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### Review

# Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism

Laurence J. Kirmayer <sup>a,b,\*</sup>

<sup>a</sup> Division of Social & Transcultural Psychiatry, McGill University, Canada

<sup>b</sup> Culture and Mental Health Research Unit, Lady Davis Institute for Medical Research, Jewish General Hospital, Canada

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### ABSTRACT

Evidence-based practice (EBP) and cultural competence (CC) aim to improve the effectiveness of mental health care for diverse populations. However, there are basic tensions between these approaches. The evidence that purports to ground EBP is limited, often in ways that are biased by specific disciplinary, economic or political interests and cultural assumptions. In particular, the paucity of evidence regarding cultural minorities results in standard practices based on data from the majority population that have uncertain relevance for specific cultural groups. As well, research evidence about intervention outcomes tends to focus on individual symptoms and behaviors and may not reflect culturally relevant outcomes. To some extent, these limitations can be addressed by refining and extending current methods of evidence production. However, consideration of culture raises two deeper problems for EBP: 1) The diagnostic and conceptual frameworks used to pose questions, devise interventions, and determine outcomes in EBP are themselves culturally determined and therefore potentially biased or inappropriate; and 2) Cultural communities may have “ways of knowing” that do not rely on the kinds of observational and experimental measures and methods that characterize EBP. Attention to the nature of clinical evidence and to the importance of cultural context in illness and healing can help both EBP and CC move beyond their current limitations and contribute to the evolution of mental health services that respond effectively to cultural diversity.

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### Introduction

Evidence-based practice (EBP) and cultural competence (CC) are key concepts in current efforts to improve the quality and effectiveness of mental health services. EBP aims to ground clinical work in the most demonstrably effective strategies and interventions, while CC hopes to enable clinicians to respond in appropriate ways to the cultural backgrounds and social contexts of their clients. On the face of it, both are laudable initiatives, and should be highly complementary in their goals and implementation. However, each raises contentious issues concerning the epistemology, methodology, pragmatics and politics of mental health research and practice. Moreover, as currently configured, EBP and CC lead to tensions or contradictions that may make them incompatible.

This paper will review some conceptual problems inherent to EBP and CC as currently practiced. The challenges of addressing cultural diversity in EBP and of grounding CC in evidence will be outlined. The limitations of existing approaches to EBP can be addressed in part by expanding research and training to include a wider range of methods, participants and perspectives. CC can be refined by thinking through the meanings of culture in specific social contexts. However, individuals and communities that root their identity in specific ways of knowing pose deeper challenges to EBP and CC that lead to consideration of the values of epistemic and political pluralism.

### Research evidence as a basis for effective mental health care

Mental health services have been the arena of a great variety of treatments, some outlandish and all making claims of efficacy that often far exceed any evidence. The call for evidence-based practice promises a firmer foundation for mental health care (Norcross, Beutler, & Levant, 2006). EBP involves commitments on several fronts: (i) an epistemological commitment to science as a method of generating evidence; (ii) a professional commitment to base

\* Institute of Community and Family Psychiatry, Jewish General Hospital, 4333 Côte-Ste-Catherine Rd., Montréal, Québec H3T 1E4, Canada. Tel.: +1 514 340 7549; fax: +1 514 340 7503.

E-mail address: [laurence.kirmayer@mcgill.ca](mailto:laurence.kirmayer@mcgill.ca).

clinical practice on scientific research and rational decision making; and (iii) a political commitment to use science to guide health policy and services and to arbitrate and challenge the influences of marketing and other vested interests.

Evidence-based practice emerged in medicine as an attempt to improve clinical outcomes by getting clinicians to base their choice of interventions on research evidence rather than clinical impression, intuition or convention (Sackett & Rosenberg, 1995). Clinical practice is influenced by a wide range of factors that may bias clinicians' judgments of which treatments are most effective. Potential sources of bias include: the salience of clinicians' own training in and commitment to specific theoretical models and treatment methods; the tendency to over-generalize from recent clinical cases or idiosyncratic events; pressure or desire to conform to local communities of practice; and a host of general expectancy effects and confirmation biases that serve to justify and maintain previous decisions and courses of action (Makhinson, 2012).

The evidence-based medicine (EBM) movement aims to get clinicians to base their decision making not on rhetorical claims or advertising but on the best available evidence as determined by research including randomized clinical trials (RCTs), rigorous methods of systematic literature review, statistical meta-analysis, and formal clinical decision-making (Taylor, 2009). Each of these sources of evidence involves different epistemological assumptions but, taken together, they stand to improve confidence in claims for the relative efficacy and effectiveness of specific interventions. In actual implementation, however, each of these strategies has particular methodological and practical problems.

RCTs have become an accepted gold standard for assessing treatment efficacy because, with large enough samples, randomization allows statistical control for the impact of unknown variables on outcome and because the double-blind administration of an intervention reduces various forms of cognitive bias on the part of patients and clinicians. However, far from producing unequivocal evidence, RCTs raise significant epistemological, methodological and interpretive problems (Ashcroft, 2004; Cartwright, Goldfinch, & Howick, 2009; Thompson, 2010). Moreover, not all interventions lend themselves to RCTs. Psychosocial interventions may be difficult to standardize (though there are now fidelity measures for many psychosocial EBPs), randomize (because they must be tailored to individuals), and blind (because psychosocial treatments may require explicit awareness, engagement, and commitment from patients for efficacy).

Efforts to support evidence-based clinical decision-making have emphasized making systematic reviews readily available and guiding clinicians in appropriate inferential reasoning. However, systematic literature reviews depend entirely on what evidence is available to critically evaluate and synthesize. Not everything gets studied and not every study that is completed gets published. Many scientists and most journals are uninterested in replications and less than enthusiastic about negative findings or failures to replicate (Dwan et al., 2008; Young, Ioannidis, & Al-Ubaydli, 2008). Gaps in the literature represent untested possibilities that then lose credibility. Moreover, some of these gaps or failures to publish represent deliberate efforts by the pharmaceutical industry to suppress information that conflicts with its economic interests (Angell, 2004; Healy, 2004). Recent years have seen revelations of high levels of corruption in the research and clinical marketing enterprise, with suppression of findings, "doctoring" of evidence, ghost written articles, and other distortions in the clinical literature, forming an unreliable basis for decision making (Angell, 2004, 2009; Dwan et al., 2008; Healy, 2004; Ioannidis, 2008; Sismondo, 2007; Young et al., 2008). Reforms in scientific publishing have attempted to insure that all RCTs are registered before publication so that negative trials do not simply disappear but can be accurately

counted in meta-analysis to give more accurate weight to results (Milette, Roseman, & Thombs, 2011). As well, authors must declare the organizations that supported the research and potential conflicts of interest that might bias the study. Unfortunately, reviews and meta-analyses usually do not reproduce the information on conflicts of interest present in the original research reports (Roseman et al., 2011).

For clinical psychology, the rise of evidence-based practice has been a logical extension of the tradition of the clinician–scientist, who seeks to ground clinical practice in research (Norcross et al., 2006); for psychiatry, it has been part of the ongoing biologization of theory and practice, overturning decades of dominance by psychoanalysis, with claims for a renewed connection to science and closer fraternity with other areas of biomedicine (Taylor, 2009). For other mental health disciplines (e.g. social work), the relationship to evidence defined in terms of RCTs and other research strategies has been more ambivalent, in part because of concerns about the adequacy of current approaches to evidence in EBP to address many of the contextual issues related to service delivery and policy (Berger, 2010; Bond, Drake, & Becker, 2010; Thyer & Myers, 2011).

Resistance to EBP sometimes reflects a simple defense of the status quo. The historical traditions that define the modes of practice and identity of a profession have a life of their own and are defended to maintain the coherence and authority of the profession (Armstrong, 2007). This can be rightly challenged as self-interest but raises concern that good ideas and time-tested practices may be displaced by newer approaches that have received some experimental support, even if they have limited efficacy. Of course, given the prevalent cognitive and social biases already mentioned, any claims that a treatment has been "time-tested" must be critically appraised. The mere fact that a practice persists does not prove that it is effective.

In the case of medicine, these potential biases take on heightened significance because there are very powerful vested interests in the pharmaceutical industry involved in generating evidence. EBP tends to ignore the power dynamics involved in the production of knowledge – although it provides the tools to identify systematic bias in reported research studies and uncover hidden agendas. A spate of recent studies show how positive results of new treatments are associated with the level of pharmaceutical company involvement, and how positive results diminish over time as trials are repeated and the initial enthusiasm for a treatment wears off (Trikalinos et al., 2004). EBP was intended to counteract the self-serving biases of clinicians and purveyors of remedies but it has been easily co-opted and distorted by interests with the power and resources to direct research and subvert regulatory bodies. Understanding the role of these conflicts of interest and, more broadly, the political economy of the generation of evidence is essential to appreciate the magnitude of the distortions in the evidence-base.

### The relevance of EBP for culturally diverse populations

Concerns about evidence-based mental health practice include the limitations of the existing corpus of studies (Gupta, 2007). Research studies typically are conducted on samples that often do not reflect actual patient populations. For example, patients enrolled in RCTs of psychiatric medications usually have a single psychiatric disorder, without medical or other comorbidity. Outcome is generally measured in terms of levels of symptoms, diagnostic criteria, and level of functional impairment. Measures are usually limited to a few domains and a short period of time; follow-up usually spans a few weeks or at best a few months. Hence, the potential trade-offs of treatment (in terms of concurrent

benefits and negative effects or long-term consequences) are usually unexamined and unknown.

In the case of cultural diversity, the extant research literature does not represent the diversity of the population in the U.S. or elsewhere (Aisenberg, 2008; Sue & Zane, 2006; Whitley, Rousseau, Carpenter Song, & Kirmayer, 2011). In general, authors simply assume that studies conducted with highly selected specific groups can be generalized to real-life situations. Both basic and clinical psychological research is heavily weighted toward studies of Western, middle class, educated young people (Henrich, Heine, & Norenzayan, 2010) and drastically under-represents the ethno-cultural groups who are the majority of potential clients in most places (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010; Smedley et al., 2003). It is thus difficult on the basis of existing evidence to decide whether treatments are effective for specific populations. Moreover, given that most psychological interventions are grounded in individualistic notions of the person (Kirmayer, 2007), it is unclear to what extent the efficacy of specific interventions depends on adopting a specific conception of personhood with attendant goals, desirable outcomes and tolerable trade-offs. We need studies examining diverse samples — not only demographically representative samples, but focused studies with specific groups to identify what works for them.

There are deeper epistemological problems in assessing the cross-cultural validity of evidence. The categories used to identify problems, measure outcomes, and organize interventions may not fit specific cultures well (Aisenberg, 2008; Gone & Kirmayer, 2010). Psychopathological theories (as enshrined in official nosologies) are based on limited samples of the population and measured against cultural norms and values that may vary across groups. Mis-identifying a problem by applying a category that does not fit well across cultures, may lead to spurious findings of treatment ineffectiveness because heterogeneous problems are being addressed. Measuring outcomes in ways that are not calibrated to social and cultural norms and that do not canvas culturally central concerns can also give an inaccurate picture of treatment effectiveness. Standardized interventions may have less efficacy than they would if culturally framed and adapted.

A final epistemological problem associated with the cultural shaping of illness experience and treatment response involves what Hacking (2002) has called the “looping effect”: the categories and constructs of psychology and psychiatry are cultural products that circulate in the larger world, reshaping individuals’ illness experience, clinical presentations, expectations and response to interventions. To an unknown degree, outcomes in treatment may reflect these culturally-shaped expectations. If so, then effectiveness may reflect the self-vindicating effects of disseminating a way of looking at problems and solutions. Interventions that do not achieve this wider circulation may not fit patients’ expectations and will therefore be less effective.

### Cultural competence as a response to diversity

There is good evidence that culture, language, ethnicity and religion influence the causes, manifestations, and course of mental disorders, including symptomatology and illness experience, attributions and explanations for distress, help-seeking and coping, treatment adherence and response (Gone & Kirmayer, 2010). Cultural competence—the capacity of practitioners and health services to respond appropriately and effectively to patients’ cultural backgrounds, identities and concerns—has been proposed as a strategy to respond to this diversity and reduce mental health disparities (Brach & Fraser, 2000). However, by the standards of EBP, very little is known about how cultural competence affects clinical outcomes. Moreover, the ethnographic research that is central to

anthropological studies of culture is viewed as ‘anecdotal’ from the perspective of EBP and therefore as having little to contribute beyond posing questions or hypothesis for future methodologically sound research.

The focus on practitioner cultural competence is based on assumptions that: (i) mental health services and interventions can reduce health disparities; (ii) that these interventions are more accessible, acceptable and effective when they are culturally adapted; and (iii) that practitioners can acquire specific knowledge, attitudes and skills that will improve their delivery of effective culturally appropriate and responsive mental health services. There is modest evidence for each of these propositions (Alegria et al., 2010; Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Brach & Fraser, 2000; Castro, Barrera & Holleran Steiker, 2010; Griner & Smith, 2006; Lie, Lee-Rey, Gomez, Bereksnyei, & Braddock, 2011).

Critiques of cultural competence focus on several issues: (i) most major health disparities reflect structural inequalities in society that cannot be remedied by mental health services; (ii) effective interventions may not need cultural adaptation—indeed, over-emphasis on cultural adaptation or packaging may sacrifice crucial ingredients in effective interventions; and (iii) changes in practitioner knowledge, attitudes and skills may be insufficient to change clinicians actual behavior or improve the quality of services without changes at other levels including the structure of health care systems and institutions and the models of intervention themselves (Alegria et al., 2010; Bhui, Ascoli, & Nuamh, 2012; Kirmayer, 2012).

Another line of critique centers on the ways that culture has been conceptualized in cultural competence training and practice (Carpenter-Song, Nordquest Schwallie & Longhofer, 2007; Kleinman & Benson, 2006; Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007; Taylor, 2003; Willen, Bullon, & Good, 2010). In most clinical and epidemiological research, culture is conflated with ethnoracial identity. As a result, training draws on a literature that tends to ignore the ways in which ethnoracial categories are themselves culturally constructed and contested. There is enormous variation in experience within any ethnoracial category and this is further amplified by the ongoing inter-mixing of cultures and the creation of new hybrid identities that draw not only from local communities but from global, diasporic and international networks. Properly applied, the concept of culture would address the unique social contexts of knowledge and power at the levels of individuals, families, communities and larger social systems that give meaning and consequence to illness experience for every patient and practitioner.

An added critique of cultural competence comes from the concern that focusing on practitioners’ skills serves to further accentuate the power imbalance in the clinical encounter (Kirmayer, 2012). As an alternative, authors have proposed concepts of *cultural humility* and *cultural safety*. Cultural humility emphasizes the clinician’s limited access to insider culture knowledge and the need to respect and be open to clients’ own culturally-based understandings of their illness and treatment interventions (Tervalon & Murray-Garcia, 1998). Cultural safety shifts attention to the historical and political contexts of health care, insisting that clinicians and health care institutions have a responsibility to work to make the clinical encounter safe by acknowledging and addressing structural violence and inequality (Papps & Ramsden, 1996). The hope is that explicit attention to historical and current social factors that make the clinical encounter unsafe can facilitate open dialog and collaboration.

The importance of cultural competence for health care follows from recognition of major disparities for specific ethnoracial or cultural groups (Alegria et al., 2010; Smedley et al., 2003). The social determinants of health are structured, rationalized and maintained

by cultural values, institutions and practices. The trajectories of mental health problems, including the stresses that set them in motion and the vicious circles that maintain them are all shaped by cultural systems and interactions. However, current approaches to cultural competence tend to conflate culture with ethnic identity and individual traits (Kumas-Tan et al., 2007). Culture involves many different social and psychological processes and is not a single system, discrete entity or set of variables (Leung, Chiu, & Hong, 2011; Vogeley & Roepstorff, 2009). Race and ethnicity are products (social constructions) of interacting systems that involve both dominant (majority) and subdominant (minority) cultures. Most people have multiple ethnocultural strands to their identities that become salient to varying degrees in specific social contexts. Only a small part of culture is conscious or carried by the individual. Much of culture remains unconscious or implicit, embodied and embedded in habits, routines, and practices. Still more of culture resides in patterns of interaction that depend on families, groups, communities and institutions including those of global society. Culture, therefore, must be viewed as fluid, situated and negotiable intersubjective systems of meaning and practice relevant to specific social contexts.

Given that a culture is not simply a bundle of variables that can be disentangled and studied in isolation, but rather a more or less densely woven social fabric or dynamic system, it may not be possible to decompose a cultural context into discrete factors, traits or elements. Indeed, cultures include not only systems of interpretation for symptoms or illness and strategies for coping with distress, but whole ontologies of being, hierarchies of values, and moral systems that articulate the meaning of suffering and socially appropriate responses.

The implication of these conceptual critiques for CC is that addressing the cultural dimensions of illness requires knowledge of social contexts as much as individual identities. Generating and applying evidence about cultural variations therefore is not simply a matter of studying different ethnic groups but of understanding the specific contingencies, constraints, opportunities and demands inherent to their social worlds. This moves from a focus on the diagnosis of decontextualized health problems and delivery of generic interventions toward an effort to understand patients' predicaments and devise solutions based on their individual, family and community resources. An example of this strategy is provided by the cultural formulation in DSM-IV, which aims to help the clinician situate illness experience in context (Mezzich, Caracci, Fabrega, & Kirmayer, 2009). Unfortunately, little empirical work has been done to evaluate the impact of the use of the outline for the cultural formulation in clinical settings.

### **Tensions between evidence-based practice and cultural competence**

CC needs research to provide knowledge about diverse populations and to validate its practices. EBP needs CC to determine the generalizability of knowledge and the ways to translate generic knowledge into locally appropriate interventions. Despite this interdependence, there are ways in which the two approaches stand in tension or opposition to each other. EBP aims to produce generalizable knowledge, but generalized ("nomothetic") knowledge about culture tends to lead to stereotypes. CC aims to avoid stereotypes through idiographic knowledge that situates patients in their social and historical contexts, but knowledge gathered about an individual's unique situation may be difficult to validate, replicate or extend.

In reality, the available evidence always under-determines practice, leaving much room for discussions of values and

priorities driven by cultural, political and economic considerations. Indeed, in public health, "While EBM remains a professionalizing strategy through its potential to control the indeterminacy in the doctor–patient relationship, it can also be seen as a mechanism for giving what are essentially 'political' decisions an illusion of objectivity" (Armstrong, 2007, p. 81). Applying research evidence in clinical practice involves many additional considerations of context and intervention. Proponents of EBM recognize the need to combine scientific evidence with attention to patients' values and life contexts (Fulford, 2011). However, the process of integrating of multiple forms of knowledge in clinical practice remains under-theorized, unspecified and little studied (Charles, Gafni, & Freeman, 2011).

Clinical and public health applications of scientific knowledge involve complex negotiations among many different stakeholders who must make value-laden choices from alternatives whose impacts are only ever partially understood and anticipated. "EBM's ability to guide health care decision making by appealing to "the evidence" as the bottom line is attractive to many because it proposes to rationalize this complex social process. Yet it does so through the positivistic elimination of culture, contexts, and the subjects of knowledge from consideration, a move that permits the use of evidence as a political instrument where power interests can be obscured by seemingly neutral technical resolve" (Goldenberg, 2006, p. 2622). Of course, the social influences on EBP are not unique—they apply to varying degrees to every domain of knowledge. But the rhetoric of EBP tends to obscure the social, moral and political contexts that necessarily shape both research and clinical practice.

EBP exerts an influence on how problems are conceptualized and so shapes research and clinical practice in ways that may sideline alternative models and interventions. Through its embrace of a specific set of methodological tools and an underlying epistemology, EBP assumes an ontology of the experiences that constitute mental health generally as well as specific types of mental health problems. This is illustrated by the recent debate over the widening definition of depression and its relationship to grief in which experiences that might be understood as normal and integrated into social rituals of mourning are increasingly pathologized and treated with medication (Horwitz & Wakefield, 2007). Similar changes have occurred in other societies in the labeling and treatment of common forms of social adversity (Kitanaka, 2012). These changes in what counts as a mental health problems reflect cultural processes of labeling, interpretation and intervention mediated by the health care system, driven by marketing supported by appeals to scientific evidence (Kirmayer, 2002).

Notions of effectiveness depend on ways of identifying problems or disorders for which a specific treatment may be helpful, as well as definitions and corresponding measures of outcome. The organization of current psychiatric nosology emphasizes generic knowledge about mental disorders and treatments keyed to categories of disorder. The tools that have been created to diagnose psychiatric disorders are used to generate volumes of evidence about discrete disorders and their treatments, all of which serves to stabilize the nosology. This whole system of diagnosis, mechanisms of pathology, treatment and outcome draws its validity both from standards of evidence within each domain of inquiry and their interface (e.g. differential diagnosis is associated with prognosis and with claims for treatment specificity). Each domain, however, is also embedded in discursive practices that it does not share with the others and that may create conflicts when concepts or findings are carried across domains. For example, despite claims for specificity (embedded in the very names of classes of medications), antidepressants and antipsychotics have effects on a great many different kinds of symptoms or problems suggesting that the

diagnostic classification system and the range of therapeutics do not mesh as closely as it might first appear.

In an extension of the idiographic method central to CC, some have proposed a radical shift that would make the person and not the disease the focus of clinical research and attention (Mezzich et al., 2010). In person-centered care, the perspectives of patient and family provide the context essential for understanding illness and devising interventions built on patients' strengths and resources. This shift in focus is consonant with calls to listen to the voice of patients and respect their agency that are central to approaches like shared decision making (Drake, Deegan, & Rapp, 2010; Munthe, Sandman, & Cutas, 2011) and narrative-based medicine (Silva, Charon, & Wyer, 2011). But if this means that simple testimonials will suffice to establish treatment credibility, we risk an epistemological melee in which anything goes. Patients are not always the best judges of what works even in their own case for many reasons: they have limited experience (an "n of one"); they are subject to all the usual judgment biases; they are not blind to the treatment and hence are likely to confound expectations with outcomes. Reconciling EBP and CC in any person-centered approach therefore requires attention to the problems raised by knowledge claims that may be based on differing epistemologies.

### Indigenous ways of knowing and healing

Cultures provide their own interpretive frameworks, notions of authority and standards of truth. Listening to the voice of patients therefore means considering other sorts of evidence: not only their own "subjective" experience but also the specific sources of authority and ways of knowing they privilege. The problem of competing epistemologies arises in a wide variety of health care contexts including the response to ethnocultural communities within diverse societies and in global mental health. The concerns of Aboriginal peoples in Canada will serve to illustrate the dilemma. In Canada, arguments for the efficacy of traditional or contemporary forms of indigenous healing have been supported by claims about the need for recognition of alternative ways of knowing grounded in traditional or collective wisdom (Smith, 1999; Waldram, 2008). Indigenous peoples may constitute distinct 'epistemological communities' or epistemic cultures, with their own expectations for what constitutes an important question and a meaningful, evidence-based answer (Nelson, 1993). Taking this seriously means finding a place for individual and collective experience as sources of knowledge that are complementary to the knowledge produced by science.

For post-positivist science, "experience remains central to our evidential claims, [but] it must be understood to be inherently social, for we experience the world through the lens of our projects, categories, theories, and standards. Therefore, what constitutes evidence for specific claims or theories includes not only experience, but the knowledge and standards constructed and adopted by epistemological communities" (Goldenberg, 2006, p. 2626, citing Nelson, 1993, p. 142). Current philosophy of science recognizes that (i) scientific observations (indeed, all aspects of methodology, including the posing of questions and the recognition of satisfactory answers) are theory-laden; and (ii) theories usually are underdetermined by data and their confirmation depends in part on their fit with a larger system of knowledge.

Indigenous communities can be said to be epistemic cultures not only because they have specific notions of how knowledge may be acquired and what counts as evidence, but because they may center aspects of their collective identity, belonging and unique values precisely on such forms of knowledge. These forms of knowledge may be viewed as traditional, sacred or intrinsically indigenous, tied to place, local ecological knowledge and particular

ontologies. The epistemic cultures of indigenous communities differ from those described by Knorr-Cetina (1999) in her studies of science in part because they represent a people with political claims and also because indigenous epistemology cannot be separated from a community's form of life and social institutions. What privileges the epistemology is not only a form of life but also a construal of the world to which it pertains, which may differ in some respects from the world within which psychological science has developed and from within which it defines problems and solutions.

Healing practices are central to these epistemic claims. For many indigenous peoples, systems of healing are important expressions of traditional forms of spirituality, social organization and worldview (Kirmayer, Brass, & Valaskakis, 2008). Traditional systems of healing were grounded in a specific cultural ontology of spirits, animal powers, or non-human persons animating the world and served to demonstrate the reality of these powers through healing efficacy. Hence, the loss, disruption or displacement of traditional healing practices went hand-in-hand with the undermining of worldviews and the destruction of a way of life (Lear, 2006). Revitalizing culture and community then can be achieved in part by re-instating, strengthening and investing in culturally grounded healing practices.

This social, communal and political level of healing is not addressed in most considerations of evidence of treatment efficacy. Simply attending to the impact of interventions at communal and political levels could lead to recognizing new forms of efficacy. However, methodologically this is difficult because the unit of change might be a whole community and so the measures, comparison and randomization have to occur at the community level—something that is usually impossible for many practical, political and ethical reasons (Kirmayer, Sedhev, Whitley, Dandeneau, & Isaac, 2009). Moreover, although the notion that traditional healing might have an effect on people's sense of identification with or commitment to culture and community is plausible, such sociopolitical explanations of efficacy are not entirely satisfying for people within the tradition. They may see the move toward revitalization not simply as a compensatory response to or restitution for cultural oppression but as the recognition and application of fundamental truths about the world. To affirm this, there must be conviction that the intervention works independently of any of its political meanings or impact.

A second level at which healing can be understood involves the metaphoric transformation of experience (Kirmayer, 2004). Language can have rhetorical power to persuade and so to change cognition, emotion and action. The power of rhetoric resides not only in the interpersonal dynamics of social influence but equally in the mutative effects of metaphor and other tropes. Metaphors bridge bodily-grounded experiences and cultural shaped narratives that define mythic worlds or spaces. By mapping bodily experience onto a mythic representation and moving metaphorically within the myth-space, healing rhetoric can effect changes in the individuals' illness experience and self-representation. At the same time, the consonance of the healing practice with over-arching cultural myths lends it rhetorical power and coherence and may contribute to its efficacy (Benish, Quintana, & Wampold, 2011). This approach to understanding the efficacy of healing through the cognitive-social processes of metaphor can make sense of a wide variety of practices.

Once again, though, for patients and healers within the tradition, the account of healing in terms of metaphor may be unsatisfying or even subversive. The healing spirits, energies or medicines are not "just" metaphors—they are real, active agents, and fundamental constituents of reality with their own agency. Participating within the healing system means accepting an

ontology that makes the healing actors primary. Construing them as metaphors seems to imply they lack active agency and that they simply stand for some deeper reality that is non-metaphorical. Of course, this implies a kind of literalism that not all holders of traditional knowledge may take quite the same way. It is possible to hold that the myths and medicines are stories and metaphors—but they are *sacred* stories and so must be treated with all of the respect and protocol one accords other sacred presences.

One way to integrate these different kinds of knowledge is to view them as constituting distinct levels in a biosocial system (Kirmayer, 2004). The efficacy of any healing system then lies in its coordination of three levels: bodily experience; cognitive-emotional representations; and sociopolitical discourse and action. The efficacy of any intervention depends on multiple mechanisms, only some of which are recognized by the theory or worldview from which the intervention arose. These different mechanisms also involve different outcomes so that, again, any intervention has effects at levels other than the outcomes it specifically targets. It follows that diverse methods are needed to produce evidence for efficacy at each of these levels and outcomes.

### From epistemic to political pluralism

The challenge of integrating EBP and CC then leads us to questions of methodological, epistemological and political pluralism. While seeking to ground practice in good evidence, we need to recognize different types of knowledge that address broader questions of efficacy and outcome. Outcome may be measured not only in terms of symptom reduction, behavioral change, or level of instrumental functioning but in terms of individuals' ability to pursue culturally relevant goals and, at the same time, in terms of the impact of an intervention on larger social circles including family and community. Most EBP studies measure limited sets of outcomes at the level of the individual over short periods of times. To capture the larger frames of meaning inherent to cultural models of efficacy, we need to measure broader sets of outcomes over longer periods of time. A focus on symptoms or functioning defined in generic terms may not capture crucial aspects that are important to patients and their families and both experience-near narrative methods and assessment of social ecosystems are needed to understand the true impact of interventions.

Empirical research is the best way we have to get around certain cognitive biases and identify potentially effective interventions. But these cognitive biases are not the only constraints on devising and delivering wise and effective treatment. There are other kinds of bias that reflect cultural categories or values that put blinders on our view of the clinical alternatives (Fulford, 2011). These cultural categories are implicit in how problems are framed, prioritized and approached. Moreover, the theory of knowledge implicit in EBP does not capture crucial elements of knowledge production and testing. The social sciences can be used to uncover hidden interests and agendas that shape the landscape of science. If scientific empiricism helps us to identify causal chains and move beyond our cognitive biases and perceptions of illusory correlations, social analysis helps us to see the larger forces that hide evidence, constrain the field of possibilities and rhetorically frame our choices in ways that force our hand.

Traditional knowledge systems introduce other dimensions to experience and value hierarchies and goals that provide new frames and priorities. Alternative ways of knowing draw attention to alternate ways of framing problems and different hierarchies of values. These can guide research and clinical decision making when faced with alternative choices in treatment goals, modalities and methods. Ultimately, however, these need to be brought into dialog in a shared social space. This requires a minimal set of shared

epistemic assumptions (Talissee, 2012). Recognizing the different goals and outcomes that arise from distinct epistemic frames is one way to work toward this common ground.

Highlighting the dilemmas raised by epistemic differences does not imply that all frameworks have equal validity across all domains. Indeed, what changes across epistemic communities are not only the kind of evidence that is viewed as compelling but the kind of question that is considered important. To the extent that these differences are intrinsic to individual and collective constructions of identity and community, they deserve careful consideration not only in weighing the appropriate intervention for a context, but in designing and interpreting studies of treatment outcome. This is because an intervention may have unanticipated effects in other domains or at other levels than intended. The different epistemic frame is what initially draws attention to these other domains or levels (e.g. "the spiritual", "the community", etc.). To some extent, knowledge about these domains can be translated back into the scientific, individualistic frame of psychology and studied as such. But unless they are lumped together with diverse other aspects of experience under some abstract rubric (e.g. "meaningfulness", "sense of coherence", "well-being"), they generally will require developing new measures of process and outcome, some of which may well lie beyond the individual, in family interactions, communities, or relationships to larger social systems. Epistemic pluralism then leads to methodological pluralism, and through empirical work, to new forms of political recognition and engagement.

### Conclusion: kinds of diversity worth having

Despite the promise of EBP, there have been cogent critiques of its limitations as a unique standard for practice. The production of evidence does not occur on a level playing field. Economic interests, notably the pharmaceutical industry, have exerted strong biases on the accrual of evidence, suppressing and distorting results, resulting in inflated estimates of the efficacy of many medications (Angel, 2004; Ioannidis, 2008). At the same time, other potentially effective treatments have not received adequate evaluation. The absence of evidence for effectiveness due to a lack of studies is not at all the same as evidence of a lack of effectiveness in well-designed trials. Unfortunately, in organizing practice based on available evidence, the lack of information counts against both conventional and promising new practices. The limitations of current evidence can be addressed by an expanded research program driven not primarily by economic interests but by scientific, clinical and community priorities.

Beyond this problem of the uneven or biased accrual of evidence, there are important concerns with the quality and generalizability of evidence from even well-designed studies. Studies often occur in specialized clinical settings, with highly selected samples of patients that are not representative of general clinical populations. A narrow range of outcomes are measured over a limited period of time so that basic questions cannot be answered about adverse effects, trade-offs (i.e. improvement in one area with no effect or deterioration in another) and the stability or durability of positive outcomes. To address this limitation researchers must work with samples that represent the populations of concern and employ a broader range of measures that reflect culturally salient definitions of positive and negative outcomes at individual as well as family, community and wider systemic levels over longer intervals of time. Intervention studies must be designed not simply to demonstrate potential benefits but to identify the trade-offs that likely occur with any intervention.

Rethinking EBP to encompass cultural diversity also will require a broader view of evidence. This has epistemological,

methodological, and political implications. Epistemologically, different cultures recognize and privilege different ways of knowing. These must be investigated in their own right as forms of knowledge and practice intrinsic to certain value systems and ways of life of central importance to specific communities. This requires a wide range of methods including those of the humanities and social sciences which can expose the historical roots, contextual meaning and rhetorical force of particular ways of construing self and other, in health and illness. This type of investigation has implications for understanding the healing effects of specific interventions not simply in terms of generic psychological mechanisms but in terms of the effectiveness of specific myths and metaphors to reorganize social life and both individual and collective experience.

Diverse systems of knowledge and knowing direct attention to different levels of process and outcome. Recognizing that these levels require different languages of description and explanation supports a pluralistic view of knowledge that can accommodate a wide range of kinds evidence within an empirical paradigm. This does not mean that all systems of knowledge are equally useful to address every question about efficacy or outcome. In fact, each poses somewhat different questions and seeks different kinds of answers. Apparently incommensurable or irreconcilable differences can be understood in terms of these different questions and measures of outcome. This view, however, assumes a shared social space in which people (patients, practitioners) are concerned to work toward mutual understanding and coexistence (Kirmayer, 2011). Introducing these epistemic claims into a larger social space therefore is not simply an expression of methodological or epistemic pluralism but an explicit move toward some form of political pluralism.

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