Evidence-Based Treatment & Patient Diversity: What We Know & Why It Matters

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Cultural Responsiveness Hypothesis

• 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 & clinicians must be culturally competent
Questions We Asked in Grad School

• Are EVTs effective with ethnic minorities?
  – Sometimes maybe. But often not.

• Do White youth benefit more than minorities from the same treatments?
  – Of course Whites benefit more

• Do cultural adaptations enhance outcomes for ethnic minorities?
  – Yes, definitely
6 Questions To Address

• Are treatments effective with ethnic minorities?
• Are treatment outcomes worse for minorities compared to Euro-Americans?
• Does cultural tailoring enhance treatment outcomes for minorities?
• What about other domains of diversity?
  – E.g., class, religious beliefs, sexual orientation
• Does culture matter?
• How to best address diversity in the treatment context?
Are Therapies Effective with Ethnic Minorities?
Meta-Analysis Primer

• What is Meta-Analysis?
  – Quantitative Review of Therapy Effects
  – Active Treatment vs. Control Group in Randomized Trials (RCTs)
  – Effect Size
    • $d=.20$ is small effect
    • $d=.50$ is medium effect
    • $d=.80$ is large effect
    • Effects adjusted for sample size
Treatment Outcome Meta-Analyses with Ethnic Minorities

Gillespie & Huey, 2015; Huey & Polo, 2008; Huey et al., 2014; Huey & Tilley, 2016
Mental Health Treatment Effects for Ethnic Minorities Across 140 Randomized Trials

Huey et al., 2014
EBTs for Minorities

- **More than 50 EBTs** for ethnic minorities with diverse mental health problems
  - At least 24-28 EBTs for youth
- Family systems therapies (*e.g.*, FFT, BSFT, MDFT, MST)
- Interpersonal psychotherapy (*IPT*)
- Diverse cognitive-behavioral treatments (*CBTs*)
- Infant-parent relationship therapy, motivational interviewing, play therapy, and other therapies
- Modality doesn’t seem to matter much
  - Family vs. group vs. individual (*e.g.*, Bernal; Nayamathi; Szapocznik)
Common Elements of Minority EBPs

• Theoretical coherence, with underlying theory of change
• Structured or semi-structured protocol, or treatment manual
• Standard number of sessions or clear termination criteria
Are Treatment Outcomes Worse for Ethnic Minorities vs. Euro-Americans?
Differential Effectiveness?

• Reviews by Huey & Polo (2008) & Miller et al. (2007)
  – Most relevant studies show no ethnic differences in treatment effects
  – 15%-23% show effects favoring minorities

• Results from 29 Meta-Analyses (Huey & Smith, 2014)
  – 62% show no ethnicity effects
  – 14% show effects that favor whites
  – 17% show effects that favor minorities

• Summary: No consistent ethnicity effects
Does Cultural Tailoring Enhance Outcomes for Ethnic Minorities?
General Reasons to Consider Culture

- Implicit bias against outgroups is the norm, & such biases affect judgment & behavior
- Interracial interactions can be cognitively taxing
- Majority & minority groups often have different perceptions of opportunity & discrimination

Banaji & Greenwald, 2013; Norton & Sommers, 2011; Richeson & Shelton, 2007
Clinical Reasons to Consider Culture

• Stigma
• Help-Seeking
• Underutilization
• Patient preferences
• Clinician/system biases
• Greater psychopathology or severity
• Symptom profile/presentation
• Unique MH correlates for minorities & immigrants
• Attrition/dropout
• Treatment barriers
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
Cultural Competence Models

- Rogler ➔ (1) Increase access, (2) Select traditional treatments that fit, (3) Modify traditional treatments
- Bernal ➔ Metaphors, language, etc.
- Sue et al. ➔ Tripartite Multicultural Competencies
- Lopez ➔ Shifting Cultural Lenses Model
- Fuertes & Gretchen ➔ 8 Theories of Multicultural Counseling
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 form of “you” (usted) with adults
Evidence

• Most minority-focused treatments are culturally-tailored

• 10 meta-analyses summarized by Huey et al. (2014)
  – All show that culturally tailored treatment better than no treatment, placebo, & services-as-usual controls
  – BUT, do culturally tailored treatments work better than generic treatments?

• Huey (2013) meta-analysis
  – Rigorous, direct comparison of tailored vs. generic treatments
  – Overall effect size of $d=0.01$, no effect
Effect Sizes for 10 Randomized Trials of Culturally Tailored vs. Generic Treatments

Note: A positive effect size means that outcomes favor the culturally tailored condition; a negative effect size means that results favor the “generic” condition.
Why Might Tailoring *Diminish* Effects?

- **Reactivity**
  - Some cultural content may evoke negative emotional rxns
  - Chang; Webb

- **Less Activation of Change Mechanisms**
  - Some tailoring may *distract* from core strategies or create *inefficiencies* that *interfere* with active ingredients
  - Castro; Lau; Kumpfer et al.; Kliewer et al.
Kliewer, Lepore Et Al. (2011)

• Sample & Design
  – Black youth (91%) in high-violence, urban neighborhoods
  – Classroom randomly assigned to Standard vs. Enhanced Expressive Writing vs. Control

• *Standard* Expressive Writing
  – Write about their deepest thoughts and feelings related to violence

• *Culturally Enhanced* Expressive Writing
  – Given option to write stories, skits, songs, or poetry about violence, and to share their work with others in the classroom
  – Rationale?
    • Strong oral tradition within African American culture
    • Popularity of “Spoken Word” & role of rap in popular culture
    • Reflects cultural experience of African Americans

• Results
  – Enhanced *less effective* at reducing teacher-rated aggression!
  – Why? Maybe less emotional processing in enhanced condition
Summary

• What we know so far
  – Therapies are generally effective for ethnic minorities
    • In lab and real-world settings
  – Many EBTs for Blacks & Latinos
    • And increasing for Asians Americans, indigenous populations, & ethnic minorities in other countries
    • Mostly CBTs, but not exclusively
  – Minorities & Euro-Ams mostly benefit equally
  – No persuasive evidence that cultural tailoring necessarily enhances treatment effects
Other Aspects of Diversity?
Low-Income Status

- Do EBTs work for low-income youth?
- Dozens of RCTs include predominantly low-income youth & families
- E.g., Most trials for Coping Power, MST, & MTFC focus on low-income youth
- EBTs are generally effective with this population
- Not much discussion of tailoring efforts
Other Diversity Categories

• Religion
• Gender
• Sexual orientation/ID
• Immigrant status
• Age
• Region of country
• Disability
• Family structure
• Etc.
"But counting sheep makes me hungry."
Evidence that Culture Matters
Race & Culture Matter

- Cultural adaptation with Asian Americans
  - Culturally adapted OST works better with Asian Americans
  - Directiveness helps reduce depressive symptoms in Asian Americans
- Ethnicity moderates intervention effects
  - Dissonance treatment reduces ED risk for Asian Americans but not Euro-Americans
- Ethnicity and treatment process
  - Black & White families show different patterns of resistance over the course of treatment

Chithambo & Huey, 2017; Huey & Pan, 2006; Pan & Huey, 2017; Pan et al., 2011; Sayegh et al., 2016
OST for Phobic Asian Americans

- One Session Treatment (OST) for Phobias (Öst, 1996)
- 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, 2011
OST Phobic Stimuli

- Common House Spider
- Cellar Spider

Pan, Huey, & Hernandez, 2011
Behavioral Approach

Pan, Huey, & Hernandez, 2011
Treatment “Resistance” in MST

• Ethnic diffs in “Struggle & Working Through” Hypothesis?
• 41 youth and families in MST clinical trial
  – Juvenile drug offenders ($M=15.4$ years)
  – 59% African American, 41% White
• Resistance Coding
    • Client behavior that appeared to “block, divert, or impede the direction set by the therapist or if the client criticize[d] present family members”
  – Coded 3 audio-taped sessions from each client
• Cannabis use & recidivism at post-tx & follow-up
• Results
  – Different resistance trajectories for Black vs. White families
  – Negative quadratic Whites who desisted from crime; but positive quadratic for Black desisters

Sayegh et al., 2017
Treatment Resistance, by Race

Sayegh et al., 2017
Results

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<th>Sample Category</th>
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<th>Resistance (SD)</th>
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<td></td>
<td>II</td>
<td>11.08 (.10)</td>
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<td></td>
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<td></td>
<td>III</td>
<td>6.02 (.09)</td>
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Resistance Proportion for African Americans Who Desisted at Follow-up compared to All Other Youth.
Addressing Diversity in Evidence-Based Practice
Strategies for Addressing Diversity

• Strategies that allow one to consider a variety of diversity concerns while minimizing stereotyping

• Many consistent with manualized approaches & “common sense” clinical practice

• Derived from review of hundreds of EBTs for diverse populations
  – But many don’t have “gold standard” evidence
Strategies for Addressing Diversity

• Inclusivity
• Reduce access barriers
• **Role induction**
  • Start & stick with client goals
  • “Fit” analysis
• Strength-focus
• Cultural knowledge but avoid assumptions
• **Humility**
Inclusivity

• Diversity Cues
  – Claude Steele & “Whistling Vivaldi”
  – Diverse staff, pictures, brochures, etc.
  – U Wisconsin brochure
  – Wood website

• Use sensitive and inclusive language
  – Use “partner” vs. “boyfriend”
    – Donald Trump
    – Bernie Sanders
Role Induction

• Key elements of role induction
  – Review expected frequency of attendance & services available
  – Elicit treatment expectations & correct misperceptions
  – Clarify therapist & client responsibilities
  – Elicit reasons for entering treatment & discuss how treatment relates to identified problems
  – Elicit barriers to attendance & problem-solve

• Improves engagement & reduces dropout for ethnic minority clients (Katz et al., 2004)
“Cultural” Knowledge

• Some familiarity with norms, experiences, & challenges of population you’re working with
  – E.g., “coming out” & higher suicidality for LGBT youth
  – E.g., higher substance abuse among LBT women
  – E.g., discrimination & higher schizophrenia in AfrAms

• You should NOT be “colorblind”
  – E.g., Apfelbaum, Norton research

• Avoid assumptions about the importance/relevance of race, class, sexual orientation, etc. for client
Humility

"Look, I know you think you've got the stuff, but I'm telling you: walk God."
Humility

• We often don’t know what we don’t know
• We have self-serving & self-enhancing biases
  – Therapists give inflated ratings of competence/adherence
  – Generally, experienced therapists no better than novices
• Solicit client’s perspective & experiences, but...
• Don’t presume you’ll truly understand that experience, esp. if cultural differences
• Southpark
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References:


Hyperlinks
"That's the racist bone in your body you claimed you didn't have."
Bias as Zero-Sum Game

Fig. 1. White and Black respondents’ perceptions of anti-White and anti-Black bias in each decade.
Struggle-and-Working-Through

Patterson & Chamberlain, 1994
What **NOT** to do
What *NOT* to do