

## Assessing the Effects of Evidence-Based Psychotherapies with Ethnic Minority Youths

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### OVERVIEW

Nearly 45% of youth in the United States are ethnic minority or multiracial, and minority youth currently represent a numerical majority or near majority in 25% of U.S. counties (Pollard & Mather, 2009). Not surprisingly, ethnic minority youth also make up a large percentage of those who utilize mental health services in the United States (McCabe et al., 1999), particularly in large metropolitan areas. Yet our understanding of optimal ways to treat ethnic minority youth with behavioral/emotional problems is limited. Although evidence-based treatments (EBTs) exist for youth with diverse mental health problems, many doubt whether standard EBTs can be used effectively to treat ethnic minorities (e.g., Hall, 2001).

In debates over treatment efficacy with ethnic minorities, the *ethnic disparity* and *ethnic invariance* perspectives make different predictions concerning the possibility of ethnic differences in therapy outcomes. The ethnic disparity perspective argues that EBTs are less effective for ethnic minorities than for European Americans. EBTs might shortchange ethnic minorities because conventional treatments are developed by and for European Americans, and thus clinicians and clinical researchers may be more inclined to ignore cultural considerations. In contrast, the ethnic invariance perspective suggests that EBTs affect all cultural groups equally because basic principles of therapeutic change are universal.

The goal of this chapter is to shed some light on this debate by summarizing what we know about EBTs for ethnic minority youth with psychosocial problems. Specifically, we examine several questions regarding psychotherapy efficacy and engagement with minority youth. First, what treatments are efficacious for ethnic minority youth and how

robust are treatment effects? Second, are treatments equally efficacious for European American and ethnic minority youth? Third, what adaptations are made to EBTs that incorporate the needs of ethnic minority populations, and do these adaptations enhance treatment effects for ethnic minority youth? Finally, what evidence-based methods exist for successfully engaging ethnic minorities in mental health treatment? We draw primarily from our recent review and meta-analysis of EBTs with ethnic minority youth (Huey & Polo, 2008); however, we also summarize findings from other empirical work addressing treatment outcome issues with ethnic minority youth. The focus is on U.S. youth ages 18 years or younger with preexisting behavioral and emotional problems.

### EFFICACIOUS TREATMENTS FOR ETHNIC MINORITY YOUTH

To address the extent to which treatments are efficacious for ethnic minority youth, we reviewed published randomized trials comparing active treatment with no-treatment, placebo, or treatment-as-usual (TAU) control groups (Huey & Polo, 2008). Efficacious treatments had to meet criteria as well-established, probably efficacious, or possibly efficacious based on standards developed by the Task Force on Promotion and Dissemination of Psychological Procedures (Chambless et al., 1998). Well-established treatments require support from at least two randomized trials by independent research teams showing that treatment is superior to placebo or another treatment (or equivalent to an established treatment). Probably efficacious treatments require only one placebo-controlled trial, or two trials comparing treatment and no treatment. Possibly efficacious treatments require only one study showing that a treatment is more efficacious than control but does not meet criteria as well-established or probably efficacious. In addition, studies had to meet one or more of the following conditions: (1) At least 75% of participants were ethnic minorities, (2) separate analyses with ethnic minority youth showed that treatment was superior to control conditions, and (3) analyses showed that ethnicity did not moderate treatment effects or that treatment was effective with ethnic minority youth despite moderator effects (Huey & Polo, 2008). If these criteria were met for a particular treatment, it was classified as an ethnic minority EBT, and supporting studies were included in our meta-analysis.

Overall, 13 treatments were considered as probably efficacious for ethnic minority youth and 17 as possibly efficacious (Huey & Polo, 2008). None met criteria for a well established treatment for ethnic minority youth. Efficacious treatments were found for minority youth with a broad array of psychosocial problems, including attention-deficit/hyperactivity disorder, conduct problems, trauma-related problems (e.g., posttraumatic stress disorder), depression, substance use problems, anxiety-related problems, suicidal behavior, and mixed/comorbid problems (i.e., no one target problem predominated) (Table 29.1).

The overwhelming majority of EBTs were group- or family-based treatments identified either for African American or Latino youth. Also, cognitive-behavioral approaches (e.g., treatments derived from social learning principles and cognitive theories of psychopathology) showed the strongest record of success with minority youth, although interpersonal psychotherapy and family systems interventions (i.e., brief strategic family therapy [BSFT], multidimensional family therapy, and multisystemic therapy [MST]) were also efficacious. Moreover, treatments for conduct problems constituted more than

**TABLE 29.1. Probably Efficacious and Possibly Efficacious Treatments for Ethnic Minority Youth with Behavioral/Emotional Problems**

Problem domain	Youth ethnicity	Evidence-based treatments
ADHD	African American and Hispanic/Latino	Behavioral treatment + stimulant medication
Anxiety-related problems	African American	AMT, group CBT, modified AMT, study skills training
	Hispanic/Latino	Group CBT
Conduct problems	African American	Anger management group training, assertive training, attribution training, behavioral contracting, cognitive restructuring, Coping Power, MST, response cost, social relations training
	Hispanic/Latino	Brief strategic family therapy, child-centered play therapy
	Mixed/other ethnicity	Rational emotive education, structured problem solving
Depression	Hispanic/Latino	CBT, interpersonal psychotherapy
Substance use problems	African American	MST
	Mixed/other ethnicity	Multidimensional family therapy
Suicidal behavior	African American	MST
Trauma-related problems	African American	Fostering individualized assistance program, resilient peer treatment, trauma-focused CBT
	Hispanic/Latino	School-based group CBT
Mixed/comorbid problems	African American	Reaching educators, children, and parents
	Multiracial Hawaiian	MST

*Note.* ADHD, attention-deficit/hyperactivity disorder; AMT, anxiety management training; CBT, cognitive-behavioral treatment; MST, multisystemic therapy. Data from Huey and Polo (2008).

40% of all EBIs for minority youth. For example, seven treatments were probably efficacious for minority youth with conduct problems (i.e., anger management group training, attribution training, BSFT, child-centered play therapy, coping power, MST, rational emotive education), and six were possibly efficacious (i.e., behavioral contracting, cognitive restructuring, response cost, assertive training, social relations training, structured problem solving).

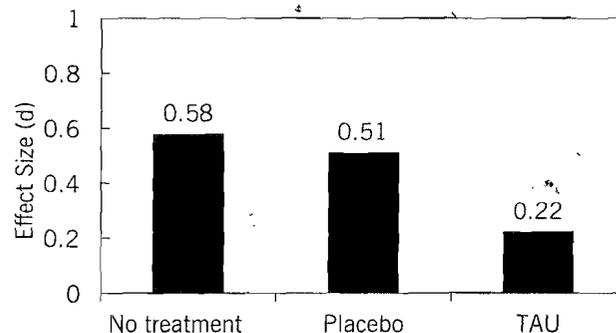
We also calculated effect size coefficients (Cohen's *d*) to provide a quantitative overview of treatment effects, assess the clinical relevance of treatment, and discern whether certain factors influenced treatment outcomes (Huey & Polo, 2008). Each study that met our ethnic minority criteria and reported appropriate effect size data was included, regardless of whether all participants were ethnic minorities. A coefficient of about 0.2 represents a small effect; 0.5, a medium effect; and 0.8, a large effect. Positive effects indicate that treated youth show more favorable outcomes than comparison youth. Results

showed that the mean posttreatment effect size for these EBTs is  $d = .44$ , which represents a medium effect. This indicates that in the typical ethnic minority clinical trial 67% of treated participants were better off at posttreatment than the average control participant. At various follow-up periods (4–6 months, 1–1.7 years, 4 years, 13.7 years) treatment effects were generally maintained. Also, effects were stronger when treatment was compared with no treatment or placebo versus TAU (see Figure 29.1). However, type of target problem (externalizing vs. internalizing), problem severity (clinically significant vs. not clinically significant), and diagnostic status (*Diagnostic and Statistical Manual of Mental Disorders* diagnosis vs. no diagnosis) did not affect outcomes (Huey & Polo, 2008).

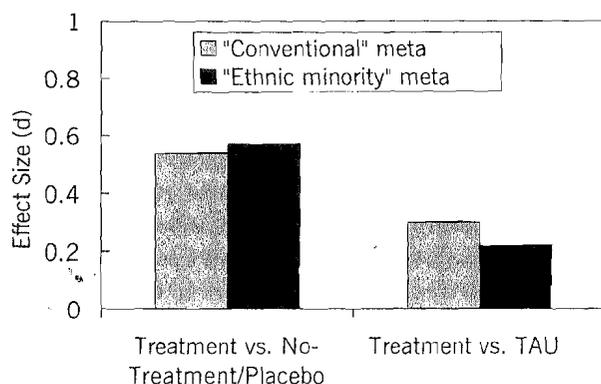
Next, studies were divided into those that compared active treatment with no treatment or placebo control, or compared active treatment with TAU, and effect sizes were recalculated. These results were then contrasted with two conventional treatment meta-analyses that included studies with mostly nonminority youth (or youth with unspecified ethnicity; Weisz, Weiss, Han, Granger, & Morton, 1995; Weisz, Jensen-Doss, & Hawley, 2006). Figure 29.2 shows that our effect sizes for ethnic minorities were roughly equivalent to those found in conventional youth treatment meta-analyses.

Thus, EBTs exist for ethnic minority youth with a broad array of behavioral and emotional problems (particularly conduct problems), although no treatments met the highest level of empirical support (i.e., well-established). Also, similar to findings with nonminority youth (Weisz et al., 1995), treatment effects were generally of medium magnitude and did not vary by problem type or severity. Moreover, although cognitive-behavioral treatments predominated, other forms of treatment were also identified as efficacious for ethnic minority youth.

However, our review revealed that there is still much that we do not know about effective treatments for ethnic minority youth. For example, whereas dozens of EBTs were found for African American and Latino youth, other ethnic minority groups (e.g., Asians, Pacific Islanders, Native Americans) are mostly absent from this literature. Also, despite the availability of effective approaches for autism, eating disorders, and other clinical syndromes with predominantly White youth, we know little about how minority youth might respond to these treatments. Finally, the majority of EBTs summarized



**FIGURE 29.1.** Type of comparison group as moderator of treatment effects for ethnic minority youth (TAU, treatment-as-usual). Data from Huey and Polo (2008).



**FIGURE 29.2.** Mean effect sizes for conventional (Weisz et al., 1995, 2006) versus ethnic minority (Huey & Polo, 2008) youth treatment meta-analyses (TAU, treatment-as-usual).

here are “research therapies” (Weisz, Huey, & Weersing, 1998) that involve (1) recruited versus clinic-referred youth; (2) homogenous samples with one focal problem; (3) highly structured, manualized treatment; and (4) clinicians with extensive training and supervision. Thus, with few exceptions, it is unclear how well these treatments translate to ethnic minority youth in “real-world” mental health settings.

### ETHNICITY AS A MODERATOR OF TREATMENT EFFECTS

Another important question concerns whether EBTs are differentially effective for European American versus ethnic minority youth. We addressed this issue by summarizing 13 randomized trials that tested ethnicity as a moderator of treatment effects (Huey & Polo, 2008). A significant moderator effect (i.e., a treatment condition  $\times$  ethnicity interaction effect) would indicate that treatment was more efficacious for one ethnic group versus another. We found that eight of 13 studies showed no significant moderator effects, two showed stronger treatment effects for European Americans, and three showed stronger effects for minorities.

Beyond individual trials, several investigators have used meta-analyses to test whether treatment outcomes differ as a function of youth ethnicity. These studies found that effect sizes for treatment of ADHD (Fabiano et al., 2009) juvenile offending (Wilson, Lipsey, & Soydan, 2003), phobic/anxiety disorders (Silverman, Pina, & Viswesvaran, 2008), and diverse problems in usual care settings (Weisz et al., 2006) did not differ significantly for European Americans compared with other ethnic groups. Moreover, our meta-analysis (Huey & Polo, 2008) showed no significant effect size differences across ethnic minority groups (i.e., African American vs. Latino vs. mixed/other non-White).

There are several ways to explain these results. Because most studies show no ethnicity effects, one interpretation is that EBTs are equally potent regardless of youth ethnic background; in other words, the data could support the ethnic invariance perspective. However, another possibility is that the results are indeterminate given methodological concerns. First, because true ethnicity effects are likely in the small to medium range,

null findings may have resulted from low power to detect significant treatment moderators (Huey & Polo, 2008). For example, the five studies showing moderator effects had larger average samples ( $n = 84$  per treatment condition) than the eight null studies ( $n = 61$  per condition). Thus, ethnic disparity in outcomes might have been apparent in more studies had samples been larger.

Second, the complexity of treatment moderator effects often makes appropriate interpretation difficult. For example, Rohde, Seeley, Kaufman, Clarke, and Stice (2006) found that cognitive-behavioral treatment (CBT) was superior to life skills training for depressed White youth, but no treatment effects were found for non-White youth (mostly "mixed" or "other" ethnicity). Although a cursory review of these findings might suggest that CBT is ineffective for non-White youth, a careful inspection of outcomes by condition and ethnicity argues for an alternative interpretation: that CBT is equally potent for both groups, whereas life skills training is particularly efficacious for non-White youth. Similarly, Lochman and Wells (2004) found that Coping Power (a social skills intervention for aggressive youth) reduced substance use for White but not Black youth, although a review of posttreatment means suggests these results were driven by particularly strong effects of the comparison condition on Black youth. Thus, for both studies, results that initially appeared to favor European American youth were actually more ambiguous.

Third, the inclusion of culturally adapted therapies may have masked potential disparities in treatment response. Because many of the 13 treatments included culture-responsive elements, this may have enhanced the therapeutic experience for minority participants and thus minimized the possibility of differential outcomes by ethnicity. For example, Silverman et al. (1999) found that group CBT was efficacious for youth with anxiety disorders, with no evidence of differential outcomes for Caucasian and Latino youth (i.e., ethnicity did not moderate treatment effects). However, investigator efforts to "sensitize therapists to issues specific to working with multicultural populations" (Silverman et al., 1999, p. 996) may have been particularly beneficial to Latino participants and thus mitigated potential disparities. Given the limited sample size, this possibility was not evaluated by the investigators.

In summary, evidence for ethnic disparities in youth EBT outcomes is equivocal, with most studies showing no significant moderator effects. However, it is possible that null effects result from either low power to detect significant moderator effects or the failure to account for the potential benefits of incorporating cultural content in standard EBTs. The influence of cultural adaptations on psychotherapy outcomes for ethnic minority youth is explored more directly in the next section.

### EFFECTS OF CULTURE-RESPONSIVE TREATMENTS

A third question addresses whether culture-responsive treatments are more effective than standard treatments for ethnic minority youth. Although efforts to generate cultural competence guidelines are emerging, there is no consensus concerning what it means for a treatment to be culturally adapted or tailored (Fuentes & Gretchen, 2001). Our recent review (Huey & Polo, 2008) revealed a number of culture-responsive elements that were incorporated into the design and implementation of youth EBTs with ethnically diverse samples. Table 29.2 summarizes these approaches and specifies which

**TABLE 29.2. Culture-Responsive Elements in Evidence-Based Treatments for Ethnic Minority Youth**

Category	Adaptation	Ethnicity
Counselor training/ education/experience	Sensitizing therapists to issues specific to working with ethnic minorities	Latino/Hispanic
	Family resource specialist to assist clinical team in understanding client cultures	Multiracial Hawaiian
	Experience working with ethnic minority populations	Latino/Hispanic
Counselor–client match	Counselor–youth or peer–youth ethnic match	African American, Latino/Hispanic
	Counselors/peers with common cultural experience or background	African American
	Counselor–youth language match	Latino/Hispanic
Therapy content	Vignettes, examples, materials changed to make more “culturally sensitive”	African American, Latino/Hispanic
	Address intergenerational, cultural conflict	Latino/Hispanic
	Use of cultural themes, symbols, content	Latino/Hispanic
Other/miscellaneous/ vague	Treatment individualized to deal flexibly with sociocultural differences	African American
	Cultural agents involved in treatment development	African American
	Miscellaneous adaptations for culture or diversity	African American, Latino/Hispanic
	Use of clients’ cultural/ethnic strengths	African American

*Note.* Data from Huey and Polo (2008).

ethnic groups were targeted. These include, for example, efforts to use therapists of the same ethnicity as the youth/families receiving treatment. Others have incorporated changes to the protocol during the development of the intervention or during the training of therapists. In some cases, adaptations also consist of modifying the content of treatment manuals to provide examples that are more applicable to ethnic minority participants.

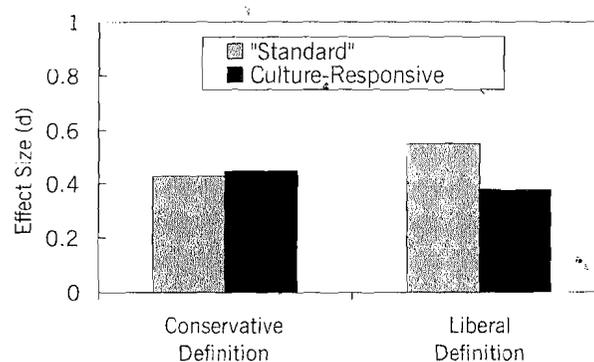
Unfortunately, only a handful of studies over the past 30 years have assessed how culture-responsive modalities affect youth therapy outcomes. Correlational studies generally show that counselor–client ethnic match is associated with positive treatment outcomes for African American, Mexican American, and Asian American youth (e.g., Flicker, Waldron, Turner, Brody, & Hops, 2008). However, correlational methods leave open the possibility that ethnic match is not a true causal factor.

A better approach is to conduct randomized trials comparing standard EBTs with culturally modified versions of the same EBTs. Although this approach is increasingly common in the youth prevention and adult treatment literature (e.g., Botvin, Schinke, Diaz, & Botvin, 1995; Huey & Pan, 2006), our search identified only two experimental studies that have assessed the importance of culture-responsive approaches in evidence-

based treatment for youth. Szápocznik, Rio, et al. (1986) compared BSFT with bicultural effectiveness training (a culturally enhanced adaptation of BSFT) in a randomized trial with behaviorally disordered, Cuban American youth. No significant group differences were found at posttreatment, suggesting that cultural enhancement offered no additional benefits. In a recent study, McCabe and Yeh (2009) compared standard parent-child interaction therapy (PCIT) with culturally modified PCIT and TAU in a randomized trial for externalizing Mexican American youth. They found that culturally modified PCIT was superior to TAU for most youth and parenting outcomes, but standard PCIT was superior to TAU for only a few outcomes. However, standard and culturally modified PCIT did not differ significantly for any outcomes. Thus, results from both studies show no clear outcome enhancements from cultural adaptations, although small sample sizes in both studies ( $n < 20$  per group) suggest that power may have been inadequate to detect significant differences.

To address this question in our meta-analysis (Huey & Polo, 2008), we directly compared two types of clinical trials: those evaluating culture-responsive EBTs and those evaluating standard EBTs (i.e., treatments with no apparent culture-responsive elements). We used a conservative approach (i.e., the clinical trial suggested treatment was modified for minority youth) and liberal approach (i.e., supplementary sources suggested the treatment was modified for minorities) to classify treatments as culture-responsive. Fifty percent of treatments were culture-responsive using the conservative definition, whereas 70% were culture-responsive based on the liberal definition. Figure 29.3 shows that, regardless of definition, no significant differences were found for standard versus culture-responsive treatments.

Thus, although efforts have been made in a number of studies to consider culture/ethnicity when treating ethnic minority youth, we cannot say whether cultural adaptations result in enhanced treatment outcomes. Although two randomized trials and our meta-analysis show mostly null effects, methodological problems limit what conclusions can be drawn. Existing studies probably lack adequate statistical power, and cultural elements of most treatments are often missing or poorly specified. As a result, null effects



**FIGURE 29.3.** Mean effect sizes for standard versus culture-responsive treatments, based on conservative versus liberal definition. Differences between standard and culture-responsive treatments not significant. Data from Huey and Polo (2008).

may reflect design limitations or a lack of identification of potent cultural elements that have a more direct impact on treatment effects. Clearly, experimental research is needed to discern the effectiveness of various cultural adaptations with ethnic minority youth.

### ENGAGING ETHNIC MINORITY YOUTH IN TREATMENT

As a final issue, we discuss approaches aimed at increasing participation and engagement of ethnic minority youth in mental health treatment. Research indicates that a large proportion of at-risk minority youth do not receive the mental health services they need (Kataoka, Stein, Nadeem, & Wong, 2007), and that utilization rates are lower than those for European American youth (Garland et al., 2005). When they do receive treatment, ethnic minority youth are more likely to terminate prematurely (Miller, Southam-Gerow, & Allin, 2008), attend fewer sessions (Bui & Takeuchi, 1992), and show less clinical improvement (Weersing & Weisz, 2002) than European American youth. Even when receiving EBTs, dropout rates for African American and other ethnic minority youth are often higher than for European American youth (e.g., Kazdin & Whitley, 2003). These data suggest that, in addition to focusing on symptom reduction and functional improvement, research is needed on how interventions can address individual, socioeconomic, cultural, and structural barriers that may determine whether or not ethnic minority families enroll and are retained when offered EBTs.

A number of strategies have been utilized to increase participation in treatment and reduce unilateral termination, including several that have focused on ethnic minority populations. Some of the earliest research in this area focused on single prompts as an engagement method. These studies found that verbal (e.g., telephone) or written (e.g., letter) prompts immediately before a scheduled session significantly increased treatment attendance for poor minority adults and families (e.g., Hochstadt & Trybula, 1980; Planos & Glenwick, 1986).

Subsequent efforts have used more elaborate strategies for recruiting and retaining ethnic minority families. McKay, Stoewe, McCadam, and Gonzales (1998) evaluated the effects of two engagement strategies in an urban mental health agency serving predominately low-income ethnic minority children and adolescents. The authors randomly assigned families to one of three conditions: (1) a 30-minute telephone call before the intake appointment; (2) the same telephone call combined with an in-person engagement interview also conducted before the intake appointment; or (3) usual intake procedures. The engagement interventions included an exploration of both within-family and environmental barriers and problem solving to address these obstacles. Families who received the phone call alone or the combined call and interview were more likely to show up to their scheduled appointments. However, relative to those who received the usual intake procedures, only those in the combined call/interview condition showed improved attendance in subsequent scheduled appointments.

Szapocznik and colleagues' (1988) intervention, strategic structural systems engagement (SSSE), uses family therapy techniques (e.g., joining and restructuring) to reduce resistance and increase the initial engagement of adolescents and their families in treatment. In the first randomized trial of this intervention, Latino families who had an ado-

lescent involved in substance use and received SSSE were significantly more likely to attend the intake and less likely to drop out of treatment than those who received a control condition simulating usual care procedures (Szapocznik et al., 1988). A second trial of SSSE, also involving an exclusively Latino sample (Santisteban et al., 1996), confirmed its efficacy in increasing engagement, as measured by increased rate of attendance of the intake interview and subsequent therapy sessions. Moderator analyses revealed that Cuban Americans were significantly less likely to engage than non-Cuban American Latinos.

More recently, one of us has been involved in the adaptation of a brief intervention inspired by the work of a community nonprofit organization from Lawrence, Massachusetts (see [www.rightquestion.org](http://www.rightquestion.org)). This educational strategy, The Right Question Project-Mental Health (RQP-MH), aims to increase the level of participation in treatment-related decisions of individuals receiving services and reduce their likelihood of dropping out of care. This strategy has been successfully implemented with adult outpatients from ethnic minority backgrounds, particularly immigrant Latinos (see Alegría et al., 2008). Using three 45-minute sessions, the intervention teaches participants to identify important decisions that are relevant to their care and to generate carefully constructed questions directed to their providers. Through this process, participants shift their role from being a passive recipient of information to feeling more empowered to make collaborative decisions and shape their course of treatment in partnership with their therapists and other providers. In a quasi-experimental design, we found that, relative to those receiving usual care, RQP-MH participants reported significantly higher engagement in their interactions with mental health providers. Furthermore, RQP-MH participants were also significantly more likely to attend scheduled sessions and less likely to drop out of care (Alegría et al., 2008). We have further refined the intervention and are testing it in a randomized trial. A version of this program for youth with mental health problems and their parents is also being developed.

In sum, a few strategies exist and others are being developed to increase treatment participation and retention of ethnic minority youth and their families. The vast majority have focused on the initial engagement of clients and devote less effort to reducing dropout postintake. These interventions are not yet available in manual form, which may facilitate dissemination in community settings or integration into existing EBT protocols. Also, engagement strategies for Asian American and Native American youth and families were not found, and the vast majority of the work has been done with African Americans and Latinos. Interestingly, one strength of available engagement strategies is that, in contrast to many EBTs, they have been developed and tested in community settings and compared with usual care procedures. Experimental designs evaluating the impact of EBTs with or without engagement components are much needed, including those conducted in laboratory and naturalistic settings.

## DIRECTIONS FOR RESEARCH

Overall, our appraisal of EBT research with ethnic minority youth is fairly optimistic. A number of EBTs exist for African American and Latino youth with diverse problems, and ethnic minorities generally benefit as much as European Americans. Although

treatments are often adapted for ethnic minorities, compelling evidence was not found for the need to use separate or specialized procedures to treat ethnic minority youth. Finally, evidence suggests that several successful strategies exist for engaging and retaining minority youth and families in treatment.

Of course, these conclusions must be qualified, given the limited and often inadequate research on treatment issues with minority youth. In an earlier article (Huey & Polo, 2008), we offered six recommendations for improving the quality of psychotherapy research with ethnic minority youth. These included (1) expanding the number of clinical trials with ethnic minority youth, particularly those from immigrant and non-English-speaking backgrounds; (2) focusing greater attention on ethnicity, nativity, and related factors as moderators of treatment effects; (3) consistently describing investigator efforts to make treatments culture-responsive; (4) rigorously assessing whether cultural adaptations enhance treatment effects with minorities; (5) ensuring that sample sizes are appropriate for evaluating key research questions regarding minority youth; and (6) assessing culturally appropriate outcomes. Next, we briefly offer two additional agenda items for future research.

### ***Address Diversity Issues in Treatment Manuals***

Although treatment manuals have been critical for the operationalization and dissemination of EBTs, with few exceptions (Rosselló & Bernal, 1996) they do not provide guidelines for how to implement core techniques to serve youth of diverse backgrounds or directly address how to consider culture when working with ethnic minorities. Assuming that culture-responsive adaptations are useful for minorities, it is important to specify how to implement such strategies. One approach is to develop supplementary guides to use in conjunction with therapy manuals that specify how to adapt treatments for particular minority groups (Huey & Pan, 2005, 2006). However, there is also a need for illustrations in mainstream manuals that demonstrate flexible applications of modules with youth and families of different ethnic groups, socioeconomic backgrounds, and settings. For example, a therapist who is teaching a module on activity selection for mood enhancement may benefit from having examples of how this skill can be implemented with youth living in rural or suburban areas as well as youth of poor and urban backgrounds. Fortunately, increased attention has been given to case studies focused on youth of culturally diverse backgrounds participating in CBTs (e.g., Ngo et al., 2008).

### ***Assess Within-Group Differences in Treatment Response***

Earlier we discussed whether minorities and European Americans differ in how they respond to treatment; yet it is also critical to test for within-group differences to avoid the assumption of ethnic minority homogeneity of therapy response. For example, limited research suggests that immigration and acculturation status may determine which minorities respond optimally to standard or culturally adapted treatment (Martinez & Eddy, 2005; Pan, Huey, & Hernandez, 2009; Telles et al., 1995). None of these studies included ethnic minorities with preexisting behavioral/emotional problems, however. Thus, future research should assess what culture-related factors determine whether an EBT is efficacious for particular ethnic minority youth.

Assuming that an EBT with demonstrated efficacy for one ethnic group will be equally efficacious across all ethnic minority groups can also be problematic. For example, in a prevention trial, Cardemil, Reivich, Beevers, Seligman, and James (2007) compared ethnic minority youth randomly assigned to either the Penn Resiliency Program (PRP) or a no-treatment control group. PRP focuses on teaching cognitive and social problem-solving skills to youth at risk for depression. A differential effect (fewer depressive symptoms and negative automatic thoughts) in favor of PRP was found for Latino youth, but not for African American youth.

A related question is whether particular modes of treatment, such as family- or group-based interventions, are optimal for ethnic minority youth compared with other approaches. Some initial work in this area leads to very different conclusions. Several randomized trials with Latino youth found no outcome differences between conjoint family therapy versus one-person therapy (Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1986) or group-based versus individual therapy (Rosselló, Bernal, & Rivera-Medina, 2008). However, a meta-analysis by Waldron and Turner (2008) comparing family, group, and individual interventions for adolescents with substance use problems found significant disparities. Whereas individual and family treatments were efficacious, group CBT effects were much smaller and indistinguishable from control conditions among studies with predominantly Latino youth. Thus, group-focused interventions may be less effective than other interventions for Latino youth with drug use problems. Waldron and Turner (2008) suggest that poor effects for group treatment may be because therapists were less able to attend to cultural factors in group settings compared with individual and family therapy contexts.

As a final note, findings regarding comparisons across cultural groups should be interpreted with caution given the economic, social, and educational disparities that are a reality in the United States. Ethnic comparisons are often fraught with ambiguity because culture and ethnicity are often confounded with risk factors such as lack of insurance, poverty, and a host of other factors which can also directly impact treatment effects. Thus, strong claims about treatment efficacy with ethnic minorities without attention to these other variables should be avoided.

## CONCLUSIONS

Despite these concerns, significant progress has been made regarding our understanding of EBTs for ethnic minority youth. The evidence is particularly strong for African American and Latino youth, who represent the two largest ethnic minority groups in the United States. Many gaps remain, however, and much more work is needed to address critical questions concerning what treatments are efficacious for which minority youth, what mechanisms account for clinical change for ethnic minority youth in treatment, and which factors enhance or impede treatment efficacy for these youth. Of special concern is whether these "minority" EBTs can be transported effectively to real-world clinical practice, particularly because ethnic minorities with mental health needs are less likely than European Americans to receive evidence-based care (Wang, Berglund, & Kessler, 2000). We hope that greater attention will be directed toward dissemination efforts, with the ultimate goal of increasing EBT access and use for ethnic minority youth in community settings.

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# Evidence-Based Psychotherapies for Children and Adolescents

SECOND EDITION

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*Edited by*

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**THE GUILFORD PRESS**

New York London

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A Division of Guilford Publications, Inc.  
72 Spring Street, New York, NY 10012  
www.guilford.com

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Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

**Library of Congress Cataloging-in-Publication Data**

Evidence-based psychotherapies for children and adolescents / edited by John R. Weisz and Alan E. Kazdin. — 2nd ed.

p. cm.

Includes bibliographical references and index.

ISBN 978-1-59385-974-9 (hardcover: alk. paper)

1. Child psychotherapy. 2. Adolescent psychotherapy. 3. Evidence-based psychiatry.

I. Weisz, John R. II. Kazdin, Alan E.

RJ504.E95 2010

618.92'8914—dc22

2009049689