
CHAPTER 21

Evidence-Based Psychotherapies with Ethnic Minority Children and Adolescents

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Ethnic minorities¹and immigrants make up a large and growing percentage of youth in many Western nations (Manilla, Messing, van den Broek, & Vidra, 2010; U.S. Census Bureau, 2014), and the mental health needs of ethnic minority youth are expanding rapidly (Molcho et al., 2010; Costello, He, Sampson, Kessler, & Merikangas, 2014). Despite this need, enormous racial disparities in mental health care exist for youth (Alegría, Vallas, & Pumariega, 2010; Flores & the Committee on Pediatric Research, 2010; Garland, Lau, McCabe, Hough, & Landsverk, 2005; Kataoka, Zhang, & Wells, 2002). Yet our understanding of optimal ways to engage and treat ethnic minority youth with behavioral and emotional problems is limited.

In recent years, scholars have debated whether evidence-based psychotherapies (EBPs) for mental health problems are effective for ethnic minority youth and adults (Hall, 2001; Huey & Polo, 2008; Huey, Tilley, Jones, & Smith, 2014). Two broad perspectives are dominant, representing opposite ends of a continuum. The ethnic invariance perspective argues that conventional EBPs are equally effective across cultural groups because the principles underlying psychotherapeutic change are essentially universal. In contrast, the ethnic-specific perspective argues that EBPs are ineffective or less effective for ethnic minorities because they were not developed or evaluated with ethnic minorities, and because they tend to ignore cultural considerations that are critical to treating culturally diverse populations.

In this chapter, we shed some light on this debate by summarizing what we know about treatment more generally, and EBPs more specifically, for ethnic minority youth with mental health problems. We draw primarily from youth-focused treatment outcome reviews and meta-analyses published over the past decade. Although we focus mostly on ethnic diversity within the United States, we also include research on diverse populations in other Western nations.

EFFICACIOUS PSYCHOTHERAPIES FOR ETHNIC MINORITY YOUTH

First, we briefly summarize efficacious psychotherapies for ethnic minority youth. We began with a list of minority-focused EBPs published in our earlier review (Huey & Polo, 2008; 2010), then expanded our search to include additional randomized trials published from 2007 through 2014. Interventions were classified as *well established*, *probably efficacious*, and *possibly efficacious* psychotherapies for ethnic minority youth based on criteria summarized by Huey and Polo (2008). Well-established therapies require support from two or more randomized controlled trials (RCTs) by independent teams comparing treatment to placebo; probably efficacious therapies require one placebo-controlled trial (or two trials comparing treatment to no treatment); and possibly efficacious therapies require one study showing treatment superiority to no treatment. In addition, studies had to include (1) a sample that was at least 75% ethnic minority, (2) analyses showing that therapy was effective for ethnic minority participants, or (3) analyses showing that ethnicity did not moderate outcomes or that therapy was effective for minority participants regardless.

Only one treatment, motivational interviewing, was considered *well established* for ethnic minority youth. In addition, 22 treatments were considered *probably efficacious*, and 22 as *possibly efficacious*. In Table 21.1, the interventions listed in regular font were identified as EBPs in the 2008 review (Huey & Polo, 2008), and those in bold are new ones identified from our recent search. Efficacious psychotherapies were found for ethnic minority youth with a diverse array of psychosocial problems, including attention-deficit/hyperactivity disorder (ADHD), anxiety-related problems, conduct problems, depression, suicidal behavior, trauma-related problems, and mixed/comorbid problems (i.e., no single problem type predominated). Psychotherapies for conduct problems and substance use problems accounted for the majority (56%) of interventions listed in Table 21.1.

The majority evaluated group- or family-based interventions, while only a few used individual therapy. Cognitive-behavioral psychotherapies (i.e., those derived from social learning principles and cognitive theories of psychopathology) predominated, accounting for more than 53% of EBPs listed. However, treatments derived from other treatment paradigms were also well represented, including interpersonal psychotherapy, family systems therapies (e.g., brief strategic family therapy), motivational interviewing, and art/play therapies.

The evidence base is strongest for African Americans and Latinos, the two largest ethnic minority groups in the United States. In contrast, evidence supporting the use of psychosocial interventions with other non-European American youth in the United States is extremely rare. Only one EBP was found for Asian American youth (Lau, Fung, Ho, & Liu, 2011), one for multiracial Hawaiian youth (Rowland et al., 2005), and *none* for Native American youth. Indeed, of the three trials that focused on symptomatic Native American youth, none were effective at reducing alcohol use, depressive symptomatology, or smoking (Bowen, Henderson, Harvill, & Buchwald, 2012; Carpenter, Lyons, & Miller, 1985; Listug-Lunde, Vogeltanz-Holm, & Collins, 2013) in this high-risk population.

In terms of trends, one interesting thing to note from Table 21.1 is the large number of EBPs that have emerged for Latino youth over the past 7 years, particularly for those with substance use problems. Another positive trend is the emergence

TABLE 21.1. Well-Established, Probably Efficacious, and Possibly Efficacious Psychotherapies for Ethnic Minority Youth with Behavioral/Emotional Problems

| Problem domain | Youth ethnicity | Evidence-based psychotherapies |
|--------------------------|--------------------------------------|---|
| ADHD | African American and Hispanic/Latino | Behavioral treatment + stimulant medication |
| | Hispanic/Latino | PCIT |
| 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 |
| | Asian American | The Incredible Years |
| | Hispanic/Latino | Brief strategic family therapy; CCPT; child-parent relationship therapy ; familias unidas ; PCIT |
| | Mixed/other ethnicity | CCPT ; rational emotive education; structured problem-solving |
| Depression | African American | CBT-based quality improvement intervention |
| | Hispanic/Latino | CBT; group CBT ; interpersonal psychotherapy |
| Substance use problems | African American | BSFT ; MST |
| | Hispanic/Latino | BSFT ; ecologically based family therapy ; MI ; structural ecosystems therapy |
| | Mixed/other ethnicity | MI ; multidimensional family therapy |
| Suicidal behavior | African American | MST |
| Trauma-related problems | African American | Fostering Individualized Assistance Program; prolonged exposure ; resilient peer treatment; trauma-focused CBT |
| | Hispanic/Latino | School-based group CBT |
| | Mixed/other ethnicity | Psychodrama ; trauma-focused expressive art therapy |
| Mixed/comorbid problems | African American | Reaching educators, children, and parents |
| | Multiracial Hawaiian | MST |

Note. Updated from Huey and Polo (2010). Interventions shown in regular font were identified as EBTs in Huey and Polo (2008); those in **bold** font are those identified as EBTs in our most recent search. ADHD, attention-deficit/hyperactivity disorder; AMT, anxiety management training; CBT, cognitive-behavioral treatment; CCPT, child-centered play therapy; MI, motivational interviewing; MST, multisystemic therapy.

of EBPs for ethnic minority youth outside the United States. For example, several trials have assessed cognitive-behavioral treatments for diverse youth with behavioral problems in the Netherlands (Leijten, Raaijmakers, de Castro, van den Ban, & Matthys, 2015; Liber, de Boo, Huizenga, & Prins, 2013). In both trials, moderator tests showed that the active treatments were equally effective at reducing disruptive behavior for ethnic Moroccan/Turkish and ethnic Danish youth. Additional trials support the use of Triple P for disruptive aboriginal youth in Australia (Turner, Richards, & Sanders, 2007) and group cognitive-behavioral therapy (CBT) for depressed Māori youth in New Zealand (Woods & Jose, 2011).

In terms of the breadth of evidence supporting EBPs for ethnic minority youth, several other reviews have reached similar conclusions. For example, in a review of interventions for Latino youth, Bernal, Saez-Santiago, and Galloza-Carreno (2009) identified 17 EBPs for externalizing, internalizing, and mixed/other problems. Similarly, Ho, McCabe, Yeh, and Lau (2010) identified 16 therapies as *well-established*, *probably efficacious*, or *possibly efficacious* for ethnic minority youth with (or at risk for) conduct problems. Thus, the evidence strongly suggests that a number of interventions are available for treating ethnic minority youth, in the United States and elsewhere, with a broad array of mental health problems.

MAGNITUDE OF TREATMENT EFFECTS

As others have noted (e.g., Hinshaw, 2002), treatments may show statistically significant effects yet not be clinically impactful. To address this issue, we present results from several meta-analyses evaluating the magnitude of treatment effects for ethnic minority youth. With treatment outcome meta-analysis, effect size coefficients of 0.20 or lower represent “small” effects, coefficients of 0.50 represent “medium” effects, and coefficients of 0.80 or higher represent “large” effects (Cohen, 1988), and positive effects mean that treated youth show more favorable outcomes than comparison youth.

The Huey and Polo (2008) meta-analysis assessed EBP effects for ethnic minority youth with behavioral and emotional problems, with findings from 25 RCTs comparing active treatments to controls. Results showed a medium effect size of $d = 0.44$, which indicates that 67% of treated participants were better off at posttreatment when compared to control youth. Moreover, therapy effects were generally maintained at follow-up. Although treatment effects were significantly larger when treatment was compared to no treatment or placebo (vs. treatment as usual[TAU]), problem type (externalizing vs. internalizing), problem severity (clinically significant vs. not significant; DSM diagnosis vs. no diagnosis), and youth ethnicity (African American vs. Latino vs. mixed/other) did not affect outcomes.

One limitation, however, is that the Huey and Polo (2008) meta-analysis deliberately excluded ineffective treatments; thus, the magnitude of treatment effects was likely inflated. Indeed, when we reviewed six additional prevention and treatment meta-analyses focused on ethnic minority youth (Gillespie & Huey, 2015; Hodge, Jackson, & Vaughn, 2010a, 2010b; Hodge et al., 2012; Jackson, Hodge, & Vaughn, 2010; Yuen, 2004), we found effect sizes ranging from a low of 0.12 to a high of 0.39 (see Figure 21.1), which were all significant effects but smaller than that found for

Huey and Polo (2008). However, most of these meta-analyses are limited as well, in that they included only culturally adapted treatments, targeted diverse behavioral health outcomes (e.g., dietary behavior, sexual behavior, substance use), evaluated preventive and indicated interventions, or included a mix of randomized and non-randomized trials.

Thus, notwithstanding the qualifications noted earlier, the limited evidence suggests that interventions for ethnic minority youth generally show small to medium treatment effects. Moreover, positive effects are found for diverse ethnic minority youth with a broad array of mental health problems. These results are generally consistent with findings from other published meta-analyses assessing interventions effects for youth more broadly (e.g., Weisz, Jensen-Doss, & Hawley, 2006; Weisz, McCarty, & Valeri, 2006).

ETHNICITY-AS-MODERATOR EFFECTS

Another important question for investigators is whether therapy effects vary by youth ethnicity. In considering this issue, Huey and Polo (2008) summarized 13 randomized trials that assessed youth ethnicity as a moderator of treatment effects. Eight of the 13 trials showed no significant ethnicity-as-moderator effects. While the remaining trials did show significant moderator effects, two showed effects favoring European American youth, whereas three showed effects favoring ethnic minorities (Huey & Polo, 2008).

Recent meta-analyses reveal similar trends with regard to ethnicity effects in clinical trials. Table 21.2 briefly summarizes results from 18 youth-focused meta-analyses that test whether treatment effects vary by youth ethnicity. The meta-analyses focused on treatment for ADHD (Fabiano et al., 2009), antisocial behavior

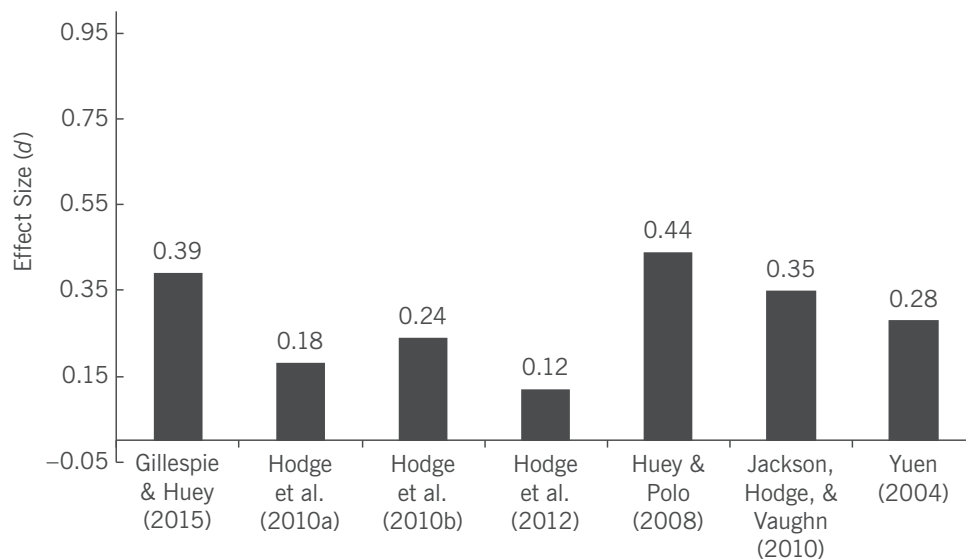


FIGURE 21.1. Meta-analyses evaluating effects of interventions for ethnic-minority youth.

TABLE 21.2. Summary of 18 Meta-Analyses Evaluating Youth Ethnicity Effects on Treatment Outcomes

| Significant ethnicity effects | Null effects |
|---|-------------------------------------|
| James et al. (2013) (ethnic-minority status associated with larger effects) | Baldwin et al. (2012) |
| Lin (2012) (ethnic-minority status associated with larger effects) | Comer et al. (2013) |
| van Stam et al. (2014) (European/European American background associated with larger effects) | DeSwart et al. (2012) |
| Wilson & Hoge (2013) (European/European American background associated with larger effects) | Fabiano et al. (2009) |
| | Ghafoori (2010) |
| | Lipsey (2009) |
| | McCart et al. (2012) |
| | Sawyer (2012) |
| | Silverman et al. (2008) |
| | Sussman et al. (2006) |
| | Trask et al. (2011) |
| | Weisz, Jenson-Doss, & Hawley (2006) |
| | Whipple (2007) |
| | Wilson et al. (2003) |

(James, Stams, Asscher, De Roo, & van der Laan, 2013; Lipsey, 2009; McCart, Pries-ter, Davies, & Azen, 2012; Sawyer, 2012; van Stam et al., 2014; Wilson & Hoge, 2013; Wilson, Lipsey, Soydan, 2003), anxiety disorders (Silverman, Pina, & Viswesvaran, 2008), externalizing behaviors (Comer, Chow, Chan, Cooper-Vince, & Wilson, 2013; Ghafoori, 2001; Lin, 2011; Whipple, 2007), smoking (Sussman, Sun & Dent, 2006), mixed drug use and delinquent behavior (Baldwin, Christian, Berkelijon, Shad-ish, & Bean, 2012), diverse psychosocial problems in real-world treatment settings (Weisz, Jensen-Doss, et al., 2006), problem behavior in institutional care (DeSwart et al., 2012), and psychosocial sequelae to sexual abuse (Trask, Walsh, & DiLillo, 2011). The majority found no significant ethnic differences in treatment effects. When ethnic differences were found, effects favored ethnic minority youth (James et al., 2013; Lin, 2011) just as often as they favored European American youth (van Stam et al., 2014; Wilson & Hoge, 2013).

Overall, results from individual trials and meta-analyses show few ethnic differ-ences in youth treatment outcomes. Moreover, when ethnic differences do emerge, studies show similar outcomes for youth of ethnic minority and European back-grounds. These results generally support an ethnic invariance perspective.

As noted in greater detail elsewhere (Huey & Jones, 2013; Huey & Polo, 2008; Huey & Polo, 2010), four methodological limitations qualify what conclusions can be drawn concerning ethnic disparities in treatment effects. First, because modera-tor effects are more difficult to detect than main effects, the preponderance of null findings may mostly result from low power (e.g., because of small sample sizes). For example, using integrative data analysis techniques, Greenbaum et al. (2015) pooled data from five randomized trials of multidimensional family therapy (MDFT) and found previously undetected ethnicity-as-moderator effects. For African Americans and European Americans, MDFT was significantly more effective than control

at reducing drug use; however, for Latino adolescents, there were no significant treatment effects. Second, even when treatment moderator effects are significant, appropriate interpretation of such effects can be challenging, particularly when control groups are robust (e.g., placebo, TAU). Third, in ethnic comparison analyses, most studies combine diverse non-European American youth into a generic “ethnic minority” group, which improperly assumes homogeneity across minority groups and potentially masks outcome disparities that might exist for some groups. Finally, because a large percentage of minority-focused treatments are culturally tailored (Huey et al., 2014), the therapeutic experience of ethnic minority youth may be enhanced in these trials, which may minimize differential outcomes by ethnicity. Given these limitations, caution should be exercised when concluding that psychotherapies are equally beneficial for ethnic minority and European American youth.

CULTURAL TAILORING EFFECTS

Demonstrating that evidence-based psychotherapies can benefit ethnic minority youth is a positive development in the treatment outcome literature. However, documenting that “standard” treatments work for ethnically diverse youth and families does not mean that it is unwarranted to evaluate whether tailoring or adapting these treatments also produces beneficial effects. That would be like saying that because CBT for anxiety disorders has been found to be efficacious, we should not pursue examining whether mindfulness interventions are also beneficial.

One view in the health disparities field is that standard treatments ought to be adapted to maximize outcomes for ethnic minority youth and adults (Fuertes & Gretchen, 2001; Sue, Zane, Hall, & Berger, 2009). Indeed, results from two meta-analyses show that the majority of published trials with predominantly ethnic minority youth include some form of culturally tailored treatment (Gillespie & Huey, 2015; Huey & Polo, 2008), suggesting that many clinical investigators share this assumption. These adaptations were very diverse and involved using cultural agents during the treatment development and refinement process, ethnic/linguistic match between provider and client, adapting treatment manuals for cultural sensitivity, and integrating culture-related content into treatment sessions, among other strategies (Huey & Polo, 2008).

However, only a handful of studies have rigorously assessed whether cultural adaptations actually improve youth outcomes. Table 21.3 summarizes five trials that include two basic elements that allow for “strong inference” with regard to cultural tailoring effects: (1) comparison of a culturally tailored versus generic intervention in an RCT, and (2) use of tailored and generic treatments that differ only in the inclusion or absence of key cultural features (Huey et al., 2014). Two trials compared generic and culturally tailored treatment to a no-treatment, placebo, or TAU control. Grodnitzky (1993) recruited Puerto Rican and Anglo youth with “maladaptive behavior” and assigned them to hero modeling (which utilized biographies of Puerto Rican historical figures), non-hero modeling (Puerto Rican role models were excluded), or no-treatment control. No posttreatment effects on maladaptive behavior were found for either ethnic group.

TABLE 21.3. Summary of Randomized Trials Comparing Generic and Culturally Tailored Treatments for Youth Mental Health Problems

| Study | Participants | Treatment | Findings |
|---|--|---|--|
| Burrow-Sanchez & Wrona (2012) | 35 Latino adolescents ($M = 15.49$ years) with substance use disorders | Randomly assigned to standard CBT (S-CBT) or culturally accommodated CBT (A-CBT) | No group differences in substance use outcomes over 3-month follow-up. |
| Burrow-Sanchez et al. (2015) | 70 Latino adolescents ($M = 15.2$ years) with substance use disorders | Randomly assigned to S-CBT or A-CBT | No group differences in substance use outcomes over 3-month follow-up. |
| Grodnitzky (1993) | 35 Puerto Rican and 29 Anglo youth showing “maladaptive behaviors” | Randomly assigned to Hero Modeling (utilizing Puerto Rican figures), Non-Hero Modeling (Puerto Rican role models excluded), or no-treatment control | For Puerto Rican and Anglo youth, no group differences in maladaptive behavior at posttreatment. |
| McCabe & Yeh (2009); McCabe et al. (2012) | 58 Mexican American youth with behavioral problems and their parents | Randomly assigned to standard PCIT, <i>Guiando a Niños Activos</i> (GANA; a culturally modified version of PCIT), or TAU | At posttreatment and follow-up, GANA was superior to TAU for externalizing and ADHD symptoms; at posttreatment, but not follow-up, PCIT was superior to TAU; GANA and PCIT did not differ at either time period. |
| Szapocznik et al. (1986) | 31 Cuban American youth ($M = 15.1$ years) with conduct/maladjustment problems and their families | Randomly assigned to structural family therapy (SFT) or bicultural effectiveness training (BET; a culturally enhanced version of SFT) | No group differences at post-treatment across four behavior problem and five psychiatric problem scales. ^a |

^aSzapocznik et al. (1986) did report a significant treatment effect for “impulse-control disturbance,” but appeared to dismiss the finding as being due primarily to baseline differences between SFT and BET.

McCabe and colleagues (McCabe & Yeh, 2009; McCabe, Yeh, Lau, & Argote, 2012) assigned externalizing Mexican American youth and their parents to parent-child interaction therapy (PCIT), *guiando a niños activos* (GANA; a culturally modified version of PCIT), or treatment as usual (TAU). At posttreatment, both GANA and PCIT led to greater reductions in externalizing behavior than TAU, but only GANA led to greater reductions in ADHD symptoms than TAU (McCabe & Yeh, 2009). At follow-up, GANA remained superior to TAU for externalizing and ADHD symptoms, but there were no significant effects for PCIT (McCabe et al., 2012). No significant differences were found between GANA and PCIT for externalizing problems or ADHD symptoms at either time period.

Three additional trials compared culturally tailored and generic treatments but did not include a control group. In two randomized trials, Burrow-Sanchez and colleagues (Burrow-Sanchez, Minami, & Hopps, 2015; Burrow-Sanchez & Wrona,

2012) evaluated the effects of standard versus culturally accommodated group CBT for Latino juvenile offenders with substance use problems. No differential treatment effects were found for either study. Szapocznik et al. (1986) compared structural family therapy (SFT) to bicultural effectiveness training (BET; a version of SFT focused on mitigating intergenerational cultural conflicts) for Cuban American youth with conduct/maladjustment problems and their families. Again, no treatment effects were found.

The evidence across these five trials suggests that culturally tailored interventions do not outperform other, equivalent, standard evidence-based interventions for ethnic minority youth. However, with only 15–35 youth per condition, all of these studies probably lacked adequate power to detect significant cultural tailoring effects. As we note elsewhere (Huey & Polo, 2008), at least 65 participants per group would be needed for adequate power if moderate cultural tailoring effects (e.g., $d = 0.50$) were anticipated. Thus, results based on small sample studies such as these must be interpreted with caution.

Another approach involves using meta-analysis to determine how cultural tailoring affects youth outcomes. Three recent meta-analyses are relevant here and, curiously, each reaches different conclusions about the importance of cultural tailoring. The meta-analysis by Yuen (2004) evaluated whether cultural tailoring was associated with differential outcomes for youth participating in primary prevention, secondary prevention, and positive youth development interventions. Surprisingly Yuen found that inclusion of cultural values and degree of cultural tailoring were associated with *poorer* treatment outcomes, suggesting that tailoring might attenuate treatment effects. In their meta-analysis, Huey and Polo (2008) tested whether cultural tailoring enhanced treatment outcomes within the context of minority-focused youth EBPs. Overall, they found no outcome differences between “standard” versus “culture-responsive” EBPs for ethnic minority youth. Finally, two meta-analyses showed that culturally adapted therapies might be particularly beneficial for ethnic minority youth. Gillespie and Huey (2015) assessed therapy effects for ethnic minority youth with conduct problems and assessed whether cultural adaptation moderated treatment effects. They found that culturally adapted interventions ($d = 0.56$) for conduct problems were indeed more effective than “generic” interventions ($d = 0.28$). Similarly, a meta-analysis by Benish, Quintana, and Wampold (2011) compared culturally adapted and unadapted therapies for ethnic minorities of diverse ages. Overall, culturally adapted treatments were more effective than unadapted treatments, and participant age did not moderate outcomes.

Thus, given these diverse outcomes, one cannot say definitely whether cultural tailoring is necessary to obtain superior treatment effects for ethnic minority youth. Some scholars have argued that cultural tailoring works best when it reduces client reactance and maintains fidelity to core treatment principles, but it can be problematic when it reduces treatment dosage or eliminates core treatment content (Huey et al., 2014; Kumpher, Alvarado, Smith, & Bellamy, 2002). However, research addressing the parameters of cultural tailoring effects is nearly nonexistent. Ultimately, more experimental research is necessary to discern the conditions under which tailoring is effective for ethnic minority youth.

ENGAGING ETHNIC MINORITY YOUTH AND THEIR FAMILIES IN TREATMENT

As a final issue, we discuss approaches aimed at increasing participation and engagement of ethnic minority families in mental health treatment. A large proportion of ethnic minority youth do not receive the mental health services they need (Kataoka, Zhang, & Wells, 2002) and have lower use of inpatient and outpatient mental health services than youth of European American backgrounds (Garland, Lau, McCabe, Hough, & Landsverk, 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 EBPs, dropout rates for African American and other ethnic minority youth are often higher than for European American youth (e.g., Kazdin & Whitley, 2003). A recent meta-analysis of 48 studies focusing on predictors of treatment dropout of youth receiving mental health outpatient treatment (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013) found that ethnic minority youth were more likely to drop out across both efficacy and effectiveness study designs. Other factors that disproportionately impact ethnic minority families are also often associated with dropout from treatment. These include lower socioeconomic status, single-parent household, unemployment, Medicaid coverage/lack of insurance, and being placed on a wait list rather than receiving immediate treatment (Austin & Wagner, 2010; Muzik et al. 2014; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012; de Haan et al., 2013). In addition to focusing on symptom reduction and functional improvement, research is needed on how interventions can address structural barriers that may determine whether ethnic minority families enroll and are retained when offered EBPs and mental health services in general (Polo, Alegria, & Sirkin, 2012).

A number of strategies have been used to increase participation in treatment and reduce unilateral termination, including several that have focused on ethnic minority populations. Early research in this area with poor, ethnic minority adults and families successfully focused on single prompts (e.g., phone calls and letters) immediately prior to a scheduled session (e.g., Hochstadt & Trybula, 1980; Planos & Glenwick, 1986). Subsequent efforts (McKay, Stoewe, McCadam, & Gonzales, 1998) evaluated the effects of a 30-minute telephone call prior to the intake appointment and an in-person engagement interview. In an RCT, 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) developed an intervention called strategic structural systems engagement (SSSE), which 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 adolescent 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 both by increased rate of attendance during the intake interview and subsequent therapy sessions.

More research is needed to advance the understanding of ethnic differences beyond attendance and dropout. For example, a recent review of *parent* engagement and participation in treatment found that, despite the well-established differences in engagement across ethnic groups, only about 50% of the studies report on the ethnic background of their participants, and those that do predominately include European American samples (Haine-Schlagel & Walsh, 2015). Similarly, a meta-analysis of engagement strategies among adolescents and early adults reported the ethnic composition of the eligible studies but did not examine ethnicity as a potential moderator of the effects found (Kim, Munson, & McKay, 2012).

Antonio J. Polo 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). They adapted this educational strategy, called the Question Formulation Technique, to increase the level of participation in treatment-related decisions of individuals receiving services and to reduce their likelihood of dropping out of care. This strategy has been successfully implemented with adult outpatients from ethnic minority backgrounds, particularly immigrant Latinos (Alegría et al., 2008, 2014). 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, clients shift their role from passive recipients of information to empowered partners invested in making collaborative decisions and shaping their course of treatment. Two trials have documented the positive impact of this intervention. In a quasi-experimental design, the authors found that, relative to those receiving usual care, participants reported significantly higher activation in their interactions with their mental health providers, higher attendance at their scheduled appointments, and lower dropout rates (Alegría et al., 2008). The latest version of the intervention, called DECIDE, was evaluated in an RCT that included 13 outpatient community mental health clinics across five states and one U.S. territory with adult participants, most of whom (85%) were of ethnic-minority backgrounds (Alegría et al., 2014). Compared to usual care, those enrolled in the DECIDE sessions were found to have greater engagement with their providers (e.g., asked more questions) and greater self-management. The intervention, however, was not associated with increased retention in care. A current RCT is examining the impact of DECIDE, combined with an intervention to help therapists be more receptive to these clients when they bring up questions and express interest in collaboratively making key decisions related to their mental health care. To date, interventions such as DECIDE, which aim to increase empowerment and retention, have only been evaluated with ethnic-minority adults. These interventions, when successfully applied to youth and parents with ethnic-minority backgrounds, could help reduce and eliminate the well-documented service use disparities.

In summary, although strategies exist to increase the 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 would facilitate dissemination in community settings or integration into existing EBP 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 EBPs, they have been developed and tested in community settings and compared to usual care procedures. Experimental designs evaluating the impact of EBPs, with or without engagement components, are much needed, including those conducted in laboratory and naturalistic settings.

FUTURE DIRECTIONS

Over the past two decades, there has been a significant increase in the documented participation of ethnic-minority youth and families in psychotherapy research. As a result, evidence regarding the effects of specific interventions across a number of mental health problems has been accumulating. Although there is reason for optimism regarding positive impact of these standardized psychotherapies with ethnically and culturally diverse populations, a few critical issues that remain unresolved temper our enthusiasm.

As noted earlier, needed are studies specifically designed to examine ethnicity as a moderator, which requires that investigators recruit and enroll diverse samples large enough to evaluate this question with sufficient power. Carefully designed studies could additionally shed light on some of the inconclusive findings regarding the therapeutic effects of cultural tailoring and other adaptations. Several other broader issues are also outlined below.

The first issue is the limited reporting of demographic characteristics in RCTs, many of which have been notoriously absent from published reports. For example, Weisz, Jensen-Doss, and Hawley (2005) found that almost 60% of their identified treatment studies of youth psychotherapy ($N = 236$) did not report the ethnic composition of their samples. Another troubling finding in that review was that almost three out of four trials did not report on the socioeconomic characteristics of their participants. As a result, the studies that reported on ethnicity or that focused on documenting outcomes across ethnic groups represent a relatively small fraction of all the clinical trials that have been conducted on youth. There is no doubt that this has limited the ability to examine treatment effects across ethnic and socioeconomically diverse groups.

A second issue is that of representation. As noted earlier, it is simply not possible to make conclusive statements regarding the effects of psychotherapy for groups such as Asian American and Native American children and adolescents, as there are hardly any trials conducted on these populations. Similarly, because socioeconomic status is rarely reported, it is difficult to estimate the impact of psychotherapies for children and adolescents with *both* low income and ethnic-minority backgrounds. In a recent meta-analysis focusing specifically on socioemotional interventions conducted with low-income youth in urban school settings, an overall effect size was found at posttreatment of 0.08 across 23 studies, most of which were RCTs (Farahmand, Grant, Polo, & Duffy, 2011). In the United States, a large and

disproportionate number of ethnic-minority youth live in poverty. Meta-analyses of psychotherapy outcomes have not documented the effects of EBPs specifically for these youth, and the evidence thus far is not very promising.

Future research should also focus on a related representation concern. Evidence is needed to determine whether rates of *participation* in psychotherapy trials vary by key demographic characteristics, including income, ethnicity, nativity, and language. Studies are needed to document that specific groups can be successfully recruited and that they are not being systematically excluded from treatment outcome research. These include immigrants, linguistic minorities, and low-income populations with limited literacy or educational attainment.

Finally, as noted earlier, disparities in utilization of mental health services are present and significant. Ethnic-minority youth do not have equal access, retention, and participation rates compared to youth from European American backgrounds. Future research focused on developing strategies that eliminate these disparities is needed. This research should address ethnic disparities in lab-based EBTs, as well as usual care settings.

CONCLUDING COMMENTS

The impact of psychotherapy on ethnic-minority clients has been of interest dating back to the pioneering work by Smith and Glass (1977), who were among the first to systematically quantify treatment effects across studies. The search continues almost 40 years later. Although most psychotherapy trials with children and adolescents have been conducted with European Americans, there is now greater representation of ethnic and geographically diverse youth. The research questions have also become more sophisticated, addressing not just whether therapy works for diverse youth but under what circumstances (e.g., culturally tailored psychotherapies). The implementation of evidence-based psychotherapies in real-world settings warrants significantly more attention to the contexts under which treatments are delivered, and the client characteristics that may shape or determine their success, including, but not limited to, ethnicity, socioeconomic status, nativity, and cultural affiliation. Nonetheless, the evidence in this chapter suggests that youth of ethnic-minority backgrounds can benefit from these interventions.

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NOTE

1. In the United States and other Western nations, the term “ethnic minority” refers broadly to youth of non-European backgrounds. We acknowledge the limitations of this term given that historical “minorities” are actual numerical majorities in some Western regions. We also recognize that our use of specific ethn racial categories (e.g., African

American, Asian American, Latino) might implicitly minimize the enormous heterogeneity that exists within groups. However, we retain these terms, in part, to be consistent with other literature.

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