Cultural Adaptation of a Group Treatment for Haitian American Adolescents

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As the psychology field moves towards establishing more evidence-based treatment (EBT), the applicability of EBT for different racial and immigrant groups (i.e., African American, Asian Americans and Pacific Islander, and Native American/Native Alaskan) is paramount. The current paper highlights the process of culturally adapting an EBT group cognitive behavioral therapy (CBT) intervention for use with Haitian American adolescents diagnosed with depression. Overall the main objective of this project was to culturally adapt the Adolescent Coping with Depression Course (ACDC) to ensure that it includes cultural factors that are likely to engage and retain Haitian adolescents in mental health treatment. The paper summarizes the cultural training of the focus group leaders, the focus group sessions with a group of Haitian middle-school students, and the feedback received from the participants regarding the intervention.

Keywords: culture, treatment, Haitian, immigrant, adolescent

Culturally diverse youth under the age of 18 now constitutes 30% of the population, and will account for approximately 40% of the total population by the year 2020 (U.S. Census Bureau, 2004). However, a recent methodological analysis of 236 published randomized trials conducted from 1962 to 2002 found major gaps in the representation of African American, Latino/a American, Asian American and Pacific Islander, and Native American/Native Alaskan (ALANA) individuals in these trials (Weisz, Doss, & Hawley, 2005). Moreover, research findings on efficacious interventions for immigrant adolescents are scarce. For a more detailed review of the literature, see Bernal, Jiménez-Chafey, & Domenech Rodríguez (2009). In this paper, the steps used to culturally adapt an evidence-based treatment (EBT), using a cultural framework, for Haitian American adolescents with depression are reviewed.

Mental Health Issues Among Black Immigrant Youth

For any immigrant, the transition to a new country, culture, and environment can be particularly stressful. Such struggles are often exacerbated by the developmental changes associated with childhood and adolescence. For example, Caribbean youth face tremendous physical stressors during their transition to the United States that can significantly impact their identity development. Caribbean adolescents may be particularly vulnerable, as it is common practice among Caribbean youth to immigrate without immediate family members and to have other relatives assume caretaker roles for them. As a result of this "traumatic disruption in social and psychological support systems" (Bibb & Casimir, 1996, p. 102), it is suspected that Caribbean immigrant youth will experience mental health problems beyond those of the general African American youth population (Bibb & Casimir, 1996).

Stressors relating to discrimination and prejudice, coupled with acculturation issues, may predispose immigrant youth to a number of mental health problems. For example, in a study examining Caribbean adolescents’ health, Halcón et al. (2003) found that 1 in 10 of the participants reported a disability, significant health problems, and exposure to violence. Thomas, Stone, Osborn, and Fisher (1993) conducted an independent project examining the experiences of African and Caribbean people involved in mental health services in the United States. They found that second generation African and Caribbean people had significantly higher first admission rates to inpatient hospital units compared with
White people in the same age group. Approximately 45% of the second generation African and Caribbean group had a diagnosis of schizophrenia, compared with 5% for White age-matched patients. Equally disturbing, approximately 35% of African and Caribbean patients were admitted involuntarily to inpatient units, compared to 8% of White patients. Furthermore, research has shown that attitudes and perceptions of health care professionals about the causes, consequences, and appropriateness of responses to mental health problems differ in significant ways depending on the racial classification of the patients (Weisz et al., 2005). The tendency of health care professionals to misinterpret differences in cultural and racial expression and experiences of mental health and illness has serious implications for Black people in this country (Jackson et al., 2004).

The Haitian community in the United States is growing steadily. According to the 2000 Census, there were 419,317 documented Haitian immigrants in the United States, making Haitians the second largest population of Black immigrants in the United States, after Jamaicans. Many Haitian immigrants hold unique views of the world that may influence their understanding and experience of illness and mental illness, thus impacting treatment outcomes. Non-Haitian clinicians need to be knowledgeable of the culture to provide competent care (Nicolas, DeSilva, Grey, & Gonzalez-Eastep, 2006). However, to date there is no literature on what mental health treatment works for Haitian immigrants.

A number of studies have shown that cognitive behavioral treatments are effective in the treatment of depression among youth (Curry, 2001; Weiss, 2004). Specifically, reviews of psychotherapy for the treatment of adolescent depressive disorders provide empirical support for the benefits of cognitive behavioral therapy (CBT) in treating depression among children and adolescents (Brent et al., 1997; Clarke et al., 1995; Reinecke, Ryan & DuBois, 1998). (See Hays, 2009, for a discussion of the integration of cognitive–behavioral and multicultural therapies.) Rossello and Bernal’s (1999) successful modification of an EBT for depression to better serve the needs of Puerto Rican adolescents, suggests that the adaptation of empirically supported therapeutic models may be a viable approach to explore in developing mental health treatment of ALANA and immigrant individuals (see Bernal, Jiménez-Chafey, & Domenech Rodríguez (2009) for further information).

Models of Cultural Adaptation

In the intervention field, adaptation is defined as the modification of key characteristics, elements, and methods of delivery while maintaining the core elements and theory of the intervention (McKleroy et al., 2006). Although there are many methodological studies on the cultural adaptation of instruments and measures (Li, Wang, & Shen, 2003), there are fewer methods for culturally adapting mental health interventions for adolescents. The two most cited models for treatment development are: the Model for Effective Deployment and Translation of Science Into Practice and the Stage Model of Behavioral Changes.

The Model for Effective Deployment and Translation of Science Into Practice (MEDTSP), developed by the Workgroup on Child and Adolescent Mental Health Intervention Development and Deployment (National Advisory Mental Health Council, 2001), is a theoretical framework that guides the development, testing, and dissemination of treatments. The model includes six key elements: (a) basic research and theory (i.e., developmental and epidemiologic research and learning and cognitive theories); (b) intervention development, refinement, and adaptation; (c) intervention testing with respect to efficacy; (d) transferring and translation of treatment across settings; (e) the identification of the effectiveness of interventions; and (f) the integration of social, economic, and cultural factors in the translation, transportation, and effectiveness of intervention. This model demonstrates the complexity of development, implementation, and testing of any intervention or many interventions. In the same year as the development of the MEDTSP, the Stage Model of Behavioral Therapies (SMBT) developed by Onken, Blaine, and Battjes (1997) underwent a revision by Rounsaville, Caroll, and Onken (2001). The SMBT framework describes three stages of treatment development from initial development to research efficacy to treatment effectiveness. The first stage includes treatment development and includes the adaptation of existing therapies for a population. Stage 1 involves identifying promising clinical, behavioral, and cognitive science relevant to treatment, generating, and formulating new behavioral therapies, operationally defining the therapies in manuals, and pilot testing and refining the therapies. Stage 2 consists of efficacy testing of promising therapies identified in Stage 1 and involves the replication, at other sites, of efficacy studies with positive results. The last stage, Stage 3, focuses on the effectiveness of transporting treatment into various clinical settings, including community centers. Although these models are important frameworks to pursue in designing new treatments, none of them directly incorporate or integrate the role of culture in the designing, implementation, and evaluation of interventions. Bernal, Bonilla, and Bellido (1995) provided a potential guideline for addressing this issue of evaluating the cultural appropriateness of an intervention. Specifically their Ecological Validity and Cultural Sensitive Framework highlights that which researchers need to assess multiple components including the language, person, metaphors, context, concepts, goals, methods, and contexts of an intervention for a particular cultural group. More detailed information about this approach is provided in other papers in this special issue (see Bernal et al., 2009) therefore we are providing only a brief description of the eight elements of the model below.

The Ecological Validity and Culturally Sensitive Framework (Bernal, Bonilla, & Bellido, 1995) focuses on eight culturally sensitive elements: language (whether it is appropriate and culturally syntonic), person (role of ethnic similarities and differences between client and therapist in shaping therapy relationships), metaphors (symbols and concepts), content (cultural knowledge of the therapist), concepts (treatment concepts consistent with culture and context), goals (support of positive and adaptive cultural values), methods (cultural enhancement of treatment methods), and context (consideration of economic and social context). This framework has been used successfully to culturally adapt CBT for depressed Puerto Rican adolescents (Bernal, Bonilla, & Santiago, 1995), and proved to be effective in reducing depression among this population. We summarize the process of using this framework to culturally adapt a group evidence-based treatment for use with Haitian American adolescents diagnosed with depression. Hwang (2009) also described a community-based developmental approach, the formative method for adapting psychotherapy (FMAP). His bottom-up approach involves collaborating with community stakeholders to generate and support ideas for therapy
adaptation and involves five phases that target developing, testing, and reformulating therapy modifications. The FMAP phases include: (a) generating knowledge and collaborating with stakeholders, (b) integrating generated information with theory and empirical and clinical knowledge, (c) reviewing the initial culturally adapted clinical intervention with stakeholders and revising the culturally adapted intervention, (d) testing the culturally adapted intervention, and (e) finalizing the culturally adapted intervention. It is hoped that both the FMAP model described by Hwang, and the cultural adaptation model described here can serve as additional frameworks towards replication and implementation with other cultural groups.

The Treatment

The Adolescent Coping With Depression Course (ACDC) is a group CBT treatment targeted for youth in an active depressive episode. The intervention is a psycho-educational, cognitive-behavioral intervention for treating adolescents’ depression. The intervention consists of sixteen 2-hr sessions conducted over an 8-week period. The intervention is designed for use with groups of 5 to 10 adolescents. The treatment sessions are conducted as a class in which a group leader teaches adolescents skills for controlling depression. The areas covered include relaxation, pleasant events, negative thoughts, social skills, communication, and problem solving. Each adolescent is provided with a student workbook, which is closely integrated with intervention discussions and group activities. The workbook contains brief readings, structured learning tasks, self-monitoring forms, homework assignments, and short quizzes. Detailed guidelines for running the intervention groups are provided in a leader’s manual by Lewinsohn, Rohde, Hops, and Clarke (1990).

The Cultural Adaptation Process of the ACDC

The methods used to adapt the ACDC with Haitian American adolescents include: (a) creation of an advisory board, (b) developing a partnership with the community, (c) training the focus group leaders, (d) conducting focus group sessions with Haitian adolescents, and (e) integration of focus group data to modify the treatment manual.

Creation of an Advisory Board

The researchers of this current study recruited six members comprised of a community director, school administrator, clergy, child psychiatrist, immigrant and adolescent researcher, and a community member to create an advisory board for the project. The principle of creating an advisory board to maintain participants’ and the community’s trust in the research process is embedded in Community Based Participatory Research theory (CBPR; Israel, Schultz, Parker, & Becker, 1998). The board members provided the team with feedback about the research plan, helped develop a theoretical framework for understanding cultural interpretations (e.g., immigration and acculturation) of the results, and also assisted in finding the optimal meeting place and time for the focus groups.

Community Partnership

Given the team’s perspective that intervention projects should be grounded in the community, the project director and team members spent the last 5 years developing relationships and partnerships with several community mental health centers and schools in developing prevention and intervention programs for ALANA and immigrant youth. We contacted school personnel, community agency directors, community leaders, clergy leaders, and parents of the communities where we wanted to develop partnerships. We met with mental health professionals and lay members of the community and shared with them the existing depression constructs available. We also listened intently to their feedback about the applicability of this construct for them and the development of new constructs specific to other Haitians. As a result of these interactions, a new framework was developed that incorporated the specific cultural ideas of the Haitian community. Moreover, through these meetings an ongoing partnership was formed between the community and us. Through this partnership, we are able to conduct projects in collaboration with the members of the community, share resources, and serve as links to additional agencies and institutions. These are some of the many ways we fostered partnership with this community through culturally competent research. In particular, partnerships were developed with six schools and five community centers in the Boston area. Our community partners participated in all phases of the project from the design to the implementation and evaluation of the project. For this adaptation intervention project, the community site participated in all phases of the project and was instrumental in the selection, procedure, and evaluation of the focus group project.

Focus Group Leaders Selection and Training

Focus group leaders were recruited through the university’s graduate school programs. Graduate students in the mental health counseling and school counseling programs applied to become focus group leaders. Applicants wrote essays and selected applicants underwent an interview with the research coordinators. Identified focus group leaders were applicants that had strong interests and prior knowledge about depression and ALANA mental health and experience interviewing adolescents and immigrants. Focus group leaders underwent intensive training prior to conducting focus groups. Research coordinators organized two 6-hr trainings in which coordinators led lectures, group discussions, and exercises. The objectives of the focus group meetings were to provide the focus group leaders with diversity and culturally sensitive research training and an overview of the study protocol, focus group details, and ACDC manual and workbook. Members were expected to actively participate in all discussions, activities, and written self-reflections. The first training aimed at addressing diversity and culturally sensitive research. Coordinators led lectures and discussions on the importance and goals of conducting culturally sensitive research. Members also explored their experiences, assumptions, and fears working with immigrant and ALANA adolescents. Focus group leaders reflected and shared their own diverse identity in small and large group discussions. An example of an exercise that members participated in is the privilege walk, which aimed at demonstrating privilege issues. This activity provides individuals the opportunity to understand the intricacies of privilege.

The second training provided an overview of the research project, outlined the details of the focus groups, and introduced leaders to the ACDC manual and workbook. The coordinators
provided a background of the Haitian culture, values, immigration history, and personal experiences of the community. In addition to the two trainings, focus group leaders were assigned to read a packet of articles related to diversity, culturally sensitive research, and focus groups. Members were required to become familiar with the ACDC manual and workbook. Additional practice for focus group leaders included a short mock focus group in which members’ role played a focus group and then coordinators and members offered feedback. Focus group leaders needed to complete both trainings to qualify to continue as focus group leaders in the project.

Recruitment of and Characteristics of the Focus Group Members

The standard method of focus groups, developed by Krueger (1994), was employed in this project. This method consists of using two group facilitators for the focus group, a leader for the discussion, and a facilitator (a note taker) to document the process and content of the group sessions. The research coordinators alternated facilitating the group meetings. Topic areas for each of the focus group sessions were developed prior to the meetings, which consisted of lead questions and follow-up prompts.

Triangle schools and community centers were identified as sites for conducting the group meetings. Community leaders and school personnel were identified as important in establishing trust in the process and in creating a forum of shared ownership of the research identified in these settings. The focus groups were conducted at a middle school. The school personnel of the school identified and selected the students to take part in the focus group meetings. Students who were active in school activities and demonstrated leadership characteristics were asked to participate in this project by the school psychologist. Subsequently, a phone screening protocol was followed to review participant inclusion and exclusion criteria. Once adolescents were identified as eligible participants for the project, retaining strategies (in accordance with empirically validated procedures; Brelund-Noble, Mitchell, Nicolas, Taylor, & Miller, 2005) such as follow-up letters, postcards, and phone reminders the day before the meeting were employed. The overall goals and objectives of this pilot project were clearly explained to both the participants and legal guardians and questions about the project were answered. The consent forms were translated into French and Haitian Creole to provide parents and legal guardians with the opportunity to read about the project in their native language. In addition, the informed consent was read aloud to all of the participants to ensure comprehension of the objectives and procedures of the study prior to signing the form. Separate informed consent for the audiotaping of the focus groups was also obtained from each participant’s parent or legal guardian and assent was obtained from each participant.

Focus Group Meetings

Each focus group, conducted in English, was conducted in three sessions each with clinical or nonclinical adolescents separately at their particular site, lasting approximately 90 min each. After each session, transportation vouchers were provided (if needed) and a catered meal was provided as compensation for participating in the study. The following sequence was followed in conducting the focus groups: parental informed consent and participant informed assent procedures were reviewed with each participant. Once informed consent and assent were completed, participants attended the group meeting; a demographic questionnaire to obtain information on ethnicity, gender, age, level of education, marital status, proficiency in English, years in the United States, nativity, literacy, experience seeking mental health services, and religious affiliation were administered next; the meeting concluded with a discussion of broad to more focused questions. Such a sequence has been found to generate the greatest contribution from participants (Morgan, Krueger, & King 1998).

In the first group session, the participants were asked to talk about manifestation of depression symptoms among Haitian adolescents, perceptions of precipitating factors of depression, and how these symptoms should be treated. At the end of the first session, the participants were provided with the manual for the 16-week sessions of the group ACDC intervention for review at home. The participants were asked to examine the items to be used in the sessions, homework assignments, and examples that will be used to explain the concepts for each session. The facilitators requested that the participants come up with their own wording and examples for the items that they had difficulties with and to also document these changes for discussion at the next meeting of the areas that they found problematic. The participants were asked to bring the intervention document and their notes to the next meeting, which was held the following day or no more than 2 days after the first session. The research coordinators contacted each participant the day prior to the second session to remind the youth of the upcoming group meeting.

The second and third group sessions focused on an evaluation of the intervention, Haitian youth perceptions of barriers to mental health treatment, challenges that mental health professionals may face working with Haitian youth, and the best strategies to use to ensure treatment adherence and to reduce dropouts. Two sessions were scheduled to review these domains to allow for a comprehensive review of these aspects of the interventions as well as an in-group review of the manual in the event that the adolescents did not complete the review outside of the sessions. With regard to the intervention, the participants were asked to evaluate the specific domains of the intervention using the eight elements of the Ecological Validity and Culturally Sensitive Framework developed by Bernal, Bonilla, and Bellido (1995). This framework has been used successfully to culturally adapt CBT for depressed Puerto Rican adolescents (Bernal, Bonilla, & Santiago, 1995), and was proven to be effective in reducing depression among this population.

Qualitative Data Analysis Procedures

The materials obtained from the focus groups were audiotaped and transcribed verbatim. A grounded theory approach (Glaser, 1978, 1992, 1994, 1995) and the framework of Emerson, Fretz, and Shaw (1995) for coding, themes detection, and discordant instances were used to capture the themes in the data from each focus group. A grounded theory framework was useful because it allowed researchers of the current study to go from the general to the specific without losing sight of what makes the subject of a study unique (Strauss & Corbin, 1998). The text derived from the focus groups was thoroughly inspected, following standard qualitative research techniques (Miles & Huberman, 1994). Indepen-
dent readings of the transcripts by the researchers of the current study were conducted. Open coding runs were done to identify emergent themes or concerns, followed by a discussion between the researchers of the current study to settle on provisional synthetic codes. Subsequently, focused coding was conducted, followed by another meeting to discuss the coding of new and old transcript materials, and to make any necessary revisions to the coding protocol. This process created a coding protocol and indexing system using HyperRESEARCH (Hesse-Biber, Dupuis, & Kinder, 1991).

HyperRESEARCH 2.6 (Hesse-Biber et al., 1991), a qualitative data analysis software package, was used to analyze the qualitative data. This program permits coding and retrieval of the data, theory building, and data analyses. HyperRESEARCH comes with a hypothesis tester, which presents the data for examination in a manner similar to a statistical analysis. From the consensual codes, larger themes or cultural domains were developed and tested, and discrepant data were evaluated. Using the elements of the Ecological Validity and Culturally Sensitive (described above), the data obtained from this project determined the specific modifications made to the group ACDC intervention.

Feedback Regarding the Treatment Manual and Protocol. Using the eight elements of the Ecological Validity and Culturally Sensitive framework, the adolescents in the focus group meetings provided informative feedback about the ACDC intervention. A sample of some of the changes that the participants suggested in making the treatment more culturally sensitive is provided in this section. Using language as an example, the participants were asked to evaluate the examples used and the language and metaphors of the CBT manual for accuracy in reflecting the culture of Haitian youth. Issues such as the meaning of certain words, lack of understanding of certain concepts, difficulties understanding certain examples, and generating examples and words that are better suited were addressed in the group session. For example, an area in the CBT manual that was changed is the use of cognitive-behavioral theory to explain the onset of symptoms. The youth pointed out different cultural rationales for the onset of depression, and they provided examples, such as supernatural forces (Desrosiers & St. Fleurose, 2002; Kemp, 2002), often induced spiritually by an offended “lwa” (a spiritual god). Even natural illness or injury is treated with massage, herbal teas, over-the-counter antibiotics (available in Haiti without a prescription), and other traditional remedies. Illnesses may also be treated by religious ceremony. This belief system has clear implications for help-seeking behavior and adherence to treatment and will need to be monitored throughout the course of the treatment. With respect to metaphors, the participants were asked to indicate their understanding of the pictures and examples used in the treatment manual. The majority of the participants informed us that use of examples, pictures, and stories that are relevant to adolescents today and that reflect the Haitian culture was needed. Another area that received considerable attention by the focus group participants were the goals and homework assignments for each of the modules. The practice of active listening exercises is one activity that the focus group members felt that the majority of Haitian adolescents may not be familiar with nor actually engage in outside of the group meetings.

The focus group’s evaluations of the intervention were quite informative. Although the materials that were obtained from focus groups could be biased due to their lack of representativeness of the population, not obtaining such information prior to evaluating the efficacy of the intervention could lead to unsuspected errors and biases. Subsequently, the manual was reviewed by the Advisory Board members for alternative examples, language, and metaphors that are more compatible with Haitian youth culture. During the refinement of the treatment protocol, the researchers paid close attention to feedback pertaining to the influence of culture, language, and acculturation on the intervention as well as structural issues associated with coordinating the sessions (e.g., time, place, agenda with regard to time, etc.).

Currently, the culturally adapted ACDC intervention is being tested with a sample of Haitian adolescents that are clinically depressed in the school setting. Although the final results are not available regarding the effectiveness of this treatment for this sample, similar results are found in the Bernal and Scharrón del Río (2001), with the participants reporting decreased depression symptoms at the end of the treatment and at follow-up.

Conclusions and Summaries

Over the last 4 decades, child and adolescent mental health has gained increased attention, creating extensive evidence of the efficacy of psychotherapy for mental health problems and disorders among youth (National Institute of Mental Health, 2002; National Mental Health Association, 2000). Despite such notable gains in the field, to date, there exist significant disparities in the availability and service utilization of mental health treatments for ALANA individuals and immigrant populations. Although there are a myriad of explanations for the existence of these disparities (ranging from stigma associated with mental illness, misdiagnoses, or no proven treatment options available for treating them), these are issues that call for immediate attention from the psychology field.

Although EBT provides a venue for addressing cultural disparities through designing mental health treatments that have been shown to be efficacious for different cultural groups (Rishel, 2007), such practice also has its limitations. One major concern is the process of implementing EBT interventions to various ethnic and immigrant groups without consideration of the cultural background of the participants. Such practices can further alienate ALANA and immigrant groups from mental health treatments. Thus, it is essential that EBTs are carefully evaluated and culturally adapted (if necessary) for use with different cultural groups.

The cultural adaptation process described in this paper provides more evidence for the need to culturally adapt EBT interventions for use with ALANA and immigrant youth. The information obtained through the adaptation of the CBT has contributed significantly to our knowledge of what works and how it works for depressed adolescents. The information obtained through the adaptation process has been instrumental in our testing of the ACDC treatment as well as depression instruments for use with Haitian American youth. More important the process summarized in this paper gives prudence for the need to develop culturally appropriate EBT at the inception instead of adapting an EBT intervention for a particular ALANA and immigrant group. Given the increasing diversity of the United States and the world, it should no longer be acceptable in the field of psychology for researchers to develop EBT without clear demonstration of its applicability to the diverse segments of the population. The creation of EBTs without account-
ing for culture further increases the existing disparities in treatments and service utilizations.

In addition to addressing disparities at the practice and research levels, the findings from research such as those summarized in this special section (Bernal et al., 2009; Hays, 2009; Hwang, 2009), should increase the knowledge of the public and policy makers as well as to promote the public and ALANA and immigrant communities’ understanding of the intersection of EBT and culture. Increased collaboration between researchers, practitioners, and public health officials from all sectors would promote policies and practices that will help to ensure equal and culturally sensitive treatment for ALANA youth. Through such collaborations and partnership, funding and public policy institutions can create accountability policies for researchers and practitioners in establishing mental health services that are culturally relevant to the populations served. Given the ethnic diversity of the United States, mental health treatments that fail to take into account or integrate cultural aspects.

References


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