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CHAPTER 4

Evidence-Based Treatments for Mental, Emotional, and Behavioral Problems in Ethnic Minority Children and Adolescents

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Over the past 20 years, the clinical child and adolescent psychology area has witnessed the rise of treatment outcome studies identifying several interventions and modalities as efficacious for targeting youth with mental, emotional, and behavioral problems (e.g., Bor, Sanders, & Markie-Dadds, 2002; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kendall, 1994; Mufson et al., 2004; Silverman et al., 1999a; Webster-Stratton, Reid, & Hammond, 2004; Wells et al., 2006). Despite these advances, relatively little is known about the use of evidence-based treatments (EBTs) with ethnic minority and culturally diverse youth (hereafter referred to as ethnic minority youth). Moreover, comprehensive information about theoretical, methodological, and practical issues in the treatment of ethnic minority youth is scant. This chapter reviews and synthetizes the little work that has been done with a focus on clinical practice.

Population estimates show that minority youth (immigrant and U.S. born) comprise a significant proportion of the nation's existing and growing population. For instance, estimates suggest there are about 18 million Hispanic/Latino, 11 million African American, 3 million Asian American, and 1 million Native American youth in the United States (U.S. Census Bureau Current Population Survey 2013, U.S. Census Bureau Population Division, 2013). Moreover, Census Bureau projections indicate that the number of ethnic minority youth in the United States will increase significantly over time (e.g., an increase of almost 6 million for Hispanic/Latino, 2 million for African Americans, and 1 million for Asian Americans is expected by 2020) (U.S. Census Bureau, 2008). With the strong emphasis on utilizing EBTs and the prominent growth of ethnic minority youth in the United States, there is urgency for determining and establishing *whether* and *how* currently available treatments developed for one cultural group can be used with another cultural group. This is an important issue as research indicates the existence of mental health disparities with ethnic minorities being at greater risk for mental health disorders but having lower levels of treatment-seeking behaviors and higher levels of attrition (U.S. Department of Health and Human Services, 2001). Furthermore, ethnic minority groups historically have been underrepresented in efficacy and effectiveness trials, so the benefit of existing treatment modalities with minority youth is largely unknown.

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DEFINING KEY TERMS

Before engaging in a discussion about culturally informed treatment protocols, it is important to delineate a few basic terms. At the core of cultural adaptations lies an understanding of the term "culture." Typically thought of as a complex and multifaceted construct, the term encompasses a group of people's shared history, values, norms, goals, and practices that are transmitted from generation to generation through social interactions. Equally important yet often overlooked in our thinking about culture are subcultures. Subcultures are generally smaller, more homogenous groups that make up the larger cultural or ethnic group. Subcultural groups, such as Mexican or Puerto Rican, often have unique cultural experiences that differentiate them from other groups within the same ethnicity. Hispanic/Latino children and families, for instance, vary across subcultures in terms of immigration circumstances (e.g., reasons for migration, generational status) and sociodemographic characteristics (e.g., educational and income levels) (Umana-Taylor, Diversi, & Fine, 2002). Both culture and subculture can be manifested through observable factors, such as patterned behaviors, symbols, and artifacts, and through cognitive components, such as belief systems and schemas, both of which have been considered in designing and delivering treatment protocols to diverse cultural groups (Barrera, Castro, Strycker, & Toobert, 2012).

When it comes to defining parameters related to culturally informed interventions, the terminology becomes more convoluted with different theories using different terms to describe similar types of cultural modifications. Nevertheless, three distinct categories of cultural consideration in treatment modification typically emerge in the literature: cultural attunement, cultural tailoring, and cultural adaptation.

Cultural attunement, also referred to as cultural sensitivity, is the process by which culturally relevant treatment elements are added to a previously existing treatment protocol in order to enhance treatment engagement and retention of a specific ethnic minority group (Falicov, 2009). Using bilingual therapists, integrating cultural idioms into treatment, and addressing culturally specific barriers to participation are all examples of attunement strategies designed to increase the attractiveness and effectiveness of the therapy program for a specific cultural group. It is important to note, however, that the cultural attunement process focuses on adding to the standard treatment protocol without modifying core treatment components.

Cultural tailoring, or a culturally prescriptive approach, utilizes a more individualized method to modify existing treatment protocols. Kreuter and Skinner (2000) suggest that culturally tailored treatment programs incorporate culturally specific information that is intended to meet the needs of a particular client rather than an entire ethnic group. When using a tailoring approach, cultural modifications are determined by collecting information about the client's personal connection to his/her cultural background as it relates to the targeted therapeutic goal.

Cultural adaptation is a third category of treatment modification. Although this term often is used interchangeably with "cultural attunement" and/or "cultural tailoring," cultural adaptation has been defined by Bernal and colleagues as "the systematic modification of an [EBT] protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009, p. 362). The key feature that differentiates cultural adaptation from attunement or tailoring is the systematic nature of the modification process. As described in more detail later in this chapter, models of cultural adaptation tend to: (1) use a culture-based theoretical foundation to identify components of therapy that may need adapting in order to successfully treat a particular ethnic minority group, and (2) carefully examine the standard treatment using input from minority group members to shape the adaptation.

In our review of the literature, we found a modest body of work focusing on the treatment of mental, emotional, and behavioral problems in ethnic minority youth. In an effort to advance the knowledge base, this chapter synthesizes theory and research by discussing three key questions: Do current EBTs need to be modified for use with ethnic minority youth? What elements of EBTs should be modified for ethnic minority youth? For whom (what subgroups of ethnic minority youth or individuals) should EBTs be modified? Thus, we begin by providing an evaluative summary of the current research that supports the efficacy of standard treatment protocols with ethnic minority youth. Then we discuss theoretical and methodological approaches to developing culturally informed treatments. Challenges and recommendations to advance the treatment of disorders in ethnic minority youth are identified last with a special focus on clinical application today.

EVIDENCE FOR USING CURRENT TREATMENT PROTOCOLS WITH ETHNIC MINORITY YOUTH

There is some research evaluating the use of child and family treatment protocols with ethnic minority youth and we summarize selected studies in Table 4.1. In the table, we focus primarily on treatments for anxiety, depression, disruptive disorders, and attention-deficit/hyperactivity disorders (ADHD), but the conceptual issues discussed in the body of the chapter also are relevant to treatments for other problems and disorders (e.g., substance use, posttraumatic stress disorder). The purpose of the table is to report on treatments (e.g., cognitive and behavioral therapies [CBTs], interpersonal therapy) that have been successful in reducing symptoms and disorder rates in minority youth. In the table, we provide "exemplar" treatments for each major problem category and offer evidence for the utility of these treatments with minority youth. To this end, we provide a basic description of the research supporting each intervention, including treatment features (i.e., protocol, modality), participant characteristics (i.e., sample size, age, and ethnicity), and program effects data (primary and secondary outcomes).

Overall, our review indicates that encouraging evidence supports the use of certain procedures for targeting anxiety, depression, disruptive disorders, and ADHD among ethnic minority youth. With one exception (Arnold et al., 2003), studies have provided robust evidence that the identified treatments result in symptom reductions for Hispanic/Latino and African American youth at levels similar to what has been found for Caucasian youth. Approximately half of these studies relied on standard treatment protocols while the other half relied on treatments with at least some cultural consideration in program design and/or implementation.

In terms of cultural modifications in treatment design and implementation, there seems to be some variability in the degree of cultural consideration. Seven of the protocols use cultural attunement strategies to modify standard treatments. More specifically, six studies indicate that therapists were trained to be generally sensitive to the cultural background of the client (Garza & Bratton, 2005; Pina et al., 2003; Rossello & Bernal, 1999; Rossello et al., 2008; Szapocznik et al., 1989). The most basic and typical way therapists were sensitive to the targeted culture was by providing the treatment in the client's native language. In some cases, this was necessary for client participation in the treatment; in other cases, it served to enhance engagement by encouraging participation from parents or other family members who were less fluent in English. Often bilingual therapists were used to accommodate the possibility of differing language preferences within and across families (e.g., Garza & Bratton, 2005; Pina et al., 2012).

Culturally sensitive therapists also were charged with learning and understanding fundamental cultural values, norms, and customs associated with the client's ethnic background. Then this

TABLE 4.1 Summary of Evidence-Based Treatments for Ethnic Minority Youth

Treatment	Sample and Treatment Characteristics	Outcomes
Anxiety		
CBTs 1. Ferrell, Beidel, & Turner, 2004 2. Ginsburg & Drake, 2002 3. Pina, Silverman, Fuentes, Kurtines, & Weems, 2003 4. Pina, Zerr, Villalta, & Gonzales, 2012 5. Treadwell, Flannery-Schroeder, & Kendall, 1995	Studies utilized child-focused cognitive and behavioral protocols with varying degrees of parent involvement. Sample sizes ranged from 12 to 178 children (ages 6–17). Studies (1), (2), and (5) reported on African American children; studies (3) and (4) reported on Hispanic/Latino children.	The intervention resulted in significant reductions in child-, parent-, teacher-, and clinician-reported anxiety symptoms for Hispanic/Latinos, program effects were evidenced in terms of reductions in child-, parent-, and clinician-reported anxiety symptoms. Program-related reductions in child-reported depression and loneliness, parent-reported reductions in internalizing behaviors, and child-reported improvements in extraversion were found for African American youth in study (1). For Hispanic/Latinos, reductions in child-reported depression and parent-reported internalizing behaviors were evidenced in study (4).
Depression		
CBTs 1. Rosselló & Bernal, 1999 2. Rosselló, Bernal, & Rivera-Medina, 2008 3. Stark, Kaplinski, & Gudernatsen, 2009	Studies utilized child-focused cognitive behavioral protocols with varying degrees of parent involvement. Studies (1) and (3) delivered the intervention in individual format. Study (2) utilized both individual and group format. Sample sizes ranged from 50 to 112 youth (ages 12–18). Studies (1) and (2) focused on a sample of Hispanic/Latino youth living in Puerto Rico; study (3) reported on Hispanic/Latino and African American youth. Studies (1) and (2) were designed to compare interpersonal therapy and CBT for depression.	The intervention resulted in significant reductions in child-reported depression symptoms for Hispanic/Latino and African American youth. For Hispanic/Latinos, improvements in child-reported self-concept and parent-reported internalizing and externalizing behaviors were evidenced in study (2). Study (2) also found that reduction of depression symptoms, internalizing and externalizing behaviors, and improvements in self-concept were greater for Hispanic/Latino youth who received CBT compared to those who received interpersonal therapy.
Interpersonal Psychotherapy 1. Rosselló & Bernal, 1999 2. [illegible] et al., 2008	Studies utilized interpersonal therapy protocols with varying degrees of parent involvement. Study (1) delivered the intervention in individual format. Study (2) utilized both individual and group format. Sample sizes ranged from 71 to 112 youth (ages 12–18). Studies focused on a sample of Hispanic/Latino youth living in Puerto Rico. Studies (1) and (2) were designed to compare interpersonal therapy and CBT for depression.	The intervention resulted in significant reductions in child-reported depression symptoms for Hispanic/Latino youth living in Puerto Rico. In study (1), program-related improvements in child-reported self-concept and social adaptation skills were found for Hispanic/Latino youth who received interpersonal therapy compared to wait list controls. This was not the case for youth who received CBT.
Disruptive Disorders		
Multisystemic Therapy 1. [illegible] et al., 1995 2. [illegible], Melton, & [illegible], 1992	Studies utilized multisystemic therapy protocols delivered in family format. Sample sizes ranged from 84 to 176 youth (ages 12–17). Studies (1) and (2) reported on African American youth.	The intervention resulted in significant reductions in disruptive behavior problems in African American youth. Program effects were evidenced in reductions in arrests were reported for African American youth in studies (1) and (2). Program effects were also evidenced in reductions in total days incarcerated and child-reported criminal activity for African American youth in study (2).

TABLE 4.1 Summary of Evidence-Based Treatments for Ethnic Minority Youth (*continued*)

Treatment	Sample and Treatment Characteristics	Outcomes
		Program-related improvements in parent- and child-reported family cohesion and adaptability as well as observer-reported positive family interactions were also found for African American youth in study (1). Program-related improvements in child- and mother-reported family cohesion and peer aggression were found for African American youth in study (2).
CBTs 1. Hudley & Graham, 1993 2. Lochman & Wells, 2003 3. Lochman & Wells, 2004	Study (1) utilized cognitive intervention protocol delivered in group format. Studies (2) and (3) utilized a cognitive and behavioral intervention and included both child and parent components delivered in group format. Sample sizes ranged from 106 to 245 youth (fourth–sixth grade). Studies reported on African American youth.	The intervention resulted in significant reductions in disruptive behavior problems for African American youth. Program-related improvements in child-reported hostile attribution and teacher-reported aggressive behavior were evidenced for African American youth in study (1). Reductions in teacher-reported aggression were found for African American youth in study (2) and teacher-reported improvements in school behavior were evidenced for African American youth in study (3). Program-related decreases in child-reported substance use were found for African American youth who were older and had moderate risk in study (2). Program-related decreases in parent-reported child drug use were found for African American youth in study (3).
Brief Strategic Family Therapy 1. Santisteban et al., 2003 2. Szapocznik et al., 1989	Studies utilized brief strategic family therapy protocols delivered in family format. Sample sizes ranged from 79 to 126 youth (ages 6–18). Studies focused on samples of Hispanic/Latino youth.	The intervention resulted in significant reductions in parent- and child-reported disruptive behavior problems for Hispanic/Latino youth. Program effects were evidenced in improvements in parent-reported delinquency and aggression and reductions in child-reported drug use for Hispanic/Latino youth in study (1). In study (2), program effects were evidenced in reductions parent-reported behavior problems. Program-related improvements in observer-, parent-, and child-reported family functioning were also evidenced for Hispanic/Latino youth in studies (1) and (2). Child-reported improvement in self-concept was found for Hispanic/Latino youth in study (2).
Child-Centered Play Therapy Garza & Bratton, 2005	Study utilized a child-centered play therapy protocol delivered in individual format. Sample size consisted of 29 children (ages 5–11). Study focused on a sample of Hispanic/Latino children of Mexican descent.	The intervention resulted in significant reductions in parent-reported conduct problems for Hispanic/Latino youth. Program-related improvements in parent-reported internalizing and anxiety symptoms were found for Hispanic/Latino youth in the study.

Continued

TABLE 4.1 Summary of Evidence-Based Treatments for Ethnic Minority Youth (*continued*)

Treatment	Sample and Treatment Characteristics	Outcomes
Attention-Deficit/Hyperactivity Disorder		
Behavioral Treatment and Medication Management Arnold et al., 2003	Study was designed to compare behavioral intervention, medication management, and combined behavioral intervention and medication management. The medication management condition included daily parent ratings and regular doctor visits. The behavioral intervention had multiple components including parent training, full-time summer treatment program for youth, and use of a token economy. Sample size consisted of 579 children (ages 7–9). Study reported on Hispanic/Latino and African American youth.	The interventions resulted in differential program effects across ethnicity. Compared to Caucasian youth, African American youth evidenced significantly less reduction in teacher-reported attention deficit/hyperactivity and oppositional/defiant symptoms and Hispanic/Latino children evidenced significantly less reduction in parent-reported oppositional/defiant symptoms across all three treatment conditions in the study. Compared to the control condition, the behavioral intervention condition resulted in a significantly greater reduction in parent-reported oppositional/defiant symptoms for African American compared to Caucasian youth. Compared to the medication management condition, the combined behavioral intervention and medication management condition resulted in significantly greater reduction in parent-reported oppositional/defiant symptoms for Hispanic/Latino compared to Caucasian youth. Of note, all ethnic differences in outcomes were nonsignificant after controlling for an indicator of socioeconomic status.

knowledge was incorporated into the treatment protocol for delivery. For example, in their clinical trials of a CBT program for childhood anxiety, Silverman and colleagues (1999a, 1999b; also see Pina et al., 2003) trained clinicians in Hispanic and Caribbean conceptualizations of anxiety and coping styles, including on the heightened fears of the unknown and the use of folk healers (e.g., *curanderos*, *santeros*) to alleviate mental and physical health problems. Similarly, culturally attuned treatments targeting depression in Puerto Rican youth have trained clinicians to be sensitive to the cultural emphasis on the family as a source of support and also the value of absolute parental authority and respect (Rosello & Bernal, 1999; Rosello et al., 2008; Shirk et al., 2009). By acknowledging the unique role family may play in treatment of this particular cultural group, therapists can strengthen the positive aspects of these values and address associated challenges that may arise (e.g., an extended period of dependence on parents) (Rosello & Bernal, 1999). The infusion of cultural values and beliefs in this way serves to enhance the relevancy and appeal of the treatment materials and content to ethnic minority youth and their families, thereby boosting engagement and retention in the treatment program.

As described, cultural attunement can also be accomplished through the inclusion of culturally relevant add-ons to standard treatment protocols. Such add-ons typically involve incorporating culturally salient themes or elements into the treatment. Szapocznik and colleagues (1989), for example, included a Bicultural Effectiveness Training component to the standard Family Effectiveness Training protocol in their treatment of disruptive disorders in Hispanic/Latino youth.

Recognizing that varying degrees of acculturation within families may elevate intergenerational conflict, this addition incorporated bicultural skills, such as developing a shared worldview, aimed at reducing the cultural conflict that can occur as each member experiences his or her own cultural change. The addition of culturally attuned materials is also helpful in improving treatment engagement. For example, Garza and Bratton (2005) provided multicultural toys in their play therapy protocol to treat disruptive disorders in Mexico-origin youth. Culturally relevant toys such as dolls with darker skin tones and games (e.g., Loteria) were selected based on input from five Hispanic, Spanish-speaking play therapists.

Whereas culturally attuned add-ons for Hispanic youth emphasize language, customs, and values respected by one's country of origin, treatments for African American youth typically have highlighted contextual experiences that occur within the immediate ecological framework. Ginsburg and Drake (2002), for instance, incorporated specific examples of stressors often faced by low-income African American communities into their standard CBT protocol for anxiety with African American youth. Situation examples were modified to include experiences often faced by this population, such as neighborhood crime and financial hardship. Just as a culturally sensitive therapist enhances the appeal of the treatment, the use of these culturally relevant add-ons ensures that the content is engaging and directly applicable to situations likely to occur in the everyday life of certain ethnic minority youth. Despite variability in the degree and manner of culturally sensitive modifications, each of the identified culturally attuned treatments was found to be effective in improving targeted outcomes (i.e., anxiety, depression, disruptive behaviors) in ethnic minority youth.

Notably, none of the studies in the current review was consistent with current conceptualizations of a culturally adapted treatment protocol as defined herein. In fact, our review of the literature found only one study that moved beyond cultural attunement and met criteria for the culturally tailored category. Pina and colleagues (2012) used a culturally prescriptive strategy in their implementation of CBT for Hispanic/Latino children with anxiety. This approach allowed therapists to include Hispanic/Latino cultural values, traditions, and customs that are relevant to each client on an individual basis. For example, in addition to providing services in Spanish, as needed, the therapists were encouraged to share culturally relevant anecdotes and incorporated Hispanic/Latino sayings (*dichos*) into sessions for families with low acculturation. This approach was theoretically and empirically driven by the understanding that not all minority youth will be equally responsive to a one-size-fits-all approach to applying culturally sensitive psychosocial treatments (Pina, Villalta, & Zerr, 2009).

It is noteworthy that over half of the studies we highlight in Table 4.1 did not include any cultural considerations when delivering the evidence-based protocol to ethnic minority youth. Still, improvements in treatment outcomes were observed in these studies, as in the studies that included cultural considerations. As such, it is likely that not all treatments require an inclusion of culture to successfully treat ethnic minority youth. This is consistent with the idea that not all ethnic minority clients need a treatment that considers culture. However, little is known about factors that may influence whether a standard treatment will have equivalent effects for minority youth. One study we reviewed in Table 4.1 examined socioeconomic status (SES) as a factor that may elucidate ethnic differences in program outcomes. Arnold and colleagues (2003) found differences in treatment effects across Hispanic/Latino, African American, and Caucasian youth, such that the reduction in ADHD and oppositional symptoms experienced by minority youth was significantly less than that exhibited by Caucasian youth. However, ethnic group differences became nonsignificant after controlling for SES. It may be the case that the extent to which cultural considerations should be applied to current treatments varies as a function of unexamined factors that may or may not be linked to ethnic background, such as SES or acculturation level.

Overall, the studies reviewed herein suggest that aspects of EBT appear to be appropriate for use with ethnic minority youth and demonstrate that some treatment protocols that consider the unique needs and cultural values of ethnic minorities are beneficial in reducing symptoms in youth. Although this emerging research shows progress in efforts to identify effective and efficacious treatments for minority youth, a closer examination of the research does suggest that additional work is needed to fully understand the extent to which aspects of EBT are most and least appropriate for use with minority groups.

INTEGRATING CULTURE IN THE TREATMENT OF DISORDERS IN ETHNIC MINORITY YOUTH

Despite the promising effects of using current EBTs with ethnic minority youth, there is evidence to suggest that treatment efforts need to be strengthened, particularly for ethnic minority or culturally diverse child populations. For example, Cardemil, Reivich, and Seligman (2002) implemented a cognitive and behavioral treatment for depression with low-income African American and Latino children. In their study, the original structure of the program was maintained but materials were culturally attuned. Fewer depression symptoms, negative automatic thoughts, and hopeless thoughts were found immediately following the treatment program for Latino youth, including at the 6-month follow-up. In addition, at the follow-up only, Latino youth evidenced higher self-esteem compared to controls who received no treatment. For African American youth, findings were not encouraging. There were no differences between the treatment and control conditions on any of the measures or at any measurement point. At the 2-year follow-up (Cardemil, Reivich, Beevers, Seligman, & James, 2007), Latino youth showed program-related gains but African American youth did not.

In another study focusing on African American youth, Cooley, Boyd, and Grados (2004) and Cooley-Strickland, Griffin, Darney, Otte, and Ko (2011) modified the FRIENDS for Life program (a cognitive and behavioral preventive intervention program for anxious youth) to be used with African American youth living in an urban setting. Modifications focused on replacing references specific to Australian culture and including examples relevant to the contexts of inner city African American youth. In their trial, Cooley-Strickland et al. (2011) found no statistically significant program differences on any of the primary outcome variables including anxiety symptom levels (not even for those children with higher levels of pretest community violence exposure or as a function of child's sex) compared to wait-list controls.

Despite efforts made to develop culturally robust treatment programs, overall findings suggest there is still room for improvement. This appears to be true when it comes to African American children in particular (e.g., Cardemil et al., 2002; Cooley-Strickland et al., 2011). In contrast, the evidence for Latino youth seems to be more encouraging (e.g., Cardemil et al., 2002). It is important to highlight, however, that the literature is limited and predominantly exploratory in nature, with studies often lacking adequate statistical power. Moreover, these findings cannot be considered to be robust across cultures and subcultures as the research examining treatments for anxiety, depression, disruptive disorders, and ADHD has focused entirely on African American and Hispanic/Latino youth. Conclusions cannot be made about the utility of current treatments with other ethnic minority groups, such as Asian or Native American youth. Further, the use of broad ethnic categories (e.g., Hispanic/Latino versus Mexican American or Puerto Rican) to describe participants can be problematic, given variations that exist within ethnic minority groups.

TOWARD EBTS WITH ETHNIC MINORITY YOUTH: THEORY-BASED APPROACHES

Moving forward, it appears that three important questions need to be considered when it comes to culture. First, do current EBTs need to be modified for use with ethnic minority youth? Second, what elements of EBTs should be modified for ethnic minority youth? And third, for whom (what subgroups of ethnic minority youth) should EBTs be modified? An appraisal of the research literature suggests that cultural modifications are indeed warranted, as certain minority youth segments do not seem to benefit as much as their counterparts from treatment efforts considered efficacious. In terms of identifying which treatment components should be targeted in the modification process and what subgroups need to receive adapted treatments, research has yet to sufficiently examine and pinpoint the process of successful cultural modification (beyond language). Although it is clear that additional research is needed to further develop answers to these questions, theory on cultural modifications can be used to guide current practice as well as future research.

In the absence of empirical evidence to determine if and when cultural modifications are necessary, several models recently have emerged that are designed to guide a clinician or researcher through the process of culturally adapting a standard EBT (Barrera & Castro, 2006; Kumpfer, Pinyuchon, Melo, & Whiteside, 2008; McKleroy et al., 2006; Wingood & DiClemente, 2008). At the core of each of these models is an emphasis on combining both theory and data to determine whether a cultural adaptation is needed and what components should be adapted. For instance, Lau (2006) cautions against haphazardly modifying all EBTs for all ethnic minority clients and instead articulates the use of selective and directed modification strategies. The selective approach requires that there be evidence of a lack of fit between a particular treatment protocol and the targeted population. That is, a cultural modification may be warranted if there is evidence of group-specific risk and resilience processes that influence the development, maintenance, and/or amelioration of the targeted clinical problem, or characteristics that might limit engagement in the particular treatment protocol. If modifications are merited, the directed nature of Lau's approach stresses the use of data to establish and design the specific treatment modifications based on the identified group-specific qualities.

Efforts to outline the process of integrating culture into standard EBTs focus on whether and how cultural adaptations should be conducted (Barrera & Castro, 2006; Kumpfer et al., 2008; McKleroy et al., 2006; Wingood & DiClemente, 2008). A related, but often separate, body of work concentrates on which treatment parameters should be adapted and for whom. Resnicow, Baranowski, Ahluwalia, and Braithwaite (1999) and Resnicow, Soler, Braithwaite, Ahluwalia, and Butler (2000) conceptualize adaptation as happening on two levels: surface structure and deep structure. At the surface structure level, adaptations focus on adjusting the treatment materials and messages to be consistent with and relevant for the targeted minority group. This is consistent with cultural attunement defined at the beginning of this chapter. Resnicow et al. (2000) suggest that surface structure adaptations are akin to face validity of empirical measures, indicating that modifications at this level are based on observable and often superficial cultural characteristics, such as language. As such, surface-level adaptations address issues related to how a specific ethnic or cultural group will receive and engage with the treatment (Simons-Morton, Donohew, & Crump, 1997). To this end, surface structure adaptation ensures feasibility of the modified EBT. Deep structure adaptations, in contrast, determine program impact by focusing on making the treatment salient to the targeted group (Resnicow et al., 2000). This type of adaptation is complex and requires a thorough understanding of the group's cultural values, norms, and stressors (e.g., historical, environmental,

social, and economic). In deep-structure adaptations, these cultural factors are considered in terms of how they influence the development and treatment of the targeted mental health issue. Currently, culturally adapted EBTs have focused on surface structure modifications; however, it is generally agreed that deep-structure adaptations may be necessary to successfully reach certain populations of minority youth.

CONCLUSIONS AND CLINICAL RECOMMENDATIONS

Theory and research relevant to the treatment of ethnic minority youth with problems related to anxiety, depression, disruptive disorders, and ADHD are growing, with empirical work suggesting that some current EBTs are successful in reducing symptoms and disorder rates in Hispanic/Latino and African American youth. However, research remains scant on the appropriateness of using EBTs with other ethnic minority groups (e.g., Asian American, Native American) and with specific subcultural groups (e.g., Dominicans, Haitians, Navajo). Moreover, there is a lack of sufficient evidence to indicate whether current treatment protocols should be modified for use with ethnic minority youth as well as which treatment elements should be modified and for whom modifications are necessary. Additional research efforts are needed to evaluate and refine treatment protocols for ethnic minority youth with a focus on identifying individual, cultural, and contextual factors that may influence efficacy. As these data accumulate, findings are likely to show the degree to which culture-related treatment modifications are warranted for specific treatments (e.g., depression) and selected populations (e.g., less acculturated Mexican immigrant adolescents undergoing discrimination stressors). As the field continues to work toward a deeper understanding of the extent to which aspects of EBTs are appropriate for use with minority youth, clinicians currently working with minority children and families should strive to provide services in a culturally competent manner. To this end, it is important that clinicians stay abreast of empirical advancements in EBTs with minority populations and utilize cultural modifications when there is evidence to do so. In the absence of research supporting culture-specific treatments and/or modifications, it is recommended that clinicians implement the standard EBTs with an awareness of and sensitivity to the cultural background of the individual client. This awareness includes knowledge of cultural characteristics relevant to the presenting problem as well as treatment engagement and participation. Clinicians should be cognizant of their own preconceived notions related to specific ethnic groups and make every effort to avoid making assumptions about the values, beliefs, and preferences of ethnic minority clients based on nondata. As clinicians increase their level of cultural competence and research moves toward the development of culturally appropriate EBTs, greater progress can be made to improve the mental health of ethnic minority children and families in the United States.

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