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Culture and motivational interviewing

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Studies from the United States (U.S.) have shown that when compared with European-Americans, racial/ethnic minorities (REM) and other cultural minorities are often less likely to utilize mental health services [1–5], more likely to terminate treatment prematurely [6], and less likely to receive the highest quality of care [7]. This is attributable to a range of factors that challenge the mental health profession to attend to issues of culture and diversity [8]. Carpenter-Song and colleagues [9] found Blacks and Hispanics often questioned or disagreed with their psychiatric providers about diagnoses, the causes of psychological problems, and treatment options. Other studies indicate that REM can feel judged, coerced, and misunderstood by their psychiatric providers [10–14]. Failing to address cultural diversity can stymie expected treatment outcomes or cause clients to disengage. And so in light of considerable service disparities, leaders of mental health systems have been promoting general cultural awareness amongst providers, while assessing the need to modify treatments to better target people who underutilize services.

One important evidence-based practice (EBP) used to engage people in treatment is Motivational Interviewing (MI), a goal-directed and person-oriented counseling style designed to elicit behavioral changes by leveraging the person's intrinsic motivation, and by helping the person sort through ambivalence [15]. MI has been used widely in various settings to facilitate entry into services and retention thereafter. Despite its effectiveness, MI has seldom been culturally adapted, largely because extant research of EBP has painted an ambivalent and incomplete picture of the utility of cultural adaptations.

Are cultural adaptations of Evidence-Based Practices effective?

Culture is a broad term that refers to race, ethnicity, sexuality, gender, religion, and more; but in the U.S., research on cultural adaptations has primarily grappled with issues of race and ethnicity. Historically, efficacy studies did not include sufficient numbers of REM, prompting researchers to investigate whether EBP were effective for REM across a broad range of mental health problems, including anxiety, depression, externalizing problems, schizophrenia, smoking, substance use, and trauma [16]. According to a review by Huey and colleagues [16], studies showed that EBPs worked for REM, but the moderating effects of race/ethnicity on treatment outcomes depended on the type of treatment, the outcome of

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interest, and the racial/ethnic groups being compared. In brief, some treatments were more efficacious for European-Americans, while other treatments were more efficacious for REMs. A majority (60–70%) of the randomized trials that examined racial/ethnic differences found no significant moderating effects at all, raising the question: Are cultural adaptations of EBPs worthwhile?

Cultural adaptation involves systematically identifying the areas of conflict or mismatch between the intervention and the client, and then modifying the intervention to become congruent with a person's culture, often by changing the language, content, concepts, goals, and/or methods. The degree of adaptation can vary from making surface-level changes to altering the core elements and theoretical underpinnings of the intervention [see 17]. The end result is an intervention that is more natural or familiar –that is, intellectually and emotionally accessible –to an individual or community, resulting in enhanced efficacy, satisfaction, and retention. Scholars have different perspectives on how to adapt, and have set forth useful adaptation frameworks that account for the social processes and contexts that surround individual behavior (e.g. Ecological Validity Model, Cultural Sensitivity Model, etc. [18–21]). Many have argued that we should try to be faithful to the original intervention as much as possible in order to preserve the original ingredients, making only incremental changes as needed, though this is not always a straight-forward process. The underlying fear seems to be that adaptations can actually compromise effectiveness, or even become iatrogenic, if they are not carefully executed.

While there is reason to believe that culturally adapted EBP are promising [22], it is not known whether they are *more* efficacious than un-adapted interventions. One meta-analysis found that simply conducting an intervention in a person's native language can be twice as effective as interventions conducted in English, and that cultural modifications of traditional mental health treatments in general can have a moderately stronger benefit when compared with un-adapted interventions [23]. Further, a recent review of studies on Screening, Brief Interventions, and Referrals to Treatment (SBIRT) with REMs documented the potential for cultural adaptations to maximize impact [24]. On the other hand, a few studies suggest that some forms of cultural tailoring are minimally beneficial or even deleterious when compared with standard treatments [see 25]. This diverging research creates a precarious basis for cultural adaptations of EBP.

Are cultural adaptations for Motivational Interviewing effective?

With respect to Motivational Interviewing, it seems that REM may benefit just as much, if not more, when compared with Whites. Hettema and colleagues [26] conducted a meta-analysis of 72 studies, 37 of which looked at racial/ethnic composition (in the majority of these studies, REM composed no more than 15% of the overall sample). The authors found that effects of MI were significantly larger for minority samples than for White samples. Lundahl and colleagues [27] conducted another meta-analysis and also found that MI was particularly effective for REM, but not necessarily for African-Americans. Other studies cast doubt on the idea that MI is more effective for REM when compared with Whites [28–29]. Researchers may be tempted to conclude that in the absence of strong evidence, culturally adapted MI is unnecessary.

We should bear in mind a few limitations when evaluating this research. First, the overall number of MI studies that examine race/ethnicity is still relatively small and limits generalizability. In Hettema and colleagues' meta-analysis [26], only about half of the studies examined race/ethnicity, with only 16 studies of the total 72 studies focusing exclusively on REMs. Further, ten of those 16 studies used samples predominantly consisting of African Americans. Very few studies have examined the effect of MI among other REM groups, such as Asian Americans, who may have culture-specific thresholds for distress or impairment, different understandings of the causes of addiction, and different social norms and acceptability around intoxication [30].

Second, studies that examine the moderating effects of race/ethnicity have used broad categories (e.g. Black, White, Asian, Hispanic) that mask intra-group variation (e.g. African American vs. Caribbean Black; Japanese vs. Vietnamese; Mexican vs. Puerto Rican, etc.). And so our understanding of how specific ethnic cultures influence the outcomes of MI is still rather crude.

Third, study designs—including randomized control trials—suffer from limitations [31]. Efficacy research can only tell us about REMs who select into the studies, and not the REMs who are unwilling to engage in treatment or who drop out prematurely. Conceivably, REMs who resist treatment might benefit the most from cultural adaptations. MI researchers strive to understand how MI works and for whom [32], but few studies have been able to capture the preferences of those who are wary of initiating treatment.

Finally, adaptations of MI abound with little discussion of the moderating effects of culture. In fact, most clinical trials already use some form of adapted MI, which include (1) adding feedback (exemplified by Motivational Enhancement Therapy) [33], (2) combining the MI style with non-MI techniques [34–36], or (3) condensing MI into very brief interactions (a few minutes) in health care settings [37]. Such adaptations are considered acceptable insofar as they retain the core principles and spirit of MI. If adaptations of MI characterize much of the literature already, we argue here that cultural adaptations deserve as much attention as the other adaptations that are already being made to accommodate mainstream populations.

What efforts have been made to culturally adapt Motivational Interviewing?

Culturally adapted MI is still emerging, and virtually all efforts have been conducted within Latino American and American Indian populations.

Latino Americans

Añez and colleagues [38] were among the first to discuss how the integration of cultural values and MI principles could enhance therapeutic engagement and address the underutilization of services among Latinos. Drawing largely from their clinical experiences, the authors urged practitioners to inquire about the cultural values and beliefs of clients (such as personability, respect, and trust), which could influence communication during treatment.

Later, Field and colleagues [39] found that ethnic matching between a provider and patient enhanced the effectiveness of a brief motivational intervention, presumably because the provider and patient shared a culture and could therefore communicate more comfortably. Their findings validated the idea that adaptations might work by establishing cultural connections between providers and the service users, thereby strengthening the therapeutic alliance, which is a key mechanism of change in MI [40].

Interian and colleagues [41] ran focus groups to understand how MI could promote medication adherence among Latinos with depression. The authors stated the importance of administering MI ingredients in a way that is compatible with the client's values and social context (including language, attitudes, behaviors, preferences) in order to increase the social validity of MI and to increase the likelihood of engagement and retention. The stigma of depression proved to be a salient deterrent of medication adherence, and so the authors suggested developing a menu of actions to quell social pressures, such as educating others about depression. Interian and colleagues [42] later tested the intervention in a randomized control trial, but only used a 'usual care' control group.

Lee and colleagues [43] used a small sample of Hispanic respondents with heavy-drinking behaviors, and found that participants who received culturally adapted MI were engaged in and satisfied with treatment, which suggested that adaptations were promising. Almost all participants reported that understanding culture was important to understanding drinking behaviors. The authors posited that adaptation should account for both the individual-level as well as the social and environmental influences on drinking behaviors. They found that the quality of the clinical intervention improved by addressing social factors such as the immigration context, changing family dynamics, social support, and knowledge about the health effects of alcohol.

Lee and colleagues [44] then conducted a small pilot randomized control trial between culturally adapted MI and standard MI, and found that while both conditions showed reductions in heavy drinking days per month, the culturally adapted MI condition had greater reductions in drinking consequences at two- and six-month follow-up. Their study design was one of the first to assess whether culturally adapted MI improves treatment outcomes beyond standard MI, which is notable because adaptation studies have tended to make comparisons between culturally adapted MI and different treatments (e.g. treatment as usual), or lack comparison groups entirely [see 45-46]. A larger randomized controlled trial comparing culturally adapted MI against standard MI is currently underway, which tests the active ingredients and causal effects of specific cultural adaptations.

American Indian/Alaska Native Americans

Recent studies on adaptations for American Indian/Alaska Native populations have also yielded promising results. Venner and colleagues [47] conducted focus groups and identified a number of recommendations for adaptation. Examples of recommendations are depicted in Table 1, and many of these recommendations seem to be applicable to REM populations more broadly. Venner followed up with pilot study [48] that combined motivational interviewing with another evidenced-based treatment for substance use, resulting in The Motivational Interviewing Community Reinforcement Approach (MICRA). The authors

culturally adapted the program, which was delivered in up to 20 counseling sessions by counselors from the tribal community. MICRA led to reductions in percent days abstinent, as well as improvements in alcohol use, distress, and legal problems, but the study lacked a comparison group. As such, the effects could not be solely attributable to the adaptations of MI. Dickerson and colleagues [49] drew from Venner and colleague's work and developed an alcohol and drug program for youth called The Motivational Interviewing and Culture for Urban Native American Youth (MICUNAY), which incorporated cultural practices and content, while addressing identity issues as well as community stressors (e.g. gang violence, deprivations of resources). Currently, this intervention is being tested in a randomized clinical trial.

Theoretical Considerations

Self-determination within social context

In keeping with the practices of intervention science, cultural adaptations for MI should be guided by theory. Self-Determination Theory (SDT) [50–52] has been used as a rationale for MI and posits that humans naturally tend to pursue activities that lead to growth. When people are allowed to pursue growth on their own accord (i.e. in a *self-regulated* manner), then their behavioral changes become more stable and durable than the behavioral changes that are forced upon them (i.e. externally-regulated). For this reason, MI focuses on promoting the person's intrinsic motivations for growth while minimizing external controls, which in theory elicits longer lasting changes when compared with changes that are brought about by forms of coercion, contingent rewards, and punishments.

But it is important to remember that individuals are situated within families, communities, and the larger society, all of which shape individual-level beliefs, attitudes, and behaviors. Self-determination, thus, should be understood within these complex and interlocking ecological systems [43, 45, 53–54]. For this reason, Dickerson and colleagues [49] adapted MI to account for the lack of neighborhood resources for American Indian/Alaska Native youth, and Interian and colleagues [41] adapted MI to frame medication adherence in a meaningful way for Latinos. Lee and colleagues [44] predicated their small pilot trial on the premise that adaptations should account for social context in order to maximize relevance and effectiveness, and are currently formalizing a Social Context Theory for cultural adaptations. Environmental constraints can significantly influence internal and external motivation, which is evident when considering how MI should be used with someone who is incarcerated [55–56], or with someone wanting to make a lifestyle change in community that is deprived of opportunities and resources [see 57].

Mixed messages

Certain cultures may regard filial piety, obedience, submission, discipline, inter-dependence, duty, honor, and accountability as virtues [58], and these virtues might be construed as “externally regulated” motivations for behavioral changes. Researchers in the past have had to reconsider how interventions interact (and clash) with traditional Asian, Hispanic, and American Indian cultures, where individuals have been raised to honor the elders and submit to authorities [see 59–60]. In such cultures, it may be possible that a person can internalize

an external motivation (this is known as *introjection*), producing only ephemeral behavioral changes that are driven by approval or shame [51].

Rather than pathologizing cultures for their shame-inducing tendencies, we must recognize the strength and resilience that these cultures provide. After all, retaining traditional culture has proven to be protective against negative outcomes [61–63]. Religious cultures can also be protective against mental illness and substance use [64–65], and can play a key role in recovery [66]. Thus, studies have underscored the need to consider acculturation issues in culturally adapted MI [21; 43; 44].

MI is designed to promote person-centeredness and autonomy, and so it is possible that the ambivalence exhibited by the client –the very ambivalence that MI is supposed to help resolve –may actually derive from tensions that emerge from using an individualistic approach to help a person change within a collectivistic cultural frame of reference [59–60]. Castro and colleagues [17] acknowledge that interventions can convey messages that clash with cultural norms and values, leading an individual to resist change, thereby necessitating adaptations. Recently, researchers have explored the use of MI with the involvement of significant others in the session [67], which seems like a promising form of adaptation for individuals who hold strong collectivistic values.

We should note that there are certain elements of the social environment that we should strive to eliminate. Social stigma, for instance, emerges when the larger society disapproves of a person or group based on a distinguishing characteristic, such as mental illness or substance use disorder, criminal history, sexual orientation, and so forth. Stigmatized individuals feel dishonor and shame, and often feel deterred from acknowledging psychological problems, seeking help, or initiating behavioral changes. Stigma can make a person more susceptible to introjection, and so scholars have started to adapt MI to address negative social attitudes that are endemic and pervasive in certain cultures [41]. For example, MI has been adapted to help reduce risky sexual behaviors among young gay and bisexual men [68–69]. Overall, MI should consider the lived experiences of minorities and the environments in which they reside [57, 70].

Future Directions

Framework

In order to advance culturally adapted MI, we must be prepared to conduct a considerable amount of systematic research. Barrera and Castro [21] offer a framework to guide this process. Efforts should begin with a needs assessment of the community, and a determination of whether MI is effectively meeting those needs. If not, preliminary adaptations are made, often by way of focus groups, which inform small pilot studies. Most adaptation research has stopped here, but we really need to go further. Pilot study results need to be integrated into further adaptations (possibly requiring multiple iterations), which should then inform an RCT that tests the effectiveness of culturally adapted MI against standard MI. If culturally adapted MI proves superior, then we must ensure that it is disseminated and implemented faithfully in real-world settings [see 71–72]. After this, we

should continue to engage and assess the community on an on-going basis, because culture is complex, evolving, and dynamic.

Focus Groups

Typically the first attempts to culturally adapt MI have relied heavily on focus groups [41; 47; 49], which are useful in capturing a range of views and experiences, identifying social and community norms, and seeking community-level information. Focus groups have proven to yield a wealth of insights for adaptation, and continue to be appropriate for conducting exploratory, explanatory, evaluative research of culturally adapted MI [73]. But focus groups also tend to lack depth, and are not generally useful for eliciting individual narratives or describing complex change processes within varying systems of meaning, which can be better captured through surveys, diaries, and semi-structured interviews. All qualitative inquires should try to elicit information from individuals who are wary of treatment.

Observation

Observations of clinical encounters (by audio or video recordings) can be informative, and can provide a different perspective when compared with focus groups. Clinical interactions may activate core ingredients of MI, and cultural congruence between the provider and client can augment the therapeutic alliance. Rather than basing adaptations solely on the self-reported experience of the client, observations of MI sessions can also examine the clinician's behaviors and the dynamics that emerge between the clinician and the client.

Randomized Control Trials

Qualitative findings should make way for properly executed randomized control trials. That is to say, we need to be clear about what components (the structure or content) we are adding, deleting, or modifying. Each modification should have a strong rationale, and should be explicitly linked to outcomes (e.g. efficacy, retention, satisfaction). Is a mechanism more or less relevant for a particular cultural group when compared with others? Does the use of cultural metaphors, symbols, and myths enhance engagement? These lines of inquiry should be rigorously pursued using of theory, as well as randomization into appropriate comparison conditions.

Cultural responsiveness

We recognize that cultural adaptations run the risk of operating on stereotypes. Culture cannot be reduced to something singular or static –it is variegated and evolving, and people identify with their cultures to varying degrees, or have intersecting identities [53, 54]. And so we acknowledge that adaptations alone are not enough to meet the complex needs of REM and other cultural minorities. Adapting MI to diverse populations should coincide with principles set forth in the cultural competence literature [25]. Practitioners should be aware of their own values and biases, and how these may influence perceptions of the client, the client's need/problem, and the therapeutic relationship [16]. Cultural competence skills involve familiarity with the client's background and worldviews, which practitioners consider while evaluating and intervening in a manner that is culturally sensitive and

relevant. Further, practitioners must also attend to the dynamic processes that underlie the therapeutic relationship, exploring how both the provider's and client's cultural values, perspectives, and behaviors affect the relationship and the goals of therapy. The provider must also have structural competency and an awareness of the macro-level forces that influence health [57]. Cross-cultural competence contributes to client satisfaction beyond general competence [74]. We note that cultural competence does not comprise a checklist of behaviors, but instead forms the ideals of cross-cultural therapy that lead us to adopt a posture of curiosity, humility, and self-reflection.

Closing Remarks

With rapidly changing demographics around the world, providers must determine whether key components of MI are ubiquitous across cultures. Individuals possess intersecting identities and inhabit evolving cultures, and so MI requires the right posture, a bit of finesse, and a good amount of flexibility in order to respond to the culturally heterogeneous population, especially those who have been historically underserved. Manuel and colleagues [24] concluded that cultural adaptations of brief interventions for addiction were promising (notably for REM and immigrant groups), and their recommendations have reached mental health organizations across the US [75]. The quick national response indicates that the momentum for more cultural adaptations in addiction treatment is accelerating. Cultural adaptation can help meet the unique characteristics and needs of minority populations, but the adaptation process is meticulous and requires good evidence for every modification. We argue that there should be more conversation about how MI is being used in real-life settings, to what extent MI adaptations lead to better outcomes, and how to move forward adapting MI for different cultures in a way that is parsimonious and unified. We hope that our insights can inspire future investigations where researchers and healthcare providers can partner with people from various cultural backgrounds to develop effective MI adaptations and trainings for practitioners.

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Table 1.

Some recommendations for cultural adaptations while working with American Indian/Alaska Native populations

- Have the provider disclose more personal information
- Inquire about ethnic background (i.e. identity, language, spirituality, and ties to the community)
- Avoid stereotypes
- Acknowledge historical traumas and losses (including discrimination)
- Exhibit greater cultural competence about celebrations, ceremonies, and traditions
- Reflect on biases
- Focus on strengths
- Use humor
- Use metaphors, myths, and storytelling
- Develop discrepancies between alcohol use and values (family, clan ties, community, spirituality)
- Ask the person about potential solutions to their own problems.