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Recruitment of Ethnoracial Minorities for Mental Health Research

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To ensure a complete understanding of mental disorders and their treatments, it is essential that research samples include all segments of society. As the percentage of ethnoracial minorities in the United States is increasing, there is an urgent need to clarify whether therapeutic methods are effective across populations (Harris et al., 2003). Inclusion is important because assessing the effects of treatment on ethnoracial minorities may help establish the external validity of research in psychotherapy, determining the generalizability of certain therapeutic approaches (Hohmann & Parron, 1996). This is particularly vital when considering the growing elderly population that is most in need of psychological care, many of whom are minorities (Arean & Gallagher-Thompson, 1996). However, ethnoracial minorities continue to be underrepresented in mental health research. By excluding minorities, mental health professionals are not learning the best ways to care for them, which means they are not making full efforts to promote their well-being and are possibly even causing harm.

The Belmont Report (Department of Health, Education, and Welfare, 1979) explains the unifying ethical principles that form the basis for the inclusion of human subjects in research. The three fundamental ethical principles are respect for persons, beneficence, and justice. The principle of respect for others states that individuals should be treated as if they are autonomous, unless they are found to be otherwise. This includes taking into consideration each autonomous individual's opinions and choices, and only excluding them if they need protection. Thus, excluding ethnoracial minorities who are not in need of protection violates the principle of respect for persons. While minorities are being protected from potential harm in research, they are also being deprived of potential benefit. In addition, the principle of beneficence states that treating a person ethically involves maximizing benefits, preventing harm, and "making efforts to secure their well-being." In terms of justice, the Belmont principles

outline the idea that benefits and burdens of research should be fairly distributed. Research findings that are not inclusive of ethnoracial minority participants mainly benefit the majority who are being researched, because treatment approaches become tailored based on their results. In order to fully benefit these groups, research must be conducted in order to determine what works best with different groups. Americans of all races and ethnicities contribute to the costs of research through tax dollars that pay for studies funded by agencies such as the National Institutes of Health (NIH), National Science Foundation (NSF), and Department of Defense (DoD). Thus, it is critical that findings benefit all groups as well.

In 1989, the NIH encouraged research proposals to include women and minorities and provide a rationale if they were excluded. To facilitate this process, Congress legally mandated inclusion through the NIH Revitalization Act of 1993, and researchers were instructed to include in their proposals strategies by which they would achieve diversity in their samples. By 1994, the NIH had revised its policy to require that women and minorities must be included, and by 1995 the NIH refused to fund any project that did not adhere to these policies (U.S. Department of Health and Human Services [USDHHS], 2002).

According to the Outreach Notebook for the NIH Guidelines on Inclusion of Women and Minorities as Subjects in Clinical Research, "it is imperative to determine whether the intervention or therapy being studied affects women or men or members of minority groups and their subpopulations differently" (USDHHS, 2002, p. 103). The USDHHS states that "sufficient and appropriate representation of minority groups to permit valid analyses of differential intervention effect" must be included in the study design, unless it is apparent that including minorities will not resolve any crucial public health issues (USDHHS, p. 25). This rule usually requires researchers to include a higher percentage of minorities than what would be

seen in a nationally representative sample in order to attain sufficient statistical power to be able to examine whether group differences are present in important outcome variables.

Despite some strong words from Congress and the NIH, clinical studies frequently lack adequate minority participation. As of the last available NIH report, ethnoracial minorities constituted 28.1% of enrollment across all U.S. domestic clinical studies, which is unchanged over the last 10 years (USDHHS, 2011). This is less than representative as ethnoracial minorities are 36.6% in U.S. population and 50.4% of all births (U.S. Census Bureau, 2011, 2012), but high enough to illustrate that these groups can and do participate in clinical research.

Most mental health researchers recognize the importance of including diverse samples in their research studies but are often unsuccessful in recruiting adequate numbers. For example, Mendoza and colleagues (2012) found that 82.7% of participants across 19 studies of panic disorder were non-Hispanic White; ethnoracial minorities included 4.9% African Americans, 3.4% of Hispanic origin, 1.1% of Asian origin, and 1.4% of another ethnoracial group. Wetterneck et al. (2012) found even lower rates of inclusion among Latino Americans in OCD clinical studies; of 46 trials surveyed, only 8.6% of participants were non-White. In another OCD-related study, Williams, Powers, Yn, and Foa (2010) found similar low rates of minority inclusion, with 91.5% European American participants in 21 studies. Only 1.3% were African American, 1.0% Hispanic, 1.6% Asian, and 1.5% other.

Based on information compiled from a review of many studies involving recruitment of ethnoracial minorities, there are several possible solutions to the problem of underrepresentation in mental health research. These solutions may be useful across cultures and should be taken into consideration when attempting to recruit a diverse sample.

Training in Cultural Competence

It is vitally important that study personnel have a genuine commitment to minority mental health and have been adequately trained in culturally informed assessment and treatment techniques. Although most clinicians are now receiving some sort of diversity education in training programs (Green, Callands, Radcliffe, Luebbe, & Klonoff, 2009), practical skills in interacting with specific ethnoracial minority

groups are not typically included. When clinicians and researchers lack the needed skills and education for effective cross-cultural interactions, they may rely on a color-blind approach. Color-blindness is the ideology that different ethnoracial groups should all be treated the same, without regard to cultural differences (Terwilliger et al., 2013). Minorities are treated as if they lack characteristics that make them different from the dominant majority. Although the intent of color-blindness is to create fairness, it often causes confusion and can actually increase prejudice (e.g., Richeson & Nussbaum, 2004). When the idea of “treating everyone the same” is proposed, it is typically from the perspective of the dominant majority, implying that everyone should be treated as if they were culturally European American. From a clinical standpoint, color-blindness could unintentionally result in negative consequences for an ethnic minority patient if a therapist were to suggest that the patient engage in behaviors that are generally deemed as “adaptive” according to European American psychological tradition but that may in fact be culturally incongruent. The goal, therefore, is not to treat participants as if they were European American, but as they want to be treated, based on the norms and practices of their particular culture. This approach, called multiculturalism, embraces the differences, strengths, and uniqueness of different ethnoracial groups.

Americans are socialized not to acknowledge race and ethnicity, perhaps out of concern of appearing biased or racist (Gaertner & Dovidio, 2005). However, this socialization contributes to difficulty in recognizing, discussing, and adapting to differences (Terwilliger, Bach, Bryan, & Williams, 2013). Thus, it is vitally important that researchers understand culture-specific differences, which can range from amount of eye contact to culture-bound idioms of psychological distress. Researchers are also charged with the dual mandate to avoid stereotyping, as ethnoracial group members are not homogeneous and vary in their levels of acculturation. There are too many different groups for any one person to have an in-depth understanding of all, so the focus of staff trainings should be on the specific ethnoracial groups targeted for study inclusion. Yancey, Ortega, and Kumanyika (2006) recommended the inclusion of sufficient numbers of at least one minority group to conduct subgroup analyses.

Development of Racial Consciousness

Before undertaking any serious cross-cultural efforts, some introspection may be in order. Researchers must consider the possibility that low minority participation could be the result of systemic exclusion due to discomfort working with ethnoracial minorities and/or the unspoken assumption that such individuals may not be good research participants (e.g., Joseph & Dohan, 2009). For example, one large review of minority participation in medical research, involving over 70,000 potential participants, found that minorities were just as willing and eligible to participate as their non-Hispanic White counterparts (and in some cases, more willing), but were significantly less likely to be invited as study participants (Wendler et al., 2006).

Researchers may be selectively excluding participants they believe would be poor candidates based on beliefs that minorities may drop out prematurely, be unable to follow directions properly, or fail to follow study rules and procedures. Thus, it could be that bias on the part of researchers is a contributing factor to underrepresentation (e.g., Joseph & Dohan, 2009). Therefore, study personnel should conduct critical self-assessments to ensure they do not harbor negative feelings, perhaps unwittingly, about ethnoracial minorities that could be resulting in an implicit selection bias. Those who become aware of such biases can improve through the deliberate cultivation of cross-cultural personal relationships and ongoing multicultural education (McKinney, 2006; Okech & Champe, 2008). Additionally, study coordinators should encourage team members to focus on treating their minority participants with respect and appreciation, rather than simply to avoid bias (Gaertner & Dovidio, 2005).

Diverse Staff

Several studies have documented having adequate staff members from diverse groups as key to successful efforts at minority recruitment (Chao et al., 2011; Gallagher-Thompson, Solano, Coon, & Areán, 2003; Jackson et al., 2004). Creating multicultural project teams helps extend cultural awareness and competence so that all staff can learn from new issues as they are raised (Gallagher-Thompson et al., 2003).

According to a report of the U.S. Surgeon General, “research documents that many members of minority groups fear, or feel ill at ease with, the mental health sys-

tem” (USDHHS, 1999). Therefore, it could make a critical difference in participation, willingness, and overall comfort level for several important members of the research team to be actual members of the targeted minority communities. It is reassuring and makes the outcome of the study more personally relevant when participants see people like themselves invested in the research program and occupying key leadership roles.

Additionally, research participants may feel more comfortable discussing psychological problems with someone of the same ethnoracial background (e.g., Jackson et al., 2004), and some minorities may answer questions about symptoms differently when ethnographically mismatched (e.g., Williams & Turkheimer, 2008). In most cases, therapists conducting assessment interviews should be matched by race and ethnicity. For example, Hispanic Spanish-speaking participants should be matched to Hispanic evaluators who will be able to conduct assessments in Spanish, if desired, as this can improve diagnostic accuracy (Malgady & Costantino, 1998). Given that cultural matching is not always possible or desirable from a participant’s perspective (e.g., could be viewed as “forced segregation”; Pole, Gone, & Kulkarni, 2008), cross-cultural training is essential for all clinicians. Mental health professionals must learn to make culture an integral part of each assessment as it influences patterns of communication between clinician and patient and subsequent diagnostic and treatment outcomes.

Community Outreach

Community outreach is an important part of a successful recruitment effort and should be undertaken extensively. For African American and Hispanic participants, research has shown that community involvement by project staff is particularly important for study retention (Yancey et al., 2006). Study personnel should invest in making and maintaining personal connections with important people and organizations within the communities of interest, such as church leaders and local officials (Clay et al., 2003; Gallagher-Thompson et al., 2003; Meinert et al., 2003). One or more study team members should regularly participate in community organizations and maintain regular contact with organizations and health centers via phone calls, mailings, and visits. Research assistants can work with project investigators to organize educational lectures about the topic under study at local churches, public schools, community colleges, and community men-

tal health organizations to raise awareness about the study and at the same time provide a valuable educational opportunity for attendees. Research assistants can also help by acting as liaisons to local media outlets and arrange faculty interviews on local TV news and talk shows, radio shows, and in community newspapers (Jackson et al., 2004).

At the Center for Mental Health Disparities (CMHD) at the University of Louisville, we are in the process of recruiting Black, White, and biracial participants for our new multiracial family study. In preparing for this effort, we had a team brainstorming session of all avenues for recruitment we could think of to find diverse families of various socioeconomic backgrounds. We are recruiting from several local sources, including Jefferson County Public Schools, Seven Counties Services (community mental health center serving Jefferson county and the six surrounding counties), African American churches, the Lincoln Foundation, and 2not1.org (an organization serving community fathers and their families). Additionally, free parenting workshops for which parents select the topics are conducted at these organizations to facilitate recruitment. The CMHD has established several community partners and a Community Advisory Board that serves diverse families from the community and assists with recruitment for studies.

Professional Referrals

Individuals report being most willing to participate in a medical research study when recommended by their own doctor, and this is true for African American, European American, and Hispanic American study participants (Katz et al., 2006). Thus, community family physicians, psychiatrists, and mental health center staff are an important outreach source (Sweeny, Robins, Ruberu, & Jones, 2005). In one study of Asian Americans, researchers successfully recruited Chinese senior citizens by establishing outreach clinics in Chinatown, where local practitioners could refer patients for specialty evaluations (Chao et al., 2011).

Mental health providers may learn about studies through professional organizations such as the Association of Black Psychologists, Society of Indian Psychologists, Asian American Psychological Association, and the National Latina/o Psychological Association. Local members should be sent mailings about the study, followed by a personal contact to ensure re-

ceipt and promote the study. Drs. Williams and Chapman are both members of the Kentucky Psychological Association (KPA), which has in the past been receptive to mental health disparities research, and both investigators were invited speakers at a recent diversity-themed conference for the organization. This opportunity raised awareness about the study efforts among the membership of the KPA, generating professional interest and referrals.

If study personnel are licensed clinicians, that creates another avenue for community connections. For example, at the CMHD, Dr. Chapman receives numerous referrals through local churches and other community mental health providers. Dr. Williams receives regular inquiries from people with OCD due to educational articles she has written about the topic for the general public that are posted on the internet. ABCT and other organizations that have provider directories are a source of contact for treatment-seeking individuals who might also be interested in research studies—but keep in mind that these avenues are traditionally good sources of non-Hispanic White participants and may not be adequate for identifying minorities.

Paid Advertising

Advertisements are most effective when they are culturally specific (e.g., Gallagher-Thompson et al., 2003). Study staff should carefully develop culturally appropriate advertisements by featuring photos of the minority group of interest to facilitate a more positive impression about the study among these groups (Avery, Hernandez, & Hebl, 2004). If researchers are interested recruiting people who are likely to be nonnative English speakers, it is important to translate ads and include appropriate language and culturally specific terms for mental health symptoms. Materials should be developed and revised using feedback from early participants (e.g., first few subjects, focus groups, pilot/feasibility studies).

Because of historical abuses and ongoing discriminatory experiences, African Americans may be particularly mistrustful of researchers; therefore, advertisements should clearly state the purpose of the study, participant burden, incentives, and sponsoring organization, when space permits (Clay et al., 2003; Hatchett, Holmes, Duran, & Davis, 2000). The term “research” should be avoided in favor of other, less incendiary terms, such as “project” and “study,” to distance recruitment efforts from associations with past research abuses, such as the Tuskegee Syphilis Study. For Hispanic par-

ticipants, advertisements should be available in both English and Spanish and separate phone numbers should be listed for English and Spanish speakers.

Less acculturated groups may be unfamiliar with DSM-defined disorders. Therefore, advertisements can also be educational in nature and describe specific symptoms in culturally appropriate terms. In a medical study of Native Americans by Stoddart and colleagues (2000), researchers met with the community and tribal leaders to obtain feedback and help develop the protocol. Due to the population involved, questions regarding income and alcohol were specially considered, and questions related to money did not necessitate writing in an exact dollar amount. For terms related to psychosocial variables, some of the Native American consultants stated that tribe members may not understand certain words or they may take offense. Specifically, words and phrases such as “stress” and “feeling blue” were changed because they did not translate well (Stoddart et al.).

Researchers should utilize multiple advertising venues to reach the widest range of participants. Keep in mind that members of any ethnoracial group will include people from every background and SES, so it is important to cast a wide net to increase heterogeneity and thereby improve generalizability of findings. Colorful fliers about the study should be placed in areas with a high proportion of minorities. Fliers should feature attractive photos of the ethnoracial group targeted for recruitment. Mass mailings about the study can be sent to households in neighborhoods that are predominantly African American or Hispanic. To accomplish this, it is possible to purchase mailing lists from survey research companies, specifying specific demographics (e.g., neighborhoods with 50% or greater Korean American residents). As a single mailing is unlikely to be effective, mailings should be sent out several times in varied formats (letter, postcard, etc.), followed by a phone call from a research assistant, as needed (Dillman, 2000; Yancey et al., 2006). Electronic methods, such as email and text messaging, should also be considered.

As many groups have their own preferred newspapers (Clay et al., 2003), advertisements can be placed in local newspapers that are typically read by ethnoracial minorities. For example, recent studies conducted in Philadelphia have had good success recruiting African Americans with ads in specific free newspapers (Foa & Williams, 2010; Williams, Proetto,

Casiano, & Franklin, 2012). Advertisements can be placed on buses, subways, trolleys, and regional rail systems. Such an ad campaign will have a broad reach to all ethnoracial groups; however, African Americans and Hispanic Americans are disproportionately disadvantaged and are therefore more likely to rely on public transportation than others, making this an important medium for urban areas.

The Internet can be an effective means of reaching a diverse population. Advertisements can be placed on minority-specific sites (i.e., BlackPlanet.com, DisgrAsian.com, American Arab Forum) and other similar venues, with a link to the study website. It is possible to expand the use of Google ads by introducing targeted keywords for specific minority groups of interest. Researchers should carefully review their own study websites, add information specific to these groups, and ensure that multicultural images of people appear who are similar to the target participants (e.g., CMHD at www.mentalhealthdisparities.org). Research suggests that minority participants recruited via the Internet may be of a higher SES than the general population (Im & Chee, 2005), but this may appropriately offset the fact that other proposed advertising techniques may disproportionately target lower-income participants. We have also found Internet advertising to be a good way to recruit students from all ethnoracial groups.

Radio ads were not a cost-effective means of advertising in our most recent study (Williams et al., 2012). However, no-cost media outlets may be utilized to generate interest in study, including guest appearances on local television and radio shows. For example, Dr. Chapman has been featured on statewide and regional talk shows, including “The Power to Change,” hosted by an African American local personality, Charla Young, and the Kentucky Education Television (KET) show “Health 360” describing cognitive-behavioral therapy.

Keep in mind that advertising efforts can be expensive, so be sure to include adequate funding in grant proposal budgets. This expense can be justified by the need to realize diversity goals, such as those outlined by the NIH Outreach Notebook (USDHHS, 2002).

Incentives

Incentives can be offered to potential participants to make study participation more likely. Underrepresented minorities are more likely to be disadvantaged, mak-

ing it more difficult to participate, as practicality dictates that inadequate compensation from the time spent in a study is outweighed by other responsibilities, such as a job or taking care of a family (Fisher et al., 2002). Therefore it is important to provide meaningful and adequate compensation to participants for their time and show appreciation for their participation (Williams, Beckmann-Mendez, & Turkheimer, 2013).

When possible, participants should be offered personalized feedback about the results of their participation. Participants from our prior studies have found the feedback helpful and informative (Chapman, Petrie, Vines, & Durrett, 2012; Williams et al., 2012). For example, if conducting a comprehensive psychological evaluation, offer to provide a report of results to the participant and/or their mental health provider to facilitate treatment.

If participants are not receiving adequate mental health care, provide quality referrals for providers accepting insurance, Medicare, and low-cost options. Consider providing treatment directly to participants when needed, and cultivate relationships with a diverse array of local providers who would be willing to see participants after their study participation is over.

Screening

In our study of African Americans with OCD, less than a third of those screened ultimately had lifetime OCD (Williams et al., 2012). Research assistants expended considerable effort contacting and screening potential participants, and a high number of ineligible participants poses a financial and practical burden that must be taken into account. One of the greatest difficulties in recruitment involved responding to potential participants who left a message for study personnel. Many of these calls were not returned as participants often left non-working phone numbers, numbers with no voice mail, or no numbers at all. To improve the acquisition of eligible participants, it is recommended that a qualified screener be available at all times to take such calls. If this is not possible, early morning and late evening calls could be routed to a cell phone that is rotated among study staff.

Environment

A comfortable environment has been identified as an important factor in the ability to recruit and retain research participants. Participants can be put at ease if the study is conducted in a private, peaceful environment that is clean and well-main-

tained (Williams et al., 2013). Consider making participants feel welcome by including ethnically themed magazines and artwork in the waiting room (e.g., *Ebony* magazine, *Vanidades*, *Hyphen* magazine). Williams, Chambless, and Steketee (1998) struggled to recruit African American participants for an OCD outcome trial in Washington, DC, which has a substantial African American population, and deduced that Black participants felt uneasy traveling to an affluent and largely White part of the city. Therefore, it may be preferable to conduct the study within the participants' community in order to avoid the discomfort associated with a setting that is outside of their usual experience, such as a university laboratory. Having the data collected in the minority community and thereby collaborating with community members demonstrates that study organizers have an actual connection with that community, which will help engender trust and improve recruitment through increased awareness (Chao et al., 2011; Hatchett et al., 2000; Meinert et al., 2003).

Ongoing Review of Efforts

The research team should hold regular meetings to review recruitment technique effectiveness. Team members should review goals and how well these have been achieved based on enrollment to date. A self-correcting process can be implemented whereby methods that are not effective are reduced and those that are effective will be retained and/or increased (Clay et al., 2003).

Conclusion

Without adequate representation of ethnoracial minority groups in scientific studies, mental health researchers cannot completely understand or treat psychopathology cross-culturally. Current recruitment methods are resulting in less-than-representative proportions of ethnoracial minority participants and imbalanced reports of findings. Important strategies to increase participation and retention include formal training in cultural competence, development of multicultural awareness, a diverse staff, community outreach, professional networking, careful advertising, meaningful incentives, a comfortable environment, and ongoing review of efforts. Such strategies should be put in place to ensure that mental health research is adequately and appropriately addressing the needs of ethnoracial minority groups.

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DISCLOSURE STATEMENT: Dr. Monnica Williams is a speaker for TZK Seminars.

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Cognitive Behavioral Therapy's Mindfulness Concepts Reflect Both Buddhist Traditions and Native American Medicine

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While clicking through the many photographs of the American Indian Select List of our National Archives in 2008, I found my face on a Kiowa chief named Satanta. Having grown up with all connections to my Native American ancestors severed, I was fascinated by this photograph that looked so much like me, and I immersed myself in learning more. Along the way, it became apparent that Native American medicine shares many important ideas with Buddhism (and others have written on this subject; for example, see <http://taramandala.org/article/buddhism-native-american-practices>).

Interestingly, some of these shared ideas, such as compassionate mindfulness, have recently been embraced by modern Western psychology, such as with cognitive behavioral therapy. I find this development

to be very exciting for its potential as portending a cultural paradigm shift from an every-man-for-himself perspective to a we-are-all-connected perspective.

Such a shift would be in alignment with the larger brewing group process—if social media is an accurate gauge (e.g., the Occupy movement). Others, however, wonder if it is just the latest passing fad (Gerald C. Davison, verbal communication, April 2013). According to Steven Hayes (blog comment, June 27, 2013), perhaps there is room for both mindsets:

If the data hold up it seems more likely that both flavors will hang around a long time and people will vote with their feet based on what they find most useful. But that issue of usefulness includes another hidden issue: what do people really want. Acceptance and mindfulness work is not just another means to an

end—to some degree its a different end. My guess is that the modern world has changed that part of the equation and people are yearning for peace of mind, with connection to others and a sense of purpose. That is a bigger agenda than pain reduction and it fits the acceptance and mindfulness work far more deeply. (Hayes, 2013)

Stressful events in the modern world (e.g., September 11, 2001) do seem an important factor in having set us up for this awakening of moving toward a “we are all in this together” perspective that includes such expanded goals.

The Buddhist practice of mindfulness asks us to practice waiting silently at our internal center—to compassionately observe and accept our own internal flow of thought and emotion, and to practice stepping back from that flow, in nonjudgmental detachment (or acceptance). The Buddhist mandala is a Sacred Circle that symbolizes an enlightened mind, and depicts four directions with a center. Like the practice of mindfulness, both the Buddhist mandala and the Native American Medicine Wheel direct us to go inside ourselves (to our center) to wait in silence and observe with compassion: