Evidence-Based Psychosocial Treatments for Ethnic Minority Youth:
A Review and Meta-Analysis

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Abstract

This article reviews research on evidence-based treatments (EBTs) for ethnic minority youth using criteria from Chambless et al. (1996, 1998) and Chambless and Hollon (1998). Although no well-established treatments were identified, probably efficacious or possibly efficacious treatments were found for ethnic minority youth with anxiety-related problems, attention-deficit/hyperactivity disorder, depression, conduct problems, substance use problems, trauma-related syndromes, and other clinical problems. In addition, all studies met either Nathan and Gorman’s (2002) Type 1 or Type 2 methodological criteria. A brief meta-analysis showed overall treatment effects of medium magnitude ($d = .44$). Effects were larger when EBTs were compared to no treatment ($d = .58$) or psychological placebos ($d = .51$) versus treatment as usual ($d = .22$). Youth ethnicity (African American, Latino, mixed/other minority), problem type, clinical severity, diagnostic status, and culture-responsive treatment status did not moderate treatment outcome. Most studies had low statistical power and poor representation of less acculturated youth. Few tests of cultural adaptation effects have been conducted in the literature and culturally-validated outcome measures are mostly lacking. Recommendations for clinical practice and future research directions are provided.
Evidence-Based Psychosocial Treatments for Ethnic Minority Youth: A Review and Meta-Analysis

Psychotherapy research with children and adolescents has flourished in recent years, with many treatments tested on youth with diverse mental health problems (Durlak, Wells, Cotton, & Johnson, 1995; Kazdin, 2000; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz, Weiss, Han, Granger, & Morton, 1995). Although considerable variation in outcomes exists, results converge around one central finding: Research based treatments are superior to “placebo” or no treatment, with the average treated youth faring better post-treatment than 75% of controls (Casey & Berman, 1985; Weisz, Huey, & Weersing, 1998; Weisz & Weiss, 1987; Weisz, Weiss et al., 1995). In other words, youth psychotherapy works.

This body of research has helped generate enthusiasm for evidence-based treatment (EBT) as a way to select individual therapies that are efficacious for youth and adults (Chambless & Hollon, 1998; Lonigan, Elbert, & Johnson, 1998; Nathan & Gorman, 1998). Yet, given the apparent absence of efficacious treatments with ethnic minorities and alarming mental health disparities, some scholars have argued that data generated from existing clinical trials cannot be generalized beyond European American samples (Bernal, Bonilla, & Bellido, 1995; Bernal & Scharron-Del-Rio, 2001; Hall, 2001; Sue, 1998). In support of this perspective, Chambless and colleagues (1996) report, “we know of no psychotherapy treatment research that meets basic criteria important for demonstrating treatment efficacy for ethnic minority populations. . .” (p. 7). Similarly, a review of clinical trials used to generate professional mental health treatment guidelines found that none analyzed the efficacy of treatment by ethnicity or race (U.S. Department of Health and Human Services, 2001). Other reviewers have been equally pessimistic concerning the availability of efficacious treatments for ethnic minority populations.
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Fortunately, a recent look at the literature suggests reason for optimism. Child and adolescent treatment outcome research has increased dramatically in recent decades, giving rise to dozens of randomized controlled trials that evaluate treatment efficacy with ethnic minority youth (or in samples that include ethnic minority youth). This review synthesizes this literature, with a focus on efficacious treatments for ethnic minority youth, particularly those treatments meeting criteria as EBTs. In the first part of this article, a summary of existing support for EBTs with ethnic minority youth is provided. Next, other critical topics that clarify the parameters of treatment efficacy with this population are addressed. Finally, recommendations for clinical practice and treatment outcome research are offered. Whenever possible, aggregate effect size data are used to evaluate key questions about the efficacy of treatment with ethnic minority youth.

Search and Selection Criteria

A search using the PsycInfo database (years 1960 through 2006) served as the primary source for study selection. Terms representing treatment (e.g., “psychotherapy,” “training,” “modification”), evaluation (e.g., “comparison,” “effect,” “outcome”), and youth (e.g., “child,” “adolescent,” “boys”) were utilized. This search was supplemented with (1) a manual review of all studies included in youth treatment outcome meta-analyses published through the year 2006, (2) reference trails (i.e., references in target studies to other controlled trials), and (3) in press and published studies recommended by treatment outcome researchers. Studies were included only if the mean age of participants was 18 years or younger and youth presented with behavioral or emotional problems. Formal psychiatric diagnosis was not required for inclusion because (1) the
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The majority of trials with clinically-impaired ethnic minority youth did not assess diagnostic status, (2) many clinic-referred youth do not present with DSM diagnoses (e.g., Jensen & Weisz, 2002), and (3) other reviews of youth EBTs have used similar criteria (e.g., Kaslow & Thompson, 1998; Ollendick & King, 1998).

The term “treatment” was broadly defined to incorporate a wide array of interventions for youth. The approach used by Weisz, Weiss, et al. (1995) was adopted who defined treatment as “any intervention to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counseling, structured or unstructured interaction, a training program, or a predetermined treatment plan” (p. 452). Excluded were interventions involving: (1) medication only, (2) reading only (i.e., bibliotherapy), (3) teaching or tutoring focusing only on increasing knowledge of a specific subject, (4) relocation only (e.g., moving child to foster home), and (5) treatment exclusively intended to prevent problems in youth at-risk (i.e., primary prevention). Also, because the focus was on behavioral and emotional problems in youth, excluded were treatments focusing primarily on (1) reading ability, learning disabilities, and academic concerns, (2) peer rejection or unpopularity, (3) somatic or medical problems (e.g., distress/pain associated with a medical procedure, migraines, obesity, sleep difficulties), and (4) client adherence to a treatment regimen (e.g., diabetes care).

Evidence-based treatment criteria. For this review, the framework originally developed by the Task Force of the American Psychological Association and outlined in Chambless et al. (1996, 1998) and Chambless and Hollon (1998) was used to guide the identification of EBTs (see Table 1). The guidelines classify treatments as well-established, probably efficacious, or possibly efficacious treatments. The first two labels are from Chambless et al. (1996, 1998) and the third is from Chambless and Hollon (1998).
Well-established treatments have the highest level of empirical support, requiring at least two high-quality (e.g., random assignment, adequate sample size) between-groups trials by different investigative teams showing that treatment is superior to placebo or another treatment, or equivalent to an already established treatment. Probably efficacious treatments require only one high-quality trial comparing treatment to placebo (or alternative treatment) or two trials comparing treatment to no treatment. Finally, possibly efficacious treatments have at least one study showing the treatment to be efficacious but do not meet criteria as well-established or probably efficacious.

The second set of criteria, summarized in Table 2, is from Nathan and Gorman (2002; 2007) and was used to evaluate the methodological robustness of a study. Type 1 study designation requires random assignment to treatment conditions, clear inclusion and exclusion criteria, blinded assessments (i.e., assessor or informant was unaware of treatment assignment), “state-of-the-art” diagnostic methods (operationalized here as the use of valid and/or reliable measures), adequate sample size (operationalized as 12 participants per condition; Kazdin & Bass, 1989)², and clearly described statistical methods. Type 2 studies included clinical trials that were missing one or more elements of a Type 1 study. Nathan and Gorman (1998) also describe Type 3, 4, 5, and 6 studies; however, these criteria were not applied to this review because such studies have serious methodological flaws (e.g., no comparison group).

To evaluate treatments for ethnic minority youth, several additional factors were considered. These features were established solely for this review and do not represent any organization’s (e.g., APA) official guidelines for classifying treatments as evidence-based for ethnic minorities. After EBT criteria were met, an intervention was considered well-established, probably efficacious, or possibly efficacious for ethnic minority youth if supporting studies met
one or more of three conditions listed in Table 2 as “additional considerations.” The first was based on the proportion of ethnic minority participants included in the study. Eligibility was met if an EBT study included at least 75% of participants who were ethnic minorities (Condition A). Although lower thresholds have been used by some reviewers (e.g., 50% cut-off by Tobler, 1997; 60% cut-off by Wilson, Lipsey, & Soyden, 2003), the 75% threshold used here (representing a 3-to-1 ratio of ethnic minority to non-minority participants) provided stronger evidence that treatment effects were applicable to minorities. If most participants were not ethnic minorities, however, a treatment could still meet EBT criteria if either separate analyses with the subset of ethnic minority participants demonstrated superiority of treatment over control/comparison conditions (Condition B), or analyses showed ethnicity did not statistically moderate treatment outcomes (or treatment was efficacious for ethnic minorities despite “ethnicity-as-moderator” effects) (Condition C). Thus, statistical evidence that ethnic minority participants benefited from treatment (or did not differ from non-minorities in terms of treatment benefit) was considered when making determinations about EBT status.

Although the Task Force and Nathan and Gorman guidelines apply primarily to DSM-IV psychiatric disorders (American Psychiatric Association, 1994), the studies reviewed here include youth with a broad array of clinical syndromes that often do not map onto discrete diagnostic categories (e.g., aggressive behavior, internalizing problems). Indeed, only seven of the efficacy trials summarized here target youth with DSM diagnoses. However, given the prior use of these guidelines to identify treatments for maritally distressed couples and other sub-clinical populations (e.g., Baucom et al., 1998; Kaslow & Thompson, 1998), they would appear similarly applicable to the symptom clusters described in this article.
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**Effect size estimation.** According to the Task Force and Nathan and Gorman guidelines, treatment efficacy is evident when an intervention is statistically superior to a control condition. However, the treatment *effect size* is of greater clinical and practical importance than statistical significance (e.g., Hinshaw, 2002; Kraemer, Wilson, Fairburn, & Agras, 2002); a treatment may be statistically superior but yield small clinical effects of little practical value to patients, clinicians, or policymakers. Thus, to supplement the narrative review, effect sizes were estimated for each study when adequate data were available.

The effect size statistic represents the standardized difference in outcomes between a treatment and comparison group at post-treatment or follow-up. For continuous outcomes, comparisons were calculated using the standardized mean difference effect size statistic \((d)\), with the pooled standard deviation as the denominator. When means and standard deviations were not available, effect sizes were estimated from other statistics (e.g., \(t\)-value and \(df\) from a \(t\)-test) when possible (Lipsey & Wilson, 2001). Because \(d\) is upwardly biased when based on small samples (particularly when \(N < 20\)), Hedges correction for small sample sizes was applied (Hedges & Olkin, 1985). The Cox log odds ratio method (Sanchez-Meca, Marin-Martinez, & Chacon-Moscoso, 2003) was used to transform dichotomous outcomes (e.g., arrests, diagnostic status) into a form equivalent to \(d\). A positive effect size indicated that treatment youth showed more favorable outcomes than comparison youth.

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Table 3 summarizes studies evaluating EBTs with ethnic minority youth. Column 1 identifies the investigatory team and publication date. Column 2 corresponds to the study’s participant characteristics (sample size, age, gender, and ethnicity), including whether the youth presented with clinically significant problems. A clinically significant problem was operationally
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defined as one of the following: a clinical diagnosis, referral to a mental health facility, having a score in the “clinical” range on a standardized scale, multiple referrals to a school office or principal for problem behavior, or out-of-home placement (e.g., arrest, residence in group home). Column 3 specifies treatment assignment/procedures, treatment modality (e.g., individual, group, multicomponent), therapist background, treatment setting, and whether or not treatment was manualized or culture-responsive. Column 4 specifies the outcome measures.

Column 5 describes the findings, but only for those outcomes directly relevant to referral problems (e.g., if youth were referred for anxiety disorders, outcomes representing post-treatment fear or internalizing symptoms would be presented, but externalizing symptoms would not). However, when youth were referred for unspecified and/or a broad array of problems, outcomes for all youth symptoms were presented (e.g., Rowland et al., 2005; Weiss et al., 2003). Finally, column 6 specifies the EBT classification status, type of study (1 or 2 based on Nathan & Gorman, 2002), and which ethnic minority eligibility criteria were met. Note that no treatments summarized in this review met criteria as well-established for ethnic minority youth.

To establish interrater reliability for the Task Force and Nathan and Gorman criteria, studies representing 10 randomly selected treatments (of the 30 total treatments summarized in Table 3) were independently coded by the two authors. The kappa statistic was used to assess agreement between coders. The Kappa was .80 for the Task Force criteria (probably efficacious vs. possibly efficacious) and .63 for the Nathan and Gorman criteria (Type 1 vs. Type 2).

Anxiety-related problems. Current research points to several efficacious treatments for ethnic minority youth with anxiety disorders. Two studies indicate that group-CBT (GCBT) is possibly efficacious for Hispanic/Latino and African American youth with anxiety disorders (Ginsburg & Drake, 2002; Silverman, Kurtines, Ginsburg, Weems, Lumpkin, et al., 1999).
GCBT involves the use of cognitive and behavioral strategies including exposure, self control training, contingency management and contracting, peer modeling, and feedback. Silverman et al. (1999) found significant treatment effects for GCBT compared to waitlist control, and outcomes did not differ by ethnicity (Caucasian vs. Hispanic/Latino). To address the needs of African American youth in school settings, Ginsburg and Drake (2002) adapted GCBT by reducing the length of treatment, altering examples for developmental and cultural sensitivity, and excluding parents from treatment. Although the sample size was very small (n = 12), Ginsburg and Drake (2002) found that adapted GCBT benefited anxious African American adolescents and that adapted GCBT was superior to an attention control placebo.

Also, anxiety management training (AMT), study skills training (SST), and the combination of both (Modified AMT) meet criteria for possibly efficacious in the treatment of test anxious African American youth. In a small sample experiment (n = 11 per condition), Wilson and Rotter (1986) found that AMT, SST, and modified AMT led to greater reductions in test anxiety than attention placebo or no treatment, but no differences across experimental conditions were evident.

**Depression.** In a randomized trial conducted in Puerto Rico with depressed youth, Rossello and Bernal (1999) found Cognitive-Behavioral Therapy (CBT) and Interpersonal Psychotherapy (IPT) were superior to a waitlist control, but differed little from one another. In a subsequent trial, Rossello, Bernal, and Rivera-Medina (in press) assigned depressed, Puerto-Rican youth to individual CBT, group CBT, individual IPT, or group IPT, although conditions were combined to form one CBT condition and one IPT condition. Whereas depression decreased significantly in both conditions, CBT led to greater reductions in depression than IPT. Thus, CBT meets criteria for probably efficacious in treating Latino youth with depression,
whereas IPT meets criteria for possibly efficacious. Incidentally, Mufson and colleagues (Mufson et al., 2004; Mufson, Weissman, Moreau, & Garfinkel, 1999), found IPT superior to placebo control and treatment-as-usual in two randomized trials with predominantly Latino youth. However, Latinos comprised less than 75% of each sample, and thus neither met inclusion criteria for this review.

Conduct problems. Although recent reviews point to several successful approaches for preventing juvenile delinquency (Huey & Henggeler, 2001), MST is perhaps the only treatment shown to reduce criminal offending among African American, delinquent youth in randomized trials. MST is a family-centered, individualized intervention that targets the multiple systems in which youth are embedded. MST is intensive (daily contact when necessary) yet time-limited (services range from 3 to 6 months), and delivered in the individual’s natural environment (e.g., home, school) by therapists trained in the use of diverse evidence-based treatments (e.g., contingency contracting, communication training, behavioral parent training).

Four clinical trials support the efficacy of MST with African American juvenile offenders (Borduin et al., 1995; Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Henggeler, Melton, & Smith, 1992; Henggeler et al., 1997). Compared to usual services and individual therapy, MST led to greater reductions in re-arrests and time incarcerated. These effects lasted as long as 13.7 years post-treatment (Schaeffer & Borduin, 2005), and youth ethnicity (African American versus European American) did not moderate outcomes (Borduin et al., 1995; Henggeler et al., 1992; Henggeler et al., 2002; Schaeffer & Borduin, 2005). Although MST efficacy was also established by independent research teams in the U.S. and Norway (Ogden & Halliday-Boykins, 2004; Timmons-Mitchell et al., 2006), neither trial assessed whether ethnic minorities benefited.
Lochman’s Coping Power program (in various formats) is similarly efficacious with aggressive, African American youth (Lochman, Curry, Dane, & Ellis, 2001). Coping Power (the child-only version) involves social problem solving, positive play, group-entry skills training, and training for coping with negative emotions. In their first ethnic minority-focused trial, Lochman, Coie, Underwood, and Terry (1993) found that Social Relations Training (an early version of Coping Power) led to greater improvement than no treatment control for aggressive-rejected African American youth. In subsequent trials (Lochman & Wells, 2003; 2004), youth in the Coping Power intervention (adapted to include behavioral parent training) again showed greater improvement than either treatment as usual or no treatment. Moreover, results showed that ethnicity did not moderate treatment effects for most outcomes (Lochman & Wells, 2003; Lochman & Wells, 2004).

Brief Strategic Family Therapy (BSFT; Szapocznik, Hervis, & Schwartz, 2003) may be the only efficacious treatment designed for Latino youth (primarily Cuban) with conduct problems. Based on the family systems work of Salvador Minuchin (Minuchin & Fishman, 1981), BSFT adopts strategies such as joining, reframing, and boundary shifting to restructure problematic family interactions of externalizing youth and their parents. Over the past two decades, Szapocznik and colleagues have carried out an extensive program of research testing the efficacy of various forms of BSFT including one-person BSFT (Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983; 1986), Bicultural Competence Training (Szapocznik, Rio et al., 1986), Family Effectiveness Therapy (Szapocznik, Santisteban et al., 1989), and standard BSFT (Santisteban et al., 2003; Szapocznik, Rio et al., 1989). However, only three trials evaluated BSFT’s efficacy relative to either a placebo or waitlist control. Two of these studies showed that BSFT was superior to control (Santisteban et al., 2003; Szapocznik, Santisteban et al., 1989). In
In a third, process-oriented evaluation, BFST was not superior to a recreational comparison control (Szapocznik, Rio, et al., 1989).

MST, Coping Power (with parent training component), and BSFT all have been validated in two or more clinical trials with ethnic minority youth, although no replications by independent investigators have been carried out with minorities. Thus, MST and Coping Power (with parent training) are *probably efficacious* for African American youth whereas BSFT is *probably efficacious* for Hispanic youth.

Ten additional treatments show efficacy for ethnic minority youth with conduct problems, although none have been tested in more than one randomized trial with this population. Four of these are *probably efficacious* for ethnic minority youth because they meet all *well-established* criteria except replication by another investigator. These include rational emotive education for Black and Hispanic youth (Block, 1978), attribution retraining for African American youth (Hudley & Graham, 1993), child-centered play therapy for Mexican-American youth (Garza & Bratton, 2005), and anger management group training for predominantly African American, Latino, and mixed ethnicity youth (Snyder, Kymissis, & Kessler, 1999). The six remaining treatments are *possibly efficacious* for ethnic minority youth because they were compared with no treatment or waitlist control, included fewer than 12 participants per condition, or used outcome measures of questionable reliability/validity. These include structured problem-solving for Black and Hispanic youth (De Anda, 1985), and cognitive restructuring, response-cost, assertive training, social relations training, and behavioral contracting for African American youth (Forman, 1980; Huey & Rank, 1984; Lochman & Wells, 2003; Stuart, Tripodi, Jayaratne, & Camburn, 1976).
**Substance use problems.** Multidimensional Family Therapy (MDFT; Liddle et al., 2001) was the only *probably efficacious* treatment for drug-abusing ethnic minority youth. MDFT is a family-based, multi-component treatment that targets the multiple systems (e.g., family, school, work, peer) that contribute to the development and continuation of drug use. At the youth level, therapists focus on building youth competencies by teaching communication and problem-solving skills. At the family level, therapists work to change negative family interaction patterns, and coach parents in ways to appropriately engage with their children. Therapists also help family members gain access to concrete resources such as job training and academic tutoring. Liddle et al. (2004) found MDFT led to more rapid decreases in drug use than group-based CBT for a diverse group of ethnic minority youth.

MST, another family-based treatment, meets criteria for *possibly efficacious* for drug-abusing African American youth. In a recent clinical trial for juvenile drug offenders, MST was more successful than usual services (wherein youth received only minimal mental health or substance abuse treatment) at decreasing drug use at post-treatment (Henggeler, Pickrel et al., 1999) and four years later (Henggeler et al., 2002). Moreover, ethnicity (African American vs. White) did not moderate treatment outcomes (Henggeler, Pickrel et al., 1999; Henggeler et al., 2002).

**Trauma-related problems.** Several treatments were efficacious for ethnic minority youth with trauma-related problems. Resilient Peer Treatment (RPT), a peer-based modeling intervention, was classified as *probably efficacious* for abused, African American youth. Although three studies showed that RPT was superior to placebo, all were conducted by the same primary investigator. In two separate trials, Fantuzzo and colleagues found that RPT was superior to placebo at improving social behavior among socially withdrawn, African American...
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preschoolers (Fantuzzo, Manz, Atkins, & Meyers, 2005; Fantuzzo et al., 1996). Furthermore, maltreatment status (maltreated vs. not maltreated) did not moderate outcomes. Also, in an early evaluation with 39 maltreated, socially-withdrawn preschoolers (54% African American, 46% White), Fantuzzo et al. (1988) found peer-mediated modeling (PMM – an earlier version of Resilient Peer Treatment) led to greater positive social behavior and fewer behavior problems than adult-initiated modeling (AIM) or placebo control. Although no formal analyses were reported, the authors noted that there were “no clear suggestive patterns in race... that differentiated those who responded most positively from those who responded least positively” (p. 38, italics added).

Similarly, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Deblinger & Heflin, 1996) is efficacious for trauma-exposed ethnic minority youth. TF-CBT is a 12-session parent- and child-focused treatment involving psychoeducation, coping skills training, gradual exposure, cognitive processing of the abuse experience, and parent management training. In a multi-site evaluation for sexually-abused youth with PTSD, Cohen, Deblinger, Mannarino, and Steer (2004) found TF-CBT led to greater PTSD symptom reduction than child centered therapy, although ethnicity (White vs. non-White [70% African American]) was not a significant moderator of treatment (Cohen et al., 2004; J.A. Cohen, personal communication, June 2004). Because all well-established criteria were met except replication by an independent investigator, TF-CBT is probably efficacious for ethnic minority youth.

Two additional treatments, the Fostering Individualized Assistance Program (FIAP; Clark et al., 1998) and Cognitive-Behavioral Intervention for Trauma in the Schools (CBITS; Stein et al., 2003) are also efficacious for traumatized, ethnic minority youth. FIAP is an individualized case management intervention involving strength-based assessment, life domain planning, and
help with linkages to family and community supports. Clark et al. (1998) found that compared to standard foster care, FIAP was efficacious for abused/neglected African American youth with behavioral or emotional problems. These outcomes were not moderated by youth ethnicity, suggesting that FIAP was similarly effective for African Americans and Caucasians. CBITS utilizes cognitive-behavioral techniques such as relaxation training, exposure, and social problem-solving. Stein and colleagues found that compared to waitlist control, CBITS was efficacious in treating violence exposed, Latino youth with PTSD symptoms (approximately 80% were born in the U.S. to Mexican immigrant parents; B.D. Stein, personal communication, July 2004). These treatments are classified as possibly efficacious because one treatment lacked a treatment manual (Clark et al., 1998), the other was compared to waitlist control (Stein et al., 2003), and neither has been replicated as yet.

**Mixed behavioral and emotional problems.** Though validated primarily with juvenile offenders (Henggeler et al., 1998), MST was evaluated recently with multiracial, Hawaiian youth in need of intensive mental health services (Rowland et al., 2005). At post-treatment, MST reduced externalizing symptoms, internalizing symptoms, minor criminal activity, and length of out-of-home placements compared with usual community services. Because MST meets all well-established criteria except replication by an independent investigator, this treatment is probably efficacious for multiracial Hawaiian youth.

One controlled outcome study supports the efficacy of RECAP (Reading, Education, Children, and Parents) for African American youth with comorbid problems that are less severe in nature (Weiss, Harris, Catron, & Han, 2003). RECAP is a semistructured skills training program with intervention components targeting the child (e.g., reattribution training, communication skills training) and parent/teacher (e.g., contingency management, child-adult
communication training) contexts. In a recent evaluation, RECAP reduced externalizing problems and internalizing problems compared to no treatment control, and treatment effects were not moderated by ethnicity (African American vs. Caucasian). Because this study used a no treatment comparison rather than placebo, RECAP meets criteria as *possibly efficacious* for African American youth with comorbid problems.

*Evidence-based treatments for other psychosocial problems.* Recent data point to one efficacious treatment for African American and Latino youth with attention deficit/hyperactivity disorder (ADHD), and another for suicidal African American youth. Results from the Multimodal Treatment Study of Children with ADHD (MTA Study) suggest that behavioral treatment in conjunction with stimulant medication is *probably efficacious* for African American and Latino youth with ADHD and related problems (Arnold et al., 2003). Although no ethnic differences in treatment outcome were found for most outcomes (Arnold et al., 2003), several treatment condition X ethnicity moderator effects suggested that intensive behavioral treatment plus medication was more beneficial than either medication alone or community services for both African American and Latino participants. Unfortunately, no other clinical trials speak to the efficacy of psychosocial treatments for ethnic minority youth with ADHD. Other evidence suggests that MST is *possibly efficacious* for suicidal, African American youth. In a recent clinical trial, youth referred for psychiatric emergencies were randomly assigned to MST or emergency hospitalization (Henggeler, Rowland et al., 1999; Huey et al., 2004). MST was more successful than hospitalization at decreasing rates of attempted suicide (Huey et al., 2004). Moreover, for African American youth but not European Americans, MST led to faster recovery than hospitalization.
Thus, emerging research shows limited but significant progress in efforts to treat ethnic minority youth with ADHD or suicidal tendencies. Unfortunately, virtually nothing is known about how best to treat ethnic minority youth with elimination disorders, tic disorders, eating disorders, or a host of other clinical syndromes, despite the availability of efficacious approaches for non-minorities (e.g., Evans et al., 2005; Houts, 2003). Clearly more research is needed to bridge this gap.

A Brief Meta-Analysis of Psychotherapy Effects

To provide a quantitative overview of treatment effects, a meta-analysis was carried out drawing from eligible EBTs identified earlier and presented in Table 3. Only studies comparing an active treatment with a no treatment, placebo, or treatment-as-usual control group were included. To avoid violating assumptions of statistical independence, only one effect size per study was included in any particular analysis (Lipsey & Wilson, 2001).

Twenty-five studies were included in the final pool of studies (marked with an asterisk in the References), representing 22 distinct controlled trials. Thirteen studies provided post-treatment results only, five follow-up results only, and seven post-treatment and follow-up results. The final set of studies differed considerably in terms of sample size, ranging from N = 12 (Ginsburg & Drake, 2002) to N = 213 (Lochman & Wells, 2004). Because large samples yield more reliable and precise effect sizes (Lipsey & Wilson, 2001), for statistical analyses \( d \) was weighted by the inverse of its sampling error variance to more accurately estimate true population effects (Hedges & Olkin, 1985; Lipsey & Wilson, 2001).

At post-treatment, the mean effect size was \( d = .44, \text{SE} = .06, 95\% \text{ confidence interval (CI)} = .32 \text{ to } .56 \). This indicated that overall, 67% of treated participants were better off at post-treatment than the average control participant. Because coefficients of .20 or below represent
“small” effects, coefficients around .50 “medium” effects, and coefficients of .80 or above “large” effects, the overall $d$ reported here falls somewhat below the standard for a “medium” effect (Cohen, 1988). To contrast with findings from a large-scale meta-analysis by Weisz and colleagues (Weisz, Weiss et al., 1995), $d$ was recalculated but limited to studies comparing active treatment to no treatment or placebo control at post-treatment (i.e., treatment-as-usual control excluded). Results yielded a mean effect size of $d = .57$, SE = .08, 95% CI = .42 to .72, which is comparable to the “medium” effect ($d = .54$) reported by Weisz, Weiss et al. (1995).

Next, the Q statistic (Hedges & Olkin, 1985) was calculated to test for homogeneity of effects across all studies at post-treatment. A significant Q statistic indicates a heterogeneous distribution and suggests that study characteristics may serve as sources of difference between studies. By contrast, a nonsignificant Q indicates homogeneity across studies and suggests that effects vary primarily because of sampling error rather than systematic differences. The overall Q statistic was significant, $Q (19) = 50.16, p < .001$, suggesting that overall treatment effects were moderated by one or more factors.

Additional tests were conducted to evaluate whether youth ethnicity (African American vs. Latino vs. mixed/other) or other selected factors moderated treatment outcomes. Interrater reliability for these codes (based on 10 randomly selected studies) ranged from $\kappa = .69$ to $\kappa = 1.00$ (see Table 4 for details). No significant effects were found for ethnicity, $Q (2) = 3.47, p = .18$, type of target problem, $Q (1) = .84, p = .36$, problem severity, $Q (1) = 2.67, p = .10$, or youth diagnostic status, $Q (1) = .92, p = .34$. However, significant effects were found for comparison group, $Q (2) = 6.30, p < .05$, with the largest effects evident for no treatment control and placebo control versus treatment as usual. Table 4 summarizes these findings.
The limited follow-up data suggest that treatment effects for ethnic minorities are maintained for 4 to 6 months ($d = .36$), 1 – 1.7 years ($d = .28$), 4 years ($d = .68$), and 13.7 years ($d = .37$) post-treatment. Most follow-up studies, however, focused on youth with conduct problems; and 63% of these were long-term evaluations of Multisystemic Therapy. Thus, it is unclear whether follow-up results generalize to other treatments or to ethnic minority youth with non-externalizing mental health problems.

Treatment Outcome Summary

In summary, current findings show that EBTs do exist for ethnic minority youth with diverse mental health problems. Overall, these interventions produced treatment effects of “medium” magnitude, although outcomes differed by comparison group. Each treatment is listed briefly in Table 5, and categorized by EBT classification, problem focus, and youth ethnicity. With ethnic minority groups and target problems treated separately, 13 treatments meet criteria for probably efficacious, and 17 as possibly efficacious. Again, no treatments were well-established for ethnic minority youth.

Several limitations should be noted, however. First, only a small number of studies evaluated outcomes beyond the post-treatment assessment, and most of these focused on youth with conduct problems. Although results suggest that treatment effects are generally maintained over time, these findings may not represent long-term outcomes for ethnic minority youth with anxiety disorders, depression, or other clinical problems. Second, efficacious treatments for some clinical syndromes such as eating and elimination disorders are lacking for ethnic minority youth. Thus, we know little about how ethnic minority youth fare when treated for problems other than those summarized earlier. Third, seven of the outcome studies included fewer than 15 participants per condition, and overall these small sample studies produced relatively high effect
size estimates (unadjusted mean $d = 1.40$; excluding Forman et al. [1980] and Lochman et al. [1993] because effect sizes could not be estimated). As others have noted, this pattern may reflect a publication bias in favor of significant treatment effects – i.e., when samples are small, only large effects will be statistically significant and thus more likely to be published (e.g., Weisz, Weiss et al., 1995).

Also, Table 3 shows occasional discrepancies between treatment outcomes as reported in published evaluations and the effect size coefficients noted here (e.g., Henggeler et al., 1999; Huey et al., 2004). Curiously, many of these studies were evaluations of MST. For example, Henggeler et al. (1999) reported that MST led to greater reductions in post-treatment drug use, yet the overall effect size estimate was actually negative. Usually, these discrepancies resulted because treated youth showed higher levels of baseline psychopathology than comparison youth, suggesting that random assignment was not always successful at equating groups. Because $d$ was derived from post-treatment and follow-up results only, it did not adjust for baseline discrepancies across treatment conditions. Thus, for these studies, the effect size estimate may not serve as an accurate index of treatment effects.

Finally, because only treatments showing superiority to control conditions were included and effect size statistics were unavailable for many studies, the summaries presented here may not represent the true magnitude of effects for ethnic minority youth. Thus, a comprehensive meta-analysis is still necessary to evaluate the full range of successful and unsuccessful treatments for ethnic minority youth.

_Treatment Equivalence, Adaptation, and Mechanisms_

Current research shows that many treatments are efficacious for ethnic minority youth. However, this still leaves unresolved critical questions concerning the parameters of treatment
effects with ethnic minority youth. For example, are standard EBTs equally beneficial for ethnic minority and European American youth? Do cultural adaptations enhance treatment outcomes for ethnic minority youth? What do we know about factors that either mediate or moderate treatment outcomes for ethnic minority youth? And to what extent have EBTs been successfully validated with ethnic minority youth in “real-world” treatment contexts? In this section each of these questions will be addressed. Yet, given the methodological limitations intrinsic to this literature, caution must be exercised when interpreting the findings below. For example, most studies reviewed in this section probably lack adequate statistical power to detect moderator as well as cultural adaptation effects, and thus bias findings in the direction of the null hypothesis (i.e., no ethnic differences). These and other limitations are discussed later in detail.

Are treatments equally beneficial for ethnic minorities and non-minorities? A key empirical question is whether treatment effects vary as a function of ethnicity. If treatments show “ethnic invariance” (i.e., standard treatments are equally powerful when applied to ethnic minorities), such evidence could facilitate efforts to disseminate treatments to diverse populations. Conversely, if “ethnic disparity” is supported (i.e., standard treatments are less powerful when applied to ethnic minorities), substantial modifications might be required to ensure appropriate use with ethnic minority youth. These competing perspectives have been debated by scholars for many years. Whereas “mainstream” intervention researchers often assume ethnic invariance, multicultural health scholars argue that ethnic disparity is likely when cultural considerations are ignored (de Anda, 1997). Thus, discerning which perspective is most consistent with current evidence could be of theoretical and clinical importance.

To shed light on this debate, 13 studies were examined that evaluated ethnicity as a treatment moderator in the context of a randomized controlled trial (Table 6). A treatment
moderator is defined as a pre-treatment variable which has an interactive effect with treatment condition on clinical outcomes (Kraemer et al., 2002). With regard to ethnicity, significant treatment condition X ethnicity interaction effects would generally indicate that treatment was more efficacious for one ethnic group than for another.

Although most studies summarized in Table 6 did not report significant moderator effects, a few studies did show that ethnicity influenced treatment outcomes. Surprisingly, three studies suggested that identical treatments may show stronger effects for ethnic minority youth compared with European American youth (Arnold et al., 2003; Huey et al., 2004; Weiss, Catron, Harris, & Phung, 1999), whereas two treatments favored European American youth over ethnic minorities (Lochman & Wells, 2004; Rohde, Seeley, Kaufman, Clarke, & Stice, 2006). Yet this summary does not fully convey the complexity of these moderator findings. For example, although Rohde et al. (2006) found superior CBT effects only for depressed White youth, ethnic differences were likely a function of the unusually positive response by non-White youth to placebo control (i.e., life-skills training). Thus, neither the ethnic invariance nor ethnic disparity perspective is clearly supported by these findings.

Although many of these treatments included culture-responsive elements, none directly tested for culture-responsive effects and thus say little about the true impact of culture-related modifications on differential treatment outcomes. As suggested by multicultural health theorists (Bernal et al., 1995; Sue & Zane, 1987; Tharp, 1991), other evidence may show that culture-responsive treatment does confer unique benefits to ethnic minorities. This issue will be explored next.

_Do culture-responsive EBTs enhance outcomes?_ Many scholars argue that treatments should be tailored to match the needs of ethnic minority clients (e.g., American Psychological
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Association, 2003; Tharp, 1991; Vega, 1992). When culture is ignored, miscommunication and value conflicts may arise, leading to client discomfort, low therapeutic engagement, and subsequent treatment failure. In response to such concerns, clinical researchers have developed culturally tailored frameworks for treating ethnic minority youth, families, and adults (e.g., Bernal et al., 1995; Castro & Alarcon, 2002; Rossello & Bernal, 1996; Sue, 1998; Sue & Zane, 1987; Szapocznik, Scopetta, & King, 1978). Unfortunately, with few exceptions (e.g., Huey & Pan, 2006; Rossello & Bernal, 1999; Szapocznik, Santisteban et al., 1989), formal application of such models in controlled trials is rare.

Nonetheless, culture-responsive methods have been identified and utilized by a small but growing number of clinical investigators. The diversity of culture-responsive approaches is reflected in Table 7, which summarizes the different ways that treatments in this review were adapted to address the needs of ethnic minority clients. Unfortunately, with the exception of those studies described below, the clinical impact of such modifications has rarely been tested.

Correlational data provide some evidence linking culture-responsive methods to beneficial responses in treatment outcome studies. Specifically, two studies indicate that ethnic match between client and therapist was associated with positive outcomes following youth- and family-based treatment (Halliday-Boykins, Schoenwald, & Letourneau, 2005; Yeh, Eastman, & Cheung, 1994). For both studies, however, non-random assignment to matched therapists leaves open the possibility that factors other than match accounted for the significant findings.

In contrast to correlational studies, experimental evaluations do not support the culture-responsive perspective. Szapocznik and colleagues compared Brief Structural Family Therapy (BSFT) with Bicultural Effectiveness Training (BET) for 31 Cuban American families with behaviorally disordered youth (Szapocznik, Rio et al., 1986). BET was identical to BSFT,
except that BET also focused on teaching “bicultural skills” to family members (e.g., methods for addressing intercultural conflict between the youth and parents). The treatments differed minimally on post-treatment ratings of behavioral problems, suggesting that bicultural skills training was not associated with additional benefits.

A second study yielded similar results. Specifically, Genshaft, and Hirt (1979) evaluated how ethnic matching influenced outcomes in the context of a peer-modeling intervention. Sixty African American and European American youth were randomly assigned to a same-race model, an opposite-race model, or no treatment control. Regardless of ethnicity, training by “White” models was more successful at ameliorating cognitive impulsivity than training by either “Black” models or no treatment. Thus, neither Szapocznik, Rio et al. (1986) nor Genshaft and Hirt (1979) provide empirical support for the utility of culture-responsive treatment.

Aggregate effect size data were also used to evaluate whether ethnic minority youth fared better with culturally modified approaches. There is no consensus definition in the field about whether or not a treatment is considered culture-responsive or how to decide whether an adaptation is warranted (see Lau, 2006 for an emerging model). Therefore, for this study, two broad methods were used for classifying EBTs as culture-responsive. First, EBTs were defined as culture-responsive only when the clinical trial from which post-treatment effect size estimates were derived identified intervention or clinician characteristics that made treatment more appropriate for ethnic minority participants. Using this conservative approach (κ = .80), 10 treatments were considered culture-responsive and 10 were classified as standard (i.e., treatment has no apparent culture-responsive element) (Table 8). However, because investigators sometimes omit such information from published clinical trials, a second more liberal approach (κ = .78) defined treatment as culture-responsive when information from supplementary sources
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(e.g., treatment manuals, prior clinical trials, book chapters) suggested that treatments were modified for ethnic minority participants. Using this approach, 14 treatments were classified as culture-responsive and six as standard. Table 4 shows the resulting effect size estimates. No significant effects were found based on either the first, $Q(1) = 0.01, p = .93$, or second, $Q(1) = 1.79, p = .18$, definition. Notably, these findings contrast with results from a recent meta-analysis of culturally adapted interventions (Griner & Smith, 2006).

However, some scholars (e.g., Rogler, Malgady, Costantino, & Blumenthal, 1987) contend that such standard ways of defining culture-responsive practice may be unduly narrow, arguing that conceptualizations of “cultural-sensitivity” should be broadened to encompass mainstream modalities with particular relevance for ethnic minorities. For example, some contend that in contrast to individual psychotherapy, family- or group-based treatments may be ideal for ethnic minority youth because such modalities permit clinicians to better consider the cultural context when planning and conducting treatment (Rogler et al., 1987; Tharp, 1991). Yet empirical support for this perspective is lacking as well. Szapocznik and colleagues tested the relative efficacy of one-person versus conjoint family therapy for conduct-disordered Latino youth and found no outcome differences (Szapocznik, Kurtines et al., 1986; Szapocznik et al., 1983). Moreover, a recent trial by Rossello et al. (in press) indicated that individual treatments (CBT and IPT) were just as effective for depressed Puerto Rican youth as group-based versions of the same therapies. These findings suggest that, for Latinos, individual treatment is equal to family- and group-based modalities. Unfortunately, because only two suitable studies focused on individual psychotherapy (Garza & Bratton, 2005; Rossello & Bernal, 1999), this hypothesis could not be further tested in the meta-analysis.
In summary, little evidence exists that culture-responsive treatment is more beneficial than standard treatments for ethnic minority youth. Yet, numerous methodological problems also limit what conclusions can be drawn from this literature. For example, key studies (e.g., Genshaft & Hirt, 1986; Szapocznik, Rio et al., 1986) probably lacked power to detect significant group differences, and the meta-analysis did not distinguish treatments in terms of the content or quality of culture-responsive adaptation. These equivocal findings suggest the need for additional experimental work testing the potential for cultural adaptations with ethnic minority youth.

Outcome mediators and moderators. As EBTs grow in number, reviewers increasingly argue for research on factors that mediate and moderate treatment outcomes (Kazdin, 2007; Kazdin & Nock, 2003; Kraemer et al., 2002; Weersing & Weisz, 2002b). Mediator tests permit investigators to evaluate the mechanisms through which clinical improvement occurs and whether such mechanisms are consistent with the “theory of change” posited by particular treatment models. An accurate understanding of why treatments work could also form the basis for eliminating inert or harmful treatment methods while retaining active treatment ingredients, thus maximizing the efficacy and efficiency of clinical practice.

Unfortunately, evaluation of youth treatment mediation is exceedingly rare (Hinshaw, 2002; Kazdin & Nock, 2000; Weersing & Weisz, 2002b). However, the limited research does show that efficacious, minority-focused treatments are often successful at modifying hypothesized mediators of ultimate outcomes, including family functioning (Henggeler et al., 1992; Liddle et al., 2004; Lochman & Wells, 2004; Santisteban et al., 2003; Stuart et al., 1976), parenting competencies (Cohen et al., 2004), peer functioning (Liddle et al., 2004; Lochman et al., 1993), and individual cognitions (Cohen et al., 2004; Hudley & Graham, 1993). Moreover, using more formal analytic tests (Holmbeck, 1997), several investigators have assessed specific
mediation effects within ethnic minority samples. Lochman and Wells (2002a) provide a compelling example of mediation-testing within the context of a clinical trial with aggressive, predominantly African American youth. They found that intervention effects (i.e., Coping Power vs. control) on drug use, delinquency, and school behavior were partially mediated by changes in parenting behavior and youth cognitions.

Two non-experimental studies of MST similarly revealed significant outcome mediators. Huey and colleagues found that for rural, mostly African American offenders, changes in family functioning and deviant peer affiliation mediated the relationship between therapist adherence to MST and reductions in delinquent behavior (Huey, Henggeler, Brondino, & Pickrel, 2000). These results were replicated in a sample of urban, predominantly European American offenders, suggesting that these mechanisms were not ethnic- or region-specific (Huey et al., 2000). In a larger multi-site evaluation of MST, Halliday-Boykins et al. (2005) found that the relations between therapist-client ethnic match on discharge success was partially mediated by higher therapist adherence to MST. Findings from these three studies are encouraging and suggest that clinical change for ethnic minority youth may occur via theory-consistent mechanisms.

However, the mediator framework articulated by Kraemer et al. (2002) suggests that only the Lochman and Wells (2002a) study would serve as an example of treatment mediation. According to Kraemer et al. (2002), a treatment mediator must satisfy several conditions including: (1) association with treatment condition (e.g., ratings on the mediator variable are higher for treatment vs. control youth), (2) association with the outcome variables, and (3) change during the period of active intervention. Because Huey et al. (2000) and Halliday-Boykins et al. (2005) included only youth assigned to the MST condition – and thus did not
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satisfy the first condition – the factors tested in these studies cannot be considered true mediators of MST effects (Hinshaw, 2000; Kraemer et al., 2002).

Although treatment mediation effects are rarely studied in youth, formal tests of moderation are more prevalent. Moderator evaluations test the extent to which a specified variable influences treatment efficacy, and address the question for whom does treatment work and under what conditions (Hinshaw, 2000; Kraemer et al., 2002). Perhaps the clearest examples are the studies noted earlier testing ethnicity as a treatment moderator. Additional research suggests that other demographic and clinical factors may also moderate youth treatment effects within ethnic minority samples. The programs of research on Coping Power and narrative treatment best illustrate such effects.

Lochman et al. (1993) found that Social Relations treatment was successful at reducing aggression and peer-rejection for some African American youth but not others. Youth who were both aggressive and peer-rejected at pre-treatment benefited from treatment whereas rejected-only youth did not (Lochman et al., 1993). In a subsequent study, Lochman and Wells (2003) evaluated the extent to which Coping Power reduced delinquency/aggression and prevented drug use in aggressive, ethnic minority youth, and whether effects were moderated by gender, age, neighborhood status (problem vs. non-problem neighborhood), or initial problem severity (moderate vs. high). At the one-year follow-up, preventive effects on tobacco, alcohol, and marijuana use were strongest for youth who were older and evidenced moderate initial risk. Neighborhood status and gender did not moderate drug use outcomes. Also, none of the moderator effects were significant for delinquency or aggression outcomes. Thus, although Coping Power outcomes were influenced by several significant moderators, no clear pattern of effects emerged.
In contrast, Costantino and colleagues (Costantino, Malgady, & Roger, 1986; Costantino, Malgady, & Rogler, 1994; Malgady et al., 1990) identified age as a consistent moderator of outcomes for narrative treatments with Latino youth. Cuento Therapy is a 20-session, narrative intervention involving Puerto Rican “cuentos” or folktales. During treatment, bilingual/bicultural therapists read cuentos to youth, promote group discussion of prominent themes, facilitate role-play and dramatization of themes, and verbally reinforce youth for adaptive responses. In an initial evaluation (Costantino et al., 1986), 208 K – 4th grade Puerto Rican youth with below-median ratings of problem behavior were randomly assigned to original cuento therapy (i.e., stories were consistent with the original Puerto Rican cuentos), adapted cuento therapy (i.e., stories were modernized to match the mainland U.S. context), art/play therapy, or no treatment control. Costantino and colleagues found that grade level moderated the effect of treatment condition on trait anxiety outcomes. For first grade children only, adapted cuento therapy led to greater reductions in trait anxiety than all other treatment conditions (Costantino et al., 1986). This moderator effect was not found at the one-year follow-up.

Based on these moderator findings, Costantino and colleagues modified this narrative approach to match the developmental needs of older youth. Yet curiously, age continued to moderate treatment effects (Costantino et al., 1994; Malgady et al., 1990). Malgady et al. (1990) randomly assigned 8th and 9th grade Puerto Rican students with below-median ratings on a behavior checklist to Hero/Heroine Modeling (a variation of Cuento Therapy designed for adolescents) or attention-placebo control. Moderator analyses showed that for 8th but not 9th grade youth, treatment led to significantly lower trait anxiety than control. Similarly, Costantino et al. (1994) found that the efficacy of their Tell-Me-A-Story Intervention (TEMAS – a variation of Cuento Therapy using pictorial stimuli and designed for multiracial Hispanic youth) varied as
a function of both grade level and gender among Hispanic youth with conduct, anxious, or phobic symptoms. Compared with placebo control, TEMAS led to fewer school conduct problems for sixth graders only, and fewer phobic symptoms for fifth grade males and fourth and fifth grade females only.

Thus, across three “prevention” trials, Costantino and colleagues found evidence that narrative treatment shows its greatest success in ameliorating anxiety-related symptoms among younger children. However, narrative therapy did not meet the APA Task Force criteria (Chambless et al., 1996; 1998; Chambless & Hollon, 1998) because (a) outcome effects did not clearly match the target behavior (e.g., treatment ameliorated anxiety problems but youth often showed above median levels of externalizing behavior) (Costantino et al., 1986; Malgady et al., 1990), (b) treatment had the purported goal of increasing ethnic identity and self-concept rather than decreasing symptomatology (Malgady et al., 1990), and (c) none of the trials reported treatment main effects.

Other research suggests that the absence of moderator effects may also have important practical and theoretical implications. In two controlled outcome studies, Fantuzzo and colleagues found that maltreatment status consistently failed to moderate the effects of RPT on socially withdrawn, African American preschoolers (Fantuzzo et al., 1996; Fantuzzo et al., 2005). These results appear to support the broader utility of RPT with African American children. Although specifically designed for maltreated youth, RPT is apparently effective at building social skills in youth regardless of abuse history.

Relevance to “real-world” treatment. Despite evidence that EBTs work for ethnic minority youth, it is unclear whether efficacious treatments translate well to “real-world” clinic practice where most treatment occurs. Weisz and colleagues describe the gap between lab-based
treatments and clinic-based services for youth and conclude that the efficacy demonstrated in research treatments is not representative of the poor outcomes achieved in actual clinic practice (Weisz, Donenberg, Han, & Weiss, 1995; Weisz et al., 1998). Moreover, the lab-clinic gap appears to exist for ethnic minority youth as well (Weersing & Weisz, 2002a; Weiss, Catron, Harris, & Phung, 1999; Weisz, Jensen-Doss, & Hawley, 2006).

Fortunately, some progress has been made in bridging this gap. At least two treatment models provide a framework for treating ethnic minority youth under circumstances that reflect “real-world” conditions. Both approaches permit clinicians to respond flexibly to circumstances unique to the individual client, and appear to work for ethnic minority youth with clinically-significant problems.

The first model uses treatment principles to guide intervention conceptualization and implementation. Family-based MST presents one example of such an approach with ethnic minority youth. Throughout the assessment and treatment phases, MST therapists evaluate the “fit” of initial and ongoing problem behaviors within the youth’s larger social context (Henggeler et al., 1998). This “fit” assessment informs the selection of evidence-based treatment strategies which are then used to alter individual, family, and contextual factors that contribute significantly to problem behavior. As noted earlier, MST is beneficial for ethnic minority youth with diverse clinical problems including antisocial behavior, suicidal behavior, “soft” drug use, and mixed behavioral and emotional problems (Borduin et al., 1995; Henggeler et al., 1992; Henggeler, Pickrel, et al., 1999; Huey et al., 2004; Rowland et al., 2005). Moreover, two clinical trials (Henggeler et al., 1997; Rowland et al., 2005) were conducted with ethnic minority youth in community settings using professional therapists and supervisors (rather than graduate student therapists and research supervisors), thus representing a true dissemination of MST to service-
based clinic settings. Note, however, that outcomes for the dissemination studies were generally not as favorable as in prior MST clinical trials, perhaps due to poor treatment fidelity when “real-world” therapists are not regularly supervised by MST experts (Henggeler et al., 1997).

The second approach involves enhancing the “quality” of traditional mental health by supplementing usual care with evidence-based treatments. The Youth-Partners-in-Care (YPIC) study (Asarnow et al., 2005) offers a template for how such a model can be integrated into a medical setting. In a multisite evaluation, Asarnow et al. (2005) assigned 418 depressed, predominantly minority youth (56% Hispanic/Latino, 13% African American, 13% White, 14% mixed, 4% other) to either usual primary care or a quality improvement intervention. Quality improvement involved supplementing usual care with training and resources to encourage patients and clinicians to select CBT as a treatment option for depression. Several outcomes of clinical importance were found at the six-month assessment. First, quality-improvement youth were more likely than usual-care youth to receive psychotherapy, whereas no between-group difference was found for pharmacological treatment. Second, although the effects were small, quality improvement led to significantly greater reductions in depression and increases in quality of life compared with usual care.

The examples noted here represent only two possible approaches to treating youth in “real-world” clinic settings. Other promising examples of psychotherapy dissemination exist (e.g., Herschell et al., 2004), but these await testing with ethnic minority samples.

Recommendations for Best Practice with Ethnic Minority Youth

Less than a decade ago, randomized trials with significant numbers of ethnic minority participants were rare, raising concerns that EBTs were valid only for youth and adults of European descent (Bernal & Scharron-Del-Rio, 2001). Although well-established treatments
have yet to be identified, significant gains have been made in recent years, with many treatments classified as *probably efficacious* or *possibly efficacious* for ethnic minority youth (see Tables 3 and 5). This review adds to the emerging literature showing that ethnic minorities often benefit from well-designed psychosocial interventions (Miranda et al., 2005; Wilson, Lipsey, & Derzon, 2003).

The large number of EBTs found for African American and Latino youth with conduct problems (e.g., aggression, delinquency, disruptive behavior) is particularly noteworthy. To date, more than a dozen distinct treatments for ethnic minority youth with conduct problems have been successfully tested in randomized trials. Although efficacious treatments for other clinical syndromes are fewer in number, the evidence base nevertheless suggests that initial guidelines for how best to intervene with ethnic minority youth are possible. Hence, two primary recommendations are offered below for providing treatment services to ethnic minority youth with diverse mental health problems.

*EBTs as first-line interventions.* The first recommendation is to encourage clinicians to utilize EBTs when treating ethnic minority youth, particularly those identified as *probably efficacious* or *possibly efficacious* with this population. For example, this review suggests that using CBT or IPT may be preferable to untested alternative therapies when treating depressed Latino adolescents. Among EBTs, cognitive-behavioral approaches show the strongest record of success with ethnic minority youth. Indeed, the majority of EBTs described here are cognitive-behavioral in that core treatment elements derive from social learning principles (e.g., contingency management, peer modeling, in vivo exposure) and cognitive theories of psychopathology (e.g., cognitive processing, cognitive restructuring, self-control training). The apparent success of cognitive-behavioral approaches is consistent with meta-analytic work
suggesting that CBTs are generally superior to insight-oriented treatments for youth (Weisz, Weiss et al., 1995; Weiss & Weisz, 1995), and with arguments that ethnic minority youth respond best to treatments that are highly structured, time-limited, pragmatic, and goal-oriented (Ho, 1992).

Moreover, other forms of intervention are also supported as EBTs for ethnic minority youth. As noted earlier, IPT is possibly efficacious for clinically depressed, Puerto Rican youth (Rossello & Bernal, 1999), and may also work with Latino adolescents in the continental U.S. (Mufson et al., 1999; 2004). In addition, family systems treatments such as BSFT, MDFT, and MST are supported for youth with conduct problems and drug-related disorders. Thus, EBTs for ethnic minorities are not limited to interventions derived from a single conceptual paradigm.

Selective use of adaptations based on cultural considerations. Minority mental health researchers have long advocated that culture/ethnicity be taken into account when treating ethnic minority clients as a way to increase treatment utilization, reduce premature termination, and alleviate mental health symptoms. Yet the evidence presented here offers a mixed picture concerning the importance of culture-responsive strategies. On the one hand, many of the EBTs reported here incorporate at least one culture-responsive component in the form of provider characteristics, treatment procedures, or therapy content. Indeed, cultural adaptations are vital components of several EBTs, particularly those targeting adolescent Latinos (e.g., Szapocznik, Santisteban, et al., 1989; Rossello & Bernal, 1996). On the other hand, there is no compelling evidence as yet that these adaptations actually promote better clinical outcomes for ethnic minority youth. Overemphasizing the use of conceptually appealing but untested cultural modifications could inadvertently lead to inefficiencies in the conduct of treatment with ethnic minorities (Lau, 2006). This may be particularly risky if core intervention components are
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substituted or compromised in favor of untested adaptations that are geared towards ethnic minority youth and their families.

Given this ambiguous evidence base, at least two broad approaches to applying EBTs to ethnic minorities seem justified. The first strategy is to maintain EBTs in their original form and only apply those culture-responsive elements that are already incorporated into the EBT protocols. For example, prior to conducting group CBT with anxious Latino and European American youth, Silverman et al. (1999) “sensitiz[ied] therapists to issues specific to working with multicultural populations, such as cultural differences in modes of coping, definitions of anxiety-provoking objects or events, and particular parenting styles” (p. 996). Thus, efforts to disseminate group CBT to other Latino populations might consider retaining this element of therapist training. Of course, there are limitations to this general approach. A review of Table 7 shows that cultural adaptations are often poorly specified, thus complicating the task of replicating with fidelity. Furthermore, this approach would require that ostensibly culture-nonresponsive treatments such as Wilson and Rotter’s (1986) anxiety management training remain devoid of cultural content when implemented in real-world treatment contexts.

A second approach would allow providers to tailor treatments for ethnic minority youth, but only to the extent justified by client needs. Rather than assuming a priori that standard EBTs are culturally inadequate and therefore less effective, clinicians might initially treat ethnic minority youth just as they would non-minorities. Then, as treatment barriers or opportunities arise, clinicians would consider whether attention to ethnic minority status or cultural factors is suitable. Case studies exemplifying this approach are emerging in the literature, including those associated with clinical trials of manualized cognitive-behavioral EBTs (Fink, Beidel, & Turner, 1996; Sweeney, Robins, Ruberu, & Jones, 2005).
One advantage to individualizing treatment is the flexibility it allows to address diverse cultural experiences as well as differences based on developmental level, gender, sexual orientation, and other “person” factors. Individualizing to address culture is also consistent with the functional analysis methodology advanced by proponents of behavioral and cognitive-behavioral therapies (e.g., Hayes & Toarmino, 1995; Tanaka-Matsumi, Seiden, & Lam, 1996). Further, because clinicians generally prefer more flexible approaches to treatment (e.g., Smith, Brown, & O’Grady, 1994), recommendations to individualize for culture could readily map on to routine clinical practice. However, there are two reasons why this approach may have limited utility. First, some argue that most clinicians are not culturally competent and thus may not possess the skill set required to appropriately individualize treatments for ethnic minority populations (de Anda, 1997). Second, despite the intuitive appeal of this approach, evidence that individualizing improves treatment efficacy is mixed at best with most research showing no discernable effects on outcomes (Kendall & Chu, 2000; Schneider & Byrne, 1987; Schulte, 1996).

Thus, the utility of cultural adaptation remains ambiguous, and research to uncover specific effects of culture-responsive practice should be prioritized by youth clinical researchers. Further study could show that cultural adaptations significantly augment treatment effects for ethnic minority youth. On the other hand, additional research might reveal that even modest adaptations for culture have unintended negative consequences by inadvertently fostering stereotyped “minority” treatments (Hayes & Toarmino, 1995) or diluting ostensibly active treatment ingredients (e.g., Schulte, 1996).
Recommendations for Future Research

Despite encouraging results, it is important to acknowledge the limitations of this review to ensure that benefits for ethnic minority youth are not overstated (Bernal & Scharron-Del-Rio, 2001). In this section, these limitations are noted and recommendations for future research are offered. Generally, the recommendations focus on addressing gaps in the literature and improving the quality and relevance of treatment outcome research with ethnic minority youth.

Expand scope of minority recruitment in clinical trials. Future identification of EBTs for ethnic minority youth depends on the degree to which ethnic diversity is considered when designing and analyzing intervention studies. Although time trends show that reporting standards have improved since 1980 (Braslow, et al., 2005), most youth treatment outcome studies do not document the inclusion of ethnic minority participants (Kazdin et al., 1990; Weisz et al., 2005). Thus, clinical investigators should focus greater efforts on recruiting ethnic minorities and reporting the extent to which they are involved in clinical trials.

Although African Americans and Latinos are underrepresented, Asians, Pacific Islanders, and Native Americans are nearly excluded from the youth treatment outcome literature, and future clinical trials should include these groups in adequate numbers to permit appropriate outcome evaluation. The need is particularly acute for Native American adolescents given the high prevalence of serious mental health problems (e.g., “hard” drug abuse, completed suicide) in this ethnic group (Hawkins, Marlatt, & Cummins, 2004; NIDA, 2003). Although prevention work with Native American youth is in ample supply (Hawkins et al., 2004), no evidence-based therapies for Native American youth with pre-existing mental health problems have been developed as yet. (For one such effort see Carpenter, Lyons, and Miller, 1985.)
Moreover, the few clinical trials with Latino youth tend to sample a narrow segment of this demographic. Although eight of the studies in Table 3 evaluated outcomes for Latino youth, only two of these (Garza & Bratton, 2005; Stein et al., 2003) focused on Mexican Americans, who are the largest Latino group in the U.S. (representing 67% of U.S. Latinos; Ramirez & de la Cruz, 2003). Immigrant and low-acculturation youth are also poorly represented in treatment outcome research. Because highly acculturated ethnic minority youth are arguably most similar to European Americans in values and social resources, they may also be more likely than low-acculturation youth to participate in psychotherapy research and benefit from mainstream interventions (Hall, 2001). Thus, clinical trials that limit participation to English-fluent, acculturated youth (or their parents) may overestimate the efficacy of standard treatments for ethnic minorities. To better assess the true generalizability of EBTs, it is important to recruit immigrant youth and families for inclusion in clinical trials.

*Evaluate whether ethnicity and related factors moderate treatment effects.*

Notwithstanding the work examined in this review (Table 6), treatment outcome evaluation by youth ethnicity is rare, thus limiting whether EBTs can be generalized to ethnic minority youth. One obvious solution is for future investigators to routinely test for ethnicity as a treatment moderator when multiple ethnic groups are represented in adequate numbers (Hohmann & Parron, 1996). Because minority mental health researchers often theorize that standard treatments are less effective with ethnic minorities, moderator tests should permit investigators to assess the validity of this assumption.

However, some scholars warn against such comparative approaches, recommending instead that research with ethnic minorities focus on *within-group* evaluations. For example, Yali and Revenson (2004) advise caution when using between-group designs because ethnic
comparisons could inadvertently encourage “minority-deficit” models. Similarly, Bernal and Scharron-Del-Rio (2001) contend that because ethnic comparisons often have weak conceptualizations, “it is best to focus on specific ethnic groups, unless there is a clear theoretical basis for a comparative approach” (p. 338). Thus, an alternative approach would eschew ethnic comparisons and instead explore whether acculturation status, exposure to discrimination, and other culture-related factors serve as treatment moderators for ethnic minority youth (Alvidrez, Azocar, & Miranda, 1996; Hall, 2001). Indeed, some research suggests that immigrant minorities may respond less favorably than non-immigrants to Western therapies (Martinez & Eddy, 2005; Telles et al., 1995), and that country of origin may affect treatment outcomes for Latino youth (Kataoka et al., 2003). Another important demographic variable rarely reported (Weisz, Doss, Hawley, 2005) or considered when examining treatment moderation is socioeconomic status (SES). To our knowledge, treatment outcome studies have not been conducted which examine the differential efficacy of EBTs across youth from ethnic minority families of both low and high SES groups.

Importantly, greater attention to ethnic/cultural factors as treatment moderators should be accompanied by appropriate tests of interaction effects. Published studies, including those summarized in Table 6, generally rely on simple main effects analysis or visual inspection of means to interpret significant interaction effects. However, these methods are inadequate because neither directly tests for group differences in treatment effects (Jaccard & Guilamo-Ramos, 2002). Jaccard and colleagues (Jaccard, 2001; Jaccard & Guilamo-Ramos, 2002; Jaccard & Turrisa, 2003) offer specific recommendations for testing interactions within an ANOVA, multiple regression, or logistic regression framework, including the use of single degrees of freedom contrasts to interpret significant interaction effects.
Report use of culture-responsive treatment. Recent data suggest that therapists, on their own, may routinely use culture-responsive strategies with ethnic minority clients (Harper & Iwamasa, 2000; Robertson et al., 2001). For example, Harper and Iwamasa (2000) found that 72% of surveyed CBT therapists discussed ethnicity-related issues with ethnic minority youth when warranted by the presenting problem. Thus, many therapists may be attuned to culture in their interactions with ethnic minority clients, but respond in a culture-responsive fashion only when relevant to the presenting problem or when culture-related barriers to treatment arise. Unfortunately, culture-responsive practice is rarely described in significant detail in the youth treatment literature.

To address this disparity between treatment description and clinician behavior, clinical researchers might consider two distinct strategies when ethnic minorities are represented in adequate numbers. First, investigators might include a description of any efforts to make treatments responsive to the ethnic, language, or cultural background of participants (see Table 7 for examples). Alternatively, when culture-responsive methods are not explicit elements of treatment, investigators could evaluate and report the extent to which culture-related content emerges as a natural element of treatment process (see e.g., Jackson-Gilfort, Liddle, Tejeda, & Dakof, 2001). These recommendations are particularly important for efforts to replicate and disseminate treatments beyond the “lab” setting. If descriptions of culture-responsive methods are absent, EBT research may properly identify “what” treatments to offer ethnic minority youth, but fail to specify “how” to implement such approaches (Jackson, 2002).

Isolate unique effects of culture-responsive practice. Simply reporting the use of culture-responsive strategies tells us little about their importance as treatment ingredients. At present, it is unclear whether culture-responsive practice is an effective tool when treating ethnic minority
youth. To test for causal relations between culture-responsiveness and treatment outcomes, more appropriate research designs are needed. An ideal approach would directly compare identical interventions that differed only in the use of culture-responsive practice. This strategy might involve random assignment of ethnic minority youth to (a) standard EBT, (b) standard EBT with culture-based modifications, (c) placebo control with culture-based modifications, and (d) placebo control only, which would permit evaluation of the combined and unique effects of EBT and culture-responsive methods. A less ideal but more pragmatic design would compare only the first two conditions. Several ongoing studies in the psychotherapy outcome literature have adopted the latter approach (Huey & Pan, 2006; McCabe et al., 2005).

Yet designs of this sort may be of little theoretical value if cultural adaptations reflect only surface changes in treatment structure or content. Although cultural content differed dramatically across studies in this review, many treatments made “surface” modifications (e.g., ethnic match) that required minimal attention to cultural issues (Kumpfer, Alvarado, Smith, & Bellamy, 2002), and only a few were based on conceptual models of cultural sensitivity. Given the broad definition of culture-responsiveness adopted for this review, one could argue that the true influence of cultural adaptation was not adequately tested here. Thus, future efforts should focus on developing and testing more theoretically compelling adaptations.

An alternative to manipulating cultural content involves assessing how naturally occurring, culture-related treatment process influences therapy outcomes. For example, Jackson-Gilfort et al. (2001) found that discussion of culturally relevant content themes in treatment with African American youth (e.g., anger/rage, respect) was associated with higher engagement in treatment, although no links to ultimate outcomes were found. A major limitation is that this is essentially a correlational approach and thus causal relations can only be inferred. A recent study
shows how investigators might conduct clinical trials that utilize both experimental and correlational methods when evaluating cultural effects (Pan, Huey, & Hernandez, 2007).

*Use appropriate sample sizes.* Another concern is whether sample sizes have been sufficient to test key hypotheses. The absence of difference does not necessarily indicate group equivalence, and may suggest that studies lack adequate statistical power. For example, most studies testing treatment X ethnicity interaction effects (see Table 6) are probably underpowered, making detection of moderator effects less likely. Assuming that ethnicity is a true moderator of psychotherapy outcomes, effect sizes are likely in the small to medium range given the modest differences between cultural groups on indices of psychopathology, attitudes toward therapy, and treatment persistence (U.S. Department of Health and Human Services, 2001). Detecting interaction effects of this magnitude would require sample sizes that likely exceed the average \( n = 74 \) per condition) for trials summarized in Table 6 (Murphy & Myors, 1998).

Similarly, the two experimental efforts to isolate cultural adaptation effects for youth treatment (Genshaft & Hirt, 1979; Szapocznik, Rio et al., 1986) likely lacked adequate power. With a two-group comparison (culture-responsive treatment vs. standard treatment), sample size requirements differ dramatically depending on the anticipated strength of the culture-responsive component. If small effects (e.g., \( d = .20 \)) were expected, sample size requirements would readily exceed 800 (i.e., approximately 400 per condition; see Murphy & Myors, 1998). However, even if moderate effects (e.g., \( d = .50 \)) were anticipated, as suggested by promising work in the adult treatment literature (Huey & Pan, 2006; Kohn et al., 2002; Wade & Berstein, 1991), at least 130 participants (i.e., 65 per group) might be needed (Murphy & Myors, 1998). By contrast, both Genshaft and Hirt (1979) and Szapocznik et al. (1986) included samples with fewer than 20 participants per condition.
Thus, larger samples are needed to better answer key questions of theoretical interest to minority mental health researchers. Although there are other methods for maximizing statistical power (e.g., using more sensitive measures, adjusting alpha level), increasing sample size is perhaps the most practical approach.

**Assess culturally-appropriate outcomes.** A final limitation relates to the cultural validity of treatment outcome measures. Most studies in this review did not report the reliability or validity of outcome measures with ethnic minority participants. Specific assessment instruments may be differentially valid for ethnic minority versus European American youth, thus limiting whether ethnic comparisons in outcome can be made with such measures (Hall, 2001). One solution involves the use of culturally cross-validated assessment instruments when evaluating treatments with ethnic minority youth (Chambless et al., 1996; Sue, 1998).

However, even culturally validated measures may pose problems for cross-cultural analysis. For example, Walton and colleagues (Wachtel et al., 1994; Walton, Johnson, & Algina, 1999) studied mother versus child perceptions of child anxiety and found interesting ethnicity X informant interaction effects. They found that African American youth rated themselves as more anxious than European American youth, whereas African American mothers described their children as less anxious than did European American mothers. Moreover, this finding was not explained by ethnic differences in demographic variables, socioeconomic status, or social desirability. One possibility is that African American and European American parents use different reference groups when evaluating the experience of anxiety in their children (Walton et al, 1999). Thus, even when measures are valid and reliable within ethnic groups, cultural differences in frames of reference may still complicate outcome comparisons between groups (Heine, Lehman, Pen, & Greenholtz, 2002).
Conclusion

In summary, the psychotherapy outcome literature leaves room for considerable optimism regarding treatments for ethnic minority youth. Efficacious treatments were found for many psychosocial problems and treatment effects were moderate. Furthermore, this review highlighted emerging research on factors that influence treatment efficacy with ethnic minority youth.

Yet methodological and conceptual challenges raise concerns about the generalizability of these findings. The literature is characterized by unrepresentative samples, Eurocentric outcome measures, inadequate sample sizes, and few direct tests of key theoretical assumptions. Moreover, the simple act of defining, labeling, or classifying ethnic minorities is fraught with ambiguity. As others have noted (Betancourt & Lopez, 1993; Tharp, 1991), race, ethnicity, and culture are complex and fluid constructs, and thus not always amenable to categorization without the loss of crucial information. The ethnic labels used to categorize youth are not static, and may differ in meaning as a function of informant, assessment procedures, and level of specificity, particularly when “multiracial” youth are considered. Given the socially constructed nature of ethnic categories, and potential risks for stereotyping (Hayes & Toarmino, 1995; Sue & Zane, 1987), caution should be exercised when making claims about the efficacy of treatment for any particular ethnic group. Although these are formidable challenges, they should not detract from efforts to advance psychotherapy research with ethnic minority youth and improve the efficacy of treatment for this population.
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References marked with an asterisk indicate studies included in the meta-analysis.


randomized clinical trial comparing multidimensional family therapy and peer group


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*Lochman, J. E., & Wells, K. C. (2003). Effectiveness of the coping power program and of
classroom intervention with aggressive children: Outcomes at a 1-year follow-up.
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aggressive boys and their parents: Outcome effects at the 1-year follow-up. *Journal of
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Footnotes

1 Weisz and colleagues (Weisz, Huey, & Weersing, 1998; Weisz, Donenberg, & Han, 1995) distinguish between “research therapy” as conducted in university-based settings and “clinic therapy” as practiced in community settings. Research therapy is often characterized by (1) inclusion of youth who were recruited for treatment, (2) homogenous samples with one focal problem, (3) therapists with extensive pretherapy training and supervision, and (4) therapy that is highly structured and/or guided by a manual. Youth psychotherapy outcome research is based almost exclusively on research therapy. However, Weisz and colleagues argue that research therapies may have limited generalizability to clinical practice.

2 In a meta-analysis of psychotherapy outcome studies, Kazdin and Bass (1989) found a median sample size of 12 per condition, with treatment vs. no-treatment comparisons yielding large effects (mean ES=.85), and treatment versus placebo comparisons yielding small to medium effects (mean ES=.38).

3 However, results from the MTA study (Arnold et al., 2003), Brown and Sexson (1988), and Bukstein and Kolko (1998) do suggest that methylphenidate alone is a well-established treatment for African American youth with ADHD.
Table 1

**APA Task Force Criteria for Evidence-Based Treatments**

**Criteria 1: Well-Established Treatments**

1.1 There must be at least two good group-design experiments, conducted in at least two independent research settings and by independent investigatory teams, demonstrating efficacy by showing the treatment to be

   a) superior to pill or psychological placebo or to another treatment

   OR

   b) equivalent (or not significantly different) to an already established treatment in experiments with statistical power being sufficient to detect moderate differences

   AND

1.2 treatment manuals or logical equivalent were used for the treatment

1.3 conducted with a population, treated for specified problems, for whom inclusion criteria have been delineated in a reliable, valid manner

1.4 reliable and valid outcome assessment measures, at minimum tapping the problems targeted for change were used

1.5 appropriate data analyses

**Criteria 2: Probably Efficacious Treatments**

2.1 There must be at least two experiments showing the treatment is superior (statistically significantly so) to a wait-list or no treatment control group

   OR

2.2 One or more experiments meeting the Well-Established Treatment Criteria with the
one exception of having been conducted in at least two independent research settings
and by independent investigatory teams

Criterion 3: Possibly Efficacious Treatments

There must be at least one study showing the treatment to be efficacious in the
absence of conflicting evidence

*Note:* Criteria adapted from Division 12 Task Force on Psychological Interventions (Chambless et al., 1996, 1998) and from Chambless and Hollon (1998).
Table 2

Nathan and Gorman (2002) Study Criteria and Considerations for Ethnic Minority Youth

Nathan and Gorman (2002) Criteria

**Type 1 Studies**

I. Study must include a randomized prospective clinical trial

II. Study must include comparison groups with random assignment, clear inclusion and exclusion criteria, blind assessments, state-of-the-art diagnostic methods, and adequate sample size for power

III. There must be clearly described statistical methods

**Type 2 Studies**

Clinical trials must be performed, but some traits of Type 1 study were missing (e.g., inadequate sample size)

*Additional Considerations for Evaluation of Studies with Ethnic Minority Youth*

The between-group design experiments must include *one or more* of the following characteristics:

A. At least 75% of participants in the overall sample are ethnic minorities, *or*

B. Separate analyses with ethnic minority youth show superiority (statistically significant) to control conditions, *or*

C. Analyses indicate that ethnicity does not moderate key treatment outcomes, or that treatment is effective with ethnic minority youth despite moderator effect(s)

*Note:* Additional considerations developed exclusively for this review. Nathan and Gorman’s (2002) Type 3-6 study criteria were not included because they correspond to methodologically less rigorous studies.
### Table 3

**Controlled Trials of Evidence-Based Treatments for Ethnic Minority Youth**

<table>
<thead>
<tr>
<th>Treatment &amp; Supporting Studies</th>
<th>Participant Characteristics</th>
<th>Treatment Characteristics</th>
<th>Outcome Measure, Source, and Assessment Period</th>
<th>Target Outcomes and Effect Size</th>
<th>Study Type and Ethnic Minority Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANXIETY-RELATED PROBLEMS</strong></td>
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<tr>
<td>Possibly Efficacious Treatments</td>
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</tr>
<tr>
<td>Silverman, Kurtines, Ginsburg, Weems, Lumpkin, et al., 1999</td>
<td>N=56. Ages 6 to 16 years (M=9.96). 61% male. 46% White, 46% Hispanic/Latino, 7% other ethnicity.</td>
<td>Randomly assigned to Group Cognitive-Behavioral Treatment (GCBT) or Waitlist Control (WLC).</td>
<td>Anxiety: Self- and parent report of anxiety on RCMAS; anxiety disorders from ADIS. Symptom Severity: Clinician rating of symptom severity from ADIS; and parent report of fear on the FSSC-R.</td>
<td>For youth &amp; caregiver</td>
<td>Nathan &amp; Gorman: Type 1</td>
</tr>
</tbody>
</table>
Evidence-Based Treatment for Minority Youth

rating of symptom severity.
Post-treatment assessment only.

Ginsburg & Drake, 2002
N = 12. Age 14-17 years (M=15.6).
17% male. 100% African American.
CSP: Yes. DSM-IV criteria for anxiety disorder.
Randomly assigned to Cognitive-Behavioral Therapy (CBT) or Attention-Support Control (ASC).
Therapists: Graduate students
Setting: School
Manual: Yes.

Anxiety: CIR from Diagnostic interview w/youth via ADIS; Self-report on SCARED and SAS-A.
Post-treatment assessment only
CBT led to lower CIR and SCARED anxiety than ASC.
ES: \( d = 0.71 \).

Nathan & Gorman:
Type 2 (\( n < 12 \) per condition)
Task Force: Possibly Efficacious
Minority Condition: A.

Wilson & Rotter, 1986
N=54. 6th & 7th grade youth. 56% male.
89% Black, 11% White.
CSP: No. Test anxiety score in upper third
Randomly assigned to anxiety management training (AMT), study skills training (SST), modified anxiety management training (M-AMT).
Therapists: Graduate students
Setting: School
Manual: Yes.

Test Anxiety: Self-report on TASC.
Post-treatment and follow-up (2 months)
TASC Test Anxiety at post-treatment and follow-up: AMT, M-AMT, SST
Nathan & Gorman:
Type 2 (\( n < 12 \) per condition).
Task Force: AMT, SST, & M-AMT Possibly Efficacious

of students. training (M-AMT), attention-placebo (AP), or no-contact control (NCC).

*Modality:* Group

*Therapists:* Not specified

*Setting:* School

*Manual:* Yes

AMT, M-AMT, and SST did not differ from one another. AP and NCC did not differ from one another.

**Post-treatment ES:**

\[ d = 1.29 \text{ (amt vs. ap)} \]
\[ d = 1.44 \text{ (sst vs. ap)} \]
\[ d = 1.92 \text{ (m-amt vs. ap)} \]
\[ d = 1.02 \text{ (amt vs. ncc)} \]
\[ d = 1.20 \text{ (sst vs. ncc)} \]
\[ d = 1.73 \text{ (m-amt vs. ncc)} \]
\[ d = -0.07 \text{ (amt vs. sst)} \]
\[ d = -0.50 \text{ (amt vs. m-amt)} \]
\[ d = -0.49 \text{ (sst vs. m-amt)} \]

**Follow-up ES:**

Insufficient data for effect size.

**DEPRESSION**
### Evidence-Based Treatment for Minority Youth

**Cognitive-Behavioral Therapy and Interpersonal Psychotherapy – Probably Efficacious and Possibly Efficacious**

<table>
<thead>
<tr>
<th>Study</th>
<th>Participants</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rossello &amp; Bernal, 1999</td>
<td>N=71. Age 13-17 years (M=14.7). 46% male. 100% from Puerto Rico. CSP: Yes. DSM diagnosis of depression, dysthymia, or both.</td>
<td>Randomly assigned to cognitive-behavioral therapy (CBT), interpersonal psychotherapy (IPT), or waitlist control (WLC).</td>
<td>Depression: Self-report on CDI. and IPT lower than WLC.</td>
<td>At post-treatment, CBT and IPT did not differ.</td>
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<td>Post-treatment and follow-up (3-month) assessments.</td>
<td>Post-treatment ES: (d = .34) (cbt vs. wlc); (d = .74) (ipt vs. wlc); Follow-up ES: (d = -.34) (cbt vs. ipt).</td>
</tr>
<tr>
<td>Rossello, Bernal, &amp; Rivera-Medina, in press</td>
<td>N=112. Age 12-18 years (M=14.5). 45% male. 100% from Puerto Rico. CSP: Yes. DSM diagnosis of major depression (66%).</td>
<td>Randomly assigned to CBT-Individual (CBT-I), CBT-Group (CBT-G), IPT-Individual (IPT-I), IPT-Group (IPT-G). Groups.</td>
<td>Depression: Self-report on CDI. led to greater reductions in depression than IPT.</td>
<td>At post-treatment, CBT and IPT did not differ.</td>
</tr>
</tbody>
</table>
or clinically impaired with score of 13 or higher on the CDI (34%).

Modality: Individual & Group
Therapists: Graduate students
Setting: University clinic.
Manual: Yes.

CONDUCT PROBLEMS

Multisystemic Therapy – Probably Efficacious
Borduin et al., 1995  N=176. Age 12-17 years (M=14.8). 68% male. 70% White, 30% African American.
Randomly assigned to multisystemic therapy (MST) or individual therapy (IT).
Arrest: Archival records. Follow-up (4-year) assessment only
MST youth arrested less often than IT youth.  ES: $d = 1.18$
Nathan & Gorman: Type 2 (blind assessment unclear).
Task Force: Probably Efficacious.
Minority Condition: A.

CSP: Yes. Juvenile offenders with average of 4.2 prior offenses
Modality: Family-based multicomponent
Therapists: Graduate students
Setting: University clinic.
Manual: Yes.
Minority Condition: C
(Ethnicity did not moderate)
Schaeffer & Borduin, 2005 (Long-term follow-up of Borduin et al., 1995)

N=165. Ages 12 to 17 years (M=13.7) (Average age at follow-up was 28.8 years). 69% male. 22% African American & 76% White.

Randomly assigned to multisystemic therapy (MST) or individual therapy (IT).

Modality: Family-based multicomponent

Therapists: Graduate students

Setting: Home & community

Manual: Yes.

Number of arrests, days sentenced to adult confinement, days sentenced to adult probation: Archival records.

13.7 year follow-up assessment only.

MST more effective than IT at reducing number of arrests, and days in adult confinement, and somewhat more effective at reducing days sentenced to adult probation.

ES: $d = .37$. Nathan & Gorman: Type 2 (blind assessment unclear).

Task Force: Probably Efficacious.

Minority Condition: C (Ethnicity did not moderate outcomes).

Henggeler et al., 1992

N=84. Average age 15.2 years. 77% male. 56% African American, 42% Caucasian, 2%.

Randomly assigned to multisystemic therapy (MST) or usual services (US).

Modality: Family-based

Delinquent Behavior: Self-report on SRDS.

Arrest/Incarceration: Archival records.

MST led to lower post-treatment delinquency, arrests, and incarceration than US.

ES: $d = .37$. Nathan & Gorman: Type 2 (blind assessment unclear).

Task Force: Probably Efficacious.
<table>
<thead>
<tr>
<th>Hispanic-American.</th>
<th>multicomponent</th>
<th>Post-treatment</th>
<th>ES: $d = .54$.</th>
<th>Minority Condition: C</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSP: Yes. Juvenile offenders with average of 3.5 prior arrests.</td>
<td>Therapists: Not stated</td>
<td>assessment (average 59 weeks for arrests/incarceration) only</td>
<td></td>
<td>(Ethnicity did not moderate outcomes).</td>
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<tr>
<td>Setting: Home &amp; community</td>
<td>Manual: Yes</td>
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<tr>
<td>Henggeler et al., 1997</td>
<td>N = 155. Ages 10.4 to 17.6 years (M=15.2). 82% male. 81% African American, 19% Caucasian.</td>
<td>Randomly assigned to Multisystemic Therapy (MST) or usual services (US).</td>
<td>Delinquent Behavior: Self-report on SRDS.</td>
<td>MST youth were incarcerated for fewer days than US youth.</td>
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<td>Arrest/Incarceration: youth.</td>
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<td></td>
<td>Nathan &amp; Gorman:</td>
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<td></td>
<td>Type 2 (blind assessment unclear)</td>
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<td>Task Force: Probably Efficacious.</td>
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<td>Minority Condition: A.</td>
</tr>
<tr>
<td>CSP: Yes. Violent and chronic juvenile offenders.</td>
<td>Therapists: Professional therapists</td>
<td>assessment SRDS delinquent behavior or number of arrests</td>
<td>Post-treatment differences for</td>
<td></td>
</tr>
<tr>
<td>Setting: Home &amp; community</td>
<td>Manual: Yes</td>
<td>(delinquent behavior) and 1.7 year follow-up</td>
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<tr>
<td>Henggeler et al., 2002</td>
<td>N=80. Average age of 4-15.</td>
<td>Randomly assigned to Aggressive crimes:</td>
<td>MST led to greater</td>
<td>Nathan &amp; Gorman:</td>
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Evidence-Based Treatment for Minority Youth

<table>
<thead>
<tr>
<th>Study</th>
<th>Sample Characteristics</th>
<th>Treatment</th>
<th>Outcome Measures</th>
<th>Effect Size</th>
<th>Task Force</th>
<th>Minority Condition</th>
</tr>
</thead>
</table>
| Henggeler, Pickrel et al., 1999 | 15.7 years (at pre-treatment); 76% male; 60% African American, 40% White | Multisystemic Therapy (MST) or Usual Community Services (UCS) | Property crimes: Self-report on SRDS and archival records; Other crimes: Self-report on SRDS and archival records | ES: $d = .24$ | Task Force: Probably Efficacious | Minority Condition: C
| Lochman & Wells, 2004 | N=183, 5th and 6th grade youth; 100% male; 61% African American, 38% White, 1% other | Randomly assigned to Coping Power with child only (CI), Coping Power with child + parent (CPI), or control (C) | Overt and covert delinquency: self-report on delinquency section of NYS | CPI superior to C at Behavioral overt delinquency | Nathan & Gorman: Type 1 | Minority Condition: C

*Note: CSP = Clinical Service Providing, TRF = Teacher Rating Form, SRDS = Self-Report Data System.*
Evidence-Based Treatment for Minority Youth

Lochman & Wells, 2003

N=213. Fifth grade youth. 60% male. Percentage African American by condition: 75% CPCL; 78% CP; 78% CL; 81% C; Two were Hispanic and remainder.

Randomly assigned to Coping Power + universal classroom treatment (CPCL), Coping Power only (CP), universal classroom only (CL), or no-treatment control (C).  

Delinquency: Self-report of delinquency using items from NYS. Aggression: Teacher ratings on aggression scale of TOCA-R.  

Follow-up (1 year) assessment only.  

CPI and CI superior to C at improving school behavior.  

(i) ES:

$d = .24$ (CPI vs. C)  

$d = .14$ (CI vs. C)  

$d = .12$ (CPI vs. CI)

(Ethnicity did not moderate outcome for covert delinquency; however, for White but not African American youth, CPI & CI led to greater school behavior improvement than C).

Lochman & Wells, 2002b

[1 year follow-up from Lochman & Wells, 2002b]

N=213. Fifth grade youth. 60% male. Percentage African American by condition: 75% CPCL; 78% CP; 78% CL; 81% C; Two were Hispanic and remainder.

Randomly assigned to Coping Power + universal classroom treatment (CPCL), Coping Power only (CP), universal classroom only (CL), or no-treatment control (C).  

Delinquency: Self-report of delinquency using items from NYS. Aggression: Teacher ratings on aggression scale of TOCA-R.  

Follow-up (1 year) assessment only.  

CPI and CI superior to C at improving school behavior.  

(i) ES:

$d = .24$ (CPI vs. C)  

$d = .14$ (CI vs. C)  

$d = .12$ (CPI vs. CI)

(Ethnicity did not moderate outcome for covert delinquency; however, for White but not African American youth, CPI & CI led to greater school behavior improvement than C).

Lochman & Wells, 2003

N=213. Fifth grade youth. 60% male. Percentage African American by condition: 75% CPCL; 78% CP; 78% CL; 81% C; Two were Hispanic and remainder.

Randomly assigned to Coping Power + universal classroom treatment (CPCL), Coping Power only (CP), universal classroom only (CL), or no-treatment control (C).  

Delinquency: Self-report of delinquency using items from NYS. Aggression: Teacher ratings on aggression scale of TOCA-R.  

Follow-up (1 year) assessment only.  

CPI and CI superior to C at improving school behavior.  

(i) ES:

$d = .24$ (CPI vs. C)  

$d = .14$ (CI vs. C)  

$d = .12$ (CPI vs. CI)

(Ethnicity did not moderate outcome for covert delinquency; however, for White but not African American youth, CPI & CI led to greater school behavior improvement than C).
Evidence-Based Treatment for Minority Youth

<table>
<thead>
<tr>
<th>Caucasian.</th>
<th>(C).</th>
<th>assessment only</th>
<th>did not differ from</th>
<th>on delinquency or aggression).</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSP: No. 31% most aggressive and disruptive youth based on teacher ratings.</td>
<td><em>Modality:</em> Group and parent (for CP)</td>
<td><em>Therapists:</em> Professional therapists.</td>
<td><em>Setting:</em> School, community centers, and “research offices”</td>
<td><em>Manual:</em> Yes</td>
</tr>
</tbody>
</table>

Lochman et al., 1993

<table>
<thead>
<tr>
<th>N=52. 4th grade</th>
<th>Aggressive-rejected and rejected only youth</th>
<th>Aggressive Behavior: Teacher rating of aggressive behavior from peer nomination ratings.</th>
<th>At post-treatment, ARI showed lower teacher-rated aggression, lower rejection, and more positive peer-rated social acceptance than ARC. Also, ARI showed somewhat lower social acceptance by peers on TBC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>children. 52% male.</td>
<td>100% African American.</td>
<td>Training or No Treatment Control.</td>
<td>Nominations – 1 standard deviation above mean.</td>
</tr>
<tr>
<td>CSP: No. Aggressive and/or rejected based on peer nominations – 1 standard deviation above mean.</td>
<td>Thus 4 conditions: Aggressive-rejected intervention (ARI), rejected-only intervention (RI),</td>
<td>Peer Rejection: Teacher rating of rejection</td>
<td>Minority Condition: A.</td>
</tr>
<tr>
<td>Nathan &amp; Gorman: Task Force: Possibly Efficacious.</td>
<td>Social acceptance</td>
<td>ARI showed</td>
<td>Type 2 (blind assessment unclear).</td>
</tr>
</tbody>
</table>

ES: $d = .24$ (cpcl vs. c), $d = .31$ (cp vs. c), $d = .16$ (cl vs. c), $d = -.07$ (cpcl vs. cp), $d = .09$ (cpcl vs. cl), $d = .16$ (cp vs. cl)
aggressive-rejected preference from peer-rated
control (ARC), and peer nomination aggression than
rejected-only ratings. ARC. RI and RC
control (RC). Post-treatment and 1-
did not differ.

**Modality:** Individual & year follow-up At follow-up, ARI
group assessments. showed lower

**Therapists:** Mixed – teacher-rated
Professional aggression than
therapists & ARC. No other
graduate students significant effects.

**Setting:** School Insufficient data for

**Manual:** Not specified effect size.

---

**Brief Strategic Family Therapy – Probably Efficacious**

Santisteban, Coatsworth, et al., 2003  
N=126. Ages 12 to 18 years (M=15.6).  
75% male. 100% Hispanic (51% Cuban, 14% Nicaraguan, 10% Colombian, 6% Puerto Rican, 3%  
Randomly assigned to brief strategic behavior  
family therapy conduct disorder on RBPC; self-report of socialized symptom reduction.  
(BFST) or group aggression on  
treatment control ES: d = .26

**Behavior Problems:** For conduct disorder, Nathan & Gorman:

Self-report of socialized aggression. BFST  
**Type 1**  
**Task Force:** Probably Efficacious.  
**Minority Condition: A.**
Evidence-Based Treatment for Minority Youth

Peruvian, 2%  therapists  assessment only
Mexican, 14% other Hispanic).  Setting: Not specified
CSP: Yes. Referred to clinic by self or others; 94% scored in clinical range on RBPC.

N=79. Ages 6 to 12 years (M=9.44). 71% male. 100% Hispanic (76% Cuban).
CSP: Yes. Referred to clinic for child with behavioral (77%) or psychological (23%) problem. CSP: Yes. Referred to clinic for child with behavioral (77%) or psychological (23%) problem.


Szapocznik, Santisteban, et al., 1989

Insufficient data for effect size.

Other Probably Efficacious Treatments
<table>
<thead>
<tr>
<th>Study</th>
<th>N=40. Average age</th>
<th>Randomly assigned to</th>
<th>Disruptive behavior:</th>
<th>REE led to greater improvement (i.e., reductions in disruptive behavior and class cutting)</th>
<th>Nathan &amp; Gorman:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block, 1978</td>
<td>16.1 years. 48%</td>
<td>Rational-emotive education (REE), Human relations training (HRT), or  No-Treatment Control (NTC)</td>
<td>Teacher ratings based on standardized observations.</td>
<td>Post-treatment and follow-up (4-month) assessment.</td>
<td>Type 2 (blind assessment unclear).</td>
</tr>
<tr>
<td>CSP: Yes. Office</td>
<td></td>
<td></td>
<td></td>
<td>Post-treatment ES: $d = 3.57$ (ree vs. ntc ) $d = .04$ (hrt vs. ntc) $d = 3.90$ (ree vs. hrt)</td>
<td>Post-treatment ES: $d = 3.98$ (ree vs. ntc )</td>
</tr>
<tr>
<td>Garza &amp; Bratton, 2005</td>
<td>N=29. Ages 5 to 11</td>
<td>Randomly assigned to</td>
<td>Externalizing Problems: parent and teacher ratings of externalizing behavior</td>
<td>CCPT led to greater reduction in parent-rated externalizing problems than SGC.</td>
<td>Type 2 (blind assessment unclear).</td>
</tr>
<tr>
<td>CSP: Yes. School</td>
<td>57% male. 100% Mexican-American.</td>
<td>Child-Centered Play Therapy (CCPT) or small group counseling (SGC).</td>
<td>Problems: parent and teacher ratings of externalizing behavior problems</td>
<td>No treatment effects for</td>
<td>Task Force: Probably Efficacious.</td>
</tr>
</tbody>
</table>
Evidence-Based Treatment for Minority Youth

### Counsel Referral by Parents and Teachers

- **Modality**: Individual
- **Therapists**: Professional therapists
- **Setting**: School
- **Manual**: Yes.
- **Scored in “at-risk” or “clinically significant” range on Behavior Assessment Scale.

#### Hudley & Graham, 1993
- **N=72. Mean age 10.5 years.**
- **100% male.**
- **100% African American.**
- **CSP: No. Above median teacher ratings of aggression, positive peer aggression, and negative peer preference.**

<table>
<thead>
<tr>
<th>Group</th>
<th>Randomly assigned to</th>
<th>Aggression: Teacher</th>
<th>AI youth showed</th>
<th>Nathan &amp; Gorman:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AI</td>
<td>Attributional</td>
<td>Rating on aggression</td>
<td>Greater reductions in aggression and reactive aggression scales</td>
<td>Type 1 Task Force: Probably Efficacious</td>
</tr>
<tr>
<td>AT</td>
<td>Intervention (AI), Attention Training</td>
<td>and reactive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NTC</td>
<td>Treatment control</td>
<td>Checklist.</td>
<td>Youth</td>
<td></td>
</tr>
</tbody>
</table>

#### Snyder et al., 1999
- **N=50. Described as Antisocial behavior.**

<table>
<thead>
<tr>
<th>Office Referrals for</th>
<th>No treatment effect for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disciplinary Action:</td>
<td>Office referrals.</td>
</tr>
<tr>
<td>School archives</td>
<td>Insufficient data for</td>
</tr>
<tr>
<td>Post-treatment</td>
<td>Effect size.</td>
</tr>
<tr>
<td>Assessment only</td>
<td></td>
</tr>
</tbody>
</table>
Evidence-Based Treatment for Minority Youth

“adolescents.” 56% male, 2% Asian, 50% African American, 22% White, 16% Hispanic, & 10% Mixed Ethnicity.

CSP: Yes. Admitted to psychiatric hospital. Score of 75% or higher on Anger scale of STAXI.

Angry thoughts/feelings, disruptive behavior, or dyscontrol of anger.

anger management group training

Antisocial Behavior scale of the SSBS & nurse rating on antisocial behavior than PV youth.

Modality: Group Therapists: Professional therapists Setting: Hospital Manual: Yes

Post-treatment assessment only

Task Force: Probably Efficacious.

Minority Condition: A.

Possibly Efficacious Treatments

De Anda, 1985 N=35. 7th and 8th grade youth. 100% female. Ethnicity described as “Black

Randomly assigned to structured problem-solving (SPS) or nonstructured Grade in cooperation, grades in work

SPS led to fewer referrals to counselors or vice-principal than NPS. Nathan & Gorman:

Type 2

(validity/reliability of archival data and
Evidence-Based Treatment for Minority Youth

and Hispanic.”

CSP: Yes. High tardiness rates and 4 or more referrals to counselor or vice-principal’s office.

Modality: Group

Therapists: Professional

Post-treatment assessment only.

Setting: School

Manual: Yes.

Forman, 1980

N=18. Ages 8 to 11 years. 78% male. 89% Black, 11% White.

Randomly assigned to cognitive restructuring (CR), response cost (RC), or placebo control (PC).

Modality: Group

Therapists: Graduate students

Disruptance and Disrespect-Defiance subscales of DESBRS; teacher-rated inappropriate behaviors and inappropriate teacher-rated aggression. CR and PC did not differ. PC at decreasing teacher-rated aggression.

Task Force: Possibly Efficacious.

Minority Condition: A.

CR superior to PC at decreasing inappropriate interactions. CR and RC did not differ significantly from each other; neither did RC and PC.

ES: d = .48

Nathan & Gorman: Type 2 (n < 12 per condition; blind assessment unclear).

Task Force: Possibly Efficacious.

Minority Condition: A.
interactions from decreasing
SCAN observational classroom
coding system.
disturbance. Neither
Post-treatment RC and CR, nor CR
assessment only and PC differed
significantly.
Insufficient data for
effect size.

Stuart et al., 1976 N=102. 6th-10th grade. Randomly assigned to School grades & days For counselor/vice-

67% male. 34%
Black, 66% White. contracting (BC) or “teachers, referral
CSP: Yes. Youth waitlist control agents, and
referred for (WLC). parents.”
counseling services
by counselors and
school principals. Modality: Parent and

Therapists: Not specified
Setting: Not specified

School behavior
problems: Ratings No treatment
by teacher, differences in

counselor/assistant
father- or mother-
principal, mother,
rated home
and father on behavior.

Home behavior: Insufficient data for
effect size.

Nathan & Gorman:
Type 2
(validity/reliability
unclear).

Task Force: Possibly
Efficacious

Minority Condition: B
(For Black youth,
BC superior to
WLC for grades,
counselor- and
Huey & Rank, 1984: N=48. 8th and 9th grade youth. 100% male. 100% Black. CSP: Yes. Referred by teachers to school administrator for chronic classroom disruption.

Randomly assigned to:
- Counselor-led assertive training (CAT)
- Peer-led assertive training (PAT)
- Counselor-led discussion group (CDG)
- Peer-led discussion group (PDG)
- No-treatment control (NTC)

**Aggression: Teacher rating on Acting-Out subscale of the WPBIC.**

*Post-treatment assessment only*

CAT youth showed less classroom aggression than CDG, PDG, and NTC. PAT youth showed less classroom aggression than CDG and NTC, but did not differ from PDG. CAT and PAT did not differ from one another.

**Task Force: CAT and PAT Possibly Efficacious**

**Minority Condition: A.**

**Nathan & Gorman:** Type 2 (n < 12 per condition; blind assessment unclear).
Evidence-Based Treatment for Minority Youth

Therapists: Professional therapists

Setting: School

Manual: Yes.

ES:

\[d = 1.17 \text{ (cat vs. cdg)}\]

\[d = 1.32 \text{ (cat vs. ntc)}\]

\[d = 1.17 \text{ (pat vs. pdg)}\]

\[d = 1.12 \text{ (pat vs. ntc)}\]

\[d = 0.20 \text{ (cat vs. pat)}\]

SUBSTANCE USE PROBLEMS

Multidimensional Family Therapy – Probably Efficacious

Liddle et al., 2004 N=80. Ages 11-15 years (M=13.73).

73% male. 42% Hispanic, 38% African American,

11% Haitian or Jamaican, 3% non-Hispanic White, 4% other ethnicity.

Randomly assigned to multidimensional family therapy (MDFT) or peer group therapy (PGT).

Marijuana Use: Youth self-report using TLFB.

Post-treatment assessment only

MDFT led to greater decrease in cannabis use than PGT.

ES: \[d = 1.27\]

Nathan & Gorman: Type 1.

Task Force: Probably Efficacious.

Minority Condition: A.
## Evidence-Based Treatment for Minority Youth

### Possibly Efficacious Treatment

Henggeler, Pickrel, et al., 1999

- **N=** 118. Ages 12-17 years (M=15.7).
- 79% male. 50% African American, 47% Caucasian, 1% Asian, 1% Hispanic, 1% Native American.
- Diagnosis with substance abuse or dependence disorder; juvenile offenders on formal or informal probation; average of 2.9 prior arrests.
- **Drug Use:** Self-report of alcohol/marijuana and “other” drug use on PEI; cocaine use from urine screen.
- **CSP:** Yes.
- Randomly assigned to multisystemic therapy (MST) or usual community services (UCS).
- **Modality:** Family-based multicomponent
- **Therapists:** Professional therapists
- **Setting:** Home & community
- **Manual:** Yes.
- On average, UCS youth received only minimal mental health or substance abuse services.
- **Post-treatment and follow-up (6-month) assessment**
  - At post-treatment, MST led to greater reductions in self-report of alcohol/marijuana use than UCS.
  - No treatment effects for PEI alcohol/marijuana or “other” drug use at follow-up.
  - No treatment effects for urine screen marijuana or cocaine use at post-treatment or follow-up.

### Post-Treatment ES:

\[ d = -0.12 \]

### Follow-up ES:

<table>
<thead>
<tr>
<th>Nathan &amp; Gorman: Type 2 (blind assessment unclear)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task Force: Possibly Efficacious</td>
</tr>
<tr>
<td>Minority Condition: C (Ethnicity did not moderate outcomes).</td>
</tr>
<tr>
<td>Evidence-Based Treatment for Minority Youth</td>
</tr>
<tr>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Henggeler et al. 2002 [4-year follow-up of</strong></td>
</tr>
<tr>
<td>Henggeler, Pickrel, et al., 1999]</td>
</tr>
<tr>
<td><strong>CSP:</strong> Yes. Diagnosis with substance abuse or dependence; juvenile offenders on formal or informal probation; average of 2.9 prior arrests.</td>
</tr>
</tbody>
</table>

**TRAVMA-RELATED PROBLEMS**

*Resilient Peer Treatment – Possibly Efficacious*
<table>
<thead>
<tr>
<th>Fantuzzo et al., 1996</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N=46 (22 abused or neglected). Ages 3.8 to 5.1 years (M=4.46). 41% male. 100% African American.</td>
<td>Maltreated and nonmaltreated youth randomly assigned to Resilient Peer Treatment (RPT) or Attention Control (AC).</td>
<td>Interactive play, social attention, solitary play, and nonplay:</td>
<td>RPT youth showed more interactive play, less solitary play, and greater self-control than AC youth.</td>
<td>Nathan &amp; Gorman: Task Force: Probably Efficacious.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fantuzzo et al., 2005</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N=82 (37 maltreated). Average age of 4.35 years. 50% male. 100% African American.</td>
<td>Maltreated and nonmaltreated youth randomly assigned to Resilient Peer Treatment (RPT) or Attention Control (AC).</td>
<td>Collaborative play, social attention, &amp; solitary play during “Play Corner” and “Free-Play” observations:</td>
<td>For Play Corner youth showed more collaborative play and less solitary play than AC youth.</td>
<td>Nathan &amp; Gorman: Task Force: Probably Efficacious.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CSP: No. Youth socially withdrawn</td>
<td>Collaborative play, &amp; social attention, &amp; solitary play during “Play Corner” and “Free-Play” observations:</td>
<td>Play Corner</td>
<td>and less solitary</td>
<td>Minority Condition: A.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence-Based Treatment for Minority Youth

<table>
<thead>
<tr>
<th>withdrawn” relative to classmates, based on teacher ratings and classroom observation.</th>
<th>Modality: Peer pairing</th>
<th>Therapists: High functioning peers &amp; parent “play supports”</th>
<th>IPPOCS coding system.</th>
<th>differences for associative play or social attention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting: School</td>
<td>Play interaction, play disruption, &amp; play disconnection: teacher rating on PIPPS.</td>
<td>Self-control, interpersonal skills, &amp; verbal assertiveness: teacher rating on SSRS</td>
<td>For Free-Play observations, RPT youth showed more collaborative play and less solitary play than AC youth.</td>
<td>No treatment differences for associative play or social attention.</td>
</tr>
<tr>
<td>Manual: Not specified</td>
<td>Post-treatment assessment only</td>
<td>For teacher ratings, RPT youth show more play interaction, less play disruption, less play disconnection, more self-control, and more interpersonal skills.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evidence-Based Treatment for Minority Youth

skills than AC youth. No treatment differences for verbal assertion.

*ES: d = .49*

**Trauma-Focused Cognitive-Behavioral Therapy – Probably Efficacious**

Cohen et al., 2004

| N=203. Ages 8-14 years (M=10.76). 21% male. 60% White, 28% African American, 4% Hispanic American, 7% Biracial, 1% Other. CSP: Yes. Clinic-referral; 89% met full criteria for PTSD. | Randomly assigned to Trauma-Focused Cognitive-Behavioral Therapy – Probably Efficacious

| PTSD: Reexperiencing, avoidance, and hypervigilance symptoms from K-SADS diagnostic interview. | TF-CBT led to fewer PTSD reexperiencing, avoidance, and hypervigilance symptoms. Post-treatment assessment only

*ES: d = .53*

Nathan & Gorman: Type 1.

Task Force: Probably Efficacious

Minority Condition: C (Ethnicity [ethnic minority vs. non-minority] did not moderate treatment effects).

**Possibly Efficacious Treatments**
<table>
<thead>
<tr>
<th>Clark et al., 1998</th>
<th>N=131. Ages 7-15</th>
<th>Randomly assigned to</th>
<th>Placement outcomes:</th>
<th>FIAP more successful than SP at</th>
<th>Nathan &amp; Gorman:</th>
</tr>
</thead>
<tbody>
<tr>
<td>years. 60% male.</td>
<td>Fostering</td>
<td>Time in permanency setting (e.g., with parents, adoptive home), number or days incarcerated</td>
<td>Efficacious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>62% Caucasian, 34% African American, 2% Hispanic, 2% biracial.</td>
<td>Individualized Assistance Program</td>
<td>number of runaways, and days incarcerated.</td>
<td>Task Force: Possibly Efficacious</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abused/neglected youth in state custody experiencing emotional and behavioral disturbances defined by screen.</td>
<td>Practice foster care</td>
<td>behavior and days incarcerated.</td>
<td>Minority Condition: C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FIAP or standard practice foster care.</td>
<td>Manual: Not Specified.</td>
<td>FIAP more successful than SP at school placement outcomes. Composed of African American minority (89%) vs. Caucasian.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CSP:** Yes. **Modality:** Family-based multicomponent. **Therapists:** Professional therapists. **Setting:** Therapists served youth “across all settings” through archival records. **School outcomes:** Days absent from school, percentage days suspended, and school-to-school movement obtained. **Behavior problems:** Externalizing, internalizing, and total problem behavior. **Manual:** Not Specified.
Evidence-Based Treatment for Minority Youth

Behaviors obtained through self-report on YSR and caregiver report on CBCL.

Post-treatment (average of 3.5 years post-study entry) assessment only.

Insufficient data for effect size.

Stein et al., 2004 N=106. Approximately 80% born in U.S. to Mexican immigrants.

For Experimental: Average age of 11.0 years. 67% male. Therapists: Professional therapists.

CSP: Yes. Exposure to violence and PTSD

Randomly assigned to cognitive-behavioral intervention for trauma in schools (CBITS) or waitlist control (WLC).

Manual: Yes.

PTSD symptoms: self-report on CPSS Post-treatment assessment only.

CBITS youth showed greater reductions in PTSD symptoms than WLC youth Insufficient data for effect size.

Nathan & Gorman: Type 1.

Task Force: Possibly Efficacious.

Minority Condition: A.
Evidence-Based Treatment for Minority Youth

symptoms in the clinical range.

**MIXED/CO-MORBID CLINICAL PROBLEMS**

*Multisystemic Therapy – Probably Efficacious*  
Rowland et al., 2005  
N=31. Average age of 14.5 years. 58% male. 84% multiracial (combinations of Asian, Caucasian, & Pacific Islander), 10% Caucasian, 7% Asian/Pacific Islander.  
(Rowland et al., 2005)  
MST led to greater reductions in youth CBCL externalizing and internalizing problems, SRDS minor delinquency, and days in out-of-home placement.

| CSP: Yes. Clinic-referred; 94% DSM diagnosis; out-of-home placement imminent. | Setting: Home & community  
Modality: Family-based multicomponent therapy  
Therapists: Professional therapists  
Manual: Yes.  
Drug use: PEI self-report  
Danger to self/others: YRBS self-report.  
Externalizing problems: CBCL caregiver report; CBCL youth report.  
Task Force: Probably Efficacious.  
Minority Condition: A. |

| Randomly assigned to multisystemic therapy (MST) or usual services (US). | MST led to greater reductions in youth CBCL externalizing and internalizing problems, SRDS minor delinquency, and days in out-of-home placement. | No treatment differences in caregiver CBCL externalizing & internalizing problems, dangerousness to self/others, drug use, SRDS index. |
**Possibly Efficacious Treatment**

Weiss et al., 2003  
N=93. Average age of 9.7 years. 63% male. 56% African American, 38% Caucasian.  
CSP: Yes. From TRF, 50% in clinical range for internalizing & 56% for externalizing.  
Classrooms randomly assigned to RECAP (Reaching Educators, Children and Parents) or no treatment control (NTC).  
Externalizing & Internalizing Behavior Problems: Caregiver report on CBCL; teacher report on TRF; peer report on PMIEB; youth self-report on YSR.  
Post-treatment assessment (9 months after referral) led to greater symptom reduction than NTC from pre-
Evidence-Based Treatment for Minority Youth

problems. Also, youth 1 standard deviation above mean or higher on composite behavior problem rating.

Setting: School Manual: Yes. Post-Treatment ES:

Follow-up ES:

d = .43

OTHER CLINICAL PROBLEMS

Combined Behavioral Treatment and Medication – Probably Efficacious

Arnold et al., 2003 [Also MTA Cooperative Group, 1999; Swanson et al., 2001]

N=579. Ages 7 to 9 years. 80% male. 61% Caucasian, 20% African American, 8% Latino, 11% other.

Randomly assigned to medication management (MM), multicomponent behavioral treatment (Beh), combined medication and behavioral treatment (Comb), or community comparison (CC).

Modality: Multicomponent

ADHD and ODD symptoms: parent and teacher ratings

Overall disruptive behavior

Composite of ADHD and ODD symptoms.

Post-treatment (14-months post entry) comparison (CC).

For parent- and teacher-rated ADHD symptoms, no difference between MM and Comb, and both superior to Beh and CC (MTA Cooperative Group, 1999). For overall disruptive behavior, Comb superior to CC (MTA Cooperative Group, 1999). For parent-rated ODD and CC (MTA Cooperative Group, 1999). For overall disruptive behavior, Comb superior to CC (MTA Cooperative Group, 1999).

Minority Condition: C (Superiority of Beh over CC in reducing parent-rated ODD greater for African American than Caucasian youth.

Efficacy of Comb over MM in

Nathan & Gorman: Type 1.

Task Force: Probably Efficacious.

Nathan & Gorman: Type 1.
**Possibly Efficacious Treatment**

<table>
<thead>
<tr>
<th>Huey et al., 2004</th>
<th>N=156. Average age</th>
<th>Randomly assigned to</th>
<th>Attempted Suicide: Self-report on item from</th>
<th>MST more successful than EH at reducing YRBS attempted suicide from pre-treatment to follow-up. No treatment effects for CBCL attempted suicide,</th>
<th>Nathan &amp; Gorman: Task Force: Possibly Efficacious.</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.9 years. 65% male. 65% African American, 33% European American, 1% other ethnicity.</td>
<td>Multisystemic Therapy (MST) or Emergency Psychiatric Hospitalization</td>
<td>Multisystemic</td>
<td>the YRBS; caregiver report on item from the YRBS;</td>
<td></td>
<td>Type 2 (validity/reliability of most suicidality items and blind assessment unclear)</td>
</tr>
<tr>
<td>CSP: Yes. Referred for psychiatric emergency</td>
<td>Psychiatric Hospitalization</td>
<td>CBCL.</td>
<td></td>
<td>effects for CBCL attempted suicide,</td>
<td>Efficacious.</td>
</tr>
<tr>
<td>Modality: Multicomponent</td>
<td>Psychiatry</td>
<td></td>
<td></td>
<td>or BSI or YRBS</td>
<td>Minority Condition: C</td>
</tr>
<tr>
<td>Therapists:</td>
<td>Post-treatment and suicidal ideation.</td>
<td>(For African American but not European American youth, MST led to faster recovery [CBCL attempted suicide] than hospitalization).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional therapists (see Henggeler, Rowland, et al., 1999) assessments</td>
<td>Post-Treatment ES: $d = -.01$</td>
<td>Follow-up ES: $d = .21$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Setting:** Home & community  
**Manual:** Yes.

---

Note: ADHD = Attention-Deficit Hyperactivity Disorder; ADIS = Anxiety Disorders Interview Schedule for DSM-IV; ASI = Addiction Severity Index; BASC = Behavior Assessment System for Children; BPC = Behavior Problem Checklist; BRS = Conners Teacher Behavior Rating Scale; BSFT = Brief Strategic Family Therapy; CBCL = Child Behavior Checklist; CDI = Children’s Depression Inventory; CES-D = Center for Epidemiological Studies Depression Scale; CIR = Clinician’s Impairment Rating Scale; CPSS = Child PTSD Symptom Scale; CSP = Clinically-Significant Problem; CTC = Coie Teacher Checklist; DESBRS = Devereaux Elementary School Behavior Rating Scale; DSM = Diagnostic and Statistical Manual (of the American Psychiatric Association); FSSC-R = Fear Survey Schedule for Children, Revised; GAD = Generalized Anxiety Disorders; HCSBS = Home and Community Social Behavior Scales; IPPOCS = Interactive Peer Play Observational Coding System; K-SADS = Schedule for Affective Disorders and Schizophrenia for School-Age Children; NYS = National Youth Survey; ODD = Oppositional Defiant Disorder; PDR = Parent Daily Report; PEI = Personal Experiences Inventory; PIPPS = Penn Interactive Peer Play Scale; PMIEB = Peer-Report Measure of Internalizing and Externalizing Behavior; POSIT = Problem-Oriented Screening Instrument for Teenagers; PRABS = Proactive-Reactive Aggressive Behavior Scale; PTSD = Post-Traumatic Stress Syndrome; RBPC = Revised Behavior Problem Checklist; RCBC = Ratings of Child Behavior Change; RCMAS = Revised Children’s Manifest Anxiety Scale; SAS-A = Social Anxiety Scale for Adolescents; SCAN = Schedule for Classroom Activity Norms; SCARED = Screen for Child Anxiety Related Emotional Disorders; SCL-90 = Symptom Checklist; SNAP-IV = Swanson, Nolan, and Pelham Questionnaire; SRDS = Self-Report Delinquency Scale; SSBS = School Social Behavior Scales; SSRS = Social Skills Rating System; TLFB =
Timeline Follow-Back Method; TOCA-R = Teacher Observation of Classroom Adaptation – Revised; TRF = Teacher’s Report Form; WPBIC = Walker Problem Behavior Identification Checklist; YAS = Young Adult Self-Report; YRBS = Youth Risk Behavior Survey.

a Clinically-Significant Problem.
Table 4

Mean Post-Treatment Effect Sizes, Confidence Intervals, and Significance Values (Versus 0) by Moderator Variable for Empirically-Based Treatments with Ethnic Minority Youth

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Effect size (d)</th>
<th>Confidence interval (CI)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sample</td>
<td>20</td>
<td>.44 (.06)</td>
<td>.32 to .56</td>
<td>.001</td>
</tr>
<tr>
<td>Ethnicity (κ = .69)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African Americans</td>
<td>10</td>
<td>.35 (.08)</td>
<td>.19 to .51</td>
<td>.001</td>
</tr>
<tr>
<td>Latinos</td>
<td>4</td>
<td>.47 (.15)</td>
<td>.17 to .76</td>
<td>.002</td>
</tr>
<tr>
<td>Mixed or other ethnic minority</td>
<td>6</td>
<td>.61 (.11)</td>
<td>.38 to .83</td>
<td>.001</td>
</tr>
<tr>
<td>Target problem type(^a) (κ = .84)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Externalizing problems (aggression, delinquency, other externalizing)</td>
<td>8</td>
<td>.51 (.10)</td>
<td>.32 to .70</td>
<td>.001</td>
</tr>
<tr>
<td>Internalizing problems (anxiety, depression, other internalizing)</td>
<td>5</td>
<td>.65 (.12)</td>
<td>.41 to .89</td>
<td>.001</td>
</tr>
<tr>
<td>Target problem severity (κ = 1.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinically-significant</td>
<td>17</td>
<td>.40 (.06)</td>
<td>.27 to .53</td>
<td>.001</td>
</tr>
<tr>
<td>Not clinically-significant</td>
<td>3</td>
<td>.70 (.17)</td>
<td>.36 to 1.04</td>
<td>.001</td>
</tr>
<tr>
<td>Diagnostic status (κ = 1.00)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DSM diagnosis required</td>
<td>5</td>
<td>.35 (.11)</td>
<td>.13 to .57</td>
<td>.002</td>
</tr>
</tbody>
</table>
DSM diagnosis not required 15 .48 (.07) .33 to .62 .001

Comparison groupb (κ = 1.00)

No treatment 5 .58 (.14) .30 to .86 .001
Placebo control 8 .51 (.09) .33 to .69 .001
Treatment as usualc 5 .22 (.10) .02 to .41 .03

Culture-responsive treatment

(conservative definition) (κ = .80)

Standard treatment 10 .43 (.08) .29 to .58 .001
Culture-responsive treatment 10 .45 (.10) .25 to .64 .001

Culture-responsive treatment (liberal
definition) (κ = .78)

Standard treatment 6 .55 (.10) .35 to .76 .001
Culture-responsive treatment 14 .38 (.07) .23 to .53 .001

---

DSM = Diagnostic and Statistical Manual (of the American Psychiatric Association).

a Substance use and other problems were excluded from this analysis because few studies included these as primary referral problems. Studies were excluded if outcomes focused on both externalizing and internalizing problems.

b Studies with more than one comparison group were excluded from this analysis.

c All treatment as usual comparisons were also evaluations of Multisystemic Therapy (MST).
Table 5

Evidence-Based Treatments for Ethnic Minority Youth

<table>
<thead>
<tr>
<th>Psychosocial Treatment</th>
<th>Ethnicity</th>
<th>Citation for Efficacy Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well-Established Treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Probably Efficacious Treatments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attention Deficit/Hyperactivity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined Behavioral Treatment and stimulant</td>
<td>African American;</td>
<td>Arnold et al., 2003</td>
</tr>
<tr>
<td>Treatment and stimulant</td>
<td>Hispanic/ Latino</td>
<td></td>
</tr>
<tr>
<td>medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Conduct Problems</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger Management Group</td>
<td>Predominantly African</td>
<td>Snyder et al., 1999</td>
</tr>
<tr>
<td>Training</td>
<td>American</td>
<td></td>
</tr>
<tr>
<td>Attributional Training</td>
<td>African American</td>
<td>Hudley &amp; Graham, 1993</td>
</tr>
<tr>
<td>Brief Strategic Family Therapy</td>
<td>Hispanic/Latino</td>
<td>Santisteban et al., 2003;</td>
</tr>
<tr>
<td></td>
<td>(Predominantly Cuban)</td>
<td>Szapocznik, Santisteban et al.,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1989</td>
</tr>
<tr>
<td>Child-Centered Play Therapy</td>
<td>Hispanic/Latino</td>
<td>Garza &amp; Bratton, 2005</td>
</tr>
<tr>
<td></td>
<td>(Mexican American)</td>
<td></td>
</tr>
<tr>
<td>Coping Power (child and parent components)</td>
<td>African American</td>
<td>Lochman &amp; Wells, 2003;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lochman &amp; Wells, 2004</td>
</tr>
<tr>
<td>Treatment Type</td>
<td>Ethnic Group</td>
<td>Authors</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Multisystemic Therapy (MST)</td>
<td>African American</td>
<td>Borduin et al., 1995; Henggeler et al., 1992; Henggeler et al., 1997;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Henggeler et al., 2002; Schaeffer &amp; Borduin, 2005</td>
</tr>
<tr>
<td>Rational Emotive Education</td>
<td>African American +</td>
<td>Block, 1978</td>
</tr>
<tr>
<td></td>
<td>Hispanic/Latino</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive-Behavioral Therapy (CBT)</td>
<td>Hispanic/Latino (Puerto Rican)</td>
<td>Rossello &amp; Bernal, 1999; Rossello et al., in press</td>
</tr>
<tr>
<td>Substance Use Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multidimensional Family Therapy</td>
<td>Ethnic Minority</td>
<td>Liddle et al., 2004</td>
</tr>
<tr>
<td></td>
<td>(Hispanic/Latino, Haitian, Jamaican)</td>
<td></td>
</tr>
<tr>
<td>Trauma-Related Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilient Peer Treatment</td>
<td>African American</td>
<td>Fantuzzo et al., 1996; Fantuzzo et al., 2005</td>
</tr>
<tr>
<td>Trauma-Focused CBT</td>
<td>Predominantly African</td>
<td>Cohen et al., 2004</td>
</tr>
<tr>
<td></td>
<td>American</td>
<td></td>
</tr>
<tr>
<td>Mixed/Comorbid Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MST</td>
<td>Multiracial Hawaiian</td>
<td>Rowland et al., 2005</td>
</tr>
<tr>
<td></td>
<td>(Mixed Asian/Caucasian/Pacific Islander)</td>
<td></td>
</tr>
</tbody>
</table>
## Possibly Efficacious Treatments

### Anxiety-Related Problems

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Population</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Management (AMT)</td>
<td>African American</td>
<td>Wilson &amp; Rotter, 1986</td>
</tr>
<tr>
<td>Modified AMT</td>
<td>African American</td>
<td>Wilson &amp; Rotter, 1986</td>
</tr>
<tr>
<td>Study Skills Training</td>
<td>African American</td>
<td>Wilson &amp; Rotter, 1986</td>
</tr>
<tr>
<td>Group CBT (adapted for African Americans in school settings)</td>
<td>Hispanic/Latino</td>
<td>Silverman et al., 1999</td>
</tr>
<tr>
<td>Study Skills Training</td>
<td>Hispanic/Latino</td>
<td>Ginsburg &amp; Drake, 2002</td>
</tr>
</tbody>
</table>

### Conduct Problems

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Population</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Contracting</td>
<td>African American</td>
<td>Stuart et al., 1976</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>African American</td>
<td>Forman, 1980</td>
</tr>
<tr>
<td>Response Cost</td>
<td>African American</td>
<td>Forman, 1980</td>
</tr>
<tr>
<td>Social Relations Training</td>
<td>African American</td>
<td>Lochman et al., 1993</td>
</tr>
<tr>
<td>Structured Problem-Solving</td>
<td>African American + Hispanic/Latino</td>
<td>De Anda, 1985</td>
</tr>
</tbody>
</table>

### Depression

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Population</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Psychotherapy</td>
<td>Hispanic/Latino (Puerto Rican)</td>
<td>Rossello &amp; Bernal, 1999</td>
</tr>
</tbody>
</table>

### Substance Use Problems
### MST

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Ethnicity</th>
<th>Study Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal Behavior</td>
<td>African American</td>
<td>Huey et al., 2004</td>
</tr>
<tr>
<td>Trauma-Related Problems</td>
<td>African American</td>
<td>Clark et al. 1998</td>
</tr>
<tr>
<td>School-Based Group CBT</td>
<td>Hispanic/Latino</td>
<td>Stein et al., 2004</td>
</tr>
<tr>
<td></td>
<td>(Mexican American)</td>
<td></td>
</tr>
<tr>
<td>Mixed/Comorbid Problems</td>
<td>RECAP Intervention</td>
<td>Weiss et al., 2003</td>
</tr>
</tbody>
</table>

RECAP = Reading, Education, Children, and Parents.
Table 6

*Summary of Studies Evaluating Ethnicity as a Moderator of Treatment Effects in Randomized Controlled Trials*

<table>
<thead>
<tr>
<th>Significant Ethnicity Effects</th>
<th>Null Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N = 5</strong></td>
<td><strong>N = 8</strong></td>
</tr>
<tr>
<td>• Arnold et al., 2003 (For one of four variables, superior outcomes for African American [behavioral treatment vs. control] and Latino youth [combined treatment vs. control] over Caucasian youth)</td>
<td>• Borduin et al., 1995 (also see Schaeffer et al. [2005] for similar results at 13.7-year follow-up)</td>
</tr>
<tr>
<td>• Huey et al, 2004 (Superior outcomes for African American vs. European American youth on one of two variables)</td>
<td>• Clark et al., 1998</td>
</tr>
<tr>
<td>• Lochman &amp; Wells, 2004 (Superior outcomes for White vs. African American youth on one of two variables)</td>
<td>• Cohen et al., 2004</td>
</tr>
<tr>
<td>• Rohde et al., 2006 (For Whites, depression recovery faster in CBT compared to life-skills/tutoring control; for “non-Whites,” recovery time did not differ by condition)</td>
<td>• Henggeler et al., 1992</td>
</tr>
<tr>
<td>• Weiss et al., 1999 (For two of 16 variables, African American youth in treatment showed improvement or no effects, whereas Caucasian youth in treatment deteriorated relative to controls)</td>
<td>• Henggeler, Pickrel, et al., 1999 (also see Henggeler et al. [2002] for similar results at 4-year follow-up)</td>
</tr>
<tr>
<td></td>
<td>• Lochman &amp; Wells, 2003</td>
</tr>
<tr>
<td></td>
<td>• Silverman, Kurtines, Ginsburg, Weems et al., 1999</td>
</tr>
<tr>
<td></td>
<td>• Weiss et al., 2003</td>
</tr>
</tbody>
</table>
Table 7

**Evidence-based Youth Treatments with Culture-Responsive Elements**

<table>
<thead>
<tr>
<th>Study</th>
<th>Ethnicity</th>
<th>Treatment &amp; Problem</th>
<th>Culture-Responsive Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark et al. (1998)</td>
<td>African American</td>
<td>FIAP for abused</td>
<td>Therapists used client’s strengths across multiple life domains, including “cultural/ethnic/spiritual problems”</td>
</tr>
<tr>
<td>Fantuzzo et al. (2005)</td>
<td>African American</td>
<td>Resilient Peer Modeling for socially withdrawn, maltreated youth</td>
<td>Treatment was “culturally appropriate” in its use of family volunteers and socially high-functioning peers, with common cultural backgrounds and experiences.</td>
</tr>
<tr>
<td>Garza &amp; Bratton (2005)</td>
<td>Mexican-American</td>
<td>Child-Centered Play Therapy for behavior problems</td>
<td>Bilingual Hispanic counselors, with counselors responding “in-kind” to youth language preference. Selection of multicultural toys to “capture elements of Hispanic</td>
</tr>
<tr>
<td>Authors</td>
<td>Ethnicity</td>
<td>Intervention Type</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ginsburg &amp; Drake</td>
<td>African American</td>
<td>Group CBT for anxiety disorders</td>
<td>Manual adapted to be “culturally sensitive (e.g., examples changed, alternative situations used, etc.)”</td>
</tr>
<tr>
<td>Henggeler, Melton, &amp; Smith (1992)</td>
<td>African American</td>
<td>MST for serious and chronic antisocial behavior</td>
<td>Individualized treatment plans and assessment of multiple contexts, allows MST to “deal flexibly with sociocultural differences in adolescents’ psychosocial contexts.”</td>
</tr>
<tr>
<td>Hudley &amp; Graham (1993)</td>
<td>African American</td>
<td>Attributional Intervention for aggressive youth</td>
<td>Treatment conducted by African American females</td>
</tr>
<tr>
<td>Huey &amp; Rank (1984)</td>
<td>African American</td>
<td>Counselor- &amp; Peer-led Assertive</td>
<td>Peer and professional counselors were Black.</td>
</tr>
<tr>
<td>Study</td>
<td>Population</td>
<td>Treatment</td>
<td>Therapist Characteristics</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Liddle et al. (2004)</td>
<td>Primarily</td>
<td>Multidimensional</td>
<td>86% of therapists were either African American &amp; Hispanic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>for substance use</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hispanic</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>problems</td>
<td></td>
</tr>
<tr>
<td>Lochman, Curry, Dane, &amp; Ellis (2001)</td>
<td>African American</td>
<td>Coping Power (Anger Coping Program)</td>
<td>African American staff involved in development of intervention; in group sessions, participants encouraged to discuss what they already do that works, and those efforts are then used as positive examples; act collaboratively with participants as coaches rather than as teachers</td>
</tr>
</tbody>
</table>
| Rossello & Bernal (1999) | Latino (Puerto Rican) | CBT for depression | IPT and CBT “adapted, taking into consideration cultural aspects of the treatments that
Consider the ‘interpersonal’ aspects of the Latino culture.”

<table>
<thead>
<tr>
<th>Source</th>
<th>Population/Context</th>
<th>Treatment Type</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rossello, Bernal, &amp; Rivera-Medina (in press)</td>
<td>Latino (Puerto Rican)</td>
<td>CBT for depression, IPT for depression</td>
<td>Both CBT and IPT were culturally adapted “based on a framework that employs criteria of ecological validity.”</td>
</tr>
<tr>
<td>Rowland et al. (2005)</td>
<td>Multiracial Hawaiian (combinations of Asian, Pacific Islander, and Caucasian)</td>
<td>MST for serious emotional and behavioral problems</td>
<td>Cultural background of clinical team representative of client population. Use of “Family Resource Specialist” to “help families develop indigenous social supports and to assist the clinical team in understanding the cultures and contexts in which the families were embedded”</td>
</tr>
<tr>
<td>Silverman et al. (1999)</td>
<td>Latino</td>
<td>Group CBT for anxiety disorders</td>
<td>Therapist training involved “sensitizing therapists to issues specific to working with multicultural populations, such as cultural...”</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Ethnicity</td>
<td>Treatment Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------</td>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Stein et al. (2003)</td>
<td>Latino</td>
<td>Group CBT for PTSD symptoms</td>
<td>Intervention “designed for use. . . with a multicultural population.”</td>
</tr>
<tr>
<td></td>
<td>(children of Mexican immigrants)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Szapocznik, Santisteban et al. (1989)</td>
<td>Latino</td>
<td>FET for behavioral and psychological complaints</td>
<td>Treatment addressed intergenerational, cultural conflict. Counselors Hispanic and experience working with Hispanics</td>
</tr>
</tbody>
</table>

CBT = Cognitive-Behavior Therapy; FET = Family Effectiveness Therapy; FIAP = Fostering Individualized Assistance Program; IPT = Interpersonal Psychotherapy; MST = Multisystemic Therapy; PATHS = Promoting Alternative THinking Strategies; PTSD = Post-Traumatic Stress Disorder.
Table 8

*Studies Evaluating Treatments Identified as Culture-Responsive or Not Culture-Responsive Based on “Conservative” and “Liberal” Criteria*

<table>
<thead>
<tr>
<th>Conservative Definition</th>
<th>Liberal Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Culture-Responsive</td>
<td>Fantuzzo et al., 2005; Garza &amp; Bratton, 2005; Ginsburg &amp; Drake, 2002; Henggeler et al., 1992; Henggeler et al., 1999; Huey &amp; Rank, 1984; Liddle et al., 2004; Rossello &amp; Bernal, 1999; Rowland et al., 2005; Silverman et al., 1999</td>
</tr>
<tr>
<td>Standard (i.e., No apparent culture-responsive element)</td>
<td>Block, 1978; Cohen et al., 2004; De Anda, 1985; Fantuzzo et al., 1996; Henggeler et al., 1997; Huey et al., 2004; Santisteban et al., 2003; Snyder et al., 1999; Weiss et al., 2003; Wilson &amp; Rotter, 1986</td>
</tr>
</tbody>
</table>