


Making the Invisible Visible: Identifying and Articulating Culture in Practice-Based Evidence

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Highlights

- Identifies the operative worldview and culturally grounded theoretical framework in practice based evidence services (PBEs).
- Strengthens links among cultural beliefs and values, community needs, and intervention design.
- Guides evaluation methods to be conceptually consistent, community defined, and culturally centered.
- Invites communities to use their own indigenous epistemological frameworks to establish credible evidence.

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Abstract This study describes a conceptual tool, labeled the “culture cube,” developed to identify and articulate the cultural underpinnings of prevention and early intervention projects in five priority populations (i.e., African American, Asian Pacific Islander, Latino, Native American, and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning), participating in the California Reducing Disparities Project Phase 2 (CRDP Phase 2). The culture cube was developed for evaluation of these *practice-based evidence services* (PBEs) for three purposes: (a) to focus attention on revealing and articulating more fully the operative worldview and culturally grounded frameworks underlying PBEs, explicitly identifying the links between cultural beliefs and values, community needs, and intervention design; (b) to guide the methods used to assess and evaluate PBEs so that the outcome indicators and process measures are conceptually consistent, community defined, and culturally centered; and (c) to invite communities to use their own indigenous epistemological frameworks to establish credible evidence. After reviewing the literature in this area and describing the theoretical framework for the

culture cube, we describe its development, application, and the response to its use in the initial stages of the California Reducing Disparities Project-Phase 2.

Keywords California Reducing Disparities Project · Cultural competence · Mental health disparities · Practice-based evidence · Community-defined evidence

Introduction

Ncig Teb Chaws is a way for Hmong people to become familiar with the environment and its natural resources. In the traditional days, when Hmong families moved from one village to another village, they would need to know the surrounding hills, mountains, and valleys. So, they would go out and explore each of these and see what kinds of resources are out there that could support the family. This was very important because their decision to stay or move to another village depended on whether they can farm, find foods, shelter, and water.

In America, in whatever city a Hmong family may live in, due to barriers they have little way of going out to explore and become familiar with their environment and finding out what resources are out there that can help them. After arriving to America many Hmong adults and elder felt more lost than when they were back in the jungles of Laos. In talking with an elder he summarized best by saying, “In Laos we have feet that can trek through the jungles, mountains and valleys, but in America our feet cannot take us beyond our front and backyard.” As a

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result, the majority of the Hmong elders complained that they feel isolated and disconnected from their environment. Therefore, the goal of this [activity]. . . is to address acculturation issues by introducing participants to their environment. They will learn and become familiar with different kinds of services, resources, culture, and people. The [activity]. . . will include language interpretation, where it is necessary, to allow participants to simultaneously engage in dialogue.

Ncig Teb Chaws is a 3–4 hours cross-cultural learning of the people and environment around where the participants live. The activities under this [activity]. . . will require traveling to various locations and/or places and facilitated by a team of counselors and an interpreter, if needed.

Participants in 1–2 groups of 15–20 people will be transported from one location to another location based on the theme for the month.

From *The Fresno Center* evaluation plan for the *California Reducing Disparities Initiative (CRDP)*

Is *Ncig Teb Chaws* recognizable as a mental health intervention? Western mental health treatment typically consists of discrete psychotherapy sessions that take place in a therapist's office, emphasizing verbal interactions in the context of a supportive professional, relationship. From this perspective, psychotherapy is culturally situated, reflecting western values and social norms emerging from its European historical and cultural origins (Bernal & Domenech-Rodríguez, 2012; Bernal & Scharrón-del-Río, 2001; Cushman, 1996). Rather, this walking intervention (or more accurately, the community-based prevention program of which it was one of five elements) may be viewed as an example of *practice-based evidence services (PBEs)*. According to Isaacs, Huang, Hernandez, & Echo-Hawk, 2005, PBEs represent:

. . . a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice-based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individual and families from a culturally specific framework. Practitioners of practice-based evidence models draw upon cultural knowledge and traditions for treatment and are respectfully responsive to the local definitions of wellness and dysfunction.

(p. 16).

The PBE approach underscores how services delivered in a community setting must ultimately be viewed as

culturally appropriate, relevant, as well as effective by members of that community (Lyon, Pullmann, Walker, & D'Angelo, 2015). But how, precisely, is "effectiveness" understood in this context? That is, what is the nature of the evidence used to support PBE claims of effectiveness? Because their starting point are the "cultural knowledge and traditions for treatment" of a particular community, PBEs are not limited to western conceptions about psychological functioning and their resulting forms of mental health treatment or interventions. At the same time, differences in worldviews between such "culture-driven services" versus the "science-driven evaluation" approaches represented by *evidence-based practices (EBPs)* include basic tensions about what is considered as credible "evidence" (p 270, Echo-Hawk, 2011; Lucero, 2011).

The purpose of this study is to describe the use of a conceptual tool (labeled the culture cube) which was developed to identify and articulate the cultural underpinnings of the PBE approaches within Phase 2 of the California Reducing Disparities Project (CRDP Phase 2), a statewide mental health prevention/early intervention initiative in California. Within the context of CRDP Phase 2, the culture cube was used with PBEs for evaluation purposes: (a) to focus attention on revealing and articulating more fully the operative worldview and culturally grounded theoretical framework of the PBEs, explicitly identifying the links among cultural beliefs and values, community needs, and intervention design; (b) to guide the methods used to assess and evaluate PBEs so that the outcome indicators and process measures are conceptually consistent, community defined, and culturally centered; and (c) to invite communities to use their own indigenous epistemological frameworks to establish credible evidence.

After a brief overview of relevant literature, we describe the theoretical framework for the culture cube and provide examples of its application. Next, we briefly describe its development and use in the initial months of the CRDP Phase 2, which was designed to demonstrate the effectiveness of PBEs in five priority populations representing African American (AA), Native American (NA), Asian Pacific Islander (API), Latino, and Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQ) communities. Finally, we consider the lessons learned and implications for use of the culture cube to advance our understanding of the cultural underpinnings of practice-based evidence services.

Practice-based evidence and evidence-based practices

As defined by the American Psychological Association (2006), evidence-based practice in psychology represents ". . . the integration of the best available research with clinical

expertise in the context of patient characteristics, culture, and preferences.” Although the development of EBPs has been called a “remarkable advance” (Kazdin, 2011), the reliance on EBPs has raised concerns about their relevance or effectiveness with culturally diverse clients, especially with the inadequate representation of diverse ethnocultural groups in the samples used to establish EBP status (Aisenberg, 2008; Hall, 2001; Sue, Zane, Hall, & Berger, 2009). Other concerns, however, include the privileging of internal validity over external or ecological validity in the use of randomized control trials as the “gold standard” of research (Bernal & Saez-Santiago, 2006), as well as the overly narrow definition of evidence used to establish EBPs (Martinez, Callejas, & Hernandez, 2010; Nebelkopf et al., 2011; Yeganeh, Su, & Chrysostome, 2004).

Ideally, the relationship between practice-based evidence (PBEs) and evidence-based practice (EBPs) would be complementary, closing the gap between treatments that have demonstrated effectiveness but which are not necessarily viewed as culturally relevant or appropriate, and treatments that are viewed as culturally relevant and effective, but not necessarily grounded in evidence based in logical empiricism (Hwang, 2012). Clearly, some form of reconciliation of the PBE and EBP paradigms is essential if we are to address the service needs of diverse ethnocultural groups in a way that is supported by our institutions and systems. In practice, however, this is a formidable challenge given the fundamental tension between the two paradigms, especially when western empiricism is uncritically accepted as the dominant paradigm over indigenous epistemologies.

A major approach that has emerged to address this tension has been to adapt EBPs to the needs of culturally diverse groups (Bernal, Bonilla, & Bellido, 1995; Domenech Rodriguez, & Wieling, 2004; Hwang, 2006, 2009, 2012; Lau, 2006). The Ecological Validity Model (EVM; Bernal et al., 1995), for instance, identifies eight dimensions (e.g., language, persons, metaphors, content, concepts, goals, methods, and context) that can guide the development of culturally sensitive treatment and/or adapt EBTs for different ethnocultural groups. Although the EVM can be used either as a top-down (e.g., more EBP-based) or bottom-up (e.g., more PBE-based) practice, the most widely used approaches tend to begin with the top-down premise that the assumptions underlying evidence-based treatments are universally applicable even as they require some modifications for appropriate use or “cultural centering” in different ethnocultural groups (Bernal & Saez-Santiago, 2006). For instance, Lau (2006) shows how a systematic process for carefully selecting and adapting EBTs for parent training programs can be highly successful. Yet the fact that EBTs and their adaptations do not challenge the fundamental cultural assumptions underlying the provision of mental health services or the western-based

conceptualization of human behavior and well-being has also been a source of critique (Chakkarath, 2012; Lucero, 2011; Cheung, 2000).

In contrast, PBEs represent a bottom-up approach that can address differences in culturally based perspectives of causality, worldviews and values, perceptions of personhood, well-being, distress, and illness experiences that may affect perceptions and definitions of what is considered appropriate treatment (Hwang, 2009, 2012). For instance, an understanding of human behavior among people of African ancestry is anchored in concepts such as the spiritual essence of human beingness; the veneration of the ancestors; and the centrality and dynamic interdependence of community, nature, and spirit (Grills, 2004). Along with values of fairness, social justice, caring, compassion, and communal responsibility and the lingering effects of historical and cultural trauma resulting from generations of enslavement, colonialism, segregation, and racism, these concepts shape the community’s understanding of what it means to be human which, in turn, influence perceptions of what contributes to dis-ease and dysfunction, as well as what promotes and maintains harmonious, functional communities. In other words, they provide the foundation for an African psychology.

Note that a PBE emerging from a community rooted in this Afrocentric worldview may or may not look like a culturally adapted EBT that has been modified for use among African Americans and, further, may or may not use the same research methods or evidence to demonstrate the potential effectiveness of their services. The overlap would depend on the extent to which each of their conceptualizations of the problem, appropriate intervention, and perception of desirable outcomes are aligned with a Western perspective or an Afrocentric worldview. Table 1 summarizes this continuum of approaches and the key questions that are raised by their use in ethnocultural groups (see also Lau, Chang, Okazaki, & Bernal, 2016).

In addition, while the cultural grounding of PBEs is widely recognized, this approach raises an altogether different set of challenges. Bernal, Jiménez-Chafey, and Domenech-Rodríguez (2009) observe that “the more problematic and less often asked questions are ‘How do we know when culture has been considered in a treatment protocol?’ and ‘what does that look like?’” (p 362). Indeed, describing the way that a mental health intervention is culturally embedded may be challenging, especially specifying precisely *how* culture is viewed and *how* it informs the proposed mechanisms of change for mental health interventions. For instance, as part of a statewide inventory of “community sourced” practices or *community-defined evidence practices* (CDEPs), Lyon et al. (2015) examined applications from 65 CDEPs that were submitted in response to a call for programs with culturally specific elements. To be coded “culturally specific,” a CDEP had to state its intentionality to be

Table 1 Continuum of types of interventions from EBP to PBE related to culture

Category	Continuum/types of validity	Sample labels	Key questions (see also Lau et al., 2016)	Selected references
Evidence-Based Practices (EBPs)	Top-Down High internal validity; unknown or variable ecological validity	Evidence-Based Treatments (EBTs) or Empirically Supported Treatments (ESTs)	How generalizable are EBPs? Do EBTs work with ethnocultural groups? Do EBTs work as well with ethnocultural groups as they do with Whites? What are mechanisms of action in EBTs with ethnocultural groups?	Lau et al. (2016) and Huey and Polo (2008)
Culturally Adapted Treatments (CATs)	Top Down or integrated with Bottom-up/Mixed internal validity; higher ecological validity	Culturally Adapted EBTs (or A-EBTs) Culturally Centered Psychosocial Interventions	Do A-EBTs work for ethnocultural groups? Do A-EBTs work better than EBTs for ethnocultural groups?	Bernal et al. (1995, 2009), Bernal and Saez-Santiago (2006), Lau (2006), Hwang (2006, 2009, 2012), Cardemil (2010), Nagayama Hall, Ibaraki, Huang, Marti, and Stice (2016)
Practice-Based Evidence (PBE)	Bottom-up/unknown or variable internal validity, high ecological validity	Culturally Sensitive Treatments (CSTs) Community-Defined Evidence (CDE) and Community-Defined Evidence Practices (CDEPs)	Do CSTs work for ethnocultural groups? What are the mechanisms of action in CSTs? How well do CSTs work compared with EBTs for ethnocultural groups? Who is the community? How are mental health and illness defined by the community? What constitutes desirable outcomes for the community? How are interventions designed by the community to address these issues? How is culture manifested in these interventions? What research methods and measures are most appropriate for establishing empirical support for these practices?	Hall (2001), Lau et al. (2016), Bernal et al. (2009) Tuihawai Smith (1999), Lucero (2011), Martinez et al. (2010)

responsive in a specific way to the needs of a particular client population, which was then categorized into one of five areas: structural elements, program content, program delivery, provider behavior, and cultural match. Despite the specific nature of this prompt, fully 60% of the applications made either no mention (24.6%) or very brief mention (35.4%) of their program's cultural elements. Thus, the lack of specific information about key cultural elements, even among programs that represent bottom-up, community-defined practices, points to the critical need for strategies and tools that can help better identify the cultural underpinnings of such programs.

The Culture Cube: A Tool to Identify and Articulate Culture

Carpenter-Song, Longhofer, and Schwallie (2007) observe that culture emerges out of interpersonal realities and reflects a dynamic relational process of shared meanings

that must be considered in historical, social, political, and economic contexts (Garneau & Pepin, 2015; Gregory, Skiba, & Noguera, 2010). The real-life contexts in and through which these shared mental schemas or “cultural models” are expressed are captured through the notion of *activity settings* (Gallimore & Goldenberg, 2001; Gallimore, Goldenberg, & Weisner, 1993). Activity settings represent the everyday activities in which people come together, over time, to accomplish something (Sarason, 1972), such as dinner routines, getting ready for school, or learning a complex skill. Consequently, these settings represent the visible architecture of daily life through which the less visible cultural models for living are expressed and manifested. By their nature, these cultural models are largely nonexplicit, that is, with assumptions and beliefs that are so deeply ingrained that they are often not seen or easily recognized. With respect to how culture impacts illness and treatment issues in particular, Kleinman's concept of *explanatory models of illness* lifts up

and identifies these cultural assumptions (Kleinman, 1981, 1988; Weiss, 1997). To develop this framework, Kleinman (1978) identified and differentiated between the perceptions of patients, healers, and others coming from different cultural perspectives and institutional roles regarding the meaning of illness through the use of key questions.

Elements of the Culture Cube: The 3 Ps and 3 Cs

Adapting concepts drawn from both the *activity settings* and *explanatory* frameworks, the culture cube was developed as a conceptual tool to help identify visible and invisible dimensions of culture intrinsic to many PBEs. The visible dimensions are those that may be easily observed and assessed by any outsider whether or not they understood the program's cultural context, while the invisible aspects are those which require further interpretation by an insider to fully see and understand them.

For the visible dimensions, a CDEP as a *cultural setting* has three elements that are viewed as indivisible: *Project, Place, and Persons*. In *Ncig Teb Chaws*, for instance, a group of people are taken from location to location in the company of a counselor and bilingual staff in order to become familiar with the local environment, people, and services in their area (Project). The participants are Hmong elders and the Hmong bilingual/bicultural mental health staff who accompany them (Persons) and who engage them in conversation. The activity takes place in dynamic movement through their community so that participating in the activity is highly accessible and ambulatory (Place). The holistic emphasis on the "implementation contexts" of mental health prevention inherent in these "visible" sides of the culture cube also helps to describe a program in its totality, as an "inherently local, unique, and immovable commodity" (Bauman, Stein, & Ireys, 1991; Miller & Shinn, 2005). For some communities especially many Native-American communities, *place* holds significance beyond simply serving as the geographic and physical context of interventions (Walters, Beltran, Huh, & Evans-Campbell, 2011). In these communities, interventions cannot happen just anywhere, but are inextricably linked to the specific places, as well as people, ceremonies, and rituals, that are associated with these places and which give meaning to the interventions. The culture cube reinforces the fact that the activity or project cannot simply be "manualized" as a treatment intervention removed from, and without consideration of, the equally critical ecological factors of persons and place. Miller and Shinn (2005) argue that it is not the point to transplant entire programs in their original forms to new contexts, but to identify the critical elements, or "powerful ideas" upon which specific content and processes are built.

But what exactly is the significance of this activity, performed in this way? The three sides of the metaphorical cube that are NOT visible represent the cultural undergirding of the PBE. To assess these invisible dimensions, Kleinman's questions were initially labeled in terms of *Conceptualization [of the problem]; Causes, and Consequences*. However, after community feedback (to be described later), these dimensions were revised and relabeled *Culture, Causes, and Changes*.

For the first dimension, *Culture*, the cultural significance and meaning of the observable elements of the PBE—that is, *project, place, and persons*—are identified and articulated. For instance, in *Ncig Teb Chaws*, the 3–4 hours field trip is reminiscent and consistent with a long tradition of movement from place to place in their home country, and the intimate knowledge of one's environment and resources that came through this movement. In its new form in the United States, acculturating Hmong elders have the chance to interact with each other and staff members to ask questions, learn about their new environment, and to share stories and concerns in a context that is nonstigmatizing, culturally consonant, to gently encourage a greater sense of belonging and place.

The second dimension, *Causes*, asks how the community identifies the root causes of the issues that the PBE is designed to address. In *Ncig Teb Chaws*, the trauma associated with being a refugee in the United States—the bitter experience of war and violence in the highlands of Laos, and the resulting sense of loss of culture, dislocation from home, as well as the stress associated with acculturation, isolation, and intergenerational disconnection—is viewed as part of the root causes of the mental health symptoms manifested as depression, anxiety, and suicidality, for example.

The third dimension, *Changes*, examines the changes and outcomes that result from the PBE—both increased positive changes as well as decreased negative outcomes—that are desired by the community, given their cultural values. In *Ncig Teb Chaws*, increases in subjective happiness, as well as community connectedness, and sense of belonging are valued as well as decreases in depression. Not all of these outcomes would represent typical outcomes of interest or be equally valued by other stakeholders, but within the Hmong cultural framework are considered essential to mental health and well-being. Furthermore, these community-defined outcomes are critical for shaping how the research design and evaluation questions are framed within a PBE's cultural framework. Because cultural and contextual influences are elicited through an assessment of the "hidden" dimensions of PBE activities, the use of the culture cube also requires community-based participatory methods in its application. Figure 1 provides an illustration of the culture cube with both its visible (3Ps) and invisible (3Cs) dimensions.

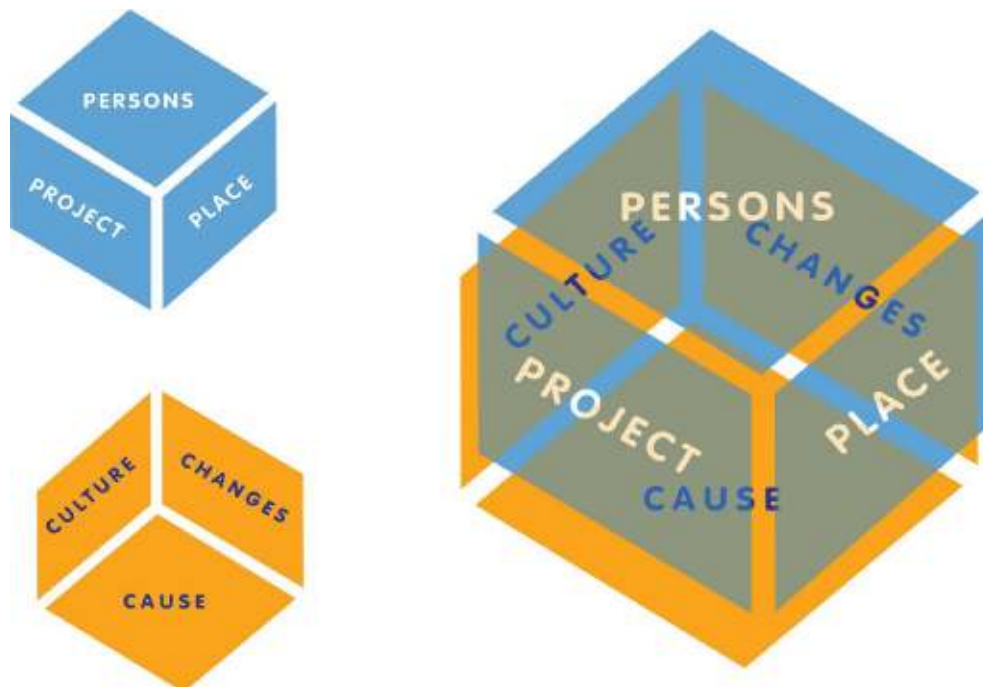


Fig. 1 The culture cube.

In sum, the culture cube is a heuristic device that serves as a bridge between EBP demands for empirical support and PBE demands for recognizing approaches to treatment based in different cultural worldviews. In identifying cultural elements in a community-defined project, the culture cube's invisible and visible dimensions can guide the development of subsequent research and evaluation approaches. For instance, while the visible dimensions of a project (3Ps) provide the basic descriptive frame—its activities, personnel, and geographic, physical, and social contexts—that form the basis of a project's "thick" description, the invisible dimensions (3Cs) reveal the indigenous epistemological worldviews that shape *how* problems are viewed (informing subsequent evaluation questions) and *what* changes (e.g., outcomes) are desired by the community.

How can this help the work of PBEs? For existing PBEs, working with the elements of the 3Ps represents a good starting point to identify and articulate the corresponding cultural framework or 3Cs. In such an instance, explicitly identifying and articulating the values and assumptions of the 3Cs can help clarify and refine the PBE's evaluation questions and point to process and outcome variables that could be measured to address these cultural mechanisms of change. Conversely, for organizations wanting to develop PBEs where none existed previously, the 3Cs serve as the starting point. In this case, identifying the perceived problems, underlying causes, and changes desired by a community can then help create particular 3P elements that would represent a new PBE.

These cultural considerations, based on Kleinman's seminal work on explanatory models of illness, drive the concepts, methods, measures, and processes that are used to evaluate relationships between intervention design and effects upon the community. Whereas there are many top-down frameworks, there are very few bottom-up frameworks that begin with the community's point of view, not the view of academic researchers (Hall, 2001). The culture cube is a bottom-up model because none of the intervention elements are prespecified and no assumptions are made about underlying worldviews guiding the intervention design. These elements depend completely on the community's perspective and definitions. Finally, while Bernal et al.'s (1995) Ecological Validity Model can be used to describe and even develop PBEs, its eight dimensions are not oriented toward the development of research and evaluation questions in the same way as the culture cube. In contrast, the cube can help existing PBEs articulate and evaluate what is already present in the intervention—making the invisible visible.

Application of the Culture Cube in the California Reducing Disparities Project

Funded through the passage of Proposition 63, the Mental Health Services Act, in 2004, the California Department of Public Health (CDPH) launched the California Reducing Disparities Project in 2009–2016 in response to a call for national action to reduce mental health disparities.

With the establishment of five strategic planning workgroups, Phase 1 identified issues and recommendations for five historically underserved populations which were subsequently published as priority population reports. CRDP Phase 2 (2016–2022) was designed to strengthen and build upon the recommendations and strategies developed through CRDP Phase 1. Toward this end, the Office of Health Equity within CDPH funded 35 community-based nonprofit organizations (seven organizations per priority population) to demonstrate, through rigorous evaluation based on community-based participatory research processes, the effectiveness of their PBEs (labeled *community-defined evidence practices* [CDEPs] within the Initiative) in reducing mental health disparities for their priority populations (identified as underserved, unserved, and/or poorly served), as well as increasing access to mental health care.

The CRDP Phase 2 evaluation occurs at two levels: the statewide, or cross-site evaluation and project-specific, local evaluations. Participating organizations had latitude in the development and implementation of both their CDEP and locally driven evaluation, with the expectation that their work would be culturally grounded and community driven, reflecting the guidance offered in the Phase 1 priority population reports. The initial version of the culture cube was designed to help already-funded organizations strengthen their description of the cultural rationale and framework for their CDEP, a description which represented the foundation of their local evaluation plans. In addition, the statewide evaluation team later reviewed the local evaluation plans to identify domains that were common, relevant, and important across communities to develop common cross-site measures. The focus of this study, however, is on the use of the culture cube with organizations to refine CDEPs and strengthen local evaluation plans.

As part of the CRDP opening convening conference in March 2017, representatives from the 35 organizations participated in a workshop introducing the culture cube. In the process of applying the culture cube to two newly funded CDEPs as an example of its use, the group also provided the evaluation team with two ways to improve its use. First, participants found it difficult to distinguish between the original culture cube elements of “conceptualization [of the problem]” and its “[root] causes.” Cultural issues were woven into both cube elements making the distinction difficult to follow. Consequently, the two dimensions were revised. The first dimension was relabeled “culture” to describe *all* the ways in which the CDEP reflected features of the population’s culture, and the second dimension, “causes” was maintained, but revised to reflect all the ways that community members saw both the problem and their causes, as they were often

used interchangeably (for instance, historical trauma could be viewed as both a root cause of depression, for instance, as well as a problem on its own). In addition, the term “consequences” conveyed a punitive connotation (for instance, a “time-out” as a negative consequence of actions), so was replaced with the more neutral term “changes” to underscore both the positive outcomes that community members wanted to increase and the negative outcomes they wanted to decrease, resulting from their CDEPs. This was a particularly salient point for Native-American organizations that preferred an emphasis on protective factor outcomes and less of a focus on problems and deficits that have historically been used to stereotype and denigrate their communities—an important point that was relevant to all the priority populations.

Following the opening convening, programs had about one and a half months to submit a draft of their evaluation plan to OHE. In a 3-month period in 2017, population-specific webinars (about 1.5 hours in length) were scheduled and completed with four of the five priority populations with a fifth webinar held several months later for the final priority population. These culture cube-focused webinars provided (a) an in-depth explanation of the culture cube, (b) program-specific examples of its application, and (c) an opportunity for live exchange of questions, answers, and comments. All webinars were conducted by the statewide evaluation team, and included representatives from OHE, technical assistance providers, program staff, and local evaluators.

Although cube webinar participation was optional, 91% of the funded organizations participated (Asian Pacific Islander [API] = 7 organizations [100%], African American = 6 organizations [86%], LGBTQ = 7 organizations [100%], Latino = 5 organizations [71%], and Native American = 7 organizations [100%]). Organizations were asked to specify how culture was manifested in their CDEPs as part of a broader process for refining their evaluation plans, although they were not obligated or required to use the culture cube training to do so. They were also given considerable latitude to refine their intervention design and evaluation plan during this process, if they so chose.

After the initial evaluation plan drafts were submitted at the end of May, the statewide evaluation team worked with expert reviewers from five population-specific research centers or psychology associations (i.e., Asian American Psychological Association, Association of Black Psychologists, National Latino Psychological Association, the Indigenous Wellness Research Institute, University of Washington, and members of Division 44 of American Psychological Association), as well as in-house reviewers who focused on different aspects of the evaluation plans, including methodology, statistics, attention to culture and context, and overall evaluation design. Each local

Table 2 (a) Application of the Culture Cube in the CA Black Women’s Health Project. (b) Application of the Culture Cube in the United American Indian Involvement, Inc. (UAI, Inc)

(a)	CA Black Women’s Health Project
Cube elements	
<i>The Observable</i>	
<i>Project:</i> What is the activity or the community-defined practice (s)/intervention(s)?	<p>Mentally Mobilized (SMM) project has two main components that blend advocacy training and support/engagement:</p> <ol style="list-style-type: none"> (1) The Advocate Training Program (ATP) provides training in (a) advocacy methods, with a particular focus on mental health inequities, (b) strategies to achieve personal and family wellness, and (c) completion of a group advocacy project where they apply skills learned about how to influence change in services, community, and policy. (2) The formation of “Sister Circles”. The circles create a safe space for Black women to share stories, experiences, and feelings affecting their mental well-being and identify strategies for coping, managing, and thriving. They also serve as a platform for participants to raise, discuss, and respond to issues and stressors impacting mental health and wellness in their community and that address mental health issues in any of four areas: (1) identification of risk factors and symptoms, (2) stigma awareness and reduction, (3) prevention of early onset and deterioration, and (4) increased awareness, solicitation, and access to care.
<i>Persons:</i> Who will be involved in delivering and participating in the CDEP and what are they doing?	<p>The overall approach is grounded in the understanding that healing could not be answered by asking, “What is wrong with me?”. Rather, Black women’s healing has to come from activism that asks and answers, “What is wrong with this system?”</p> <p>Black women (Black; African American; multiracial; African; Caribbean; Afro-Latina) from the four regions between the ages of 19–80+ years of age will be SMM participants. The lead organizers or facilitators mirror the race/ethnicity of Black women and possess a deep cultural awareness, understanding, and respect for the lived experiences of Black women across diverse class, socioeconomic, educational, professional, and faith backgrounds.</p>
<i>Place:</i> Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?	<p>SMM will be implemented in the four metropolitan and urban regions where concentrations of Black women and girls reside: Los Angeles County, Inland Empire/San Bernardino and Riverside Counties, Alameda County, and Sacramento County. Black communities in these regions face similar conditions that negatively impact quality of life and health such as disparities in education, disproportionate numbers of low-income women/families, chronic homelessness, and excess exposure to violence, trauma, and other psychosocial stressors. Actual meeting locations include community locations where Black women live, work, worship, or play; and are safe, clean, and public transportation accessible (e.g., community rooms, local recreational centers, libraries, religious and spiritual institutions, college campus, community-based organizations, or possibly even the homes of sister-circle members). The spaces will have culturally responsive elements such as background music (jazz, soul, R&B, gospel, etc.), Afrocentric artifacts (e.g., fabrics, figurines, artwork, books, magazines), ambient lighting, seating arrangements that foster comfort, connection and collaboration, and refreshments to nourish the body and soul (including potlucks).</p>
<i>The Invisible</i>	
<i>Culture:</i> How does our CDEP project reflect the cultural values, practices, and beliefs of our community?	<p>Grounded in cultural traditions that specifically embrace the unique history, experience, needs, and “flavor” of Black women, SMM’s strategy builds on essential cultural habits of Black women such as their faith-based, sorority, hair salon, social outlets, sister-circle connections, and other communal connections. Cultural principles and philosophies such as: Ubuntu (South African concept regarding the centrality of relational and communal rather individual orientation, acting from one’s humanity, sense of responsibility for others, and recognition that well-being is tied to being in community with one another), the Nguzo Saba (African-America Kwanzaa principles), Ghanaian Adinkra symbols, proverbs, and themes (serving as behavioral and ethical guides), the oral tradition (storytelling, poetry, song, humor), and other cultural values such as respect for elders, African-American historical tradition of civic engagement responsibility, promoting/fighting for fairness and justice, sisterhood, and Black women’s legacy of activism domestically and abroad (e.g., Ella Baker, Fannie Lou Hamer, Ida B. Wells, Audre Lorde, Maya Angelou, Hope Chigudu, Patrice Cullors, Chimamanda Ngozi Adichie, etc.), faith and spirituality, and a deeply rooted oral tradition that promotes reciprocal sharing. Together, these cultural elements increase Black women’s sense of empowerment and resiliency and reflects a multidimensional understanding of wellness and healing that includes heart care, mind care, and soul care where Black women can “tend and befriend” in safe spaces to talk, deal, and heal.</p>

Table 2 Continued

(a)	CA Black Women's Health Project
Cube elements	
<p><i>Causes:</i> What are the problems the project is trying to address? How did it start and why? How are causes understood in (a) a historical context, (b) through the lens of the community's values, and (c) things that concern or bother the community.</p> <p><i>Changes:</i> From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of and less of</p>	<p>Black women bear an inordinate mental health burden rooted in racism, gender bias, classism, the struggle to retain cultural traditions. African-American communities live with a multiplicity of circumstances that put Black women at high risk for mental and emotional stress—economic and housing insecurity, responsibilities of care giving, neighborhood violence, interpersonal violence, lack of social support, physical illness or disability, dramatic interactions with law enforcement, potential incarceration of themselves or loved ones, and high vulnerability to cycles of repeated abuse. Within this context, many Black women are beset by tension, anxiety, worry, and fear.</p> <p>Failure to address predisposing risk factors and adverse societal conditions intensifies pervasive mental health crises among Black women and families leading to deteriorating mental health and overexposure to conditions that further compromise their well-being including: intergenerational trauma, internalized oppression, and self-hate, self-inflicted anger, aggression, and familial intergenerational transmission of pain.</p> <p>Finally, systemically, mental health resources in the Black community are limited, inconsistent, and overtaxed and there is a severe shortage of (a) culturally competent licensed clinical practitioners and programs to support the “good mental health” of Black women; (b) mental health trained community advocates; (c) “good mental health care” based on cultural and spiritual beliefs; and (d) safe, caring, culturally responsive places to go for help (“safe spaces”).</p> <p>Increased awareness of mental health and increased utilization of mental health services</p> <p>Decreased mental health stigma and decreased anxiety and decreased isolation</p> <p>Increased empowerment and <i>ubuntu</i> (Black women act, lead, teach, and advocate for themselves, their families, and their communities strengthening their own resilience, well-being, and mental health—also referred to as increased civic engagement/social activism that contribute to a decrease in local barriers related to deficient culturally competent mental health resources in the Black community).</p>
<hr/>	
(b)	United American Indian Involvement, Inc.
<hr/>	
<p><i>The Observable</i></p> <p><i>Project:</i> What is the activity or the community-defined practice(s)/ intervention(s)?</p> <p><i>Persons:</i> Who will be involved in delivering and participating in our CDEP and what are they doing?</p> <p><i>Place:</i> Where does our CDEP take place in terms of the organizational and/or community setting and geographic location and why is this important?</p>	<p>The Native American Drum, Dance, and Regalia program (NADDAR) is a direct prevention program that promotes health and wellness through culturally based workshops that include:</p> <ol style="list-style-type: none"> 1. Drumming (historical customs) 2. Dancing (instructional classes on how various dance styles are performed) 3. Arena tradition (pow wow arena etiquette) 4. Regalia design (design and creation of regalia worn at events) <p>Careful attention is given to explaining to participants the underlying cultural meaning and ritual significance of what is taught as a way to deepen participant's understanding of the cultural traditions, how they inform and guide both community practice and individual growth, development, and behavior.</p> <p>Project staff includes AI/AN two executive staff members who are experienced in culturally based mental health and substance abuse research and treatment; an AI/AN Culture Coordinator responsible for program planning; and community subcontractors including five AI/AN dance instructors, four AI/AN drum/song instructors, and AI/AN regalia making instructors. All instructors are recognized, respected, and from within the community.</p> <p>Program participants include AI/AN children ages 3–17 and adults ages 18–59 in Los Angeles County.</p> <p>The program is located in Los Angeles County, one of the largest urban AI/AN populations in the country. Despite these high numbers, AI/AN community members only make up .6% of the population, which makes it difficult for the AIAN population to find one another to create bonds and be involved in a community. The meeting space is at a known and respected community agency within the AI/AN community in urban Los Angeles.</p>

Table 2 Continued

(b)	United American Indian Involvement, Inc.
<i>The Invisible</i>	
<p><i>Culture:</i> How does our CDEP project reflect the cultural values, practices, and beliefs of our community?</p>	<p>Dancing, drumming, and regalia making have been a part of wellness for our AIAN communities for generations. The approach supports AIAN traditions and practices and strengthens cultural identity which is a core value of wellness in the AIAN community. It also increases culture and community connection in a large urban area such as Los Angeles where the AIAN community often feels isolated.</p> <p>Cultural traditions and values are reflected in the following areas:</p> <ol style="list-style-type: none"> 1. Drumming, dancing, and regalia making provide opportunities to learn cultural traditions and engage in healing activities that have been utilized for centuries among indigenous communities. 2. Use of the Medicine Wheel highlights the four dimensions of wellness recognized historically by AI/ANs 3. Program staff represent several different tribes which helps maintain cultural relevance and legitimacy. 4. Workshops teach musical techniques, and traditional values, protocols, and expectations. <p>Interwoven in and undergirding these activities are cultural principles related to spirituality; sense of community; seeing and listening; mutualism; respect for earth and nature; quietness and respect for silence; sacred space; trusting heart, mind, intuition and inner knowing; oneness with all things; patience; the seven generations; indigenous sovereignty; and others that are conveyed to participants to deepen their understanding and practice of their cultural heritage.</p>
<p><i>Causes:</i> What are the problems the project is trying to address? How did it start and why? How are causes understood in (a) a historical context, (b) through the lens of the community's values, and (c) things that concern or bother the community.</p>	<p>In 2015, AI/AN adults had the highest rate of mental illness versus the national average (21.2% vs. 17.9%, respectively), and the highest among any racial/ethnic group (CBHSQ, 2015). Compared to any other racial/ethnic group in the United States (SAMHSA 2014). Urban AI/AN have a unique history of relocation and acculturation. The majority (70%) of AI/AN reside in urban areas away from their tribal lands (U.S. Bureau of the Census 2010) due in large part to the Indian Relocation Act of 1956. Relocation from tribal homelands has had harmful effects on those who relocated and subsequent generations with resulting psychosocial problems such as poor mental health outcomes, substance abuse, and disconnection from cultural and community (Evans-Campbell, Lindhorst, Huang, & Walters, 2006; LaFromboise, Berman, & Sohi, 1994). A diminished sense of AI/AN community in large urban centers may contribute to few opportunities to engage in AI/AN traditional healing practices (Dickerson & Johnson, 2012). This could be detrimental as connection with cultural identity can positively affect an AI/AN's self-esteem and self-construct (Smokowski, Evans, Cotter, & Webber, 2014; Stumblingbear-Riddle & Romans, 2012). Social isolation among AI/AN communities coupled with a shortage of treatments and supports that can address the unique needs of the AI/AN population, including historical trauma, oppression, and racial and cultural identity increases risk for mental health sequelae including depression and addiction, child abuse, and domestic violence.</p>
<p><i>Changes:</i> From our cultural perspective, what are the desired outcomes of the CDEP for our community? We will see more of . . . and less of . . .</p>	<p>By enhancing community connection there is a reduction in isolation and enhanced culture identity which help to improve community cohesion and a reduction in mental health and substance use problems. The culture-based activities will support the community to feel more connected, increase community supports, strengthen cultural identity, and promote wellness.</p> <p>Cultural activities promote mental health PEI and will result in the following outcomes:</p> <ol style="list-style-type: none"> 1. Strengthened connection to AI/AN traditions 2. Increased cultural identity and self-esteem 3. Increased sense of community and family connectedness 4. Decreased mental disorders 5. Decreased substance abuse 6. Improved health, wellness, and participation in health-focused culture activities

evaluation plan was independently reviewed by three to five reviewers, including at least one outside expert reviewer, with extensive written feedback provided to each organization. The cultural elements of each CDEP were one area of feedback, among other foci of review.

Programs had to revise their evaluation plans and resubmit them by the end of summer 2017, although a few programs were granted extensions. In some instances, OHE required programs to consult with the statewide evaluation team before submitting their revisions. During this approximately 3-month period, the statewide evaluation team engaged in a number of consultations with IPPs and TAPs including 28 CDEP-specific one-on-one phone consultations. Table 2a and b illustrate specific examples of how the culture cube was applied to two different CDEPs, representing African-American and Native-American priority populations, respectively.

The Development of the Culture Cube: Lessons Learned

The culture cube was used for three purposes in working with the practice-based evidence services (PBEs) participating in CRDP Phase 2, including (a) identifying and articulating how culture shaped these projects, (b) how cultural issues could guide the development of evaluation questions, methods, and selection of outcomes, and (c) how recognizing indigenous epistemological frameworks is necessary for understanding interventions and for guiding research to establish evidence.

In the process of working with PBEs in these three areas, several issues became clear. First, even though the culture cube is inherently a “bottom-up” model, because it was developed by the statewide evaluation team, it was sometimes perceived, whether accurately or not, as part of a “top-down” process. That is, as part of the Initiative, organizations were required to specify *how* culture and context were manifested in their CDEP approaches to inform their local evaluations. Thus, even with a bottom-up model, the perception of a top-down approach can still occur despite the freedom of organizations to specify their CDEP approaches. This, along with other CRDP tasks and deadlines, lead to many organizations feeling burdened and constrained. At the same time, several organizations made particular reference to the fact that the culture cube was particularly helpful in their efforts to refine their CDEPs and local evaluation plans.

Second, the disconnect between the extent to which the cultural elements of activities were reflected in written documents, even when prompted for such details, versus through oral questioning structured around the culture cube elements was sometimes quite significant. That is,

for some CDEPs, such as illustrated in the written description of *Ncig Teb Chaws* submitted by its program, the cultural elements were explicit, powerfully stated, and clear. For others, the cultural elements were only identifiable through probing and feedback. For example, the initial description of one of the African-American CDEPs, the California Black Women’s Health Project, did not convey the heart and soul of their culturally dense prevention and early intervention strategy. By the annual convening in September of 2017, however, the project’s evaluator delivered a rich description invoking cultural principles of communalism and fictive kin networks, activism, and social justice, and traditional healing coupled with multi-generational conditions of racial stress and racial oppression (see Table 2a). Through this and other examples, it became clear that while cultural elements were almost universally important in the conceptualization and implementation of activities among CDEPs, the cultural aspects of CDEPs were significantly less often described and documented. The culture cube facilitated conversations to make the cultural linkages more explicit for CDEP staff, for whom their own indigenous epistemological frameworks often seemed like such a “given” that they were not even particularly salient to them.

Third, regarding the second purpose or use of the cube, the webinars and program-specific consultations revealed that the cultural rationale for the PBEs often had to be made explicit and clear before the evaluation questions and design could be fully addressed. Some PBE projects included fairly typical or commonplace evaluation plans, but did not include any measures or questions that tapped into the cultural underpinnings of the program. For example, for a Native-American program involving drum, dance, and regalia making (see Table 2b), these cultural activities were seen as a critical protective factor for the local community (Dickerson & Johnson, 2011) but not necessarily fully reflected in the initial plan.

Subsequent iterations of the local evaluation made more salient the connection between cultural activities as a protective factor and changes in wellness, cultural identity, and community connections in the reduction in harmful alcohol and other drug use. For example, their evaluation includes assessment of changes in sense of community, youth cultural connectedness, historical loss, cultural and racial socialization, and hope. They further emphasized the importance of including qualitative methods such as preintervention and postintervention focus groups to describe such change. Thus, once the cultural elements and rationale were clarified through conversation, discussion, and intentionally valuing culture as central to both intervention and evaluation, the cultural grounding of the PBEs and the cultural complement in the evaluations also became clearer, especially the need to

ensure that culturally grounded, community-driven outcomes were represented in the measures.

Fourth, the role of diversity in worldviews and perspectives became apparent when discussing the meaning of culture itself, related to the use of the cube for identifying and articulating culture. For example, during an initial discussion of the meaning of culture, various priority populations offered different definitions that reflected their unique experiences. As a case in point, while priority populations based on race/ethnic groups often emphasized shared culturally rooted values (e.g., communalism, spirituality, respect for elders, cultural wisdom in the form of *dichos*, proverbs, or colloquial expressions), the LGBTQ priority populations focused on values that transcended cultural boundaries, such as inclusion, safety, belonging, and hospitality. These differences provide critical information about the ways in which historical, social, and political context not only shape people's experiences in the U.S. cultural milieu but also within their own respective groups. The cube proved flexible enough to enable any group to conceptualize and define culture in its own way, including values that were important for understanding both the nature of psychological suffering as well as the intervention approaches that made the most sense for each community.

To better understand *how* sociohistorical and political context work together with various identities to shape perspectives and experiences, an intersectionality framework provided a useful lens (e.g., Crenshaw, 1995). Intersectionality scholars have emphasized the importance of considering not only differences between groups (e.g., minority vs. majority) but also differences *within* a particular group (e.g., Cole, 2009). Intersectional perspectives (e.g., Bowleg, 2012; Bright, Malinsky, & Thompson, 2016; Cole, 2009) generally highlight three main themes. First, each person belongs to multiple social groups—there is no universal person—; each person has a gender, ethnicity/race, sexual orientation, and so on. Second, the meaning of each social group membership is constructed through the lens of the others. For example, a person's understanding of their sexual orientation is filtered through their race/ethnicity, and their understanding of their race/ethnicity is filtered through their sexual orientation. Third, because social categories “encapsulate historical and continuing relations of political, material and social inequality” (Cole, 2009, p. 173), the meaning attached to a social category, and thus, the experiences of advantage and disadvantage based on that category will depend on the context. In sum, intersectional models are important and can enrich the use of the cube. They can help attend to diversity *within* social groups in addition to differences between groups. These models also focus on the role of context in shaping the ways social

categories link privilege and disadvantage in people's experiences.

Fifth, racial categories, whether considered within an intersectional framework or on their own, often do not give space to the depth, breadth, and diversity of cultural expression. Ethnocultural groups within priority populations (e.g., Chinese, or Hmong, or Afghan, or Korean) varied in the extent to which they identified with the cultural values of other programs that were categorized in the same priority population category. In some instances, despite the diversity, metacultural principles were discerned. For example, in the context of diverse tribal affiliations, geographic locations (including urban–rural distinctions), and reservation vs. nonreservation experiences, the Native-American priority population shared strong common cultural values that cut across programs. Similarly, African-American and Latino/a programs also shared a strong sense of common ethnocultural values. The API priority population, however, included groups that represented quite distinct languages, representing immigrants and refugees from different countries, so that a program serving South Asian Muslim women from Afghanistan and Pakistan, for instance, was not only placed in the same population group as a program serving Hmong refugees in a rural area of central California but also with Korean immigrants living in an urban area. While some groups could share in a sense of common experiences related to their immigrant and refugee status, the cultural values of the different groups classified as API were not generalizable to the broader Asian priority population level. Thus, the application of the cube helped to identify and distinguish key differences between groups *within* priority populations so that their cultural realities were not lumped together, as well as to identify similarities in worldviews and approaches *across* populations for groups that may not have appeared to share common values or experiences based on broader population categorizations.

Conclusions

Respecting culture and emphasizing the value and necessity of its inclusion in designing, describing, and evaluating intervention strategies can notably shift the way in which PBEs are ultimately described and evaluated. If we are to reduce disparities and improve mental health access and outcomes among historically unserved, underserved, and/or inappropriately served communities, then we can and must include, and not dismiss, practices that have “worked” in those communities. We must also allow communities' cultural conceptualization of human functioning and well-being to guide the development and evaluation of prevention, early intervention, and treatment

interventions. This requires developing methods that (a) reflect they truly value culture, (b) uncover community and cultural practices, and (c) support the development of culturally meaningful credible evidence (including methods and metrics). In using indigenous alternative to theories and models of mental health to develop methods that follow culture, not supersede culture, we contribute toward building a base of empirical support for PBEs, demonstrating that science and culture are not mutually exclusive when definitions of “evidence” are expanded.

“After climbing a mighty hill, one only finds that there are many more hills to climb.” (Mandela, in Tuafu, 2007, p. 173). As we continue to develop our understanding and application of community-defined evidence practices we must articulate how culture is understood and implemented within diverse community-defined practices. Values, beliefs, assumptions, and practices are culturally, historically, and contextually determined and can be clearly articulated, understood, and evaluated. The culture cube is a tool that is now available to our diverse communities, researchers, policy makers, and funders to help us climb the hills ahead.

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