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Cultural Sensitivity and Adaptation in Family-Based Prevention Interventions[5]

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Because of the substantial impact of families on the developmental trajectories of children, family interventions should be a critical ingredient in comprehensive prevention programs. Very few family interventions have been adapted to be culturally sensitive for different ethnic groups. This paper examines the research literature on whether culturally adapting family interventions improves retention and outcome effectiveness. Because of limited research on the topic, the prevention research field is divided on the issue. Factors to consider for cultural adaptations of family-focused prevention are presented. Five research studies testing the effectiveness of the generic version of the Strengthening Families Program (SFP) compared to culturally-adapted versions for African Americans, Hispanic, Asian/Pacific Islander, and American Indian families suggest that cultural adaptations made by practitioners that reduce dosage or eliminate critical core content can increase retention by up to 40%, but reduce positive outcomes. Recommendations include the need for additional research on culturally-sensitive family interventions.

KEY WORDS: cultural issues; parent training; family therapy; substance abuse prevention; outcome research.

Strong families and wise parents are key to raising pro-social, socially competent, and healthy children. Family strengthening interventions, which teach parents skills to effectively praise, supervise, discipline, and communicate with their children, are a critical ingredient in any effective approach to the prevention of youth problems including substance abuse. Most drug prevention programs are delivered to children in schools or community youth groups and do not involve parents or family members. In our experience, ethnic families and staff prefer family-focused rather than youth-only focused prevention services. Mock (2001) believes that family interventions are popular with traditional ethnic families because of their collective "we" family identity as opposed to an individual "I" self-identity, which is stressed in many Western cultures. According to Boyd-Franklin (2001), family interventions are more culturally-appropriate for ethnic families than individualistic intervention models.

Unfortunately, even when family programs are offered in schools and communities, ethnic families are often difficult to recruit and retain, particularly if the program is not culturally appropriate. For instance, generic universal parenting programs attract only about 33% of parents when offered in schools (Weinberger *et al*., 1990). That figure drops to 20–25% if families are asked to participate in research (Coie *et al*., 1991) and as low as 10% for ethnic families (Biglan & Metzler, 1999).

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REASONS FOR THE LACK OF CULTURALLY APPROPRIATE INTERVENTIONS

Most universal prevention programs are generic programs developed for popular American culture or youth culture, which is heavily influenced by White, middle class values. Professional training has stressed "the melting pot" model of American culture, resulting in few culturally-specific models (McGoldrick & Giordano, 1996). The theoretical constructs, definitions of protective or risk factors, appropriate intervention strategies, and research evaluation strategies have all been influenced by mainstream American values (Turner, 2000). Commercial developers seek to develop generic programs culturally acceptable by diverse families; thus, making their products widely marketable.

Early attempts at revising prevention programs typically only considered surface structure or "first cut" modifications, by hiring ethnically matched staff and modifying graphic material (videos or pictures) to show ethnically similar families. Deeper structure cultural adaptations should consider critical values and traditions for within-race cultural subgroups defined by geographic location (rural, suburbs, urban, reservation), educational achievement, socioeconomic status, language, acculturation level, and the individual's own interpretation and identity with their race, ethnicity, and culture. It would be better to develop culturally-specific family programs addressing deep structure cultural values and practices (Resnicow *et al*., 2000) including sensitivity to diverse cultural values of relational orientation, human nature, a person's relationship to nature, activity orientation, and time orientation (Santisteban *et al*., 2001). Unfortunately, even culturally-specific prevention programs are sometimes based more on practitioners' perceptions of ethnic community needs than empirically tested theories. Research evidence suggests *substantial similarity* in the major causal precursors of drug use across racial groups (Newcomb, 1995), with slight variations in the strength of the relationships in risk or protective factors (Kumpfer & Turner, 1990/1991). For instance, family protective factors influence youth of color more than White youth (Turner *et al*., 1998).

Another challenge is that there are many cultural subgroups with differing dialects and languages within races. There are more than 50 Hispanic/Latino groups, 60 distinct Asian or Pacific Islander groups, more than 500 American Indian tribes and sub-clans, and many mixed race people of color with differing levels of acculturation to the White culture.

This article addresses the question of whether culturally-adapted or specific programs are more accepted and effective. Suggestions for culturally adapting existing evidence-based programs are presented based on the primary author's experience with developing culturally-tailored versions of the Strengthening Families Program. In this article, the authors use the terms *culturally*-adapted, (appropriate, tailored, sensitive, or modified) in which culture refers to the sum total of ways of living of a group (e.g., traditions, rituals, values, religion). The terms *ethnically*-sensitive or *racially*-sensitive are not employed. Ethnicity refers to a person's identification with a group and race is a biological and genetic concept (Turner, 2000). Hence, culture is the focus of the discussion rather than ethnicity or race.

Each culture has its own traditional worldviews of healing approaches. Traditional ethnic families appear to prefer family systems change approach compared to individual change approach to prevention, because of the emphasis on interconnection, reciprocity, and filial responsibility. Research supports this traditional wisdom. Meta-analyses indicate that family approaches have effect sizes on average nine times larger than youth-only interventions in reducing youth conduct problem behaviors for both traditional and acculturated minority families (Tobler & Kumpfer, 2000; Tobler & Stratton, 1997). Changes in the child will not likely continue if the family system remains unchanged regardless of ethnic orientation. According to Mock (2001), in close traditional ethnic families, individual change that is not sanctioned by family elders will be squelched through shame, guilt, a focus on duty, obligation, and respect for the authority of elders.

ARE CULTURALLY-ADAPTED FAMILY PROGRAMS MORE EFFECTIVE?

Limited research makes it difficult to answer this question because there are no randomized control trials comparing a culturally-adapted version to a generic version. The prevention field is divided on the issue as the theoretical and empirical evidence is equivocal (Dent *et al.*, 1996). Some researchers of ethnic descent believe that culturally-sensitive programs are essential for the success of family-focused prevention (Kumpfer & Alvarado, 1995; Turner, 2000) and advocate for culturally-appropriate, population-based family interventions.

This position is based more on direct observations, limited quasi-experimental research, and a desire to be respectful of ethnic family values, rather than on hard science.

Research does suggest that behavioral family interventions are more effective with diverse ethnic families than affective-based family approaches (McMahon, 1999; Taylor & Biglan, 1998), possibly because many ethnic groups, particularly Asian and American Indian, expect elders (group leaders or therapists) to provide wisdom and concrete suggestions rather than use reflective techniques. Family interventions that require sharing personal feelings are often culturally inappropriate in cultures where this is discouraged (Wong & Mock, 1997).

However, behavioral programs can be made even more effective by incorporating culturally relevant information. Sanders (2000) says "there is an ethical imperative" to ensure that interventions developed for the dominant culture do not negatively impact a child's own cultural values, competencies, or language. He cites the need to identify factors such as "family structure, roles and responsibilities, predominant cultural beliefs and values, child raising practices and developmental issues, sexuality and gender roles" within the context of developing culturally-sensitive family interventions. These efforts must be balanced against the context of the considerable heterogeneity that exists within a given culture. Catalano *et al*. (1993) note that in addition to cultural adaptations, which may aid program utilization and retention, it may also be necessary to adapt recruitment strategies.

On the other hand, several investigators (Kazdin, 1993) have argued there is little empirical support for the superiority of culturally-specific prevention programs, which would justify the additional cost. Harachi *et al*. (1997) found that culturally-adapted, but equivalent dosage versions of a family program were more locally acceptable, and slightly more effective for the ethnic families involved (e.g., African American, Latino, Native American, and Samoan). Although it is not a family-centered program, Botvin *et al*. (1995) reported slight improvements at the 2-year follow-up (but not the 1-year follow- up) for a culturally-modified version of his Life Skills program compared to the generic, standard version. These researchers concluded "tailoring interventions to specific populations can increase their effectiveness with inner-city minority populations" (p. 188). One solution is hiring culturally-matched facilitators who are encouraged to culturally adapt group process and program content (e.g., experiential exercises, wording, examples, language, etc.) of generic programs without reducing fidelity.

FACTORS TO CONSIDER FOR CULTURAL ADAPTATION

Kazdin (1993) recommends deriving principles to guide cultural adaptations of existing model programs rather than developing separate ethnic models. Ethnic researchers (Turner, 2000) recommend that these principles include sensitivity to the following elements: (a) sensitivity to the degree of influence of specific cultural family risk and protective factors, (b) level of acculturation, identity, and lifestyle preferences, (c) differential family member acculturation leading to family conflict, (d) family migration and relocation history, (e) levels of trauma, loss, and possible posttraumatic stress disorder (PTSD) related to war experiences or relocation, (f) family work and financial stressors, and (g) language preferences and impediments due to English as a second language, and level of literacy in native language. Each specific ethnic group will have special issues to consider when adapting programs. Generally, special issues to consider with Latino families include (a) extended family relationships, (b) influence of metaphysical or supernatural forces, (c) spirituality and religious practices, (d) and the role of social clubs (Cervantes, 1993). Adaptations for African American families should consider their value of (a) education, (b) strict discipline, (c) religion, (d) extended family support, (e) adaptability of family roles, and (f) coping skills in hard times (Boyd-Franklin, 1989; Turner, 2000).

CASE EXAMPLE OF CULTURAL ADAPTATION: THE STRENGTHENING FAMILIES PROGRAM

The Strengthening Families Program (SFP) is a multicomponent, 14 session family-skills intervention that was developed in 1982 on a NIDA grant. The program has three components namely: parent, child, and family skills training courses. In the first hour of the program, the parents and children meet separately. In the second hour, families practice skills such as positive playtime, communication, family meetings, planning, and effective discipline. SFP has been tested in 27 studies with diverse families in a variety of settings by independent researchers including: five NIDA grants (multiethnic Utah, American Indians, African Americans), two NIAAA grants (African Americans and Canadians), five CSAP High Risk

Youth Grants (described below), 10 CSAP Family Strengthening grants (five American Indian communities), three CSAP Children of Substance Abusing Parents (COSAP) grants, and one SAMHSA grant), a new elementary school, multiethnic version of SFP is on CD-ROM (Kumpfer & Whiteside, 2000). A junior high school version of SFP was developed (Kumpfer *et al*., 1996) and found cost-effective ($9.60 saved in future costs for each dollar invested) in reducing alcohol and drug initiation within Project Family at Iowa State University (Spoth *et al*., in press). Because of these positive results, SFP has been recommended for dissemination by a number of federal and state funding agencies (Texas, New Jersey, North Carolina, Deleware, Virginia, Tennessee, and Florida).

The original research on SFP involved 218 families with 6–11 year old children of substance abusers. A randomized 4-group dismantling design tested three alternative interventions: (a) a behavioral parenting program (PT), (b) PT plus a children's skills training program (CT), and (c) both PT & CT, plus a family relationship and practice program, compared to a no-treatment control group. The parenting program reduced children's negative behaviors, the children program improved social competencies, but the combined intervention significantly improved more parent, child, and family risk factors and drug use in the older children and parents (Kumpfer & DeMarsh, 1985). SFP is the combined intervention (Kumpfer *et al*., 1989).

RESEARCH RESULTS OF THE CULTURALLY-SPECIFIC VERSIONS OF THE STRENGTHENING FAMILIES PROGRAM

Results are presented from five studies comparing the generic SFP version implemented in the first 2 years to a culturally-modified SFP version implemented in the last 2 years. Generally the generic version had slightly better outcomes, but recruitment and retention of attending families was 41% better with the culturally-adapted versions (Kumpfer & Alvarado, 1995). The quasi-experimental, time lagged designs employed made it difficult to disentangle reasons for the lack of more positive outcomes in the culturally-adapted versions. Staff might have implemented SFP with less enthusiasm in the last 2 years, but appeared to be more experienced and committed. Families with lower risk may have been recruited, but analyses didn't suggest this. The major factor appeared to be that the dosage was reduced in three of the five studies. Longer dosage alone, however, did not necessarily equate to better outcomes as the Hawaii SFP version lengthened SFP to 20-sessions. Only 10 of the sessions were original to SFP. Cutting out four of the original SFP sessions eliminated some core content and critical practice sessions.

Rural and Urban African American SFP Versions

In rural Alabama, retention of the African American drug-abusing mothers who attended 12 of the 14 sessions improved from 61 to 92% after minor cultural-adaptations were made (e.g., culturally relevant examples, graphics, stories, and reduced reading level), but outcomes were equivalent. In Detroit the generic version had slightly better outcomes for African American drug abusers in treatment. However, completion rates (12 of 14 sessions) increased from 45 to 85% after making cultural adaptations (e.g., new local videos, sessions held in African American churches, basic living needs addressed; Aktan *et al*., 1996).

Asian/Pacific Islander SFP

Cultural consultants (without the program developers involvement) produced a longer 20-session SFP curriculum. It included 10 sessions on Hawaiian family values followed by 10 (not 14) original SFP sessions. The University of Hawaii evaluators (Kameoka, 1996) found retention decreased from 60 to 52% among families recruited in schools and communities for the longer curriculum and slightly reduced positive results. Only the original more behavioral skills-focused SFP showed significant improvements in parents' skills and depression, children's behaviors, and children's substance use. The new Hawaii SFP contains the original 14-session SFP, but retains the cultural adaptations.

Hispanic SFP

A Spanish language version of SFP was developed for Hispanic families recruited from schools and housing communities. The hallmark of this cultural version was respect for family traditions, which resulted in an increased completion rate (65–98%) by the fifth year (Kumpfer *et al*., 1996). The outcome results of versions were not as strong as prior SFP studies, possibly because lower risk children were recruited. Also, significant under reporting of problems at the pretest due to confidentiality concerns was reported by the independent evaluators.

American Indian SFP

An 8-session Ojibway tribe SFP was developed in Iowa (Whitbeck & Smith, 2001). Although there were positive results for child and family risk and protective factors, there was no statistically significant decrease in youth substance use, possibly because of reduced length (8–10 sessions) and the inclusion of more affective versus behavioral content. The researchers plan to return to the longer, more behavioral SFP content.

CONCLUSIONS AND RECOMMENDATIONS

The limited research with culturally-adapted prevention programs suggests that cultural adaptations can substantially improve engagement and acceptability leading to better recruitment and retention of ethnic families, but only slightly improve outcomes. Better outcomes should result from cultural adaptations that maintain fidelity rather than reducing dosage, cutting core interactive elements, or focusing on affective rather than behavior change. Deeper understanding of cultural parenting assumptions leading to culturally-sensitive programs should improve program success even more (Catalano *et al*., 1993; Kumpfer & Alvarado, 1995). However, more research is needed to determine if deeper cultural changes will substantially improve outcomes as well as recruitment and retention. The limited outcomes reported justify development of culturally-adapted versions of existing science-based family interventions. In order to design successful culturally-sensitive programs, a cultural emphasis is needed in all five phases of prevention research (Institute of Medicine [IOM], 1994), including Phase I testing of etiological models for ethnic minorities, Phase II development of new culturally-specific interventions, videos and evaluation methods for ethnic families, Phase III Randomized Control Trials to compare generic, culturally-adapted, and culturally-sensitive versions of evidence-based, family programs. Phase IV tests of the new cultural versions with other similar ethnic subgroups, and finally Phase V dissemination studies to test effectiveness when brought to scale. Culturally appropriate dissemination or training systems have not been considered, let alone evaluated, despite their substantial impact on quality, fidelity and outcomes. Existing ethnic communities and organizations should be tapped to collaborate with researchers in program design, modifications, effective recruitment techniques, full-scale implementation, program evaluation and interpretation of the results. Once researchers take the critical scientific steps needed to develop culturally-appropriate parenting and family programs, we will be better equipped to reduce youth problems in this country.

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