Evidence-Based Practices with Latino Youth: A Literature Review

UW Medicine
SCHOOL OF MEDICINE
University of Washington
Department Of Psychiatry and Behavioral Sciences

Authors:

Elizabeth Feldman, Ph.D.

Eric Trupin, Ph.D.

Sarah Walker, Ph.D.

Jacquelyn Hansen, MPH

Public Behavioral Health and Justice Policy
University of Washington

Dept. of Psychiatry and Behavioral Sciences

2815 Eastlake Ave. East, Suite 200

Seattle, WA 98102

UW Medicine
SCHOOL OF MEDICINE

University of Washington
Department Of Psychiatry and Behavioral Sciences

The Division of Public Behavioral Health and Justice Policy

The Division of Public Behavioral Health Policy and Justice Policy (PBHJP) was originally established in 1982 through a Washington State Legislative proviso. Part of the goal is to serve as a resource to the state by conducting research on services and systems related to public behavioral health, and to provide continuing educational opportunities for providers and families statewide. PBHJP is committed to improving the health and well-being of children, families, and adults served by the mental health, chemical dependency, child welfare, and justice systems. We aim to achieve this mission by implementing, supporting, and informing effective interventions, empirically based training, and collaborative research. We are dedicated to helping individuals and families overcome challenges by emphasizing their strengths and enhancing their skills.

Models for Change

The Models for Change initiative is an effort to create successful and replicable models of juvenile justice system reform, seeking to accelerate progress towards a more rational, fair, effective, and developmentally appropriate juvenile justice system. Washington State was one of four states selected for the Models for Change targeted investments by the John D. and Catherine T. MacArthur foundation. PBHJP's role within this initiative is to engage in projects with local, state and national jurisdictions that enhance the ability of justice systems to address the behavioral health needs of youth by examining the cultural competence of evidence-based programs as well as screening and assessment.

Table of Contents

Evidence-Based Practices with Latino Youth: A Literature Review

Recent research has led to considerable advancement in the treatment of mental health difficulties common in childhood and adolescence (Kazdin, 2000; Kazdin & Weisz, 2003). Evidence-based practices now exist for many pediatric mental health difficulties, including depression, anxiety, conduct problems, substance abuse, and PTSD. However, the effectiveness of these practices with specific sub-populations, such as Latinos and Latino immigrants in particular, remains unclear. While some scholars recommend that evidence based treatments be delivered as designed (e.g. Huey & Polo, 2008), others argue that successful generalization to specific ethnic groups is dependent upon thoughtful and informed efforts to modify treatments so that they are culturally appropriate (e.g., Chen, Kakkad, & Balzano, 2008). Because Latinos make up such a large segment of the U.S. population, and also because Latino immigrant youth are at high risk for mental health related difficulties (National Alliance for Hispanic Health, 2001; Office of the U.S. Surgeon General, 2001), it is crucial that investigation about how to respond effectively to the mental health needs of Latino children and adolescents be a part of the current research agenda.

This review will outline some of the most pressing mental health concerns for Latino immigrants and highlight what is currently known about how best to respond to these concerns. Discussion will follow about whether cultural modification or adaptation is recommended.

Demographics of Latino Immigrants

The acquisition of demographic information about Latino immigrants can be difficult due to the potential consequences for individuals who may be living in the United States as undocumented residents or illegal immigrants and who may be fearful of providing personal information. In addition, minority populations in general are more reluctant to respond to questions posed by census takers or on surveys and questionnaires, leading to significant underreporting (Robbin, 1999). However, information that is currently known about the Latino population living in the U.S. conveys a concerning picture. Especially worrisome is the information known about immigrant Latino children and adolescents, a subset that represents at least 25 percent of all Latino immigrants residing in the U.S.

Education

Compared to other ethnic groups in the U.S., Latino immigrant youth have some of the highest school dropout rates and the poorest academic performance. More than 80% of Latino immigrant students fall below Proficient on national reading and math achievement tests and only 50% graduate from high school. By comparison, nearly 80% of non-Hispanic White students earn their high school diploma (U.S. Census, 2007). In addition, the schools that serve a high percentage of Latino immigrants are frequently the most overcrowded, underfunded, and understaffed schools in the country and exist in some of the

Rising Latino Populations in the United States

Current 2008 U.S. Census data suggest that there are approximately 45.5 million people living in the U.S. who identify themselves as Latino or Hispanic, making this group the largest and fastest-growing minority group in the country.

Approximately 40% of this group, or 18 million people, were born in another country, over 9 million of whom are believed to have come to the U.S. illegally (Pew Research Center, 2007, 2006 respectively).

Data collected by the U.S. Census over the past 50 years suggest that the rapid growth of this population will continue and thus it is estimated that by the year 2050 more than one third of the national population will be of Hispanic origin.

poorest neighborhoods nationwide (Orfield, 2001, 2005; Rothstein, 2004). A group of studies conducted by the Civil Rights Project at Harvard University (2001) indicates that Latinos are more likely than any other minority group to attend schools serving a disproportionate number of low-income families and that Latino students commonly face the consequences of modern day school segregation, such as poor quality instruction, minimal school resources, and deteriorating facilities.

Physical Health

Latino immigrant youth also frequently suffer from serious physical health difficulties yet often fail to receive adequate medical care. The U.S. Department of Health reported that Latinos were more likely to have diabetes, to be obese, to have HIV/AIDS, to suffer from asthma, and to have certain forms of cancer, than non-Hispanic Whites (2006 & 2007). Kandula, Kersey, and Lurie (2004) examined the top ten Leading Health Indicators identified by *Healthy People 2010* (an initiative of The U.S. Department of Health and Human Services), and evaluated where immigrant and non-immigrant Latinos stand on these indicators. Their findings showed that compared to U.S.-born youth, immigrant Latino youth have elevated rates of obesity, are more likely to require hospitalization due to an accident or injury, are more likely to be the victim of homicide, are more likely to have been exposed to toxins and dangerous chemicals, are less likely to have received a full schedule of childhood immunizations, and are less likely to have access to high quality health care services.

A particular area in which Latino immigrant youth are at risk is sexual health. Adolescent Latinos are significantly more likely than their non-Latino White peers to contract sexually transmitted diseases (Centers for Disease Control, 2000), yet it is not uncommon for Latino adolescents and young adults to report that they have never been to a gynecologist or internist (Rodríguez, Ward, & Pérez-Stable, 2005). In addition, Latina girls consistently have the highest teen pregnancy rates in the country when compared to teen girls in other ethnic groups. While the rate of births to mothers aged 15-19 is approximately 63 and 37 per one-thousand girls for African-American and Caucasian teens respectively, the birth rate for teen Latinas is over 80 per one-thousand young women (Centers for Disease Control, 2009). In addition, during pregnancy immigrant Latina teens are also substantially less likely than other pregnant teens to receive adequate prenatal care or to be under the supervision of a doctor (National Latina Institute for Reproductive Health, 2005).

One factor undoubtedly contributing to the poor physical health of Latino immigrants is their limited access to health services due to a lack of health insurance. One in four legal Latino

residents and more than half of all non-authorized Latino immigrants (both adults and children) are uninsured and therefore rely on emergency departments and free or reduced cost community clinics for all health services (Pew Hispanic Center, 2009; U.S. Census Bureau, 2005).

Socioeconomics

Poverty and substandard housing are two additional hardships that impact Latino immigrant families disproportionately. 2007 census information revealed that more than 20 percent of Latino immigrant families were living below the poverty line, compared with just 8.2 percent of non-Hispanic Whites. In 2007 the median income of Latino immigrant families ranged from $35,000 to $41,000, depending on legal status; compared to the median income for non-Hispanic White families, which was $55,000 (Pew Hispanic Center, 2009; U.S. Census, 2007).

The housing environments of Latino immigrants tend to be of particularly poor quality. The Pew Center reports that just over one quarter of unauthorized immigrant Latino families and less than half of legal Latino immigrant families own their own homes; while nearly three-quarters of non-Hispanic White families live in their own homes (2007). More broadly, Latino families are frequently found to be living in some of the poorest communities in the country, many of which have the highest rates of violence and criminal activity, are dominated by subsidized and/or substandard housing, and have minimal neighborhood resources (Kozol, 2005).

Employment

As members of the U.S. labor force, Latino immigrants are disproportionately hired for minimum-wage, service-industry positions and agricultural work that affords no benefits and limited job security (Larsen, 2004; Pew Centers for Research, 2007). 2003 census data revealed that 45% of Latino immigrants who are employed earn less than 20 thousand dollars a year (compared to 16.5% of the native-born population and 16.5% of Asian-born immigrants) and only 7.7% earn more than 50 thousand dollars annually (compared to 30.2% of native-born individuals and 37.3% of Asian-born individuals). Given many of these statistics, it is not surprising that Latino immigrants are often deeply mired in the persistent cycle of the working poor, in which they cannot afford to quit their jobs because they need the income, but the income that they do receive is insufficient to allow them to climb out of poverty.

Summary

Latino immigrant youth (both those that are legal residents and those that are undocumented immigrants) are frequently forced to shoulder significant burdens from early childhood to late adolescence and beyond. To a greater degree than the majority of their non-immigrant, non-Latino peers, these

children and teens are in high-risk categories physically, academically, socially, emotionally, financially, and environmentally. Compounding these circumstances is the fact that most immigrants (both first- and later-generation) contend with significant challenges associated with immigration itself and biculturalism. These challenges can include a lack of familiarity and comfort with the dominant culture (especially the English language); conflicting ideals and personal values; frequent exposure to ethnic and racial discrimination (both practical and institutional); competing social demands from family members, teachers, and peers; and feelings of isolation and a sense of discomfort interacting in public settings (Davidson, 1996; Olsen, 1997). In addition, many Latino immigrants come to the U.S. having experienced substantial poverty, unemployment, poor quality education, poor living conditions, community violence, and political and civil unrest in their native countries. Finally, during the process of migration itself it is not uncommon for Latino family members, including young children and their parents, to be separated from each other for months, years, or in some cases, permanently, thus taking away an important protective factor of social and familial support. Certainly, a significant number of Latino immigrants living in the U.S. endure overwhelmingly difficult life experiences on top of the daily challenges of life in a new country.

Definition of Culture

The simple fact that it is common for Latino immigrants to have endured a similar set of hardships both prior to and following immigration raises an important point regarding the meaning of the term *culture*, particularly as it relates to members of this immigrant group. Different contributors to the professional literature define the term *culture* in many different ways and there is much discussion of the fact that no universally accepted definition exists. One of the most long-standing and commonly agreed-upon definitions is that developed by Edward Tylor in the late 19th Century (Tylor, 1871), which defined culture as,

"*that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society*."

More modern-day anthropologists generally agree that the term *culture* incorporates some central ideas. The *culture* of any given group could involve multiple components, including:

- Traditions, rituals, and customary ways of behaving;
- commonly held assumptions underlying these traditions, rituals, and behaviors;
- values and beliefs or a shared world-view;
- artifacts (such as art, music, tools, architecture, literature, etc.);
- institutions;
- patterns of social relations (Howard, 1991; Lopez et al., 1989; Ogbu, 1995).

Multifaceted Approach to Definition

How to define culture?

- It is *who* we are: assumptions and codes of conduct.
- It is *what* we do: Institutions we build and artifacts we produce.
- It is *how* we interact: patterns of social behaviors

(Ogbu, 1995)

This broad conception of culture creates a compelling case for the inclusion of a number of characteristics of "Latino immigrant culture" that go beyond more traditional and obvious aspects of culture such as native language and country of origin, and include factors such as socioeconomic status, systems of support, health indicators, living environment, perceived exposure to discrimination, family structure, and social and occupational mobility.

Role of Acculturation in Psychopathology

Elevated rates of psychological dysfunction are found to exist among both immigrant and non-immigrant Latino youth (CDC, 2004; Merikangas et al., 2010; National Council of La Raza, 2005) and Latino immigrants have recently been identified as a high-risk group for both depression and anxiety (National Alliance for Hispanic Health, 2001). Moreover, Latino immigrant youth are more likely to report heavy alcohol consumption; to show symptoms of anxiety, depression, and delinquency; and to have suicidal thoughts and/or attempt suicide than either African-American or non-Hispanic White youth (SAMHSA, 2001).

Psychological Disorders of Latino Youth

High Levels

- Posttraumatic Stress
- Depression
- Suicidal Ideation
- Social Alienation

Low Levels

- Self-efficacy
- Self-Concept

(Canino & Roberts, 2001; Fry, 2003; Hovey & King, 1996; Kao, 1999; Marshall, 2004; Roberts, 2000; Roberts, Alegría, Roberts, & Chen, 2005; Stanton-Salazar 2002)

"The Healthy Immigrant Paradox"

It is well documented that the overall mental health of Latino immigrants tends to get worse the longer they have been in the U.S. and the more acculturated they become (Escobar et al., 2000; National Council of La Raza, 2005; Vega et al., 1998, Mendoza, 2009). Additional evidence suggests that other health indicators of Latino immigrants, such as chronic disease, infant mortality, and substance abuse are worse among Latino immigrants who have lived in the U.S. for longer periods of time (Lara et al., 2005; Carter-Pokras et al., 2008; Singh & Miller, 2004; Myers et al., 2009). This finding is surprising, given the enormous stress that recent immigrants can be under due to a lack of familiarity with their surroundings, difficulty with the English language, little or no knowledge of how to navigate the health care system (and other systems) in

the U.S., and separation from important sources of social support that were left behind.

Cultural Values

Some researchers suggest that traditional Latino values are strongest in the most recent immigrants and serve as protective factors that help these newcomers cope with the difficult experiences they encounter as recent immigrants (Félix-Ortiz, Fernandez, & Newcomb, 1998; Miranda & Matheny, 2000; Szapocznik, Kurtines, & Fernandez, 1980; Ying & Han, 2007). Some of these traditional values include:

- *Familism* (prioritizing unity of the family),
- *Respeto* (having respect for elders),
- *Personalismo* (valuing warm and caring relationships over formal partnerships,
- *Collectivism* (valuing the group over the individual),
- *Religion & Spirituality* (traditionally important for Latino families).

Furthermore, these authors suggest that as time goes by and Latino immigrants become more acculturated to the U.S., these values may diminish, thus rendering the individuals more susceptible to mental health difficulties that stem from the challenges they face.

This perspective is supported by research documenting a trend in which the longer a Latino immigrant has been in the U.S. and the less that individual is connected to traditional Latino values, the more at risk he or she becomes for developing both physical and mental health difficulties (Hernandez & Charney, 1998; Kao, 1999; Lara et al., 2005; Mendoza, 2009). Unfortunately, much of the research on this topic is correlational and difficult to interpret – even though a consistent relationship is apparent between the degree of acculturation and several different indicators of health among Latino immigrants, this does not necessarily signify a causal relationship between the two. Further investigation into this topic is certainly warranted.

Acculturative Stress, Depression, and Suicidal Ideation

Many authors have commented on the impact of acculturative stress on the mental health of immigrants (NCLR, 2005; Padilla, 1988; Smart & Smart, 1993). Hovey and King (1996) examined rates of acculturative stress, depression, and suicidal ideation among first- and second-generation Latino teens, as well as ways in which acculturative stress was related to depression and suicidal ideation. Outcomes showed that there was a significant correlation between measured levels of acculturative stress and depressive symptoms. In a later investigation of this topic, Hovey and Magaña (2002) explored the relationship between acculturative stress and anxiety in a group of Mexican immigrant farm workers. These researchers interviewed 65 rural, migrant farm workers using

standardized assessments to measure participants' levels of acculturative stress, social support, education, income level, self-esteem, and anxiety (as well as several other constructs). Results demonstrated that acculturative stress was the strongest and most significant predictor of general anxiety ($p < .005$).

In a similar study (Finch & Vega, 2003), researchers investigated the relationships between acculturative stress, social support, and self-reported health. This study incorporated over 3000 individuals living in the U.S. who identified themselves as first- or second-generation Latino immigrants. Results suggested that a high percentage of respondents experienced significant stress related to their legal status, language abilities, and the various forms of discrimination they experienced in the U.S. Furthermore, a correlation was found between these forms of acculturative stress, worry about deportation, and self-reported health difficulties.

Suicidal Behaviors

Canino and Roberts (2001) conducted a meta-analysis reviewing research related to suicidal behaviors among Latino adolescents and concluded that Latino immigrant students were more at risk for suicidal behavior than either their European-American or African-American peers. These authors also suggested that acculturative stress – specifically stress stemming from cultural conflicts with family members, experiences of discrimination, few life opportunities, and lack of familiarity with the dominant language – contributed to significantly higher rates of suicidal behavior among Latino adolescents.

More recent data from the CDC (2008) aligned with Canino and Roberts' 2001 findings, showing that Latino youth were more likely to engage in suicidal behavior and to complete suicide than either Black or non-Hispanic White youth.

Suicidal Behavior in Latino Youth

Compared to other youth, Latino youth have some of the highest rates of suicide in the country -- they are more likely to engage in suicidal ideation, attempt suicide, and complete suicide than are their Black or non-Hispanic White peers.

Suicide is the third leading cause of death among Latino adolescents and young adults.

(Carr, 2004)

CBT with Latinos and Latino Immigrants

CBT as an EBP

Within the past two decades, significant advances have been made in the treatment of a number of mental health difficulties common in children and adolescents, such as anxiety, conduct problems, and depression. Currently there are numerous Evidence-Based Practices that have been evaluated in randomized controlled trials and have been endorsed by the U.S. Department of Health and Human Services (information about these programs may be found on the following website: http://www.nrepp.samhsa.gov/). The American Psychological Association has also adopted a policy statement in which it highlights Evidence-Based Practice (EBP) as a preferred approach to psychological treatment.

The vast majority of research on effective treatments for mental health difficulties in youth has pointed to cognitive-behavioral therapy (CBT) as the most effective form of treatment. As a form of EBP, CBT has been recommended by the American Psychiatric Association for many psychological symptoms and disorders.

Success of CBT

Results from randomized clinical trials have demonstrated that CBT can lead to significant reductions in symptoms of

- Depression (e.g., Beck et al., 1979; Kazdin & Weisz, 1998; Lewinsohn et al., 1996);
- Anxiety (Cohen et al., 2007; Kendall et al., 2000);
- Aggression (Lochman, 1992; Lochman et al., 2000), among others.

Cognitive-behavioral programs for parents of conduct disordered children and adolescents, such as Parent Child

Components of CBT

- Psycho-education.
- Self-monitoring of thoughts, moods, and activities.
- Coping skills such as relaxation techniques and support-seeking behaviors.
- Exposure, either imagined or in-vivo (when appropriate).
- Self-regulation and/or problem-solving.
- Cognitive restructuring to repair irrational or illogical thinking
- Parent education and training when treating children.

(Carr, 2004)

Interactive Therapy (PCIT) and The Positive Parenting Program (PPP) have also demonstrated consistently good outcomes (Thomas & Zimmer-Gembeck, 2007).

CBT for Latinos

Unfortunately, despite the many published studies demonstrating the efficacy of cognitive behavioral treatments for a wide variety of disorders in youth, evidence of the utility of these interventions for Latino youth (both immigrant and native-born) is very limited (De Arellano et al., 2005). Presently, several important questions remain:

- Are existing evidence-based treatments effective for Latino clients?
- Do cultural accommodations improve treatment effects when added to existing evidence-based practices?
- If cultural adaptations are an important aspect of treating Latino clients, what are those accommodations and how may they be operationalized to be replicable?

Research to answer these questions is limited and has yielded conflicting findings.

Efficacy of EBPs with Minorities

A recent meta-analysis by Huey and Polo (2008) thoughtfully examines these questions as they apply to ethnic minority groups in general (as opposed to considering Latinos specifically). These authors conclude that EBPs have indeed been shown to be efficacious with minority youth for a number of emotional and behavioral disorders and that ethnicity is not typically a strong moderator of treatment effects. They also point out that the "cultural responsiveness" of a treatment has not been shown through rigorous study to be related to improved outcomes for clients.

Cultural Responsiveness

The tailoring of services for specific cultural groups. Cultural Responsiveness can include surface adaptations, such as client-therapist matching or use of culturally relevant terminology, as well as more complex adaptations, such as the use of culturally based communication styles or treatment coordination with traditional healers.

Huey and Polo go on to suggest that adapting existing EBPs to be culturally relevant may in fact inadvertently render the treatments less effective, particularly if key components are altered or left out.

The following sections highlight key findings about the efficacy of EBPs for Latino clients, organized by type of presenting mental health difficulty.

Post Traumatic Stress Disorders

Violence and Trauma Exposure

Recently, the National Child Traumatic Stress Network (NCTSN) released a report summarizing data collected at over 25 mental health centers nationwide based on their work treating nearly 1400 children and adolescents (NCTSN, 2005). A specific aim of the data collection effort was to identify rates of exposure to violence across several different subsets of the sample. Data showed that there were significant differences between groups in the rates at which they experienced traumatic events ($p < .01$), with Latino youth being more likely than other ethnic and racial groups to have experienced community violence. Latino youth reported having witnessed community violence or domestic violence at a rate almost three times more often than non-Hispanic White youth. Results of a pilot study in the Los Angeles School District (Jaycox et al., 2002) showed that 80% of middle school aged students reported witnessing a violent event in the previous year and more than 60% reported witnessing a life-threatening violent event in the previous year.

One impact of the high rates of violence exposure experienced by Latino youth is that these youth also have disproportionately high rates of PTSD. Numerous studies have documented rates of PTSD approaching 70% of youth living in poor, urban settings where exposure to community violence is frequent (Berman et al., 1996; Fitzpatrick and Boldizar, 1993). Jaycox et al. (2002) reported their finding that more than one third of middle school aged students in their immigrant Latino sample met clinical criteria for PTSD.

Effective Programs

Fortunately, trauma-related disorders have responded well to a number of cognitive behavioral treatments in clinical studies. Trauma-Focused CBT (Deblinger & Heflin, 1996; Cohen, Manarino, & Deblinger, 2006) is perhaps one of the most well studied and widely implemented programs for PTSD in youth and has demonstrated effectiveness with children from a variety of backgrounds and cultures, including Latinos. Another program, the Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox et al., 2002) has been implemented with samples consisting of almost entirely Latino youth and has demonstrated consistently good outcomes. A revision of the CBITS program has also recently been tested and released: SSET or, *Support for Students Exposed to Trauma* (Jaycox, Langley, & Dean, 2009) and has shown promising results in its ability to reduce symptoms of PTSD among school-aged youth when delivered by teachers, social workers, and other school personnel.

Unfortunately, though many manualized programs designed to treat PTSD-

affected youth highlight the importance of cultural competency when delivering treatment components with minority clients, few describe specific ways in which the programs should be modified or for Latino youth in particular.

Internalizing Disorders

Effective Programs

Depression is one of the most common mental health difficulties experienced by children and adolescents; and Latinos and Latino immigrants in particular have been shown to be at high risk for Depression, Dysthymia, and other internalizing mood disorders. According to the Youth Risk Behavior Surveillance study, self-reported rates of having felt sad or hopeless almost every day for two or more weeks was higher among Latino (36.2%) than White (25.8%) or Black (28.4%) students (Culture and Trauma Special Report The National Child Traumatic Stress Network 2006; Eaton et al., 2006).

Fortunately, CBT has been found to be effective for both depressive and anxiety-related disorders and has the broadest evidence base for the treatment of adolescent depression (Jungbluth, 2009; Kennard 2009; Weisz et al., 2009). CBT for depressive disorders focuses on the relationship between thoughts, emotions, and behaviors; and also on identifying and weakening triggers that perpetuate maladaptive coping. Interpersonal Therapy (IPT) is also a well-known, research-based intervention for depression. IPT examines the interpersonal events (conflicts, relationships) that appear to be most salient in the maintenance of a depressive episode (Frank et al., 1990). In an examination of evidence-based psychosocial treatment outcome studies for depressed youth conducted since 1998, CBT and IPT for adolescents were both found to have well established efficacy (Kaslow & Thompson, 1998; SAMHSA, 2009). Additionally, the CBT based specific programs *Self-Control Therapy* and *Coping with Depression* (Lewinsohn et al., 1990, 1996; Stark et al., 1991) were found to be Probably Efficacious by the American Psychological Association (David-Ferdon and Kaslow, 2008).

Two other reviews of specific psychotherapies for childhood or adolescent depression found that no one type of CBT for children has proven more efficacious than others (Curry, 2001; Sherrill and Kovacs, 2002). The most effective CBT programs seem to involve long-term rather than short-term care, as shown in the Treatment for Adolescents With Depression Study (TADS) which evaluated the effectiveness of Fluoxetine, CBT, and their combination in adolescents with major depressive disorder. Authors of this study reported that the longer treatment groups of 12 to 18 weeks demonstrated persistent benefits after a year of naturalistic follow-up (March et al., 2009).

Latino Specific Programs

Rosselló and Bernal (1999) implemented a study in which a sample of depressed Latino teenagers living in Puerto Rico were randomly assigned either to CBT, IPT, or a wait-list control. Results demonstrated that when the treatments were modified so as to include culturally relevant components and to be sensitive to values and ideas that were dominant in the participants' culture, CBT could be an effective treatment approach and resulted in diminished symptoms of depression. Rosselló, Bernal, and Rivera-Medina have in press a follow-up to this study, in which approximately 100 Latino adolescents were randomly assigned to one of four different culturally modified treatment approaches designed to address symptoms of depression (individual or group CBT or IPT). Again, results suggest that CBT was not only an effective treatment for these adolescents, but also that it was more effective than other forms of therapy.

Pina et al. (2004) examined data collected in two previous studies (Silverman et al., 1999a; 1999b) looking at treatments for anxiety-related problems that had each incorporated a moderate proportion of Latino youth (36% and 47%, respectively) but that did not specifically tailor treatment to be culturally relevant. Results of the study showed not only that Latino and Caucasian youth responded similarly to the interventions, but also that both groups demonstrated significant improvement from pre- to post-intervention assessment, suggesting that cultural adaptations were not essential to treatment effect.

Externalizing Disorders

Effective Programs

A number of programs have been shown to be effective for reducing conduct problems among children and adolescents. The majority of these are programs that provide education, training, and support to parents and caregivers to help them manage their children's behavior more effectively. Some of the most well studied include

- Parent Child Interactive Therapy (PCIT; Eyberg, 1988),
- The Positive Parenting Program (PPP; Sanders, 1992),
- The Incredible Years (IY; Webster Stratton, 1992),
- The Anger Coping and Coping Power programs by Lochman et al. (1984, 1992, & 1993).

Multisystemic Therapy is not a program per se, but rather a model for treatment delivery specifically designed to help reduce antisocial behavior among juvenile offenders. This approach to the treatment of conduct problems has strong empirical support (Timmons-Mitchell, Bender, Kishna, & Mitchell, 2006). Part of the success of MST relies on the fact that the delivery model requires the

utilization of EBPs as sub-components of treatment (see Henggeler's publications dating from 1992 to 1998 for specific study outcomes).

Latino Specific Programs

Few treatments for externalizing disorders have been evaluated specifically for Latino clients (let alone Latino immigrant clients in particular) although some have been studied using samples with substantial Latino youth (e.g., The Incredible Years; Reid, Webster-Stratton, & Beauchaine, 2001). Evaluations of PCIT specifically with Latino families (Puerto Rican) suggest that PCIT is effective with this population; and while a cultural adaptation for Latino families is being developed, it has not yet been rigorously tested (Matos, Torres, Santiago, Jurado, & Rodriguez, 2006).

One treatment for conduct disorders that was designed specifically for Latino clients is Brief Strategic Family Therapy (BSFT: Szapocznik, Hervis, & Schwartz, 2003). Szapocznik and colleagues have tested a number of variants of this program, one in particular called Family Bicultural Effectiveness Training (1984, 1986, 1989) designed to help families navigate the unique challenges stemming from biculturalism and the acculturation process. Trials of this program have shown it to be effective at improving family functioning and decreasing youth behavior problems, when evaluated using parent self-report. However, as noted by Huey and Polo (2008), of three controlled studies examining the efficacy of BSFT, only two have shown clinical significance of the program.

Cultural Factors

In their book, *Working With Parents of Noncompliant Children* (Shriver & Allen, 2008), clinicians are advised that it is essential to consider cultural factors when supporting Latino families, and urge the consideration of traditional Latino values such as

- *interdependence*,
- *machismo* and *marianismo* (the relative strengths of men and women),
- *respeto* (respect for elders),
- *familismo* (respect for the family),
- *dislike for competition and confrontation*.

The authors comment that a central way to ensure the delivery of quality services is to adopt culturally sensitive parent training techniques (pg. 139) and then they go on to outline specific values common to a number of ethnic and cultural groups. Regrettably, little research has examined these topics in controlled trials, and therefore it is unknown whether or not they actually improve clinical outcomes.

Delinquency and Substance Abuse

Effective Programs

A number of programs designed to prevent or reduce delinquency and substance use and abuse among adolescents have demonstrated efficacy in recent years, including:

- Multidimensional Family Therapy (MDFT; Liddle et al., 2001),
- Multisystemic Therapy (MST; Henggeler, 1992),
- Family Integrated Transitions (FIT; Aos, 2004; Trupin & Stewart, 2000),
- Family Functional Therapy (Alexander, Pugh, Parsons, Sexton, 2000),
- Aggression Replacement Training (Goldstein, Glick, Reiner, Zimmerman, Coultry, 1987).

Latino Specific Studies and Programs

While some of these interventions have had materials translated into Spanish, few have had substantive Latino youth represented in clinical trials (more than ten percent of the study sample) or have developed Latino-specific adaptations. The evaluation study completed for FIT had a Latino sample comprising 12.5% of the study population. However, a meta-analysis of all types of intervention programs for delinquency found no significant differences in effectiveness for minority verus non-minority youth (Wilson, Lipsey and Soydan, 2003).

One recent study (Marsiglia et al., 2005) examined the effect of the *Keepin' it REAL* program, which is a school-based substance use prevention program, with a sample of nearly 3500 Mexican and Mexican-American youth in 35 different Arizona public schools. The study involved randomly assigning participants to four conditions – a Mexican-American, a Euro/African-American, or a Multicultural version of the program, or a control group. While researchers expected that the effect of the program would be strongest for the youth who had received the Mexican-American version of the program, no differences were found among the three versions (although treatment overall was found to be associated with better substance-use outcomes than the control group).

The Need for Cultural Competency

As evidenced by the wide range of outcomes observed in treatment studies with Latino youth, questions about best practice with Latino youth and families remain largely unanswered.

A growing proportion of the research seems to suggest, as noted by Huey and Polo's comprehensive meta-analysis, that the most likely answer to the question, "Do EBPs work for ethnic and cultural minorities?" is yes. However, questions about whether or not cultural adaptations improve outcomes and if so, what those adaptations might be are more difficult to answer.

Even more complicated are questions about whether such adaptations should be implemented, regardless of their direct effect on outcomes.

Many believe that the cultural tailoring of any treatment approach is essential when working with minority clients. For example, the American Psychological Association advises all clinicians to "recognize ethnicity and culture as significant parameters in understanding psychological processes (APA, 1990)" and to seek out opportunities to learn about the cultural backgrounds of their clients so as to be able to serve them more effectively. The National Child Traumatic Stress Network states that "cultural competency needs to be a priority (Culture and Trauma Brief, pg. 5)" and urges practitioners to consider culture and acculturation when working with Latino clients. One of the main points made in favor of this perspective is simply that the demographics of the United States are so diverse that in order to respond to the needs of the population, clinicians must be culturally competent (pg. 565).

Cultural Competency Defined

- "It is the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior;
- It is the ability to use the knowledge acquired about an individual's heritage and adaptational challenges to maximize the effectiveness of assessment, diagnosis, and treatment: and
- It is internalization of this process of recognition, acquisition, and use of cultural dynamics so that it can be routinely applied to diverse groups."

(Whaley and Davis, 2007)

Some studies demonstrate the effectiveness of un-modified EBPs delivered in their original formats to Latino clients, while other studies suggest that cultural modifications and adaptations can lead to better outcomes for minority clients.

One recent publication by Whaley and Davis (2007) summarizes the main arguments that persist in favor of encouraging cultural competence in mental heath treatment despite emerging research suggesting that such specific attention to culture and ethnicity may be unnecessary. These arguments are highlighted below:

Increasing Engagement

A common argument for culturally focused adaptations appeals to the well-documented disparity in access to mental health care across cultural lines, with minority groups both over- and underutilizing services (Latinos typically receiving less care than other groups). This is a particularly compelling rationale, as underutilization of psychological services has been linked to poor long-term outcomes at both the individual and community levels and it has been suggested that cultural adaptations are one central way to reduce disparities in access to and usage of mental health care. One researcher, Mary McKay, has written extensively about the challenges of engaging clients of color in treatment, particularly parents of children and youth referred for services in urban settings (e.g., McKay et al., 1996). McKay has demonstrated that a set of adaptations to service delivery (which may be viewed as culturally based) can dramatically increase parental participation in treatment.

Furthermore, one hypothesis stemming from outcomes of McKay's work suggests that the means by which parental engagement may be increased is by attending to and responding to cultural factors, such as parents' levels of comfort with the clinical setting, their trust in the value of treatment, their perceptions of racism within the treatment center, their own beliefs about mental health care in general, and the community stigma against receiving such care (McKay & Bannon, 2004; Rodriguez, McKay, & Bannon, 2008). McKay has demonstrated in clinical trials that by addressing these barriers to service, parent engagement, and therefore youth engagement, increases and outcomes are improved.

In line with McKay's perspective, Whaley and Davis (2007) point out that when working with clients for whom engagement is not a problem, the client-clinician relationship may be of only minimal importance and what matters most may be the critical ingredients of the treatment protocol. However, when motivation to engage is low, the client-clinician relationship might become more important as it serves as an essential catalyst to participation and follow

through (pg. 570). If cultural adaptations and modifications lead to better rapport, then they may be warranted in these cases even if they haven't been shown to contribute directly to better treatment outcomes.

Ethical Responsibility

"Cultural adaptations of evidence-based practices are necessary for treatment interventions to meet the cultural needs of families, to impact treatment engagement and treatment adherence, and to improve treatment outcomes. Current cultural modifications of evidence-based practices for Latino populations appear to be efficacious and are important in retention, consumer-satisfaction, and treatment improvement (Lau, 2006; Miranda et al., 2005)" – Culture and Trauma Special Report The National Child Traumatic Stress Network

A second argument supporting the importance of cultural competency is made on moral or ethical grounds. The American Psychological Association and American Counseling Association both advise clinicians that they are responsible for their competency to treat clients from diverse backgrounds and to be familiar with best practices for the populations they serve. Both organizations have specifically highlighted the importance of cultural competency in treatment as components of their ethical guidelines for practitioners (APA, 2002; ACA, 2005). In addition, the APA emphasizes that clinicians are expected to practice only within their area of expertise and that to practice outside an area of competence is considered an ethical violation (APA, 2002). The argument could be made that to deliver services to clients of ethnic groups with whom the clinician has little or no experience or cultural familiarity could be considered a violation of exactly this kind.

Inaccuracy of Contrary Data and a Lack of Clinical Trials

A third argument in favor of promoting cultural competency rests on the premise that research denying the empirical benefit of culturally based adaptations is not necessarily accurate. Inaccuracies in such studies may result from the sheer complexity of the concepts of *culture, diversity* and *cultural competency* (Sue et al. 2009). In addition, because minorities have so frequently been left out of much of the existing treatment research, it is difficult to interpret the results of efficacy studies systematically, especially in light of the ways in which community, provider, and setting factors might influence outcomes in the real-world setting.

In addition, clinical trials in which ethnicity and/or culture have been examined rigorously continue to be lacking (Santisteban, 2009). This lack of evidence for therapeutic practices with

minorities does not necessarily mean that such treatments are ineffective – perhaps only that they are understudied. However, in an era when reimbursement may require clinics to demonstrate that their practices are justified by research findings, the absence of a solid evidence base for therapy methods may lead to an unintended consequence of over-reliance on the one form of treatment that has consistently been shown to be effective with all populations in controlled trials, namely pharmacotherapy. While quite effective when appropriately prescribed, an overreliance on medical therapies to address mental health problems in minority clients (particularly children) is unwarranted at best and negligent at worst.

Personal Preference

Finally, it is interesting to note that even in cases in which culturally based adaptations are not supported empirically and in studies documenting that unmodified treatment can lead to equally beneficial outcomes for minority and nonminority clients, many people of color indicate a preference for treatments that include cultural adaptations as a component. For example, in one study (Kohn et al., 2002) over 80% of African-American women stated a preference for culturally modified CBT even though outcome results demonstrated that there were no significant differences between the modified and standard treatments. It appears that treatment may be more acceptable to minority clients, even if it leads to equally beneficial outcomes in the end. Certainly, when working with a client of any background, steps to make treatment more comfortable should be encouraged unless they have been shown to detract from treatment benefits.

Cultural Adaptations

Despite the conflicting evidence, many clinicians prefer to make use of cultural adaptations in an effort either to

- more fully engage Latino clients,
- make treatment more comfortable or accessible for Latino clients,
- potentially bring about better outcomes for Latino clients.

For clinicians who hope to tailor their therapeutic techniques to fit their clients' cultures, an important question is, what might those adaptations or modifications look like? This question has been far less studied and only minimally documented. Therefore, even less is known about its answer than is known about whether or not the use of adaptations is warranted in the first place.

Barriers to Service

One approach to answering questions about what might constitute effective cultural adaptations involves looking at the identified barriers to successful treatment outcomes among Latinos and then working backwards, selecting modifications to standard treatment procedures that would most effectively respond to these particular barriers. Despite their high-risk status and significant degree of need, there is broad consensus among researchers and practitioners alike that Latino immigrant

Common Approaches to Cultural Adaptations

- Learn about and demonstrating basic knowledge of some of the main traditionally-Latino values such as *familismo, marianismo, machismo,* and *rispeto*.
- When conducting assessment, inquire about culture, including the client's values, family structure, immigration experiences, acculturative stress, and exposure to discrimination.
- Incorporate culturally-based protective factors, such as extended family, demonstrated ability to overcome hardships, religious beliefs, etc.
- Provide psycho-education so as to help reduce the stigma against receipt of mental health care.
- Make use of culturally-based stories, sayings, and media.

(Chadwick Center, 2008; de Arellano, 2004, 2005)

youth are significantly less likely than their non-Latino, non-immigrant peers to seek or receive professional mental health care (National Institute of Mental Health, 1999; U.S. Department of Health and Human Services, 1999, 2001).

As an example of this underutilization of mental health service, data collected by the California Department of Public Health in the years between 1993 and 1998 revealed that people identifying themselves as Hispanic had the lowest mental health service utilization rates in the state (California Department of Mental Health, 2001). Furthermore, when the group of people who had been identified as Hispanic was broken down into U.S.-born and foreign-born respondents, it was found that those born in other countries utilized mental health services even less frequently. Specifically, data showed that of those who had been diagnosed with a mental health disorder, 11.9 percent of U.S.-born Mexicans had received care from a mental health specialist for treatment as compared with only 4.6 percent of immigrant Mexicans (Aguilar-Gaxiola et al., 2002). A similar study, conducted at the University of California, Los Angeles (Hough et al., 1987) found that among a group of individuals in Southern California who had been diagnosed with Major Depression, 22 percent of the non-Latino Whites but only 11 percent of the Mexican Americans had sought mental health services. A more recent study (Coker et al., 2009) showed that this discrepancy in service utilization has

Barriers to Mental Health Services for Latinos and Latino Immigrants

- No health insurance and cannot afford the cost of treatment.
- A lack of awareness about different psychological disorders, their symptoms, and their respective treatments.
- A lack of available information about where to obtain mental health treatment.
- Difficulty obtaining transportation to treatment centers.
- A lack of availability of Spanish-speaking professionals.
- A persistent, culturally-based stigma against self-disclosure about personal hardship and the utilization of mental health care.
- A poor alignment between preferred and available methods of responding to psychological distress.
- A general perception (and possible reality) that the mental health care afforded to Spanish-speaking, immigrant minorities is frequently of poorer quality than that provided to Caucasian, non-immigrants.

(Acosta et al., 2004; Lopéz, 2002; Muñoz & Mendelson, 2005; Organista, K, 1996; Sue et al, 1991, 1998, 1999; Surgeon General, 2000; Vega et al., 1998).

remained unchanged in the past decade and also extends to children and adolescents, with Latino youth less likely than non-Hispanic Whites to utilize mental health services, even when diagnosed with a psychological disorder.

Addressing Barriers

Certainly some of these barriers cannot be addressed by making adaptations to standard treatment protocols (e.g., the underinsurance of Latino families), but several of them can. For example, in a community in which there is low awareness about mental health disorders and their various symptoms, clinicians can tailor their treatments to include a great deal of psycho-education and outreach. Likewise, for populations with limited knowledge about how to receive care, marketing efforts can be made to educate the community about where and how to receive care. When there is a cultural stigma against self-disclosure or when there is a pervasive belief that receipt of mental health care is a sign of weakness or major mental illness, clinicians can take the time to discuss these beliefs with clients, listen to their concerns, and help clients feel more comfortable about the care they receive. When a client has specific ideas about the type of therapy she or he wants, clinicians can take the time to listen to the ideas and build into their treatment approach components of care that are desired. Unlike an approach to cultural modification in which a clinician adheres to a list of ways to respond to Latino clients in particular, all of these adaptations are built on communication with clients and encouragement of the open expression of their perspectives.

Recommendations from the Chadwick Center

The Chadwick Center published a document in 2008, entitled Adaptation Guidelines for Serving Latino Families and Children Affected by Trauma, which was co-sponsored by the National Child Traumatic Stress Network. This publication provides a clear summary of the research findings to date. It organizes recommendations into several different categories, including Assessment, the Provision of Therapy, Case Management, and Research (among others). In one section, it states, "clinicians need to be familiar with cultural values and how to engage these values in trauma treatment." Further, in another section, the manual points out that research has not yet confirmed the utility of cultural adaptations – rather, it encourages:

- "culturally sensitive" and "culturally aware" practices,
- thoughtfully displaying multicultural artwork,
- making information available in multiple languages,
- using well-trained interpreters,
- providing services in places already accessible to populations of color.

Recommendations also include suggestions about how to incorporate culture into assessment practices and provide guidance on how to further research and academic goals related to cultural competency and the treatment of ethnic and cultural minorities.

Work of Mary McKay

Also, as mentioned previously, the research and work of Mary McKay (e.g. 1996, 2003, 2005) provides clear guidance on general engagement strategies, all of which may be utilized as part of an effort to increase treatment participation among Latino and other minority clients and families. Some of McKay's suggestions to clinicians include:

- soliciting thoughts and ideas from clients (and caregivers) about their experiences with service providers and inviting clients to discuss their concerns about or lack of confidence in the treatment process;
- ensuring that caregivers view themselves as important members of a team approach to improving the mental health of their children (rather than passive recipients of care or uninvolved observers of treatment);
- taking the time to develop a personal relationship with clients and caregivers so that families can know a little bit about the people they are working with, their approach to treatment, and their path to becoming clinicians;
- making use of evidence-based practices so that when clients begin treatment, clinicians can easily and honestly provide information about treatment components and expected outcomes.

Summary

It may be some time before clinicians are able to base their decisions about treatment approaches with clients of different backgrounds on firm and clear research outcomes. Evidence-based practice in general is still fairly new to many therapists and researchers, and even more recent is direction about how EBPs may be applied effectively to specific population subgroups. However, across the field there seems to be broad consensus that clients of color, particularly Latinos and Latino immigrants, are in need of effective services and that treatment as it is most commonly delivered is not responding adequately to that need. Whether culturally competent practice involves working to eliminate barriers to care, improving resources to make them more meaningful for non English-speaking clients, or designing and testing individual treatments and treatment modifications, the message is clear that such steps are imperative.

References

Acosta, O.M., Weist, M.D., Lopez, F.A., Shafer, M.E., & Pizarro, L.J. (2004). Assessing the psychosocial and academic needs of Latino youth to inform the development of school-based programs. *Behavior Modification*, 28, 579-595.

Aguilar-Gaxiola, S.A., Zelezny, L., Garcia, B., Edmondson, C., Alejo-Garcia, C., & Vega, W.A. (2002). Translating research in to action: Reducing disparities in mental health care for Mexican Americans. *Psychiatric Services*, 53, 1563-1568.

Alexander, J.F., Pugh, C., Parsons, B.V., and Sexton, T.L. (2000). *Functional family therapy. In Blueprints for Violence Prevention* (Book 3), 2d ed., edited by D.S. Elliott. Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado.

American Counseling Association. (2005) *ACA Code of Ethics*.

American Psychological Association. (1990). Ethical principles of psychologists (Amended June 2, 1989). *American Psychologist*, 45, 390-395.

American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073.

Aos, S. (2004). *Washington State's family integrated transitions program for juvenile offenders: outcome evaluation and benefit-cost analysis*. Olympia: Washington State Institute for Public Policy.

Beck, A., Rush, A., Shaw, B., & Emery, G., (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Berman, S.L., Kurtines, W.M., Silverman, W.K., & Serafini, L.T. (1996). The impact of exposure to crime and violence on urban youth. *The American Journal of Orthopsychiatry*, 66, 329-36.

California Department of Mental Health (2001). *Medi-Cal mental health services in California: Fiscal years 1993-94 through 1997-98.* Statistical Report 01-01. Sacramento, CA: Author.

Canino, G., Roberts, R.E. (2001). Suicidal behavior among Latino youth. *Suicide and Life-threatening Behavior*, 31, 122-131.

Carr, A. (2004). Interventions for post-traumatic stress disorder in children and adolescents. *Pediatric Rehabilitation*, 7, 231-244.

Carter-Pokras, O., Zambrana, R.E., Yankelvich, G., Estrada, M., Castillo-Salgado, C., Ortega, A.N. (2008). Health status of Mexican-origin persons: do proxy measures of acculturation advance our understanding of health disparities? *Journal of Immigrant Minority Health*, 10, 475-88.

Centers for Disease Control and Prevention. (2002). *Demographic and health snapshot of the U.S. Hispanic/ Latino population*. Department of Health and Human Services.

Centers for Disease Control and Prevention. (2000). *Tracking the hidden epidemics: Trends in STDs in the United States*. Department of Health and Human Services.

Chaffin, M., Silovsky, J.F., Funderburk, B., Valle, L.A., Brestan, E.V., Balachova, T., Jackson, S., Lens graf, J., Bonner, B.L. (2004) Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72, 500-10.

Chen, E. C., Kakkad, D., & Balzano, J. (2008). Multicultural competence and evidence-based practice in group therapy. *Journal of Clinical Psychology,* 64, 1261-1278.

Cohen, J.A., Mannarino, A.P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents.* New York: Guilford Press.

Cohen, J.A., Mannarino, A.P., Perel, J.M., Staron, V. (2007) A pilot randomized controlled trial of com bined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the Ameri can Academy of Child and Adolescent Psychiatry*, 46, 811-9.

Curry, J.F. (2001). Specific psychotherapies for childhood and adolescent depression. *Biological Psychia try*, 49, 1091-100.

Davidson, A.L. (1996). *Making and molding identify in schools: Student narratives on race, gender, and academic achievement.* Albany, NY: SUNY Press.

David-Ferdon, C., Kaslow, N.J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal Clinical Child and Adolescent Psychology*, 37, 62-104.

De Arellano, M.A., Waldrop, A.E., Deblinger, E., Cohen J.A., Danielson C.K., Mannarino A.R. (2005). Community outreach program for child victims of traumatic events: a community-based project for underserved populations. *Behavior Modification*, 1, 130-55.

Deblinger, E. and Hefin, A.(1996). *Treating Sexually Abused Children and Their Non-Offending Parents: A Cognitive Behavioural Approach*. Thousand Oaks, CA: Sage.

Deblinger, E., Lippmann, J. and Steer, R. (1996) Sexually abused children suffering post-traumatic stress symptoms: initial treatment outcome findings. *Child Maltreatment*, 1, 310–321.

Escobar, J.I., Nervi, C.H., & Gara, M.A. (2000). Immigration and mental health:Mexican Americans in the United States. *Harvard Review of Psychiatry*, 8, 64-72.

Eyberg, S.M., (1988). Parent-child interaction therapy: Integration of traditional and behavioral concerns. *Child and Family Behavior Therapy*, 20, 33–46.

Finch, B. K., & Vega, W. A. (2003). Acculturation Stress, Social Support, and Self-Rated Health Among Latinos in California. *Journal of Immigrant Health*, 5, 109-117.

Fitzpatrick, K. M., & Boldizar, J. P. (1993). The prevalence and consequences of exposure to violence among African-American youth. *Journal of the American Academy of Child and Adolescent Psychia try*, 32, 424--430.

Frank, E., Kupfer, D., Perel, J.M., Cornes, C., Jarrett, D.B., Mallinger, A.G., McEachran, A.B., Grochocinski, V.J. (1990). Three-year outcomes for maintenance therapies in recurrent depression. *Archives of General Psychiatry*, 47, 1093-9.

Fry, R. (2003). *Hispanic youth dropping out of U.S. schools: Measuring the challenge*. Washington, DC: Pew Hispanic Center.

Goldstein, A. P., Glick, B., Reiner, S., Zimmerman, D. L., & Coultry, T. M. (1987). *Aggression Replacement Training: A Comprehensive Intervention for Aggressive Youth.* Champaign, IL: Re search Press.

Henggeler, S. W., Melton, G. B., & Smith, L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology*, 60, 953-961.

Hernandez, D. J., & Charney, E. (1998). *From generation to generation: The health and well-being of children in immigrant families*. Washington, DC: National Academy Press.

Hough, R.L., Landsverk, J.A., Karno, M., Burnam, M.A., Timbers, D.M., Escobar, J.I., & Regier, D.A. (1987). Utilization of health and mental health services by Los Angeles Mexican Americans and non-Hispanic Whites. *Archives of General Psychiatry*, 44, 702-709.

Hovey, J.D., & King, C.A. (1996). Acculturative stress, depression, and suicidal ideation among immigrant and second-generation Latino adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1183-1193.

Hovey, J.D., & Magaña, C.G. (2002). Psychosocial predictors of anxiety among immigrant Mexican migrant farmworkers: Implications for prevention and treatment. *Cultural Diversity and Ethnic Minority Psychology*, 8, 274-289.

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

Jaycox, L., Langley, A., & Dean, K. L. (2009). *Support for students exposed to trauma: The SSET program : group leader training manual, lesson plans, and lesson materials and worksheets*. Santa Monica, CA: RAND Health.

Jungbluth, N. (2009) Therapist strategies for building involvement in cognitive-behavioral therapy for

adolescent depression. *Journal of Consulting and Clinical Psychology*, 77, 1179-84.

Kandula, N.R., Kersey, M., & Lurie, N. (2004). Assuring the health of immigrants: what the leading health indicators tell us. *Annual Review of Public Health*, 25, 357-76.

Kazdin, A. E. (2000). *Psychotherapy for children and adolescents: Directions for research and practice.* New York: Oxford University Press.

Kazdin, A. E., & Weisz, J. R. (2003). *Evidence-based psychotherapies for children and adolescents*. New York: Guilford Press.

Kaslow, N. J., & Thompson, M. P. (1998). Applying the criteria for empirically supported treatments to studies of psychosocial interventions for child and adolescent depression. *Journal of Clinical Child Psychology*, 27, 146–155.

Kennard, B.D., Clarke, G.N., Weersing, V.R., Asarnow, J.R., Shamseddeen, W., Porta G, Berk, M., Hughes, J.L., Spirito, A., Emslie, G.J., Keller, M.B., Wagner, K.D., Brent, D.A. (2009). Effec tive components of TORDIA cognitive-behavioral therapy for adolescent depression: Prelimi nary findings. *Journal of Consulting and Clinical Psychology*, 77, 1033-41.

Kao, G. (1999). *Psychological well-being and educational achievement among immigrant youth*. In D.J. Hernandez (Ed.),Children of immigrants: Health, adjustment, and public assistance (pp. 410-77). Washington, DC: National Academy Press.

Kozol, J. (2005). Still separate, still unequal. *Harper's Magazine*, 9, 41-55

Lara, M., Gamboa, C., Kahramanian, M.I., Morales, L.S., & Bautista, D.E. (2005). Acculturation and Latino health in the United States: a review of the literature and its sociopolitical con text. *Annual Review of Public Health*, 26, 367-97.

Larsen, L.J. (2004). The foreign-born population in the United States: 2003. *Current Population Reports*, 20-551. U.S. Census Bureau, Washington, D.C.

Lewinsohn, P. M., Clarke, G. N., Rohde, P., Hops, H., & Seeley, J. R. (1996). A course in coping: A cognitive-behavioral approach to the treatment of adolescent depression. In E. Hibbs & P. Jen sen (Eds.), *Psychosocial treatment of child and adolescent disorders: Empirically based approaches* (109-135). Washington, DC: American Psychological Association Press.

Lewinsohn, P. M., Clarke, G. N., Hops, H., Andrews, J. A., & Williams, J. A. (1990). Cognitive-behavioral treatment of depression in adolescents. *Behavior Therapy*, 21, 385-401

Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., Tejeda, M. (2001). Multidimen sional family therapy for adolescent drug abuse: results of a randomized clinical trial. *American Journal of Drug & Alcohol Abuse*, 27, 65-88.

Lochman, J. E. (1992). Cognitive-behavioral intervention with aggressive boys: Three-year follow-up

and preventive effects. *Journal of Consulting and Clinical Psychology*, 60, 426-432.

Lochman, J. E., Burch, P. R., Curry, J. F. & Lampron, L. B. (1984). Treatment and generalization ef fects of cognitive behavioral and goal setting interventions with aggressive boys. *Journal of Consulting and Clinical Psychology*, 52, 915-916.

Lochman, J. E., and Lenhart, L. A. (1993). Anger coping intervention for aggressive children; Conceptual models and outcome effects. *Clinical Psychology Review*,13, 785-805.

Lochman, J.E., Whidby, J., & FitzGerald, D. (2000). *Cognitive behavioral assessment and treatment with aggressive children*. In P.C. Kendall (Ed.), Child and adolescent therapy: Cognitive-behavioral procedures (2nd ed., pp. 31-87). New York: Guilford Press.

Lopez, S.R., (2002). Mental health care for Latinos: A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatric Services*, 53, 1569-1573.

March , J., Silva, S., Susan, J., Wells, K., Fairbank, J., Burns, B., Domino, M., Vitiello, B., Severe, J. (2009). The Treatment for Adolescents With Depression Study (TADS): outcomes over 1 year of naturalistic follow-up. *The American Journal of Psychiatry*, 166, 1141-9

Marshall, G.N. (2004). Posttraumatic stress disorder symptom checklist: Factor structure and English-Spanish measurement invariance. *Journal of Traumatic Stress*, 17, 223-230.

Marsiglia, F.F., Kulis, S., Nieri, T., Parsai, M. (2005). God forbid! Substance use among religious and non-religious youth. *American Journal of Orthopsychiatry*, 75, 585-598.

Matos, M., Torres, R., Santiago, R., Jurado, M., Rodríguez, I. (2006). Adaptation of parent-child inter action therapy for Puerto Rican families: a preliminary study. *Family Process*, 45, 205-22.

McKay, M.M., Bannon, W.M., Jr. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America*, 13, 905-21.

McKay, M.M., McCadam, K., Gonzales, J.J. (1996). Addressing the barriers to mental health services for inner city children and their caretakers. *Community Mental Health Journal*, 32, 353-61.

McKay, M.M., Atkins, M.S., Hawkins, T., Brown, C., Lynn, C.J. (2003). Inner-city African American parental involvement in children's schooling: racial socialization and social support from the parent community. *American Journal of Community Psychology*, 32, 107-14.

McKay, M.M., Lynn, C.J., Bannon, W.M. (2005). Understanding inner city child mental health need and trauma exposure: implications for preparing urban service providers. *American Journal of Orthopsychiatry*, 75, 201-10.

Merikangas, K.R. (2010). Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. *Pediatrics*, 125, 75-81.

Mendoza, F.S. (2009). Health disparities and children in immigrant families: a research agenda. *Pediatric*, 124, 187-95.

Muñoz, R.F., Mendelson, T. (2005). Toward evidence-based interventions for diverse populations: The San Francisco General Hospital prevention and treatment manuals. Journal of Consulting and Clinical Psychology, 73, 790-799.

Myers, R., Chou, C.P., Sussman, S., Baezconde-Garbanati, L., Pachon, H., Valente, T.W. (2009). Ac culturation and substance use: social influence as a mediator among Hispanic alternative high school youth. *Journal of Health and Social Behavior*, 50, 164-79.

National Alliance for Hispanic Health. (2001). A primer for cultural proficiency: Towards quality health services for Hispanics. http://www.hispanichealth.org/. Cited September 30, 2003

National Child Traumatic Stress Network (2005). Promoting culturally competent trauma-informed practices, Culture and Trauma Brief, 1.

National Council of La Raza (2005). Critical Disparities in Latino Mental Health: Transforming Re search into Action. White Paper. Accessed at: http://www.nclr.org/content/publications/detail/34795/

National Institute of Mental Health (1999). Strategic plan on reducing health disparities. Rockville, MD: Author.

National Latina Institute for Reproductive Health (2005). Prenatal care access among immigrant Latinas: Policy brief. NY: Author.

National Latina Institute for Reproductive Health (2005). The Reproductive Health of Latina Immi grants. Accessed online at: http://latinainstitute.org/sites/default/files/publications/RepoHlthImgrnt-5_0.pdf

Ogbu, J. (1995). The influence of culture on learning and behavior. In J.H. Falk & L. Dierking (Eds.). Public institutions for personal learning: Establishing a research agenda. (pp. 79-95). Washington: DC: American Association of Museums.

Olsen, L. (1997). *Made in America: Immigrant students in our public schools*. NY: The New Press.

Orfield, G. & Lee, C., (2005). *Why segregation matters: Poverty and educational inequality*. Cambridge, MA: The Civil Rights Project at Harvard University.

Orfield, G. (2001). *Schools more separate: Consequences of a decade of resegregation*. Cambridge, MA: The Civil Rights Project at Harvard University.

Organista, K.C., & Muñoz, R.F. (1996). Cognitive behavioral therapy with Latinos. *Cognitive and Behav ioral Practice*, 2, 255- 270.

Padilla, A.M. (1988). Early psychological assessments of Mexican-American children. *Journal of the His tory of the Behavioral Sciences*, 24, 111-6.

Pew Research Center (2006). America's Immigration Quandary. Retrieved on May 20, 2006 from: http://pewhispanic.org/reports/report.php?ReportID=63.

Pew Research Center (2007). National Survey of Latinos: As Illegal Immigration Issue Heats Up, Hispanics Feel a Chill. Retrieved on Dec 2 from: http://pewhispanic.org/reports/report.php? ReportID=84.

Pina, A.A., Silverman, W.K., Fuentes, R.M., Kurtines, W.M., & Weems, C.F. (2003). Exposure-based cognitive-behavioral treatment for phobic and anxiety disorders: treatment effects and mainte nance for Hispanic/Latino relative to European-American youths. *Journal of the American Acad emy of Child and Adolescent Psychiatry*, 42, 1179-87.

Reid, M. J., Webster-Stratton, C., and Beauchaine, T.P. 2001. Parent training in Head Start" A comparison of program response among African American, Asian American, Caucasian, and Hispanic mothers. *Prevention Science*, 2, 209-227.

Roberts, R.E., (2000). *Depression and suicidal behaviors among adolescents: The role of ethnicity*. In, I. Cuellar & F.H. Paniagua (Eds.), Handbook of multi-cultural mental health. Sand Diego, CA: Aca demic Press, 360-380.

Rodriguez, J., McKay, M.M., Bannon, W.M. (2008). The role of racial socialization in relation to par enting practices and youth behavior: An exploratory analysis. *Social Work in Mental Health*, 6, 30-54.

Rodríguez, M.A., Ward, L.M., & Pérez-Stable, E.J. (2005). Brest and cervical cancer screening: Impact of health insurance status, ethnicity, and nativity of Latinas. *Annals of Family Medicine*, 3, 235-241.

Rosselló, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. Journal *of Consulting and clinical Psychology*, 67, 734-745.

Rothstein, R. (2004). Class and schools: Using social, economic, and educational reform to close the black-white achievement gap. Washington, DC: Economic Policy Institute.

SAMSHA, National Survey on Drug Use and Health, 2001, 2009. Accessed at: http:// www.oas.samhsa.gov/nsduh.htm.

Sanders, M.R., (1992). *Every parent: A positive approach to children's behaviour*. Brisbane: Addison-Wesley.

Santisteban, D.A., Mena, M.P, (2009). Culturally informed and flexible family-based treatment for adolescents: A tailored and integrative treatment for Hispanic youth. *Family Process*, 48, 253-

268.

Sherrill, J.T., Kovacs, M. (2002). Nonsomatic treatment of depression. *Child and Adolescent Psychiatric Clinics of North America*, 11, 579-93.

Shriver, M. D., & Allen, K. D. (2008). Working with parents of noncompliant children: A guide to evidence-based parent training for practitioners and students. Washington, DC: American Psychological Association.

Silverman, W. K., & Kurtines, W. M. (1999). Short-term Treatment for Children with Phobic and Anxi ety Problems: A Pragmatic View. *Crisis Intervention and Time-Limited Treatment*, 5 (1/2), 119-132.

Silverman, W.K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Lumpkin, P.W., & Carmichael, D.H. (1999). Treating anxiety disorders in children with group cognitive-behaviorial therapy: a ran domized clinical trial. *Journal of Consulting and Clinical Psychology*, 67, 995-1003.

Singh, G.K., Miller, B.A. (2004) Health, life expectancy, and mortality patterns among immigrant populations in the United States. *Canadian Journal of Public Health*, 95, I14-21.

Smart, J. F., & Smart, D. W. (1995). Acculturative Stress: The Experience of the Hispanic Immi grant. *Counseling Psychologist*, 23, 25-42.

Stanton-Salazar, R.D. (2001). *Manufacturing hope and despair: The school and kin support networks of U.S.-Mexican youth*. New York: Teachers College Press.

Stark, K. D., Rouse, L. W. & Livingston, R. (1991). Treatment of depression during childhood : Cogni tive-behavioral procedures for the individual and family. In P. C. Kendall (Ed.). Child and Adolescent Therapy: Cognitive-Behavioral Procedures (pp. 165 - 208). New York: Guilford Press.

Stein, B.D., Jaycox, L.H., Kataoka, S.H., Wong, M., Tu, W., Elliott, M.N., et al. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *Journal of the American Medical Association*, 290, 603-11.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling.*American Psychologist*, 53, 440—448.

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist*, 54, 1070—1077.

Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T., Zane, N.W.S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consult ing and Clinical Psychology*, 59, 533-540.

Sue, S., Zane, N., Nagayama-Hall, G.C., Berger, L.K. (2009). The case for cultural competency in

psychotherapeutic interventions. *Annual Review of Psychology*, 60, 525-548.

Sullivan, M.M. & Rehm, R. (2005). Mental health of undocumented Mexican immigrants: A review of the literature. *Advances in Nursing Science*, 28, 240-251.

Surgeon General (1999). Executive summary: A report of the Surgeon General on mental health. Washington, DC: U.S. Public Health Service.

Szapocznik, J., Hervis, O.E., & Schwartz, S. (2003). Brief strategic family therapy for adolescent drug abuse (NIH Publication No. 03-4751). NIDA Therapy Manuals for Drug Addiction. Rock ville, MD: National Institute on Drug Abuse.

Szapocznik, J., Santisteban, D., Kurtines, W.M., Perez-Vidal, A., and Hervis, O.E. (1984). Bicultural Effectiveness Training (BET): A treatment intervention for enhancing intercultural adjust ment. *Hispanic Journal of Behavioral Sciences*, 6, 317–344.

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

Szapocznik, J., Santisteban, D., Rio, A.T., Perez-Vidal, A., and Kurtines, W.M. (1989). Family effect tiveness training: An intervention to prevent problem behaviors in Hispanic adolescents. *Hispanic Journal of Behavioral Sciences*, 11, 4–27.

Thomas, R., Zimmer-Gembeck, M.J. (2007). Behavioral outcomes of Parent-Child Interaction Therapy and Triple P-Positive Parenting Program: a review and meta-analysis. *Journal of Abnormal Child Psychology*, 35, 475-95.

Timmons-Mitchell, J., Bender, M. B., Kishna, M. A., & Mitchell, C. C. (2006). An Independent Effec tiveness Trial of Multisystemic Therapy with Juvenile Justice Youth. *Journal of Clinical Child and Adolescent Psychology*, 35, 227-236.

Tylor, E. B. (1871). *Primitive culture: Researches into the development of mythology, philosophy, religion, art, and custom*. London: J. Murray.

U.S. Department of Health and Human Services (2001). Mental health: Culture, race, and ethnicity—A supplement to Mental health: A report of the Surgeon General. Rockville, MD.

U.S. Census Bureau (2008). Current population survey.. Immigration Statistics Staff, Population Division.

U.S. Census Bureau (2007). Current population survey: School enrollment and internet use supplement.. Immigration Statistics Staff, Population Division.

Vega, W.A., Kolody, B. & Aguilar-Gaxiola, S.A. (1998). Lifetime prevalence of DSM-III-R psychiatric disorders among urban and rural Mexican Americans in California. *Archives of General Psychia*

try, 55, 771-778.

Webster-Stratton, C. (1992). Individually administered videotape parent training: "Who benefits?". *Cognitive Therapy and Research*, 1, 31-35.

Weisz, J.R., Southam-Gerow, M.A., Gordis, E.B., Connor-Smith, J.K., Chu, B.C., Langer, D.A., McLeod, B.D., Jensen-Doss, A., Updegraff, A., Weiss, B. (2009). Cognitive-behavioral ther apy versus usual clinical care for youth depression: an initial test of transportability to commu nity clinics and clinicians. *Journal of Consulting and Clinical Psychology*, 77, 383-96.

Whaley, A.L., Davis, K.E. (2007). Cultural competence and evidence-based practice in mental health services: a complementary perspective. *The American Psychologist*, 62, 563-74.

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

Workgroup on Adapting Latino Services. (2008). *Adaptation guidelines for serving Latino children and families affected by trauma*. San Diego, CA: Chadwick Center for Children and Families.