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COMMENTARIES

Evidence-Based Practice in a Global Context

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This commentary examines how the adoption of benchmarking can promote the internationalization of evidence-based practice. Given the increasing evidence documenting the role of culture and context in the shaping of experiences and expressions of distress, as well as influencing attitudes and conceptions of mental health services, benchmarking may not represent the best approach to addressing global public health agendas. A brief overview of the sequential approach to developing, evaluating, and disseminating treatments in novel cultural contexts is presented, in which benchmarking can play an important, albeit secondary role. It is argued that in a global context, benchmarking's role may better function to promote dissemination within particular contexts, rather than between them.

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Spilka and Dobson (2015) have written a thoughtful article that explores how a benchmarking strategy, coupled with cultural adaptation methodology, can provide a cost-effective approach to help with the international dissemination of well-established psychological treatments. Their insightful consideration of this issue has considerable potential to encourage the field of clinical psychology to globalize its focus on evidence-based practice. As others have noted, the populations of the United States and other "Western" nations represent a fraction of the worldwide population, and yet the overwhelming majority of psychology research has been U.S. based (e.g., Arnett, 2008). This imbalance is particularly salient in the development of the evidence base of psychological treatments (Mak, Law, Alvidrez, & Pérez-Stable, 2007). Thus, efforts to expand this historically narrow scope of research are welcome. Another notable contribution of Spilka and Dobson's article is the careful attention to the ways in which cultural adaptation methodology can be used to modify established treatments for the novel cultural context, thus setting the stage for benchmarking studies to help develop a locally created evidence base. Taken as a whole, Spilka and Dobson are to be commended for challenging the field of clinical psychology to embrace the possibilities inherent in working from a broad, global perspective.

However, before promoting benchmarking as a strategy in the internationalization of evidence-based practice, it is critical to first clearly understand what is meant by evidence-based practice. If evidence-based practice is conceptualized as a set of empirically supported treatments connected to easily disseminable treatment manuals, then benchmarking can indeed offer a relatively cost-effective and pragmatic approach to help dissemination and implementation efforts be more grounded in useful, empirical evaluations (Weersing,

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2005; Weersing & Weisz, 2002). With regard to the international dissemination of well-established psychological treatments, Spilka and Dobson (2015) make an important point about the prohibitive costs and clinical research infrastructure required to conduct randomized controlled trials (RCTs). Working from within a dissemination and evaluation aim, the relative payoff from RCTs is low, and therefore, benchmarking can play an important role. However, even this approach depends on universalist assumptions of cross-cultural similarities in several critical domains, including conceptions and experiences of the underlying disorder, normative approaches to coping with the disorder, and attitudes toward psychological approaches to treatment. And although there are certainly global cultural contexts in which these conceptions of mental health, coping, and mental health care mirror Western-based conceptions and treatments, increasingly the evidence is suggesting that universalist conceptions of mental health are limited (Canino & Alegría, 2008).

Therefore, it may be more productive to conceptualize evidence-based practice as an approach or a methodology to effectively and efficiently use culturally informed perspectives to address local public health considerations. In this view, benchmarking strategies do not represent the best approach because the aim of internationalizing evidence-based practice would be understood as a desire to support communities in their use of scientific and empirically informed approaches to (a) identify context-specific experiences and expressions of distress, (b) develop and evaluate culturally relevant and efficacious treatments, and (c) utilize cost-effective and sustainable methods to disseminate and implement those treatments. These efforts would most typically occur sequentially, and benchmarking could be an integral part of dissemination efforts. In this model, however, benchmarking would represent the last, rather than the first, step in a comprehensive, multimethod approach to evidence-based practice that incorporates multiple research and disciplinary strategies. Moreover, benchmarking would represent an excellent approach to promoting dissemination of an intervention *within* a novel cultural context, rather than *between* two different contexts. In this commentary, I briefly describe each of these efforts and then articulate why I think that conceptualizing evidence-based practice in this way has advantages over viewing it as a set of empirically supported treatments to be disseminated globally.

IDENTIFICATION OF CULTURAL AND CONTEXT-SPECIFIC EXPERIENCES AND EXPRESSIONS OF DISTRESS

There is increasing recognition that a strict universalist conception of mental disorders is limited (e.g., Canino & Alegría, 2008). In particular, there is accumulating evidence demonstrating variability in the prevalence of mental disorders across cultures (Bird, 1996; Kessler, Merikangas, & Wang, 2010), as well as the existence of expressions of distress that are culture specific (e.g., Deb & Balhara, 2013; Guarnaccia, Rivera, Franco, & Neighbors, 1996). Moreover, emerging research has begun to identify ways in which culture and context may differentially affect the symptom presentation of mental disorders (e.g., Cortés, 2003; Kleinman, 1982; Martin, Neighbors, & Griffith, 2013).

Given this current state of the field, efforts to improve the delivery of mental health services should begin with a thorough assessment of the local mental health experiences. This assessment should at a minimum include anthropological, sociological, and epidemiological approaches to complement psychological research methods and, importantly, involve local experts who are familiar with commonly exhibited expressions of distress. As in the example of depression in Kuwait offered by Spilka and Dobson (2015), these assessment efforts may very well lead to the identification of a target mental disorder that is sufficiently similar to Western conceptions to allow for the transportation of an existing evidence-based treatment. However, it is plausible that these assessment efforts may also identify important variations in the expression of distress that would warrant the development of a novel treatment, rather than the importation and adaptation of existing psychological treatment.

As an example, consider *ataques de nervios*, an expression of distress that has been primarily found among Latino populations in the Caribbean (Guarnaccia et al., 1996; López et al., 2009). Among the many characteristic symptoms of *ataques* are several that resemble those found in panic disorder, including anxiety, elevated heart rate, difficulty breathing, physical trembling, and fear of losing control. However, there are important symptoms of *ataques* that are not found in panic disor-

der, including fainting, crying, becoming hysterical, and anger and aggression (Guarnaccia et al., 1996). Moreover, the social context in which *ataques* emerge is a critical aspect of the disorder and typically is associated with familial loss or conflict. Thus, the emerging consensus with regard to *ataques* is that it is distinct from panic disorder and as such it would benefit from treatment that directly targets its symptoms and putative causes.

In this example, it would be inappropriate to transport, for example, panic control treatment (PCT; Barlow & Craske, 2007) and evaluate its effectiveness through benchmarking. And yet, without the elegant anthropological and epidemiological research on *ataques* conducted by Guarnaccia and colleagues over the past 20 years, benchmarking efforts might very well have been utilized in a misguided attempt to evaluate adapted versions of PCT. My point is that universalist assumptions, coupled with well-intentioned efforts to treat human suffering, can blind us to the subtle, yet important, ways in which culture and context relativize experiences of distress. These blind spots may lead to the implementation of treatments that do not effectively treat local experiences of distress. Thus, careful attention to how local communities conceptualize and experience health and illness is a critical first step prior to intervention development.

DEVELOPMENT AND EVALUATION OF CULTURALLY APPROPRIATE AND EFFICACIOUS TREATMENTS

Once the cultural and context-specific experiences of distress have been identified, work can then begin to develop and evaluate appropriate interventions. In some instances, as with the example of depression in Kuwait provided by Spilka and Dobson, there may exist a candidate intervention that can be easily transported, adapted, and evaluated. However, even in this instance, it is unclear that benchmarking would be the ideal first step, as the cultural adaptations could very well alter important aspects of the intervention that would preclude direct comparisons. For example, Spilka and Dobson describe how "[i]mportant cultural differences in language, religious beliefs, family structure, and education may impact the appropriateness of CBT as an intervention for this culture" (2015, p. 65). Insofar as the adaptations made to the selected CBT treatment change the structure, delivery, and content of the intervention, then comparisons between the adapted intervention and the original intervention become problematic (Cardemil, 2010). Benchmarking efforts are on most solid ground when the adaptation efforts are minimal or surface level, thus allowing for the disaggregation of intervention and context effects. That is, if a benchmarking study indicates that a particular intervention has produced worse outcomes than those reported in the efficacy literature, we can conclude that the context affected the outcome only if the adapted intervention closely resembles the standard one. Conversely, if substantive differences exist between the two interventions, then it is impossible to ascertain the extent to which the worse outcome is due to unique aspects of the novel context versus a poorly adapted and ineffective intervention.

This issue has received considerable attention in the cultural adaptation literature, as researchers have documented the inherent tension between fidelity and fit (Castro, Barrera, & Martinez, 2004; Domenech-Rodriguez & Bernal, 2012). Interventions that overly emphasize fidelity may not be appealing or relevant across different populations; interventions that overly emphasize fit may lose the connection to the evidence base upon which the original intervention was evaluated (Cardemil, 2010; Castro et al., 2004). Moreover, the function of cultural adaptations has been debated: Some cultural adaptations are understood to increase participant engagement with the intervention, while other adaptations are designed to contextualize the content of the intervention to make it more meaningful to participants (Cardemil, 2010; Lau, 2006, 2012). These distinctions, while critical, are more easily made in theory than in practice, making it difficult in practice to feel confident that substantive cultural adaptations do not so change the original intervention as to prevent direct comparisons from being possible.

It is also important to recognize that limitations exist in the ability of cultural adaptations to adapt an intervention to a particular population while remaining true to the original theoretical underpinnings. In instances when the novel cultural context is so different that the necessary adaptations would alter the putative mechanisms of action, treatments should be developed *de novo* (Cardemil, 2010). This is not to say

that novel treatments should ignore well-established theories of human functioning that articulate connections among emotions, cognition, and behavior, but rather that these approaches would serve as the theoretical frame to organize the development of a novel treatment that is firmly grounded in particular cultural and contextual worldviews of mental health and illness, coping and health behavior, and attitudes toward psychological treatments.

Once a plausible treatment has been identified (or developed), then evaluative approaches should follow standard treatment development and evaluation efforts. These would typically include those approaches that are best designed to allow for causal inference (i.e., randomized controlled trials, single-case designs).

UTILIZATION OF COST-EFFECTIVE AND SUSTAINABLE METHODS OF DISSEMINATION AND IMPLEMENTATION

The final step in this sequence consists of broad dissemination and implementation of the locally established efficacious treatment. However, it is important to recognize the tremendous heterogeneity that exists within any cultural context. Much like in the United States, all nations have cultural and contextual differences within their boundaries that may affect the acceptability and effectiveness of any single intervention. Thus, the initial development and evaluation of an intervention would invariably be more relevant to some members of that population than others.

Dissemination and implementation science have advanced considerably in the last 10 years, as researchers have realized that important gaps exist between the evaluations of interventions in controlled laboratory settings and the widespread uptake of interventions across different communities (e.g., Brownson, Colditz, & Proctor, 2012). Implementation science has become a field in its own right, with its own expectations for particular methodological standards. Given the relatively nascent state of this science, however, it is unrealistic to expect that healthcare infrastructures in different cultural contexts will be able to rigorously utilize this methodology (e.g., group randomized trials, hybrid efficacy-effectiveness designs).

It is at this stage therefore that benchmarking has a critical role to play, for all the reasons that Spilka and Dobson articulate. That is, benchmarking allows for the integration of results from efficacy and effectiveness studies, it provides an assessment of generalizability, and the costs are modest relative to RCTs (Spilka & Dobson, 2015). Benchmarking within a particular cultural context would be particularly efficient, as the empirical comparisons would allow for confident interpretation of variation in outcomes. Because any adaptations within a cultural context likely would be surface level, worse outcomes could be attributed to the particularities about the context, rather than the intervention. As Spilka and Dobson note, the data generated from benchmarking studies could then be used to inform further efforts to understand any identified differences in outcomes.

CONCLUDING THOUGHTS

In this commentary, I present additional considerations of the role that benchmarking approaches could play in the internationalization of evidence-based practice. Like Spilka and Dobson (2015), I am enthusiastic about the possibilities inherent in expanding clinical psychology's focus to encompass a global perspective. However, given the increasingly visible challenges to the assumptions of universality that have undergirded much of clinical psychology's history, caution is in order when considering how to engage with the global community. Benchmarking can be a useful tool to facilitate efforts to disseminate efficacious treatments. However, they ought to be used mainly in contexts where a firm foundation has rigorously identified culturally and contextually salient expressions of distress, followed by the successful development and evaluation of culturally appropriate interventions. At that point, benchmarking efforts can be incorporated into the existing healthcare infrastructure to promote the cost-effective dissemination of these evidence-based practices. In essence, benchmarking studies would be best utilized to promote dissemination *within* cultural contexts, rather than *between* cultural contexts.

It must be acknowledged that Spilka and Dobson began their thoughtful article by suggesting that benchmarking approaches can help provide some empirical guidance in contexts where interventions are already being implemented in the absence of any empirical evidence. A fair critique of my position is that if the costs are prohibitively high to allow for the conduct of

proper randomized controlled trials, then there is little hope for anything resembling the multimethod approach to evidence-based practice I have described. And in the world of public health, there is little to be gained by making perfection the enemy of the very good.

However, as a field, it is critical that we think carefully about the unintended consequences of our research programs. If, in the interest of advancing public health interests, we export interventions that are poor fits for the cultural context, then we have ultimately not made effective use of our time and financial resources. And while cultural adaptations can provide a safeguard against naive and unthinking treatment exportation, cultural adaptations have their important limitations. Moreover, we risk missing opportunities to advance our own understanding of the underlying concepts we are attempting to address. Engaging fully with the complexity of global perspectives on mental health will invariably yield challenges to many unexamined assumptions we hold, and our willingness to embrace and work with those challenges will inevitably advance our field to the benefit of all.

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