19

RESEARCH ON PSYCHOTHERAPY WITH CULTURALLY DIVERSE POPULATIONS

- **STANLEY SUE**
  University of California, Los Angeles
- **NOLAN ZANE**
  University of California, Santa Barbara
- **KATHLEEN YOUNG**
  University of California, Los Angeles

The analysis of research on psychotherapy with ethnic minority clients (i.e., African-Americans, American Indians, Asian-Americans, and Latino-Americans) is important. If we can identify those psychotherapeutic treatments that have universal applicability, then they should prove to be effective with different populations. If, however, current treatment practices work well only with certain populations, we need to know about these limitations and devise strategies to address the mental health needs of culturally diverse groups. Such tasks are not only theoretically meaningful (i.e., knowing the generality and limitations of theories and practices), but also consistent with psychology's goal to promote human welfare.

There are other reasons why psychotherapy research on ethnic minorities is important to consider. First, about 25 percent of the population in the United States in 1990 was composed of ethnic minorities, and in California, the figure was about 43 percent! Given the rapidly changing population, we are increasingly likely to encounter individuals from a variety of ethnic groups as clients and colleagues. Intercultural skills in our roles as researchers and psychotherapists are needed; yet systematic investigations into these skills have not been conducted, and training programs in clinical psychology have not fully utilized what is known about them (Bernal & Padilla, 1982). Second, there is evidence that ethnic minority groups are experiencing significant mental health problems. Although it is beyond the scope of our review to analyze the prevalence of psychopathology, available data suggest that prevalence rates for these groups are at least as high as those in general population (Vega & Rumbaut, 1991). Immigrant/refugee background, encounters with prejudice and discrimination, cultural differences, and other experiences associated with minority group status may act as stressors that influence mental health. Third, considerable controversy has existed for the past three decades over the effectiveness of traditional psychotherapeutic approaches for members of ethnic minority clients. What evidence is there for the efficacy of psychotherapy? What are the conditions that promote effectiveness? These two questions are addressed in this chapter. Finally, psychotherapy research on ethnic minority groups is important because it is relevant to, and carries implications for, all of psychology (L. Clark, 1987).

We engage in a critical analysis of ethnic research, pointing to methodological and conceptual problems and to the need for more knowledge, as indeed any review of the literature should. Nevertheless, one cannot help but be impressed by the pioneering work of scholars in this area who continue to define and debate issues. These pioneering efforts to study relatively small populations and to grapple with issues of theoretical bias and methodological problems in the field can only help to strengthen what psychology is about — namely, the

The writing of this chapter was supported by NIMH Grant No R01 MH44331

study of human beings, and not just a particular cultural group or population. In the process, the lessons learned from ethnic research are critical in helping to advance the field of psychology in general and psychotherapy in particular.

Ethnic Minority Groups

Our discussion has relevance especially for groups who have traditionally been considered ethnic minorities. They are defined by cultural characteristics, ethnic identity, and minority group status. Although other groups may indeed be included as ethnics or minorities, we focus on four groups in addition to whites (whom we define as non–Latino whites). Thus, although we recognize cultural differences among other groups, such as white ethnics, people who live in urban and rural areas, Christians and Jews, men and women, it is beyond the scope of the present chapter to include these and other groups.

It should be noted that the very terms used to refer to groups have varied—*blacks* versus *African-American*; *Native American* versus *American Indian*; *Asian* versus *Oriental*; *Hispanic* versus *Latino*; *Caucasian* versus *white*. While recognizing the variations, we have decided to use the terms *African-American*, *American Indian*, *Asian-American*, *Latino-American*, and white to refer to the groups. Furthermore, *ethnic minority* refers collectively to the four nonwhite groups because the phrase conveys culture and identity (ethnic) as well as race and social status (minority status).

Knowing the cultural values of each group is only one critical facet in understanding that group. What must also be acquired is knowledge of the history of racial/ethnic relations in this country. Thus, problems in mental health service delivery may occur not only because ethnic minority groups have different cultural values, but also because certain relationships have developed between majority and minority group individuals. Another point is that all of the groups exhibit heterogeneity (J. Jones, 1991; Lorion & Parron, 1985; Vontress, 1988). Given this heterogeneity, discussions concerning individual minority groups and whites often have a stereotypic quality. The different levels of discourse—whether the intent is to discuss cultural differences or within-group characteristics—are important to distinguish (S. Sue, 1991). At one level, when between-group comparisons are made, generalizations about group characteristics may be needed. In this case, for ethnicity and culture to have meaning, between-group differences in values and traits have to be highlighted in an abstract manner.

Inkeles and Levinson (1969) introduced the notion of *modal personality* to describe average characteristics of different ethnic groups. While members of a particular group may exhibit heterogeneity, the modal (i.e., average) characteristics of groups may show meaningful differences when between-group comparisons are made. For example, Asians and whites may exhibit differences on certain measures of individualism and collectivism. These differences provide the context for understanding ethnic groups. However, the context or modal patterns must not be confounded with the characteristics of individual members of a group who may or may not possess the modal patterns associated with the group. Otherwise, individuals are stereotyped according to their culture. At another level of communication, we may wish to emphasize within-group heterogeneity. Not all white Americans are individualistic, even though they may as a group be higher on individualism than members of other groups. By understanding the purpose of communication and by recognizing these levels of discourse, we can discuss both between- and within-ethnic group differences with more clarity and precision.

As mentioned previously, ethnic minority groups are quite heterogeneous. For example, Latinos include individuals who come from or whose family of origin comes from Mexico, the Caribbean, and Central or South America. American Indians come from hundreds of different tribes, and discussions of American Indians often include Alaska Natives. Asian-Americans can include Chinese, Japanese, Koreans, Pilipinos, Southeast Asians, and so on, as well as Pacific Islanders. Given this diversity, there are restrictions in our ability to generalize findings from a study of one subgroup even to other subgroups within the same ethnic minority. In addition, research on a group (e.g., Latino-Americans) may be based largely on one particular group (e.g., Mexican-Americans). What this means is that for some groups within a designated ethnic group, little research may be available (e.g., among the Asian and Pacific Islander American group, not much research has been conducted on Samoans). We do not deal here with issues regarding the definition of race or ethnicity or attempt to make fine distinctions about the groups who should or should not be included in one of the four major ethnic minority categories. Although important, such issues require elaborate and extensive discussion, which is beyond the scope of this chapter.

Finally, the designation of *ethnic minority* has also been challenged in that some feel the term conveys a sense of inferiority. We acknowledge

that this designation is arbitrary. "Minority" status is relative (i.e., whites are not in the majority relative to the world population) and should not be interpreted to imply the sense of inferiority, separateness, or "minor" status sometimes associated with the term in the public mind. Thus, we need to clarify our intentions because we use a term that, by custom, is subject to misinterpretation.

Issues Discussed

We deal with several key issues. First, is there evidence that psychotherapy is effective with ethnic minority clients? In the previous reviews in the *Handbook of Psychotherapy and Behavior Change*, Lorion (1978) and Lorion and Felner (1986) noted that research on the disadvantaged, including ethnic minority groups, needs to proceed at all levels from the simple to the complex. The overall lack of research in this area was also acknowledged. Although much more research has been conducted in the years since those reviews, there continues to be a paucity of critical research on treatment outcomes for members of minority groups. There are virtually no studies comparing the outcomes of treated and untreated groups of ethnic minority clients. Moreover, most researchers and practitioners have reformulated the question of effectiveness into specifics: What type of treatment by which therapist is effective for which client with what specific problem under what conditions? Because we simply do not have much research into the specifics of psychotherapy with ethnic minorities, we can only provide glimpses into the answers to these questions. For heuristic purposes, we address three questions:

1. Do ethnic minority clients improve (show positive pre- and posttreatment changes) after undergoing psychotherapy?
2. Do they fare as well as other clients (e.g., when compared with whites or when ethnic groups are compared with each other) after treatment?
3. What client, therapist, and situational circumstances are associated with positive treatment outcomes and with the progress of psychotherapy?

The first two questions deal directly with the treatment outcome issue. We include a discussion not only of direct measures of outcome and treatment improvement but also indirect indexes such as utilization of services and dropout rates. The third question largely involves process research. Research findings pertinent to client characteristics such as acculturation and preferences, to therapist characteristics such as ethnicity and therapeutic style, and to situational variables such as treatment setting are included. Finally, a critique of research methodology and conceptual schemes is presented.

Much has been written about the problems faced by ethnic minorities in finding adequate psychotherapeutic services. The skepticism over the value of psychotherapy is based largely on conceptual models and anecdotal/experiential reports. Conceptual models derived from research on cross-cultural or ethnic/racial issues suggest that culture plays a critical role in the assessment, etiology, symptom expression, and treatment of mental disorders (Ivey, Ivey, & Simek-Morgan, 1993; Jackson, Neighbors, & Gurin, 1986; Jenkins, 1985; E. Jones & Thorne, 1987; Kleinman, 1979; Lin, 1986; Moore, Nagata, & Whatley, 1984; Munoz, 1982; Padilla & Salgadao De Snyder, 1985; Rogler, Malgady, & Rodriguez, 1989; Snowden, 1982; D. W. Sue & Sue, 1990; Suinn, Richard-Figuerod, Lew, & Vigil, 1985; Trimble & LaFromboise, 1985; Vraniak & Pickett, 1992; Zane, Sue, Castro, & George, 1982). Because the majority of ethnic minority clients are likely to see white therapists, and because many of these therapists are unfamiliar with the cultural values and lifestyles of various ethnic clients, performing valid clinical assessments and conducting effective psychotherapy logically seem to be problematic. Furthermore, there is little question that ethnic and race relations in the United States, often occurring in a context of prejudice and discrimination, may be reflected in the mental health profession. Therapist biases, stereotypes, discomfort, and so on may exist when working with clients who are dissimilar in ethnicity, race, or culture (K. Clark, 1972; Ibraham, 1985).

In the discussion of indirect and direct measures of outcome, we analyze the four ethnic groups together because much of the research offers comparisons of the outcomes for the different groups. However, in presenting the research on treatment process, each group is discussed separately. The reason for this is that process research on each group has proceeded more or less separately, with some issues being more salient for some groups than others. Indeed, it is difficult to compare ethnic groups on most variables because the extent of research varies from group to group and not all of the same variables have been studied for each group. Discussing the process research separately for each group also allows one to see the level of work conducted on each group.

INDIRECT MEASURES OF OUTCOMES FOR ETHNIC MINORITY GROUPS

We use utilization rates, dropout from treatment rates, and length of treatment as "indirect" indexes of outcomes. *Utilization* is defined as a help-seeking behavior in which the services of the mental health system are used. *Dropout* occurs when the client terminates treatment, presumably before receiving substantial psychotherapeutic benefits; and *length of treatment* is defined by number of treatment sessions. It should be noted that most studies have defined utilization by comparing the proportion of a population using services with the proportion of that population comprising the area being served. Thus, references to under- or overutilization of services are based on population comparisons and not on actual psychiatric need for services. Also, the view that premature termination (whether defined by the therapist or by failure to attend a certain minimum number of sessions) results in unfavorable outcomes is only an assumption. In most ethnic comparisons, the white population has been used as the comparison group because it is the majority group. While the wisdom of these assumptions and comparative procedures is debatable, ethnic differences on these indirect indexes of outcome are important to investigate per se.

Utilization of Services

In general, most studies reveal that African-Americans and American Indians overutilize services, and Asian-Americans and Latino-Americans underutilize them. Snowden and Cheung (1990) provided some information on the overall rates per 100,000 of the civilian population of admissions to inpatient psychiatric services (including state and county mental hospitals, nonfederal general hospitals, VA medical centers, and private psychiatric hospitals) in the United States during 1980. The rates were African-American, 932; American Indian/Alaska Native, 819; white, 550; Hispanic origin, 451; and Asian and Pacific American, 268. Differences in the kinds of services were apparent. Among African-Americans and whites, hospitalization rates were similar in private psychiatric hospitals but markedly different in all other inpatient services, with African-Americans having far higher rates. American Indians were admitted at higher rates than all other ethnic groups except African-Americans to state and county mental hospitals, nonfederal general hospitals, and VA medical centers. However, American Indian and Alaska Natives were admitted to private psychiatric hospitals at a lower rate than whites or African-Americans. Snowden and Cheung also found that overall, Latino-Americans had a lower admission rate than did whites at inpatient psychiatric services. In only one category of services, state and county mental hospitals, were Latino-Americans admitted at a higher rate than whites. In the case of Asian-Americans, underrepresentation was evident in all facilities. Two other studies, one involving 17 community mental health facilities in Seattle (S. Sue, 1977) and the other of outpatient services in the entire Los Angeles County Mental Health System (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991), found a similar pattern in which African-Americans and American Indians (only the first study reported on American Indians) overutilized and Asian-Americans and Latinos underutilized services. In a follow-up to the S. Sue (1977) study, O'Sullivan, Peterson, Cox, and Kirkeby (1989) also found overutilization by African-Americans and American Indians but no underutilization by Asian-Americans and Latino-Americans.

Other investigators have generally supported the observation of overutilization by African-Americans (Scheffler & Miller, 1989) and American Indians (Beiser & Attneave, 1982) and underutilization by Asian-Americans (T. Brown, Stein, Huang, & Harris, 1973) and Latino-Americans (Lopez, 1981).

Hu, Snowden, Jerrell, and Nguyen (1991) examined utilization patterns of a different nature. Rather than comparing the proportion of users with nonusers or with residents in a given community, the investigators confined their analysis to those who were clients within a mental health system. Based on data from San Francisco and Santa Clara counties in California, the investigators wanted to find out if there were ethnic differences in four types of mental health services used by clients seeking help. African-Americans had a relatively high probability of using emergency services, a low probability of using case management services and individual outpatient services, and an equal probability of using inpatient services compared with whites. Asian- and Latino-American clients used less emergency and inpatient but more outpatient care than did whites. Thus major ethnic differences do exist in the types of services used by clients.

Why do utilization differences exist? In Snowden and Cheung's (1990) analysis of hospitalization, the following possible explanations were discussed but none was considered sufficient to explain the results: racial differences in socioeconomic background, rates of psychopathology, help-seeking tendencies, diagnostic bias, and involuntary hospitalization. Utilization of inpatient and outpatient services may involve these factors and many others, such as knowledge of and accessibility to

facilities, attitudes and values (e.g., feelings of shame or stigma), familiarity with Western forms of treatment, and presence of bilingual-bicultural staff (Wu & Windle, 1980). Indeed, with respect to the last factor, it is interesting to note that Asian-Americans and Latino-Americans, who show underutilization, are predominantly foreign born and speak English as a second language. Furthermore, there is evidence that minority group utilization is directly related to the number of minority group staff available at mental health facilities. The most appropriate conclusion at this time is that ethnic differences exist in utilization patterns and that not enough research has been conducted to explain the reason for these differences.

Some caveats are needed. In a national survey of adult African-Americans, Neighbors (1985) found that only a small proportion of respondents used traditional mental health services for serious personal problems. Thus, there is an apparent inconsistency between utilization rates when comparing treated cases with the survey results in the case of African-Americans. One study (Wood & Sherrets, 1984) has found that African-American and white clients may seek different services or programs at mental health clinics. In that study, clients were interviewed regarding their service requests. Compared with whites, African-Americans were more likely to seek help for administrative matters (problems with the law, social service agencies, school, or other agencies), medication, questions concerning reality contact, and directions as to where to get help in the community. Information concerning the rates of psychopathology, cultural expressions of symptoms, help-seeking behaviors, availability of alternative resources, perceptions of services, and barriers to utilization for ethnic minority groups is needed before conclusions can be drawn. The other caveat is that within-group differences may make a difference. Although most studies have revealed an underutilization of services among Latino-Americans, Rogler et al. (1983) concluded from their review of research that Puerto Ricans in New York had significantly higher rates of psychiatric admissions and use of outpatient psychiatric services and community mental health facilities than did non–Latino whites. It has only been more recently that Puerto Ricans have shown relatively low rates of admissions.

Dropout Rates and Length of Treatment

Length of treatment can be considered an indirect indicator of treatment outcome as it has been consistently associated with treatment change (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; Pekarik, 1986). In the Seattle study of 17 community mental health facilities, S. Sue (1977) found that African-Americans, American Indians, Asian-Americans, and Latino-Americans terminated treatment after one session at a higher rate than white Americans. Whereas about half of the ethnic minority clients failed to return after the first session, fewer than 30 percent of the white clients did so. The difference in dropout rates was evident even after controlling for the possible influences of social class, age, marital status, referral source, diagnosis, and type of treatment. Not surprisingly, white clients were found to average more treatment sessions. Findings from other studies are mixed. In the follow-up of the S. Sue study in Seattle, O'Sullivan and his colleagues (1989) did not find any consistent differences in dropout rates between ethnics and whites. In the Los Angeles County study, S. Sue et al. (1991) found that African-Americans had a higher proportion, and Asian-Americans a lower proportion, of dropouts after one session that did whites. The results indicated that in outpatient treatment sessions, Asians had a higher, and African-Americans a lower, average number of sessions than did whites. Latino-Americans did not differ from whites. Length of treatment at various inpatient facilities did not show consistent differences between ethnic groups and whites (Snowden & Cheung, 1990). Thus, while some differences have emerged in number of sessions, they have not been consistent. The results perhaps reflect the influence of specific and local factors (e.g., regional, community, and service system differences), or time period differences (e.g., between 1977 and 1991, culturally responsive community programs were developed).

In the next sections, we review outcome and process research on the four ethnic minority groups: African-Americans, American Indians, Asian-Americans, and Latino-Americans.

RESEARCH ON AFRICAN-AMERICANS

African-Americans, with a 1990 population of 29,986,060, are currently the largest ethnic minority group in the United States. It is unfortunate that the general public's exposure to income, unemployment, crime, health, and educational statistics regarding African-Americans has reinforced popular stereotypes. Actually, in contrast to the stereotypes, about half of all African-Americans are members of the middle or upper class. A great deal of within-group heterogeneity exists in terms of family structure, socioeconomic status, educational background, cultural identity, and reactions to racism (B. Jones & Gray, 1983). Although African-Ameri-

cans as a group hold certain values, such as the importance of the collective, sensitivity to interpersonal matters, and cooperation among peers (Nobles, 1980), these values have been influenced by culture, social class, and exposure to racism. Given these influences, it is not surprising that African-Americans are quite diverse. The diversity has implications for our analysis of treatment outcomes and client, therapist, and situational/treatment variables that affect psychotherapeutic processes.

Treatment Outcome

Reviews of the literature on the effectiveness of psychotherapy with African-Americans have yielded different conclusions. Sattler (1977) largely concluded that African-Americans did not differ from whites in treatment outcomes. On the other hand, Griffith and Jones (1978) found that the client's race did have an effect on psychotherapy outcomes. Others took a more moderate position. Parloff, Waskow, and Wolfe (1978) believed that the paucity of treatment outcome studies on African-Americans did not permit conclusions to be drawn, a point supported in a review by Abramowitz and Murray (1983). Past treatment studies using outcome measures have failed to show differential outcomes on the basis of the race or ethnicity of clients. One of the first major studies of treatment outcomes for African-American clients was conducted by Lerner (1972), who investigated the effects of treatment on severely disturbed and predominantly lower-class African-American and white clients seen by white therapists. All clients, regardless of ethnicity, tended to improve after treatment. E. Jones (1978) studied the effects of therapist and client race (African-American and white) on the outcome of psychotherapy. Although some process differences were found (e.g., African-American clients were more concerned about racial issues than were white clients), client outcomes were similar regardless of the race of the client or the therapist. Finally, E. Jones (1982) studied therapist ratings of treatment outcome among African-American and white clients seen by African-American or white therapists. All clients benefited equally, and no differences were found between racially matched or mismatched therapist–client combinations. The studies by Lerner (1972) and E. Jones (1978, 1982) demonstrate not only a lack of ethnic differences in outcomes but also improvement from pre- to posttreatment. Outcomes for African-Americans were found to be similar to those for whites.

Two studies have demonstrated poorer outcomes among African-Americans. B. Brown, Joe, and Thompson (1985) examined the outcomes of African-American, Mexican-American, and white American clients seen in different drug treatment programs—resident programs, methadone programs, and drug-free outpatient programs. Particularly in outpatient programs, ethnic clients had more unfavorable outcomes at discharge and were retained in treatment longer than whites. In a study of thousands of ethnic minority clients (African-Americans, Asian-Americans, and Mexican-Americans) seen in the Los Angeles County Mental Health System, S. Sue et al. (1991) analyzed the pre- and posttreatment Global Assessment Scale (GAS) scores of clients. The GAS is a rating given by therapists to clients in order to indicate clients' overall functioning; it is highly similar to the Global Assessment of Functioning scale used on Axis V of the *Diagnostic and Statistical Manual of Mental Disorders-III-R* (American Psychiatric Association, 1987). After covarying initial GAS scores, the investigators found that African-Americans had significantly lower positive treatment outcomes than did Asian-, Mexican-, and white Americans. Thus, while all groups showed positive changes, African-Americans had the lowest improvement scores.

Obviously, it is difficult to truly compare the studies because of the differences in outcome measures used as well as possible differences in the demographic characteristics of African-Americans, type of client seen, treatment received, and other factors. Furthermore, few investigators have examined the effects of treatment for African-Americans. As a general conclusion, one can state that in no studies have African-Americans been found to exceed white Americans in terms of favorable treatment outcomes, some investigations have revealed no ethnic differences, and some studies have supported the notion that outcomes are less beneficial for African-Americans.

Treatment Process

Client variables include expectancies, preferences, attitudes, and characteristics that are pertinent to the progress of psychotherapy. Research on client characteristics points to important differences within the African-American population and the influence of these characteristics on treatment. Also affecting the psychotherapeutic process are therapist variables such as ethnicity, style, and background. Finally, situational or treatment variables are also important to consider.

Client variables

Preferences for ethnicity of therapist. The most commonly addressed question in research on culturally specific counseling or therapy has been

whether African-Americans prefer same-race or same-ethnic group therapists, whether within-group characteristics are associated with this preference, and whether ethnic preferences are a part of larger desires to find therapists who are similar in background characteristics (Helms & Carter, 1991). Some investigators have concluded that many clients prefer ethnically similar therapists (Atkinson, 1983; Harrison, 1975; Sattler, 1977), particularly in the case of African-American clients. For example, Tien and Johnson (1985) interviewed African-American clients utilizing a community mental health center in Los Angeles and found that 60 percent preferred working with an African-American therapist. While supporting an ethnic similarity position, this and other studies reveal that the preference is not unanimous among African-Americans. Therefore, some investigators have attempted to identify those within-group factors that are associated with the preference. The most widely studied factor has been African-American identity. Several investigators have tested the relationship between preferences for African-American therapists and the self-identity of African-American clients or students. In an early study, G. Jackson and Kirschner (1973) found that subjects who had a strong African-American identity (i.e., they identified themselves as black or Afro-American rather than Negro) tended to prefer an African-American counselor. However, Gordon and Grantham (1979) found racial self-designation to be unrelated to same-race preferences among African-American students. Other researchers have used measures of stages of racial identity development and then have tried to determine if preferences for African-American therapists are associated with a particular stage of identity development (Atkinson, Morten, & Sue, 1993). Based on Cross's (1971) model of racial identity, Helms has been in the forefront of developing identity measures and of stimulating research on stages of racial identity (e.g., see Helms, 1984). Parham and Helms (1981) and Morten and Atkinson (1983) found some evidence of a stage effect on preferences, with African-Americans who accept an African-American identity and are skeptical of white values being most likely to want a therapist of the same race. More complex findings were reported by Ponterotto, Anderson, and Grieger (1986), whose study revealed that the interaction between gender and stage of identity had a significant effect on preferences.

Given the array of possible variables besides race that may influence preferences for a particular therapist (attitude similarity, attractiveness of therapist, social class, etc.), perhaps race of therapist is a relatively weak predictor of preference. Preference for therapists of the same social class rather than of the same ethnicity among African-Americans was found by Gordon and Grantham (1979), and physical attractiveness rather than ethnicity of therapist has been found to influence the favorability of attitudes toward therapists (Green, Cunningham, & Yanico, 1986). Atkinson, Furlong, and Poston (1986) asked African-American subjects to express their preferences for certain characteristics among counselors, such as ethnicity; gender; educational level; age; and similarity in attitudes, religion, and personality. The preferred characteristics, in descending order were: more education, similarity in attitudes and values, older, similar personality, and same ethnicity. Thus, ethnic preference was important but relatively less so than several other therapist characteristics. Furthermore, when subjects were divided into two groups on the basis of their self-reported commitment (strong or weak) to African-American culture, the two did not differ in preferences for characteristics among therapists. In a partial replication of the Atkinson et al. (1986) study, Ponterotto, Alexander, and Hinkston (1988) reported similar results in terms of the preferences of the African-American subjects for therapists who were similar to themselves in a number of characteristics. However, preference for a same-race therapist was ranked higher in the study by Ponterotto and his colleagues than in Atkinson et al.'s (1986) investigation. Ponterotto et al. also found that African-Americans who were strongly committed to Afro-American culture ranked a racially similar therapist higher in preference than those who were weakly committed. The investigators speculate that sample differences (e.g., differences in the type of universities or racial composition of the faculty, counseling staff, and students) in the two studies may have accounted for the discrepant findings.

Rather than simply examining preferences for African-American or white therapists, Helms and Carter (1991) wanted to find out how racial identity and demographic variables of African-Americans and whites predicted preferences for therapists who differed according to race and gender (African-American male and female and white male and female therapists). Because of the large number of variables and analyses, only a brief presentation of the results pertinent to our discussion is given. For white subjects, racial identity and gender (but not social class) were important in predicting preferences for a white therapist. However, predicting preferences for an African-American therapist was not possible from the variables examined. Among African-American subjects, predictors of preference for an African-American therapist failed to reach significance, although racial identity atti-

tudes did predict their preferences for white male therapists. The overall findings suggest that predictors of preferences may be quite complex and interact according to the ethnicity and gender of subjects and therapists.

It is apparent that research on ethnic preferences has become increasingly systematized and specific. Several conclusions seem appropriate:

1. Research has evolved from simply ascertaining ethnic preferences to identifying the individual differences that are associated with ethnic, as well as other, preferences among African-Americans.
2. Ethnicity of the therapist is but one of many characteristics preferred by African-Americans.
3. In general, African-Americans prefer therapists who are similar in a wide range of characteristics.
4. Research has not yielded consistent findings regarding the role of identity and values in influencing preferences for the ethnicity of the therapist.

Perhaps the most obvious and yet the most unappreciated fact is that African-Americans represent a very heterogeneous group.

Other research on client variables. Although the issue of preference for the ethnicity of the therapist has dominated the literature, other client variables among African-Americans have also been discussed. Cultural differences between African-Americans and whites on values such as individualism and the importance of the collective have been found (Nobles, 1980)—values that may affect the attitudes, expectations, and behavioral patterns of clients and therapists. Furthermore, the relationship between clients and therapists may also be influenced by the minority group status of African-Americans and the accompanying prejudice and discrimination often experienced in society. Gibbs (1980; Gibbs & Huang, 1989) has noted the difficulties in establishing a therapeutic alliance among many ethnic minority clients. African-Americans often work from an interpersonal orientation. Individuals, such as psychotherapists, are evaluated by their ability to evoke positive attitudes and to obtain favorable reactions. The client sizes up the therapist and behaves in a "cool" manner in order to observe the therapist and to minimize expressions of distrust that may be present. If the therapist has evoked favorable responses from the client, the client becomes personally as well as professionally involved in the relationship, with increasing commitment and engagement. On the other hand, white therapists frequently have an instrumental orientation in which value is placed on the goal or task-related aspects in the relationship between two people. The two different orientations may cause misunderstandings and problems in communication during psychotherapy because the therapist and client are each seeking different goals, evaluating the relationship in discrepant ways, and failing to understand each other.

A few studies have attempted to investigate some of the issues raised by others. Based on earlier work by the Terrells (Terrell & Terrell, 1981, 1984), Watkins and his colleagues conducted some studies on trust/mistrust and attitudes toward therapists among African-American students. In an analogue study, Watkins and Terrell (1988) assigned male and female African-Americans, who reported on their degree of trust for whites, to African-American or white therapists. Mistrust was related to negative expectations of the therapist. Not surprisingly, level of trust interacted with race of therapist in predicting expectations about the therapists' trustworthiness, acceptance, and expertise. African-Americans who were assigned to a white instead of an African-American therapist and who expressed a high degree of mistrust rated the therapist unfavorably. In an extension of that study, Watkins, Terrell, Miller, and Terrell (1989) examined the effects of subject's gender, mistrust, and therapist race on evaluations of the credibility and competence of therapists. Again, an interaction was found such that highly mistrustful African-Americans gave unfavorable ratings to the white therapist. The two studies suggest that racially relevant mistrust on the part of African-Americans may have considerable consequences in the treatment process.

Therapist variables. Research on therapist variables studies the characteristics, attitudes, values, knowledge, experience, and behaviors of therapists that influence the treatment outcomes or processes of African-American clients. One of the most salient controversies in this area has been the importance of therapists' ethnicity: Is it better for African-American clients to see an ethnically similar therapist?

Ethnic match between client and therapist. Most treatment studies have failed to show differential outcomes on the basis of the race or ethnicity of clients. As mentioned earlier, Lerner (1972) found that African-Americans did not demonstrate less favorable outcomes than whites when working with white therapists. The vast majority of clients improved after treatment, and no evidence of a racial difference in outcome was found. This was also true in E. Jones's (1978) study of the effects of therapist and client race (African-American and white) on the outcome of psychotherapy

Results from the study indicated that race of therapist and race of client had no effect on outcome and that African-American and white clients improved equally. However, some process differences emerged when therapist–client interactions were tape-recorded and analyzed using a modified Q-sort. Regardless of whether African-American clients were seen by African-American or white therapists, they were more likely than white clients to express concerns involving racial issues.

In addition, no ethnic match effects on outcomes were found by E. Jones (1982), who compared therapist ratings of treatment outcome with African-American and white clients seen by African-American or white therapists. African-American and white clients benefit equally. Finally, S. Sue et al. (1991) reported on a large-scale study of the effects of ethnic match on the length of treatment and on outcomes of African-American outpatients seen in the Los Angeles County Mental Health System. African-American clients who were matched with therapists in ethnicity were compared with clients not matched in ethnicity (i.e., clients seeing a non–African-American therapist). Results revealed that African-Americans who saw an African-American rather than a non–African-American therapist attended a greater number of therapy sessions. However, on the Global Assessment Scale (GAS), no differences in treatment outcome were found as a function of match. Therefore, ethnic match appeared to affect the number of treatment sessions but not the one outcome measure that was used. The investigators speculated that perhaps the GAS is not a very sensitive measure or that ethnic match may influence interpersonal attraction and result in greater number of sessions but may fail to affect outcomes. In any event, there is no clear evidence from studies of actual clients that ethnic match enhances outcomes among African-Americans.

Clinical analogue studies in which individuals from different ethnic or racial groups are asked to play the role of therapist or client in a simulated therapy session have also been conducted. In some cases, actual counselors or therapists worked with students who presented "clinical" problems. The "clients" or "therapists" can be asked to evaluate the effectiveness (satisfaction, rapport, significance of the interaction, client preferences for ethnic therapists, etc.) of the treatment session, or the session can be rated by observers.

Evidence for a race effect has been found more often in clinical analogue studies than in actual treatment studies (Griffith & Jones, 1978). Banks (1972) as well as Carkhuff and Pierce (1967) found that self-exploration was higher in same, rather than different, race pairs involving therapists and clients. However, ethnic differences were not found in other studies, or the differences were minimal compared to those of other therapist variables (Atkinson, 1986; Porche & Banikiotes, 1982; Sattler, 1977). In addition to limitations posed by analogue designs, these studies have often used measures such as client self-exploration, preference, and ratings of therapist's level of understanding that do not directly assess client adjustment or outcomes. Also, the validity of the measures for diverse cultural groups is unknown.

Several researchers who have reviewed the literature have been unable to draw strong conclusions. As noted earlier, there is a lack of actual treatment studies. As late as 1978, Parloff et al., in a review of psychotherapy research, found that almost no reported studies of "real" therapy could be found in which African-American and white therapists were compared. In his 1986 review, Atkinson concluded that it was not possible to answer the question of the effects of client and therapist ethnicity, given the conflicting and contradictory findings. Studies that have focused on the question have also had methodological and conceptual limitations, to be discussed later.

Assessment bias among therapists. Clinical psychologists as well as researchers have become increasingly aware of limitations in the assessment tools used to evaluate the psychological status of culturally diverse groups. Many assessment tools and instruments have not been standardized, normed, or validated on these groups (Brislin, Lonner, & Thorndike, 1973). Despite these problems, assessment is essential. The clinician working with an ethnic minority client must somehow evaluate the client in order to provide treatment; researchers conducting cross-cultural investigations must often use psychological tests in order to compare different populations; and mental health planners or administrators need to evaluate treatment processes and outcomes of all clients.

Is there evidence that clinicians are biased in their assessment of African-American clients? This question has been addressed in analogue studies of clinical judgment and in archival and field studies. Many analogue studies were designed so that clinicians were given comparable case descriptions that differed in the designation of the race of the client. For example, Strickland, Jenkins, Myers, and Adams (1988) presented videotaped interviews of clients to graduate students in clinical psychology and manipulated client's race and level of psychopathology. There was some evidence that race of clinician and race of client interacted to affect clinical assessment. Archival or field studies were those

investigations that reported on the symptoms or diagnosis of actual clients in hospitals or clinical settings. For example, Bishop and Richards (1987) compared counselors' intake judgments about African-American and white clients seen at a counseling center. The evaluations were highly similar for the two groups of clients. Sattler (1977) reviewed literature on racial bias in clinical assessment and concluded that clinical judgments were not systematically biased in favor of or against African-American clients. Although some race differences were found in the evaluations, there was not a consistent pattern to the differences. However, in another review, Abramowitz and Murray (1983) disagreed. They believed that Sattler's conclusion was supported largely by analogue studies and not by archival investigations and that the possibility of bias in diagnosis is still an open issue.

Significantly, some of the studies reviewed by Sattler did reveal racial differences. However, the conclusion that bias does not exist because of a failure to find consistency (systematic bias) has been questioned. Neighbors, Jackson, Campbell, and Williams (1989) suggest that diagnosticians or clinicians may make two kinds of errors. The first involves the incorrect assumption that blacks and whites are naturally different, so that similar symptoms exhibited by both groups are judged to be nonequivalent. That is, ethnic differences in the manifestations of psychopathology are believed to exist when this is not the case. The second error is the opposite of the first in that ethnic minorities may not actually exhibit the same symptoms for a particular disorder and yet the diagnostician assumes that all individuals must show the same symptoms for the disorder. Underlying the error is the belief that there are universal criteria for disorders and that groups can be evaluated in a similar fashion. This second error has been criticized more often in the literature.

In an insightful analysis of clinical judgment, Lopez (1989) also concluded that bias can occur in opposite directions. Underpathologizing is apparent when clinicians minimize the psychopathology among ethnic minority groups. For example, when symptoms of persecution seen in a black client are automatically assumed to be caused by prejudice and discrimination, the clinician may be underpathologizing (Ridley, 1984). On the other hand, overpathologizing can occur when symptoms of persecution are judged to be signs of a paranoid delusion rather than a reality-based response to a hostile environment. By using a broadened definition of bias, which includes over- and underpathologizing, and by reexamining past studies of clinical judgments, Lopez (1989) found that more studies did than did not show bias.

Research on assessment, therefore, can fail to yield consistent results of a particular bias (i.e., over- or underpathologizing) and still demonstrate bias. The interesting research question that needs further investigation is the conditions under which clinicians show an over- or underpathologizing bias.

Other therapist variables. Although ethnic match (or therapist ethnicity) has dominated the pertinent literature, other therapist variables have also been studied, including therapist cultural sensitivity training, attitudes and behaviors, and physical characteristics.

In the past, cross-cultural mental health scholars and practitioners have devised strategies and programs to help train therapists to work with culturally different clients (see Barbarin, 1984; Myers, Wohlford, Guzman, & Echemendia, 1991). For example, Pedersen (1986) developed the DISC (Developing Interculturally Skilled Counselors) training program at the University of Hawaii. The Cross-Cultural Training Institute for Mental Health Professionals, developed by Lefley (1985), was a three-year, NIMH-funded project designed to enhance the diagnostic, therapeutic, and administrative skills of mental health professionals in providing culturally responsive services to African-American and Latino communities. The intensive eight-day training program empirically evaluated changes in trainees' abilities and changes in the agency's functioning. The program was favorably evaluated—without a control group—and found to be effective in enhancing therapeutic skills and in affecting positive changes in mental health agencies.

The effects of therapist cultural sensitivity training on African-American clients were investigated by Wade and Bernstein (1991). They assigned experienced African-American or white therapists to either a cultural sensitivity training program or a control group (no additional training). Therapists then saw as clients African-American women from the community who needed counseling. A main effect for training (but not therapist race) was found in that clients who saw culturally trained therapists rated the therapists as having greater expertise, trustworthiness, attractiveness, empathy, and unconditional positive regard than the clients whose therapists were not exposed to this training. In terms of the number of treatment sessions, main effects for training and therapist race were found. Clients of trained therapists and of therapists who were African-American attended more sessions than those with nontrained or white therapists. The effects of training appear to be dramatic, particu-

larly because the training program took only *four* hours. If the results are replicated, the implications for programs and policies may be immense.

What aspects of cultural sensitivity training affect therapeutic processes and outcomes? Not enough research is available to address this question. However, several studies have investigated therapist characteristics that may influence the psychotherapeutic process. There is some evidence to suggest that the degree of intimate self-disclosure and interest in a client's culture or race have favorable effects. Interviewers who self-disclose in an intimate rather than a nonintimate fashion to African-American clients have been found to be better liked, to have more positive evaluations, and to elicit more intimate self-disclosures from the client (Berg & Wright-Buckley, 1988). Pomales, Claiborn, and LaFromboise (1986) also demonstrated that therapists who acknowledge and deal with the cultural issues raised by African-American clients are judged to be more culturally competent than are therapists who avoid such issues. Significant interactions among several variables were also found, revealing the complexities in determining the effects of therapist factors.

In summary, the research literature on therapist variables has yielded mixed findings. There is no consistent evidence that ethnic matching of clients with therapists in the case of African-Americans results in more favorable outcomes. However, the research examining this question has been sparse and has suffered from methodological limitations. Furthermore, there is the possibility that match may show effects only with certain, and not all, African-American clients, and research on the interaction between match and other characteristics is warranted. Similarly, on the issue of assessment bias, where research seems to demonstrate the real possibility of some bias occurring, it needs to be targeted to more specific questions. Asking what factors are associated with over- and underpathologizing African-American clients is, perhaps, more meaningful than asking if bias occurs. Finally, there are a few studies that demonstrate the importance of training therapists to be culturally sensitive, open, and willing to self-disclose and to deal with cultural issues in working with African-American clients.

Situational or treatment variables. Are there certain situations or types of programs or therapies that have been found to be especially effective with African-Americans? The literature on this question is actually quite extensive. Many scholars have discussed the kinds of mental health services that may be culturally appropriate for African-Americans. Sometimes the discussions have focused on treatment modifications for particular African-American clients such as families (Boyd, 1982), women, adolescents (Franklin, 1982), and male adolescents in particular (Paster, 1985). Others have suggested modifications to traditional treatment approaches (Ramirez, 1991). For example, Lefley and Bestman (1984) have established a comprehensive mental health program with a staff that includes people indigenous to the community and is headed by a cultural broker or go-between. The investigators report that dropout rates have been low and that consumer satisfaction and treatment outcomes have been positive. Still others have recommended that ethnic-specific services (i.e., those that are specifically designed for African-Americans) or indigenous healers be more fully incorporated into the mental health system (S. Sue, 1977; White, 1984). While most of the scholars have offered suggestions regarding psychotherapy with African-Americans, few have empirically tested the effects of such suggestions.

One important modification that appears to be very helpful in the provision of services is pretherapy intervention. Ethnic minority clients may not know what psychotherapy is, how it can help, what to do, or what to expect. Acosta, Yamamoto, and Evans (1982) have devised client orientation programs aimed at familiarizing clients to psychotherapy. By using slides, audiotapes, or videotapes, the investigators try to show clients the process of seeing a therapist, and means by which to express problems, self-disclose, and communicate needs. Acosta, Yamamoto, Evans, and Skilbeck (1983) conducted an evaluation of the effectiveness of the orientation program. Prior to the first treatment session, they presented low-income African-American, Latino-American, and white outpatients with either the orientation program or a program that was neutral with regard to psychotherapy. Knowledge of and attitudes toward psychotherapy were assessed prior to and immediately after the programs. Results indicated that exposure to the orientation program increased knowledge and favorable attitudes toward psychotherapy. Therapist orientation programs have also been devised to familiarize therapists who are working with ethnic minority clients. Reviews of client and therapist preparation programs have been favorable (see E. Jones & Matsumoto, 1982).

In general, many scholars have made suggestions concerning treatment or situational variables that are important in working with African-Americans. However, few empirical studies are available that

point to effective treatment strategies. The impact of ethnic-specific services has not yet been tested. Perhaps the most encouraging programs that have been evaluated are the pretherapy orientation programs involving clients and therapists.

RESEARCH ON AMERICAN INDIANS

American Indians and Alaska Natives are a culturally heterogeneous population, consisting of over 510 federally recognized tribes, including more than 200 Alaska Native villages (Bureau of Indian Affairs, 1991). Furthermore, about half of American Indians and Alaska Natives live in urban areas, and half in rural areas or areas on or adjacent to Indian reservations (Bureau of Indian Affairs, 1991; Manson, Walker, & Kivlahan, 1987), although many move back and forth (Yates, 1987).

Between 1970 and 1980, the American Indian and Alaska Native population nearly doubled to 1.5 million, and between 1980 and 1990, the population grew 37.9 percent to almost 1.96 million. This has resulted in a young population with a median age in 1980 that was significantly younger than the median age for the U.S. population in general: 20.4 and 17.9 respectively for American Indians and Alaska Natives, 30.3 for the U.S. population (Manson et al., 1987; U.S. Bureau of the Census, 1991b). At the time of the 1980 census, over half of the American Indian population was under 23 years old (McShane, 1988).

When compared to the U.S. population at large, as a group, American Indians and Alaska Natives are economically impoverished and educationally disadvantaged. The American Indian and Alaska Native mean family income in 1980 was $6,857, less than half the mean income of whites; unemployment ranged from 20 to 70 percent, depending on the community; their 9.6 mean years of formal education represented the lowest level of any ethnic group in the United States. Social and psychological problems with the American Indian and Alaska Native population include the highest arrest rates in the United States (10 times the arrest rate of whites), high rates of alcohol abuse and alcohol-related deaths, and high rates of serious psychiatric problems (Manson et al., 1987).

However, tribes vary in terms of familial and social organizations, religious practices, economic resources, and rates of social and psychological problems. There are 200 American Indian and Alaska Native languages still used by tribal members (LaFromboise, 1988). Besides linguistic and cultural differences between tribes, individuals affiliated with particular tribes differ in their acculturation to tribal or Anglo-American values. Further, significant within-tribe differences include whether individuals live on or off a reservation. Thus, generalizations about the population need to be qualified.

Although their diversity makes generalizing about American Indians and Alaska Natives difficult, it has been generally agreed that American Indians and Alaska Natives differ from whites in worldviews or value orientations. Such value differences have included American Indians' and Alaska Natives' sharing and redistribution instead of acquisition, cooperation instead of competition, noninterference instead of intervention, harmony with nature instead of control of nature, present time orientation instead of future planning, and promoting an extended family network instead of a nuclear family network (Guilmet & Whited, 1987; D. W. Sue & Sue, 1990; Trimble & LaFromboise, 1985). Other differences that have been suggested as relevant in psychotherapy with American Indians and Alaska Natives are culturally based faith in tribal rituals, ceremonial practices, Indian medicine and traditional healing practices; different beliefs in the cause of mental health problems and the ways such problems should be solved; and culturally specific mental disorders or culturally specific manifestations of mental disorders (Manson, Shore, & Bloom, 1985; Neligh, 1988; Trimble & LaFromboise, 1985).

Treatment Outcome

There have been very few empirical studies on the effectiveness of psychotherapy in the treatment of American Indians and Alaska Natives, and no research has investigated the relative effectiveness of different therapeutic modalities (Manson et al., 1987; Neligh, 1988). The need for outcome research is apparent, given the proliferation and funding of a wide variety of treatment and prevention programs that have arisen to target the serious mental health needs of many American Indians and Alaska Natives.

The most researched American Indian mental health problem has been drug and alcohol use and abuse, although treatment evaluation studies of this problem have not been conducted very often. Query (1985), in a comparative study of white and American Indian youth in an inpatient chemical dependency treatment program at a North Dakota state hospital, did find that American Indian youth were disproportionately represented in the unit as would be expected by their percentage in the population. The youths received reality therapy and were followed up six months after discharge. Upon follow-up, whites were found to be functioning

much better than Indian youths on various outcome measures. Further, among the American Indian youth, 42 percent had thought of suicide and 25 percent had actually attempted suicide, compared to 21 and 16 percent of the white youth. From these and other outcome measures, Query suggests that the treatment program had produced more positive change in white than in American Indian youth.

More recently, prevention programs for American Indians have been advocated (see Manson, 1982, for a review). Although prevention programs are not normally discussed in terms of treatment outcome, due to the dearth of treatment outcome research with American Indians and Alaska Natives, since prevention approaches appear to be the trend in American Indian research, they are discussed here. Bobo, Gilchrist, Cvetkovich, Trimble, and Schinke (1988) developed a culturally tailored drug prevention program targeting American Indian youth that included extensive collaboration within the American Indian community. The program was found to be successful in that the researchers were able to deliver the program to six groups of American Indian youth, even highly traditional parents consented to their children's participation in the program, and the youth themselves evaluated the program favorably. However, of the six outcome variables, only one, "alcohol use identity," was found to have changed significantly after the prevention program. Bobo et al. attributed this lack of statistically significant change to their small sample size and the resulting insufficient power to detect change and also speculated that American Indian culture in general has a resistance to outside influences.

Skills training for bicultural competence is another recently suggested prevention approach, and social skills training may also have potential for intervention purposes (LaFromboise, Trimble, & Mohatt, 1990). LaFromboise and Rowe (1983) outlined the process of culturally adapting an assertion social skills training program for American Indians, with the rationale that skills training as an approach is less culturally biased than other approaches because it is less prescriptive than other approaches in its conceptualization of appropriate behaviors and thus is less culturally imposing on American Indian culture. In addition, skills training is flexible, allowing for the selection of target behaviors to be changed. This facilitates culturally appropriate modifications of the program.

Schinke et al. (1988) compared a bicultural competence skills training approach with a no-treatment control condition for preventing substance abuse in American Indian adolescents. They found that there were greater posttest and follow-up improvements with the bicultural skills program than with no-treatment on measures of knowledge about the health and social effects of substance use, self-control, assertion, and substance use rates.

It is apparent that research on interventions (i.e., treatment and prevention) has proceeded very slowly, and it would be premature to try to address the question of the efficacy of mental health interventions with American Indians at this time.

Treatment Process

Client variables. In terms of expectancy and preferences, it has often been stated that American Indians distrust non-Indian therapists (LaFromboise, 1988). The empirical investigation of such a claim, especially as it relates to American Indian expectancy and preferences for an ethnically similar therapist, has yielded mixed results (see Atkinson, 1983, for a review). LaFromboise, Dauphinais, and Rowe (1980), in a study of American Indian high school students who were attending boarding, urban, and rural schools in Oklahoma, had the students rate their preferences for qualities in a helpful person. The ethnicity of a person, specifically being an American Indian, was found to be relatively less important than other qualities, such as trustworthiness, and no differences in ratings were found among students from boarding, urban, or rural schools.

In another study, LaFromboise and Dixon (1981) had American Indian reservation high school students in Nebraska observe and rate videotaped segments of one of four counseling conditions, within which the interviewer's ethnicity was crossed with the interviewer's performance. The interviewer's ethnicity was either American Indian or non-Indian, and the interviewer acted according to a trustworthy or nontrustworthy model of counseling. Ratings of trustworthiness, expertness, or attractiveness were found to be unrelated to the interviewer's ethnicity.

By contrast, Dauphinais, Dauphinais, and Rowe (1981) studied American Indian high school students from two federal boarding schools in Oklahoma and one tribally controlled boarding school in South Dakota (40 tribal affiliations were represented in the sample). Students were randomly assigned to listen to one of three tape-recorded conditions, which differed only in that counselor responses reflected either a directive, nondirective, or American Indian culturally oriented counseling style. For each condition, half of the students were told that the counselor was American Indian, and half were told that the counselor was non-Indian. Dauphinais et al. found that students gave more

positive ratings on the Counselor Effectiveness Scale to counselors who were introduced as American Indian. Further, the culturally oriented counseling style was rated as more credible than the nondirective approach.

Havilland, Horswill, O'Connell, and Dynneson (1983) studied American Indian college students in Montana who represented 11 American Indian tribes, with a range of 3 to 100 percent American Indian blood quantum, with nearly 70 percent of the sample having lived on a reservation for some time in their lives. The researchers found that American Indian students had a strong preference for an ethnically similar counselor, and that students' willingness to use a counseling center that had an American Indian on staff was directly related to students' preferences for an ethnically similar counselor. Further, Havilland et al. found that American Indian students tended to report a preference for an American Indian counselor for personal, educational, and vocational problems. Blood quantum and percentage of life spent on a reservation were not found to affect students' preferences.

Bennett and BigFoot-Sipes (1991) utilized the methodology developed by Atkinson et al. (1986) for the study of African-American preferences. They found that although ethnicity was more important to American Indian college students than to white students, especially to those American Indian students who were more involved in American Indian culture, what tended to be more important to both American Indians and whites was having a counselor who shared similar attitudes and values.

Thus, there have been mixed results in the findings on American Indian expectancies and preferences. However, inconsistent results may be caused by the method used to study preferences. Thus, it will be useful for future preference research to take into account the type of problem a client presents and other counselor characteristics in addition to ethnicity (such as attitudes, personality, education, and especially American Indian ethnic identity or cultural commitment) (Bennett & BigFoot-Sipes, 1991). Finally, a pragmatic factor to consider is that ethnic preference studies may not reflect what is actually available to the American Indian and Alaska Native population. For example, many American Indians and Alaska Natives simply have few choices available to them, despite the preferences they may have. As noted by Mays and Albee (1992), the number of American Indian and Alaska Native therapists is quite small—in 1989, only six received doctorates in clinical or counseling psychology throughout the nation. While preference studies may provide additional justification for funding the education of American Indian and Alaska Native researchers and therapists, further research clarifying the issues is needed.

Therapist variables. The paucity of empirical research is also evident with respect to the impact of therapist variables, and what has been done has yielded mixed results (Atkinson, 1983). Dauphinais, LaFromboise, and Rowe (1980) surveyed American Indian 11th- and 12th-grade students of a variety of tribal affiliations, such as Choctaw, Creek, Kiowa, Chicksaw, Comanche, Cherokee, Sioux, Cheyenne/Arapahoe, attending Bureau of Indian Affairs boarding schools and urban and rural schools in Oklahoma and found that the students' satisfaction with previous counseling was not related to whether the counselor's race was American Indian or non-Indian.

However, as mentioned previously, in the Dauphinais et al. (1981) study with American Indian high school students, counselors were rated as more credible on the Counselor Effectiveness Rating Scale when the counselor used a culturally relevant counseling style. In addition, independent of counseling style, the counselor who was introduced as American Indian received more positive ratings. This suggests that the ethnicity of the counselor may be an important factor in the counseling of American Indians. Littrell and Littrell (1982), in a study examining high schools students' preferences for counselors, found that the preferences of American Indian students from a North Dakota reservation varied with the sex and dress of the counselor and type of the client problem.

Situational or treatment variables. There is little empirical evidence about the effectiveness of specific modes of psychotherapy with the American Indian or Alaska Native population, and no information comparing the efficacy of different psychotherapeutic approaches. However, this has not impeded the proliferation of program development, most particularly, prevention interventions (see Manson, 1982) and the group modality. The majority of these programs target the most salient mental and social problem in many American Indian communities: alcohol and drug abuse and dependence.

In addition, family-network therapy, traditional healing practices, and bicultural skills training programs have been described in the literature as possible culturally appropriate modalities to be considered in working with American Indians. For instance, Manson et al. (1987), in their review of psychiatric assessment and treatment of American Indians and Alaska Natives, propose that family-network therapy may be culturally appropriate for some American Indians and Alaska Natives, given

the cultural context of an extended family social organization. LaFromboise (1988) notes that American Indian communities have traditionally used extended families as sources of care and psychological support and describes work utilizing the extended family in a therapeutic setting.

While discussing tribally based mental health care programs, LaFromboise (1988) characterized the recent use of traditional healers and traditional approaches as "a renaissance and revitalization of traditional healing practices" (p. 391). It was feared that such practices were being extinguished in favor of Western forms of treatment. Examples of traditional practices that have been incorporated into the treatment of American Indian clients include the four circles (visualizing relationships in terms of concentric circles), the talking circle (a form of group therapy focused on the circle as a symbol of physical and psychological connectedness among individuals), and the sweatlodge (a ritual in which participants are exposed to hot rocks sprinkled with water, sweat, and experience a feeling of kinship with all living things and the universe). (See Manson et al., 1987, or Vraniak & Pickett, 1992, for a detailed description of these therapeutic strategies.)

LaFromboise and Rowe (1983) have argued that skills training for bicultural competence may meet the needs of American Indians without the imposition of more traditional forms of therapy, which they suggest may have a "culturally corrosive effect." They described the process of culturally adapting the skills training model, and as described previously, Schinke et al. (1988) have provided a preliminary investigation into the efficacy of such an approach.

Obviously, basic knowledge of psychotherapy processes and outcomes for American Indians and Alaska Natives is being established very slowly. The population is a particularly difficult one to study, given not only its cultural and linguistic heterogeneity, but also its geographical range across the United States and in cities, rural areas, and reservations. Another problem, which is by no means unique to American Indian research, is the tendency for researchers to use nonclinical populations, a methodology that limits the generalizability of findings. Additionally, there have been so few empirical studies on American Indians, and none on Alaska Natives, that those that have been done do not allow for broad generalizations. The literature on psychotherapy with American Indians and Alaska Natives consists predominantly of descriptive reports and program suggestions. However, the recent trend in American Indian research that utilizes and extends the methodologies developed to study other ethnic groups appears to have great potential to further the field in that comparisons can now be made across ethnic groups, and methodological and theoretical advances can be shared.

RESEARCH ON ASIAN-AMERICANS

Asian-American groups are the fastest growing ethnic minority populations in the United States. From 1980 to 1990, the population grew by 108 percent to 7.3 million. This increase can be attributed largely to immigration to the United States from China, the Philippines, India, Korea, Southeast Asia, and other countries, and secondarily to natural increases (births minus deaths). More than 20 Asian-American groups have been identified by the U.S. Bureau of the Census. The three largest in descending order are Chinese, Filipino, and Japanese. Most Asian-Americans (70%) live in just five States—California, Hawaii, New York, Illinois, and Texas. Comparisons of the Asian-American population with the white population have found substantial differences on characteristics such as college graduates aged 25 years and older (40 to 23%); average family size (62 to 46% living in households with children under 15); per capita income ($14,000 to $14,900), home ownership (54 to 76%), Social Security support (64 to 92%), and poverty levels (14 to 8%) (O'Hare & Felt, 1991).

An important characteristic of the population is the diversity among different Asian-American groups. For example, the vast majority of Vietnamese, Koreans, Asian Indians, Filipinos, and Chinese in the United States were born overseas. However, Samoans, Japanese, Guamanians, and Hawaiians were largely born in the United States (O'Hare & Felt, 1991). Japanese and Asian Indians had median ages that exceeded the national average, but other Asian groups had median ages lower than the national average. The median family income of Japanese-Americans ($27,400) was strikingly higher than that of Vietnamese-Americans ($12,800). Great variations also exist among Asian groups in educational attainment and achievement. The school dropout rate for Filipinos is substantially higher compared with other Asian groups and white Americans. There is also a great deal of within-group variability. For example, a majority of the Chinese are foreign born, but over one-third (37%) are American born. Moreover, foreign-born Chinese come from different parts of the world (e.g., mainland China, Taiwan, Hong Kong) and speak different Chinese dialects, adding to the within-group diversity.

Both the diversity between and within Asian-

American groups must be considered in the interpretation and generalizability of treatment process and outcome findings. Most of these studies have focused on the larger and more acculturated Asian-American groups, such as the Chinese and Japanese, and have primarily used student samples who tend to be more acculturated and homogeneous than those drawn from Asian communities. Some investigations have included different groups within the rubric of "Asian-Americans" so that differences among the groups are masked or it is unclear which Asian-American groups are being studied.

Treatment Outcome

Few studies have directly examined psychotherapy outcomes for Asian-American clients. Zane (1983) assessed outpatients at a community mental health center after the first and fourth sessions and found that Asian clients evinced significant improvement on both client self-report (Symptom Checklist) and therapist-rated (Brief Psychiatric Rating Scale) outcome measures. Most outcome studies have aggregated across different Asian groups with the exception of research on Southeast Asians. Mollica et al. (1990) reported improvement in depression among Cambodian clients following six months of psychotherapy, whereas no significant improvements in depression or anxiety were found for Vietnamese or Hmong/Laotian clients. In a pilot study of nine patients, Kinzie and Leung (1989) successfully decreased depression in Cambodians suffering from post-traumatic stress disorder, but the intervention primarily relied on drug therapy (using clonodine and imipramine) supplemented by group socialization therapy.

In terms of differential outcome, two studies have examined clinical outcome among Asian outpatients using the Global Assessment Scale (GAS), a therapist measure of general psychosocial functioning. Zane and Hatanaka (1988) found no differences between Asians and whites on posttreatment GAS adjusting for pretreatment GAS. S. Sue et al. (1991) obtained similar results as Asian outpatients showed similar improvement compared with white clients. Other studies have found some evidence of differential outcome. Zane (1983) found that by the fourth session, there were no differences in therapist-rated outcome and in self-reported symptoms of depression and anxiety. However, Asians reported greater anger than whites and were less satisfied with services and with their progress in treatment. The analyses controlled for both pretreatment level of severity and demographics that could have been confounded with ethnicity. W. Lee and Mixson (1985) had clients at a university counseling center rate the effectiveness of counseling and their therapists and indicate the reasons why they sought treatment. Despite presenting a similar number of concerns prior to treatment, Asians rated both their counseling experience and therapists as less effective than did whites.

Any conclusions about the effectiveness of treatment for Asians would be premature given the limited data (four outcome studies), but several empirical trends should be noted. First, some evidence suggests that certain Asian groups improve with psychotherapy and/or adjunct treatments. Second, with respect to differential outcome, divergent trends are found, and these are associated with the type of outcome measure used. Studies reporting no differential outcome between Asians and whites relied on a measure of general psychological functioning (e.g., GAS), whereas differential outcomes were found in studies that used client satisfaction measures and/or specific symptom scales. It is possible that the null results may reflect the unreliability and insensitivity of the global outcome measure used. The GAS essentially constitutes a one-item measure. The GAS is highly reliable if raters are extensively trained in its use, but there appeared to be no such training conducted with therapists in either study. In sum, Asian clients appear to be deriving less positive experiences from therapy than whites, but it is unclear if this difference in client satisfaction actually reflects ethnic differences in actual treatment outcomes (e.g., symptom reduction).

Process Research

Much of the empirical work in Asian-American mental health has examined ethnic differences across a wide range of variables such as personality, values, ethnic identity, acculturation and adaptation, and family attitudes and relationships (e.g., Fukuyama & Greenfield, 1983). Extensive reviews of this empirical work have been presented elsewhere (e.g., Leong, 1986). Implications for the treatment of Asians are often drawn from this research. However, relatively few studies have directly investigated how these variables are related to or affect actual processes in treatment. The empirical work that has addressed psychotherapy issues has primarily focused on variables such as client preferences and mental health beliefs, treatment and therapist credibility, and ethnic match.

Client variables. In view of the great heterogeneity that exists between and within Asian-American groups, client variables would be an important area of focus for process research with these groups. The major empirical efforts have addressed

acculturation influences and client preferences and expectancies. At times, these variables have been examined concurrently.

Client preferences and expectancies. A number of studies have examined the preferences of Asian-Americans for ethnicity of the therapist and type of counseling approach used. This research has primarily relied on nonclinical samples of Asian-American or foreign Asian students. One study (Atkinson, Maruyama, & Matsui, 1978) varied therapist ethnicity (white vs. Japanese-American) and counseling style (directive vs. nondirective). Japanese-American participants heard an audiotape on which the therapist counsels a client identified as Japanese-American. The two styles presented were based on scripts in which the directive therapist responded in a rational, problem-solving way and asked for specific information and the nondirective therapist restated and summarized the client's feelings and experience. The study used a sample of Japanese-American university students and a community sample of Japanese-American high school and college youth. In both samples, the directive therapist was rated as more credible and approachable while only the university sample indicated a preference for the Japanese-American therapist. Gim, Atkinson, and Kim (1991) used a similar design but varied therapist cultural sensitivity (culture-sensitive vs. culture-blind) instead of counseling style. In the culture-sensitive condition, therapists discussed and acknowledged cultural difference, whereas in the culture-blind condition therapists did not attend to such differences and emphasized commonalities among individuals. Asian-American students preferred Asian-American counselors over white American counselors and rated the culturally sensitive therapists as more credible and culturally competent than culturally blind therapists. These studies clearly show an Asian preference for a directive therapeutic style, but without a white comparison group, it is unclear if this effect is a preference of clients in general or an ethnic-specific preference. There also seems to be a preference for ethnically similar therapists among Asians, although ethnic match may not be the most important type of similarity that clients seek in their therapists (Atkinson, Poston, Furlong, & Mercado, 1989).

Studies that have made direct ethnic comparisons have also found a preference for or expectation of a more directive problem-solving approach in therapy on the part of Asian foreign students. Both Tan (1967) and Yuen and Tinsley (1981) found that Asian students expected therapists to have more experience and be more directive than did white students. Arkoff, Thaver, and Elkind (1966) reported that Asians expected therapists to provide more advice and direct suggestions for solving problems than did whites. Using a causal modeling approach, Akutsu, Lin, and Zane (1990) found no relationship between directive style and therapist credibility for either Chinese or white students. As suggested by the investigators, one possible reason for the difference in findings is that the directive style presented included some elements of confrontation that were absent from the directive approaches used in the other studies.

Acculturation influences. Important variations in the way Asians seek, respond to, or experience psychotherapy may depend on the individual's level of acculturation. Acculturation refers to the extent to which members of an ethnic minority group have learned or adopted the cultural patterns of the majority group (S. Sue & Morishima, 1982). Atkinson and Gim (1989) compared the attitudes toward seeking and using psychological services of Chinese-, Japanese-, and Korean-American students. No intergroup differences were found, but more acculturated Asians were more cognizant of the need for psychological help and more open to using services. Gim, Atkinson, and Whiteley (1990) also found that the more acculturated students were more willing to use therapy. In one of the few studies of Asian clients, Tracey, Leong, and Glidden (1986) examined the presenting problems of whites and seven Asian-American groups (Chinese, Filipino, Hawaiian, Korean, Japanese, Asian-white, and Asian-Asian) at a university counseling center. The most acculturated groups, Asian-whites and Filipinos, were more likely to perceive their major presenting problem as involving emotional/interpersonal issues (e.g., "feel lonely and alienated from others," "have difficulty with close personal relationship") as opposed to academic/vocational concerns (e.g., "don't know how to study," "don't know what my interests are").

Other variables. There is some evidence that Asians define and think about mental health and emotional problems somewhat differently from members of other cultures. Clinicians have noted that Asians tend not to make a strong distinction between emotional and physical problems and attribute both to bodily imbalances (Flaskerud & Soldevilla, 1986). This holistic tendency was reflected in findings in which Asians believed that emotional problems were more influenced by organic and somatic factors than did whites (Arkoff et al., 1966). On the other hand, Asians were more likely to believe that mental health is enhanced by the avoidance of negative thinking and/or self-discipline (Lum, 1982). Given that the practice of psychotherapy often requires clients to focus on painful or

negative thoughts, relies on emotional catharsis, and tends to deemphasize somatic interventions, it has been hypothesized that many Asian-American clients may find the initial conceptualization stage of psychotherapy inconsistent with their beliefs (E. Lee, 1982; Zane & Sue, 1991).

Symptom patterns of Asian clients in treatment have been examined. There is a tendency for Asians (particularly those with depressive disorders) to present with more somatic complaints that other clients, and this has been interpreted as evidence of somatization in which physical symptoms are expressed in place of psychological symptoms (Kleinman, 1977; Marsella, Kinzie, & Gordon, 1973). Tanaka-Matsumi and Marsella (1976) suggested that the experience of depression may, indeed, be somewhat different for Asians. In a word association study, Japanese Nationals (i.e., citizens) associated more external referent and somatic terms to the word *depression*, whereas white Americans associated terms that referred to internal mood states. The associations of a seemingly highly acculturated Japanese-American sample were similar to the white responses. Some research suggests that these somatic tendencies have resulted more from different help-seeking practices in which Asians have tended to use medical services for psychological disorders (Cheung & Lau, 1982). Regardless of the causal pathway, the process by which basic psychological problems are presented and/or experienced appears to be somewhat different for Asians.

Western psychotherapy relies on verbal expressiveness and open self-disclosure as primary means for resolving psychological problems. These aspects can conflict with the tendency on the part of Asians to be less verbal and to refrain from the public expression of feelings (B. Kim, 1973). In many East Asian cultures, the "language of emotion" for Asians is somewhat different in that affection is conveyed by the use of gestures, often involving the exchange of material goods and services that enhance the person's well-being (Chang, 1985). Also, metaphors are frequently used to communicate feelings. Thus, it is possible that differences in the communication styles of Asian-Americans may influence the therapeutic relationship and the development of rapport in psychotherapy. However, more research is needed to clarify the roles such differences may have.

Therapist variables

Match between the client and therapist. The match between a client and therapist has been considered to be an important factor in psychotherapy. One of the most salient aspects of match with ethnic clients in general, and with Asian-American clients in particular, is ethnic match. For those Asian-American clients who are non-English speaking, language match would also appear to be crucial.

S. Sue et al. (1991), in the previously described study of Los Angeles County mental health services, found that ethnic match between the client and therapist was associated with an increase in the use of mental health services and a lowered likelihood of dropout for Asian-American clients. In addition, for those Asian-Americans for whom English was not a primary language, ethnic match, language match, and gender match were associated with a decrease in the likelihood of premature termination and an increase in the number of sessions. Thus, at least in terms of indirect indexes of treatment efficacy, ethnic match exerted a significant influence for Asian-American clients. Moreover, in terms of outcome, non-English-speaking Asian-Americans were found to have better outcomes, as measured by GAS change, when matched with a therapist of similar ethnicity and language.

Considering that the growth of the Asian-American population in the United States is due, in a large part, to immigration, and that those immigrants tend to be non-English speaking, the availability of therapists who are of the same ethnicity and/or who speak the same language of the Asian-American client is important for service utilization and to some extent, treatment outcome. However, further research is needed to replicate S. Sue et al.'s findings and to investigate potential differences in the significance of match between Asian-American groups.

Assessment bias. There is evidence that therapist and client ethnicity may affect diagnoses and evaluations of clients. Tseng and McDermott (1981) had Japanese and white psychiatrists evaluate the characteristics exhibited by white clients. The Japanese psychiatrists were more likely than white psychiatrists to rate the clients as emotionally labile. This is especially interesting since Asian-American clients have often been characterized as passive and unemotional. Li-Repac (1980) had five white and five Chinese-American therapists rate Chinese and white clients during a videotaped interview. White clinicians rated Chinese clients as "anxious," "awkward," "confused," "nervous," "quiet," and "reserved," in contrast to the Chinese clinicians who used adjectives including "adaptable," "alert," "dependable," "friendly," and "practical." In the ratings of white clients, the white clinicians used terms such as "affectionate," "adventurous," and "capable." Chinese clinicians described the white clients as "active," "aggres-

sive," and "rebellious." The differences in the ratings were significant. White raters saw Chinese clients as more depressed and inhibited and less socially poised and as having less capacity for interpersonal relationships than did Chinese-American clinicians. Interestingly, Chinese-American clinicians rated white clients as more seriously disturbed than did white clinicians. The striking differences in evaluations point to possible problems in making valid assessments for culturally diverse groups.

Treatment variables. It often has been hypothesized that modifications in the approach to psychotherapy are needed to adequately treat Asian-American clients (Chung & Okazaki, 1991; Ho, 1976; S. Kim, 1985; Kitano, 1981; E. Lee, 1982; J. Lee & Cynn, 1991; Murase, 1977; Nishio & Bilmes, 1987; Root, 1985; Shon & Ja, 1982; D. Sue & Sue, 1991; S. Sue & Morishima, 1982; Tomine, 1991; Toupin, 1980). For example, E. Lee (1982) and others have noted important differences in family structure, value orientation, and beliefs about mental health and illness between Asian-American and white cultures. Compared with Western culture, which focuses on the nuclear family with somewhat egalitarian relationships and emphasizes values of individualism, competition, self-worth, and direct expression of emotions, many Asians have strong ties to nonegalitarian societies that center on extended family arrangements based on structured, hierarchical role relationships and stress values of collectivism, group achievement, "face," and emotional restraint. Murase (1977) has recommended that treatment approaches for Asians should recognize the family as an integral part of treatment, establish an active, highly personalized therapeutic relationship, focus on survival-related tasks to facilitate the engagement process, address the possible conflict between the cultural dynamic of "loss of face" and the confessional character of psychotherapy, differentiate between cultural behavioral propensities and pathology, reevaluate the self-determination construct, permit flexibility in session scheduling and duration, and recognize the ameliorative effect of a familiar and predictable cultural milieu.

However, despite the extensive number of published recommendations for the modification of Western psychotherapeutic approaches, there have been no empirical comparisons of efficacy between mainstream Western modalities and culturally modified modalities in the treatment of Asian-Americans, nor have there been empirical studies of the effectiveness of the culturally specific treatments or culturally modified treatments themselves. Most research has focused on aspects of "culturally sensitive services" for Asian-Americans, such as the ethnic and language match discussed in the previous section.

Nevertheless, ethnic and language match are only part of "culturally sensitive services." S. Sue (1977) suggested parallel services, which would entail not only ethnic and language match, but a systemic change of integration into the community, altering the situation in which services are rendered. That is, parallel services should be based in the community, staffed by bilingual and bicultural staff, and designed in a way that would be culturally more responsive to the Asian-American clientele serviced.

Such parallel services appear to have increased utilization by Asian-American clients. In a study of community mental health care centers in Southern California, Flaskerud (1986) found that culturally compatible factors, such as ethnic and language match and location within the community, contributed to increased utilization of mental health services by Asian-Americans. In Oakland, True (1975) found that an Asian-American community-based agency served significantly more Chinese-Americans than the county outpatient emergency mental health facility. Wong (1977) found that in San Francisco, a community mental health center served more Asian-American clients in its first few months of operation than the total number of Asian-Americans who had been served in that area for the previous five years. More recently, Zane and Hatanaka (1988), in a study of an Asian community mental health center in Los Angeles, found that except for Southeast Asians, Asian-Americans received equitable services and did not differ in dropout rate and length of treatment when compared to whites.

Although these studies are limited in that treatment outcome was not often measured, the impact of parallel services on indirect indexes for Asian-Americans is apparent. Preliminary studies strongly suggest that parallel services have increased the utilization and efficacy of mental health services with most Asian-American groups, yet there remains the direct investigation of the effect of parallel services on treatment outcomes.

RESEARCH ON LATINO-AMERICANS

With a population of 22.4 million, Latinos are the second largest ethnic minority group in the United States. The population has grown at least 53 percent between 1980 and 1990, increasing from 6.4 percent of the total U.S. population in 1980 to 9

percent in 1990, not including undocumented Latino immigrants (U.S. Bureau of the Census, 1990). The tremendous growth in the Latino population has been due to the high levels of Latino immigration into the United States. Mexican-Americans comprise the largest group of Latinos with 58 percent of the Latino population, followed by Puerto Ricans, 13 percent; Cubans, 7 percent, and other Latinos originally from South and Central American countries, 23 percent (U.S. Bureau of the Census, 1991b). The majority of the Latino-American population lives in California and Texas, followed by New York and Florida. Most Mexican-Americans live in the southwestern states and the Midwest; Puerto Ricans tend to be located in New York City; and most Cubans live in Florida and New Jersey (Malgady, Rogler, & Costantino, 1990b; Rogler et al., 1989).

Compared to the non–Latino white population of the United States, Latinos have lower levels of income, education, and occupational status, although their disadvantage varies greatly by Latino group. For example, the median family income of Cuban-Americans was 89 percent of the income of non-Hispanic families, whereas the median family income of Puerto Ricans was 57 percent and of Mexican-Americans 63 percent of the incomes of non-Hispanic families (U.S. Bureau of the Census, 1991). In New York, Cubans were found to have relatively high levels of education and higher status jobs, whereas Puerto Ricans and Dominicans had less education and lower status jobs (Gurak & Rogler, 1983). Part of the reason for these differences is the educational and economic status of immigrants prior to their arrival in the United States. Cubans, for example, tend to be from the middle or upper class, while some other Latino groups come from impoverished economic backgrounds (Gurak & Rogler, 1983).

In an evaluation of over 2,000 publications on the mental health of Latinos, the Report to the President's Commission on Mental Health (Special Regulations Subtask Panel on the Mental Health of Hispanic Americans, 1987) concluded that the field of Latino mental health research lacked a programmatic plan, and that the methodological and analytic quality of research needed to be improved. Since this report, the research on Latino mental health has continued to grow in a more conceptually consistent manner, no doubt aided by Federal funding of research and research centers devoted to Latino mental health. Although the general question remains of whether psychotherapy is effective with Latinos, research in this area has attempted to clarify the question itself. That is, what kinds of psychotherapy are most effective with Latinos? What are the client, therapist, and situational factors that influence psychotherapy with Latinos? How do within-group differences affect client preferences, leading to differential outcomes? And finally, given what is known, how can treatment programs be modified or developed to encourage service utilization and treatment effectiveness?

Treatment Outcome

It is generally assumed that mainstream mental health therapies are less effective with Latinos. This assumption, although not always tested directly, has been supported by indirect measures of treatment outcome such as treatment utilization, termination, and duration by Latinos in the mental health care system. Accordingly, there has been a movement toward "culturally sensitive" mental health services that consist of various strategies such as increasing the accessibility of treatment, selecting available treatments deemed most appropriate for Latino values or cultural orientation, modifying current therapies for Latinos, and developing therapies utilizing elements of Latino culture (Rogler, Malgady, Costantino, & Blumenthal, 1987).

Much emphasis has been given to investigating the efficacy of therapies that have been modified to fit Latino culture, and these studies will be discussed later in the section detailing the influence of treatment variables on the outcomes of psychotherapy. However, research focusing on the treatment outcome of Latinos given current Western modes of treatment has received less attention. One major large-scale study in Los Angeles County (described earlier) measured treatment outcome using pre- and posttreatment scores on the GAS; Mexican-Americans were found most likely to improve after treatment when compared to whites, blacks, and Asian-Americans (S. Sue et al., 1991). Thus, at least in this study based on data from a large metropolitan area, Mexican-Americans do appear to improve in their GAS scores. However, as discussed earlier, Mexican-Americans tend to underutilize services, so at this time it is unclear what the effect of underutilization may have been on the sample, and conclusions drawn from this study must be necessarily limited.

Treatment Process

Client variables. Client preference studies among Latino Americans have explored the relationship between client ethnicity and acculturation, and ratings of therapists of similar and different ethnicities and therapeutic styles. Acosta and Sheehan (1976) and Furlong, Atkinson, and Casas

(1979) found little evidence of an ethnic effect when subjects were asked to rate characteristics of therapists who were similar in all respects except ethnicity (or had a slight Spanish accent in the former study). Atkinson et al., (1989) found that Mexican-American students ranked similarity in therapist ethnicity sixth in order of preference for therapist characteristics, but three-fourths of the students preferred an ethnically similar therapist over an ethnically dissimilar therapist when given a choice. Atkinson (1983), in a review of the research on the role of ethnic similarity in psychotherapy, concluded that for Latinos, there did not appear to be a preference for therapist race or a race effect on therapy process variables such as perceived therapist credibility, perceived therapist effectiveness, and client verbal behavior.

In contrast, Lopez, Lopez, and Fong (1991), in a study of Mexican-American college students' preferences for ethnically similar therapists, argue that the results of previous studies that found no preferences for ethnically similar therapists may be attributable to the method by which preferences were measured. Lopez et al. contrasted the outcome of therapist preference studies by methodological approach. They propose that using a judgment method, by which subjects are asked to evaluate or rate therapists who are similar in all characteristics except ethnicity, the majority of past studies found no preference for an ethnically similar therapist. However, when a choice method was used, requiring subjects to select a therapist from several who differ in ethnicity, preferences were found for an ethnically similar therapist. Lopez et al. suggest that the choice method is a more ecologically valid means of assessing client preferences for the ethnicity of their therapist than the judgment method. They believe that the choice method more closely approximates the client's decision making at the time of the initial visit.

While investigating the main effects of client ethnicity, researchers began investigating other factors that may be related to rating differences, such as acculturation (Pomales & Williams, 1989; Ponce & Atkinson, 1989), attitudes toward acculturation (Atkinson, Ponce, & Martinez, 1984; Furlong et al., 1979), and cultural commitment to Mexican culture (Sanchez & Atkinson, 1983). Generally, researchers have found that factors such as acculturation and cultural commitment of the Latino rater, attitudinal match between the rater and therapist, and therapist style are more relevant factors in the therapeutic process than ethnic similarity alone.

Therapist variables

Match between client and therapist. In a previously discussed study of clients in Los Angeles County, S. Sue et al. (1991) found that ethnic match predicted a greater number of sessions for Mexican-American clients. When the Mexican-American clients were divided into two groups based on whether English was or was not their primary language, for those whose primary language was not English, ethnic match was found to significantly predict a decrease in premature termination, an increase in the number of sessions, and positive treatment outcomes. Thus, it appears that ethnic and language match is an important factor in the psychotherapeutic process, especially for Mexican-Americans whose primary language is not English. In an earlier described study of culturally compatible mental health services in Los Angeles, Flaskerud (1986) found that language match, ethnic-racial match, and community location made the largest contribution in discriminating between dropout and nondropout status.

In an analogue study, LeVine and Franco (1981) found different effects of ethnic match on self-disclosure. As a group, Anglo-American students were found to report more self-disclosures when compared with Latino students. The sex and ethnicity of the questionnaire administrator affected Latino student response rates in that Latino females made the most disclosures when the administrator was a female, and Latino males made the most disclosures when the administrator was a Latino female.

In addition to ethnic match, language match is a particularly important factor in the treatment of monolingual Spanish-speaking Latino clients. The Bilingual Interpreter Program in Los Angeles trained bilingual-bicultural community aides to become interpreters for English-speaking therapists (Acosta & Cristo, 1981). Spanish-speaking clients who used an interpreter believed they received more help and were understood better than bilingual Mexican-American clients who spoke to the therapist in English (Kline, Acosta, Austin, & Johnson, 1980). While more research needs to be conducted in this area, available evidence suggests that ethnic and language match are important variables in understanding psychotherapy and its outcomes among Latinos.

Assessment bias among therapists. The assessment of a client is clearly important to the treatment process, especially in regard to ethnic populations. In an overview of sources of ethnic and linguistic bias in the evaluation of Latino clients, Malgady, Rogler, and Costantino (1987) suggest that the psychodiagnosis of Latinos has been biased, due to clinician and instrument limitations. Some have suggested that the language used during the evaluation of Spanish-speaking Hispanic patients may lead to misdiagnosis. It was found that even if patients are bilingual, they appear more

disturbed when asked to speak only in English (Marcos, Urcuyo, Kesselman, & Alpert, 1973). Analogue studies have generally supported the claim of therapist bias in the assessment of Latinos.

Stevens (1981) had school psychologists, teachers, and parents rate films of Anglo-American, African-American, and Mexican-American eight-year-old boys for hyperactivity. Ethnic minority boys and those of lower socioeconomic status tended to be rated as more hyperactive than Anglo or middle SES boys. Wampold, Casas, and Atkinson (1981) tested an information-processing model of stereotyping using an illusory correlation paradigm. Anglo and ethnic (including Asian-, Chicano-, and African-American) graduate counseling trainees were given information, such as ethnicity and stereotypic characteristics, on 54 hypothetical students. Information was varied such that ethnicity (Anglo-, Asian-, or Chicano-American) and stereotypic characteristics combined into descriptions that would be considered congruent, neutral, and incongruent with racial stereotypes. Subjects were then asked to complete a questionnaire on the relationship between ethnicity and student characteristics based on the information they had been given. An error was scored if judgments made were not based upon the information presented. Upon error analysis, Anglo-American trainees were found to make fewer errors than ethnic minority trainees when the correct answer reinforced a racial stereotype, which suggests that the Anglo-American students differentially processed information regarding ethnicity and were more susceptible to racial stereotyping than ethnic students.

Therapist style. The effect of therapist style is a more recently investigated area in Latino psychotherapy research. Preliminary evidence supports the claim that Latinos prefer a directive counseling style over a nondirective style. Ponce and Atkinson (1989), as described previously, found that Mexican-American students gave more positive ratings to a directive counseling style than a nondirective style. In Pomales and Williams's (1989) study, described in a previous section, Puerto Rican and Mexican-American students were found to have an overall preference for a directive counseling style. This preference was found to exert a stronger influence than acculturation on the ratings of counselor characteristics.

However, the specific response modes associated with a directive style have not always been consistent across studies. For example, open questions have been considered directive in some studies and nondirective in others (Folensbee, Draguns, & Danish, 1986). Thus, a systematic investigation that clarifies what constitutes a directive style is important because clients may be reacting to a particular response mode rather than a particular therapeutic style. Borrego, Chavez, and Titley (1982) examined the effects of particular therapist interviewing techniques on the willingness to self-disclose and the perception of a therapist among Anglo- and Mexican-American college students. Subjects listened to an audiotape of a session in which either probing, disclosing, or reflecting statements were made by the interviewer. Subjects were then asked to imagine themselves in the role of the client and complete a questionnaire based on their reactions to the interviewer. No differences were found in subjects' willingness to disclose to or perception of the therapist based upon subject ethnicity, therapist technique, or subject gender. However, in another analogue study, Folensbee et al. (1986) had Puerto Rican community college students participate in actual interviews in which a counselor used either affective responses or closed questions. Students rated counselors higher on a counselor rating form when affective responses rather than closed questions were employed. In addition, Puerto Rican students were found to use significantly more self-referent pronouns, present tense verbs, and affect words in the affective response condition than in the closed question condition.

Clinical sensitivity training. As mentioned earlier, development of cultural sensitivity training for therapists has been an important trend toward providing effective services to minority populations (Acosta, 1984; Acosta et al., 1982; De La Cancela & Guzman, 1991; Lefley, 1985; Lopez et al., 1989). In an article reviewing clinical and empirical findings on psychotherapy with Mexican-Americans, Acosta (1984) described a research project investigating the orientation of therapists to low-income and minority patients at the Los Angeles County–University of Southern California Medical Center's Adult Psychiatric Outpatient Clinic. The orientation program consisted of a series of seminars whose topics were drawn from the book *Effective Psychotherapy for Low-Income and Minority Patients* (Acosta et al., 1982). Postprogram evaluations showed that therapists had significantly increased their knowledge and sensitivity in dealing with low-income and minority patients, and patient follow-up data suggested that therapists may have been more effective as a result of the orientation program (Evans, Acosta, Yamamoto, & Skilbeck, 1984; Yamamoto, Acosta, Evans, & Skilbeck, 1984). Another program mentioned earlier, Cross-Cultural Training for Mental Health Professionals, has also been evaluated positively for increasing the effectiveness of therapists in treating Latinos

(Lefley, 1985). Thus, preliminary research supports the efficacy of cultural sensitivity training; however, further empirical research needs to be done to replicate the findings of these studies.

Situational or treatment variables. While the need for culturally sensitive treatments for minority populations has been argued, there has been limited research into the effectiveness of services for Latinos other than by indirect indexes such as treatment utilization, premature termination, and treatment duration. There have been no comparisons between the effectiveness of mainstream and culturally sensitive services. Thus, research has tended to focus on either mainstream treatments or culturally sensitive treatments, although recent studies on cultural modification of treatments have begun to bridge the gap. A burgeoning literature on the effectiveness of culturally sensitive treatments has dominated the treatment outcome literature and, in general, has shown positive results in terms of effectiveness with particular Latino groups.

Family therapy. A number of scholars believe that the family plays an essential role for Latinos as a source of help and support (Acosta, 1984; Rogler et al., 1983; Rogler et al., 1989). Utilizing the family within treatment intervention has been advocated as potentially useful for Latino-Americans (Padilla & De Snyder, 1985). In a study comparing structural family therapy, individual psychodynamic child therapy, and a recreational control condition for Latino boys with behavioral and emotional problems, Szapocnik et al. (1989) found that both structural family therapy and individual psychodynamic child therapy were more effective than the control condition in limiting dropout and retaining cases. There were no significant differences found in the reduction of emotional and behavioral problems between the treatment conditions. However, upon follow-up, families whose child had been in individual psychodynamic child therapy were found to have deteriorated with regard to functioning, in direct contrast to those in the structured family therapy condition, where family functioning continued to improve, and the control condition, in which family functioning remained the same. Given this marked difference between conditions at follow-up, the long-term impact of intervention on family functioning appears to be an important consideration in the choice of particular therapies for Latino children.

Group therapy. The group therapy format has been advocated as useful with Latinos in certain contexts (Acosta & Yamamoto, 1984). An empirical study by Comas-Diaz (1981) compared the effects of cognitive and behavioral group therapy for depressed Puerto Rican women. Both treatment groups were found to have improved significantly more than a control condition. More recent studies with Puerto Rican children and adolescents that did compare different types of group interventions have demonstrated the efficacy of a group format (Costantino, Malgady, & Rogler, 1986; Malgady et al., 1990b). These studies are described later.

Acosta (1982) has suggested that group psychotherapy with Spanish-speaking Latino patients might be an important treatment option to consider given the scarcity of Spanish-speaking therapists. While experiential reports have tended to support the group approach as a viable form of treatment with Latinos, other factors, which remain to be empirically investigated, should be taken into consideration. Acosta (1982) recounts that Spanish-speaking patients were initially more likely to accept individual therapy over group therapy. Language fluency also is important. Philipus (1971) reported that Mexican-Americans with various English language capacities had higher dropout rates when the group was conducted in English.

Patient orientation programs. Clients of low socioeconomic backgrounds have been found to be more likely to drop out of treatment, and Rogler et al. (1983) propose that this factor may be of relevance for many Latinos. Acosta, Evans, Yamamoto, and Wilcox (1980) developed a brief audiovisual orientation program for low-income clients to enable them to understand the process of psychotherapy and act upon that understanding in therapy (e.g., be able to openly express problems and needs). As noted earlier, in an evaluation of this orientation program, low-income, Latino- and African-American and white patients who participated in the orientation program were found to be more knowledgeable and positive in their attitudes toward psychotherapy than those who participated in a control condition (Acosta et al., 1983).

Culturally specific treatments. One of the most dynamic and innovative areas of psychotherapy research with Latinos has been the development of culturally sensitive treatment modalities. Examples of developed or currently developing treatments include Szapocznik's Life Enhancement Therapy for Cuban Elders and Bicultural Effectiveness Training; Maldonado-Sierra and Trent's group therapy for Puerto Rican schizophrenics; LeVine and Padilla's pluralistic counseling, hero/heroine modeling for Puerto Rican adolescents; the Unitas Therapeutic Community in New York for children; and cuento (folktale) therapy for Puerto Rican children (Costantino et al., 1986; Malgady, Rogler, & Costantino, 1990a; Padilla & De Snyder, 1985; Rogler et al., 1983). While the effectiveness of

many of these treatments remains to be determined, those that have been subject to empirical study have been shown to be useful.

Cuento therapy utilizes *cuentos*, or folktales, to convey morals and models of adaptive behavior to children. The effectiveness of two types of cuento therapy, art/play therapy, and no intervention for high-risk kindergarten through third-grade Puerto Rican children was studied by Costantino et al. (1986). They found that there was a significant effect due to treatment, and a significant interaction between treatment and grade level, with differences between treatments only at the first-grade level. First-grade children who had received cuento therapy showed significantly less trait anxiety than those in the other groups after 20 weeks of treatment. Cuento therapy was more effective than no intervention in reducing trait anxiety, but it did not significantly differ from art/play therapy. In addition, cuento therapies significantly increased scores on the WISC-R comprehension subtest compared to art/play therapy and no intervention. In studies supporting the effectiveness of cuento therapy for Puerto Rican children, Malgady et al. (1990a, 1990b) found that cuento therapy had significant effects on anxiety, social judgment, and aggression.

Because cuento therapy seemed most effective with younger children and was perhaps age-inappropriate for older children, Malgady et al. (1990a) developed hero/heroine modeling for high-risk Puerto Rican adolescents. This social learning–based intervention used biographies of famous Puerto Rican historical individuals to convey appropriate adult role models. While there was no significant treatment effect on symptom distress, treatment did significantly affect ethnic identity. Interestingly, the effect of treatment on adolescents' self-concept varied as a function of sex and the presence or absence of the adolescent's father living in his or her household. In households where the father was absent, self-concept was enhanced by treatment; however, for those adolescents whose father was present, treatment did not affect the males' self-concept and adversely affected the females' self-concept. Malgady et al. speculate that the presentation of heroic figures may have resulted in negative outcomes because those who did have parental role models may have compared their parents to the heroic figures with resulting feelings of personal inadequacy.

It does appear that the development of culturally specific treatment for Latinos has yielded hopeful findings. However, as in the development of any treatment modality, care must be taken so that the negative effects of treatment are explored adequately.

EVALUATION OF RESEARCH METHODS AND THEORIES

Numerous methodological difficulties complicate any empirical inquiry into the process and efficacy of psychotherapy, and they have been well documented elsewhere (e.g., Kazdin, 1986). These problems include inadequate sample selection (Wolpe, 1977); inappropriate outcome criteria (Paul, 1967); ambiguity over the types of therapists and treatments used (Paul, 1967; Strupp, 1970); nonconvergence among outcome criteria (Garfield, Prager, & Bergin, 1971; Mintz, Luborsky, & Christoph, 1979); observational biases (Kent, O'Leary, Diament, & Dietz, 1974); incorrect statistical analysis of change (Manning & Du Bois, 1962); inappropriate designs for the outcome question being addressed (Kazdin, 1979; Paul, 1967); inadequate control groups (Jacobson & Baucom, 1977); uncertainty over the clinical and social value of the magnitude of change produced by treatment (Kazdin, 1977); and inadequate power in terms of design sensitivity (Kazdin & Bass, 1989). The purpose here is to examine the specific methodological and conceptual problems that have limited or complicated efforts to examine the influence of ethnicity and culture on psychotherapy processes and outcomes. These issues include types of research questions asked, reliance on analogue studies, types of samples used, selection of appropriate measures, interethnic versus intraethnic comparison designs, and controlling for potential confounds with ethnicity/culture.

Research Strategies and Issues

Research questions. Too often the research question posed has not directly addressed specific processes or outcomes of psychotherapy. Studies tend to be descriptive in nature, focusing on ethnic comparisons in values, personality styles, role relationships, and so on. A number of important implications for psychotherapy have been identified, but the actual functional relationship between these ethnic differences in values or other variables and psychotherapy process or outcome has not been ascertained. For example, Fukuyama and Greenfield (1983) found that Asians were less assertive in a number of behaviors, suggesting that Asians placed greater value on maintaining harmony in relationships. Although these findings would suggest that assertion therapy may not be as effective with Asians or that assertiveness on the part of Asians would vary depending on the target person selected in the intervention (e.g., stranger vs. family member), no outcome study has followed up on

this study and empirically tested these possible hypotheses.

Selection of a certain research strategy is partially guided by the initial conceptualization of culturally related variables in the study. Studies have varied greatly in the manner by which they have operationalized cultural variables. It often has been assumed that ethnic affiliation is an adequate representation of cultural variation. However, ethnic differences and cultural differences are not equivalent and a distinction must be made between the two. Ethnic differences involve differences in group membership (i.e., a type of social identity) that *implies* differences in culture. Cultural differences refer to variations in attitudes, values, and perceptual constructs that result from different cultural experiences. As Zane and Sue (1991) have noted,

> *Whereas the former [ethnic differences] simply involves group membership, the latter [cultural differences] constitutes a host of cognitive variables which are linked to different cultural lifestyles and perspectives. These cognitive variables, and not ethnic membership, have been the ones implicated in culture-related problems for psychotherapists. . . . Ethnic match research, while important, has not directly tested the cultural difference hypothesis of treatment. (p. 52)*

Ethnic differences are only indirect indexes of the more important cultural differences that tend to be more proximal to psychotherapy processes and outcomes. The question usually asked is: Does a certain ethnic group (compared to other ethnic groups) benefit more or less from treatment? It would be far more informative to address this question: Do differences between ethnic groups on culturally relevant variables (e.g., values, role relationships) affect a certain process or outcome in treatment? Essentially, the study of cultural influences is the study of individual difference variables that are associated with ethnic group experiences.

Use of analogue studies. In analogue studies, specific problems exist that result from the examination of cultural influences. First, it is questionable if the brevity and simulated nature of the treatment sessions in most analogue designs allow for the sensitive testing of cultural or ethnic effects. For example, studies on Latinos have found little ethnic effects in therapist credibility (e.g., Furlong et al., 1979; Hess & Street, 1991). However, Acosta et al. (1980) have noted how many ethnic minority and low-income clients have little familiarity with the process of psychotherapy. With little understanding, rating the credibility of one's therapist may have little functional meaning for many ethnic minority clients at the initial stages of treatment. Second, the reliance of analogues on student samples may restrict variation in acculturation and ethnic identity. Both of these variables have been identified as important predictors of process in treatment. Most student samples tend to be more acculturated, but also more ethnically conscious. The restriction of range on acculturation and ethnic identity limits generalizability but, more importantly, limits the design's sensitivity in testing for cultural effects as operationalized by these two variables. Finally, analogues may curtail the range of clinical problems that are typically presented by ethnic clients having real problems. Issues such as racism, cultural adjustment, ethnic identity conflicts, and intergenerational difficulties are more frequently presented by ethnic clients.

Samples selected. The heterogeneity within each ethnic minority group has often been noted by researchers (e.g., K. Clark, 1972; Leong, 1986). For each group, there are important variations in sociodemographics and psychosocial characteristics that include country of origin, immigration history (length of stay in refugee camps, immigrant vs. refugee status), place of residence (urban vs. rural, urban vs. reservation), education level (in both the United States and country of origin), motivation for leaving country of origin, acculturation level, socioeconomic level, English proficiency, ethnic identification, and preferred language, among others. Despite this documented diversity, only recently have studies articulated the specific samples used in the research. When efforts are made to examine this within-group diversity, important relationships are frequently found. For example, Pomales and Williams (1989) assessed the acculturation level of Puerto Rican and Mexican college students in both Latino- and Anglo-American culture. In responding to a directive or nondirective style, Latino-acculturated students rated the nondirective therapist as more credible than did bicultural students. On the other hand, Anglo-acculturated students found the therapist more trustworthy than did bicultural or Latino-acculturated students regardless of therapist style. By not identifying subgroup characteristics (e.g., level of acculturation, tribal affiliation, different Asian groups, and different Latino groups), it is difficult to determine to what extent the findings can truly be generalized to the various subpopulations within a particular ethnic group. Moreover, the systematic investigation of critical treatment processes is difficult because it is unclear if studies of a particular ethnic group are comparable.

One of the most significant reasons for sampling difficulties is the relatively small populations of ethnic minority groups. Small population size creates problems in trying to find not only representative samples for study but also adequate numbers of subjects. For example, finding a sufficient sample of American Indians who are using mental health services is extremely difficult.

Selection of appropriate measures. Ethnic and cultural differences can be obscured by the use of unreliable, invalid, or insensitive measures. Many investigators have pointed to methodological and conceptual problems in the assessment of ethnic minority group individuals. These problems include clinical assessments that overpathologize or underpathologize the symptoms of ethnic clients (Helms, 1992; Levine & Padilla, 1980; Lopez, 1989; Marcos et al., 1973; Neighbors et al., 1989); evaluations based on norms developed on white populations (LaFromboise, 1988; Rogler et al., 1989); conceptual and scalar nonequivalence of measures across different cultural groups (Helms, 1992; Hui & Triandis, 1985); difficulties in administering instruments to limited-English-speaking clients or in making adequate translations (Brislin et al., 1973); and cultural differences in approaching assessment tasks (Manson & Trimble, 1982; D. Sue & Sue, 1987). Despite widespread concern over the cross-cultural validity of assessment measures, the nature of cultural bias has not been empirically examined to any great extent, and solutions for cultural bias have been difficult to find. In the past, clinical and personality assessments of ethnic minorities have proceeded without the benefit of validation studies, and diagnosticians and clinicians have simply been admonished to take into account cultural differences and to avoid making strong conclusions on the basis of the assessment results. Often when a popularly used instrument is finally tested on ethnic minority populations, the instrument is not widely used among these groups because another, more recent, and sophisticated measure is developed for the rest of the country. This results in the situation in which the assessment of ethnic minority populations frequently lags behind, and ethnic minorities are given assessment instruments of unknown validity for their particular ethnic group.

Inter- and intraethnic comparison designs. Two general strategies have dominated the examination of cultural influences in psychotherapy. Studies have used either interethnic designs involving comparisons between ethnic groups (usually ethnic minority with whites) or intraethnic designs in which comparisons are made within a group with respect to different levels of acculturation or ethnic identity. Some studies have used a combination of these two approaches. Interpretations of the research have implicitly assumed that interethnic comparisons are an extension for the intraethnic approach in that the white comparison group represents the most acculturated level of the culture variable. Usually it is assumed that whites are a homogeneous, highly acculturated group, but no study has assessed if this is actually the case. As indicated earlier, ethnic affiliation appears to be a more distal variable than acculturation with respect to treatment process and outcome. Therefore, it is unclear if the two approaches are functionally related.

Potential confounds. Many studies have failed to control for variables that may be confounded with ethnicity or culture. Research has consistently found that variables such as socioeconomic status, education level, place of residence, and English proficiency covary with ethnicity or culture. By not assessing these variables, questions of internal validity can be raised about much of the previous research. Moreover, these studies have missed opportunities for increasing design sensitivity (by covarying out their effects) because some of these variables have been identified as correlates of treatment outcome (Luborsky et al., 1971).

Role of Culture

Probably the most challenging issue for ethnic mental health researchers has been the development of viable strategies for specifically examining the role of culture in psychotherapy process and outcome. In other words, it has often been difficult to incorporate variables directly related to cultural experiences into psychotherapy research designs. Three conceptual issues have complicated this task; the distal nature of ethnicity, limitations of traditional outcome designs, and the lack of conceptual or theoretical approaches to guide the research.

Distal nature of ethnic variables. Earlier it was noted that ethnicity implies certain cultural differences, and it is these differences that should serve as the focus of process and outcome studies. The focus on the broad concept of ethnicity often has obscured important variations within both the ethnic minority *and* white groups that could be related to treatment outcome. In other words, cultural differences involve important intervening variables between the ethnicity of the client and clinical outcomes. The cultural-difference approach facilitates the integration of cultural findings with other psychotherapy research because many of these vari-

ables (e.g., coping styles) have also been the focus of previous studies on process and outcome.

Limitations of outcome research. Lack of specific guidelines as to what constitutes culturally responsive treatment for ethnic minorities cannot be solely attributed to problems in ethnic minority mental health research. Progress in this area is also constrained by limitations in clinical outcome research, in general. Often it is unclear what actually happens to the client in mental health interventions. Treatments may not be well articulated in terms of their rationale, the underlying theory on which they are based, the specific methods employed, or the specific outcomes expected from therapy.

Even when treatment procedures have been clearly delineated, the extent to which therapists and clients have complied with or carried out the therapeutic tasks is often unclear. This source of treatment ambiguity involves problems in procedural reliability, which refers to the degree to which the treatment has been implemented in accordance with the experimental plan. This problem is a critical one because it appears that procedural slippage can occur for both clients (Taylor, Agras, Schneider, & Allen, 1983) and therapists (Billingsley, White, & Munson, 1980).

Another source of treatment ambiguity centers on problems in defining the end points of therapy tasks, namely, the types of learning experiences that a client should have upon completion of the treatment procedures. What are the insights, emotional catharses, or skills that clients are supposed to experience or gain during the course of psychotherapy? Often this is not clear.

Lack of conceptual/theoretical models. Within the context of program evaluation, Weiss (1972) has distinguished between a program failure as opposed to a theory failure. Programs attempt to activate a "causal process" that then leads to some desired effect. Program failure occurs when the intervention has not been successfully implemented. Theory failure occurs when the program is successful in producing the intended impact but the resultant causal process does not lead to the desired end goals. In a similar manner, treatment failure with ethnic minorities can involve either procedure or theory failure. The treatment may be ineffective because its procedures did not have the expected impact; the targeted learning experiences did not occur because the treatment as implemented may have clashed with certain cultural values held by the client or adversely affected certain peer or family relations supporting the client's adaptive behavior. On the other hand, the theory on which the treatment is based may not be sufficiently applicable to ethnic minority individuals, families, or communities. In this case, achievement of the desired changes in treatment would not be related to the mental health problem, and little improvement would result.

Few conceptual or theoretical models or approaches have been proposed to guide process and outcome research with ethnic minorities. Most conceptual schemes have focused on specific concrete recommendations for treating ethnic minorities with few ties to current theories of psychotherapy (Cervantes & Castro, 1985). What is needed are approaches that propose specific hypotheses as to how the psychosocial experiences of ethnic minorities affect certain important processes in psychotherapy.

CONCLUDING COMMENTS

We have attempted to indicate some of the major research findings on treatment outcomes and processes and to point to methodological and conceptual problems in the study of ethnic minority groups. In closing, we would like to highlight several points.

First, there is limited research on ethnic minority groups and the research is not highly programmatic. Because of the paucity of knowledge and baseline information, many studies have been descriptive and problem oriented rather than theoretical in nature. The following questions have been posed by researchers: Is psychotherapy effective for ethnic minority clients? What are the utilization and dropout rates? Which individual differences affect treatment, and how can therapy be modified and improved? Addressing these basic questions is important because they lay the foundation for other, more specific research issues that have not been adequately researched even now, and they have implications for programs and policies. Nevertheless, there is also a need for programmatic research that focuses on more theoretical issues: Why do we see underutilization of services by some ethnic groups? Why are culturally responsive or culturally congruent forms of treatment effective? A more theoretical focus is occurring in some areas, such as preferences for the ethnicity of the therapist and client's stage of ethnic identity. The field is in need of this kind of programmatic research, which helps to improve ideas, theories, and methodologies and to stimulate other research.

Second, although many researchers and practitioners believe that psychotherapy is ineffective

with members of ethnic minority groups, providing a definitive answer based on research findings is not possible. The reason is that there are only a few available empirical studies and the question of the effectiveness of psychotherapy is complex, requiring more than an affirmative or negative response. If we put aside the subtleties and complexity involved in the question of overall effectiveness, we have some reason to believe that certain conditions are related to effectiveness: ethnic similarity for clients and therapists of some ethnic minority groups; the use of some culturally responsive forms of treatment; pretherapy intervention with ethnic clients; and the training of therapists to work with members of culturally diverse groups. The most meaningful research, therefore, deals with conditions of effectiveness rather than with attempts to answer the effectiveness question in general.

Third, research on ethnic minority groups is difficult to conduct. Throughout this chapter, we have noted the problems in conducting research—for example, difficulties in finding adequate samples, achieving representativeness in sampling, devising cross-culturally valid measures, applying existing theories, and so on. Ethnic researchers must often confront additional methodological and conceptual problems that are not encountered to the same extent by other researchers. These problems mean that for ethnic research to be more programmatic, rigorous, and sophisticated, greater resources are needed (e.g., personnel training, and research funding).

Fourth, and related to the second point, the heterogeneity of ethnic minority groups is an increasingly salient characteristic to consider. The research is going beyond the evaluation of treatment issues for African-Americans, American Indians, and others as ethnic groups. Rather, the focus is now on individual differences within a particular group.

These four points as well as our analysis of conceptual and methodological problems have been well recognized by ethnic researchers. As mentioned in the introductory comments, this critical review should be placed in proper perspective. Major advances in ethnic minority research have been made, knowledge has substantially improved because of the pioneering work of many scholars, and the viewpoints of "insiders" to the groups (i.e., ethnic minority researchers) have increasingly been expressed. In closing, we would like to offer some personal comments and observations about ethnic minority research.

Ethnic minority research in general, and ethnic psychotherapy research in particular, was largely initiated on African-Americans because of the long oppressive history of black–white relations in this country and the need to address these relations. The research established the major parameters for investigation: differences in cultural values and lifestyles between African-Americans and white Americans and the effects of racism. Indeed, these parameters are pertinent to the study of American Indians, Asian-Americans, and Latino-Americans, and much work on these groups has been patterned after the research and theories developed on African-Americans.

More recent literature on the different ethnic groups demonstrates a more ethnic-specific focus. That is, each group is beginning to more clearly define its own concerns and needs and to focus research efforts on these needs. For example, the responsiveness of mental health services for African-Americans is of concern, as it is for the other groups. However, additional issues such as the underutilization of services among Asian-Americans and Latino-Americans are also salient. Unlike African-Americans and American Indians, Asian-Americans and Latino-Americans are largely voluntary immigrants to this country. Language differences, separation from other kin who reside in the "old country," and adjustment to a new culture are important. American Indians who live on reservations are more isolated from mainstream American culture than are, say, Latino-Americans living in urban ethnic communities. Many American Indians have experienced cultural genocide—the destruction of traditional folkways. Using culturally based psychotherapy approaches serves not only to increase treatment effectiveness, but also to reaffirm those cultural folkways. As indicated previously, much research has been conducted by Helms and her colleagues (e.g., Carter & Helms, 1992) on the role of ethnic identity in psychotherapy among African-Americans. For Latino-Americans, ethnic identity is also important but it is part of larger issues —acculturation and assimilation (Padilla, 1980). With the continuing immigration of Latinos to this country, there is a constant source of cultural values coming from Latino "homelands." Also, many first-generation individuals, born and raised in another country, do not seem to have the identity issues faced by American-born ethnics who grow up as members of a minority group. Issues of undocumented aliens are also pertinent to Asian-Americans and Latino-Americans. The point is that in trying to understand ethnic populations, ethnicity, culture, and minority group status are important variables that are being redefined for each group.

REFERENCES

Abramowitz, S. I., & Murray, J. (1983). Race effects in psychotherapy. In J. Murray & P. Abramson (Eds.), *Bias in psychotherapy* (pp. 215–255). New York: Praeger.

Acosta, F. X. (1982). Group psychotherapy with Spanish-speaking patients. In R. M. Becerra, M. Karno, & J. I. Escobar (Eds.), *Mental health and Hispanic Americans* (pp. 183–197). New York: Grune & Stratton.

Acosta, F. X. (1984). Psychotherapy with Mexican Americans: Clinical and empirical gains. In J. L. Martinez, Jr., & Richard H. Mendoza (Eds.), *Chicano psychology* (pp. 163–189). Orlando, FL: Academic Press.

Acosta, F. X., & Cristo, M. H. (1981). Development of a bilingual interpreter program: An alternative model for Spanish-speaking services. *Professional Psychology, 12,* 474–482.

Acosta, F. X., Evans, L. A., Yamamoto, J., & Wilcox, S. A. (1980). Helping minority and low-income psychotherapy patients "Tell it like it is." *The Journal of Biocommunication, 7,* 13–19.

Acosta, F. X., & Sheehan, J. G. (1976). Preferences toward Mexican American and Anglo American psychotherapists. *Journal of Consulting and Clinical Psychology, 44,* 272–279.

Acosta, F. X., & Yamamoto, J. (1984). The utility of group work practice for Hispanic Americans. *Social Work with Groups, 7,* 63–73.

Acosta, F. X., Yamamoto, J., & Evans, L. A. (1982). *Effective psychotherapy for low-income and minority patients.* New York: Plenum.

Acosta, F. X., Yamamoto, J., Evans, L. A., & Skilbeck, W. M. (1983). Preparing low-income Hispanic, Black, and White patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology, 39,* 872–877.

Akutsu, P. D., Lin, C. H., & Zane, N. W. S. (1990). Predictors of utilization intent of counseling among Chinese and White students: A test of the proximal–distal model. *Journal of Counseling Psychology, 37,* 445–452.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

Arkoff, A., Thaver, F., & Elkind, L. (1966). Mental health and counseling ideas of Asian and American students. *Journal of Counseling Psychology, 13,* 219–223.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist, 11,* 79–92.

Atkinson, D. R. (1986). Similarity in counseling. *The Counseling Psychologist, 14,* 319–354.

Atkinson, D. R., Furlong, M. J., & Poston, W. C. (1986). Afro-American preferences for counselors characteristics. *Journal of Counseling Psychology, 33,* 326–330.

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 36,* 209–212.

Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology, 25,* 76–85.

Atkinson, D. R., Morten, G., & Sue, D. W. (1993). *Counseling American minorities: A cross-cultural perspective.* Dubuque, IA: Wm. C. Brown.

Atkinson, D. R., Ponce, F. Q., & Martinez, F. M. (1984). Effects of ethnic, sex, and attitude similarity on counselor credibility. *Journal of Counseling Psychology, 31,* 588–590.

Atkinson, D. R., Poston, W. C., Furlong, M. J., & Mercado, P. (1989). Ethnic group preferences of counselor characteristics. *Journal of Counseling Psychology, 36,* 68–72.

Banks, W. M. (1972). The differential effects of race and social class in helping. *Journal of Clinical Psychology, 28,* 90–92.

Barbarin, O. A. (1984). Racial themes in psychotherapy with Blacks: Effects of training on the attitudes of Black and White psychiatrists. *American Journal of Social Psychology, 4,* 13–20.

Beiser, M., & Attneave, C. L. (1982). Mental disorders among Native American children: Rates and risk periods for entering treatment. *American Journal of Psychiatry, 139,* 193–198.

Bennett, S. K. & BigFoot-Sipes, D. S. (1991). American Indian and white college student preferences for counselor characteristics. *Journal of Counseling Psychology, 38,* 440–445.

Berg, J. H., & Wright-Buckley, C. (1988). Effects of racial similarity and interviewer intimacy in a peer counseling analogue. *Journal of Counseling Psychology, 35,* 377–384.

Bernal, M. E., & Padilla, A. M. (1982). Status of minority curricula and training in clinical psychology. *American Psychologist, 37,* 780–787.

Billingsley, F., White, O. R., & Munson, R. (1980). Procedural reliability: A rationale and an example. *Behavioral Assessment, 3,* 229–241.

Bishop, J. B., & Richards, T. F. (1987). Counselor intake judgments about White and Black clients in a university counseling center. *Journal of Counseling Psychology, 34,* 96–98.

Bobo, J. K., Gilchrist, L. D., Cvetkovich, G. T., Trimble, J. E., & Schinke, S. P. (1988). Cross-cultural service delivery to minority communities. *Journal of Community Psychology, 16,* 263–272.

Borrego, R. L., Chavez, E. L., & Titley, R. W. (1982). Effect of counselor technique on Mexican-American and Anglo-American self-disclosure and counselor perception. *Journal of Counseling Psychology, 29,* 538–541.

Boyd, N. (1982). Family therapy with Black families. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 227–249). New York: Praeger.

Brislin, R. W., Lonner, W. J., & Thorndike, R. W. (1973). *Cross-cultural research methods.* New York: Wiley.

Brown, B. S., Joe, G. W., & Thompson, P. (1985). Minority group status and treatment retention. *International Journal of the Addictions, 20,* 319–335.

Brown, T. R., Stein, K. M., Huang, K., & Harris, D. E. (1973). Mental illness and the role of mental health facilities in China town. In S. Sue & N. Wagner (Eds.), *Asian-Americans: Psychological perspectives* (pp. 212–231). Palo Alto, CA: Science & Behavior Books.

Bureau of Indian Affairs. (1991). *American Indians today* (3rd ed.). Washington, DC: U.S. Department of the Interior.

Carkhuff, R. R., & Pierce, R. (1967). Differential effects of therapist race and social class upon patient depth of self-exploration in the initial clinical interview. *Journal of Consulting Psychology, 31,* 632–634.

Carter, R. T., & Helms, J. E. (1992). The counseling process as defined by relationship types: A test of Helms' interaction model. *Journal of Multicultural Counseling and Development, 20,* 181–201.

Cervantes, R. C., & Castro, F. G. (1985). Stress, coping, and

Mexican American mental health: A systematic review. *Hispanic Journal of Behavioral Sciences, 7,* 1–74.

Chang, W. (1985). A cross-cultural study of depressive symptomatology. *Culture, Medicine, and Psychiatry, 9,* 295–317.

Cheung, F. M., & Lau, B. W. K. (1982). Situational variations of help-seeking behavior among Chinese patients. *Comprehensive Psychiatry, 23,* 252–262.

Chung, R. C. Y., & Okazaki, S. (1991). Counseling Americans of Southeast Asian descent: The impact of the refugee experience. In E. E. Lee & B. L. Richardson (Eds.), *Multicultural issues in counseling: New approaches to diversity* (pp. 107–126). Alexandria, VA: American Association for Counseling and Development.

Clark, K. B. (1972). Foreword. In A. Thomas & S. Sillen (Eds.), *Racism and psychiatry.* New York: Brunner/Mazel.

Clark, L. A. (1987). Mutual relevance of mainstream and cross-cultural psychology. *Journal of Consulting and Clinical Psychology, 55,* 461–470.

Comas-Diaz, L. (1981). Effects of cognitive and behavioral group treatment on the depressive symptomatology of Puerto Rican women. *Journal of Consulting and Clinical Psychology, 49,* 627–632.

Costantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Counseling and Clinical Psychology, 54,* 639–645.

Cross, W. E., Jr. (1971). The Negro-to-black conversion experience: Toward a psychology of black liberation. *Black World, 20,* 13–27.

Dauphinais, P., Dauphinais, L., & Rowe, W. (1981). Effects of race and communication style on Indian perceptions of counselor effectiveness. *Counselor Education and Supervision, 21,* 72–80.

Dauphinais, P., LaFromboise, T., & Rowe, W. (1980). Perceived problems and sources of help for American Indian students. *Counselor Education and Supervision, 20,* 37–46.

De La Cancela, V., & Guzman, L. P. (1991). Latino mental health service needs: Implications for training psychologists. In H. Myers, P. Wohlford, P. Guzman, & R. Echemendia (Eds.), *Ethnic minority perspectives on clinical training and services in psychology* (pp. 59–64). Washington, DC: American Psychological Association.

Evans, L. A., Acosta, F. X., Yamamoto, J., & Skilbeck, W. M. (1984). Orienting psychotherapists to better serve low income and minority patients. *Journal of Clinical Psychology, 40,* 90–96.

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal, 22,* 127–141.

Flaskerud, J. H., & Soldevilla, E. Q. (1986). Pilipino and Vietnamese clients: Utilizing an Asian mental health center. *Journal of Psychosocial Nursing, 24,* 32–36.

Folensbee, R. W., Draguns, J. G., Jr., & Danish, S. J. (1986). Impact of two types of counselor intervention on Black American, Puerto Rican, and Anglo-American analogue clients. *Journal of Counseling Psychology, 33,* 446–453.

Franklin, A. J. (1982). Therapeutic interventions with urban Black adolescents. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 267–295). New York: Praeger.

Fukuyama, M. A., & Greenfield, T. K. (1983). Dimensions of assertiveness in an Asian-American student population. *Journal of Counseling Psychology, 30,* 429–432.

Furlong, M. J., Atkinson, D. R., & Casas, J. M. (1979). Effects of counselor ethnicity and attitudinal similarity on Chicano students' perceptions of counselor credibility and attractiveness. *Hispanic Journal of Behavioral Science, 1,* 41–53.

Garfield, S. L., Prager, R. A., & Bergin, A. E. (1971). Evaluation of outcome in psychotherapy. *Journal of Consulting and Clinical Psychology, 37,* 307–313.

Gibbs, J. T. (1980). The interpersonal orientation in mental health consultation: Toward a model of ethnic variations in consultation. *Journal of Corhmunity Psychology, 8,* 195–207.

Gibbs, J. T., & Huang, L. N. (1989). *Children of color: Psychological interventions with minority youths.* San Francisco: Jossey-Bass.

Gim, R. H., Atkinson, D. R., & Kim, S. J. (1991). Asian-American acculturation, counselor ethnicity and cultural sensitivity, and ratings of counselors. *Journal of Counseling Psychology, 38,* 57–62.

Gim, R. H., Atkinson, D. R., & Whiteley, S. (1990). Asian-American acculturation, severity of concerns, and willingness to see a counselor. *Journal of Counseling Psychology, 37,* 281–285.

Gordon, M., & Grantham, R. J. (1979). Helper preferences in disadvantaged students. *Journal of Counseling Psychology, 26,* 337–343.

Green, C. F., Cunningham, J., & Yanico, B. J. (1986). Effects of counselor and subject race and counselor physical attractiveness on impressions and expectations of a female counselor. *Journal of Counseling Psychology, 33,* 349–352.

Griffith, M. S., & Jones, E. E. (1978). Race and psychotherapy: Changing perspectives. In J. H. Masserman (Ed.), *Current psychiatric therapies* (Vol. 18, pp. 225–235). New York: Grune & Stratton.

Guilmet, G. M., & Whited, D. L. (1987). Cultural lessons for clinical mental health practice for the Puyallup tribal community. *American Indian and Alaska Native Mental Health Research, 1,* 32–49.

Gurak, D. T., & Rogler, L. H. (1983). Hispanic diversity in New York City. In L. H. Rogler, R. C. Santana, G. Costantino, B. F. Earley, B. Grossman, D. T. Gurak, R. Malgady, & O. Rodriguez (Eds.), *A conceptual framework for mental health research on Hispanic populations* (pp. 59–65). Bronx, NY: Fordham University, Hispanic Research Center.

Harrison, D. K. (1975). Race as a counselor–client variable in counseling and psychotherapy: A review of the research. *The Counseling Psychologist, 5,* 124–133.

Havilland, M. G., Horswill, R. K., O'Connell, J. J., & Dynneson, V. V. (1983). Native American college students' preference for counselor race and sex and the likelihood of their use of a counseling center. *Journal of Counseling Psychology, 30,* 267–270.

Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A Black and White model. *Counseling Psychologist, 12,* 153–164.

Helms, J. E. (1992). Why is there no study of cultural equivalence in standardized cognitive ability testing? *American Psychologist, 47,* 1083–1101.

Helms, J. R., & Carter, R. T. (1991). Relationships of White and Black racial identity attitudes and demographic similarity to counselor preferences. *Journal of Counseling Psychology, 38,* 446–457.

Hess, R. S., & Street, E. M. (1991). The effect of acculturation on the relationship of counselor ethnicity and client ratings. *Journal of Counseling Psychology, 38,* 71–75.

Ho, M. K. (1976). Social work with Asian-Americans. *Social Casework, 57,* 195–201.

Hu, T. W., Snowden, L. R., Jerrell, J. M., & Nguyen, T. D. (1991). Ethnic populations in public mental health: Services choice and level of use. *American Journal of Public Health, 81,* 1429–1434.

Hui, C. H., & Triandis, H. C. (1985). Measurement in cross-cultural counseling: A review and comparison of strategies. *Journal of Cross-Cultural Psychology, 16,* 131–152.

Ibrahim, F. A. (1985). Effectiveness in cross-cultural counseling and psychotherapy: A framework. *Psychotherapy, 22,* 321–323.

Inkeles, A., & Levinson, S. J. (1969). National character: The study of modal personality and sociocultural systems. In G. Lindzey & E. Aronson (Eds.), *The handbook of social psychology.* Reading, MA: Addison-Wesley.

Ivey, A. E., Ivey, M. B., & Simek-Morgan, L. (1993). *Counseling and psychotherapy: A multicultural perspective.* Needham Heights, MA: Allyn & Bacon.

Jacobson, N. S., & Baucom, D. H. (1977). Design and assessment of nonspecific control groups in behavior modification research. *Behavior Therapy, 8,* 709–719.

Jackson, G. G., & Kirschner, S. A. (1973). Racial self-designation and preference for counselor race. *Journal of Counseling Psychology, 20,* 560–564.

Jackson, J. S., Neighbors, H. W., & Gurin, G. (1986). Findings from a national survey of Black mental health: Implications for practice and training. In M. R. Miranda & H. H. L. Kitano (Eds.), *Mental health research and practice in minority communities: Development of culturally sensitive training programs* (pp. 91–116). Washington, DC: U.S. Government Printing Office.

Jenkins, A. H. (1985). Attending to self-activity in the Afro-American client. *Psychotherapy, 22,* 335–341.

Jones, B. E., & Gray, B. A. (1983). Black males and psychotherapy: Theoretical issues. *American Journal of Psychotherapy, 37,* 77–85.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research, and Practice, 15,* 226–236.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology, 38,* 722–731.

Jones, E. E., & Matsumoto, D. R. (1982). Psychotherapy with the underserved. In L. Snowden (Ed.), *Services to the underserved* (pp. 207–228). Beverly Hills, CA: Sage Publications.

Jones, E. E., & Thorne, A. (1987). Rediscovery of the subject: Intercultural approaches to clinical assessment. *Journal of Consulting and Clinical Psychology, 55,* 488–496.

Jones, J. M. (1991). Psychological models of race: What have they been and what should they be? In J. D. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 3–46). Washington, DC: American Psychological Association.

Kazdin, A. E. (1977). Assessing the clinical or applied importance of behavior change through social validation. *Behavior Modification, 1,* 427–451.

Kazdin, A. E. (1979). Therapy outcome questions requiring control of credibility and treatment-generated expectancies. *Behavior Therapy, 10,* 81–93.

Kazdin, A. E. (1986). Comparative outcome studies of psychotherapy: Methodological issues and strategies. *Journal of Consulting and Clinical Psychology, 54,* 95–105.

Kazdin, A. E., & Bass, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. *Journal of Consulting and Clinical Psychology, 57,* 138–147.

Kent, R. N., O'Leary, K. D., Diament, C., & Dietz, A. (1974). Expectation biases in observational evaluation of therapeutic change. *Journal of Consulting and Clinical Psychology, 42,* 774–780.

Kim, B. L. C. (1973). Asian-Americans: No model minority. *Social Work, 18,* 44–54.

Kim, S. C. (1985). Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy, 22,* 342–348.

Kinzie, J. D., & Leung, P. (1989). Clonidine in Cambodian patients with post-traumatic stress disorder. *Journal of Nervous and Mental Disease, 177,* 546–550.

Kitano, H. H. L. (1981). Counseling and psychotherapy with Japanese-Americans. In A. J. Marsella & P. B. Pedersen (Eds.), *Cross-cultural counseling and psychology* (pp. 228–242). Elmsford, NY: Pergamon.

Kleinman, A. M. (1977). Depression, somatization and the new cross-cultural psychiatry. *Social Science and Medicine, 11,* 3–10.

Kleinman, A. M. (1979). *Patients and healers in the context of culture.* Berkeley: University of California Press.

Kline, F., Acosta, F. X., Austin, W., & Johnson, R. G. (1980). The misunderstood Spanish-speaking patient. *American Journal of Psychiatry, 137,* 1530–1533.

LaFromboise, T. D. (1988). American Indian mental health policy. *American Psychologist, 43,* 388–397.

LaFromboise, T. D., Dauphinais, P., & Rowe, W. (1980). Indian students' perceptions of positive helper attributes. *Journal of American Indian Education, 19,* 11–16.

LaFromboise, T. D., & Dixon, D. N. (1981). American Indian perception of trustworthiness in a counseling interview. *Journal of Counseling Psychology, 28,* 135–139.

LaFromboise, T. D., & Rowe, W. (1983). Skills training for bicultural competence: Rationale and application. *Journal of Counseling Psychology, 30,* 589–595.

LaFromboise, T. D., Trimble, J. E., & Mohatt, G. V. (1990). Counseling intervention and American Indian tradition: An integrative approach. *The Counseling Psychologist, 18,* 628–654.

Lee, E. (1982). A social systems approach to assessment and treatment for Chinese American families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 527–551). New York: Guilford.

Lee, J. C., & Cynn, V. E. H. (1991). Issues in counseling 1.5 generation Korean Americans. In E. E. Lee & B. L. Richardson (Eds.), *Multicultural issues in counseling: New approaches to diversity* (pp. 127–142). Alexandria, VA: American Association for Counseling and Development.

Lee, W. M. L., & Mixson, R. J. (1985). *An evaluation of counseling services by college students of Asian and Caucasian ethnicity.* Unpublished manuscript.

Lefley, H. P. (1985). Mental health training across cultures. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 259–266). Westport, CT: Greenwood Press.

Lefley, H. P., & Bestman, E. W. (1984). Community mental health and minorities: A multiethnic approach. In S. Sue & T. Moore (Eds.), *The pluralistic society: A community mental health perspective* (pp. 116–148). New York: Human Sciences Press.

Leong, F. T. L. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology, 33,* 196–206.

Lerner, B. (1972). *Therapy in the ghetto: Political impotence and personal disintegration.* Baltimore: The Johns Hopkins University Press.

Levine, E., & Franco, J. N. (1981). A reassessment of self-disclosure patterns among Anglo Americans and Hispanics. *Journal of Counseling Psychology, 28,* 522–524.

Levine, E. S., & Padilla, A. M. (1980). *Crossing cultures in therapy: Pluralistic counseling for the Hispanic.* Monterey, CA: Brooks/Cole.

Lin, K. M. (1986). Psychopathology and social disruption in refugees. In C. L. Williams & J. Westermeyer (Eds.), *Refugees and mental health.* Washington, DC: Hemisphere Publishing Corporation.

Li-Repac, D. (1980). Cultural influences on clinical perception: A comparison between Caucasian and Chinese-American therapists. *Journal of Cross-Cultural Psychology, 11,* 327–342.

Littrell, J., & Littrell, M. (1982). American Indian and Caucasian students' preferences for counselors: Effects of counselor dress and sex. *Journal of Counseling Psychology, 29,* 48–57.

Lopez, S. (1981). Mexican-American usage of mental health facilities: Underutilization reconsidered. In A. Baron, Jr. (Ed.), *Explorations in Chicano psychology* (pp. 139–164). New York: Praeger.

Lopez, S. R. (1989). Patient variable biases in clinical judgement: Conceptual overview and methodological considerations. *Psychological Bulletin, 106,* 184–203.

Lopez, S. R., Grover, K. P., Holland, D., Johnson, M. J., Kain, C. D., Kanel, K., Mellins, C. A., & Rhyne, M. C. (1989). Development of culturally sensitive psychotherapists. *Professional Psychology: Research and Practice, 20,* 369–376.

Lopez, S. R., Lopez, A. A., & Fong, K. T. (1991). Mexican Americans' initial preferences for counselors: The role of ethnic factors. *Journal of Counseling Psychology, 38,* 487–496.

Lorion, R. P. (1978). Research on psychotherapy and behavior change with the disadvantaged. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (pp. 903–938). New York: Wiley.

Lorion, R. P., & Felner, R. D. (1986). Research on psychotherapy with the disadvantaged. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 739–776). New York: Wiley.

Lorion, R. P., & Parron, D. L. (1985). Countering the countertransference: A strategy for treating the untreatable. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 79–86). Westport, CT: Greenwood Press.

Luborsky, L., Chandler, M., Auerbach, A. H., Cohen, J., & Bachrach, H. M. (1971). Factors influencing the outcome of psychotherapy: A review of quantitative research. *Psychological Bulletin, 75,* 145–185.

Lum, R. G. (1982). Mental health attitudes and opinions of Chinese. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 165–189). New York: Praeger.

Malgady, R. G., Rogler, L. H., & Costantino, G. (1987). Ethnocultural and linguistic bias in mental health evaluation of Hispanics. *American Psychologist, 42,* 228–234.

Malgady, R. G., Rogler, L. H., & Costantino, G. (1990a). Hero/heroine modeling for Puerto Rican adolescents: A preventive mental health intervention. *Journal of Counseling and Clinical Psychology, 58,* 469–474.

Malgady, R. G., Rogler, L. H., & Costantino, G. (1990b). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Counseling and Clinical Psychology, 58,* 704–712.

Manning, W. H., & Du Bois, P. H. (1962). Correlational methods in research on human learning. *Perceptual and Motor Skills, 15,* 287–321.

Manson, S. M. (1982). *New directions in prevention among American Indian and Alaska Native communities.* Portland, OR: Oregon Health Sciences University.

Manson, S. M., Shore, J. H., & Bloom, J. D. (1985). The depressive experience in American Indian communities: A challenge for psychiatric theory and diagnoses. In A. Kleinman & B. Good (Eds.), *Culture and depression* (pp. 331–368). Berkeley: University of California Press.

Manson, S. M., & Trimble, J. E. (1982). American Indian and Alaska Native communities: Past efforts, future inquiries. In L. R. Snowden (Ed.), *Reaching the underserved: Mental health needs of neglected populations* (pp. 143–164). Beverly Hills, CA: Sage.

Manson, S. M., Walker, R. D., & Kivlahan, D. R. (1987). Psychiatric assessment and treatment of American Indians and Alaska Natives. *Hospital and Community Psychiatry, 38,* 165–173.

Marcos, L. R., Urcuyo, L., Kesselman, M., & Alpert, M. (1973). The language barrier in evaluating Spanish-American patients. *Archives of General Psychiatry, 29,* 655–659.

Marsella, A. J., Kinzie, D., & Gordon, P. (1973). Ethnic variations in the expression of depression. *Journal of Cross-Cultural Psychology, 4,* 435–458.

Mays, V. M., & Albee, G. W. (1992). Psychotherapy and ethnic minorities. In D. K. Friedman (Ed.), *History of psychotherapy: A century of change* (pp. 552–570). Washington, DC: American Psychological Association.

McShane, D. (1988). An analysis of mental health research with American Indian youth. *Journal of Adolescence, 11,* 87–116.

Mintz, J., Luborsky, L., & Christoph, P. (1979). Measuring the outcomes of psychotherapy: Findings of the Penn Psychotherapy Project. *Journal of Consulting and Clinical Psychology, 47,* 319–334.

Mollica, R. F., Wyshak, G., Lavelle, J., Truong, T., Tor, S., & Yang, T. (1990). Assessment symptom change in Southeast Asian refugee survivors of mass violence and torture. *American Journal of Psychiatry, 147,* 83–88.

Moore, T., Nagata, D., & Whatley, R. (1984). Training community psychologists and other social interventionists: A cultural pluralistic perspective. In S. Sue & T. Moore (Eds.), *The pluralistic society: A community mental health perspective* (pp. 237–253). New York: Human Sciences Press.

Morten, G., & Atkinson, D. R. (1983). Minority identity development and preference for counselor race. *Journal of Negro Education, 52,* 156–161.

Muñoz, R. F. (1982). The Spanish-speaking consumer and the community mental health center. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 362–398). New York: Praeger.

Murase, K. (1977). Minorities: Asian-Americans. *Encyclopedia of Social Work, 2,* 953–960.

Myers, H. F., Wohlford, P., Guzman, L. P., & Echemendia, R. J. (1991). *Ethnic minority perspectives on clinical training and services in psychology.* Washington, DC: American Psychological Association.

Neighbors, H. W. (1985). Seeking professional help for personal problems: Black Americans' use of health and mental health services. *Community Mental Health Journal, 21,* 156–166.

Neighbors, H. W., Jackson, J. S., Campbell, L., & Williams, D. (1989). The influence of racial factors on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal, 25,* 301–311.

Neligh, G. (1988). Major mental disorders and behavior among American Indians and Alaska Natives [Monograph]. In *Behavioral health issues among American Indians and Alaska Natives: Explorations on the frontiers of the biobehavioral sciences. American Indian and Alaska Native Mental Health Research, 1,* 116–159.

Nishio, K., & Bilmes, M. (1987). Psychotherapy with Southeast Asian American clients. *Professional Psychology: Research and Practice, 18,* 342–346.

Nobles, W. W. (1980). African philosophy: Foundations for Black psychology. In R. Jones (Ed.), *Black psychology* (pp. 99–105). New York: Harper & Row.

O'Hare, W. P., & Felt, J. C. (1991). *Asian Americans: America's fastest growing minority group.* Washington, DC: Population Reference Bureau.

O'Sullivan, M. J., Peterson, P. D., Cox, G. B., & Kirkeby, J. (1989). Ethnic populations: Community mental health services ten years later. *American Journal of Community Psychology, 17,* 17–30.

Padilla, A. M. (1980). *Acculturation: Theory, models, and some new findings.* Boulder, CO: Westview Press.

Padilla, A. M., & Salgado De Snyder, N. (1985). Counseling Hispanics: Strategies for effective intervention. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 157–164). Westport, CT: Greenwood Press.

Parham, T. A., & Helms, J. E. (1981). The influence of Black students' racial identity attitudes on preferences for counselor's race. *Journal of Counseling Psychology, 28,* 250–257.

Parloff, M. B., Waskow, I. E., & Wolfe, B. E. (1978). Research on therapist variables in relation to process and outcome. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed., pp. 233–282). New York: Wiley.

Paster, V. S. (1985). Adapting psychotherapy for the depressed, unacculturated, acting-out, Black male adolescent. *Psychotherapy, 22,* 408–417.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology, 31,* 109–118.

Pedersen, P. B. (1986). Developing interculturally skilled counselors: A prototype for training. In H. P. Lefley & P. B. Pedersen (Eds.), *Cross-cultural training for mental health professionals* (pp. 73–89). Springfield, IL: Charles C Thomas.

Pekarik, G. (1986). The use of termination status and treatment duration patterns as an indicator of clinical improvement. *Evaluation and Program Planning, 9,* 25–30.

Philipus, M. J. (1971). Successful and unsuccessful approaches to mental health services for an urban Hispanic American population. *American Journal of Public Health, 61,* 820–830.

Pomales, J., Claiborn, C. D., & LaFromboise, T. D. (1986). Effects of Black students' racial identity on perceptions of White counselors varying in cultural sensitivity. *Journal of Counseling Psychology, 33,* 57–61.

Pomales, J., & Williams, V. (1989). Effects of level of acculturation and counseling style on Hispanic students' perceptions of counselor. *Journal of Counseling Psychology, 36,* 79–83.

Ponce, F. Q., & Atkinson, D. R. (1989). Mexican-American acculturation, counselor ethnicity, counseling style, and perceived counselor credibility. *Journal of Counseling Psychology, 36,* 203–208.

Ponterotto, J. G., Alexander, C. M., & Hinkston, J. A. (1988). Afro-American preferences for counselor characteristics: A replication and extension. *Journal of Counseling Psychology, 35,* 175–182.

Ponterotto, J. G., Anderson, W. H., & Grieger, I. Z. (1986). Black students' attitudes toward counseling as a function of racial identity. *Journal of Multicultural Counseling and Development, 14,* 50–59.

Porche, L. M., & Banikiotes, P. G. (1982). Racial and attitudinal factors affecting the perceptions of counselors by Black adolescents. *Journal of Counseling Psychology, 29,* 169–174.

Query, J. M. N. (1985). Comparative admission and follow-up study of American Indians and Whites in a youth chemical dependency unit on the North Central Plains. *The International Journal of the Addictions, 20,* 489–502.

Ramirez, M. (1991). *Psychotherapy and counseling with minorities. A cognitive approach to individual and cultural differences.* Elmsford, NY: Pergamon.

Ridley, C. R. (1984). Clinical treatment of the nondisclosing Black client: A therapeutic paradox. *American Psychologist, 39,* 1234–1244.

Rogler, L. H., Cooney, R. S., Costantino, G., Earley, B. F., Grossman, B., Gurak, D. T., Malgady, R., & Rodriguez, O. (1983). *A conceptual framework for mental health research on Hispanic populations.* Bronx, NY: Fordham University, Hispanic Research Center.

Rogler, L. H., Malgady, R. G., Costantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean?: The case of Hispanics. *American Psychologist, 42,* 565–570.

Rogler, L. H., Malgady, R. G., & Rodriguez, O. (1989). *Hispanics and mental health: A framework for research.* Malabar, FL: Krieger Publishing Company.

Root, M. P. P. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22,* 349–356.

Sanchez, A. R., & Atkinson, D. R. (1983). Mexican-American cultural commitment, preference for counselor ethnicity, and willingness to use counseling. *Journal of Counseling Psychology, 30,* 215–220.

Sattler, J. M. (1977). The effects of therapist–client racial similarity. In A. S. Gurman & A. M. Razin (Eds.), *Effective psychotherapy: A handbook of research* (pp. 252–290). Elmsford, NY: Pergamon.

Scheffler, R. M., & Miller, A. B. (1989). Demand analysis of mental health service use among ethnic subpopulations. *Inquiry, 26,* 202–215.

Schinke, S. P., Orlandi, M. A., Botvin, G. J., Gilchrist, L. D., Trimble, J. E., & Locklear, V. B. (1988). Preventing substance abuse among American-Indian adolescents: A bicultural competence skills approach. *Journal of Counseling Psychology, 35,* 87–90.

Shon, S. P., & Ja, D. Y. (1982). Asian families. In M. McGoldrick, J. K. Pearce, & J. Giordano (Eds.), *Ethnicity and family therapy* (pp. 208–228). New York: Guilford.

Snowden, L. R. (1982). *Reaching the underserved: Mental health needs of neglected populations.* Beverly Hills, CA: Sage.

Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by members of ethnic minority groups. *American Psychologist, 45,* 347–355.

Special Populations Subtask Panel on the Mental Health of Hispanic Americans. (1978). *Report to the President's Commission on Mental Health.* Los Angeles: University of California, Spanish Speaking Mental Health Research Center.

Stevens, G. (1981). Bias in the attribution of hyperkinetic behavior as a function of ethnic identification and socioeconomic status. *Psychology in the Schools, 18,* 99–106.

Strickland, T. L., Jenkins, J. O., Myers, H. F., & Adams, H. E. (1988). Diagnostic judgements as a function of client and therapist race. *Journal of Psychopathology and Behavioral Assessment, 10,* 141–151.

Strupp, H. H. (1970). Specific vs. nonspecific factors in psychotherapy and the problem of control. *Archives of General Psychiatry, 23,* 393–401.

Sue, D., & Sue, D. W. (1991). Counseling strategies for Chinese Americans. In C. C. Lee & B. L. Richardson (Eds.), *Multicultural issues in counseling: New approaches*

to diversity (pp. 79–90). Alexandria, VA: American Association for Counseling and Development.

Sue, D., & Sue, S. (1987). Cultural factors in the clinical assessment of Asian Americans. *Journal of Counseling and Social Psychology, 55,* 479–487.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice.* New York: Wiley.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32,* 616–624.

Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43,* 301–308.

Sue, S. (1991). Ethnicity and culture in psychological research and practice. In J. D. Goodchilds (Ed.), *Psychological perspectives on human diversity in America* (pp. 47–85). Washington, DC: American Psychological Association.

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

Sue, S., & Morishima, J. K. (1982). *The mental health of Asian-Americans.* San Francisco: Jossey-Bass.

Suinn, R. M., Richard-Figuerod, K., Lew, S., & Vigil, P. (1985). Career decisions and an Asian acculturation scale. *Journal of the Asian American Psychological Association, 10,* 20–28.

Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vazquez, A., Hervis, O., Posada, V., & Kurtines, W. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Counseling and Clinical Psychology, 57,* 571–578.

Tan, H. (1967). Intercultural study of counseling expectancies. *Journal of Counseling Psychology, 41,* 122–130.

Tanaka-Matsumi, J., & Marsella, A. J. (1976). Cross-cultural variations in the phenomenological experience of depression: I. Word association studies. *Journal of Cross-Cultural Psychology, 7,* 379–396.

Taylor, C. B., Agras, W. S., Schneider, J. A., & Allen, R. A. (1983). Adherence to instructions to practice relaxation. *Journal of Consulting and Clinical Psychology, 51,* 952–953.

Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among blacks. *Western Journal of Black Studies, 5,* 180–184.

Terrell, F., & Terrell, S. L. (1984). Race of counselor, client sex, cultural mistrust level, and premature termination from counseling among black clients. *Journal of Counseling Psychology, 31,* 371–375.

Tien, J. L., & Johnson, H. L. (1985). Black mental health client's preference for therapists: A new look at an old issue. *International Journal of Social Psychiatry, 31,* 258–266.

Tomine, S. I. (1991). Counseling Japanese Americans: From internment to reparation. In C. C. Lee & B. L. Richardson (Eds.), *Multicultural issues in counseling: New approaches to diversity* (pp. 91–106). Alexandria, VA: American Association for Counseling and Development.

Toupin, E. (1980). Counseling Asians: Psychotherapy in the context of racism and Asian-American history. *American Journal of Orthopsychiatry, 50,* 76–86.

Tracey, T. J., Leong, F. T. L., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology, 33,* 331–336.

Trimble, J. E., & LaFromboise, T. (1985). American Indians and the counseling process: Culture, adaption, and style. In P. Pedersen (Ed.), *Handbook of cross-cultural counseling and therapy* (pp. 127–134). Westport, CT: Greenwood Press.

True, R. (1975). Mental health services in a Chinese American community. In W. Ishikawa & N. Hayashi (Eds.), *Service delivery in Pan Asian communities.* San Diego: Pacific Asian Coalition.

Tseng, W. S., & McDermott, J. F. (1981). *Culture, mind, and therapy: An introduction to cultural psychiatry.* New York: Brunner/Mazel.

Tyler, F. B., Brome, D. R., & Williams, J. E. (1991). *Ethnic validity, ecology, and psychotherapy: A psychosocial competence model.* New York: Plenum.

U.S. Bureau of the Census (1990). *The Hispanic population in the United States: March 1989* (Series P-20, No.444). Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census (1991a). Published population census results for 1970 and 1980 and preliminary census figures for 1990. *Population Bulletin, 46,* Washington, DC: U.S. Government Printing Office.

U.S. Bureau of the Census (1991b). *The Hispanic population in the United States: March 1990* (Series P-20, No.449). Washington, DC: U.S. Government Printing Office.

Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17,* 351–383.

Vontress, C. E. (1988). An existential approach to cross-cultural counseling. *Journal of Multicultural Counseling and Development, 16,* 73–83.

Vraniak, D. A., & Pickett, S. A. (1992). Improving interventions with American ethnic minority children: Recurrent and recalcitrant challenges. In T. Kratchowill & R. Morris (Eds.), *The handbook of psychotherapy with children.* New York: Macmillan.

Wade, P., & Bernstein, B. (1991). Culture sensitivity training and counselor's race: Effects on Black female clients' perceptions and attrition. *Journal of Counseling Psychology, 38,* 9–15.

Wampold, E. E., Casas, J. M., & Atkinson, D. R. (1981). Ethnic bias in counseling: An information processing approach. *Journal of Counseling Psychology, 28,* 498–503.

Watkins, C. E., Jr., & Terrell, F. (1988). Mistrust level and its effects on counseling expectations in Black client–White counselor relationships: An analogue study. *Journal of Counseling Psychology, 35,* 194–197.

Watkins, C. E., Jr., Terrell, F., Miller, F.S., & Terrell, S. L. (1989). Cultural mistrust and its effects of expectational variables in Black client–White counselor relationships. *Journal of Counseling Psychology, 36,* 447–450.

Weiss, C. H. (1972). *Evaluation research.* Englewood Cliffs, NJ: Prentice Hall.

White, J. L. (1984). *The psychology of blacks: An Afro-American perspective.* Englewood Cliffs, NJ: Prentice Hall.

Wolpe, J. (1977). Inadequate behavior analysis: The Achilles' heel of outcome research in behavior therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 8,* 1–3.

Wong, H. (1977, June). *Community mental health services and manpower and training concerns of Asian Americans.* Paper presented to the President's Commission on Mental Health, San Francisco.

Wood, W. D., & Sherrets, S. D. (1984). Requests for outpatient mental health services: A comparison of Whites and Blacks. *Comprehensive Psychiatry, 25,* 329–334.

Wu, I. H., & Windle, C. (1980). Ethnic specificity in the

relationship of minority use and staffing of community mental health centers. *Community Mental Health Journal, 16*, 156–169.

Yamamoto, J., Acosta, F. X., Evans, L. A., & Skilbeck, W. M. (1984). Orienting therapists about patients' needs to increase patient satisfaction. *American Journal of Psychiatry, 141*, 274–277.

Yates, A. (1987). Current status and future directions of research on the American Indian child. *American Journal of Psychiatry, 144*, 1135–1142.

Yuen, R. K. W., & Tinsley, H. E. A. (1981). International and American students' expectations about counseling. *Journal of Counseling Psychology, 28*, 66–69.

Zane, N. (1983, August). *Evaluation of outpatient psychotherapy for Asian and non–Asian American clients*. Paper presented at the American Psychological Association Conference, Anaheim, CA.

Zane, N., & Hatanaka, H. (1988, October). *Utilization and evaluation of a parallel service delivery model for ethnic minority clients*. Paper presented at the Professional Symposium: Recent Trends and New Approaches to the Treatment of Mental Illness and Substance Abuse, Oklahoma Mental Health Research Institute, Tulsa.

Zane, N., & Sue, S. (1991). Culturally-respective mental health services for Asian Americans: Treatment and training issues. In H. Myers, P. Wohlford, P. Guzman, & R. Echemendia (Eds.), *Ethnic minority perpsectives on clinical training and services in psychology* (pp. 49–58). Washington, DC: American Psychological Association.

Zane, N., Sue, S., Castro, F., & George, W. (1982). Service system models for ethnic minorities. In L. R. Snowden (Ed.), *Reaching the underserved: Mental health needs of neglected populations* (pp. 229–258). Beverly Hills, CA: Sage.