Evidence-Based Treatment for Ethnic Minority Youth: What We Know and Don't Know

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Background

- Potential Problem with Conventional Therapies:
  - Developed for White, Western, English-speaking
  - Majority of clinicians are White
  - Not consider language, beliefs, worldview of culturally different
- When culture is ignored:
  - Value conflicts & miscommunication
  - Client discomfort & poor engagement
  - Dropout & treatment failure
- So treatments must be culturally-responsive???

What is Culturally-Responsive Tx?

- No uniform view
- Many opinions, many frameworks, many labels:
  - Culturally-competent, minority-specific, ethnically-sensitive, culturally-tailored, culturally compatible, etc.
- CRT = Efforts to make treatments more "appropriate" for ethnic minorities

What is Culturally-Responsive Tx?

- How do clinicians define?
- Survey by Zayas et al. (1996)
- 150 White members of APA & NASW
  - Awareness of existence of differences (33%)
  - Knowledge of client's culture (12%)
  - Distinguishing between culture and psychopathology in assessment (21%)
  - Taking culture into account in therapy (34%)

What is Culturally-Responsive Tx?

- APA Guidelines for Multicultural Education, Training, Research, Practice
  - Recognize that attitudes & beliefs can neg. influence interactions with culturally different
  - Recognize importance of multicultural sensitivity/responsiveness to understanding culturally different
  - Apply culturally appropriate skills in clinical and other applied psychological practices

What is Culturally-Responsive Tx?

- 1980 Division 17 Report (Sue et al., 1982)
- 11 cross-cultural competencies identified
- CCCI based on this report
- 3 Factors based on factor analysis
  - Cross-cultural counseling skill
    - Communication is appropriate for client
    - Acknowledges and comfortable w/cultural differences
  - Socio-political awareness
    - Appreciates social status of client as ethnic minority
    - Perceives problem within client's cultural context
  - Cultural sensitivity
    - Demonstrates knowledge about client's culture
    - Aware of institutional barriers that affect the client

Cultural-Responsiveness Models

- Bernal → Metaphors, language, etc.
- Rogler → (1) Increase access, (2) Select traditional txs that fit, (3) Modify traditional tx
- Sue & Zane → Credibility & Gift-Giving
- Smith et al.
  - Appreciation of minority culture
  - Understand special terms & language
  - Knowledge of client's community
  - Awareness of probs living in bicultural world
- Fuertes & Gretchen – 8 Theories of Multicultural Counseling

What is Culturally-Responsive Tx?

- Structural "Adaptations"
  - Addresses how treatment is structured
  - Examples:
    - Therapist-client ethnic & language match
    - Group-based tx; Structured & time-limed tx
- Content/Process "Adaptations"
  - Addresses in-session behaviors of counselor
  - Examples:
    - Use culturally-relevant materials, examples
    - Avoid demands for emotional disclosure

What is Culturally-Responsive Tx?

- Some Pan-Minority Recommendations:
  - Short-term, time-limited, pragmatic, directive, goal-oriented, problem-focused treatment
  - Attentive to effects of minority status or discrimination
  - Assess whether behavior matches values & norms of host culture (i.e., is it adaptive in client's culture?)
  - Assess & validate client experiences w/racism
  - Attend to nonverbal/indirect forms of communication
  - Role induction

What is Culturally-Responsive Tx?

- Recommendations for African Americans:
  - Incorporate spirituality & faith-based coping
  - Selected use of AAVE
- Recommendations for Asians/Asian-Americans:
  - Accept & tolerate low levels of expressivity
  - Avoid comments construed as critical or disapproving
- Recommendations for Latinos:
  - Involve family in treatment
  - Use polite for of "you" (usted) with adults

Content Analysis of CRTs

- Huey, Wood, & Arizago (2010)
- Based on 35 randomized trials that include cultural adaptations
- Must be clear link to race, ethnicity, culture
- 12 cultural-responsiveness categories

Content Analysis of CRTs

- Provide Education/Training
  - E.g., Teach providers about values or beliefs of cultural group
- Cultural Content
  - E.g., Use pictures, images, video, or objects that depict or target ethnic minorities
- Client-Provider Cultural Match
  - E.g., Use providers who are knowledgeable of or sensitive to cultural background/needs of clients
- Cultural Themes/Values
  - E.g., Adopt treatment structure/modality that matches the norms, values, or expectancies of ethnic group

Huey, Wood, & Arizago, 2010

Content Analysis of CRTs

- Linguistic Matching
  - E.g., Conduct treatment in the client's preferred or "needed" language
- Culturally-Responsive Interaction Style
  - E.g., Attend to the hierarchical relationship between provider and client
- Use Family, Peer, or Community Agents
  - E.g., Include community peers as intervention agents
- Cultural Labeling of Program or Concepts
  - E.g., Use culturally-relevant sayings, proverbs, idioms, or honorifics

Huey, Wood, & Arizago, 2010

Content Analysis of CRTs

- Design/Validation by Cultural Agents or Experts
  - E.g., Use cultural agents/experts to review/endorse/rate the appropriateness of intervention or intervention components
- Individualizing Treatment
  - E.g., Allow client to direct the course of treatment
- Prior Support with Ethnic Group
  - E.g., Use interventions or strategies that are empirically-supported with the cultural group
- Cultural Experiences, Psychopathology, & Treatment Processes
  - E.g., Address how ethnic/cultural factors affect treatment engagement, process, or outcomes

Huey, Wood, & Arizago, 2010

Key Questions

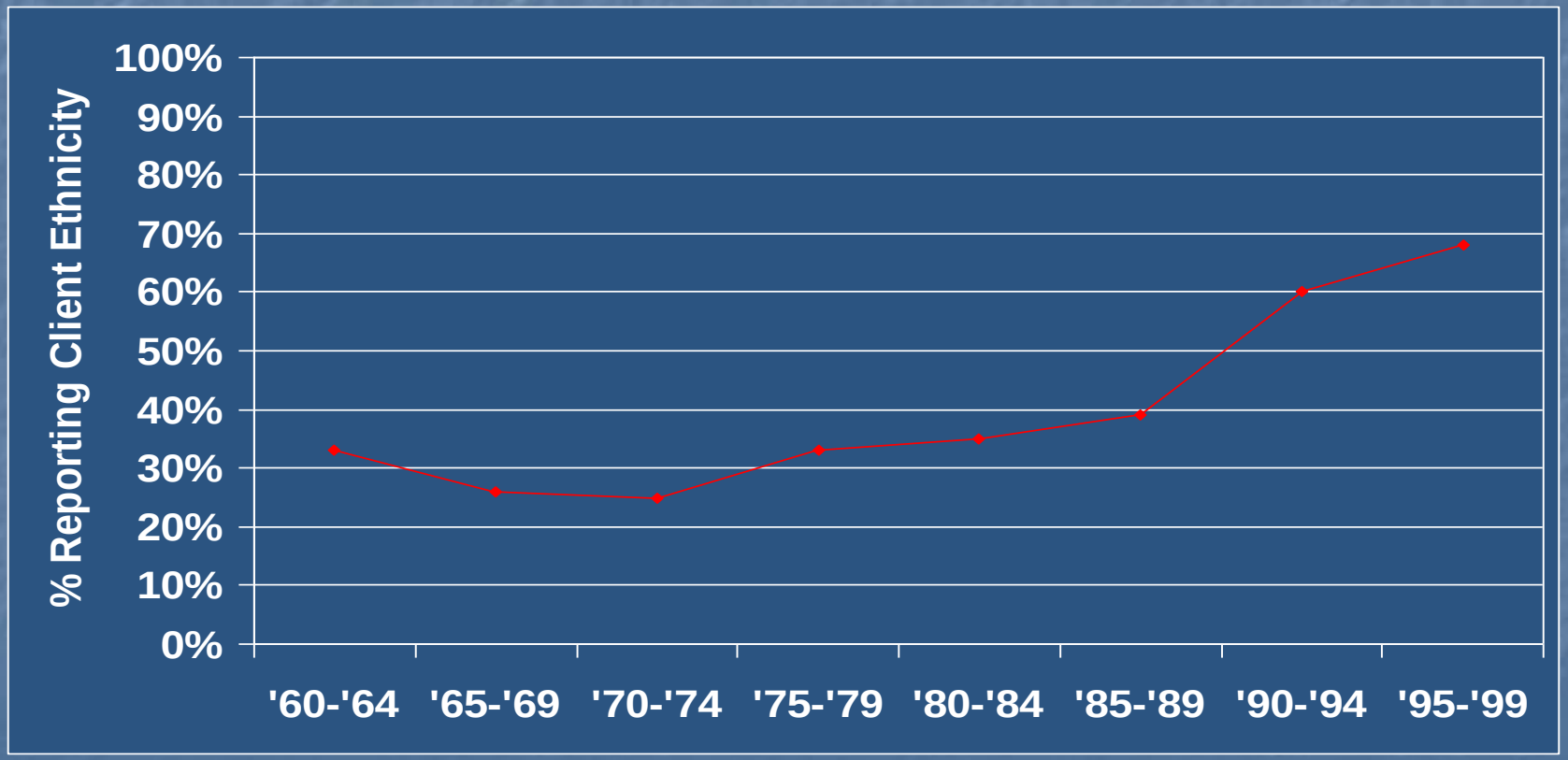
- Are ethnic minority youth adequately represented in clinical trials?
- Are EBTs efficacious with ethnic minority youth?
- Do minorities and non-minorities benefit differentially from the same treatments?
- Do cultural adaptations enhance outcomes for ethnic minorities?

Are Ethnic Minority Youth Well-Represented in Clinical Trials?

Are Minorities Well-Represented?

- Mak et al., 2007
  - Review of 379 NIMH clinical trials (1995-2004)
  - 27% no ethnicity reported; 26% incomplete ethnicity; 48% complete ethnicity
  - When ethnicity *was* reported:
    - Euro-Americans (67%) & Native Americans (1%) at parity
    - African Americans (25%) *overrepresented*
    - Other ethnic groups *underrepresented*

Ethnicity Reporting in Youth RCTs (Huey, Polo et al., in progress)



Do Treatments Work with Minorities?

Meta-Analysis Methods

- What is Meta-Analysis?
  - Quantitative Review of Txs
  - Active Tx vs. Control Group in RCT
    - Why are RCTs and control groups necessary?
  - Effect size
    - d=.20 is small effect
    - d=.50 is medium effect
    - d=.80 is large effect

Meta-Analysis Methods

- Search Process:
  - PsycInfo search of RCTs from 1960-2006
  - Review of child treatment meta-analyses through 2006
  - Reference trails
- Included EBTs focused on treating behavioral and emotional problems in youth
- Active treatment vs. no treatment, placebo, or treatment-as-usual
- Effect sizes weighted to account for sample size differences

Defining Minority EBTs

Well-Established EBT Criteria:

I. Two between-group experiments showing
   A. Superior to placebo
   B. Equivalence to established tx
II. Treatment manual
III. Sample clearly specified
IV. At least 2 different investigating teams

Defining Minority EBTs

Probably Efficacious EBT Criteria:

I. Two between-group experiments showing Treatment > No treatment; OR

II. Two experiments meeting Well-Established Criteria I, II, & III, but not & IV

Possibly Efficacious EBT Criteria:

I. At least one study showing treatment efficacious compared to control, absent conflicting evidence

Defining Minority EBTs

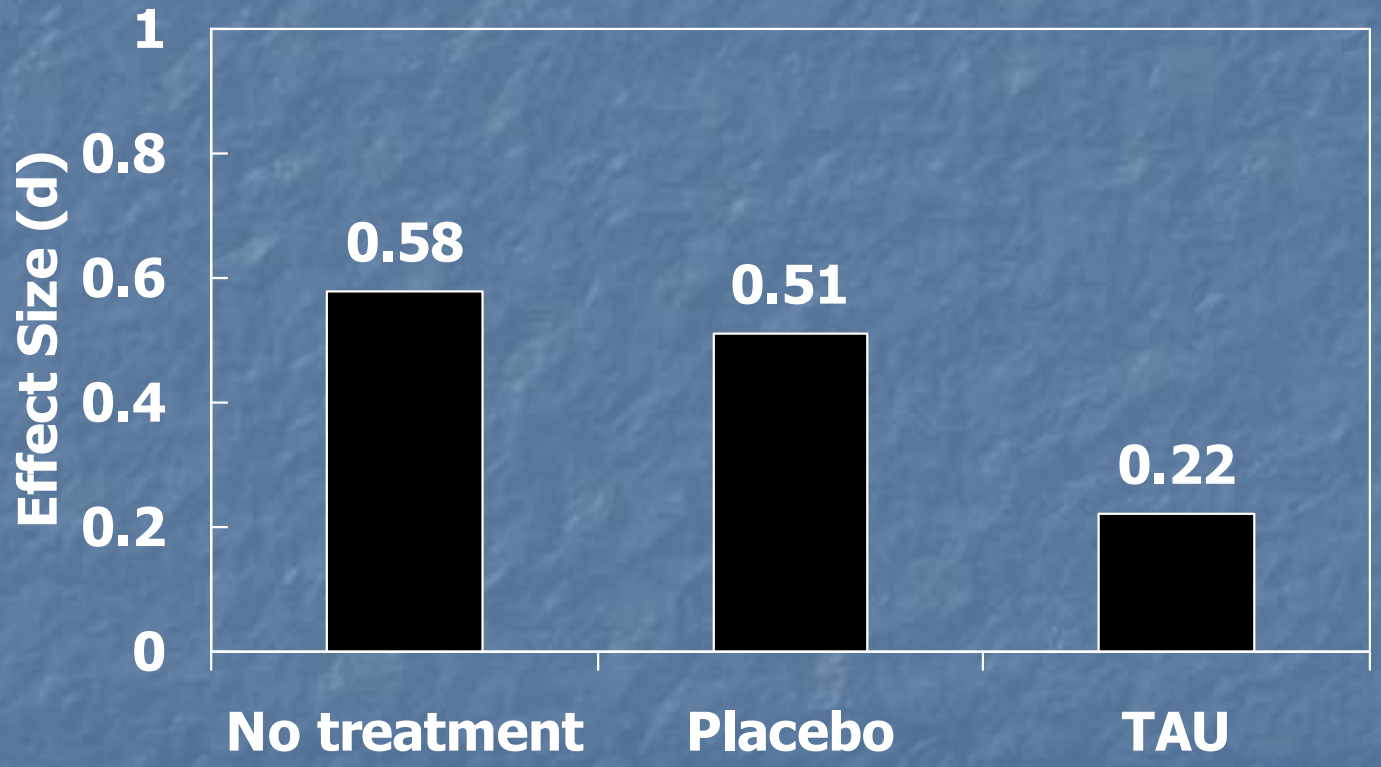
Supplemental Conditions:

I. Study meets the following conditions:
   - A. 75% or more minority; OR
   - B. Separate analyses with minority youth show superiority to control condition; OR
   - C. Ethnicity not moderate treatment effects

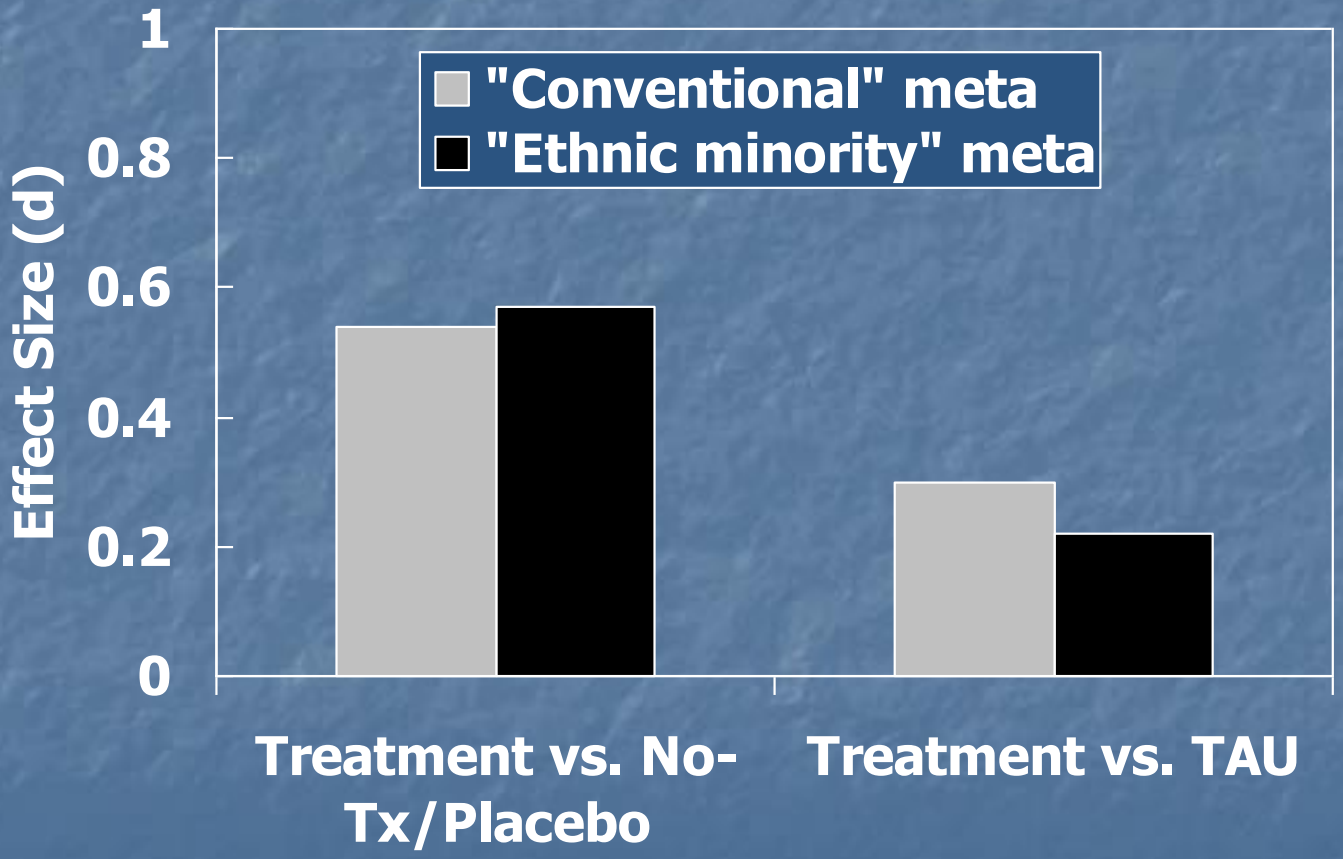
Evidence

- Overall Treatment Effects:
  - N=25 studies
  - ES=.44 post-tx; ~medium effect
  - 13 *probably efficacious* & 17 *possibly efficacious* treatments for minority youth w/diverse problems

Comparison Group Type as Moderator of Treatment Effects for Ethnic Minority Youth (Huey & Polo, 2008)



Effect Sizes for "Conventional" (Weisz et al., 1995; 2006) vs. "Ethnic Minority" (Huey & Polo, 2008) Youth Treatment Meta-Analyses



Evidence

- Evidence-Based Treatments for:
  - Anxiety Disorders
  - ADHD
  - Conduct Problems
  - Depression
  - Drug Use/Abuse
  - Trauma-Related, Suicidality, & Mixed Problems
- No Well-Established Psychosocial Treatments
- Mostly CBTs and Behavioral Therapies
- Mostly for African American & Latino youth

Anxiety Disorders

- Well-Established
  - None
- Probably Efficacious
  - None
- Possibly Efficacious
  - Anxiety Management Training for African Americans with Test Anxiety
  - Group CBT for African Americans & Cuban-Ams with various Anxiety Disorders

Depression

- Well-Established
  - None
- Probably Efficacious
  - CBT for Puerto Ricans
- Possibly Efficacious
  - IPT for Puerto Ricans

Attention-Deficit/Hyperactivity

- Well-Established
  - Methylphenidate for African Americans
- Probably Efficacious
  - Combined medication & behavioral treatment for African Americans & Latinos

Conduct Problems

- Well-Established
  - None
- Probably Efficacious
  - Anger Management Training for African Americans
  - Attributional Retraining for African Americans
  - BSFT for Cuban Americans
  - Child Centered Play Therapy for Mex-Ams
  - Coping Power for African Americans
  - Multisystemic Therapy for African Americans
  - Rational-Emotive Treatment for AfrAm/Latinos

Conduct Problems (*cont'd*)

- Possibly Efficacious
  - Assertive Training for African Americans
  - Behavioral Contracting for African Americans
  - Cognitive Restructuring for African Americans
  - Response-Cost for African Americans
  - Structured Problem-Solving for AfrAm/Latinos

Substance Use/Abuse

- Well-Established
  - None
- Probably Efficacious
  - Multidimensional Family Therapy for *Minorities*
- Possibly Efficacious
  - Multisystemic Therapy for African Americans

Trauma-Related Problems

- Well-Established
  - None
- Probably Efficacious
  - Resilient Peer Treatment for maltreated African Americans showing social withdrawal
  - Trauma-Focused CBT for Minorities (predom African American) with sexual abuse-related PTSD
- Possibly Efficacious
  - CBT for Mex-Ams with violence-related PTSD sxms
  - FIAP for abused/neglected African Americans with emotional and behavioral problems

Suicidal Behavior

- Well-Established
  - None
- Probably Efficacious
  - None
- Possibly Efficacious
  - Multisystemic Therapy for African Americans

Mixed/Comorbid Problems

- Well-Established
  - None
- Probably Efficacious
  - MST for Mixed Hawaiian (Asian/Caucasian/PI)
- Possibly Efficacious
  - RECAP for African Americans

Common Elements of Minority EBTs

- Contingency Management
- Exposure
- Fading
- Feedback
- Homework
- Modeling
- Overcorrection
- Positive Reinforcement
- Problem-Solving Training
- Prompting
- Psychoeducation
- Reframing/Reappraisal
- Rehearsal/Role-Play
- Relaxation
- Response-Cost
- Self-Monitoring & Tracking
- Self-Statements
- Shaping
- Stimulus Control
- Task Analysis

What Might *Not* Work?

Use with Caution

- Insight-Oriented Treatments
  - With disruptive African American & Latino boys (Block, 1978)
  - With boys referred for behavior problems (Szapocznik et al., 1989)
  - But common in real-world settings
- Group-based treatments
  - With delinquent youth (Hackler & Hagan, 1975)
  - Risk of "deviancy training" (Arnold & Hughes, 1999; Dishion et al., 1999)
  - Common in real-world settings

Are EBTs Less Effective for Minority vs. Euro-American Youth?

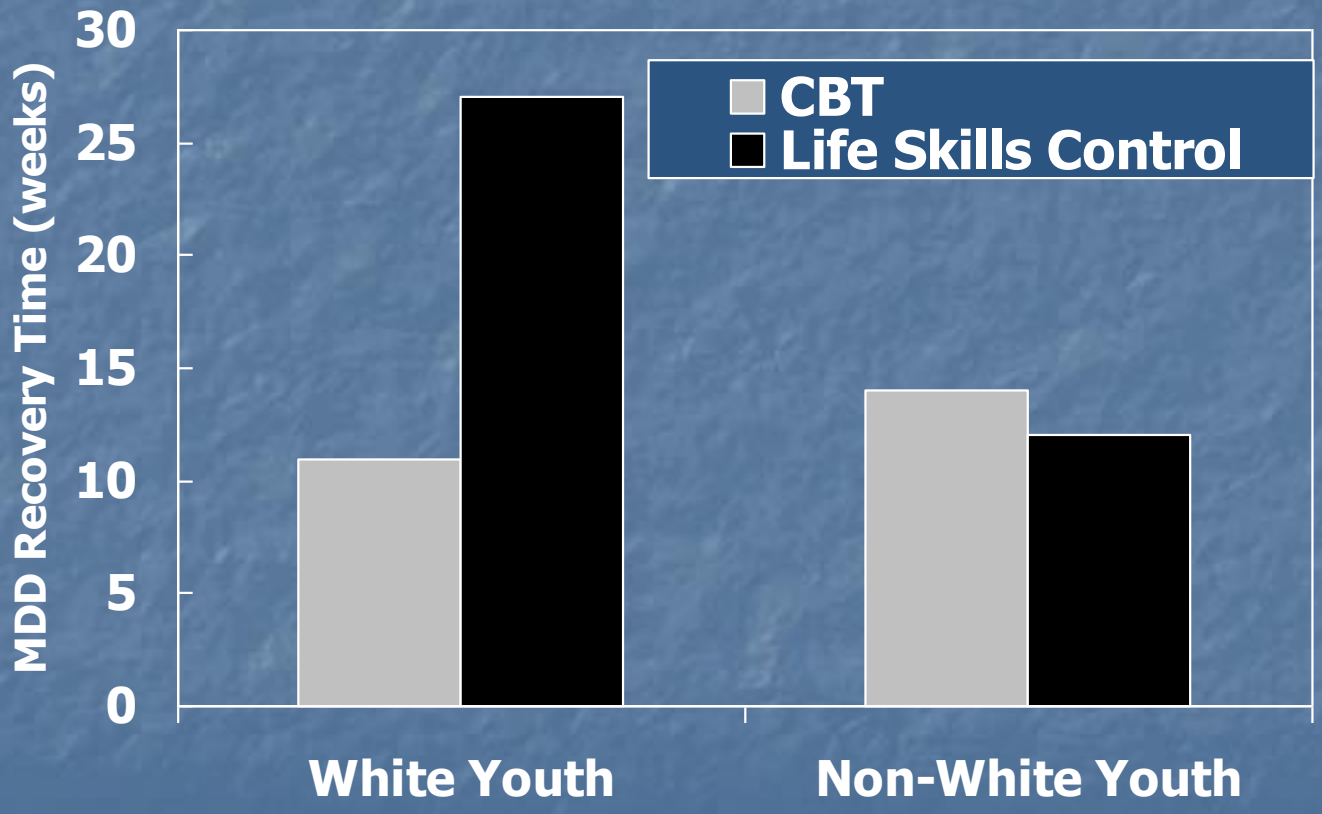
Less Effective?

- Results from Meta-Analyses
  - Outcomes for minorities and Euro-American youth *do not differ*
    - Fabiano et al., 2009; Silverman et al., 2008; Weisz et al., 2006; Wilson et al., 2003
    - Smit et al, 2008; Stice et al, 2006 (Prevention Studies)
  - *Worse* outcomes for Latino youth in Group Tx
    - Waldron & Turner (2008)
  - *No difference* for African Americans vs. Latinos vs. Other/mixed
    - Huey & Polo, 2008
  - *Summary*: Overall no ethnic differences

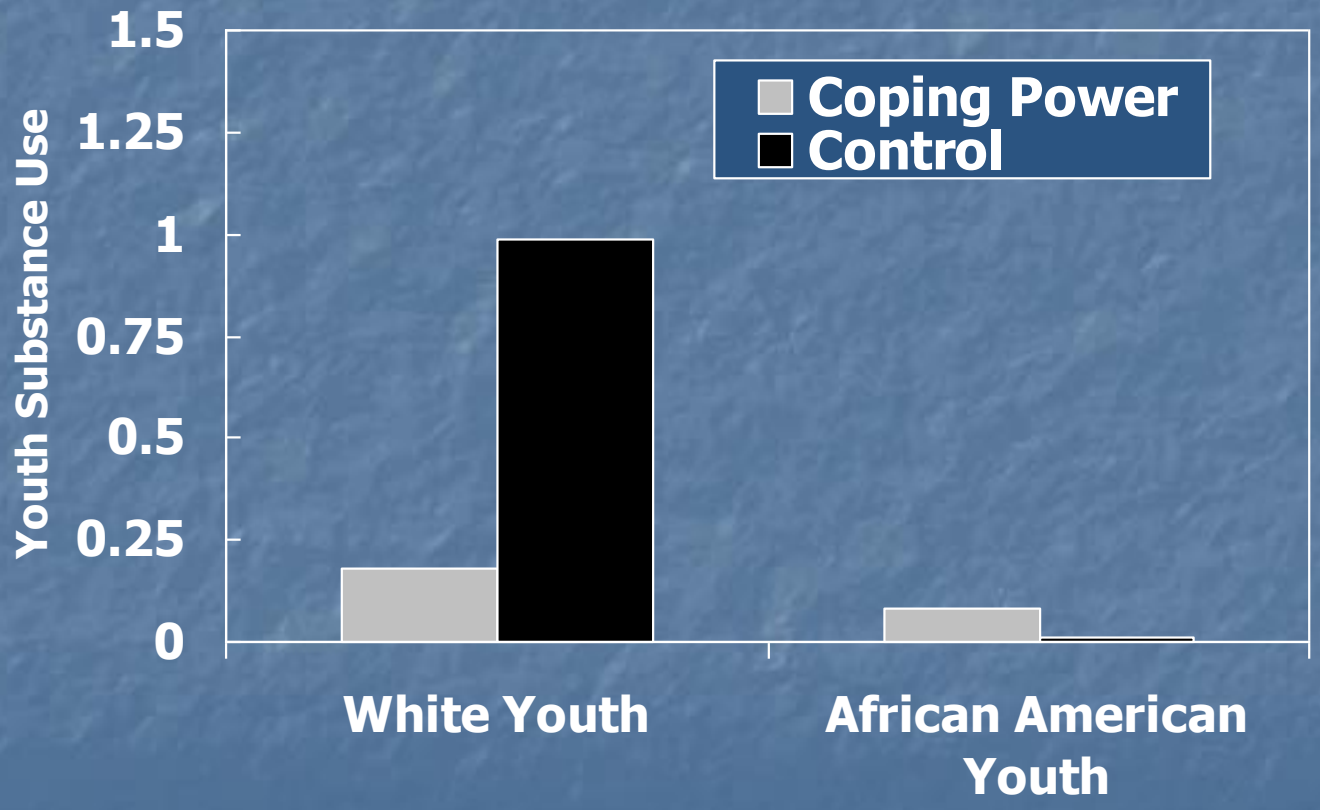
Less Effective?

- Results from Individual Trials
  - Alcohol/drug trials: 4 of 10 show ethnicity effects
  - Youth trials: 5 of 13 show ethnicity effects
  - Sometimes more effective for Euro-Ams, other times more effective for minorities
  - *Summary*: Mixed, but mostly no ethnic differences

Median Time to Major Depression Disorder (MDD) Recovery, by Treatment Condition and Ethnicity (Rohde et al., 2006)



Youth Substance Use at 1-Year Follow-Up, by Treatment Condition and Ethnicity (Lochman & Wells, 2004)



Do Cultural Adaptations Enhance Outcomes for Minority Youth?

Cultural Components

- Culture-Responsive Components:

  Counselor Training/Education:

  - Sensitizing therapists to issues specific to working with minorities
  - Family resource specialist to assist the clinical team in understanding the client cultures

  Interventionist/Client Match:

  - Counselor-youth or peer-youth ethnic match
  - Counselors/peers with common cultural experience or background

Cultural Components

- Culture-Responsive Components (cont'd):

  Therapy Content:

  - Vignettes, examples, materials changed to make more "culturally sensitive"
  - Address intergenerational, cultural conflict
  - Use of cultural themes, symbols, content

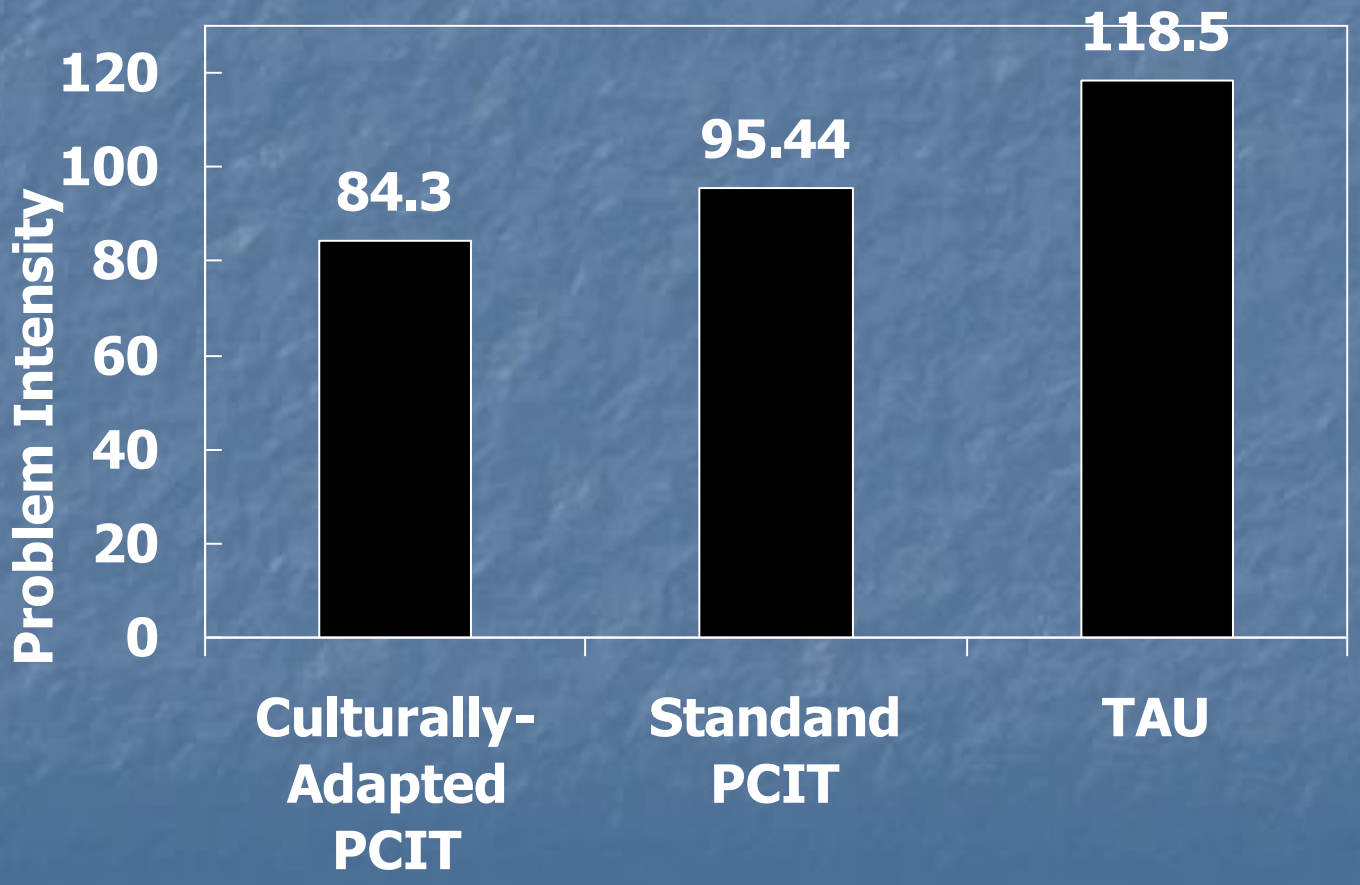
  Other/Miscellaneous/Vague:

  - Treatment individualized to deal flexibly with sociocultural differences
  - Cultural agents involved in treatment development
  - Misc. adaptations for culture or diversity

Evidence

- Are CRTs more efficacious?
  - Correlational Data on Ethnic Match
    - Individual studies (Halliday-Boykins et al, 2005; Yeh et al., 1994) ➔ YES
    - Meta-analysis of ethnic match effects (Maramba & Hall, 2002) ➔ NO
  - Experimental Data – CRT vs. Non-CRT
    - Szapocznik et al. (1986), BSFT w/Latinos ➔ NO
    - Huey, Pan, & Hernandez (*adults*) (2006; 2010) ➔ YES
    - McCabe & Yeh (2009), PCIT w/Latinos ➔ Maybe

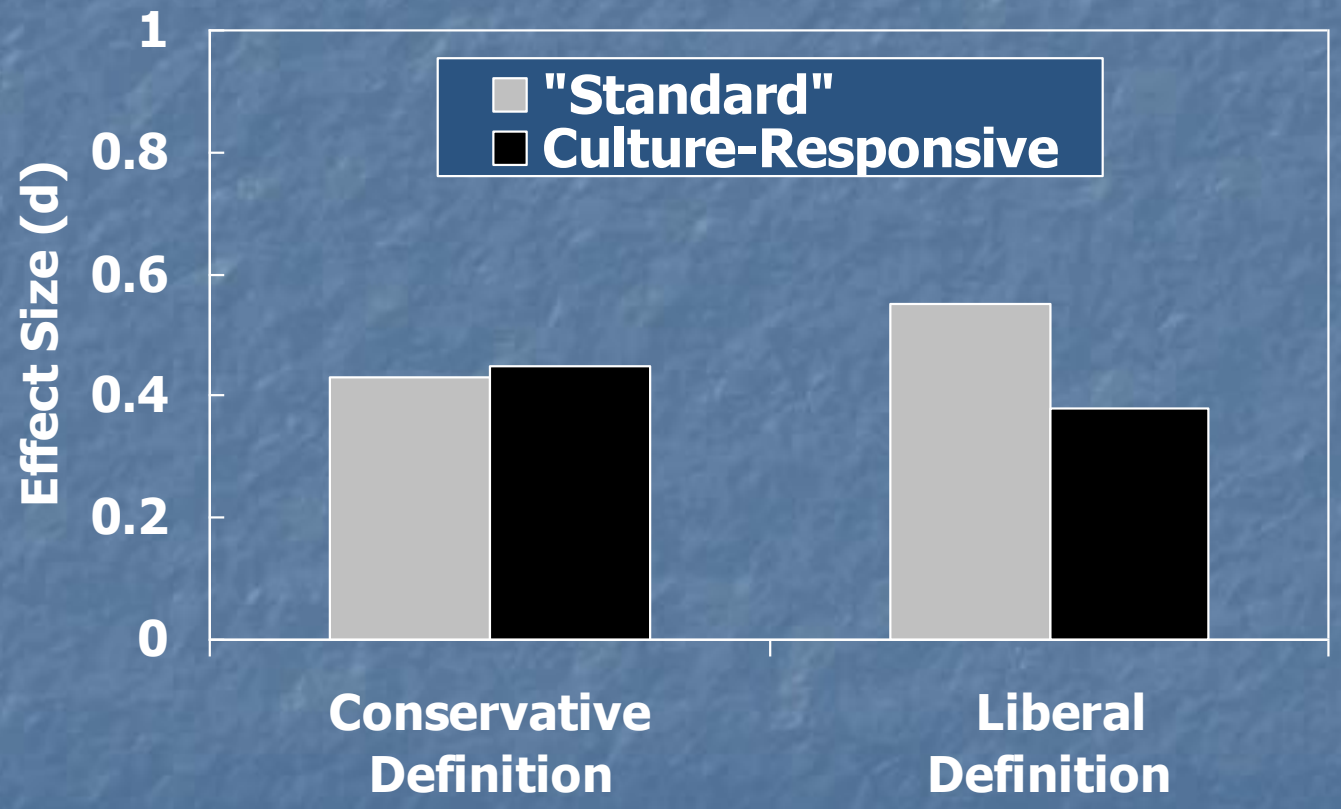
Standard vs. Culturally-Adapted PCIT, Post-Treatment Outcomes for ECBI Intensity Scale (McCabe & Yeh, 2009)



Evidence

- Are CRTs more efficacious (cont'd)?
  - Experimental Data – Individual Tx vs. Family or Group Tx
    - Rossello & Bernal (2004; 2007) → NO
    - Szapocznik et al. (1983; 1986) → NO
  - Treatment Meta-Analyses
    - Griner & Smith (2006) with *adults* → YES
    - Huey & Polo (2008) with youth → NO

Effect Sizes for "Standard" vs. "Culture-Responsive" Treatments



Summary

- EBTs appear to be effective w/ethnic minority youth
- Minority & Euro-Am youth seem to benefit equally
- Mixed picture re: importance of CRTs
  - Most minority EBTs are culturally-responsive
  - Yet no good evidence that CRTs enhance treatment efficacy for minority youth

Limitations

- Non-CBTs rarely tested in RCTs
- Limitations of RCTs:
  - E.g., exclusion criteria, focus on one disorder
- Know little about eating disorders, habit disorders, enuresis, etc. for minorities
- Diverse & potentially "superficial" CRTs
- Cultural-responsiveness effects not isolated
- Influence of acculturation status mostly untested
- Minimal evidence for Asian Americans, Native Americans

Recommendations for Clinical Practice (Tentative!)

What to Recommend for Minorities?

- CBTs (& other EBTs) as first line treatments
- Verbal/written prompts to improve utilization & retention
  - Hachstadt & Trybula, 1980; McKay et al., 1998; Planas & Glenwick, 1986
- Cautious use of "culturally-responsive" strategies
- CRT as means for hypothesis testing

Possible CRT Approaches

Individualize EBTs to Match Youth Culture

- Advantages:
  - Common sense approach
  - Most clinicians do anyway (Harper & Iwamasa, 2000)
  - Permits tailoring of treatment
- Disadvantages:
  - No clear evidence this works
  - Potentially inefficient and distracting
- Fink et al. (1996) – Integrating cultural themes to address impasse

Possible CRT Approaches

Use Treatments only as Validated with Minorities

- Advantages:
  - Cultural content central to some EBTs
  - Most minority EBTs include culturally-responsive components
- Disadvantages:
  - Would be stuck using EBT only with procedures and populations in validation samples
  - Many EBTs ostensibly devoid of cultural content

Possible CRT Approaches

Use Adaptations Tied to Research Evidence

- Advantages:
  - Empirically-based
  - Some very preliminary evidence with adults (e.g., Huey & Pan, 2006; Pan, Huey, & Hernandez, 2010)
- Disadvantages:
  - No good model for this yet
  - Currently impractical – most clinicians not familiar with appropriate research

Alternative Hypotheses

<u>CRT Perspective is Valid, but of Limited Value</u>

- CRT redundant with conventional practice
  - Individualizing as the Norm?
  - E.g., Harper & Iwamasa (2000) survey
  - CRT = good clinical judgment?
- CRT is *effective* but hard to do *effectively*
  - Are "deep structure" CRTs too esoteric, complex, or impractical for general clinical practice?
  - Christensen (1984) – cross-cultural training does not improve White counselor empathy or "attending" behavior
- Cultural "discordance" is optimal for minorities
  - Kim et al. – White therapists who challenge worldview of Asian Americans may be optimal for Asians

Alternative Hypotheses

CRT Perspective is Valid, but of Limited Value

- CRT facilitates engagement, not clinical change
  - For AfrAm female clients, higher credibility & treatment persistence/satisfaction when culturally sensitive counselors (Wade & Bernstein, 1991)
  - For depressed AsianAms, directive treatment leads to greater working alliance than non-directive treatment, but no effect on depression (Pan & Huey, 2010)
- CRT works but mostly with low acculturation clients
  - Pan, Huey, & Hernandez (2010)

OST Phobic Stimuli

- Common House Spider

- Cellar Spider

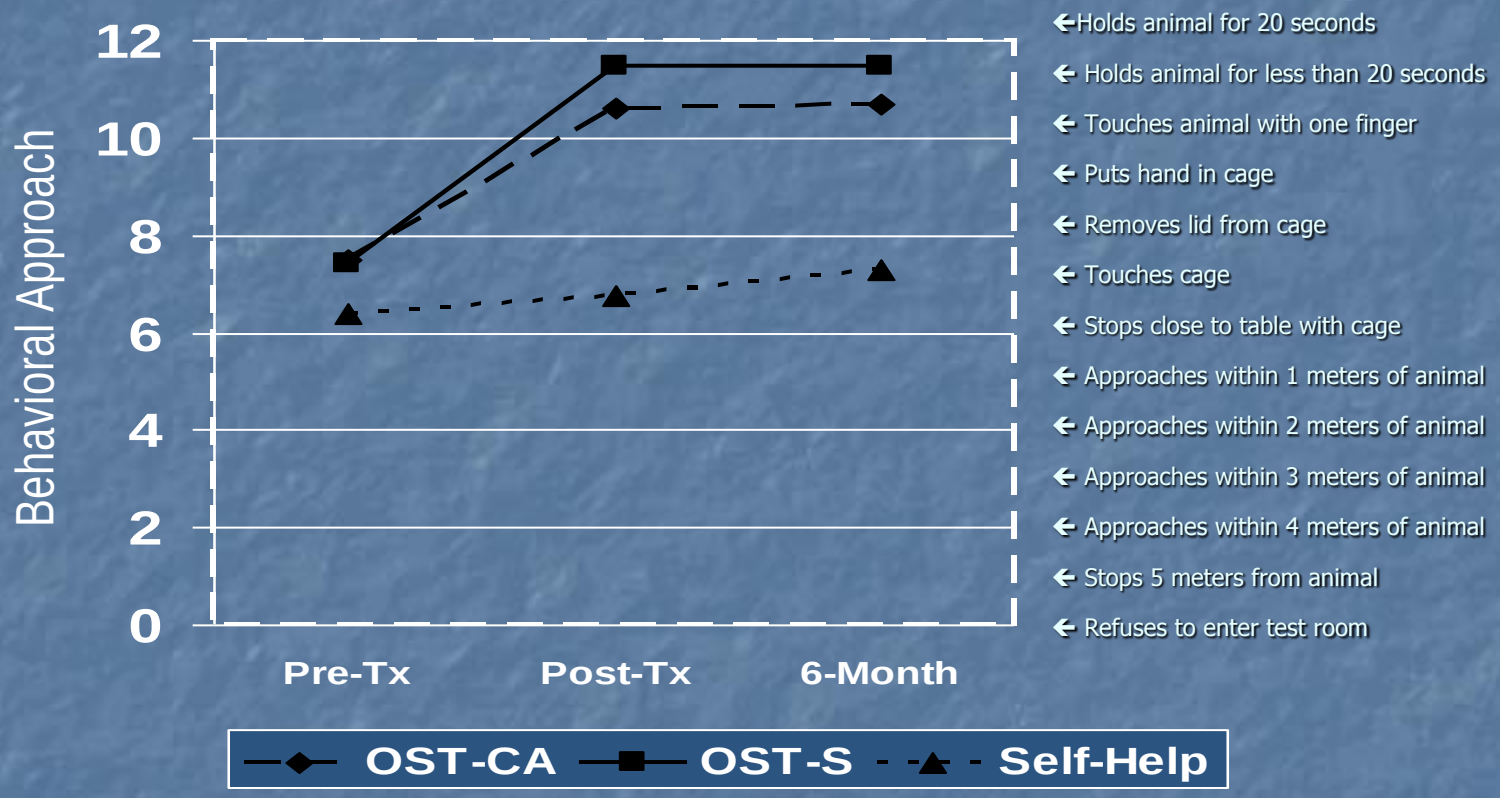
Pan, Huey, & Hernandez, 2010

Procedures

- Participants: 30 Asian Americans, English speaking, screened for at least one phobia
- Fears of spiders, crickets, worms, & dead fish
- Design: Randomized into three conditions: OST-S, OST-CA, & self-help manual
- 7 Cultural Adaptations: E.g., Normalize problem; Emphasize/facilitate emotional control; Exploit vertical nature of therapy

Pan, Huey, & Hernandez, 2010

Behavioral Approach

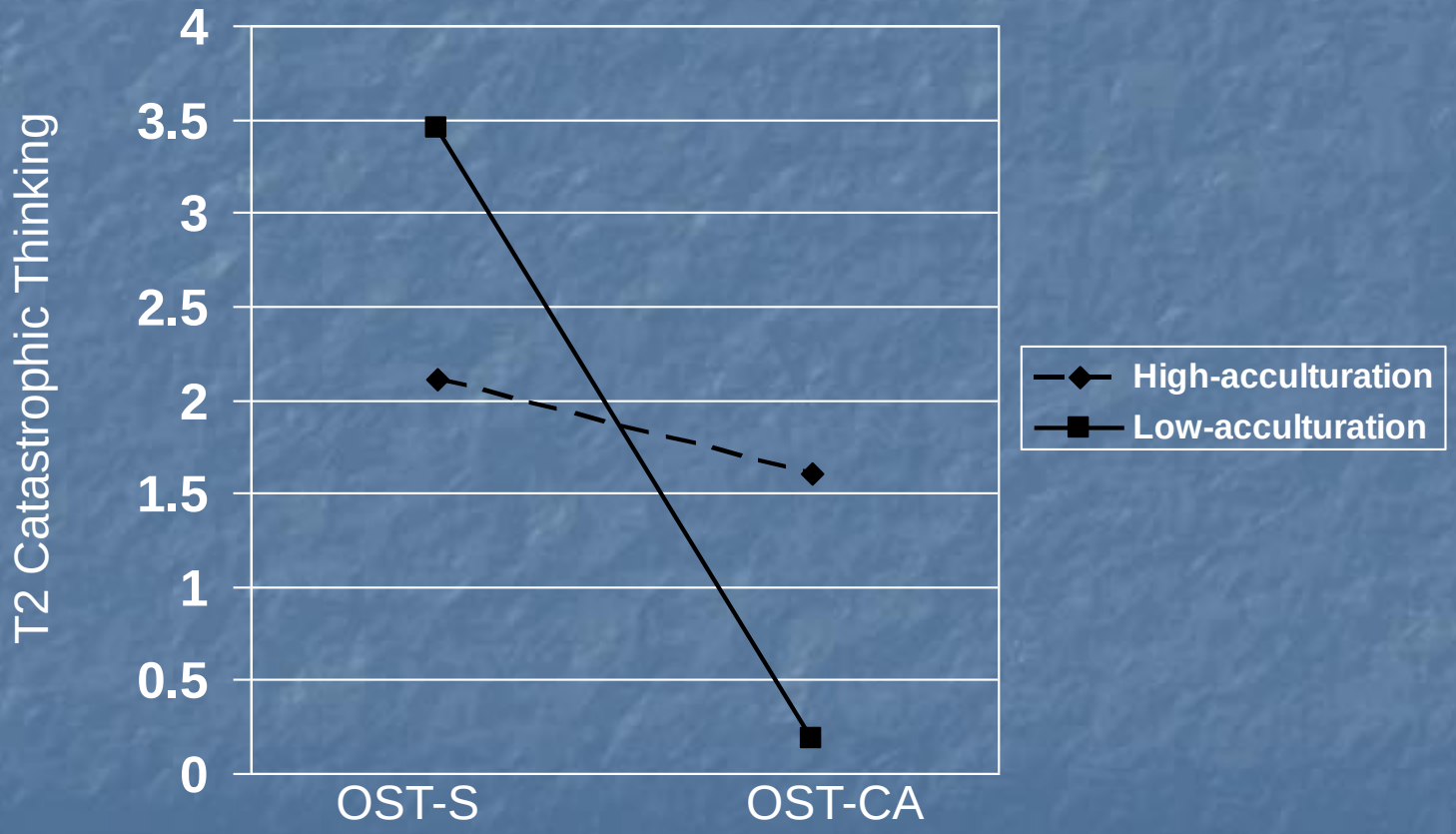


Pan, Huey, & Hernandez, 2010

Self-Report Ratings

Variable	Group Differences
Fear/Avoidance symptoms (ADIS)	OST-S < OST-S OST-CA < Self-help
Catastrophic Thinking (FTQ)	OST-CA < OST-S OST-CA < Self-help

Acculturation Status as a Moderator of Treatment Effects



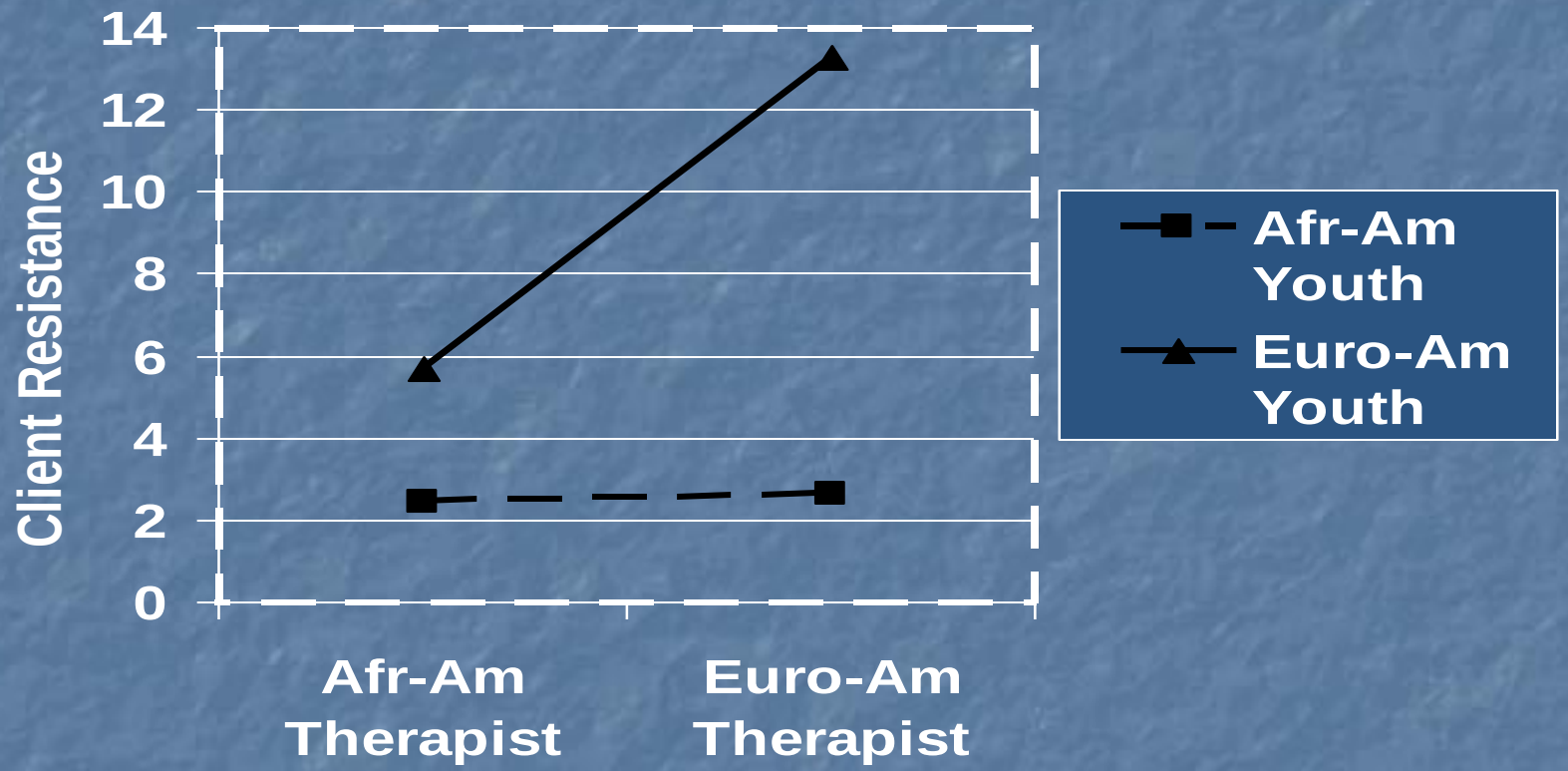
Pan, Huey, & Hernandez, 2010

Alternative Hypotheses

CRT Perspective is Invalid in Some Situations

- CRT as inefficient clinical practice
  - Black therapists address race more (Jones, 1978). Is that better?
  - CRT as *distraction* from more effective methods
  - E.g., Schulte et al. (1992); Foa et al. (1999)
- CRT as harmful practice
  - Group-based treatments (Arnold & Hughes, 1999)
  - Normalizing problems (Brown et al., 2003)
- CRT as impediment to collaboration
  - Clients may view minority therapists as less competent
  - Minority therapists may "overidentify" with clients
  - Asian American clinicians smile less often than Euro-American clinicians when paired with Asian American clients (Kim, Liang, & Li, 2003)

Client & Therapist Effects on Phase II Resistance



Huey, Hall, & McDaniel, 2008

Conclusions

- What do we know?
  - Lots of progress with treatment of minority youth
  - EBTs generally work with Black/Latino youth
  - Generally, minority and White youth respond equally well to EBTs
- What do we *not* know
  - Do immigrant & less acculturated youth respond less favorably to EBTs?
  - How do Asian, Middle-Eastern, Native-American, or other minority youth respond well to EBTs?
  - Does cultural-responsivity enhance treatment effects for minority youth?

Final Thoughts for Researchers

- How to show that a strategy is truly culturally-responsive?
  1. Strategy must be consistent with some "theory" (*many examples*)
  2. The culturally-responsive treatment must be better than no-treatment or placebo (*many examples*)
  3. The culturally-responsive treatment must be better than a "non-responsive" equivalent (*1 or 2 examples*)
  4. "High-risk" minorities must benefit more than "low-risk" minorities (*1 or 2 examples*)
  5. Minorities must benefit more from the culturally-responsive treatment than Whites (*no examples*)

Final Thoughts for Providers

- My idiosyncratic guidelines for using culturally-responsive strategies:
  - When conventional approaches not working
  - If you approach as *hypothesis, not assumption*
  - If doesn't interfere with ethical practice
  - If doesn't interfere with your "active ingredients"
  - If it's something you can reasonably do or learn
  - If reasonable belief that will help client get better

References:

Huey, S. J., Jr., & Pan, D. (2006). Culture-responsive one-session therapy for phobic Asian Americans: A pilot study. Psychotherapy: Theory, Research, Practice, and Training, 43, 549-554.

Huey, S. J., Jr., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. Journal of Clinical Child and Adolescent Psychology, 37, 262-301.

Huey, S. J., Jr., & Polo, A. J. (2010). Assessing the effects of evidence-based psychotherapies with ethnic minority youths. In J.R. Weisz and A.E. Kazdin (Eds.) Evidence-Based Psychotherapies for Children and Adolescents (2nd Ed.) (pp. 451-465). New York, NY: Guilford.