Adapting Pediatric Psychology Interventions: Lessons Learned in Treating Families From the Middle East

Marisa E. Hilliard,1 PhD, Michelle M. Ernst,2,4 PhD, Wendy N. Gray,1 PhD, Shehzad A. Saeed,3,4 MD, and Sandra Cortina,1,4 PhD

1Center for Treatment Adherence, Division of Behavioral Medicine and Clinical Psychology, 2Division of Behavioral Medicine and Clinical Psychology, 3Division of Gastroenterology, Hepatology, and Nutrition, and 4Department of Pediatrics, Cincinnati Children’s Hospital Medical Center

All correspondence concerning this article should be addressed to Marisa E. Hilliard, PhD, Center for Treatment Adherence, Division of Behavioral Medicine and Clinical Psychology, Cincinnati Children’s Hospital Medical Center, 3333 Burnet Avenue, MLC 7039, Cincinnati, OH 45229, USA.
E-mail: Marisa.Hilliard@cchmc.org

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Objective Pediatric psychologists are increasingly called upon to treat children from non-Western countries, whose cultures may contrast with a Western medical setting. Research on cultural adaptations of evidence-based treatments (EBTs), particularly for individuals from the Middle East, is sparse. To address this need, we discuss clinical issues encountered when working with patients from the Middle East.

Methods Synthesis of the literature regarding culturally adapted EBTs and common themes in Middle Eastern culture. Case vignettes illustrate possible EBT adaptations.

Results Integrating cultural values in treatment is an opportunity to join with patients and families to optimize care. Expectations for medical and psychological treatment vary, and collaborations with cultural liaisons are beneficial.

Conclusions Critical next steps include systematic development, testing, and training in culturally adapting EBTs in pediatric medical settings. Increased dialogue between clinicians, researchers, and cultural liaisons is needed to share knowledge and experiences to enhance patient care.

Key words case study; evidence-based practice; professional and training issues.

Introduction

The population of ethnic minority and immigrant families in the United States is increasing (Passel & Cohn, 2008), and people from the Middle East represent one of the fastest growing groups (Camarota, 2002; Pew Research Center, 2011). Immigration from this region has occurred in three waves: in the early 1900s, during the mid to late twentieth century, and at present in response to war, intensified violence, and political unrest throughout the Middle East. Many recent immigrants are refugees with histories of direct or vicarious exposure to war (Hakim-Larson & Nassar-McMillan, 2008) and ongoing exposure to racial tensions and discrimination (Awad, 2010; Nassar-McMillan & Hakim-Larson, 2003).

Healthcare needs in the Middle East are growing, and Middle Eastern people are increasingly seeking medical treatment in other parts of the world (Jamal, 2011). For example, patients from Middle Eastern countries nearly quadrupled from 2006 to 2010 at the authors’ institution (Julie Morin, personal communication, March 23, 2011).

The influx of Middle Easterners in the United States poses a unique challenge to pediatric psychologists, as there is little guidance regarding the provision of culturally relevant care to children and families from this region. Heterogeneity in religion, values, language, acculturation, and previous experiences with Western medical settings can result in differing treatment needs and expectations. Ethnic identity and the salience of cultural issues vary at different levels of acculturation, even across generations within the same family (Nassar-McMillan & Hakim-Larson,
Providing Culturally Relevant Care

Experts debate the optimal approach to providing culturally relevant psychological care (Whaley & Davis, 2007). Supporting the view that evidence-based treatments (EBTs) should not be modified (Elliott & Mihalic, 2004), some EBT protocols have demonstrated efficacy for ethnic minority youths without substantial changes (Kataoka, Novins, & DeCarlo Santiago, 2010). However, consistent implementation of EBTs can be difficult even within the majority culture (Waddell & Godderis, 2005), and some degree of treatment adaptation is typical. Others advocate for treatments developed “bottom-up” from specific cultures’ values and practices (Allwood & Berry, 2006).

When standard EBTs do not have the expected outcomes and endemic approaches are not feasible, adaptations for particular cultural groups may be made within an EBT framework (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). This has been described as individualized evidence-based practice in the best interest of patient care (Whaley & Davis, 2007; Whiteley, 2007) and has demonstrated empirical support (Griner & Smith, 2006). Frameworks for adapting therapies address practical issues, communication styles, cultural explanations for symptoms, healing traditions, and acculturation (Lipson & Meleis, 1983; Sue, Zane, Nagayama Hall, Berger, 2009). Specific strategies include incorporating culturally salient examples and values, directly addressing issues of racism, spirituality, and acculturation, involving family members, and delivering interventions in community settings (Kataoka et al., 2010; Sue et al., 2009). These approaches are not limited to particular interventions, and experts agree that such alterations should only be used to the degree indicated by individual patient needs (Huey & Polo, 2008; Sue et al., 2009).

Culturally adapted EBTs for mood, anxiety, and substance abuse disorders have been studied primarily with Latino and African-American youth and families (Bernal, 2006; Bonner, et al., 2002; Huey & Polo, 2008; Kataoka et al., 2010; Osuna et al., 2009; Sue et al., 2009). Although untested, similar adaptation strategies may be beneficial for youth from the Middle East. The few published case reports in this population describe psychiatric treatment or therapy with older adolescents and adults in Middle Eastern mental health settings (Al-Krenawi, 1998; Budman, Lipson, & Meleis, 1992; Lipson & Meleis, 1983; Ozerdem, Oguz, Miklowitz, & Cimilli, 2009), but cases documenting treatment adaptations in pediatric psychology for patients of Middle Eastern descent have not been published.

Terminology and Historical Context

The terms Middle Eastern, Arab, and Muslim are often used interchangeably, yet refer to distinct geographic areas and ethnic and religious groups. We use the broadest term, Middle East, unless otherwise noted. The Middle East is a geographic region encompassing portions of Northern Africa, Southwestern Asia, and Europe (Camarota, 2002), one portion of which includes the 22 Arab League states (e.g., Syria, Egypt, and Iraq; Al-bab, 2009). An estimated 3.5 million Arab Americans have immigrated to the United States or trace their family roots to an Arab country (Arab American Institute, 2011).

Muslims are people who practice the religion of Islam. Islam is prevalent but not exclusive in the Middle East and is also practiced in other regions of the world. Arab Muslims are the fastest growing group of Arab Americans (Camarota, 2002). Core tenets of Islam include belief in the providence of Allah; dedication to charity; and worship that includes daily prayers, fasting during Ramadan, and making pilgrimage to Makkah (Yosef, 2008). Compared to other Middle Easterners, Muslims may be more overtly distinct from mainstream American culture due to religious practices and attire. Islamic health practices, such as greater modesty or less inclination to engage in preventive care, may also diverge from Western and even other Middle Eastern cultures (Yosef, 2008).
Particularly since the events of September 11, 2001, many people of Middle Eastern descent have been subjected to considerable discrimination and intolerance (Awad 2010; Nassar-McMillan & Hakim-Larson, 2003). Some Middle Eastern immigrants may have negative feelings about the United States’ foreign policy, while others may feel positively about the principles of democracy or the availability of educational and economic resources (Arab American Institute, 2009). There is also substantial variability in opinions about the Middle East within the United States (Pew Research Center for People & the Press, 2011).

Middle Eastern Culture and Western Models of Care
The case vignettes that follow illustrate how features of Middle Eastern culture can influence pediatric psychological treatment in a Western medical setting. We describe each patient’s presentation, relevant cultural themes, and how the therapist adapted treatment based on cultural factors (Table I). While each case illustrates unique issues, they share common features. The referrals to psychology were made by medical teams who were becoming increasingly frustrated with slow progress or behavioral issues interfering with medical care. This frustration reflected mismatched expectations of the families, therapists, and medical teams. Each therapist attempted to deliver a pediatric psychology EBT based on symptom presentation, subsequently recognizing that cultural issues were impacting treatment, and adapted the intervention approach. Each case demonstrates how cultural issues that may initially be seen as treatment barriers can be conceptualized as strengths or resources and used to personalize and support therapy (Table I). Per institutional policies, the clinical cases described here did not qualify as human subjects research and did not require IRB review.

Two common themes of Middle Eastern culture in the case vignettes were medical and mental health beliefs and family structure and hierarchies.

Medical Beliefs and Practices
Western medical practices may contrast with the health-related beliefs and expectations of some Middle Eastern cultures (Kulwicki et al., 2000). Given their high regard for Western medicine, many Middle Easterners expect expertise and effectiveness (Meleis, 1981). For example, some parents may insist their child be treated by the provider with the highest status, rank, or education (Lipson & Meleis, 1983; Meleis, 1981; Zahr & Hattar-Pollara, 1998), which some providers might perceive as demanding. While a thorough assessment of history and symptoms is typical in Western medical settings, some Middle Eastern patients may be uncomfortable sharing such private information outside of the family (Nassar-McMillan & Hakim-Larson, 2003), yet expect accurate diagnosis and effective treatment (Lipson & Meleis, 1983; Meleis, 1981; Yosef, 2008). Contrasting with Western models of patient-centered care that emphasize shared decision making between the patient and provider, obtaining patient input or discussions about treatment options may be perceived as a lack of expertise or authority (Al-Krenawi & Graham, 2000; Meleis, 1981). Furthermore, it is often extended families, rather than medical providers, that share health information with the patient (Kulwicki et al., 2000; Yosef, 2008).

Traditional Middle Eastern beliefs about illness may also differ from Western beliefs. While the biomedical foundations of Western medicine are generally respected (Meleis, 1981), some Middle Easterners may also attribute symptoms to spiritual causes and use folk healers with or without the knowledge of the medical team (Al-Krenawi & Graham, 2000; Zahr & Hattar-Pollara, 1998). Individuals with less experience in medical settings may be unaccustomed to medical terminology and may use nonspecific terms or metaphors to describe symptoms (Al-Krenawi & Graham, 2000; Zahr & Hattar-Pollara, 1998). In addition, some Western providers that value individual proactivity may perceive Muslims as passive or fatalistic due to the Islamic belief that illness and healing are at the will of Allah (e.g., “In-sha-allah” or “god-willing”; Lipson & Meleis, 1983; Zahr & Hattar-Pollara, 1998).

Mental Health Beliefs
Given the stigma around mental illness (Al-Krenawi & Graham, 2000; Youssef & Deane, 2006), psychological symptoms can be manifested somatically or be interpreted as a medical issue (Hakim-Larson & Nassar-McMillan, 2008; Zahr & Hattar-Pollara, 1998). Some Middle Eastern patients may therefore expect to undergo a medical procedure or be prescribed medication (Al-Krenawi & Graham, 2000; Lipson & Meleis, 1983), and be less interested in behavioral treatments. The emphasis on individual assertiveness and behavior change in cognitive-behavioral therapy, a mainstay of pediatric psychology, may be particularly discordant with cultural values (Dwairy & Van Sickle, 1996).

Family Structure and Hierarchies
The family unit, including extended family, tends to be valued over the individual, and solutions are often sought from within the family before turning to external supports.
Traditional gender roles are common (Hakim-Larson & Nassar-McMillan, 2008), and the family patriarch may be the gatekeeper of private information and make health-related decisions for the patient (Lipson & Meleis, 1983; Zahr & Hattar-Pollara, 1998).

**Case Vignettes**

The following case vignettes illustrate these and other common cultural issues in treating youth and families from the Middle East. The therapists were licensed clinical psychologists, supervised predoctoral interns, or postdoctoral fellows with specialized training in pediatric...
psychology. They were all Caucasian or Hispanic women. The disposition of each case was determined by the therapist and referring medical provider(s).

**Case 1**

“Faisal” was a preadolescent male with a blood disorder requiring frequent blood draws, injections, and transfusions. He was referred for needle phobia in anticipation of an upcoming inpatient hospitalization. The selected EBT was systematic desensitization and in vivo exposure (Öst, Hellström, & Kåver, 1992; Rainwater et al., 1988). Treatment consisted of eight outpatient sessions. Faisal’s case illustrates the cross-cutting themes of family patriarchy and expectations for mental health treatment, and an example of how refugee experiences played into therapy.

**Family Patriarchy**

Faisal’s father was the primary informant regarding Faisal’s symptoms and history, and Faisal’s participation in therapy depended upon his father’s beliefs about treatment efficacy. Initially, it was difficult to obtain subjective ratings of distress from Faisal, and his father expressed dissatisfaction with the therapist relying on Faisal’s self-report. He observed that Faisal was providing underestimates of his distress, possibly due to cultural norms around privacy (Nassar-McMillan & Hakim-Larson, 2003). In order to obtain paternal “buy in” and respect his status in the family, the therapist subsequently addressed Faisal’s father first and involved him in all aspects of treatment (Youssef & Deane, 2006; Zahr & Hattar-Pollara, 1998). Faisal’s father met regularly with the therapist to discuss perceptions of treatment progress and provide suggestions. For example, the therapist asked him to help create the exposure hierarchy and to provide his own ratings of Faisal’s distress during exposure exercises, which was used in conjunction with Faisal’s self-report and the therapist’s proxy ratings of distress (e.g., heart rate).

**Mental Health Beliefs**

At intake, Faisal’s parents expressed their belief that Faisal’s needle phobia was a medical, not psychological, problem. This impacted their expectations for treatment. Faisal’s father voiced frustration with perceived limited progress despite multiple treatment sessions, which at that time had included a diagnostic interview, one session of relaxation training, and one session of psychoeducation and fear hierarchy creation. In order to align the therapist’s and family’s expectations for therapy and link the behavioral treatment plan with Faisal’s somatic symptoms, the therapist provided additional education, empirical support, and rationale for treatment. She emphasized the physiological aspects of anxiety (i.e., autonomic arousal) and the expectation that repeated exposure to the feared stimulus (i.e., procedures with needles) would decrease Faisal’s conditioned response and improve his coping. Based on empirical support for consolidated exposure sessions (Zlomke & Davis, 2008), weekly hour-long treatment sessions were replaced with twice-weekly 2-hr sessions. In vivo exposures were conducted in medical clinic space with Faisal’s nurses to enhance the relevance of the treatment to his medical care. To help the family recognize treatment progress, the therapist also highlighted evidence of reduced distress during exposure exercises to and routinely communicated to the family reports from medical team about decreases in resistance and time needed for blood draws.

**Refugee Experiences**

Among Middle Eastern immigrants, exposure to wartime trauma and persecution has been linked with poor psychological adjustment (Keyes, 2000) and high rates of mood disorders and post-traumatic stress disorder (Cardozo et al., 2004). Parents and children with refugee status are at particular risk (Hosin, 2005; Montgomery, 2010), which may interfere with their ability to cope with medical stressors (Nassar-McMillan & Hakim-Larson, 2003). In Faisal’s case, the therapist observed the family using coping strategies that appeared to heighten rather than ameliorate Faisal’s anxiety reaction, such as crying, yelling, and coercing him during medical procedures. Given that Faisal’s family had refugee status, the therapist recognized how his parents’ prior coping strategies for refugee-related stressors may have generalized to difficulties coping with Faisal’s needle phobia. She thus assessed their emotional states to determine their ability to manage their worries about Faisal’s health and endure the initial difficulty of exposure therapy. Despite initial reluctance, as rapport grew, Faisal’s father described his experiences coping with refugee-related challenges and current difficulties with social isolation, discrimination, and limited financial resources. By processing these stressors, the family gained emotional strength to face the difficulties of Faisal’s illness and support him during treatment.

**Disposition**

The cultural adaptations made to Faisal’s case enhanced treatment progress and resulted in a significant decrease in his fear around medical procedures. Faisal and his father reported only minimal distress prior to subsequent blood draws and injections, and the medical team reported no difficulties during his inpatient hospitalization. Respecting the family’s patriarchal structure and grounding behavioral...
therapy in an empirical medical context enhanced rapport and increased the family’s confidence and engagement in treatment. Processing refugee-related stressors also benefitted Faisal by addressing his parents’ distress and enhancing their ability to provide him support.

**Case 2**

“Nadia” was an adolescent female treated on an inpatient medical unit for anorexia following an unsuccessful course of outpatient therapy (e.g., attempts to disguise weight loss, inability to gain or maintain weight). Her inpatient treatment followed a standard EBT protocol for anorexia, including prescribed caloric intake, restriction from exercise, contingency management, and family therapy (American Psychiatric Association, 2006). She received four sessions with a therapist as part of the protocol. This case illustrates two themes of Middle Eastern culture, religious practices, and traditional gender roles, in a family with different levels of acculturation across generations.

**Religious Practices**

Muslim faith requires multiple daily prayers that involve repeatedly moving from standing to a prostrate position. Nadia’s family encouraged her to observe religious practice. While Nadia initially only read religious texts in her room, her nurses communicated concern about her increasing use of physically active prayer on the medical floor as a potential source of exercise and a possible barrier to treatment. The therapist discussed this potential treatment barrier with Nadia’s family, who was uncomfortable limiting her involvement in prayer. In order to learn more about Islamic religious beliefs and prayer practices in this context, her therapist consulted with a female Muslim physician at the hospital and an imam, a religious leader in the community. This consultation provided information regarding an exemption from prayer for individuals with a medical condition and increased the family’s acceptance of prayer without the typical physical exertion.

**Gender Roles**

Nadia and her older brother were the first generation born in the United States and their parents had distinct expectations for them based on their genders (Hakim-Larson & Nassar-McMillan, 2008). Nadia’s brother was strongly encouraged to attend college and was allowed considerable social freedom, while she was expected to help with the home and family business. In order to consider how these issues played into Nadia’s symptoms, the therapist encouraged Nadia to process the contrasts between Islamic expectations for females and American culture with the imam. Through this process, it became evident that Nadia felt more socially limited than her brother and peers, and that she was attempting to gain control by restricting her diet and engaging in exercise. To promote shared decision making and foster a reconnection between Nadia and her family, the therapist included Nadia’s parents and brother in therapy. This also ensured that family values were respected during the process of developing strategies to enhance Nadia’s sense of freedom (e.g., Nadia’s brother chaperoned her in social settings).

**Disposition**

With treatment informed by cultural factors, Nadia successfully gained weight during her inpatient admission and transitioned to an outpatient therapist. Consultation with experts in Islam allowed the therapist to learn about prayer practices, build trust, and ultimately provide effective treatment in the context of the family’s religious and cultural background. The imam provided valuable normalization of religious struggles and assured the family’s concerns about refraining from physically active prayer during her hospitalization. By addressing gender issues, Nadia and her brother generated ideas to increase her social interactions in ways that were acceptable to her family.

**Case 3**

“Salma” was a young girl temporarily in the United States to receive cancer treatment. Inpatient psychology was consulted to address uncooperative behaviors compromising medical care on both the part of Salma (e.g., refusing to take her medication) and her family (e.g., parents allowing Salma to refuse her medication or not having Salma ready for therapies). Treatment involved eight consultation sessions focusing on implementation of evidence-based behavioral strategies to increase adherence, such as parent behavior management training, establishing daily routines, and developing a behavioral plan to enhance cooperation with medication and procedures (Kahana, Drotar, & Frazier, 2008). This case is an example of Middle Eastern family and parenting practices.

**Collectivist Family Structure**

Due to illness in Salma’s father, her mother was the head of household and was supported by extended family members. The therapist sought their opinions about Salma and included them in treatment when they were present. Salma and her family typically returned from day passes much later than expected, which interfered with the medical team’s schedule for medication administration. Salma’s mother expressed that spending time with the family was more important to her than following the hospital’s schedule, yet the team was frustrated and felt that it was wrong.
for Salma to be out so late at night. Recognizing this as an important cultural issue, the therapist educated the team about cultural norms and worked with the family to understand the practicalities of a busy nursing staff. In order to allow maximum time with the family while meeting Salma’s medical and rehabilitative needs, the therapist worked with the family and staff to develop effective and realistic schedules for medication and therapies (e.g., shifted later in the evening).

**Parenting Styles**

In some Middle Eastern families, strict child control is seen as necessary to preserve family dynamics and roles, consistent with a higher rate of authoritarian parenting practices (Baumrind, 1967) than is typical in Western cultures (Dwairy & Achoui, 2010). Three unique parenting styles have been observed in this population: controlling (combines Baumrind’s authoritarian and authoritative styles), flexible (combines authoritative and permissive), and inconsistent (combines authoritative and permissive). The controlling and flexible styles are typically seen as positive in Middle Eastern cultures, and only inconsistent parenting has demonstrated negative implications for child development in this group (Dwairy, 2008). In order to engage Salma’s family in behavior management, the therapist provided education about behavioral reinforcement to all family members, modeled providing praise, and introduced a behavioral chart. However, the family resisted these interventions because they were not consistent with their permissive (e.g., resisted setting firm behavioral expectations around medical procedures or meals) and authoritarian (e.g., uncomfortable providing praise for engaging in procedures; punishment for using the bedpan rather than toilet) parenting approaches. The family acknowledged that behavioral charts were useful for increasing Salma’s participation in therapies and meals and for decreasing outbursts, but preferred that staff rather than family provide reinforcers and consequences. The therapist therefore utilized the nursing staff to be the agents of Salma’s behavior change and worked with Salma’s family to identify culturally appropriate forms of praise, such as increased warmth and attention rather than verbal or tangible reinforcement.

**Disposition**

By recognizing the importance of spending time with family, the team adapted Salma’s medical and nonmedical therapy routines to be more flexible and consistent with the family’s schedule, and her adherence to medication administration and participation in therapies increased. Similarly, behavior management became more effective when the therapist considered Salma’s mother’s parenting behaviors from a cultural perspective. However, despite improvements when staff oversaw behavior management, the absence of consistent limit-setting and reinforcement from the family resulted in Salma successfully avoiding some aversive yet necessary medical care. These challenges may be due to a discrepancy between the inconsistent parenting style of Salma’s family and the emphasis on authoritative parenting that characterizes parent behavior management training. They may also reflect a cultural reference to experts in addressing and remediating health and behavior problems (Al-Krenawi & Graham, 2000; Meleis, 1981).

**Discussion**

There is an urgent need for culturally relevant provision of EBTs in pediatric psychology, particularly for children and families from the Middle East. The influx of immigrants, recent political unrest, ongoing exposure to violence and discrimination, and anticipated medical and mental health needs of Middle Easterners in the United States call for more clinical and empirical attention. Pediatric psychologists have the opportunity to liaison with our medical colleagues regarding the intersection of culture with medical care. Increased research and clinical training with this population is a critical next step. Opportunities for researchers and clinicians to share their experiences will be valuable to increase awareness and prompt dialogue regarding strategies for culturally relevant care.

The typical biopsychosocial approach to pediatric psychological care encompasses all of the relevant themes to working with Middle Eastern families discussed in this paper, including considering parenting practices and family structure, being aware of communication styles, and assessing for trauma exposure (Roberts & Steele, 2009). However, as providers we must challenge our assumptions on an individual and family level. Despite common themes, there is great heterogeneity, and individual assessment and case conceptualization incorporating relevant cultural issues are crucial to appropriately and effectively tailor treatment. While general awareness of cultural themes is a good starting point, ongoing evaluation of specific family and individual norms, values, and beliefs is necessary for appropriate treatment planning and intervention delivery.

The three case vignettes presented in this article highlight the similarities and heterogeneity of pediatric patients from the Middle East and their families. Through these cases and in Table I, we provided examples of how cultural themes may emerge in treatment, how they can be
understood as resources rather than barriers to care, and culturally relevant approaches to adapting treatment. Commonalities include the importance of family and desire for the best possible care from the most qualified providers, consistent with the broader literature regarding Middle Eastern patients and families. While the patriarchy of Faisal and Nadia’s families contrasted with the matriarchy and extended family network in Salma’s family, the centrality of close family relationships and parents’ concern for their children’s health and recovery was pivotal in all cases. Each case also involved addressing family’s expectations about provider expertise. For example, Faisal’s father expressed frustration with the therapy process and rate of improvement in order to advocate for Faisal to receive the best care, although this may have initially disrupted rapport building and created defensiveness in the therapist. Efforts to demonstrate expertise included emphasizing data regarding progress and receiving support from the medical team.

Cultural factors that may be initially perceived as barriers to treatment may be better understood as opportunities for enhanced, personalized treatment. For example, the paternal role of family advocate in Faisal’s case, the importance of extended family members in Salma’s case, and the role of prayer and faith in Nadia’s case were originally seen as major challenges to providing evidence-based care. The therapists faced difficult decisions in whether, to what degree, and how to deviate from EBT protocols in the context of these factors. However, by viewing these cultural issues as strengths, these perceived barriers were incorporated into treatment and ultimately benefitted care. The therapists were able to join with the children and families to work toward common goals in a manner that was acceptable and appropriate. On an individual level, pediatric psychologists may be challenged to adapt their therapeutic approach or style to meet the needs and cultural contexts of their patients and families. This approach to true family- or patient-centered care has strong potential to improve treatment outcomes.

While some patients may benefit from standard care with no cultural adaptations (Kataoka et al., 2010), treatment adaptations can be beneficial in many cases (Griner & Smith, 2006). Developing and using culturally based therapeutic approaches (i.e., “bottom-up” or endemic approaches; Allwood & Berry, 2006; Kataoka et al., 2010) may be especially useful with particular cultural groups. Another treatment factor to consider is the “mismatch” of patient and provider ethnicity in these cases. The therapists were not of Middle Eastern descent, which could have impacted the therapeutic relationship. However, evidence for this is equivocal (Karlsson, 2005), and the collaboration with cultural liaisons of similar backgrounds may have minimized this risk.

Given the current lack of empirical guidance, providers must often be creative in assessing and integrating cultural issues into therapy and must consider practical challenges, such as how to gather cultural information and communicate effectively. A primary challenge is assessing which aspects of the child’s presentation reflect illness symptoms versus individual, family, or cultural characteristics. In line with Ecological Systems Theory (Bronfenbrenner, 1979), factors on each of these levels likely influence patient presentation. In addition to literature about cultural norms, therapists are encouraged to use their own clinical observations and those made by nurses and other medical providers. For example, the concerns Nadia’s nurses initially raised about her physically active prayer ultimately benefitted her treatment success. Although rapport can initially be slow to develop (Al-Krenawi & Graham, 2000; Dwairy & Van Sickle, 1996), asking respectful questions can also garner valuable information about health beliefs, expectations for treatment, and sources of support. For example, after discussing family values with Salma’s mother, the focus of conversation with the medical team changed from “bad parenting” to exploring modifications to routine medical care.

Differences in language and communication style, including volume and tone of speech, gesticulation, eye contact, and distance between speakers (Dwairy & Van Sickle, 1996; Hakim-Larson & Nassar-McMillan, 2008), are commonly cited as barriers to care for people from the Middle East in Western medical settings (Kulwicki et al., 2000; Nassar-McMillan & Hakim-Larson, 2003). Language interpreters can be helpful for nonnative English speakers. However, interpreters can affect rapport, and some may inadvertently paraphrase, omit therapist comments or directives, or minimize or exaggerate symptoms (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). In Salma’s case, the family became close with one interpreter and frequently had peripheral conversation in Arabic that interfered with therapy. Therapists are encouraged to consult with cultural brokers or liaisons to increase their awareness of relevant cultural factors and enhance communication (Al-Krenawi & Graham, 2000). Interpreters can serve this role by sharing cultural insights about patients’ behavior (Dysart-Gale, 2007; Miller et al., 2005; Searight & Searight, 2009). For example, Faisal’s therapist regularly consulted with the interpreter for a cultural perspective on the family’s behavior in session, coping, and “buy in” to the therapy process.
which enhanced rapport and generated ideas for treatment adaptations. In Nadia’s case, consultation with two cultural liaisons was a critical piece of her care.

Increased cultural awareness in pediatric psychology has implications for the translation of clinical research. The challenge of providing culturally relevant care is not unique to treating families from the Middle East. Because EBT protocols are typically not developed in the “real world,” problems with translating from research to practice settings are inevitable (Waddell & Godderis, 2005). This is especially relevant whenever patients present from diverse backgrounds, or with complex medical histories or psychological comorbidities (i.e., when real patients deviate from the standard research sample). More systematic development and testing of culturally relevant EBT adaptations in pediatric medical settings are needed to facilitate the process of translating treatments from research to practice for patients from ethnic minority groups.

There is a range of scientific approaches to implement and examine cultural adaptations of EBPs, including case series, quality improvement approaches, or clinical trials. The themes and strategies reviewed in this paper are specific to children and families from the Middle East, yet may be generalizable in principle to other cultural groups.

Finally, clinical training should involve practical experiences in making adaptations to evidence-based treatment strategies based on individual and family culture. While the development of culturally relevant interventions for every ethnic group and symptom presentation is not practical, supervised experience in making educated deviations from EBT protocols are possible and could increase confidence and competence in working with diverse families. Illustrative cases, like those presented here, may be of particular value in this endeavor (Stewart & Chambless, 2010). Awareness of one’s own biases and assumptions is a vital first step toward ethical practice with any patient or family and may be especially helpful to pediatric psychologists working with families from the Middle East in the post 9/11 era.

Conflicts of interest: None declared.

References


