Evidence-Based Practice and Youth Diversity: What We Know & Why It Matters

Stan Huey, Ph.D.
Department of Psychology
University of Southern California

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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 EVT 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
5 Questions To Address

• Are EBPs effective with ethnically diverse youth?
• Are EBP outcomes worse for minorities compared to Euro-Americans?
• Does cultural tailoring enhance EBP outcomes for minority youth?
• What about other domains of diversity?
  – E.g., class, religious beliefs, sexual orientation
• How to best address diversity in EBP?
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
    • $d=0.20$ is small effect
    • $d=0.50$ is medium effect
    • $d=0.80$ is large effect
    • Effects adjusted for sample size
Treatment Outcome Meta-Analyses with Ethnic Minorities

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

Effect Size (d) for various conditions:
- Anxiety: 0.74
- Depression: 0.46
- Externalizing Problems: 0.47
- Schizophrenia: 0.76
- Substance Use: 0.37
- Smoking: 0.38
- Trauma-Related: 0.64
- Misc/Other: 0.29

Huey et al., 2014
EBPs for Minorities

• **More than 50 EBTs** for ethnic minorities with diverse mental health problems
• 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
  – Family vs. group vs. individual (*e.g.*, Bernal; Nayamathi; Szapocznik)
Common Elements of Youth 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?
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?

• Some Pan-Minority Recommendations:
  – Short-term, 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 clients 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
  – E.g., Huey & Polo (2008), Gillespie & Huey (2013)

• 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 $d=.01$, no effect
Effect Sizes for 10 Randomized Trials of Culturally Tailored vs. Generic Treatments

![Graph showing effect sizes for 10 randomized trials, with positive and negative effect sizes indicated.]

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
  - E.g., Speech anxious Latinos undergoing exposure feel less anxious in front of a “Latino” audience (Perez, 2008)
    - Paradoxically, cultural concordance could make clients *too comfortable*
  - Castro; Lau; Kumpfer et al.; Kliewer et al.
Kliewer, Lepore Et Al. (2011)

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

• 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 EBPs for Blacks & Latinos
    • And increasing for Asians Americans & indigenous populations
  – Minorities & Euro-Ams mostly benefit equally
  – No persuasive evidence that cultural tailoring necessarily enhances treatment effects
Other Aspects of Diversity?
Low-Income Youth

• Do EBPs 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
• EBPs are generally effective with this population
• Not much discussion of tailoring efforts
LGBT Youth

• Do EBPs work for LGBT youth?
• No RCTs focused specifically on LGBT youth with mental health problems
• Lots of adult-focused RCTs, but mostly focused on HIV prevention or treating sequelae of HIV (e.g., depression)
• EBPs generally effective with LGBT adults with anxiety-related problems, depression, & substance-use problems
• But efficacy with LGBT youth unknown, & importance of LGBT-specific tailoring unclear
Other Diversity Categories

• Religion
• Gender
• Immigrant status
• Age
• Region of country
• Disability
• Family structure
• Etc.
"But counting sheep makes me hungry."
Addressing Diversity in Evidence-Based Practice
Strategies for Addressing Diversity

• Mostly derived from review of hundreds of EBPs, but many don’t have “gold standard” evidence
• Allows one to consider a variety of diversity concerns while minimizing stereotyping
• Consistent with manualized approaches & “common sense” clinical practice
Strategies for Addressing Diversity

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

• Diversity Cues
  – Claude Steele & “Whistling Vivaldi”
  – Diverse staff, pictures, brochures, etc.
  – [Wood website](#)

• Use sensitive and inclusive language
  – Use “partner” vs. “boyfriend”
  – [Bernie Sanders](#)
Reducing Access Barriers

• Linguistic access
• Geographic access
  – Home-based approaches
  – Mobile Triple P!
• Transportation, insurance, sliding scales, work schedule, childcare, etc.
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)
Focus on Client Goals

• Goals often reflects client *priorities and values*
• Elicit treatment goals from relevant family members
• Let client’s goals direct course of treatment
• Resist impulse to change vs. collaboration on tx goals
Involve Natural Agents

- Engage parents & other *feasible* natural agents
- As “explainers”, interpreters, idea generators, supervisors, coaches, parent surrogates, etc.
- Who “takes over” when treatment ends?
- **50,000 coaches**
“Fit” Analysis

• In CBT terms, a functional analysis
• Evaluate ABC’s – antecedents & reinforcing consequences of behavior
• In the MST world, involves “fit” circles
• Modify & individualize treatment based on evolving “fit”
Strength-Focused

- Emphasize what youth/family is doing “right”
- Build on preexisting values & competencies
- Utilize preexisting resources
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

• Avoid assumptions about the importance/relevance of race, class, sexual orientation, etc. for client
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
Contact:
Stan Huey, Ph.D. Phone: 213-839-5217
University of Southern California Email: hueyjr@usc.edu
Department of Psychology, SGM 501
3620 S. McClintock Ave.
Los Angeles, CA 90089

References:
