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State of the Science on Psychosocial Interventions for Ethnic Minorities

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INTRODUCTION

According to a recent report of the Surgeon General (U.S. Department of Health and Human Services 1999), a range of treatments exist for most mental disorders, and the efficacy of those treatments is well documented. However, a supplement to that report (U.S. Department of Health and Human Services 2001) notes that minorities are largely missing from the efficacy studies that make up the evidence base for treatments. Because of this omission, questions arise as to whether it is appropriate to advocate for providing evidence-based care for minority populations. Do efficacious treatments generalize to minority populations? Should we adapt care for each cultural group? Does poverty affect outcomes of care? If we were better able to encourage ethnic minorities to enter care, would outcomes be similar to those found for majority patients? New data have become available regarding the impact of mental health interventions on ethnic minorities. Although data are not available to answer each question posed above, we examine what is known about outcomes of mental health treatments for ethnic minorities and begin to answer these important questions about providing care to our growing and diverse ethnic minority populations.

Outcomes of mental health care are obtained through two types of research, efficacy and effectiveness studies. Efficacy studies, or randomized, controlled trials, are useful in identifying the outcomes that are likely to be associated with precisely defined care provided by experts. These studies identify the impact of interventions on outcomes, such as decreases in psychiatric symptoms and remission of syndromes. The goal of efficacy studies is to determine whether or not an intervention works for a specific syndrome. Thus, the populations studied need to meet criteria for that syndrome and be relatively free of comorbid disorders. Furthermore, highly trained, specialized clinicians provide the care under carefully specified conditions. To date, these studies have predominantly been conducted in nonminority populations; well-controlled efficacy studies examining outcomes of mental health care for minorities are rarely available. In fact, in an analysis conducted for the report of the Surgeon General entitled “Mental Health: Culture, Race and Ethnicity” (U.S. Department of Health and Human Services 2001), it was found that of 9266 participants involved in the efficacy studies forming the major treatment guidelines for bipolar disorder, schizophrenia, depression, and attention deficit/hyperactivity disorder (ADHD), only 561 Black, 99 Latino, 11 Asian American/Pacific Islanders, and zero American Indians/Alaskan Natives were included. Few of these studies had the power necessary to examine the impact of care on specific minorities. In this chapter, we examine available data from treatment outcome studies with minorities.

Effectiveness studies are also important when thinking about outcomes of psychosocial interventions because these studies help evaluate outcomes of care given in real-world settings. Once an intervention is found to be efficacious, effectiveness studies then determine how they work within more diverse (both in terms of diagnosis and comorbidities) populations and when given by less-specialized clinicians. Clinicians in effectiveness studies are more likely to be generalists working in clinical settings. Outcomes often include factors such as whether or not care is sought, length of care, and adequacy of interventions. In addition, because of generally larger sample sizes, some of these trials are able to examine outcomes associated with not only symptom reduction, but also with functioning, quality of life, and cost effectiveness of care. Newer studies tend to include more diverse samples and a few have specifically included a minority sample. Again, we examine data available for minorities and compare outcomes with nonminority samples.

OUTCOME OF MENTAL HEALTH CARE FOR CHILDREN AND YOUTH

Efficacy Studies of Children and Youth

Studies documenting efficacious interventions for mental disorders experienced by children and youths are available in four major areas: depression, anxiety disorders such as phobias and obsessive compulsive behaviors, attention deficit hyperactive disorder, and disruptive behavior disorders. We briefly review these studies below.

DEPRESSION—Cognitive behavioral therapy (CBT) has been established as an effective treatment for depression in both children and adolescents. Stark and colleagues (1987, 1991) have documented that CBT is effective for decreasing symptoms of depression and anxiety in preadolescents and that outcomes are enhanced with conjoint family meetings. Brent and colleagues (1997) have documented superior effects of CBT over systematic brief family

therapy in treating adolescent depression. CBT interventions have been developed for use in groups in school settings (Clarke et al. 1992, Lewinsohn et al. 1996), and have documented not only reductions in depression, but also improved cognitive functioning and increased activity levels for treated versus control participants.

No studies published to date examine the relative effects of CBT for reducing depression among different ethnic groups. However, some evidence demonstrates that culturally sensitive applications of CBT can be successful with youths from diverse cultural backgrounds. Rosselló & Bernal (1999) conducted the first randomized, controlled trial to examine interventions specifically adapted to Latino adolescents living in Puerto Rico. In this trial, 71 Puerto Rican adolescents with depression were randomly assigned to CBT, interpersonal therapy, or wait-list control. Considerable work was conducted prior to this trial to culturally adapt both of the psychotherapies to include such factors as *familism* and *respeto* within the interventions (Bernal et al. 1995). More recently, J. Rosselló & G. Bernal (manuscript submitted) completed a second trial of CBT and IPT, comparing individual and group formats of each therapy for the treatment of depression in adolescents. A total of 112 Puerto Rican adolescents were randomized to four conditions and assessed at pretreatment, posttreatment, and at a three-month follow-up. The results indicated that both CBT and IPT in group and individual formats were effective in reducing depression symptoms. However, CBT produced significantly greater decreases in depression symptom scores than did IPT. Outcomes of care were generally similar to those found in the literature in terms of amelioration of depressive symptoms. Specifically, the effect size (or amount of improvement in symptoms) was similar to that found in two meta-analytic studies (Casey & Berman 1985, Weisz et al. 1987). Both treatments resulted in improvements in depressive symptoms. In addition, Latino youths receiving the IPT also improved self-esteem and functioning.

ANXIETY—CBT and behavioral models have received the most empirical support in the treatment of childhood anxiety disorders. Kendall's Coping Cat intervention (Kendall 1994) incorporates skills training, exposure, and practice in the treatment of separation anxiety and generalized anxiety. Several randomized, controlled trials of this intervention have been conducted, with positive results published by at least two different research teams (Barrett et al. 1996, Kendall 1994, Kendall et al. 1997). Long-term follow-up has indicated that treatment gains were maintained 7.4 years posttreatment, with some positive impact on the sequelae of anxiety, including substance abuse (Kendall et al. 2003). Mixed evidence supports incremental treatment gains with adjunctive family-based CBT interventions in reducing child anxiety (Barrett et al. 1996). Some preliminary evidence demonstrates the efficacy of CBT in reducing child anxiety when delivered in a group format (Shortt et al. 2001, Silverman et al. 1999).

An emerging literature suggests the treatments mentioned above may be effective for minority youths. A recent pilot study has demonstrated the efficacy of Silverman's school-based group CBT intervention for anxiety in a small sample of low-income African American adolescents (Ginsburg & Drake 2002). In this study, some modifications were made to the manualized protocol to be culturally sensitive. Specifically, examples were modified to include experiences that this population was likely to encounter, including

neighborhood crime and violence, issues related to stepparents, and financial hardship. Despite these modifications, the key CBT treatment ingredients were preserved including psychoeducation about anxiety and CBT, relaxation exercises, cognitive restructuring, and exposure to fear hierarchies using contingency contracts and self-rewards. Compared to youths assigned to an attention-support condition, youths receiving CBT were more likely to be free of their pretreatment anxiety disorder diagnosis as well as to have lower levels of anxiety symptoms.

Two published studies have explored potential ethnic differences in response to CBT for childhood anxiety. First, Treadwell et al. (1995) examined potential ethnic and gender differences CBT interventions delivered at the Child and Adolescent Anxiety Clinic at Temple University. In this study, 89% of participants were Caucasian and 11% were African American. Using a mixed-factorial repeated measures analysis of variance, they found no significant interaction between ethnicity and assessment period, which indicated that improvements in symptomatology, fears, and worries held across ethnic groups. Second, Silverman et al. (1999) conducted a randomized trial assigning youths to either CBT for childhood anxiety disorders or a wait list control with a sample that was 46% Latino and 46% white (with the remainder coming from other ethnic groups). Their longitudinal analyses found no significant interaction of treatment condition (group CBT versus wait list control) by time (pre vs. post) by ethnicity (Hispanic versus white). Over time, the response of Latino youths to CBT treatment for childhood anxiety disorders was similar to that of nonminority youths.

Two recent studies containing minority populations have examined treatments for depressed adolescents. First, the Treatment for Adolescents with Depression Study Team (2004) compared fluoxetine alone, CBT alone, fluoxetine with CBT, and placebo in treatment of 12- to 17-year-olds with major depressive disorder. In this study, 12.5% of participants were black and 8.9% were Hispanic. Overall results indicate that the combination of fluoxetine with CBT was superior to either fluoxetine or CBT alone. Furthermore, fluoxetine alone was superior to CBT alone. No results are presented comparing response to depression care of the minority youths as compared with the nonminority youths. In the second study, IPT adapted for depressed adolescents was compared with care as usual in five school-based mental health clinics in New York City. In this low-income sample, 71% of the students were Latino. Results indicate that the IPT delivered in school-based clinics was superior to treatment as usual for reducing depressive symptoms and improving functioning in depressed adolescents.

ATTENTION DEFICIT HYPERACTIVE DISORDERS—Although this review is focused on the efficacy of psychosocial interventions, we would be remiss in omitting a brief discussion of psychopharmacologic interventions for attention deficit hyperactive disorder (ADHD). Multiple well-designed studies now show that ADHD can be treated effectively with psychostimulants for 75% to 90% of children. These medications have resulted in substantial improvement in hyperactivity, impulsivity, inattention, defiance, aggression, oppositionality, and classroom behavior, as well as increased interaction with teachers, parents, and peers (see reviews by Barkley 1990, Greenhill et al. 1998, Pelham 1993, Swanson et al. 1995). However, they have not been shown to achieve long-term

changes in outcomes such as peer relationships, social or academic skills, or school achievement (Pelham 1998).

Behavioral and family interventions: Psychosocial treatments for ADHD have also been evaluated. Randomized trials have documented the efficacy of behavioral intervention programs of intensive contingency management conducted in specialized classrooms or summer camps (Abramowitz et al. 1992, Pelham & Hoza 1996). Empirical support also exists for the efficacy of parent training in contingency management techniques for ADHD, such as positive reinforcement, response cost, and/or time-out strategies (Anastopoulos et al. 1993, Pisterman et al. 1992, Pollard et al. 1983). Disagreement exists regarding whether behavioral interventions for ADHD contribute to outcomes beyond those provided by psychostimulants.

Findings from the recently completed Multimodal Treatment of ADHD (MTA) study have shown that the efficacy of behavioral approaches to the treatment of ADHD depends largely on the type and context of the outcome being assessed (MTA Cooperative Group 1999, Swanson et al. 2002). When assessing changes in ADHD symptomatology, stimulant combined with behavioral parent training intervention was no better than a rigorously controlled medication regimen. However, when outcome assessment included measures of functional impairment (e.g., family functioning), combined treatment yielded greater therapeutic benefits than did stimulants alone. In addition, children with comorbid anxiety benefited more from combined treatment than from psychostimulant treatment alone.

The large, multisite MTA study was able to evaluate ethnic differences in response to treatment. Ethnic minority families were found to have similar rates of engagement and satisfaction with either medication or behavioral treatment, as did nonminority families. Because ethnic representation was confounded with treatment site in the study, a matched-pair strategy, controlling for site, treatment group, and sex, was used to evaluate outcomes of care. African American and Latino children were randomly matched to Caucasian participants from the same site, of the same sex, and in the same treatment group. Successful matches were available for 92 (out of 115) African Americans and 37 (out of 49) Latinos. Findings revealed overall outcome differences (across treatment groups) in teacher-rated ADHD and oppositional defiant disorder (ODD) symptoms between African American and matched control Caucasian participants, and an overall difference in parent-reported ODD symptoms between Latino American and matched Caucasian controls. In all cases, minority groups were rated as more symptomatic posttreatment. At one treatment site, a three-way ethnic comparison was possible and indicated an ethnic difference on teacher-rated ODD favoring Caucasians and disfavoring African Americans. However, none of these ethnic differences was significant after controlling for socioeconomic disadvantage (as measured by reliance on public assistance).

DISRUPTIVE DISORDERS—Several strategies exist for the treatment of disruptive disorders in children and youths. Interventions include parent management training, multisystemic therapy, CBT, and structural family therapy.

Parent management training: Several randomized, controlled trials of psychosocial interventions demonstrate that disruptive disorders, such as ODD or conduct disorder, respond well to behavioral interventions. Many of the well-established treatments are parent management-training programs that focus on teaching parents behavioral strategies to reduce target behaviors such as temper tantrums, noncompliance, aggression, defiance, stealing, and destruction of property. Examples of efficacious parenting programs include the Living with Children Program (Patterson et al. 1975), the Incredible Years group discussion/videotape modeling program (Webster-Stratton 1981), parent-child interaction therapy (PCIT; Eyberg & Robinson 1982), the Helping the Noncompliant Child program (Forehand & McMahon 1981), and the Delinquency Prevention Program (Tremblay et al. 1992). These programs share similar goals, procedures, and assumptions, and yield similar therapeutic outcomes (Lonigan et al. 1998).

Recently, studies have examined ethnicity as a potential moderator of mental health outcomes that result from parent management-training programs. Barrera et al. (2002) evaluated the effectiveness of the Schools and Homes Partnership (SHIP) program in a sample of 168 Latino and 116 Caucasian families with young children with aggression and/or reading problems. Families were randomly assigned to the intervention program or to an assessment-only control condition. The intervention encompassed several components, including parent training using the Incredible Years Parenting Program (Webster-Stratton 1992); the Dina Dinosaur Social Skills Program, a young children's social skills intervention that uses puppets and videotaped modeling to teach appropriate classroom and social behavior (Webster-Stratton 1992); a classroom-based contingency-management system for academic and social skills (Hops & Walker 1988); and supplemental reading instruction. At one-year follow-up, the intervention had beneficial effects on directly observed negative social behavior as well as on parent- and teacher-rated internalizing behavior problems and parent-reported coercive and antisocial behavior. Only one clear interaction between the intervention and ethnicity was found: The intervention appeared to show beneficial effects of teacher-rated internalizing problems for Caucasians but not for Latino children. Overall, the intervention was as successful in decreasing conduct problems for Latino children as it was for Caucasian children.

PCIT was recently augmented to treat physically abusive parents, with the ultimate goal of changing abusive behavior rather than targeting child conduct problems. This randomized trial found that PCIT—either as originally developed or as enhanced to address parental depression, marital distress, domestic violence, or parental substance abuse—reduced parental physical abuse during the following two years (19% versus 49%) when compared with standard community group treatment. The sample included 110 families; 52% were Caucasian, 40% were African American, and 8% were from other ethnic groups. The investigators found no significant moderation of intervention condition effects by parent race (Caucasian versus other).

In a study that was unusual in that it included sufficient numbers of four ethnic groups, Reid et al. (2001) evaluated the effectiveness of the Incredible Years Parenting Program with a low-income sample of 370 Caucasian, 120 African American, 71 Latino, and 73 Asian American mothers whose children were enrolled in Head Start. Head Start centers were

randomly assigned to an experimental condition (8–12 weeks of weekly two-hour parenting classes) or a control condition (regular Head Start without parenting classes). Families were assessed at baseline, posttreatment, and one-year follow-up. According to both home observations and parent reports, treated parents were more positive, consistent, and competent, and less critical, in their parenting. Children of intervention parents exhibited fewer behavior problems than did control children. Ethnic differences in treatment effects were few and did not exceed those expected by chance.

One published study examined the efficacy of a parent management training intervention specifically developed to be responsive to the needs of Latino families by addressing cultural issues. Pantin and colleagues (2003) evaluated the *Familias Unidas* program, a group intervention supplemented by home visits. *Familias Unidas* was designed to reduce antisocial behavior and drug abuse by targeting family conditions associated with these outcomes. The three stages of the program focus on (*a*) treatment engagement, (*b*) promoting parental investment in adolescents' three primary worlds (family, peers, and schools), and (*c*) fostering parenting skills necessary for decreasing adolescent behavior problems and increasing academic achievement. Findings suggested that the intervention performed well in improving parental investment and reducing adolescent behavior problems, but did not affect academic achievement.

Multisystemic therapy: Multisystemic therapy (MST) is an intensive family- and community-based treatment for adolescents with severe willful misconduct that places them at risk for out-of-home placement. Based on the findings from eight published outcomes studies (seven randomized and one quasi experimental), MST has demonstrated considerable promise in the treatment of youths with criminal behavior, substance abuse, and emotional disturbance. Three randomized trials have been conducted with chronic and violent juvenile offenders (Borduin et al. 1995; Henggeler et al. 1992, 1997), one with substance-abusing juvenile offenders (Henggeler et al. 1999a), one with youths presenting in psychiatric crises (i.e., suicidal, homicidal, or psychotic) (Henggeler et al. 1999b), one with adolescent sexual offenders (Borduin et al. 1990), one with maltreating families (Brunk et al. 1987), and one with inner-city delinquents (Henggeler et al. 1986). Several follow-up studies have found that MST can prevent psychiatric inpatient hospitalization and is related to increased family cohesion, decreased youth aggression in peer relations, and fewer re-arrests at four-year follow-up as compared with individual therapy.

MST has been assessed in samples primarily composed of African American and Caucasian adolescents. No differential treatment effects by ethnicity have been found for posttreatment arrests (Borduin et al. 1995), incarceration, youth-reported delinquency (Henggeler et al. 1992), and suicide attempts (Huey et al. 2004).

Cognitive behavioral treatment: More limited support has been found for the use of CBT interventions aimed at reducing aggression in children. A few studies have implemented CBT with samples comprised primarily of African American boys. For example, Lochman and colleagues (1993) evaluated the efficacy of a school-based social skills training program for African American boys and reported that the intervention was effective in reducing aggression and peer rejection among aggressive and rejected boys. Hudley & Graham

(1993) evaluated an attributional intervention with aggressive African American boys and found that the treatment was effective in decreasing hostile attribution tendencies in children and improving teacher-rated aggression relative to control conditions. A third study, by Dubow et al. (1987), indicated that CBT training was superior to behavioral training or cognitive training alone for reducing teacher-rated aggression and increasing prosocial behavior in a sample of 104 school-aged aggressive boys, 70% of whom were African American or Latino. These investigators recomputed their results for the African American children only and yielded similar results to those reported for the entire sample; thus, they concluded that race had no significant effect on outcome.

Structural family therapy: The efficacy of structural family therapy for Latino youths with conduct problems has also been evaluated. In a study of 69 six-to twelve-year-old Hispanic boys with emotional and behavioral problems, Szapocznik et al. (1989) reported that structural family therapy was superior to a control condition in improving ratings of child functioning, and was also superior to child psychodynamic therapy in improving family functioning at one-year follow-up. The investigators conducted extensive work on Cuban family values to inform their treatment (Szapocznik et al. 1978, 1979). The therapists were predominantly Latino and the treatment could be conducted in Spanish. More recently, Santisteban and colleagues (2003) extended these findings by demonstrating the efficacy of brief structural family therapy in the treatment of externalizing behavior problems and substance use among Latino adolescents. The intervention was compared to a group condition designed to control for attention, support, and drug abuse information. The family intervention was superior to the control condition in reducing parent- and youth-reported conduct problems, peer-based delinquency, and youth-reported drug abuse at posttreatment.

Preventive Interventions with Minority Children and Youths

Several preventive intervention studies have focused on minority youths. These studies include populations of Latino, African American, and Chinese children who do not have psychiatric disorders but are considered at risk for developing mental disorders.

INFANT-PARENT PSYCHOTHERAPY—Latina mothers from Mexico and Central America (n = 100), all of whom had been residents of the United States for fewer than five years and were of low socioeconomic status, took part in an intervention to improve the infant-mother attachment bond (Lieberman et al. 1991). Anxiously attached 12-month-olds and their mothers, as assessed in the strange situation task, were randomly assigned to an intervention and a control to test the hypothesis that infant-parent psychotherapy can improve the quality of attachment and social-emotional functioning of the children. Securely attached dyads comprised a second control group. The intervention ended when the child was two years old. The treated toddlers scored higher in partnership with mothers, and the mothers were rated as more empathetic and engaging with their children than were the anxious controls. Following the intervention, the treated groups did not differ from the secure control group on any measure.

CUENTO THERAPY—Studies have been conducted with poor New York City Latino children (Costantino et al. 1986) and adolescents (Constantino et al. 1988, Malgady et al.

1990) to examine the impact of using *cuentos*, or Puerto Rican folk tales or biographies, to improve self-concept of children at risk for problems. In the first study, 210 children (primarily Puerto Ricans) in kindergarten through grade 3 were identified by teacher ratings as in the bottom half of the class in adaptive behavior. Of those identified, 48% participated. Children and their mothers were randomly assigned to attend sessions as follows: (*a*) original folk tales were read, (*b*) the original folk tales adapted to reflect adjustment in the United States were read, (*c*) art/play therapy was conducted, or (*d*) no intervention occurred. Modest improvements in anxiety were achieved and maintained through one-year follow-up. The adapted cuento therapy was most effective, followed by the original cuento therapy.

In an additional study of New York City Latinos (primarily Puerto Rican and Dominican), adolescent students were screened for anxiety symptoms, conduct problems, and phobic concerns (none met diagnostic criteria), and 30 were randomly assigned to treatment or control. The treatment group examined Hispanic thematic pictures, then discussed the situation in the picture as a group, and finally were encouraged to discuss personal feelings, followed by acting out the picture story. After eight weeks, the groups did not differ on depression, but the intervention participants had lower anxiety and phobic symptoms, and improved behavioral conduct in school.

In the third study, 90 Puerto Rican eighth and ninth graders were randomly assigned to (*a*) groups where biographies of successful Puerto Ricans were read, discussed, and acted out over 18 sessions, or to (*b*) a control group that met for 8 sessions to discuss current events. Students were identified by teacher ratings as in the bottom half of their class in terms of behavior problems. At the end of treatment, students did not differ in symptoms of psychological distress, but the intervention students in eighth grade reported fewer anxiety symptoms. Gains were also made in ethnic identity and self-concept by the intervention students, but this was complexly related to gender and the presence or absence of fathers in the homes.

FAMILY (BICULTURAL) EFFECTIVENESS TRAINING—Szapocznik and colleagues (1984, 1986, 1989) have developed a family-oriented intervention to enhance bicultural skills in family members in order to manage within-family cultural differences and to prevent conflict and youth conduct problems. Szapocznik et al. (1989) examined the efficacy of bicultural effectiveness training compared with a minimal contact control condition among 79 Latino families with a six- to twelve year-old child with behavioral difficulties. The treatment, which was delivered over the course of 13 weeks, included a bicultural training experience aimed at helping deal with intergenerational conflict brought about through migration. Families getting treatment showed significantly greater improvement on measures of family functioning and youth problem behaviors as reported by parents, but no long-term follow-up data on substance abuse prevention is available. The results of another published controlled trial indicated that this intervention for families with adolescents with behavioral problems was as effective as structural family therapy in bringing about improvement in adolescent and family functioning (Szapocznik et al. 1986).

OPTIMISTIC CHILD INTERVENTION—The interventions described above were specifically intended to prevent problems associated with minority status and/or migration-

related stresses. A few controlled prevention trials have been carried out to study prevention of a clinical syndrome, depression, in white youths. Jaycox et al. (1994) and Gillham et al. (1995) reported that a school-based intervention program aimed at improving optimism was able to reduce depressive symptoms in predominantly middle-class white prepubescent school children for as long as two years after the intervention. Clarke et al. (1995) reported that a similar program for adolescents reduced the incidence of unipolar depressive disorder in half in comparison with a control group.

Recently, studies have examined the impact of the "Optimistic Child" prevention intervention on minority youths. Each of the studies described below retained the intervention found to be effective in reducing depressive symptoms in middle-class white youths, but the intervention was modified to be relevant to the minority and lower-income populations studied. The Optimistic Child intervention was studied in two Philadelphia schools, and outcomes were examined for 23 Latino intervention participants compared with 26 Latino controls. The intervention was effective in reducing depressive symptoms at postintervention and six-month follow-up. In the second school, 47 African Americans assigned to the preventive intervention were compared with 56 African American youths assigned to the control condition. No differences were found between African American intervention and control participants. A similar intervention was also examined in 220 Mainland Chinese children selected for depressive symptoms and family conflict. The children randomly assigned to the intervention reported lower depressive symptoms at post, three- and six-month follow-ups. Failure to find the effect of lower symptoms of depression following the optimism intervention for the African American youths is not well understood.

AMERICAN INDIAN SUBSTANCE ABUSE PREVENTION—In our review of the literature, we were unable to find any studies evaluating outcomes of mental health care for American Indians/Alaskan Natives. Although treatment of substance abuse per se is outside the scope of this chapter, we review preventive interventions for substance abuse among American Indian youths because these interventions offer opportunities to look at important issues regarding mental health care for this understudied population.

Schinke et al. (1988) conducted a bicultural competence skills training intervention for the prevention of substance abuse. In this trial, 137 youths were randomly assigned by reservation site into prevention and control conditions after pretesting. Youths in the bicultural competence condition learned communication, coping, and discrimination skills using behavioral and cognitive procedures and were compared with a no-intervention control. Youths in the intervention condition showed greater posttest and 6-month follow-up improvements than did those in the control group on measures of substance abuse knowledge, attitudes, and interactive abilities and on self-reported substance use. Subsequently, a 10-reservation substance abuse prevention study by Schinke and colleagues (2000) was conducted. Schools they attended were randomly assigned to one of three experimental conditions: cognitive-behavioral life skills training, cognitive-behavioral life skills training plus community involvement, and no intervention control. This intervention was effective in reducing the rates of smokeless tobacco, alcohol, and marijuana use among participants compared with those in the control group. Interestingly, youths in the condition

that emphasized skills plus community involvement had lower rates of alcohol use than did the control group, but their rates were higher than those of youths in the skills-only group.

An after-school alcohol prevention program entitled the Seventh Generation Project (Moran & Reaman 2002) followed similar life skills procedures with urban American Indian fourth- through seventh-grade students. A total of 257 intervention youths were compared with 121 nonintervention youths using a quasi-experimental design at pretest, posttest, and one-year follow-up. In this study, a measure of depression was included among outcome measures to assess the effectiveness of the intervention. This program was successful in helping youths develop appropriate attitudes and beliefs around alcohol use, as well as make a personal commitment to sobriety. The intervention also lowered levels of depression symptoms among these youths at one-year follow-up.

Mental disorders are associated with early onset of substance use and problem drinking in American Indian youths. Similarly, depression and conduct disorder are noted risk factors for adolescent suicide in this population (Dinges & Duong-Tran 1993, Grossman et al. 1991, Manson et al. 1985, May 1987, O'Nell 1992–1993). To address the problem of American Indian adolescent suicide, LaFromboise and Howard-Pitney (1995) worked with the Pueblo of Zuni to create and evaluate an intervention for suicide prevention entitled the Zuni Life Skills Development Curriculum. This prevention intervention is a school-based life skills development program with the purpose of reducing factors associated with suicidal behavior (e.g., depression, hopelessness, stress, problem solving). The intervention merges a social cognitive, life skills development approach with peer helping. This life skills intervention proved to be effective in a multimethod evaluation study following a quasi-experimental design including self-report, behavioral observation, and peer rating. In the evaluation study, 128 students in language arts classes were randomly assigned to treatment and control conditions. At posttest, those who participated in the intervention group scored better than did those in the no-intervention control on suicide probability and hopelessness. They also showed greater ability to perform problem-solving and suicide-intervention skills in a behavioral assessment.

OUTCOMES FOR MINORITY CHILDREN AND YOUTHS

Our review of the literature has found several recent studies of interventions with children and youths focusing on African Americans and/or Latinos. Some have examined evidence-based care, such as parent management training, and determined that African American and/or Latino youths respond to the interventions similarly to white youths. Others have examined evidence-based interventions that have been culturally adapted for a specific minority group. These culturally enhanced interventions also appeared to be effective. Only two studies have found that ethnic minority participants do not respond as well to care as do white youths. In the large, multisite MTA study examining care for ADHD, African American and Latino youths had higher levels of symptoms following treatment. However, these differences were no longer significant once socioeconomic disadvantage was taken into account. The only study to find poorer outcomes based on minority status alone was one on prevention of depression with African American youth. White, Latino, and Chinese students responded to this intervention to increase optimism, but no significant differences

were found between the intervention and control for African American students. Further study is needed to determine whether this intervention is indeed less effective for African American youths or whether another explanation could account for this finding.

Although data are more limited than is desirable, taken together, these findings support the idea that the evidence base that has been developed for treating depression, anxiety, ADHD, and disruptive disorders is likely to be effective for African American and Latino youths. Although no data are available to determine to what extent culturally adapting the interventions would improve outcomes for minority youths beyond that achieved with a more generic intervention, these interventions achieve the inclusion and engagement of minorities in treatment trials. Most culturally adapted treatments retain the therapeutic interventions found to be effective in middle-class white populations, but include sensitivity to issues and concerns of a particular cultural group. Clinically, it could be argued that this type of adaptation is important for all culturally distinct populations, such a rural youths.

Only one study examined an Asian sample, and we were unable to find any studies of American Indian/Alaskan Native children and youths. Studies focusing on substance abuse or suicide prevention in American Indian youths are available. These studies clearly demonstrate that American Indian youths engage in interventions when they are offered in the schools; successful interventions are provided to all students, thereby preventing stigmatization of at-risk individuals. Successful interventions for this population have also demonstrated decreases in mental health factors such as depression, hopelessness, and suicidal ideation. Overall, the extent to which evidence-based mental health interventions are effective for populations other than African American and Latino youths is unknown.

OUTCOMES OF MENTAL HEALTH CARE FOR ADULTS

Efficacy Studies of Adults

Well-developed and tested interventions are available in three major areas of adult psychopathology: depression, anxiety, and schizophrenia. Below, we review data regarding treatment of major adult disorders and examine outcomes for ethnic minorities.

DEPRESSIVE DISORDERS—Two psychotherapy interventions are well established among white Americans. CBT (Beck et al. 1979) and IPT (Klerman et al. 1984) are both effective for reducing symptoms of nonpsychotic depression and improving interpersonal functioning (Depression Guideline Panel 1993). There is no evidence that one is differentially effective, and both have some relapse-prevention effects (Elkin et al. 1989, Thase 1995). Six major studies have found CBT comparable in efficacy to pharmacotherapy (Blackburn et al. 1981, DiMascio et al. 1979, Hersen et al. 1984, Hollon et al. 1992, Murphy et al. 1984, Rush et al. 1977); none of the studies included analyzable subsamples of ethnic minorities. Finally, in the National Institute of Mental Health Treatment of Depression Collaborative Research Project (Elkin et al. 1989), an extremely important study documenting the effectiveness of CBT and IPT as compared with medications, only 11% of the participants were ethnic minorities, and there was no power to examine ethnic responses to care.

Although this review focuses on psychotherapy, it would be remiss to ignore a large literature on the efficacy of antidepressant medication. These medications are effective across the full range of major depressive episodes (American Psychiatric Association 1993), including severe and psychotic depressions. The degree of effectiveness, however, varies according to the intensity of the depressive episode. With mild depressive episodes, the overall response rate is about 70% (Thase & Howland 1995); with severe depressive episodes, the overall response rate is much lower, about 20% to 40% (Spiker 1985). For many, recurrent depression required an extended maintenance phase. Antidepressants are used throughout the world. Several small studies have found ethnic minorities respond positively to antidepressants (e.g., Alonso et al. 1997, Escobar & Tuason 1980, Versiani et al. 1999).

Dai et al. (1999) have conducted the only study of treatment of depression in Chinese Americans. Elderly Chinese Americans with minor depressive symptoms were treated with eight-week CBT as compared with a no-treatment control group. Although there was nonrandom assignment of patients, those in the cognitive behavioral group reported significant improvement in depressive and somatic symptoms, whereas those assigned to the control group did not improve.

One small, randomized trial of psychotherapy for depression in Latinos was published more than two decades ago. Comas-Diaz (1981) examined outcomes of cognitive group therapy as compared with behavioral group therapy for a small sample (n = 26) of unmarried Puerto Rican mothers. Both conditions improved more than the control condition, and outcomes were generally similar to findings with non-Latino populations. Latinos were also included in one nonrandomized study of CBT. In this naturalistic study of treatment of depression in 175 low-income and minority medical patients, Organista and colleagues (1994) found modest improvements in care for individual and group psychotherapy. In this study, 44% of the patients were Latino, and though ethnicity did not predict outcome for treatment completers, minority patients were more likely to drop out of treatment.

Treatment of antepartum major depression was studied recently in a sample of 50 outpatient women in New York City (Spinelli & Endicott 2003). Of those randomly assigned to care, only 38 women remained in the study (including 13 Latina, 6 white, and 2 African American). The women received either IPT or parent education. At termination, 60% of those in the IPT group recovered, whereas only 15% of those receiving parent education recovered.

A recent study examined outcomes of depression care in poor women in Mexico (Lara et al. 2003). In this study, women were treated with an educational six-week group approach tailored to problems and issues of women in Mexico (Lara et al. 1997) as compared with a 20-minute individual psychoeducational meeting. Women were not randomly assigned, but the groups appeared similar in demographic characteristics. No significant differences in depression were found between the two groups.

Brown et al. (1999) analyzed differences in treatment for depression in primary medical care patients comparing African American (n = 58) to white patients (n = 92). Patients were

randomly assigned to manual-based IPT or guideline-based medication. They found that African Americans were more likely to be adherent to interpersonal psychotherapy than were white Americans (100% versus 76%); however, African Americans had a lower medication adherence rate than did white Americans (35% versus 61%). Eight-month outcomes revealed a reduction in depression severity in both treatment and racial groups and no race differences in symptomatic recovery in IPT or medication conditions. Some evidence suggested that the African Americans did not respond as well in terms of functional outcomes.

Studies of specialized populations of depressed patients have found contradictory results for African Americans. An exploratory randomized study of CBT or supportive psychotherapy or combined treatment (medication and supportive psychotherapy) among 101 HIV-positive patients experiencing depressive symptoms found that African Americans receiving CBT reported significantly poorer outcomes in comparison to Latino or white patients (Markowitz et al. 2000). However, the analyses were based on just four African Americans of the 18 in the study. In contrast, a study of treatment for depression among African American elderly medical patients found behavioral therapy to be effective in improving clinical outcomes (Lichtenberg et al. 1996). Similarly, Kohn et al. (2002) conducted a small exploratory within-group study to examine the impact of cultural adaptations to manualized CBT for depressed African American women referred for treatment from primary care doctors. Findings indicate that women receiving culturally adapted treatment exhibit greater decreases in depressive symptoms than do demographically matched African American women receiving nonadapted CBT in the same clinic.

Miranda and colleagues (2003) examined whether supplementing CBT with clinical case management would improve outcomes of care for low-income medical patients. In this randomized trial, supplemental case management was associated with greater retention in care for all participants. Response to group CBT did not differ by language or ethnicity. Furthermore, the supplemental case management resulted in greater improvement in symptoms and functioning than for CBT alone for Spanish-speaking patients (n = 77), but was less effective for English-speaking patients (n = 122; 53 of the patients were African American). In posthoc analyses, African Americans were found to benefit more from CBT alone than from the supplemental case management.

A recently published study (Miranda et al. 2003) examines the impact of cognitive behavioral psychotherapy and paroxetine (switched to buproprion if clinically necessary) on Latina and African American women. The women participants in this study were largely working poor women; 60% were below federal poverty guidelines and another 34.2% were near-poor. Study participants included 117 U.S.-born African American, 16 white, and 134 Latina immigrants to the United States. In total, 66 of 88 women assigned to medication received guideline care, 32 of 90 women assigned to CBT received six or more sessions, and 15 of 89 referred to community care attended at least one mental health visit. The interventions were modified to be sensitive to low-income women, and separate modest cultural adaptations were made for Latina and African American women. Culturally sensitive methods were used to encourage women to enter care, and babysitting and transportation were provided to enable women with such needs to attend care regularly.

Guideline care was effective over and above community care for decreasing depressive symptoms and improving functioning of these women. Whether or not they received guideline care, the women randomly assigned to medications were twice as likely to be asymptomatic by month 6 as were those referred to community care. By six months, 44% of medication patients, 32% of psychotherapy patients, and 28% of referred patients were asymptomatic. There were no interactions of treatment with ethnicity on outcomes in this study; all ethnic groups responded to treatment equally.

We should note, however, that the CBT treatment employed by Miranda and her colleagues in these studies is one that has been repeatedly tested in ethnic and language minority populations in both treatment and prevention trials. The different iterations of the CBT protocol evolved from the “Control Your Depression” course that for more than 20 years has been empirically evaluated, modified, and refined with low-income minority populations (Muñoz & Mendelson 2005). Thus, one would expect such a protocol to work well with minority groups.

ANXIETY DISORDERS—Several randomized, controlled trials have established that CBT is useful in reducing symptoms of white American patients with anxiety disorders (Chambless et al. 1988). However, approximately 20% to 25% of patients with obsessive-compulsive disorder (OCD) are unwilling to participate in this treatment (March et al. 1997). In addition, benzodiazepines are useful for short-term intervention; however, the possibility of producing drug dependence limits their longer-term use. Most antidepressant medications have substantial antianxiety and antipanic effects, in addition to their antidepressant action (Kent et al. 1998). Moreover, a large number of antidepressants have antiobsessional effects (Perry et al. 1997). Both outcome remission and return to functioning occur after proper treatment for most patients with anxiety disorders (American Psychiatric Association 1998, March et al. 1997).

A study of treatment outcome following in vivo exposure for 15 African American and 43 white agoraphobic outpatients found that both groups improved with treatment (Chambless & Williams 1995). However, African American patients exhibited greater phobic responses prior to and following treatments, and exhibited less change for frequency of panic attacks following treatment in comparison with white patients. Another study of African American (n = 43) and white (n = 100) patients with panic disorder and agoraphobia reported moderately successful treatment response for both races (Friedman et al. 1994). A small trial (n = 9) of interpersonal psychotherapy treatment for social phobia included three African American patients (Lipsitz et al. 1999). Analyses indicate that clinical and self-report ratings of symptoms of phobia improved with interpersonal psychotherapy, although outcomes were not reported separately by race.

Friedman and collegues (2003) have reported results of a naturalistic treatment outcome study examining the effectiveness of exposure therapy and ritual prevention on 62 ethnically diverse urban outpatients with OCD. African American and Caribbean American patients were as likely as white patients to demonstrate moderate improvement with treatment. Williams and colleagues (1998) treated two African American patients with OCD, using exposure and response prevention. They describe significant treatment improvements. A

study of treatment outcomes for 125 ethnically diverse battered women with posttraumatic stress disorder found that cognitive trauma therapy was equally effective for white (n = 66) and ethnic minority women, at both three- and six-month follow-up (Kubany et al. 2004). Similarly, CBT was equally effective for African American and white women with posttraumatic stress disorder in another study (Zoellner et al. 1999).

We were able to find only one study examining the efficacy of a psychological intervention for treating anxiety among Asians. Zhang et al. (2002) developed an intervention called Chinese Taoist Cognitive Psychotherapy, which combines elements from cognitive therapy with Taoist philosophy. They randomly assigned 143 Chinese patients (in China) with generalized anxiety disorder to one of three conditions: the Taoist-adapted cognitive therapy, benzodiazepines, or a combined condition. Patients were evaluated at one and six months. Results indicate that patients in the medication group experienced a rapid reduction in symptoms after one month, but that symptom reduction was transient and symptoms returned at six months. The psychotherapy patients experienced a slower reduction in symptoms, but reported superior response at six months. Those in the combined group reported improvements at both times.

Recently, larger studies have examined response to care for anxious ethnic minority patients. Minority status predicted poor paroxetine response in a study of primary care panic patients. Although roughly 30% of subjects were nonwhite Americans, minorities comprised 45% of the nonresponders and only 22% of the responders (Roy-Byrne et al. 2003). However, lower income was an even stronger predictor of nonresponse, which suggests that poverty, rather than minority status, was a more powerful determinant of outcomes of anxiety care.

PSYCHOTIC DISORDERS—Pharmacotherapies for schizophrenia have been studied extensively. Conventional antipsychotics are highly effective both in treating acute symptoms and in long-term maintenance and prevention of relapse (Davis et al. 1989). In studies, positive symptoms associated with schizophrenia improve in about 70% of subjects. Unfortunately, the side effects resulting from medications can range from uncomfortable to disabling (Davis et al. 1989). Efficacy data on the newer antipsychotics indicate that they are as efficacious as the older agents at reducing positive symptoms and they carry fewer side effects. They also offer improvement for 30% to 50% of formerly treatment-resistant patients (Buchanan 1995, Kane 1996, Kane & Marder 1993, Kane & McGlashan 1995, Lieberman et al. 1994). Psychosocial treatments include family interventions, psychosocial rehabilitation and skills development, and vocational rehabilitation. Recent controlled studies have shown the effectiveness of supported employment models, which emphasize rapid placement in real job settings and strong support from a job coach to learn, adapt, and maintain the position (Drake et al. 1994, 1996).

We were able to find one efficacy study examining interventions for schizophrenia among Latinos. Telles and colleagues (1995) examined the effectiveness of behavioral family management for low-income, Spanish-speaking populations. The authors report that less acculturated patients who were treated with the family management program had a significantly poorer course and one-year outcome than did those who received case management. The authors suggest that a highly structured intervention program such as

behavioral family management might be experienced as intrusive and stressful by less acculturated families.

One small study also examined outcomes of care for a predominantly African American sample (n = 44 of 46) (Baker et al. 1999). This two-year study of outcomes of psychosocial rehabilitation among patients with chronic mental illness including schizophrenia, mood disorders, or dual diagnosis found an increase in the amount of time patients stayed out of the hospital, a decrease in dysfunction at work, a significant reduction in symptoms, an increased ability to maintain personal hygiene, and greater participation in leisure activities.

We were able to find two randomized, controlled trials examining the efficacy of psychological interventions for schizophrenia among Asians; both were conducted in China. Xiong et al. (1994) examined the effects of a culturally modified family-based intervention group to a usual care control in patients after admission to a psychiatric hospital. Results indicated that patients assigned to a comprehensive and structured family-based intervention program were less likely to be rehospitalized, had shorter durations of hospitalizations, and were more likely to remain employed at 6-, 12-, and 18-month follow-up. In one of the largest randomized controlled trials (n = 326), Ran et al. (2003) found that Chinese patients randomized to medication plus psychoeducational family intervention evidenced increased treatment compliance, significant gains in knowledge about their condition, and a positive change in the caring attitudes of relatives when compared to a medication-only group and a no-intervention control.

EFFECTIVENESS STUDIES OF ADULTS—Effectiveness studies have examined care for depression in community settings. Because most persons with depression fail to seek psychiatric care but are seen in primary health care settings, outcomes of care for depression in primary health care settings are likely generalizable to minority populations. Overall, Schulberg and colleagues (1996) found that outcomes of care for depression in primary care settings are similar to those found in psychiatry when care is guideline concordant.

A recent study examined the impact of a quality-improvement intervention on outcomes of depression care for Latino and African American medical patients (Miranda et al. 2003). This study took place in 46 primary care practices in six U.S. managed-care organizations, utilizing 181 clinicians. Matched practices were randomized to usual care or to one of two quality-improvement programs. The intervention termed “QI Meds” focused on improving medication management to meet guideline standards for depressed patients; whereas “QI Therapy” focused on delivering evidence-based treatment, CBT, to these patients. For both interventions, local experts were trained to educate clinicians regarding depression care. In addition, nurses were taught to educate, assess, and follow up with patients. In the QI Therapy arm, psychotherapists were taught to conduct CBT. The sample of patients consisted of 398 Latinos, 93 African Americans, and 778 whites, all with probable depressive disorder. The intervention significantly improved rates of care for each ethnic group, with no significant difference in response by ethnic group. The interventions significantly decreased the likelihood that Latinos and African Americans would report probable depression at months 6 and 12; the white intervention sample did not differ from controls in reported probable depression at either follow-up. Five years after

implementation, the participants in the intervention arms of this study had improved outcomes relative to those in usual care (Wells et al. 2004). Furthermore, disparities in outcomes were reduced through markedly improved health outcomes and lower unmet need for appropriate care among Latinos and African Americans relative to whites.

Miranda and colleagues (Miranda et al. 2004) used data from this trial of improving care for depression in primary health care settings to determine whether appropriate care results in similar outcomes for minority and nonminority medical patients. They used an instrumental variables approach (using the random assignment of the quality improvement interventions as the instrument) to examine whether outcomes of appropriate care (either medications or psychotherapy) result in similar outcomes for minorities and nonminorities, while using the instrumental variables technique to control for factors, such as level of illness, that predict entry into care. Results of this analysis found that minorities and nonminorities responded similarly to care. Although sample sizes were small, analyses suggest that this similar response was true of both Latinos and African Americans.

A recent study (Araya et al. 2003) investigated stepped care for depression in primary-care clinics in 240 low-income women in Santiago, Chile. Stepped care, a three-month, multicomponent intervention led by a nonmedical health worker, included a psychoeducational group intervention, structured and systematic follow-up, and drug treatment for patients with severe depression. At six-month follow-up, 70% of the stepped-care group, compared with 30% of the usual-care group, was no longer symptomatic.

Outcomes for Minority Adults

In our review of the literature, we found several studies addressing the impact of evidence-based mental health care for Latinos and African Americans. Both naturalistic and large randomized trials with Latinos and African American participants have found that well-established psychotherapies, such as CBT and IPT, are effective for these diverse populations. In addition, studies in primary care settings, where many minority patients receive depression care, show particularly impressive outcomes for ethnic minorities. In particular, quality improvements for depression appear not only to significantly improve outcomes for minorities, but also to eliminate disparities in care over time.

Three studies show negative findings for African Americans, but one was based on an extremely small sample. The other two found that African Americans responded symptomatically to standard care very similarly to other ethnic populations. However, in one study, lower levels of functional improvements were noted, and in the other, supplemental case management did not appear to be as effective in improving outcomes as it had been with Latinos.

Two small, nonrandomized studies of depression treatment offer interesting findings that need further investigation. A small study in Mexico (Lara et al. 2003) found that addressing issues relevant to Mexican women—issues discovered through earlier work—was not more effective than a 20-minute psychoeducational session. This suggests that tailoring care to population concerns may not be effective if the established elements of care (i.e., CBT or interpersonal therapy techniques) are omitted. Another small study (Kohn et al. 2002)

suggests that when the established elements of care (in this case CBT) are specifically adapted for a cultural group (in this case African American women), outcomes may exceed those of care not specifically adapted.

Only one study, a small study of minor depression, is available to examine outcomes of care for depression in Asians. We were unable to find studies of American Indians. As with studies of children, we are unable to determine the extent to which evidence-based care for depression might benefit American Indians.

Fewer studies are available that examine outcomes of care for ethnic minorities with anxiety disorders. African Americans have been studied in exposure and CBT interventions and appear to fare as well as do white Americans. A naturalistic evaluation included Latinos; they too seemed to benefit equally from OCD care. One study examined the impact of cognitive behavioral approaches for Asians; the intervention included a Taoist perspective. In this study, Chinese patients improved through the intervention. As in other areas, no studies are available to enable us to determine the impact of evidence-based anxiety care on American Indians/Alaskan Natives. Outcomes for ethnic minorities were poorer than for white patients in a primary care study; however, these differences were accounted for primarily through income.

The literature on treatment of severe mental disorders, such as schizophrenia, is particularly sparse. In one study of family therapy with Latinos, the family intervention was not helpful for this immigrant population. Psychosocial interventions were shown to be useful for African Americans and Mainland Chinese populations. Clearly, more research is needed to understand the impact of psychosocial interventions on those with severe mental disorders.

CONCLUSIONS

Our review of the research literature on the impact of evidence-based mental health care on ethnic minorities found a growing literature that supports the effectiveness of this care for ethnic minorities. The largest and most rigorous literature available clearly demonstrates that evidence-based care for depression improves outcomes for African Americans and Latinos, and that results are equal to or greater than for white Americans. Much fewer data are available for Asian populations, but the literature that is available suggests that established psychosocial care may well be effective for this population.

American Indian/Alaskan Native populations are largely missing from the literature on effectiveness of mental health care. The available literature focuses on preventive interventions for youths. These studies show us that Native populations engage in school-based interventions that do not target particular youths, but rather provide interventions for all. In addition, these cognitive-based interventions appear helpful for lowering depressive symptoms and suicidal ideation.

We return to the three primary questions that were posed at the beginning of this chapter. Do our efficacious treatments generalize to minority populations? Should we culturally adapt care for each cultural group? Does poverty affect outcomes of care? We believe that the existent literature suggests that evidence-based parent management training and ADHD care

for children and depression treatments for adults do generalize to African American and Latino populations. In fact, the literature to date would suggest that evidence-based care is likely to generalize to both African American and Latino populations. Although the evidence is very sparse for Asian Americans, initial studies appear positive.

A particularly important yet unanswered question is the extent to which interventions need to be culturally adapted to be effective for minority populations. The efficacy literature provides little insight into this area. Adapted interventions have been shown to be effective; however, tests of adapted versus standard interventions aren't yet available to guide care. Nevertheless, the wide recognition that culture and context need to be considered in treatments has led to the development of guidelines for multicultural clinical practice, research, and education. In fact, recently the American Psychological Association (2003) officially adopted a set of guidelines to inform psychologists on issues of diversity. As clinicians, we believe that all psychosocial interventions are tailored to the individual being served. If we were treating medically ill patients for depression, we would address the impact of illness on mood. If we were treating impoverished patients for depression, we would develop lists of pleasant activities that include many opportunities that are either free of charge or have minimal costs attached. Similarly, when treating Latina women, we would be aware that we may need to encourage them to take care of themselves in order to care for their families, as we know that they may not feel focusing on themselves is appropriate. Thus, knowledge of the culture and context and the capacity to distinguish between what may be culturally adaptive versus pathological are minimal considerations of culturally competent care.

Our review of the literature has led us to believe that evidence-based care is likely appropriate for most ethnic minority individuals. In the absence of efficacy studies, the combined used of protocols or guidelines that consider culture and context with evidence-based care is likely to facilitate engagement in treatment and probably to enhance outcomes. We also believe that two areas of research need immediate attention. First, methodologies for tailoring evidence-based interventions for specific populations would be extremely helpful. Because culture is continually evolving, the ability to identify factors that are amendable to adaptation, while maintaining the critical ingredients of care, would provide a methodology for continually ensuring that care is sensitive to the needs and concerns of any client group. Second, although beyond the scope of this review, we would be remiss in not noting that ethnic minorities are less likely to receive mental health care than are majority populations (U.S. Department of Health and Human Services 2001). Furthermore, those who do receive care are less likely to obtain evidence-based care than are their majority counterparts (U.S. Department of Health and Human Services 2001). We believe that research focusing on methods for actively engaging ethnic minorities in mental health care is extremely important. For example, studies of American Indian youths have included entire classrooms. Could there be appropriate ways for identifying and treating American Indian youths with disorders that would avoid stigmatizing them? Clearly, working with communities to identify ways to bring appropriate care to minority populations is a priority.

In conclusion, we encourage clinicians to provide state-of-the-art, evidence-based care to our ethnic minority populations. We also believe that tailoring this care to be sensitive to the

culture of the individual is extremely important. It is our hope that future research will help us to systematically identify ways to consistently tailor care to be most effective for diverse clients.

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