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Treating ethnic minority adults with anxiety disorders: Current status and future recommendations☆

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ABSTRACT

The past three decades have witnessed an increase in the number of empirical investigations examining the phenomenology of anxiety and related conditions. There has also been an increase in efforts to understand differences that may exist between ethnic groups in the expression of the anxiety disorders. In addition, there is now substantial evidence that a variety of treatment approaches (most notably behavioral and cognitive behavioral) are efficacious in remediating anxiety. However, there continues to be comparatively few treatment outcome studies investigating the efficacy of anxiety treatments among minority populations. In this paper, we review the extant treatment outcome research for African American, Hispanic/Latino[a] American, Asian American, and Native Americans suffering with one of the anxiety disorders. We discuss some of the specific problems with the research in this area, and then provide specific recommendations for conducting treatment outcome research with minority populations in the future.

1. Introduction

The last three decades have witnessed a dramatic growth in the number of treatment outcome studies for the variety of anxiety disorders (McManus, Grey, & Shafran, 2008). Of particular importance, the field has gathered sufficient evidence to establish certain approaches for anxiety disorders as effective in significantly reducing anxious symptomatology over the course of treatment (Anthony, 2010). Specifically, there are evidence-based approaches established for exposure treatments for Obsessive Compulsive Disorder (Abramowitz, Foa, & Frankiln, 2003), social skills training and cognitive behavioral group treatment for social anxiety disorder (Heimberg, Salzman, Holt, & Blendell, 1993; Herbert et al., 2005), cognitive behavioral therapy for panic disorder (McHugh, Smits, & Otto, 2009), prolonged exposure for PTSD (Foa, Hembree, & Rothbaum, 2007), exposure for specific phobia (Emmelkamp, Bowman, & Scholing, 1995), and more recently for the approach of mindfulness for generalized anxiety (Vollestad, Sivertsen, & Nielson, 2011). Additionally, Curkowicz et al. (2011) found evidence that shifting to empirically supported treatments in a training clinic led to significant improvements in patient outcomes that was maintained for a period up to 10 years (Curkowicz et al., 2011).

Despite available evidence suggesting that behavioral and cognitive behavioral approaches are particularly effective in the treatment of anxiety, the treatment outcome literature examining (a) the impact of ethnic minority group membership on outcome; (b) the impact of tailoring treatment; or (c) developing new treatments for ethnic minorities has been comparatively slow in coming and is relatively sparse. The purpose of this review is to examine the current state of the treatment outcome literature for ethnic minorities suffering with one of the anxiety disorders defined in the DSM (APA, 2000). As such we will review the available treatment outcome literature for African American, Hispanic/Latino[a] American, Asian American, and Native American adults. We have limited our review to these groups for two reasons. First, the aforementioned groups represent the largest minority groups in this country (U.S. Bureau of the Census, 2010). And second, because most of the treatment outcome research has been conducted with these populations. In this review we include all available treatment outcome studies. This includes well controlled studies that have incorporated random assignment and use of treatment control groups, those that simply report on a specific treatment approach with no treatment control condition, and case studies with single or multiple participants. We have chosen to be broad in our

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inclusion of studies to be as comprehensive as possible and because the treatment outcome literature in this area is limited. Our review will cover the treatment outcome studies for each of the ethnic minority groups listed above. For each group, we will review the extant literature, summarize the findings, and discuss possible future directions. We begin with a review of the treatment outcome literature for African Americans as this group has received the largest attention in the empirical literature for treating anxiety disorders among minority populations.

2. African Americans

African Americans constitute the second largest minority group in the United States (U.S. Bureau of the Census, 2010). Additionally, extant data continues to show that a larger percentage of this group live below the poverty line compared to European Americans. In 2007, the U.S. Census bureau reported that 24.5% of African-Americans in comparison to 8.2% of non-Hispanic Whites were living at the poverty level. In 2007, the unemployment rate for Blacks was twice that for non-Hispanic Whites (8% and 4%, respectively) (DeNavas-Walt, Proctor, & Smith, 2008),

Consequently, African Americans are exposed to higher levels of stress from economic and social stressors (Clark, Anderson, Clark, & Williams, 1999). While the increased level of stress has led some to postulate that African Americans may have higher rates of anxiety disorders, most available evidence indicates that African Americans have a lower prevalence rate for most anxiety disorders (Himle, Baser, Taylor, Campbell, & Jackson, 2009). The exception is a higher rate of posttraumatic traumatic stress disorder among African Americans compared to European Americans (Breslau et al., 2005; Himle et al., 2009). The decreased rates of most anxiety disorders have been linked to resiliency (Neal-Barnett & Turner, 1991) and religiosity (Taylor, Chatters, & Jackson, 2007), while the elevated rates of PTSD have been linked to exposure to high-trauma environments (Carter, Sbrocco, & Carter, 1996).

Available evidence of treatment utilization is mixed. Studies indicate that African Americans use mental health services less than European Americans (Wang et al., 2005) and that utilization rates may depend on the disorder being examined (Chen & Rizzo, 2010). There is also evidence that African Americans compared to European Americans drop out of treatment with greater frequency (Sue, Zane, & Young, 1994). Lester, Resick, Young-Xu, and Arts (2010), for example, found in their examination of data from 2 randomized controlled trials that African American participants who were survivors of physical or sexual trauma were more likely to drop out prior to starting treatment than European Americans (21% versus 7%) or be partial completers (34% versus 18%). As well, the evidence of treatment efficacy for African Americans is mixed. As indicated by Sbrocco et al. (2005), poorer adherence and outcomes may be related to program content or delivery (e.g., therapist's level of cultural competency) rather than participant characteristics.

2.1. African American treatment outcome studies

2.1.1. Panic disorder

The first study examining the treatment outcome of African Americans with panic disorder was conducted by Friedman and Paradis (1991). In this study the authors compared the symptom severity and treatment response of 15 African American and 15 European American patients with panic disorder and agoraphobia. Treatment consisted of in vivo exposure and tricyclic antidepressants. It was noted that there were no differences between groups at the start of treatment in terms of age of onset or symptom severity. However, at post-treatment it was noted that 84% of European Americans were rated as moderately or significantly improved with only 16% rated as slightly improved or were early dropouts. Conversely, only 33% of the African American group were rated as moderately or significantly improved with 66% rated as slightly improved or were early dropouts. From this early investigation, it became apparent that African Americans may have a different response to treatment than European Americans. It could not be determined however, if the poorer results for African Americans was the result of a specific component of therapy (i.e., use of medication among African Americans), lack of cultural sensitivity, or other more pragmatic factors (e.g., cost, time, transportation). Nonetheless, this study served as the starting point for subsequent investigations in this area (see Table 1 for a summary of African American treatment outcome studies).

Chambliss and Williams (1995) compared the treatment response of 18 African Americans to that of 57 European Americans. Treatment consisted of 10–20 session of therapist-assisted in vivo exposure. The samples were comparable on fear of fear, panic frequency, and depression at post-treatment. The African American group, however, was rated more phobic at the start of treatment than the European American sample. From pretest to post-test, both groups evidenced significant improvement in measures of anxiety and avoidance, although African Americans did not improve in panic frequency. Comparisons between groups indicated that African Americans continued to be more severe on their primary phobia, anxiety, and avoidance. These differences continued at the 6 month follow-up assessment. The reason for the comparatively poorer performance of African Americans in behavior therapy is difficult to explain. As noted by the authors, it is possibly related to severity of illness, the addition of racial stress, low SES (possibly resulting in difficulty in attending sessions), or the therapeutic approach itself. It may be that that a standard behavioral treatment does not allow for the systematic management of cultural variables in the course of treatment. More recent applications of cognitive behavioral treatment have produced somewhat stronger effects in the treatment of panic disorder.

Carter, Sbrocco, Gore, Marin, and Lewis (2003) conducted one of the only randomized control trials of the treatment of African Americans with panic disorder. In this investigation, the authors randomly assigned panic patients to either 11 sessions of cognitive behavioral treatment (CBT) or a wait-list condition. All participants were diagnosed with moderately severe panic disorder with agoraphobia. It was noted that participants in the treatment group experienced a significant reduction in panic frequency, avoidance behavior, state and trait anxiety and anxiety sensitivity. There was also a trend for the treatment group to report a significant decrease in associated depressive symptoms. There were no changes noted among the wait-list condition. Of some import, the authors further reported that 54% of the sample was classified as recovered, and 17% classified as improved but not recovered, and a strong overall effect size. Comparatively, 95% of participants in the wait-list condition remained unimproved. While the results from this investigation are promising, it should be noted that the percentage of high endstate functioners (those who score within normal limits on all measures at the end of treatment) is considerably lower than the percentage reported in studies with predominantly European American participants. Of particular note in this study is that an African American therapist was used, treatment was tailored to prompt discussion of cultural issues (e.g., anxiety from being African American in a European American workplace), and the sample was mid- to upper Socio Economic Status and well educated.

Friedman, Braunstein, and Halpern (2006) compared the efficacy of CBT in treating panic disorder with or without agoraphobia in a sample of 24 African American and 16 European American patients residing in an urban setting. All participants were rated as moderately severe at the start of treatment. Treatment consisted of approximately 16 individual sessions of standard CBT. The authors