Chapter 22

Improving Treatment Engagement and Psychotherapy Outcomes for Culturally Diverse Youth and Families

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I. INTRODUCTION

Ethnic minority[1] youth are less likely than European American youth to receive professional care for mental health problems (Flores and The Committee on Pediatric Research, 2010; Garland et al., 2005; Kataoka, Zhang, & Wells, 2002; Kataoka et al, 2007; Snowden & Yamada, 2005), and disparities persist when controlling for income, diagnostic status, and other confounding factors (Garland et al., 2005; Kataoka et al., 2002). When they do receive treatment, minority youth are more likely to drop out prematurely, attend fewer sessions, and receive services that are fragmented or inappropriate (Flores and The Committee on Pediatric Research, 2010). Moreover, ethnic minority youth in clinical settings may show less improvement than European American youth in identical settings (Weersing & Weisz, 2002). The breadth of these disparities is frustrating to mental health professionals, and many wonder whether existing research offers guidance that can help inform clinical practice when working with ethnic minority youth. We believe that it does.

This chapter summarizes what is currently known about effective ways to improve treatment engagement and outcomes for ethnic minority youth with mental health problems. Specifically, we address the following five questions: (a) What approaches increase treatment engagement for ethnically

1. In this chapter, "ethnic minority" refers broadly to non-White youth in the United States. We acknowledge the inadequacy of this term given that traditional "minorities" are actual majorities in many parts of the country (US Census Bureau, 2011). However, we retain this term to be consistent with the literature reviewed.

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diverse youth? (b) What psychosocial interventions are effective at treating ethnically diverse youth? (c) How robust are the effects of such treatments? (d) Do treatment effects differ by ethnicity? and (e) Does cultural tailoring enhance treatment effectiveness? To answer these questions, we draw primarily from treatment outcome meta-analyses, as well as randomized trials with minority youth. Because rigorous trials addressing minority engagement in treatment are rare, we focus most of this chapter on psychotherapy outcomes for minority youth.

II. WHAT APPROACHES INCREASE TREATMENT ENGAGEMENT FOR ETHNICALLY DIVERSE YOUTH?

Given the ethnic disparities in mental health care, effective strategies for engaging minority youth in treatment are sorely needed. Unfortunately, only a handful of experimental studies directly address this issue. Following initial referral to a mental health center, Planos and Glenwick (1986) randomly assigned predominantly Black and Latino families to receive (a) phone prompting prior to the initial appointment, (b) letter prompting prior to the appointment, or (c) no intervention. Both phone and letter prompting increased session attendance compared to control. Although the active conditions did not differ in terms of session attendance, a cost analysis indicated that the phone prompt generated more revenue than the letter. McKay, Stoewe, McCadarTI, and Gonzales (1998) evaluated the effect of a more involved engagement strategy for predominantly African American families referred to an urban mental health agency. Families were randomly assigned to the following conditions: (a) a 30-minute pre-intake telephone call that addressed engagement barriers; (b) the same telephone call combined with an in-person engagement interview; or (c) usual intake procedures. Both engagement approaches were more effective than usual intake at increasing initial attendance. However, only those in the combined condition showed improved attendance at subsequent scheduled appointments.

The family therapy literature offers effective engagement strategies for Latino youth. In a series of studies, Szapocznik and colleagues (Sanisteban et al., 1996; Szapocznik et al., 1988) tested whether *structural systems engagement* (SSSE) improved treatment attendance for substance using Latino adolescents and their families. SSSE involved the use of "joining" and "restructuring" techniques to address resistance and other family-related barriers to accessing treatment. Across studies, they found that families randomized to SSSE were more likely to attend intake and less likely to terminate prematurely than control participants (Sanisteban et al., 1996; Szapocznik et al., 1988). Moreover, moderator tests showed that non-Cuban Latinos appeared to benefit more from SSSE than Cuban Americans (Sanisteban et al., 1996).

The engagement strategies summarized thus far involve mainstream approaches, with no explicit cultural elements. However, a number of

scholars have argued that cultural tailoring of conventional therapies may be another useful way to better engage ethnic minorities in treatment (e.g., Cardemil, 2010). To our knowledge, only two studies have rigorously tested whether cultural enhancements, per se, increase minority youth participation in therapy. McCabe and Yeh (2009) compared standard *Parent-Child Interaction Therapy* (PCIT) to a culturally modified version of PCIT (*Guiando a Ninos Activos* or GANA) for externalizing Mexican American youth and their parents. The modifications included giving culturally relevant labels to the program name and concepts, presenting "time out" and other intervention concepts from the parents' worldview, and adding images of Mexican American families in written handouts. Similarly, an unpublished study by Burrow-Sanchez, Wrona et al. (2011) compared standard CBT to culturally accommodated CBT for Latino (primarily of Mexican descent), juvenile offenders with substance use problems. Accommodations included addressing issues of acculturative stress and ethnic identity, and providing bus tokens to eliminate transportation barriers, among other strategies. In neither case did the cultural enhancements lead to increased session attendance or decreased dropout from treatment (Burrow-Sanchez, Wrona et al., 2011; McCabe & Yeh, 2009). However, given the small sample size for both studies ($n = 58$ and 35, respectively), power to detect significant group differences may have been inadequate.

In summary, generic strategies such as prompting (by phone or letter) and addressing diverse barriers to attendance (by phone or in person) show some effectiveness at initial engagement in treatment and reducing subsequent dropout for Black and Latino youth. However, there is no evidence as yet that culture-related strategies facilitate treatment engagement for these groups.

III. WHAT PSYCHOSOCIAL INTERVENTIONS ARE EFFECTIVE IN TREATING ETHNICALLY DIVERSE YOUTH?

Access to mental health care does not guarantee that services will necessarily be effective. Indeed, a persistent concern among many experts is that established treatments may not be optimally effective for ethnic minorities. Fortunately, a large number of randomized trials have addressed the question of treatment efficacy for minority youth. Rather than describe individual trials, we rely instead on three recent reviews of the literature. First, Bernal, Sáez-Santiago, and Galloza-Carrero (2009) summarized the best available evidence for treating Latino youth and families. Second, Ho, McCabe, and colleagues (2010) identified empirically supported treatments for ethnic minority youth with conduct problems or at-risk for conduct problems. Third, Huey and Polo (2008) reviewed the literature on EBTs for ethnic minority youth with behavioral and/or emotional problems.

Although each review identified efficacious treatments for ethnic minority youth, they differed significantly in their inclusion criteria and how they defined evidence-based treatments (see Table 22.1). For example, whereas Bernal et al. (2009) avoided ranking treatments by quality of support, Ho et al. (2010) and Huey and Polo (2008) classified treatments into three categories according to level of empirical support: well-established, probably efficacious, and possibly efficacious. Well-established treatments were supported in at least two randomized control trials (RCTs) by independent research teams showing that the treatment was superior to another treatment or placebo, or equivalent to an established treatment (Chambless & Hollon, 1998). Probably efficacious treatments required either one trial in which

TABLE 22.1 Summaries of Three Reviews of Evidence-Based Treatments for Ethnically Diverse Youth

	Bernal et al. (2009)	Ho et al. (2010)	Huey & Polo (2008)
EBT Criteria	RCTs with 40% or more Latino participants	RCTs with 20% or more of one major ethnic minority group as participants	RCTs with 75% ethnic minority participants, separate analysis showing treatment with ethnic minorities is superior to control, or separate moderator analysis showing treatment more effective (or equivalent) for minorities
Target Group(s)	Latino youth with preexisting psychosocial problems	Ethnic minority youth with, or at-risk for, conduct problems	Ethnic minority youth with preexisting psychosocial problems
# of EBTs for Externalizing Problems	2 EBTs	16 EBTs: 2 well-established 6 probably efficacious 8 possibly efficacious	13 EBTs: 7 probably efficacious 6 possibly efficacious
# of EBTs for Internalizing Problems	12 EBTs	Not included in review	11 EBTs: 3 probably efficacious 8 possibly efficacious
# of EBTs for Mixed/Other Problems	3 EBTs	Not included in review	6 EBTs: 3 probably efficacious 3 possibly efficacious

Note: EBT = Evidence-based treatment; RCT = Randomized clinical trial.

treatment was more effective than placebo, or two trials wherein treatment was more effective than no treatment. Possibly efficacious treatments required only one study showing that treatment was more effective than no treatment.

As summarized in Table 22.1, each review differed in terms of the number of EBTs reported. Bernal et al. (2009) identified 17 EBTs for externalizing problems, internalizing problems, or mixed/other problems. Ho and colleagues (2010) identified two well-established, six probably efficacious, and eight possibly efficacious treatments. Huey and Polo (2008) identified 13 probably efficacious and 17 possibly efficacious treatments. Summarizing across reviews, multiple treatments were identified for minority youth with internalizing disorders (e.g., depression, anxiety, trauma), externalizing disorders (e.g., ADHD, conduct problems), substance use problems, and miscellaneous other problems (e.g., suicidality, "maladjustment"). Efficacious interventions for minority youth were also identified across different intervention paradigms including family systems treatments, individual cognitive-behavioral therapies, parent management training, skills training, and multicomponent treatments. As shown in Table 22.2, over 30 unique treatments were identified as efficacious for ethnic minority youth. Available evidence was particularly strong for treating conduct problems in Latino and African American youth. However, virtually no evidence was available to

TABLE 22.2 Evidence-Based Treatments for Ethnically Diverse Youth with, or At-Risk for, Behavioral/Emotional Problems*

Problem Domain	Youth Ethnicity	Evidence-Based Treatments
ADHD	African American	Behavioral treatment + stimulant medication
	Latino	Behavioral treatment + stimulant medication
Anxiety-related problems	African American	AMT, modified AMT, GCBT, study skills training
	Latino	*Cuento* therapy, GCBT
Conduct problems	African American	AMT, assertive training, attribution training, behavioral contracting, cognitive restructuring, CBT, group CBT, Coping Power, Incredible Years, MST, combined PSST + PMT, response cost, SAAF, Social Relations Intervention
	Asian Americans	Incredible Years

(*Continued*)

TABLE 22.2 (Continued)

Problem Domain	Youth Ethnicity	Evidence-Based Treatments
	Latino	BET, Bridges Puentes, BSFT, one-person BSFT, group CBT, CCPT, Family Unidas, FET, GANA, Incredible Years, Nuestras Familias, PCIT, SHIP Intervention Program
	Mixed/other ethnicity	REE, structured problem solving
Depression	Latino	CBT, group CBT, IPT, group IPT
Substance use problems	African American	MST
	Latino	MDFT
	Mixed/other ethnicity	MDFT
Suicidal behavior	African American	MST
Trauma-related problems	African American	FIAP, CBITS, resilient peer treatment, TF-CBT
	Latino	CBITS, *TEMAS* narrative therapy, TF-CBT
Mixed/comorbid problems	African American	RECAP Intervention
	Latino	CBITS
	Multiracial Hawaiian	MST
Other problems	Latino	Infant-mother psychotherapy

*Based on EBTs reported in Bernal et al. (2009), Ho et al. (2008), and Huey and Polo (2008).
Note: ADHD = attention-deficit/hyperactivity disorder; AMT = anxiety management training; BET = Bicultural Effectiveness Training; BSFT = brief strategic family therapy; CBITS = cognitive-behavioral intervention for trauma in schools; CBT = cognitive-behavioral treatment; CCPT = child-centered play therapy; FET = family effectiveness therapy; FIAP = Fostering Individualized Assistance Program; IPT = interpersonal therapy; MDFT = multidimensional family treatment; MST = multisystemic therapy; PMT = parent management training; PSST = problem-solving skills training; RECAP = Reaching Educators, Children, and Parents; REE = rational emotive education; SAAF = Strong African American Families; SHIP = Schools in Homes in Partnership; TF-CBT = trauma-focused cognitive behavioral therapy.

support the use of psychosocial interventions for Asian youth, Native American youth, or other non-White youth. Finally, there were many disorders for which there is still little to no available evidence in treating ethnic minority youth (e.g., trichotillomania, eating disorders).

In summary, evidence is strong across reviews that a broad array of treatments are effective for treating and preventing mental health problems in ethnic minority youth.

IV. HOW EFFECTIVE ARE PSYCHOSOCIAL TREATMENTS FOR ETHNICALLY DIVERSE YOUTH?

The previous literature reviews are helpful in that they clarify what treatments are efficacious for what youth and for what problems. However, it is possible for treatments to show statistically significant effects but not be clinically relevant (Hinshaw, 2002). To address this issue of treatment magnitude, we turn to meta-analyses evaluating treatment outcomes for ethnic minority youth. Meta-analytic procedures allow researchers to compute degree of effectiveness (e.g., effect size) across studies with different study designs, client populations, and treatment types. In meta-analysis, effect size coefficients (typically Cohen's d)[2] of 0.20 or lower represent "small" effects, coefficients of around 0.50 "medium" effects, and coefficients of 0.80 or higher "large" effects (Cohen, 1988).

Huey and Polo (2008) completed a meta-analysis evaluating the effects of EBTs for ethnic minority youth with behavioral and emotional problems. The final analysis included 25 studies comparing active treatments to no treatment, placebo, or treatment-as-usual (TAU). Across all studies, they found a medium effect size of $d = 0.44$, indicating that 67% of treated participants were better off at posttreatment compared to the average control participant. Therapy effects were generally maintained at follow-up, although effects were strongest when treatment was compared to no-treatment or placebo versus TAU.

A major limitation is that this meta-analysis included only efficacious treatments (Huey & Polo, 2008), and thus effect sizes are likely inflated because ineffective treatments were excluded. Indeed, four additional meta-analyses that included a broader array of interventions found effect sizes ranging from 0.18 to 0.35 for African American youth, Latino youth, and a mixed array of ethnic minority youth (Hodge, Jackson, & Vaughn, 2010a, 2010b; Jackson, Hodge, & Vaughn, 2010; Yuen, 2004). These effects were smaller than those found for Huey and Polo, but still statistically significant. Yet, these meta-analyses are limited too in that they focused exclusively on culturally tailored treatments and included both preventive and indicated treatment studies. Given the explicit "cultural" focus of these meta-analyses, we discuss them in greater detail when we evaluate the role of cultural tailoring on treatment outcomes.

Overall, the uniformly positive effects found in these meta-analyses further support the use of psychosocial interventions for ethnic minority youth. It should also be noted that the small to medium effects from these minority-focused meta-analyses are consistent with other meta-analyses evaluating psychosocial interventions for adolescents as a whole (e.g., Kim, 2007; Weisz, Jensen-Doss, & Hawley, 2006; Weisz, McCarty, & Valeri, 2006).

2. Cohen's d is the most common effect size estimate used for clinical trials. It represents the standardized mean difference in outcomes between the treatment and comparison condition.

V. DO TREATMENT EFFECTS DIFFER BY ETHNICITY?

Despite accruing evidence that psychosocial interventions are effective with diverse youth, scholars continue to debate whether treatments are *equally effective* for ethnic minority and European American youth (i.e., "ethnic invariance") or whether treatments are *more effective* for European Americans than minority youth (i.e., "ethnic disparity"; de Anda, 1997; Huey & Polo, 2008). To explore empirically whether treatment effects vary as a function of youth ethnicity, we once again turn to meta-analysis. We identified five meta-analyses evaluating

TABLE 22.3 Summary of Meta-Analyses Evaluating Effects of Youth Ethnicity on Treatment Outcomes

Study	Meta-Analysis Focus	Ethnicity/Cultural Description	Ethnicity Effect
Fabiano, Pelham et al. (2008)	Behavioral treatments for ADHD ($N = 20$ "between groups" studies)	Percentage Caucasian	*No.* Percentage of Caucasian participants not associated with effect size.
Silverman, Pina, and Viswesvaran (2008)	Evidence-based treatments for anxiety disorders in youth ($N = 32$ studies)	Unspecified "ethnicity" (but presumably White vs non-White) Whether trial conducted in North America	*Mixed.* Ethnicity not correlated with effect size. However, effects were larger in trials conducted in North America compared to other regions.
Sussman, Sun, and Dent (2006)	Teen smoking cessation interventions ($N = 48$ studies)	Percentage White	*No.* Ethnicity composition not associated with quit rates.
Weisz, Jenson-Doss, and Hawley (2006)	EBTs vs usual clinical care for youth ($N = 20$, those reporting ethnicity of participants)	Proportion Caucasian (vs Minority)	*No.* Proportion Caucasian not associated with effect size.
Wilson, Lipsey, and Soydan (2003)	"Mainstream" programs for juvenile delinquency ($N = 305$)	Predominantly ethnic minority ($> 60\%$) or predominantly White ($> 60\%$)	*No.* Studies with predominantly White vs predominantly minority samples did not differ on mean delinquency effect size.

psychosocial treatments for youth that directly addressed the ethnicity-as-moderator question (see Table 22.3).

Generally, results show no significant ethnicity effects. In a meta-analysis of behavioral treatments for ADHD, Fabiano, Pelham et al. (2009) found no significant outcome differences for "Caucasian" versus "non-Caucasian" youth. Sussman and colleagues (2006) conducted a meta-analysis of teen smoking cessation studies, and results showed no significant association between ethnicity and smoking quit rates. A meta-analysis by Weisz, Jensen-Doss, and Hawley (2006) evaluated randomized trials comparing EBTs to usual care and failed to find evidence supporting ethnicity as a treatment moderator. Wilson, Lipsey, and Derzon (2003) completed a meta-analysis of school-based interventions for preventing and reducing aggressive behavior. Moderator analysis did not show an association between ethnicity and pre-post change.

However, one meta-analysis did report findings suggesting ethnocultural differences in treatment outcome. A meta-analysis by Silverman, Kurtines et al. (2008) examined the effects of therapy for youth with phobic and anxiety disorders. They tested ethnicity as a correlate of treatment outcomes, but results were nonsignificant. However, when clinical trials were compared by country of origin, effects were larger in studies conducted in North America compared to other regions, suggesting that cultural differences in treatment outcomes might exist.

It is important to point out that these meta-analyses have significant limitations that qualify what conclusions can be reached regarding ethnicity effects. Most critically, the majority reported that a significant proportion of studies included in the meta-analyses failed to report sufficient information on participant ethnicity (Fabiano et al., 2009; Sussman et al., 2006; Weisz et al., 2006; Wilson, Lipsey, & Derzon, 2003). When ethnicity data was available, the samples generally included only small proportions of ethnic minorities. Given the limited numbers of ethnic minority participants across studies, the meta-analyses frequently lumped diverse youth into a generic "ethnic minority" category and compared them to generic "White" youth (see Table 22.3). This approach assumes homogeneity across ethnic minority groups and makes it impossible to ascertain whether specific minority groups fair better or worse when compared with European American youth, further complicating the "ethnic invariance" versus "ethnic disparity" debate.

Huey and Polo (2008) took a different approach to evaluating "ethnic invariance" by summarizing 13 clinical trials that tested whether treatment outcomes differed as a function of youth ethnicity. Approximately 80% compared outcomes for African American versus European American youth, whereas 20% compared Latino versus European American youth. The results were varied, with eight of 13 treatment studies showing no moderator effects, two showing stronger treatment effects for European Americans, and three showing stronger effects for minorities. With such mixed results, additional research is needed before firm conclusions can be drawn about the relative efficacy of treatments for ethnic minorities versus European American youth.

Thus, although findings from meta-analyses and individual trials mostly support "ethnic invariance," in light of the limitations discussed, it appears that it is still premature to conclude that psychosocial interventions benefit ethnic minorities and European Americans equally well.

VI. DOES CULTURAL TAILORING ENHANCE TREATMENT EFFECTS?

The evidence thus far suggests that psychosocial treatments are effective with Black and Latino youth, and that treatment effects are similar for non-White and European American youth. Questions about how to maximize treatment benefits, however, have led many to advocate for culturally tailored treatments (Sue, Zane, Hall, & Berger, 2009). Such cultural tailoring is perceived to be effective at improving engagement, retention, and ultimately, treatment outcomes for ethnic minority youth and families (Cardemil, 2010). However, few studies have actually investigated the specific role of cultural tailoring on treatment efficacy.

To address whether cultural tailoring improves treatment outcomes for minority youth, we again turn to meta-analysis. Specifically, we synthesize evidence from nine meta-analyses comparing culturally tailored treatments to either (a) a mixed array of control conditions, (b) "bona-fide" therapies, or (c) "generic" versions of the tailored treatment. Mean effect sizes from seven of these meta-analyses (i.e., those reporting effect size coefficients for youth) are displayed in Figure 22.1.

Four meta-analyses comparing culturally tailored treatments to a mixed set of control groups (e.g., no treatment, placebo, usual care) are highlighted. Yuen (2004) evaluated the efficacy of culturally tailored primary prevention, secondary prevention, and positive youth development interventions ($N = 87$) for ethnic minority youth from infancy to 25 years of age. The analysis yielded small but significant effects ($g = 0.28$)[3], supporting the efficacy of culturally tailored, psychosocial prevention programs with minority youth.

Three meta-analyses by Hodge and colleagues (Hodge et al., 2010a, 2010b; Jackson et al., 2010) examined the efficacy of culturally sensitive interventions (CSIs) in treating health and behavioral health problems for minority youth. The first meta-analysis looked specifically at CSIs designed to reduce high-risk behaviors among African American youth and yielded a small-to-medium effect size ($g = 0.35$, $n = 7$; Jackson et al., 2010). The second meta-analysis examined CSIs targeting health outcomes for Latino youth and found a more modest effect size falling in the small range ($g = 0.18$, $n = 11$; Hodge et al., 2010a).

3. Hedges' g is an unbiased version of Cohen's d (i.e., the *corrected* standardized mean difference). Except when sample sizes are extremely small (i.e., less than 10), the difference between d and g is usually trivial (Borenstein et al., 2009).

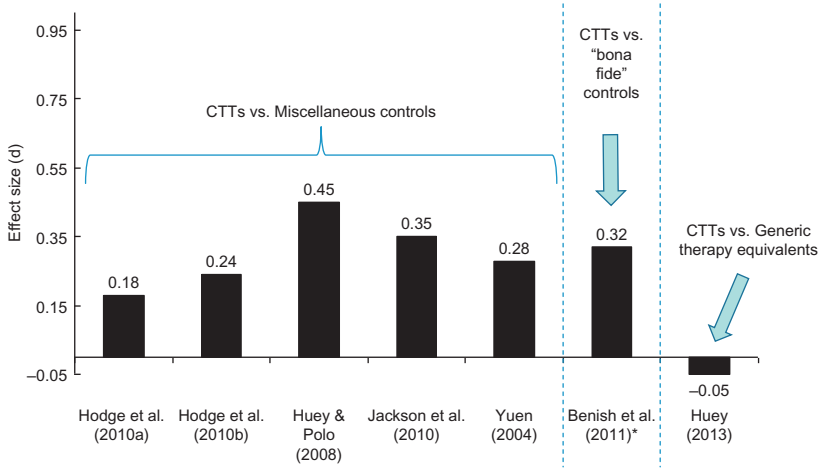

FIGURE 22.1 Meta-analyses evaluating effects of culturally tailored treatments (CTTs) for ethnically diverse youth. **Note:* Benish et al. (2011) effect size for youth is estimated from the overall effect, because treatment outcomes did not differ by age.

Finally, the third meta-analysis examined both health and behavioral health outcomes for African American, Latino, and Native American youth and also found a small effect ($g = 0.24$; $n = 21$; Hodge et al., 2010b). For the latter study, no significant differences were found between CSIs that addressed different outcomes (e.g., externalizing, internalizing, or physical health outcomes) or targeted different ethnic groups.

The following meta-analyses by Smith and colleagues (Griner & Smith, 2006; Smith, Rodriquez, & Bernal, 2011) were primarily adult-focused, but included analyses addressing age-related treatment effects. Griner and Smith (2006) conducted a meta-analysis of culturally adapted treatments ($N = 76$) that included experimental and quasi-experimental studies, symptomatic and nonsymptomatic participants, and adolescents and adults. The overall effect size was $d = 0.40$, which is roughly of "medium" magnitude. However, they also found that studies with older participants yielded effect sizes of greater magnitude than studies with younger participants. Smith et al. (2011) conducted a second meta-analysis of culturally adapted treatments, but limited inclusion to experimental and quasi-experimental designs, and studies aimed at treating preexisting psychosocial problems. The average effect was of "medium" magnitude ($d = 0.46$), although adults again appeared to benefit significantly more from cultural adaptations than youth. Thus, results from both of these meta-analyses suggest that cultural tailoring may be more useful for minority adults than for minority youth.

These findings, however, are limited in what they tell us about the unique role of cultural tailoring because they do not disaggregate cultural tailoring

from generic treatment effects. Following is a brief summary of four approaches to isolating cultural tailoring effects within the context of meta-analysis.

The first approach is essentially correlational, namely, assessing whether degree of cultural tailoring is associated with positive treatment effects. This approach was utilized in two meta-analyses that showed conflicting results. The Yuen (2004) prevention meta-analysis used regression methods to examine the relationship between cultural components and treatment outcomes. Two unexpected findings emerged. First, degree of cultural tailoring (a composite of 8 cultural dimensions) was associated with *negative* treatment outcomes. Second, the more an intervention incorporated cultural values, the *less effective* it was. These findings stand in contrast to supplemental results reported by Smith et al. (2011) in their meta-analysis with predominantly adult samples. They found that total number of culturally adapted intervention components was associated with positive treatment effects. Thus, these two meta-analyses lead to opposite conclusions regarding the utility of cultural tailoring for ethnic minorities. One interesting possibility is that cultural tailoring is beneficial under some circumstances but harmful under others (Huey, 2013).

A second approach uses meta-analysis to contrast two types of clinical trials: (a) those comparing culturally tailored treatments to controls, and (b) those comparing generic treatments (i.e., therapies with no apparent cultural features) to controls. Cultural tailoring is then tested as a moderator of treatment effects. Huey and Polo (2008) used this approach in their meta-analysis of youth EBTs, defining "culture-responsiveness" in both a conservative (i.e., cultural elements were described in the RCT) and liberal (i.e., cultural elements were described only in secondary sources) fashion. They found that regardless of definition, no significant differences between "standard" versus "culture-responsive" treatments were found (see Figure 22.2).

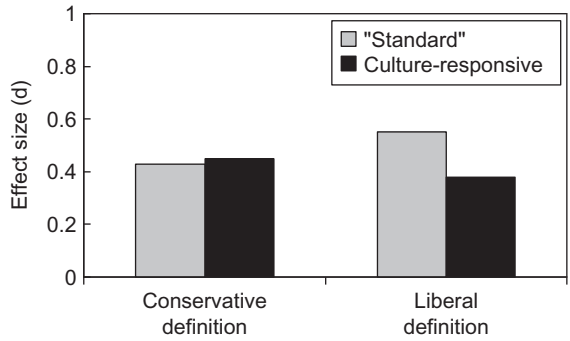

FIGURE 22.2 Mean effect sizes for "standard" vs "culture-responsive" treatments, based on conservative vs liberal definitions. Differences between standard and culture-responsive treatments were not significant. *(From Huey & Polo, 2010.)*

A third approach was utilized recently in a meta-analysis by Benish, Quintana, and Wampold (2011) comparing "culturally adapted" psychotherapies to unadapted, "bona fide" psychotherapies (i.e., therapies that include a relationship with a therapist tailored to the client). Treatments were classified as bona fide if they possessed two or more of the following characteristics: (a) used an established psychotherapy approach, (b) incorporated the use of psychological processes, (c) used a manual or training guide for therapists, and/or (d) identified the active ingredient of the therapy. Benish et al. (2011) found an average effect size of $d = 0.32$, indicating that culturally adapted treatments are generally more effective than other active, yet unadapted, treatments. According to Benish et al. (2011), these findings imply that conventional therapies are more effective when they are "adapted in a manner consistent with the client's cultural worldviews" (p. 9).

However, we argue that the Benish et al. (2011) meta-analysis falls short of showing that cultural tailoring, per se, enhances treatment effects because core elements of the culturally adapted and bona fide treatments were frequently dissimilar. For example, one trial included in their meta-analysis compared two conceptually distinct interventions for Puerto Rican youth—interpersonal psychotherapy (the "adapted" intervention) versus cognitive-behavioral therapy (the unadapted "bona fide" intervention). Moreover, the inclusion of quasi-experimental (nonrandomized) trials, as well as studies with nonsymptomatic participants, poses a significant threat to internal validity. To address these limitations, Huey (2013) used a fourth approach to isolate cultural tailoring effects. In an unpublished meta-analysis, he included 10 randomized trials that directly compared culturally tailored versus "generic" interventions for individuals with mental health problems. For each trial, the culturally tailored and generic interventions were essentially identical, except for the inclusion of cultural elements in the former. Overall, cultural tailoring effects were small and nonsignificant ($d = 0.01$). Moreover, age did not moderate effects, with negligible effect sizes for youth ($d = -0.05$) and adults ($d = 0.07$). Table 22.4 gives a brief summary of the four youth-focused trials (Burrow-Sanchez, Wrona et al., 2011; Grodnitzky, 1993; McCabe & Yeh, 2009; Szapocznik, Rio et al., 1986) included in this meta-analysis.

Although these meta-analyses show that culturally adapted treatments are superior to no treatment, placebo, and standard clinical services, there is little proof that cultural tailoring, per se, enhances youth treatment outcomes. When analyses focus only on the small set of internally valid studies (i.e., randomized trials comparing treatments that differ only in terms of cultural elements), no overall effects for cultural tailoring are found (Huey, 2013). Future research should continue to examine the comparative benefits of "generic" EBTs and culturally tailored treatments in an effort to identify the active ingredients (e.g., reducing communication barriers, addressing the client's explanatory model; Pan, Huey, & Hernandez, 2011) that might provide unique benefits for ethnic minority clients.

TABLE 22.4 Summaries of Four Randomized Trials Comparing Culturally Tailored versus Generic Treatments for Ethnically Diverse Youth

Author	Sample	Treatment Conditions	Key Cultural Elements	Outcomes (& Effect Sizes)*
Burrow-Sanchez, Wrona et al. (2011)	35 juvenile offenders "in need of substance abuse treatment." 100% Latino (mostly Mexican-American)	Standard group CBT vs culturally accommodated group CBT	5 cultural themes were integrated into CBT: family, acculturation, ethnic identity, perceptions of substance abuse treatment, & barriers to treatment	No effects on days of substance use at posttreatment $d = -0.42$
Grodnitzky (1993)	48 junior high school youth showing "maladaptive behavior." 55% Puerto Rican, 45% Anglos	Non-hero modeling vs hero modeling	Includes biographies of prominent Puerto Rican historical figures to provide role models for youth	No treatment effects on externalizing problems $d = -0.58$ (Puerto Ricans); $d = -0.14$ (Anglo)
McCabe and Yeh (2009)	40 clinic-referred youth with clinically significant behavior problems. 100% Mexican-American	Parent-Child Interaction Therapy (PCIT) vs Guiando a Ninos Activos (a culturally modified version of PCIT)	Involves (1) tailoring program based on a cultural assessment; (2) referencing cultural concepts; (3) framing treatment as educational; (4) focusing on rapport-building; (5) translating, simplifying, & adding images of Mexican American families in written handouts; (6) adding engagement protocol	No treatment effects for externalizing behavior or ADHD symptoms $d = 0.28$

(*Continued*)

TABLE 22.4 (Continued)

Author	Sample	Treatment Conditions	Key Cultural Elements	Outcomes (& Effect Sizes)*
Szapocznik, Rio et al. (1986)	31 youth with "behavior problems and maladjustment pathology." 100% Cuban American	Structural Family Therapy (SFT) vs Bicultural Effectiveness Training (a culturally tailored SFT)	Frames intergenerational conflict in terms of cultural conflicts and develops bicultural skills in all family members	No treatment effects for behavior problems or psychiatric status $d = 0.00$ (estimated)

**A positive effect size means that outcomes favor the culturally tailored condition; a negative effect size means that results favor the "generic" condition.*

VII. SUMMARY

Considerable gains have been made in our understanding of psychotherapy effects with ethnic minority youth. Several approaches are effective for engaging minority youth and their families in treatment, including verbal and written prompts. More than 30 distinct therapies are known to prevent or remediate mental health symptoms in minority youth (particularly Black and Latino youth), and treatment effects are mostly in the small to medium range. In terms of clinical significance, results suggest that 57 to 67% of minority youth who receive these treatments are generally better off than the average youth in a comparison condition. Treatments appear to work equally well for minority and European American youth, although some evidence of ethnic disparity was found. Finally, we know that culturally tailored therapies are generally effective for minority youth, but we cannot yet say *what* tailoring approaches are most effective, whether certain youth respond better to tailoring than others, or whether tailoring itself actually enhances treatment effects.

Despite considerable progress, there are many gaps in this literature, and elsewhere we offer specific recommendations for improving the quality of psychotherapy research with ethnic minority youth and families (Huey & Polo, 2008, 2010). These include (a) expanding clinical trials research with ethnic minority youth, to go beyond the narrow focus on Blacks and Latinos; (b) considering how ethnicity, nativity, and related cultural factors influence treatment effects for youth; (c) consistently describing investigator efforts to culturally tailor treatment; (d) rigorously assessing whether cultural tailoring enhances treatment effects; (e) making sure that sample sizes are large enough to properly evaluate key research questions; (f) ensuring that

outcome measures are culturally appropriate; (g) addressing diversity-related issues in treatment manuals, and (h) assessing within-group differences in treatment response.

A final concern is how well psychotherapy outcome results generalize to circumstances in real-world mental health settings. Most published trials with minority youth are conducted in universities rather than clinic-based settings (Weisz et al., 2006). Thus, we cannot yet say whether the efficacious treatments summarized here necessarily translate to real-world clinic practice. To ensure that minority youth benefit optimally from our clinical science research, we strongly encourage that more trials be conducted directly in clinics that serve predominantly minority youth.

REFERENCES

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology*, *58*(3), 279–289.

Bernal, G., Sáez-Santiago, E., & Galloza-Carrero, A. (2009). Evidence-based approaches to working with Latino youth and families. In F. A. Villarruel, G. Carlo, J. M. Grau, M. Azmitia, N. J. Cabrera, & T. J. Chahin (Eds.), *Handbook of U.S. Latino psychology: Developmental and community-based perspectives* (pp. 309–328). Thousand Oaks: CA: Sage.

Borenstein, M., Hedges, L. V., Higgins, J. P. T., & Rothstein, H. R. (2009). *Introduction to meta-analysis*. West Sussex, UK: Wiley & Sons.

Burrow-Sanchez, J., Wrona, M., Varela, A., & Frausto, K. (2011, April). *Enhancing the social validity of empirically-supported substance abuse treatment for Latino adolescents: The VIDA Program.* Poster presented at the From Disparities Research to Disparities Interventions Conference, Washington, DC.

Cardemil, E. V. (2010). Cultural adaptations to empirically supported treatments: A research agenda. *The Scientific Review of Mental Health*, *7*, 8–21.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, *66*(1), 7–18.

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates.

De Anda, D. (1997). *Controversial issues in multiculturalism*. Boston: Allyn & Bacon.

Fabiano, G. A., Pelham, W. F., Jr., Coles, E. K., Gnagy, E. M., Chronis-Tuscano, A., & O'Connor, B. (2009). Evidence-based treatments for attention-deficit hyperactivity disorder: A meta-analysis of behavioral treatments. *Clinical Psychology Review*, *29*, 129–140.

Flores, G., & The Committee on Pediatric Research (2010). Race and ethnic disparities in the health and health care of children. *Pediatrics*, *125*, e979–e1020.

Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and ethnic differences in utilization of mental health services among high-risk youths. *American Journal of Psychiatry*, *162*, 1336–1343.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy*, *43*(4), 531–548.

Grodnitzky, G.R. (1993). *Hero Modeling versus Non-Hero Modeling as interventions for Puerto-Rican and Anglo adolescents exhibiting behavior problems*. Unpublished doctoral dissertation. Hempstead, NY: Hofstra University.

Hinshaw, S. P. (2002). Intervention research, theoretical mechanisms, and causal processes related to externalizing behavior patterns. *Development and Psychopathology*, *14*, 789–818.

Ho, J. K., McCabe, K. M., Yeh, M., & Lau, A. S. (2010). Evidence-based treatments for conduct problems among ethnic minorities. In R. C. Murrihy, A. D. Kidman, & T. H. Ollendick (Eds.), *Clinical handbook of assessing and treating conduct problems in youth* (pp. 455–488). New York, NY: Springer Science + Business Media.

Hodge, D. R., Jackson, K. F., & Vaughn, M. G. (2010a). Culturally sensitive interventions and health and behavioral health youth outcomes: A meta-analytic review. [Meta-Analysis]. *Social Work in Health Care*, *49*(5), 401–423.

Hodge, D. R., Jackson, K. F., & Vaughn, M. G. (2010b). Culturally sensitive interventions for health related behaviors among Latino youth: A meta-analytic review. *Children and Youth Services Review*, *32*(10), 1331–1337.

Huey, S. J., Jr., & Polo, A. (2010). Assessing the effects of evidence-based psychotherapies with ethnic minority youths. In J. R. Weisz, & A. E. Kazdin (Eds.), *Evidence-based psychotherapies for children and adolescents* (2nd ed., pp. 451–465). New York: Guilford.

Huey, S. J., Jr., & Polo, A. J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 262–301.

Huey, S. J. (2013). *Do cultural adaptations enhance psychotherapy effects? A meta-analysis of culturally tailored versus generic psychotherapies*. submitted for publication.

Jackson, K. F., Hodge, D. R., & Vaughn, M. G. (2010). A meta-analysis of culturally sensitive interventions designed to reduce high-risk behaviors among African American youth. *Journal of Social Service Research*, *36*(3), 163–173.

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among US children: Variation by ethnicity and insurance status. *American Journal of Psychiatry*, *159*, 1548–1555.

Kim, J. S. (2007). Examining the effectiveness of solution-focused brief therapy: A meta-analysis. *Research on Social Work Practice*, *18*(2), 107–116.

McCabe, K., & Yeh, M. (2009). Parent child interaction therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child and Adolescent Psychology*, *38*, 753–759.

McKay, M. M., Stoewe, J., McCadarTI, K., & Gonzales, J. (1998). Increasing access to child mental health services for urban children and their caregivers. *Health and Social Work*, *23*, 9–15.

Pan, D., Huey, S. J., Jr., & Hernandez, D. (2011). Culturally-adapted versus standard exposure treatment for phobic Asian Americans: Treatment efficacy, moderators, and predictors. *Cultural Diversity and Ethnic Minority Psychology*, *17*, 11–22.

Planos, R., & Glenwick, D. S. (1986). The effects of prompts on minority children's screening attendance at a community mental health center. *Child and Family Behavior Therapy*, *8*, 5–13.

Sanisteban, D. A., Szapocznik, J., Perez-Vidal, A., Kurtines, W. M., Murray, E. J., & LaPerriere, A. (1996). Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology*, *10*, 35–44.

Silverman, W. K., Pina, A. A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 105–130.

Smith, T. B., Rodriguez, M. D., & Bernal, G. (2011). Culture. *Journal of Clinical Psychology*, *67*(2), 166–175.

Snowden, L. R., & Yamada, A. (2005). Cultural differences in access to care. *Annual Review of* Clinical Psychology, *1*, 143–166.

Sue, S., Zane, N., Hall, G. C. N., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*, *60*, 525–548.

Sussman, S., Sun, P., & Dent, C. W. (2006). A meta-analysis of teen cigarette smoking cessation. *Health Psychology*, *25*(5), 549–557.

Szapocznik, J., Perez-Vidal, A., Brickman, A., Foote, F. H., Santisteban, D., Hervis, O. E., et al. (1988). Engaging adolescent drug abusers and their families into treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology*, *56*, 552–557.

Szapocznik, J., Rio, A., Perez-Vidal, A., Kurtines, W., Hervis, O., & Santisteban, D. (1986). Bicultural effectiveness training (BET): An experimental test of an intervention modality for families experiencing intergenerational/intercultural conflict. *Hispanic Journal of Behavioral Sciences*, *8*, 303–330.

US Census Bureau. (2011). The Hispanic population: 2010. Retrieved from: <http://www.census.gov/prod/cen2010/briefs/c2010br-04.pdf>.

Weersing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *Journal of Consulting & Clinical Psychology*, *2*, 299–310.

Weisz, J. R., Jensen-Doss, A., & Hawley, K. M. (2006). Evidence-based youth psychotherapies versus usual clinical care: A meta-analysis of direct comparisons. *The American Psychologist*, *61*(7), 671–689.

Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin*, *132*(1), 132–149.

Wilson, S. J., Lipsey, M. W., & Derzon, J. H. (2003). The effects of school-based intervention programs on aggressive behavior: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *71*(1), 136–149.

Wilson, S. J., Lipsey, M. W., & Soydan, H. (2003). Are mainstream programs for juvenile delinquents less effective with minority youth than majority youth? A meta-analysis of outcomes research. *Research on Social Work Practice*, *13*, 3–26.

Yuen, R. K. (2004). The effectiveness of culturally tailored interventions: A meta-analytic review. *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 4311.