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EMPIRICAL PAPER

## Ethnic differences in response to directive vs. non-directive brief intervention for subsyndromal depression

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### Abstract

**Objective:** Analog research suggests that directive interventions might increase treatment engagement for non-symptomatic Asian American (AA) students; however, no studies have assessed whether directiveness improves therapy processes or clinical outcomes for AAs with mental health symptoms. This study tested the comparative efficacy of brief directive vs. non-directive intervention for AAs and European Americans (EAs) with subsyndromal depression. **Method:** Participants were randomly assigned directive, non-directive, or cultural values interview conditions, and assessed three times over six months. Directive and non-directive treatment involved meeting with a therapist for a single, 20-minute session to receive psychoeducation and personalized feedback on depressive symptoms and coping strategies. Cultural values participants also met with a therapist. **Results:** Although results were mixed for the overall sample, directive treatment was generally superior to non-directive treatment and cultural values at addressing depressive symptoms, coping behavior, and working alliance. Ethnicity did moderate treatment effects for some outcomes, but in an unexpected manner. At six-month follow-up, the directive intervention was more effective than cultural values at reducing depressive symptoms for AAs; however, *the cultural values condition was more effective than the non-directive intervention at reducing depressive symptoms for EAs.* **Conclusion:** Mixed evidence was found for directiveness as an Asian-specific treatment enhancement.

**Keywords:** directiveness; cultural adaptation; Asian Americans; subsyndromal depression; therapeutic alliance

**Clinical or methodological significance of this article:** This article adds to a complicated body of research and clinical work aiming to inform best practices for ethnic minorities. We found some evidence that a directive therapeutic style may be a “culturally invariant” clinical technique that could be beneficial to Asian American and European American populations alike. Yet, other findings suggest that directiveness might be uniquely advantageous for Asian Americans, particularly for long-term improvement of depressive symptoms.

### Introduction

In recent decades, the Asian American (AA) population in the US has been increasing steadily, and grew faster than all other racial groups between 2000 and 2010 (US Census Bureau, 2012). As the AA population has increased, there has been greater focus on the utilization and effectiveness of mental health services for this group (Abe-Kim et al., 2007), particularly since AAs have significant mental health needs that often go unaddressed (Lee et al., 2009; USDHHS, 2001). Along with increased

attention to the mental health needs of AAs, a greater focus on culturally adapted interventions has been promoted as a way to increase service access and maximize treatment outcomes in this population (APA, 2008; Sue & Sue, 2013). Indeed, recent meta-analyses suggest that culturally adapted interventions can be more effective than unadapted interventions (Benish, Quintana, & Wampold, 2011) and that congruence with therapeutic approach and target culture are important for outcomes (Xu & Tracey, 2016).

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Although there is no consensus on the best way to adapt interventions for AA populations, a common recommendation from researchers is to take a more *directive* approach with AAs, by giving commands or instructions, providing information, and eliciting specific responses, among other strategies (Huey & Pan, 2006; Kim, Liang, & Li, 2003; Li & Kim, 2004; Pan, Huey, & Hernandez, 2011; Sue & Zane, 1987). In analog research from counseling psychology with AA and Chinese students, directiveness is associated with positive outcomes, greater perceived counselor effectiveness (Atkinson, Maruyama, & Matsui, 1978), and higher perceived credibility (Atkinson & Matsushita, 1991; Exum & Lau, 1988). Additionally, AAs give directive therapists higher ratings on cross-cultural competence, empathic understanding, working alliance, and session depth than non-directive therapists (Kim, Li, & Liang, 2002; Li & Kim, 2004).

Directive approaches may be preferred by AAs because this style is more culturally congruent with clients' expectations for therapy. Among less acculturated AAs, power differentiation is often apparent in interpersonal interactions, requiring those in lower status positions to defer to and show respect for higher status individuals (Chen & Davenport, 2005). Asians and AAs are more likely than European Americans (EAs) to hold positive beliefs about the legitimacy of authority and social hierarchy in varied social contexts (Cheng, O'Leary, & Page, 1995; Kim, Atkinson, & Yang, 1999; Wink, Gao, Jones, & Chao, 1997), and such beliefs might be rooted in early socialization patterns. Whereas Asian parents are more likely to promote relatedness by encouraging children to obey and respect authority, EAs are more committed to encouraging choice and free expression in their children (Chao, 1995; Rothbaum, Morelli, Pott, & Liu-Constant, 2000). Thus, AAs may be more likely to ascribe greater trust and credibility to therapists with authority-enhancing credentials or who behave like professionals such as teachers or physicians (Chen, 1995; Kim et al., 2002). When therapists use a directive style, they are more likely to control the structure of the session by directing discussion topics and behavior (Atkinson & Matsushita, 1991; Hagebak & Parker, 1969; Li & Kim, 2004), thus positioning themselves as knowledgeable authority figures in the therapist–client relationship.

However, the evidence supporting directiveness as an *Asian-specific* treatment enhancement is mostly circumstantial. Indeed, directiveness is a common component of many evidence-based therapies (Martell, Dimidjian, & Herman-Dunn, 2010; Watson & McMullen, 2005), and some argue that directiveness may be optimal for clients regardless of cultural or

ethnic background (Barbe, Bridge, Birmaher, Kolko, & Brent, 2004; Bond, Wingrove, Curran, & Lader, 2002). Thus, directiveness may be of universal importance as an intervention strategy, with no ethnic- or culture-specific utility when treating AAs.

### Current Study and Hypotheses

Depression is a common mental health concern for both AAs (Young, Fang, & Zisook, 2010) and EAs (Cuijpers, van Straten, Andersson, & van Oppen, 2008), and this study focused on treating individuals with subsyndromal depression (SSD). Individuals with SSD can experience clinically significant levels of depression (Brent, Birmaher, Kolko, Baugher, & Bridge, 2001; Forsell, 2007), and are at high risk for developing Major Depressive Disorder (MDD) at some point in their lives (Judd, Akiskal, & Paulus, 1997; Judd et al., 1998). Research shows that depressive symptoms, even at the subsyndromal level, can cause significant functional impairment and strain (da Silva Lima & de Almeida Fleck, 2007). This study compared the effects of brief *directive intervention* (DI), *non-directive intervention* (NI), and *cultural values interview* (CVI) with AA and EA populations with SSD.

A study by Geisner, Neighbors, and Larimer (2006) served as the foundation for the brief interventions used here. They found that a brief, mailed intervention focused on psychoeducation and personalized feedback was effective at alleviating depressed mood and improving coping skills among primarily AA and EA college students. The current study adapted and expanded upon Geisner et al.'s (2006) design to incorporate their therapeutic content into a face-to-face session with a therapist. It was hypothesized that both active conditions, DI and NI, will be more effective than CVI at reducing depressive symptoms, improving coping strategies, and strengthening the therapeutic working alliance.

If directiveness is indeed a “culturally responsive” therapeutic style with particular salience for AAs, then the superior effects of DI should be most evident for AA participants compared to EAs. However, if the effects of directiveness are “culturally invariant” (Huey & Polo, 2008; Huey, Tilley, Jones, & Smith, 2014), then DI should be equally efficacious for AAs and EAs. Thus, although it is expected that treatment effects will be seen across the sample as a whole, our attention will be primarily on *ethnicity-as-moderator* outcomes. Secondarily, acculturation status was tested as a moderator of treatment outcomes. We hypothesized that among AAs, acculturation level would moderate the effects of treatment condition on all outcomes. Specifically, we anticipate

that DI will be more effective than NI for less acculturated AAs, whereas the active conditions will be equally effective for more acculturated AAs.

## Method

### Participants and Screening

Participants were recruited through email announcements, flyers, and the psychology subject pool at a private, West Coast university. This study was approved by the university's Institutional Review Board. Potential participants were directed to an online screening questionnaire to determine if they met the following inclusion criteria: (1) self-identified as AA or EA, (2) fluent in English, (3) 18 years of age or older, and (4) reported depressive symptomatology congruent with SSD, based on the Beck Depression Inventory-II (BDI; Beck, Steer, & Brown, 1996). Individuals were excluded if they (1) had a total BDI score below 14 or above 28, (2) endorsed suicidal thoughts or wishes, (3) were currently receiving mental health services, or (4) were taking mood stabilizing medications. Demographic information (e.g., age, ethnicity) was collected through this questionnaire as well. Figure 1 details recruitment and enrollment of participants.

One hundred and twenty individuals participated in the study (60 AA and 60 EA). The sample consisted primarily of female (78%) undergraduate or graduate students (97%), with an average age of 21.2 years. Among AA participants, 65% identified as Chinese, 17% Korean, 7% Taiwanese, and 11% other Asian. Seventy-eight percent of AAs reported being bilingual (i.e., English and other language), whereas only 28% of EAs were bilingual. All participants gave written informed consent to participate in the study.

### Design

The study followed a 3 (condition: DI, NI, CVI)  $\times$  3 (time: pretreatment [T1], post-treatment [T2], six-month follow-up [T3])  $\times$  2 (ethnicity: AA, EA) factorial design, with 120 participants randomly assigned to conditions (see Figure 1). To ensure equal distribution of AAs and EAs across conditions, a stratified random assignment approach was used. The T2 assessment occurred approximately one month following the treatment session and the T3 assessment occurred approximately five months after T2.

### Measures

Unless otherwise noted, the following measures were administered at all time points.

*Depressive symptoms.* Two questionnaires were used to measure depressive symptoms: the BDI and the DSM-IV-based Depression Scale (DDS; Cox & Enns, 1995; Cox, Enns, Borger, & Parker, 1999). The BDI is a self-report, 21-item measure with good convergent, divergent, and construct validity (Segal, Coolidge, Cahill, & O'Riley, 2008). Although prior research shows good internal consistency for the BDI ( $\alpha = .90$ ; Segal et al., 2008; Steer, Rissmiller, & Beck, 2000), for this sample, coefficient alpha was poor at T1 ( $\alpha = .38$ ) but excellent at T2 ( $\alpha = .92$ ) and T3 ( $\alpha = .93$ ). The low alpha at T1 may be attributable to range restriction on the BDI based on our inclusion criteria (i.e., restricting inclusion to those with scores between 14 and 28) (Sackett, Laczó, & Arvey, 2002).

The DDS includes items that reflect DSM-IV symptoms for MDD. It has good reliability ( $\alpha = .90$ ) and demonstrates convergent validity with the BDI ( $r = .76$ ) (Geisner et al., 2006). Internal consistency with this sample was  $\alpha = .86$  at T1,  $\alpha = .91$  at T2, and  $\alpha = .94$  at T3.

*Coping strategies.* The Brief COPE (COPE) was used to assess respondents' coping strategies (Carver, 1997) and consists of 28 items measuring 10 adaptive and four maladaptive coping patterns (Carver, Scheier, & Weintraub, 1989). The COPE shows good convergent and discriminant validity (Carver et al., 1989), and acceptable internal reliability (Carver, 1997; Shen, McCreary, & Myers, 2004). For this study, the COPE had a coefficient alpha of .82 for the adaptive and  $\alpha = .62$  for the maladaptive coping strategies subscales at T1.

*Working alliance.* To assess working alliance between therapist and participant, the 12-item Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was completed by the participant at the end of the treatment session. The WAI has evidence of good convergent, discriminant, and predictive validity (Horvath & Greenberg, 1989). Internal consistency for this sample was excellent ( $\alpha = .91$ ).

*Acculturation.* To assess acculturation level, participants completed two instruments: the Asian American Values Scale—Multidimensional (AAVS-M; Kim, Li, & Ng, 2005) and the European American Values Scale for Asian Americans—Revised (EAVS-R; Hong, Kim, & Wolfe, 2005). Both of these measures were designed to capture to what extent an individual holds traditional Asian (e.g., "The welfare of the group should be put before that of the individual," "Failing academically brings shame

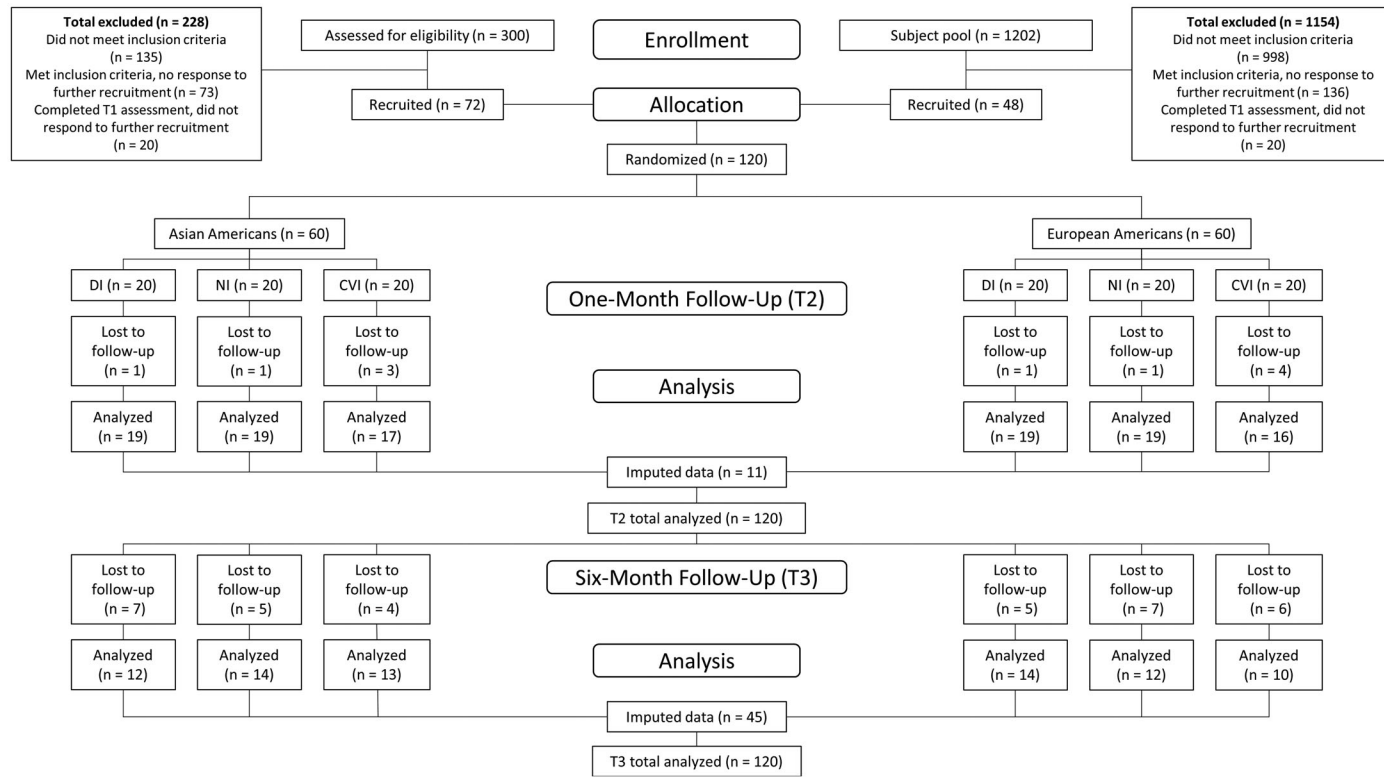


Figure 1. Flowchart of study recruitment, allocation, follow-up, and analysis.

to one's family") and EA (e.g., "You can do anything you put your mind to," "The world would be a better place if each individual could maximize his or her development") values. The AAVS-M and EVAS-R have shown evidence of test-retest reliability, concurrent, construct, and discriminant validity (Hong et al., 2005; Kim et al., 2005).

### Procedure

*Treatment conditions.* All participants had an individual, 20-minute session with a clinical psychology graduate student who had at least one year of training. Sessions took place at the university's psychology training clinic. For the DI and NI conditions, the session focused on three components: (1) *psychoeducation*—wherein the therapist provided information about the prevalence and presentation of depressive symptoms; (2) *feedback on symptoms*—wherein personalized feedback was provided based on participant responses on the BDI and DDS; and (3) *feedback on coping strategies*—wherein personalized feedback was provided to participants based on responses on the COPE.

The DI and NI conditions differed only in the manner in which the content was provided to clients. In the DI condition, the therapist used a directive therapeutic approach which involved conveying and probing for information, directing behavior, making interpretations, using direct questions, eliciting specific responses, and making statements that control the conversation in a session (Atkinson & Matsushita, 1991; Hagebak & Parker, 1969; Li & Kim, 2004). The NI condition focused on the same components as the DI condition, but the therapist used non-directive techniques such as probing for affect, reflection, and summarization of feeling, and restatement (Atkinson & Matsushita, 1991; Hagebak & Parker, 1969; Li & Kim, 2004). Individuals in the CVI condition also participated in a 20-minute session with a therapist; but instead of discussing depressive symptoms and coping strategies, they were asked to expand upon their responses to the AAVS-M and EVAS-R.

### Therapist Training

Three male and four female clinical psychology graduate students (including the first author) served as study therapists. Four of the therapists were AA and three were EA. Each therapist had at least one year of supervised clinical training and experience prior to participating in the study. Therapists were trained by the first author to administer all three conditions (DI, NI, and CVI) during a series of workshops and discussions that were designed to clearly delineate the

different therapist styles. The first author viewed therapy videotapes approximately every fifth session, and supervision was provided as needed.

## Results

### Attrition

Of the 120 participants recruited at T1, 91% and 62.5% completed the T2 and T3 follow-up assessments, respectively. Figure 1 details participant follow-up and attrition. There were no significant differences on T1 measures between study completers and those lost to follow-up. For most analyses, missing values were generated using multiple regression imputation by treatment condition and ethnicity.

### Treatment Fidelity and Manipulation Check

To assess treatment fidelity, two independent coders rated all available videotaped sessions ( $n = 69$ ; 25 DI, 23 NI, 21 CVI) using the therapeutic approach checklist (TAC), a 35-item fidelity measure developed specifically for this study. The TAC utilizes a 5-point Likert scale that assesses to what extent the therapist engaged in directive, non-directive, or CVI-specific techniques during the session. Table I shows good evidence of treatment discrimination, with therapists engaging in significantly more behaviors specific to their assigned treatment conditions.

After the treatment session, participants were asked to rate the level of directiveness/non-directiveness they perceived during the session on a scale from 1 (*non-directive*) to 7 (*directive*). A significant effect was found for treatment condition,  $F(2, 117) = 3.37, p = .04$ . *Post hoc* estimates using least significant difference (LSD) tests revealed that NI participants ( $M = 4.33, SD = 1.70$ ) rated therapists as significantly less directive than did DI participants ( $M = 5.11, SD = 1.18$ ) and CVI participants ( $M = 5.08, SD = 1.65$ ). However, no significant differences were found between DI and CVI participants on ratings of directiveness.

### Treatment Outcomes Analyses

Multilevel modeling, with participants nested within therapists (level 1 = participant level, level 2 = therapist level), was conducted to examine whether there was significant variation between therapists in participants' subsequent (T2 and T3) depressive symptoms and coping strategies. First, unconditional means models were fit to examine between-therapist variation in participants' T2 and T3 depressive

Table I. ANOVA tests on means and SDs for ratings from the TAC.

Therapeutic techniques	Treatment condition						Group differences <sup>a</sup>
	DI		NI		CVI		
	Mean	SD	Mean	SD	Mean	SD	
Directive behaviors	3.01	0.42	2.46	0.21	1.90	0.33	DI > NI DI > CVI
Non-directive behaviors	2.26	0.44	2.76	0.45	1.86	0.35	NI > DI <sup>b</sup> NI > CVI
Placebo behaviors	1.09	0.40	1.11	0.52	2.85	0.80	CVI > DI CVI > NI

Note: DI: directive intervention; NI: non-directive intervention; CVI: cultural values interview; SD: standard deviation; TAC: therapeutic approach checklist.

<sup>a</sup>Unless otherwise noted, all *post hoc* group differences are significant at  $p < .001$  using LSD tests.

<sup>b</sup> $p = .002$ .

symptoms and coping strategies. The intercepts in these models were all non-significant ( $ps > .13$ ), with intraclass correlation coefficients typically within the single digits ( $\rho = 0.015$  to  $\rho = 0.09$ ), and with only the intraclass correlation coefficient for T2 BDI reaching double digits ( $\rho = 0.13$ ). These results show that little of the variance in participants' T2 or T3 depressive symptoms or coping strategies was due to variance between therapists. Similarly, conditional models found that therapists' mean working alliance was not a significant level-2 predictor of participants' T2 and T3 depression levels and coping strategies ( $ps > .18$ ). Because level-2 predictors accounted for minimal variance in participants'

T2 and T3 depressive symptoms and coping scores, hypotheses were tested using traditional statistical tests.

A series of one-way analysis of covariance (ANCOVA) tests were conducted to determine whether there were significant differences between DI, NI, and CVI on SSD symptoms and coping strategies at T2 and T3, using T1 ratings as covariates. Table II displays the means, standard deviations, and summaries of group differences for all outcome variables. Partial eta-squared ( $\eta_p^2$ ) was selected as the index of effect size, with 0.01–0.06 representing a small effect, 0.06–0.14 a moderate effect, and >0.14 a large effect (Cohen, 1992).

Table II. Multiple comparison tests on means and SD for depression, coping, and working alliance at 1-month (T2) and 6-month follow-up (T3).

Variable	Time point	DI		NI		CVI		Group differences <sup>a</sup>
		Mean	SD	Mean	SD	Mean	SD	
BDI	T1	19.38	4.39	20.20	4.66	19.13	3.69	–
	T2	11.20	7.73	14.34	11.39	12.23	7.45	None
	T3	10.65	7.88	15.19	9.64	11.15	6.64	DI < NI
DDS	T1	25.03	10.39	24.35	11.17	23.90	10.71	–
	T2	13.76	9.25	17.49	13.96	15.64	9.30	None
	T3	13.73	10.73	17.58	15.08	13.59	9.06	None
Maladaptive coping	T1	13.45	2.81	13.98	3.43	13.80	3.69	–
	T2	11.28	2.43	12.91	3.92	11.50	2.77	DI < NI; CVI < NI
	T3	11.84	2.02	12.09	2.96	12.28	3.44	None
Adaptive coping	T1	46.68	8.33	42.15	8.73	44.45	8.91	–
	T2 <sup>b</sup>	46.99	10.95	73.94	9.47	41.50	10.55	DI > CVI; NI > CVI
	T3	46.36	8.74	41.95	10.96	40.37	7.14	DI > CVI
Working alliance		5.27	.83	4.71	.96	4.57	1.20	DI > NI; DI > CVI

Note: T1: Time 1; T2: Time 2; T3: Time 3; DI: directive intervention; NI: non-directive intervention; CVI: cultural values interview; BDI: Beck Depression Inventory; DDS: DSM-IV-based Depression Scale; SD: standard deviation.

<sup>a</sup>All *post hoc* group differences are significant at  $p < .05$  using LSD tests.

<sup>b</sup> $p = .06$ .

**Depressive symptoms.** No significant treatment effects were found for the BDI at T2,  $F(2, 116) = .89, p = .41, \eta_p^2 = .02$ , or the DDS at T2,  $F(2, 116) = 1.61, p = .20, \eta_p^2 = .03$ , or T3,  $F(2, 116) = 1.72, p = .18, \eta_p^2 = .03$ . At T3, significant differences were found for the BDI,  $F(2, 116) = 3.07, p = .05, \eta_p^2 = .05$ . LSD comparisons indicated that DI led to significant reductions on the BDI compared to NI; however, neither DI nor NI differed significantly from CVI.

**Coping strategies.** At T2, significant differences were found between treatment conditions for maladaptive coping,  $F(2, 116) = 3.44, p = .04, \eta_p^2 = .06$ . LSD comparisons revealed that DI and CVI led to greater reductions in maladaptive coping than NI. No significant differences were found for maladaptive coping at T3,  $F(2, 116) = .17, p = .85, \eta_p^2 = .003$ . Additionally, a marginally significant trend was found for adaptive coping at T2,  $F(2, 116) = 2.95, p = .06, \eta_p^2 = .05$ . LSD comparisons showed that individuals in the DI and NI conditions had significantly greater increases in adaptive coping than CVI. At T3, significant differences were also found for adaptive coping,  $F(2, 116) = 3.89, p = .02, \eta_p^2 = .06$ ; LSD comparisons revealed that DI participants had significantly greater gains on adaptive coping compared to CVI participants. No differences were found between NI and CVI participants.

**Working alliance.** A one-way analysis of variance (ANOVA) revealed significant treatment effects for working alliance,  $F(2, 115) = 5.32, p = .006, \eta_p^2 = .09$ . *Post hoc* LSD tests indicate that working alliance was higher for DI participants compared to both NI and CVI. No significant differences were found between NI and CVI.

### Moderation Analyses

**Participant ethnicity.** To assess whether ethnicity moderated treatment effects on depressive symptoms and coping outcomes, a series of independent three (treatment condition: DI, NI, CVI) by two (ethnicity: AA, EA) between-groups ANCOVA analyses were conducted, using T1 ratings as covariates. Additionally, a two-way ANOVA examined participant ethnicity as a potential moderator of treatment effects on working alliance.

At T3, there was a significant interaction between ethnicity and treatment condition on the BDI,  $F(2, 113) = 3.20, p = .04, \eta_p^2 = .05$  and DDS,  $F(2, 113) = 5.40, p = .01, \eta_p^2 = .09$ . For the BDI, an analysis of simple effects revealed a marginally significant treatment effect for EAs,  $p = .055$ , but not AAs,  $p = .12$ . Unexpectedly, LSD comparisons show that for EAs, CVI led to significantly greater reductions on the BDI than NI,  $p = .02$ ; DI did not differ from CVI,  $p = .28$ , or NI,  $p = .17$  (Figure 2).

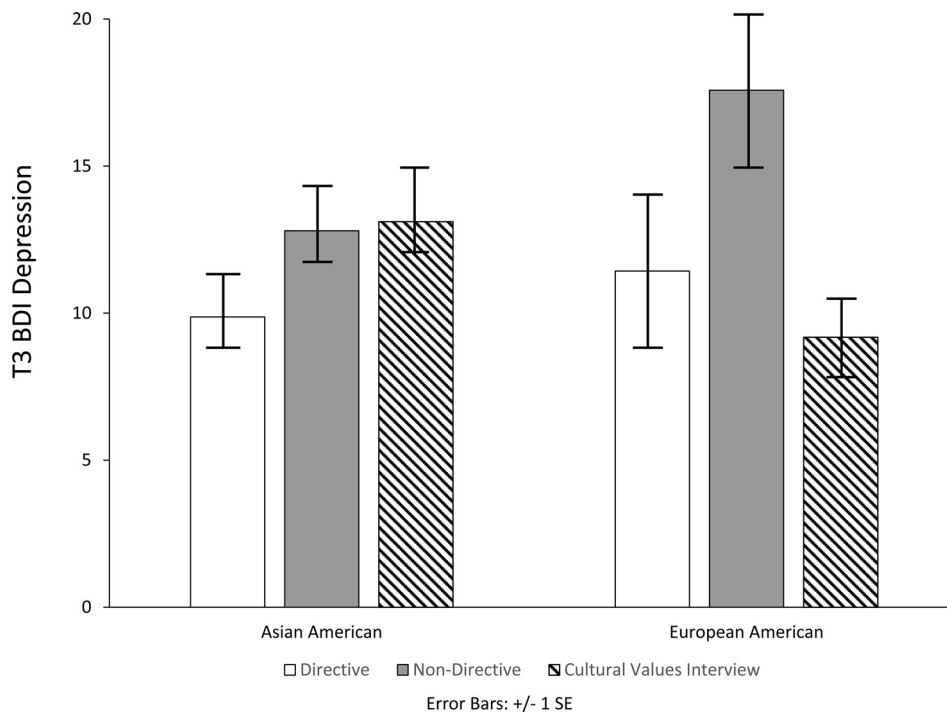


Figure 2. Moderation of T3 BDI depression by participant ethnicity using adjusted means.



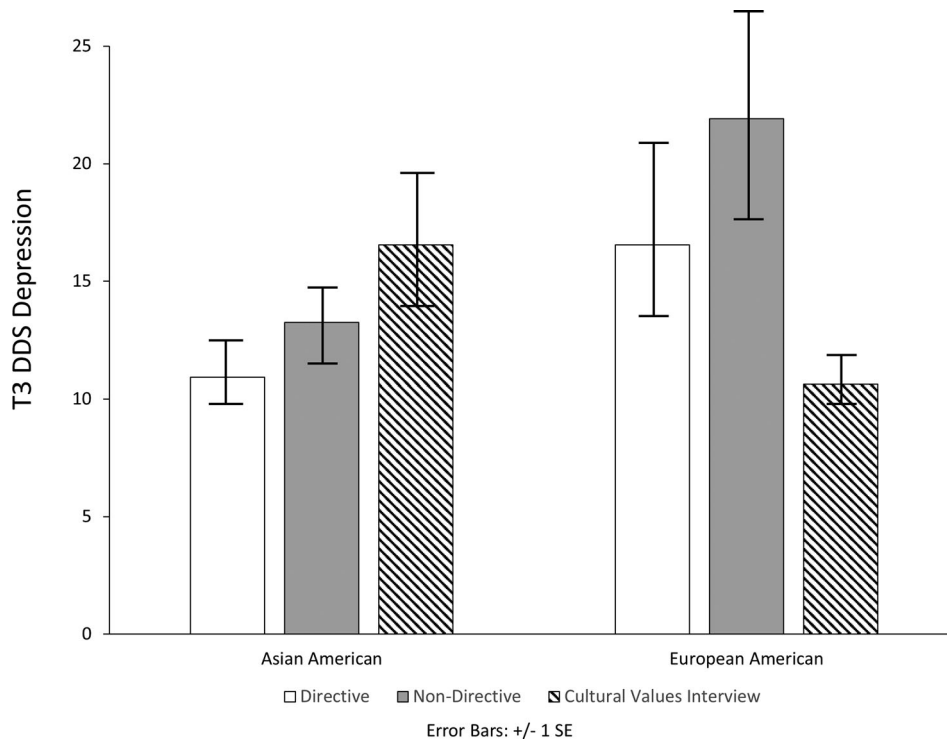


Figure 3. Moderation of T3 DDS depression by participant ethnicity using adjusted means.

For T3 DDS, simple effects again revealed significant treatment effects for EAs,  $p = .03$ , and a marginally significant effect for AAs,  $p = .07$ . Again, LSD comparisons indicate that for EAs, CVI led to significantly greater reductions on the DDS than NI,  $p = .009$ ; DI did not differ from CVI,  $p = .11$ , or NI,  $p = .29$ . For AAs, DI led to greater reductions on the DDS than CVI,  $p = .02$ , but not compared to NI,  $p = .24$ ; NI and CVI did not differ,  $p = .23$  (Figure 3). No significant moderation effects were found for T2 BDI and DDS, T2 and T3 coping strategies, and working alliance.

**Acculturation.** AAs ( $M = 4.22$ ,  $SD = .57$ ) reported significantly higher levels of adherence to Asian values on the AAVS-M than EAs ( $M = 3.97$ ,  $SD = .52$ ),  $F(1,118) = 6.22$ ,  $p = .01$ . Additionally, EAs ( $M = 2.97$ ,  $SD = .24$ ) reported significantly higher levels of adherence to EA values on the EAVS-R,  $F(1,118) = 11.37$ ,  $p = .001$  than AAs ( $M = 2.83$ ,  $SD = .21$ ). For the moderation analyses, participants were divided into groups based on a median split on both acculturation measures (Farver & Lee-Shin, 2000). Separate two-way ANCOVA analyses were conducted using (1) the entire sample; (2) AAs alone; and (3) EAs alone to determine moderation effects of acculturation status on depressive symptoms, coping, and working alliance. These moderation analyses yielded no significant effects.

## Discussion

Although it was hypothesized that both active conditions would be superior to CVI, treatment effects were mixed and varied across time points. However, when significant improvements were found (i.e., BDI, coping strategies, and working alliance), participants in the DI condition had better outcomes compared to the other two conditions when analyzing the full study sample. These findings are consistent with prior research demonstrating that a directive therapeutic approach can be effective at improving SSD symptoms and working alliance (i.e., Loeb et al., 2005; Wettersten, Lichtenberg, & Mallinckrodt, 2005; Woody & Adessky, 2002).

These findings help inform current research on how improving working alliance may reduce treatment dropout. Initial positive experiences in psychotherapy appear to improve the chances of returning for subsequent sessions (Meier, Donmall, McElduff, Barrowclough, & Heller, 2006; Robbins, Turner, Alexander, & Perez, 2003). For AAs in particular, this is notable because of the many barriers to accessing, entering, and remaining in mental health treatment (Kung, 2004; Leong & Lau, 2001). A directive therapeutic approach may help engage individuals in therapy and strengthen working alliance, thus reducing dropout and improving outcomes.

### Moderator Effects

Regarding ethnicity effects, AAs and EAs showed similar outcome patterns for coping and working alliance. However, ethnicity did moderate treatment effects for depressive symptoms at follow-up. For AAs only, DI led to greater reductions in depressive symptoms than CVI, which aligns with prior analog research suggesting that directiveness may be a treatment approach with particular salience for AAs (e.g., Waxer, 1989). Conversely, for EAs, it was found that CVI was more effective than NI at reducing depressive symptoms at six-month follow-up.

Steele's (1988) Self-Affirmation Theory offers one possible way to explain this unexpectedly strong CVI effect for EAs. The theory argues that individuals are generally motivated to maintain a sense of worth and integrity. When that worth is threatened (e.g., by doing poorly on an exam, having a fight with one's partner, having one's political views challenged), individuals tend to respond defensively (e.g., rumination, avoidance, heavy drinking) in ways that might contribute to depressive symptoms and other mental health problems (Steele, 1988). However, when aspects of the self are affirmed (e.g., through experimental manipulation such as writing about important values or reflecting on recent sources of pride), the need to sustain one's sense of worth is met, and individuals are less likely to respond defensively to perceived threat (Cohen & Sherman, 2014; Steele, 1988). Thus, one possibility is that by having CVI participants reflect on cultural values they considered to be "very important," depressed EAs were implicitly reminded of important potential sources of self-worth and pride, which may have helped protect them from depression-inducing sources of threat by reducing their defensiveness.

Why then would such affirmations not have the same effect on AAs? Some research suggests that individuals from East Asia may be less susceptible to standard affirmation manipulations than non-Asians because they may be more collectivist in their cultural worldview (Heine & Lehman, 1997; Hoshino-Browne, Zanna, Spencer, & Zanna, 2004). Because collectivist notions of the self are more centered on group membership (vs. individual qualities), self-affirmation may work for East Asians only when reflective tasks tap into the person's sense of collective identity. Supporting this notion, one study found that affirmation effects were apparent for East Asians only when the instructions were framed as *values important to the participant's family* (Hoshino-Browne et al., 2004). Thus, our CVI condition may have functioned as a true placebo for AA participants, but unexpectedly as an affirmation intervention for EAs. This possibility should be explored in future

intervention studies comparing outcomes for AAs and EAs.

### Study Limitations

This study has several limitations that should be acknowledged. This study's sample size was relatively modest which may have resulted in inadequate statistical power. Additionally, the AAs in this study were more highly acculturated to EA values than expected. Though AAs had significantly lower scores on the EAVS than EAs, almost all AA participants had a score greater than the scalar midpoint of the measure (i.e., 2.5), which indicates general endorsement of *agreeing* or *strongly agreeing* with statements supporting EA values. This may have limited our ability to detect acculturation-related moderation effects due to the homogeneity of responses.

It should also be noted that the heterogeneity of cultures that are classified as *Asian* or *Asian American* is vast (i.e., Chinese, Japanese, Taiwanese, etc.). A major challenge with this area of research is judging whether individuals from such diverse cultures can or should be placed into a singular category such as *Asian*. This study's sample included AAs with ethnic backgrounds from many different countries of origin, yet they are all identified as *Asian American*. Future research may want to examine what are the optimal circumstances in which individuals from diverse backgrounds can be grouped together under more broad categories to strengthen external validity.

Another factor that may have influenced results relates to the ephemeral nature of depressive symptoms, particularly at a subsyndromal level. Symptoms of subclinical depression can appear and remit spontaneously without intervention (Forsell, 2007). Detection of significant differences may have been more difficult in this study because it is possible that depressive symptoms related to SSD simply improved naturally. However, individuals with SSD can later develop more severe depressive symptoms to meet an MDD diagnosis (Forsell, 2007) and are at high risk for developing MDD at some point in their lives (Judd et al., 1997, 1998).

Further potential concerns relate to participant attrition. Thirty-seven percent of the original sample was lost to follow-up at T3. If more severely depressed individuals dropped out of the study, thus leaving less symptomatic participants to complete the T3 assessment, it may have affected the ability to detect significant differences. However, analyses found no pretreatment differences between study completers and those lost to follow-up at either time point. Moreover, this attrition rate is comparable to other successful randomized trials with a

six-month follow-up (e.g., Foa et al., 2005; Markowitz, Kocsis, Bleiberg, Christos, & Sacks, 2005).

### Conclusion

Overall, results from this study add to a complicated body of research and clinical work aiming to inform best practices for ethnic minorities. Some evidence was found that directiveness may be a “culturally invariant” therapeutic technique that could be beneficial to AA and EA populations alike. Yet, other findings suggest that directiveness might be uniquely advantageous for AAs, particularly for long-term improvement of subsyndromal depressive symptoms. Interpretation of treatment moderator effects can be a complex task when conducting research on culturally responsive therapies (Huey & Polo, 2010). As evidence mounts that culturally adapted psychotherapy can lead to superior outcomes for diverse client populations (e.g., Benish et al., 2011), future well-controlled research on adapted therapeutic skills and techniques is strongly recommended.

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