems intervention model; *leadership drivers*, reflecting skill in both “technical” and “adaptive” leadership; and *competency drivers*, including staff selection, training, and coaching along with consistent

performance assessment for fidelity. The presence or absence of these factors influence the practitioner's ability and investment in participating in a change process. Leadership commitment, strategic planning, leadership directives, policy and regulatory changes, funding support, staff time, fidelity measurement, leadership teams, field mentoring, modeling, and quality supervision are examples of tools and methods required for faithful implementation (Gray et al., 2013; Rapp et al., 2005; Rapp et al., 2008).

*Organizational culture and climate.* Additional organizational forces influence the atmosphere surrounding the helping relationship; these forces include "the structural aspects of the organization, the physical characteristics of the workplace, the political and economic context in which the practice operates, and the network of social relationships and roles that their work setting and professional identity provide" (Koeske & Koeske, 2000, p. 219). These elements reveal the organization's manner of addressing factors such as gender, race, ethnicity, physical ability, sexual orientation, gender expression, and age, as well as their stance related to innovations, EBTs, cultural competence, and other types of change. Organizational culture and climate are both reflected in and influenced by these features.

*Organizational culture* represents the attributes of the organization that give it identity and reflect how the people in the organization are connected to one another. At the cognitive level, organizational culture is the emotionally charged shared values, norms, beliefs, manners of interpreting information, and assumptions about the organization itself and others. This shared view of the organization and the world is reflected in the symbols of the organization, as in its artifacts, rituals, and stories (Beyer, Hannah, & Milton, 2000; Kopelman, Brief, & Guzzo, 1990; Schein, 1992). The stories, myths, and awards; the way people dress; and how people interact with one another all tell a story about what the organization values.

The organizational culture reveals formal and informal messages about its stance on evidence-based practice and/or cultural competence in overt actions (and inactions) and in its methods. Although the socialization process within the organization directs individual practitioners towards conformity, each person must make individual interpretations of the messages about these factors and make decisions as to how he or she will act within that particular cultural environment.

*Organizational climate* is the workforce's perceptions of the psychological environment of the workplace as a collective representation of individual perceptions. It connotes the work environment's impact on sense of well-being or psychological safety (Glisson, 2000; Kopelman, Brief & Guzzo, 1990). In positive climates, the work environment contributes to the worker's positive self-image and offers the types of rewards that make investment of personal energy in the organization worthwhile. Kopelman and colleagues (1990) suggests human resource management aspects that influence climate, such as clarity of job expectations, clarity of processes to accomplish expected tasks, sufficiency of supports needed to be successful, associated rewards related to successful completion of tasks, and assurance of protection of the welfare of the workforce.

Organizational culture and climate together set an atmosphere that influences performance (Sackman, 2011). Culture and climate can influence the worker's attachment or loyalty to the organization (Beyer et al., 2000), which influences quality of performance, level of productivity, and willingness to take on actions beyond those required. Glisson (2000) has documented that this dynamic influences staff performance in social service agencies.

Organizational culture and climate are of vital importance as critical factors in the implementation of innovations such as EBTs and cultural competence. Hemmelgarn, Glisson, and James (2006) note that "organizational culture and climate provide a social context that invites or inhibits the activities required for success and sustains or alters adherence to the protocols that compose the organization's core technology" (p. 77). Mental health interventions are considered "soft technologies" (Glisson, 2002), because they are subject to disagreements on the best way to implement services and achieve variable outcomes. This is in contrast to "hard technologies," which use rigid descriptors and measures. EBTs have a goal of constraining variability in practice in the direction of "hard technologies." Even so, a nonsupportive organizational climate and culture can create the type of pressure that causes incremental distortions of the innovation such that it loses its innovative qualities. Thus, a more positive organizational culture can promote positive provider attitudes toward innovation (Aarons & Sawitsky, 2006). The organizational climate and culture represent critical factors that influence the practitioner's ability to implement EBTs and/or culturally competent practices.

## Summary recommendations

The discourse related to evidence-based practice and cultural competence must not be confined to either silo but rather must recognize both as contributing factors to a complex helping transaction. The following suggestions would build on this perspective.

*Revisit the clinical relationship.* The behavioral health field seems to have allowed the attention to the science of treatment to overwhelm attention to the art of treatment. Some in the field seem to have ignored the scientific analysis that points to the importance of relationship in the therapeutic encounter, and the research on relationship needs to continue. The field will benefit from enhanced attention to the therapeutic relationship and working alliance. Agreement on goals and the tasks needed to achieve those goals and the development of an interpersonal bond constitute core elements for successful relationships (Bordin, 1979; Norcross, 2002). The role of culture is inextricable from the task of relationship-building. Further, effective implementation of evidence-based practices depends on quality relationships.

*Invest in practitioners beyond cultural awareness.* Practitioners need education and support to allow them to become the best instruments they can be to support

change that addresses the client's distress. As such, they must be permitted and encouraged to understand themselves as cultural beings—not only to discover how they are different from their clients and to understand their own biases and stereotypes, but to discover the manner in which their cultural being may contribute to the helping relationship.

*Consider cultural adaptations of EBTs as only one aspect of cultural competence.* Cultural and linguistic competence operates at multiple levels. When the entire infrastructure of the organization is engaged in working with the implications of culture in its functioning, the organizational culture and climate may become welcoming, engaging, and knowledgeable. Cultural adaptations of EBTs cannot correct the problems inherent in an organization or system that is not culturally competent. Conversely, one would expect a culturally competent organization to make good decisions in collaboration with the service population regarding the interventions that might be most useful to that population (Samuels, Schudrich, & Altschul, 2009).

*Expand research to include multiple methods and populations.* The behavioral health field cannot afford to limit its knowledge about what helps to one type of research. The knowledge that comes from anthropology and sociology can further an understanding of the healing elements that emerge from a wide range of cultures with their attendant views of knowledge, health, and healing. Indeed, the Western orientation to science must include *culture* as a key variable in order to represent accurate knowledge development. Concurrently, the field must acknowledge that the conceptualization of *science* is cultural and therefore knowledge can be obtained in multiple ways. The National Network to Eliminate Disparities has offered a platform to share and teach culture-specific interventions and interventions grounded in practice-based evidence ([www.nned.net](http://www.nned.net)).

## Closing comment

What is required to facilitate the resolution of the physical signs and symptoms, the emotional distress and problems in interpersonal relationships and role function, and the existential angst afflicting a given individual and his or her family? The answer is embodied in a mixture of interventions implemented by helpers connected to organizations, engaged in relationships with the person(s) in distress, and influenced by a social and family network within the context of societal forces that facilitate both healing and exacerbation of the problem. Research must continue to examine the multiple forces that create meaningful change, including the personal identity of the practitioner and the organizational context in which the work takes place.

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## Note

1. The word “client” will be used throughout this article to denote the “consumer,” “patient,” “person,” “youth,” or “family unit” seeking assistance to address emotional distress.

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