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Psychological Intervention and Cultural Diversity

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14 Ethnic Minority Intervention and Treatment Research

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This chapter deals with research issues concerning ethnic minority interventions and treatment. It specifically focuses on (1) conceptual and methodological research issues, (2) psychotherapeutic outcome and process findings, and (3) applications of research to treatment and mental health practices. To aid students and practitioners who want to learn more about how to conduct research with ethnic minorities, as well as practitioners interested in using research in their work, we have attempted not only to present issues and research findings but also to suggest how to use these findings. Those who work with ethnic minority populations must be aware of the issues and be able to translate these issues into research and clinical practice.

Ethnic minority research in psychotherapy has had a relatively short history. Most psychotherapy research initiated about half a century ago examined the question of whether psychotherapy was effective. In time, questions were raised concerning what kinds of treatment were effective and what kinds of treatment were appropriate with what kinds of therapists, clients, and situations (for a history of psychotherapy including ethnicity and treatment, see Freedheim, 1992). The client variable of ethnicity was only of peripheral interest, for a variety of reasons: lack of interest in ethnicity on the part of researchers, lack of available funding for ethnic research, the belief among some that psychotherapy was unimportant because massive social and political interventions were needed in order to address race and ethnic relations, and difficulties in conducting ethnic research. Over time, the situation has changed, as reflected in the growing interest in ethnic research, greater availability of funding opportunities, and realization that although mas-

sive interventions are needed, so are efforts to help individual clients. Research contributions have increased, and the numbers of researchers who are themselves members of ethnic groups have helped to provide insider perspectives. Despite the fact that ethnic research has been an exciting area and its contributions have been highly important, a number of conceptual and methodological issues continue to confront the field.

Conceptual Considerations

Many conceptual issues arise in the field of ethnic research: What is the definition of ethnicity (or race)? How can we conceptualize observable ethnic differences? Are Western and traditional concepts of human beings really applicable to culturally different groups?

Definition of Ethnicity

In research and practice, ethnicity has been used to convey group membership according to race or ethnic background. Ethnic groups such as African Americans are often compared with Whites on utilization of services and treatment outcomes. Although such comparisons are meaningful in a broad sense, they often violate a more strict sense of the concept of ethnicity. The strict sense of the concept refers to a social-psychological sense of "peoplehood" in which members of a group share a unique social and cultural heritage. Yet we often fail to ascertain whether members of particular ethnic groups really share cultural features. Data are many times based on self-identification: If we want to conduct a study of clients and we combine self-identified Latino Americans into one group, we have no assurance that the clients are "ethnically" Latino. Some may have similar backgrounds, experiences, and attitudes, whereas others may be quite different. For example, Puerto Rican Americans who have recently arrived on the mainland may not share the same sense of ethnicity as fourth-generation Mexican Americans. Yet, in research, they are often conceptualized as all being Latino Americans. This problem also exists when we compare ethnics to "Whites," who are themselves quite diverse.

How can we address this problem? At times, the broad concept of ethnicity is important to use, especially if we want to establish parameters for ethnic comparisons. For example, in the present era of managed care, which means streamlining services to reduce costs, the absence of ethnic comparisons may lead to elimination of needed services for ethnic minorities (Abe-Kim & Takeuchi, 1996). In this case, however, researchers should acknowledge the limitations in aggregating diverse individuals into an ethnic category. Another way of addressing the problem is to begin studying individual differences among members of an ethnic group. For example, Helms (1984) has studied whether African Americans prefer to see a therapist who is racially similar. She has found that African Americans who accept an African American identity and who are skeptical of White values are most likely to want a therapist of the same race. Those at other stages of identity development are less likely to exhibit a racial preference. The value of the research is not solely in its demonstration that African Americans differ from one another. The specification of the individual difference variables that are important in explaining research results is also important.

Conceptualization of Differences

In the past, studies have revealed behavioral differences among ethnic groups. For instance, Malzberg (1959) found differences in utilization rates of mental facilities in New York between African Americans and Whites. The problem with this study was that other demographic differences, such as gender and social class, that could be confounded with ethnicity were not controlled. Problems like this one are obvious. Less obvious is how the very concept of ethnicity is confounded with another important phenomenon—namely, minority group status.

We often attribute differences between ethnic groups to cultural factors. For example, traditional Chinese values are contrasted with Western values in order to explain why Chinese Americans may tend to show certain attitudinal or personality differences from White Americans. In essence, the two cultures are conceptualized as being orthogonal or independent variables, while in reality, the two are interactive and not independent (Sue, 1983). Chinese Americans have had a long history in the United States. Because they are members of a minority group who have experienced prejudice and discrimination, their attitudes and behavior may be a product not only of Chinese culture but also of their history and experiences in this country. In studying ethnic minority groups, researchers should be aware that minority group status is intertwined with the concept of ethnicity and should attempt to study the interactions between culture and minority group status.

Applicability of Western Theories

Disciplines such as psychology, psychiatry, social work, and nursing, are highly developed in Western societies in terms of their empirical, methodological, and theoretical contributions. An issue raised by many cross-cultural and ethnic minority researchers concerns the applicability and validity of theories developed in the West to non-Western societies or cultures. The issue is exemplified in the *etic-emic* distinction. The term *etic* refers to culture-general concepts or theories, whereas *emic* is defined as a culture-specific phenomenon. This important distinction can be illustrated as follows: Let us assume a psychotherapist finds that catharsis (e.g., having clients express pent-up emotions directly) relieves tension and depressive feelings. For the principle of catharsis to be *etic* or universal in nature, it should be applicable to different cultural groups. If it is not, then the principle is *emic*— perhaps specific only to the cultural group from which the client came.

A common error in research and in people's everyday thinking is to believe that one's concepts, practices, or principles are universal in nature (Brislin, 1993). A parent who believes that all children are better off in an atmosphere of parental permissiveness, a teacher who advocates that the best way to learn is through competition among all students, or a psychotherapist who assumes that nondirective techniques are effective with all clients may be confusing *emics* for *etics* to the extent that these truisms are confined to particular cultures. Of course, theory is necessary in any science. Rather than discarding theoretically based research, one may use cross-cultural or ethnic investigations to test whether proposed theories are applicable to different groups.

In clinical practice, some researchers and clinicians believe that current psychotherapeutic practices based on Western modes of treatment may be culturally inappropriate

with certain members of ethnic minority groups. They advocate more culturally responsive forms of treatment. It is important to have treatment approaches consistent with clients' cultural lifestyles. However, the concept of "culturally responsive" interventions often consists only of vague notions of being culturally sensitive and knowledgeable about the client's culture. There is a need to specify more carefully what the concept of culturally responsive therapy means and to test the effectiveness of these interventions, as discussed later.

Methodological Considerations

Conducting research on ethnic minority groups is difficult. Researchers often have difficulty finding and selecting an appropriate sample to study, choosing a good research design and controlling for confounding variables, and finding valid measures. It is important to be familiar with these methodological difficulties, not only to improve future research designs but also to understand better the contributions and limitations of past research findings.

Research Participants

Although ethnic minority populations are rapidly increasing, researchers still face difficulties in finding adequate and representative samples to study. These difficulties include the relatively small size of the populations and the unwillingness of some ethnic minorities (e.g., illegal immigrants in the United States) to become research subjects. For example, large-scale epidemiological studies of the prevalence of mental disorders have been conducted among Americans (Myers et al., 1984). Yet, these studies have failed to include sufficient numbers of ethnic groups such as Native Americans and Asian Americans, so that accurate prevalence rates for these groups have not been found. Similarly, it is frequently difficult to study the effectiveness of treatment for Asian Americans at a particular mental health center because Asian Americans tend to avoid such services.

These difficulties in finding adequate samples may have two unfortunate consequences. First, researchers may simply be unable to find a representative sample of ethnic minority populations. Rather than studying the population of Native Americans, they may confine their investigation to urban rather than reservation Native Americans, or to students rather than those in the community at large. Second, investigators may lump diverse groups together in order to achieve adequate sample sizes. In the past, research compared Whites with the broad category of non-Whites. Even today, research on "Latinos" or "Hispanics" combines many diverse groups—Mexican Americans, Puerto Ricans, immigrants from Cuba, El Salvador, and elsewhere. Asian American research includes as subjects Chinese, Japanese, Koreans, Pilipinos (many Asian American researchers now use this term rather than *Filipino*), Vietnamese, and other groups. The problem is that focusing on a particular segment of the ethnic population limits the generalizability of findings. Forming a large aggregate group (e.g., Latino Americans) often fails to reveal the individual differences within the aggregate group. This problem of limited generality and of failure to consider individual differences also exists in studies of the "White" population. However, it is

especially true for ethnic minority populations, which are small in numbers and exhibit considerable cultural and experiential variations.

Research that focuses on a particular segment or on an aggregate group can have important value. Researchers need to draw conclusions that are appropriate to the samples under study and to the research questions being addressed. Furthermore, greater efforts and funds should be expended to overcome some of the problems inherent in studying small and culturally diverse populations. For such populations, researchers must often spend a great deal of time and research funds to find adequate numbers of subjects and to achieve a representative sample. For example, conducting a representative survey of urban Native Americans is far more problematic than conducting a similar survey of urban Whites.

Research Designs and Confounding Variables

Psychological research has available a wide range of research designs and strategies. Research emphasizing experimental, correlational, field, longitudinal, analogue, and other approaches have been used in ethnic minority research. In devising research strategies, however, investigators have often had to consider the availability of sample sizes of ethnics. This is apparent in clinical and counseling studies. For example, a researcher who wants to study whether ethnic similarity between therapist and clients affects treatment outcomes may not be able to find sufficient numbers of ethnic clients and therapists. Consequently, the researcher may use an analogue approach in which students, rather than actual clients and therapists, play the roles of clients and therapists. There are obvious limitations in analogue studies. The external validity and generality of findings can be questioned. But such compromises in research ideals must sometimes be made because of practical realities.

Ethnographic techniques and qualitative methods are recommended in ethnic research (Sue, Kurasaki, & Srinivasan, in press). Ethnographic studies involve more descriptive-analytic techniques to study aspects of culture or the effects of culture, especially as viewed by members of that culture. Often used by anthropologists, ethnography is useful for identifying important aspects of culture, categorizing phenomena, and exploring relationships between cultural variables and behavior. In psychology, it is frequently used to establish research parameters for further investigations. For example, before comparing how different cultural groups fare in psychotherapy, we may wish to study ethnographically how these groups generally respond to those healers already in their cultures in order to understand cultural practices in the different groups and their familiarity with and reactions to Western psychotherapists.

In any research design, it is important to be able to control for confounding variables. As mentioned previously, ethnicity is a broad variable, encompassing many features. Because ethnicity is often associated not only with culture but also with variables such as social class, investigators have often argued whether observed differences between, say, African Americans and Whites are really a matter of race or of social class. Research designs must obviously control for social class, as well as other demographic and social variables, before attributing differences to ethnicity or race. It is important to note that the "disadvantaged" status of ethnic minority groups cannot simply be attributed to social class differences. Although we know that certain groups such as African Americans,

Native Americans, and Latino Americans have lower educational and income levels than do Whites, being a member of an ethnic minority group may involve other disadvantages that are important to study.

Valid Measures

Validity refers to whether tests or assessment instruments accurately measure what they purport to measure. Researchers often have difficulty finding valid measures to use with different cultural groups. Take, for example, this item from the MMPI: "I feel blue." For people in U.S. society who are familiar with English idioms, this statement refers to feeling depressed or sad. But recent immigrants or those with limited English proficiency may not understand the meaning of "blue" in this context and may interpret the item as literally referring to the color blue.

Brislin (1993) identifies two major problems that are pertinent to our discussion of measures. First, concepts may not be equivalent across cultures. He notes that the concept of intelligent behavior is not equivalent in the United States and among the Baganda of East Africa. In the United States, one sign of intelligence is quickness in mental tasks, in East Africa, by contrast slow, deliberate thought is considered a part of intelligence. Obviously, tests of intelligence devised in the two cultures would differ, and individuals taking the tests could be considered intelligent on one measure but not the other. As another example, consider the concept of sincerity. In the United States, sincerity refers to being truthful, genuine, and straightforward—not to enacting roles. For Japanese, however, the sincere individual is one who acts in accordance with role expectations, not subjective personal feelings (DeVos, 1978).

Second, scalar or metric equivalence refers to whether scores on assessment instruments are really equivalent in cross-cultural research. For example, many universities use the Scholastic Aptitude Test (SAT), which has a verbal and quantitative component, as a criterion for admission. Many members of ethnic minority groups score lower on the SAT than do Whites. Do the test scores accurately assess academic potential, achievements, and ability to succeed? SAT scores moderately predict subsequent university grades. However, Sue and Abe (1988) found that the ability of the SAT score to predict success varies according to ethnicity and the components of the SAT. Whereas the SAT verbal component was a good predictor of university grades for Whites, the SAT quantitative portion was a good predictor of grades for Asian American students. Thus, Asian American and White students who have the same total SAT score (combining verbal and quantitative subscores) may perform quite differently on grades, depending on the subscores. Researchers must study the conceptual and scalar equivalence of tests when working with ethnic minority groups. The use of multiple measures is also important to see if the measures provide consistent findings.

The conceptual and methodological issues and the short history of ethnic minority research have had several consequences. Research has had to proceed carefully in order to take into consideration the difficulties in ethnic research. Accordingly, much of the research is exploratory because of the lack of baseline information and the uncertain applicability of Western theories. Nevertheless, as we shall see, much of the research has been pioneering and exciting. The work has also provided insight into the applicability of existing theories

and methods to use in cross-cultural studies. Keeping in mind the conceptual and method-ological issues that have been raised, we would now like to review the substantive research on psychotherapy with ethnic minority groups.

Psychotherapy Research

Is psychotherapy effective with members of ethnic minority groups? This question is prob-ably better stated as: "Under what conditions is psychotherapy helpful to members of ethnic minority groups?" Critics of psychotherapy with ethnic groups rarely challenge the value of psychotherapy or psychological interventions. What they do often challenge are the outcomes of psychotherapy when traditional psychotherapeutic practices do not con-sider the culture and minority group experiences of ethnic minority clients. Some critics may also advocate for prevention and for social, political, and economic changes rather than psychotherapy. But few would argue that psychotherapy cannot be effective with ethnic minority group clients.

In our review, we examine several issues: (1) Do ethnic minority groups use mental health services? (2) How long do ethnic clients remain in treatment? (3) What are the find-ings of research on psychotherapy outcomes? Although research has provided some insights into the answers to these questions, we need much more research to enable us to draw stronger conclusions. Our analysis is based primarily on a comprehensive review of psychotherapy research by one of the authors (see Sue, Zane, & Young, 1994).

Utilization of Mental Health Services

Investigations on utilization of mental health services by ethnic minorities have repeatedly found that African Americans and Native Americans tend to overutilize, whereas Asian Americans and Latino Americans tend to underutilize mental health services (Beiser & Attneave, 1982; Brown, Stein, Huang, & Harris, 1973; López, 1981; Mollica, Blum, & Redlich, 1980; O'Sullivan, Peterson, Cox, & Kirkeby, 1989; San Francisco Department of Mental Health, 1982; Scheffler & Miller, 1989; Snowden & Cheung, 1990; Sue, 1977). These patterns of utilization of the four major ethnic groups vary little from inpatient to outpatient settings and among various types of service facilities (e.g., community mental health facilities, state and county mental hospitals, Veterans Administration medical cen-ters, general hospitals, and private psychiatric hospitals). In studies that do report different utilization patterns depending on service type, African Americans and Hispanics under-utilize outpatient care and overutilize inpatient care in comparison to Whites (Cheung & Snowden, 1990; Hu, Snowden, Jerrell, & Nguyen, 1991; Scheffler & Miller, 1989). Accord-ing to the findings of a study by O'Sullivan et al. (1989), which was a follow-up to the Sue (1977) study in Seattle, the utilization pattern of some groups appears to be changing. They found that, although African Americans and Native Americans continued to overutilize, Asian Americans and Latino Americans no longer underutilized services. More studies are needed to confirm these findings.

Many different explanations have been offered by investigators for the presence of ethnic differences in service utilization. Unfortunately, few were based on research find-

ings, and most were speculative (Sue et al., 1994). Snowden and Cheung (1990) and others (Akutsu, 1997; Akutsu, Snowden, & Organista, 1996; Alvidrez, Azocar, & Miranda, 1996; Aponte & Barnes, 1995; Bastida & Gonzalez, 1995; Harada & Kim, 1995; Kang & Kang, 1995; Padgett, Patrick, Burns, & Schlesinger, 1995; Rodriguez & O'Donnell, 1995; Takeuchi, Sue, & Yeh, 1995) have attributed the group utilization differences to the group differences in socioeconomic status, rates of psychopathology, help-seeking tendencies, cultural variables, minority status, therapists' diagnostic bias and involuntary hospitalization (especially in the case of African Americans), and structural barriers. It is imperative that more research be conducted because these differences have serious implications for determining the mental health needs of these groups and the effectiveness of the currently available treatments for them.

Some caution should be taken in interpreting these findings. First, there may be some inconsistencies in service utilization patterns between findings from national surveys that include those who have not sought treatment at mental health facilities and findings from treated samples from community, state, or county mental health facilities. Neighbors (1985) found that in his national survey of adult African Americans, only a relatively small number reported that they used mental health services for psychological problems. Yet, the studies cited earlier on utilization patterns demonstrated that African Americans *overutilized* services. Second, in a review article by Rogler et al. (1983), Puerto Ricans in New York had significantly higher rates of psychiatric admissions, use of outpatient psychiatric services, and community mental health facilities than did non-Latino Whites. Only recently have Puerto Ricans shown relatively low rates of admission. This points to the fact that utilization patterns or statistics change and need to be monitored over time. Third, we have used the terms *underutilization* and *overutilization* loosely to refer to whether groups differ in use compared to their relative population figures. A group may have a low percentage of users simply because it has a low prevalence of mental disorders. Similarly, groups that statistically overutilize services may not be overutilizing if the prevalence of disorders in that group is high. In this case, statistically defined under- and over-utilization are discrepant with definitions based on need for services. Because we do not know enough about the prevalence of mental disorders among ethnic minority populations, most studies have employed a statistical definition as indicators of utilization. It should be noted, however, that indirect indicators of well-being suggest that Asian Americans and Latino Americans are not extraordinarily well adjusted. Thus, their underutilization may reflect actual low use rather than low needs for services.

Length of Treatment

Another commonly used method of examining the impact or effectiveness of psychotherapy for ethnic minorities is investigating the length of treatment. The assumption behind this type of research is that an effective therapy can keep clients in treatment, whereas an ineffective therapy will be terminated prematurely by clients. In fact, studies have consistently shown that the longer clients stay in treatment, the more change occurs (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Pekarik, 1986).

Findings on length of treatment of ethnic minority clients are inconsistent. Length of treatment has been measured either as the average number of sessions or the dropout rate

after the first session of treatment. Sue (1977) investigated the dropout rate of African Americans, Native Americans, Asian Americans, and Latin Americans in Seattle. He found all groups of ethnic minorities to have significantly higher dropout rates after the first session than White Americans. In the follow-up study in Seattle, O'Sullivan et al. (1989) found no consistent differences in dropout rates between ethnic and White groups. In another study of the outpatient facilities in Los Angeles County (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), only African Americans had a higher dropout rate from treatment after the first session than White Americans. Latino Americans did not differ from White Americans and Asian Americans had even a lower dropout rate than White Americans. Therefore, Asian Americans had the highest average number of sessions, followed by White and Latino Americans. African Americans had the lowest average number of treatment sessions. The inconsistency between the findings of the different studies may be due to variations in region, service system, and time period (Sue et al., 1994), or it may be an indication of some recent improvement in our mental health system's cultural responsiveness.

One study of different ethnic groups has provided some insight into factors associated with length of treatment. The Los Angeles County study (Sue et al., 1991) revealed that among African Americans, Asian Americans, Mexican Americans, and Whites, two factors were related to number of sessions across all groups: income and ethnic match between clients and therapists. Being poorer and not having an ethnically similar therapist predicted a lower number of treatment sessions. Having a psychotic diagnosis was also associated with fewer sessions in all groups except Mexican Americans. Thus, in this study, poor clients were more likely to average fewer sessions than were clients with higher incomes. The finding that having a therapist of the same ethnicity results in more sessions is interesting, although the reasons for this finding are unclear. Perhaps ethnic match tends to increase interpersonal attraction or influence of therapists. Finally, in a study that examined utilization of mental health services by older Asian Americans in Los Angeles County, older clients with a combination of financial coverage were nearly five times as likely as their privately insured counterparts to drop out of treatment after just one session (Harada & Kim, 1995).

Treatment Outcome Research

The paucity of treatment outcome studies on ethnic minorities makes it difficult to draw any definitive conclusions about the effectiveness of psychotherapy with ethnic groups. We need many more studies that rigorously examine treatment effects using (1) within- and between-ethnic group comparisons, (2) sufficient sample sizes, (3) different forms of treatment, (4) a variety of cross-culturally valid outcome measures, (5) follow-up strategies that can shed light on the stability of treatment effects over time, and (6) adequate methodological designs so that researchers can control for confounding variables or alternative explanations for findings. The few studies that are available often provide conflicting findings for all major ethnic groups. In none of the studies, however, did ethnic minorities consistently fare better than White Americans. Ethnic minorities tended at best to have similar treatment outcomes to White Americans.

Treatment outcome literature on African Americans seems to indicate that African Americans do not fare better than other ethnic clients, including White Americans, and

that they may even have worse outcomes (Sue et al., 1994). Earlier studies on African Americans have revealed no racial differences from White Americans (Lemer, 1972). Jones (1978; 1982) has repeatedly found that African American clients showed similar rates of improvement to those of White Americans regardless of the ethnicity of their therapists. In more recent studies, however, the treatment outcomes of African Americans were poorer than the outcomes of White Americans and sometimes even poorer than the outcomes of other ethnic minority groups in drug treatment programs and in Los Angeles County mental health facilities (Brown, Joe, & Thompson, 1985; Sue et al., 1991). In no study were the outcomes of African Americans superior to those of White Americans and other ethnic minority groups.

Less is known about the effectiveness of psychotherapy for Native Americans (Manson, Walker, & Kivlahan, 1987; Neligh, 1988). Most mental health-related programs intended for Native Americans have focused on treatment and prevention programs for substance abuse. Query (1985) compared the outcomes of White and Native American adolescents in an inpatient chemical dependency treatment program at a North Dakota State Hospital. He found that Native American adolescents were overrepresented in the unit compared to their population figure. Furthermore, during the six months after discharge, significantly more Native American adolescents than White American adolescents had either thought of or attempted suicide. Overall, the treatment was more effective with White American adolescents than Native Americans. Prevention programs for Native Americans have been more successful in producing positive changes, especially in bicultural competence skills (LaFromboise, Trimble, & Mohatt, 1990; Schinke et al., 1988). Given the few findings, discussion of treatment outcome of Native Americans should wait until more research is conducted.

Outcome studies on Asian Americans, compared to other ethnic minority groups, have found more positive results. In Zane's study of the effectiveness of psychotherapy with Asian American clients in a community-based, ethnic-specific mental health clinic in Richmond, California (1983), Asian American clients showed significant improvement on both client self-report and therapist-rated outcome measures. Southeast Asian Americans have also been successfully treated for depression and posttraumatic stress disorder through psychotherapy and psychopharmacotherapy (Kinzie & Leung, 1989; Mollica et al., 1990). Compared to other ethnic groups, Asian Americans did not differ on posttreatment Global Assessment Score (GAS) from White Americans, even after controlling the pretreatment GAS scores (Zane & Hatanaka, 1988). Sue et al. (1991) have also found that Asian and White Americans had similar outcomes (in the same study, African Americans had worse outcomes than White Americans). In terms of clients' satisfaction with the therapy, however, Asian Americans have been found to be much less satisfied with service or progress of the therapy than were White Americans (Lee & Mixon, 1985; Zane, 1983; Zane & Hatanaka, 1988). Asian Americans in Lee and Mixon's study have rated both the counseling experience and the therapists as less effective.

Much of the treatment outcome research on Latino Americans has examined the effects of "culturally sensitive" treatment programs that can effectively meet the mental health needs of Latinos (Rogler, Malgady, Costantino, & Blumenthal, 1987). These culturally sensitive treatments have aimed to improve the accessibility of services to Latinos (e.g., by providing flexible hours or by placing the treatment facility in a Latino community),

employing bicultural/bilingual staff, and selecting, modifying, or developing therapies that either utilize or are most appropriate for Latino cultural customs, values, and beliefs (e.g., involving indigeneous healers or religious leaders in the community in treatment, or increasing participation of family members in treatment). Research suggests that these treatments may increase service utilization, length of treatment, and clients' satisfaction with treatment and may decrease premature termination of treatment (Rogler, Malgady, & Rodriguez, 1989; Sue et al., 1994). How do Latinos fare in mainstream mental health services? When compared to other ethnic groups in mainstream treatments, Mexican Americans in one study were most likely to improve with treatment (Sue et al., 1991). However, having ethnic matches between therapist and client (a Mexican American therapist with a Mexican American client) was associated with better treatment outcomes than were mismatches. The research suggests that interventions involving culturally sensitive approaches produce more positive changes than interventions that do not consider cultural factors.

Treatment outcome research with ethnic groups can be characterized as sparse and targeted to many different aspects of psychotherapy. Under such circumstances, there is a need for more systematic research in order to address more fully the issue of effectiveness of both the mainstream and ethnic-specific treatment plans for ethnic minorities (Akutsu, Snowden, & Organista, 1996). Such research can help us identify treatment elements that are universally effective and those that are culture-specific.

Process Research

Our review has emphasized treatment outcome research. However, we would like to mention that a number of investigators have examined treatment process variables. Research has been conducted on client preferences for the ethnicity of therapists. In many cases, studies have shown that ethnic clients tend to prefer or to view more positively ethnically similar therapists (Atkinson, 1983; Dauphinais, Dauphinais, & Rowe, 1981; López, López, & Fong, 1991; Sattler, 1977), although other investigations have questioned these findings or have questioned whether therapist ethnicity is a very important variable relative to other therapist variables (Acosta & Sheehan, 1976; Furlong, Atkinson, & Casas, 1979; LaFromboise & Dixon, 1981). Preferences for an ethnically similar therapist appear to be a function of individual differences, such as a client's ethnic identity, gender, trust of Whites, and level of acculturation (Bennett & BigFoot-Sipes, 1991; Helms & Carter, 1991; Parham & Helms, 1981; Ponce & Atkinson, 1989; Ponterotto, Alexander, & Hinkston, 1988; Watkins & Terrell, 1988). Thus, research suggests that many ethnic clients prefer ethnically similar therapists but that other variables mediate the preferences. Aponte and Barnes (1995) discuss minority status as a variable that impacts the treatment process. Ethnic minorities are likely to bring their mistrust into the therapeutic setting. When they are met with insensitivity or outright racism on the part of the therapist, poorer outcomes are likely to result.

Ratings of therapist competence or preferences for a therapist are also influenced by the nature of psychotherapy. Therapists who intimately self-disclose to African American clients elicit more intimate self-disclosures than do therapists who do not intimately self-disclose (Berg & Wright-Buckley, 1988); those who acknowledge and deal with cultural issues raised by therapists are perceived to be more culturally competent than are therapists who avoid such issues (Pomales, Claiborn, & LaFromboise, 1986). Culturally sensitive

therapists or those who are trained to deal with cultural issues (Dauphinais et al., 1981; Gim, Atkinson, & Kim, 1991; LaFromboise et al., 1990; Wade & Bernstein, 1991) are also judged to be more competent or more favorable. Some studies have found that Asian Americans and Latino Americans prefer directive over nondirective therapists (Atkinson, Maruyama, & Matsui, 1978; Pomales & Williams, 1989; Ponce & Atkinson, 1989). However, further studies are needed to examine whether nondirective approaches may still be effective despite their preferences, and how these preferences and the treatment effectiveness of various approaches may vary by other factors such as acculturation (Akutsu, 1997).

Rather than focusing on therapists, some researchers have examined the benefits of culture-specific forms of treatment—that is, therapies or modification of treatment approaches designed especially for certain ethnic groups. Family-network therapy, extended family therapy, or other forms of treatment that integrate traditional cultural healing practices or cultural aspects have been advocated by some (Comas-Díaz, 1981; Costantino, Maigady, & Rogler, 1986; LaFromboise, 1988; Lee, 1982; Manson et al., 1987; Szapocznik et al., 1989). Although systematic studies of the effectiveness of these culturally based forms of treatment are limited, they appear to be valuable, according to practitioners.

Application of Research Findings to Treatment

Some skepticism has been expressed over the value of research in affecting practice. As noted by Beutler (1992), many practitioners and clinicians do not read research reports, do not find reports helpful, or fail to use research findings in their practice. Nevertheless, Beutler also noted that research has had an impact on the practice of psychotherapy over the course of time. Although a single piece of research may have no had direct impact, the cumulative effect of many studies has been important. How can we apply the research findings and writings of different scholars to psychotherapeutic practice? We can apply research findings to practice by way of incorporating them into how we prepare ourselves as therapists, how we train therapists, and how we design services. Some general recommendations follow.

First, ethnicity, culture, and minority group status are important concepts for psychotherapists who work with ethnic minority clients. The available evidence suggests that therapists should be prepared to deal with these concepts and issues with their clients. While cultural issues may not be salient to all ethnic clients in all situations, therapists who are uncomfortable with these issues may not be able to deal with the issues if they do arise. Therapists should become knowledgeable about the cultural background of ethnic clients and should be adept at working in cross-cultural situations.

Second, having available a therapist of the same ethnicity as the client may be advantageous. While ethnic matches are not necessary for positive outcomes, at times certain clients may prefer or work better with an ethnically similar therapist. Having bilingual and bicultural therapists is vital to clients who are recent immigrants and are not fully proficient in English. The problem is that ethnic clients often have little choice, unless we train more ethnic minority, bilingual, and bicultural therapists.

Third, therapists who are unfamiliar with the cultural backgrounds of their clients may want to consult with mental health professionals who are knowledgeable of the clients' culture. Receiving training in working with culturally diverse clients is also recommended.

It is difficult to be fully proficient in working with many diverse groups. Assistance should be sought in the assessment or treatment of any client whose cultural background or life-style is unfamiliar to the therapist or markedly different from that of the therapist.

Fourth, culture-specific treatment should be available to ethnic clients, especially those who are unacculturated or who hold very traditional ethnic values that are discrepant from Western values. As mentioned previously, many researchers have argued that such treatment is valuable and beneficial.

Fifth, for clients who are unfamiliar with Western psychotherapy, some sort of pre-therapy intervention may be important. Before therapy, clients should receive some knowledge of what psychotherapy is, what roles clients and therapists adopt, what to expect in treatment, and how treatment can affect mental disorders. Similarly, efforts should be made to educate community groups on how to recognize emotional disturbance, what to do with someone who is disturbed, what mental health services are, and how to use such services. Issues of confidentiality, client rights, and the like should also be presented to the community. These strategies increase the likelihood that ethnic clients will better understand treatment and reduce feelings of strangeness in the client role.

Conclusions

This chapter has reviewed some of the conceptual and methodological issues facing researchers who study ethnic minority groups. Despite the many problems encountered in ethnic research, psychotherapy research has been growing and has provided some preliminary ideas on helpful strategies to use in providing mental health services to these groups. Much more research is needed that go beyond the descriptive level of discovering ethnic differences in therapy outcome and to begin to identify cultural elements that are important in psychotherapy. The existence of a critical need for more and better ethnic minority research does not imply that current ethnic investigators have failed to make important contributions. Indeed, the relatively small number of ethnic and cross-cultural investigators have made many pioneering contributions despite the obstacles encountered in ethnic minority research. These contributions are the basis for the next generation of research.

What directions should future research take? Beyond the recommendations for conducting more research and methodologically stronger research (in terms of adequate sample sizes, representative samples, valid measures, rigorous research designs, etc.), it is meaningful for future research to be targeted to certain issues. First, research should be devoted to uncovering how cultural elements influence treatment processes and outcomes among ethnic minorities. Second, the application of these cultural elements in devising culture-specific treatment programs needs to be investigated. Third, ethnic minority groups show much within-group variation, and effective therapeutic strategies for a highly acculturated ethnic minority client may differ from those for a recent immigrant. Research on individual differences is needed in order to overcome stereotypes that particular treatment tactics are effective with all members of a certain ethnic minority group. Fourth, because of the multicultural nature of our society, therapists will be increasingly exposed to clients from different ethnic groups. An important research direction is to discover those psychotherapeutic skills that enable therapists to work effectively with a diverse clientele and to find means of training therapists to develop effective skills.

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