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• DEDICATION •

This fifth edition of the Handbook is dedicated to the distinguished editors of the previous four editions, Allen E. Bergin and Sol S. Garfield. These mentors and friends have modeled the importance of critical appraisals of the field of psychotherapy. There is no doubt that their timely and tireless efforts have been an important contribution to enhancing the effectiveness of psychotherapy and patient care.

RESEARCH ON PSYCHOTHERAPY WITH CULTURALLY DIVERSE POPULATIONS

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The analysis of research on psychotherapy with ethnic minority clients (i.e., African Americans, American Indians, Asian Americans, and Latino/a Americans) is important. If we can identify those psychotherapeutic conditions that have universal applicability, then these conditions 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 it is important to consider psychotherapy research on ethnic minorities. First, about 30% of the population of the United States in 2000 was composed of ethnic minorities, and in California, ethnic minorities constitute the majority of the state's population (U.S. Census Bureau, 2001). Given the rapidly growing ethnic population, we are increasingly likely to encounter individuals from a variety of ethnic groups as clients. Intercultural skills in our roles as researchers and psychotherapists are

important to develop in an increasingly diverse society, yet few systematic investigations into these skills have been conducted, and training programs in clinical psychology have not fully utilized what is known about intercultural skills (Bernal & Castro, 1994). Second, there is evidence that ethnic minority groups are experiencing significant mental health problems. It is beyond the scope of our review to analyze the prevalence of psychopathology. However, available data suggest that overall prevalence rates for these groups are comparable to, or higher than, those in the general population (Hall, Bansal, & Lopez, 1999; Kessler et al., 1994; 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. In addition, some of the groups are disproportionately represented in vulnerable populations such as the homeless and poor (U.S. Surgeon General's Supplement to the Report on Mental Health, in press). Considerable controversy has existed for the past three decades over the effectiveness of traditional psychotherapeutic approaches for members of ethnic minority clients. Specifically, what evidence is there for the

efficacy of psychotherapy? What are the conditions that promote effectiveness? This chapter addresses these two questions. Psychotherapy research with ethnic minority groups helps determine the generalizability of psychological principles that have been developed primarily by and for European Americans.

We engage in a critical analysis of psychotherapy research on ethnic minorities, identifying the major empirical trends as well as discussing the major methodological and conceptual challenges. The present analysis is an update of our earlier review of research in this area (Sue, Zane, & Young, 1994). We continue to be impressed by the pioneering work of scholars in this area who strive to define and debate issues.

ETHNIC MINORITY GROUPS

Our discussion has relevance especially for groups that traditionally have been considered ethnic minorities. Such groups are commonly defined by cultural characteristics, ethnic identity, and minority group status. Other groups may indeed be included as ethnics or minorities. However, we shall focus on four groups along with Whites (which we define as non-Latino/a Whites). Although we recognize cultural differences between other groups such as White ethnics vs. non-White ethnics, people who live in urban and rural areas, Christians and Jews, men and women, and so on, it is beyond the scope of this chapter to include these groups.

It should be noted that the very terms used to refer to groups vary—for example, "Blacks" versus "African American"; "Native American" versus "American Indian"; "Asian" versus "Oriental"; "Hispanic" versus "Latino/a"; "Caucasian" versus "White." Although variations exist, we have decided to use the terms *African American, American Indian, Asian American, Latino/a American,* and *White* to refer to the groups. Furthermore, the term *ethnic minority* refers collectively to the four non-White groups because the phrase conveys culture and identity (ethnicity) as well as race and social status (minority status). *Ethnicity* involves shared social and cultural characteristics that have a bearing on psychological functioning (Sue, 1991). *Race* is a biologically based concept that may have some bearing on one's sociocultural identity but is dependent on the context in which one's sociocultural identity is developed. For example, the amount of social and cultural similarity between one person from a particular racial group and other racial groups often depends on the amount of contact the person has had with persons from the particular group. For our purposes, ethnicity is more germane than is race. Thus, the terms *ethnicity* and *ethnic minority* will be used in this chapter.

Knowing the cultural values of each ethnic group is only one critical facet of understanding the group. What must also be acquired is knowledge of the history of racial/ethnic relations in this country. 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. In addition, all four groups and Whites exhibit heterogeneity in terms of identification with their group, socioeconomic status, education, acculturation, psychopathology, and the like. (Jones, 1991; Phinney, 1996). Given this heterogeneity, discussions concerning groups such as American Indians, Asian Americans, and Whites often have a stereotypic quality. The different levels of discourse—whether the intent is to discuss between-group cultural differences or within-group variability—are important to distinguish (Phinney, 1996; 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. Members of a particular group may exhibit heterogeneity. However, the modal (i.e., average) characteristics of groups may show meaningful differences when between-group comparisons are made (Kwon, 1995). 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 group patterns. 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 place a higher value 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, Latino/a's are composed of individuals whose origin or family of origin is Mexico, the Caribbean, or Central or South America. American Indians are composed of hundreds of different tribes, and discussions of American Indians often include Alaskan Natives. Asian Americans include Chinese, Japanese, Koreans, Filipinos, Southeast Asians, and Pacific Islanders. Given this diversity, there are restrictions in terms of our ability to generalize findings even from a study of one subgroup to other subgroups within the same ethnic minority. In addition, research on a group (e.g., Latino/a Americans) may be largely based on one particular subgroup (e.g., Mexican Americans). For some subgroups 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).

Finally, the designation of "ethnic minority" has also been challenged in that some feel the term conveys a sense of inferiority. We acknowledge that the designation of "ethnic minority" is arbitrary. Their "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. Thus we clarify our intentions because we use a term that, by custom, is subject to misinterpretation.

Issues Discussed

There are few studies comparing the outcomes of treated and untreated groups of ethnic minority clients. Moreover, most researchers and practitioners have reformulated the therapeutic effectiveness question 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 five questions: (1) Do ethnic minority clients improve after undergoing psychotherapy (show positive pre-post treatment changes), (2) do clients from a particular ethnic group fare as well as other clients after

treatment (e.g., compared to Whites or compared to other ethnic groups), (3) are certain types of treatments more or less effective with ethnic minority clientele, (4) what client, therapist, situational, and treatment variables are associated with treatment outcomes and with progress in psychotherapy, and (5) what conceptual and methodological issues must be addressed in psychotherapy research on culturally diverse populations? The first three 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 indices such as utilization of services and treatment dropout rates. The fourth 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, to features of the treatment process such as pretherapy orientations and the incorporation of purportedly culturally relevant elements, or to situational variables such as the service delivery 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. Skepticism regarding the value of psychotherapy for ethnic minority clients 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 (e.g., Betz & Fitzgerald, 1993; Ramirez, 1999; Sue & Sue, 1999). 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 for these clients presumably is problematic. Furthermore, it is likely 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 with clients who are dissimilar in ethnicity, race, or culture (Clark, 1972; Garb, 1997; Whaley, 1998).

Much of the research on utilization indices related to treatment outcomes offers comparisons of the four different groups (often including

Whites as a comparison), so the groups are examined together rather than separately. However, in presenting the research on actual treatment outcome and treatment process, each group is discussed separately. The reason for this is that outcome and process research on each group has proceeded more or less separately, with certain issues esteemed as more salient for some groups than for 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. Although this methodology limits an accurate assessment of between-group comparisons, it affords the opportunity to discuss the outcome and process research separately for each group in order to see the level of work conducted on each group. Nevertheless, the quality of treatment process affects treatment outcome.

Client and therapist variables are categorized separately in this chapter based on the foci of the studies presented. However, it should be noted that most client variables are related implicitly to one or more therapist variables and vice versa. For example, preference for ethnicity of therapist is classified as a client variable, when ethnic match obviously depends on a given therapist characteristic—in this case, ethnicity. Similarly, therapeutic alliance depends on a relationship between therapist *and* client, implying that client variables are involved.

INDIRECT MEASURES OF OUTCOME FOR ETHNIC MINORITY GROUPS

Utilization rates, premature treatment termination, and length of treatment are commonly used as "indirect" indices of outcome. Utilization is defined as a help-seeking behavior in which the services of the mental health system are used. Premature termination occurs when the client drops out of treatment, presumably before receiving substantial psychotherapeutic benefits. Length of treatment is defined as the number of treatment sessions attended. Most studies have defined utilization as a comparison of 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 the 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 addition, in most ethnic comparisons, the White population has been used as the comparison group because it is the majority group. The wisdom of these assumptions and comparative procedures is debatable. However, ethnic differences on these indirect indices of outcome per se are important to investigate because they may reveal different patterns of effectiveness of services by ethnic group.

Utilization of Services

The results of utilization studies vary depending on the ethnic minority group examined. Some studies reveal that African Americans and American Indians overutilize services, whereas Asian Americans and Latino/a Americans underutilize services. One study involving 17 community mental health facilities in Seattle (Sue, 1977) found a pattern in which African Americans and American Indians overutilized services and Asian Americans and Latino/a's underutilized services. A second study of outpatient services in the entire Los Angeles County Mental Health System (Sue, Fujino, Hu, Takeuchi, & Zane, 1991) found a similar pattern in which African Americans overutilized services and Asian Americans and Latino/a's underutilized services. In a followup to the 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/a Americans. Other community studies have suggested that African Americans are less likely than are Whites to use mental health services (Kessler et al., 1994). Thus, there is evidence of ethnic differences in the utilization of mental health services, but consistent patterns of overutilization and underutilization have been found for only certain groups such as underutilization for Asian Americans. There is also evidence of ethnic differences in the referral process into mental health care. In a study of community mental health clinics that served predominantly poor populations in Los Angeles, African Americans (particularly men) were more likely than other ethnic groups to be involuntarily placed in psychiatric facilities (Takeuchi, Bui, & Kim, 1993; Takeuchi & Cheung, 1998).

Why do utilization differences exist? In Snowden and Cheung's (1990) analysis of hospitalization, several possible explanations were discussed, but none was considered sufficient to

explain the results. These differences included racial differences in socioeconomic background and rates of insurance for medical/mental health services, rates of psychopathology, help-seeking tendencies, diagnostic bias, and involuntary hospitalization. In addition, mental health providers are located primarily in urban areas, whereas many members of certain ethnic minority groups are located in rural areas of the country. Thus, access to facilities may hinder utilization rates by ethnic minorities. Utilization of inpatient and outpatient services may involve these factors and many others such as knowledge about and accessibility of facilities, attitudes, and values (e.g., feelings of shame or stigma), familiarity with Western forms of treatment, and presence of bilingual-bicultural staff. Indeed, Asian Americans and Latino/a Americans who show underutilization are predominantly foreign born and speak English as a second language or don't speak English at all. Furthermore, there is evidence that among minority groups 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 a number of factors may account for these differences.

Length of Treatment

Length of treatment can be considered an indirect indicator of treatment outcome because it has been consistently associated with treatment effects (Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971; see Lambert & Ogles, Chapter 5, this volume). A dose-response relationship has been identified in that clients' self-reported improvement is positively associated with their number of therapy sessions (Lambert et al., 2001). O'Sullivan and his colleagues (1989) did not find any consistent differences in dropout rates between ethnics and Whites at community mental health centers in Seattle. In the previously mentioned Los Angles County study, Sue et al. (1991) found that 19.4% of African Americans, 15.3% of Whites, 14.6% of Mexican Americans, and 10.7% of Asian Americans dropped out of treatment after one session. The group averages for number of treatment sessions attended were 6.3 for Asian Americans, 5.1 for Mexican Americans, 5.1 for Whites, and 4.0 for African Americans. These ethnic differences were statistically significant and suggest that relative to other groups, African Americans prematurely terminate services. In a similar study, length of treatment at

various inpatient facilities did not show consistent differences between ethnic groups and Whites (Snowden & Cheung, 1990). However, in examining the treatment of depression with cognitive-behavioral therapy, Organista, Munoz, and Gonzalez (1994) found that even among low-income patients, ethnic minority status was associated with a higher dropout rate, although specific ethnic group data on dropouts were not reported.

The results of research to date suggest that, although some differences have emerged in number of sessions, they have not been consistent. The results could 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 when many culturally oriented community programs were developed), or individual differences in generation level, a possible shift in values and attitudes toward mental health services, or changes in degree of identity with the dominant culture.

PSYCHOTHERAPY OUTCOME RESEARCH WITH ETHNIC MINORITY GROUPS

A major movement in clinical psychology has been the identification and development of empirically supported therapies (ESTs). ESTs are treatments that have been demonstrated to be superior in efficacy to a placebo or another treatment (Chambless & Hollon, 1998). The criteria for *well-established* effective treatments are at least two good between-group design experiments or 10 or more single-case design experiments by at least two different investigators demonstrating superiority to pill or psychological placebo or to another treatment, or equivalence to an already established treatment. Treatment manuals are required in the experiments, and client characteristics must be clearly specified. The criteria for *probably efficacious* treatments are two experiments showing that the treatment is more effective than a waiting list control group, or one or more experiments meeting the well-established treatment criteria, or four or more single-case design experiments. Well-established and probably efficacious treatments have been identified for anxiety and stress, depression, health problems, childhood psychological disorders, marital discord, and sexual dysfunction (Chambless et al., 1996; DeRubeis & Crits-Christoph, 1998). However, there is limited empirical support for the efficacy of ESTs with ethnic minority groups (Sue, 1998).

Hall (2001) has contrasted EST with culturally sensitive therapy (CST). CST involves the modification of psychotherapy to specific cultural contexts. Persons from one cultural group may require a form of psychotherapy that differs from psychotherapy found to be effective for another cultural group. Several models of culturally sensitive therapy have been developed (e.g., Betz & Fitzgerald, 1993; Ivey, Ivey, & Simek-Morgan, 1993; Ramirez, 1999; Sue, Ivey, & Pedersen, 1996). Although there are ethical and conceptual rationales for CST, a review of the literature suggested that there is no more empirical support for the efficacy of CST than for EST with ethnic minorities (Hall, 2001). We will review the available evidence for the efficacy of ESTs and CSTs with ethnic minority groups. In addition, we will review outcome and process research on the four ethnic minority groups: African Americans, American Indians, Asian Americans, and Latino/a Americans.

RESEARCH ON AFRICAN AMERICANS

African Americans are currently the largest ethnic minority group in the United States, with a population of 35 million in 2000 (U.S. Census Bureau, 2001). The general public has been exposed to statistics regarding African Americans in terms of income, unemployment, crime, health, and education, but unfortunately, the statistics often are misinterpreted to reinforce popular stereotypes. Actually, in contrast to the stereotypes, about half of all African Americans are members of the middle or upper classes. In addition, a great deal of within-group heterogeneity exists in terms of family structure, socioeconomic status, educational background, cultural identity, and reactions to racism (Jones & Gray, 1983). Although African Americans 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. This 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 been evaluated in different ways, with various conclusions reflecting the methodology and focus of each study. Two studies have demonstrated poorer outcomes among African Americans. Brown, Joe, and Thompson (1985) examined the outcomes of African American, Mexican American, and White American clients seen in different drug abuse treatment programs—residential programs, methadone programs, and drug-free outpatient programs. Particularly in outpatient programs, ethnic clients were retained in treatment longer than Whites and had less favorable outcomes at discharge. In a study of thousands of ethnic minority clients (African Americans, Asian Americans, and Mexican Americans) treated in the Los Angeles County Mental Health System, Sue et al. (1991) analyzed the pre- and post-treatment Global Assessment Scale (GAS) scores of clients. The GAS was a rating given by therapists to clients in order to indicate clients' overall functioning, with higher scores indicating better functioning. It is very 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). GAS scores at the termination of treatment, adjusted for initial GAS scores, were: 47.9 for Mexican Americans, 46.8 for Whites, 46.7 for Asian Americans, and 45.8 for African Americans. These scores suggest moderate levels of adaptive functioning. Although these ethnic group differences were statistically significant, such differences in large samples would not necessarily be clinically significant (Maramba & Hall, in press).

Specific types of therapy have been investigated for depressed African American clients. Both interpersonal therapy and nortriptyline have been found to be effective in reducing depression among African American adults in studies at the outpatient clinic of the University of Pittsburgh School of Medicine (Brown, Schulberg, Sacco, Perel, & Houck, 1999; Stack et al., 1995). Interpersonal therapy focuses on problems in interpersonal relationships as the basis of depression. Nortriptyline is an antidepressant drug. In both trials, these treatments were equally effective for African Americans and European Americans. Cognitive behavioral treatment, which primarily involves interventions to change a person's thoughts and perceptions that are assumed to be the basis of depression, has also been demonstrated to reduce depression in African American adults, although the reductions were not as great as had been reported in previous research with

European Americans (Organista et al., 1994). Among the African Americans in the study, Beck Depression Inventory (BDI) scores were reduced from 27.1 pretreatment to 19.6 at treatment completion, which represents a change from severe to moderate depression. In most other studies with European Americans, BDI scores were in the mild depression range at termination. It is possible that the relatively small amount of change in the Organista et al. (1994) study was a function of sample characteristics. All were low-income and may have had few coping resources. Moreover, none of these three studies on African Americans included a control group and thus would not meet the criteria for EST validation studies (Chambless & Hollon, 1998).

Cognitive behavioral therapy has also been demonstrated to be equally effective in reducing anxiety among African American and European American children and adults (Friedman, Paradis, & Hatch, 1994; Treadwell, Flannery-Schroeder, & Kendall, 1995). Behavior therapy formulated to restructure clients' problem behaviors has fared less well in the treatment of anxiety disorders among African Americans. Exposure therapy designed to desensitize clients to their anxiety-inducing situations and physiological responses was shown to be ineffective in reducing panic attacks in a sample of African American adults (Williams & Chambless, 1994). Similar to the above studies on depression, none of these studies on anxiety included a control group, and conclusions are tentative.

It is difficult to compare previous studies because of the differences in outcome measures used as well as possible differences in the demographic characteristics of African Americans, types of clients seen, treatments received, and so on. Furthermore, relatively few investigators have examined the effects of treatment for African Americans. As a general conclusion, in no studies have African Americans been found to exceed White Americans in terms of favorable treatment outcome. Some investigations have revealed no ethnic differences, whereas other studies have supported the notion that treatment outcomes are less beneficial for African Americans.

Treatment Process

Client variables, therapist variables, and situational or treatment variables may affect the 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. Therapist variables also affect the psychotherapeutic process. These include ethnic match between client and therapist, training, therapist style (e.g., directiveness), and background. Indeed, one of the major controversies in the ethnic mental health field is the issue of whether African American therapists are more effective than White therapists in working with African American clients. Finally, situational or treatment variables are also important to consider. Are certain forms of treatment more effective than others in promoting favorable therapeutic outcomes among African Americans? And are there pretreatment variables such as cultural sensitivity training that may impact therapeutic process and outcome? These questions have been widely discussed, although little research has actually been devoted to the matter.

Client Variables

As mentioned previously, scholars have recognized that African Americans exhibit considerable variation in cultural background and in ethnic identity and that recommendations for "culturally appropriate" or "culturally specific" forms of treatment may be applicable for some but not all African Americans (Sue, 1988).

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-ethnicity therapists, whether within-group characteristics are associated with these preferences, and whether ethnic preferences are a part of a more encompassing desire to find therapists who share similar background characteristics (Helms & Carter, 1991). Some investigators have concluded that many clients prefer ethnically similar therapists (Atkinson, 1983; Fuertes & Gelso, 1998; Kenney, 1994; Okonji, Ososkie, & Pulos, 1996), particularly in the case of African American clients. 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., 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 who are skeptical

of White values most likely to want a therapist of the same race. Obviously, preference for a therapist of the same race may be a salient variable. However, given the array of possible variables that may influence preferences for a particular therapist (e.g., attitude similarity, attractiveness of therapist, social class, etc.), perhaps therapist race is only one of several variables that should be considered.

Other Research on Client Variables

Although the issue of preference for the race 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 versus the importance of the collective have been found (Nobles, 1980)—values that may affect the attitudes, expectations, and behavior of clients and therapists. For example, most psychotherapies focus on solutions to problems at the individual level. However, solutions at the individual level may not address the social context of a problem. Furthermore, the relationship between client and therapist may also be influenced by the minority group status of African Americans and the accompanying prejudice and discrimination often experienced in society. Gibbs and Huang (1989) have noted the difficulties in establishing a therapeutic alliance with many ethnic minority clients. In their view, African American clients may encounter therapists, especially non-African American therapists, who operate with different orientations. For example, African Americans often work from an interpersonal orientation, and psychotherapists are evaluated by the client based on their interpersonal perspective. Consequently, the therapist's ability to evoke positive attitudes and to obtain favorable reactions is deemed important to the African American client. 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 and not just professionally involved in the relationship as evidenced by increasing commitment and engagement. African American therapists tend to approach therapy in an interpersonal manner. On the other hand, it has been suggested that White therapists, particularly those who are not familiar with culturally diverse clients, frequently have an instrumental orientation in which value

is placed on the goal or task-related aspects in the relationship between therapist and client (Ramirez, 1999). The incompatibility of these two different orientations may cause misunderstandings and problems in communication during psychotherapy because the therapist and client may be seeking different goals, evaluating the relationship in discrepant ways, and failing to understand each other. These issues have been addressed at a theoretical level and have yet to be empirically evaluated.

Research on client variables clearly indicates the importance of such variables as attitudes and preferences and of the heterogeneous nature of the African American population. However, because of the relatively small number of studies conducted, the empirical knowledge base lags markedly behind the ideas, conceptual analyses, and theoretical/applied contributions of scholars in the field. In addition, most of the empirical investigations have been based on students rather than on the general population of clients and on analogue rather than on actual studies of psychotherapy. For instance, evidence for a therapist race effect has been found more frequently in clinical analogue studies than in actual treatment studies (Atkinson, 1986). Despite the problems and limitations of research on the interface between African Americans and psychotherapy, the increase in the number and sophistication of studies conducted on African Americans is encouraging, but there is a need to move toward hypothesis testing and away from conceptual schemes that currently remain untested.

Therapist Variables

Research on therapist variables includes characteristics, attitudes, values, knowledge, experience, and therapist behaviors 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 therapist ethnicity: Is it better for African American clients to see an ethnically similar therapist?

Ethnic Match Between Client and Therapist

Studies on variables such as therapeutic alliance and race effect presumably take into account both client and therapist variables. Yet at the same time, such research assumes that one variable (e.g., therapist style) is more salient. An investigative approach that does not attempt to differentiate client and therapist variables, but rather attempts

to determine possible effects and interactions of ethnicity is the study of ethnic match between the client and the therapist. The effects of ethnic match based on a large-scale study of the length of treatment and on outcomes of African American outpatients seen in the Los Angeles County Mental Health System were reported (Sue et al., 1991). Outcomes for African American clients who were matched with therapists on ethnicity were compared with outcomes for clients not matched on ethnicity (i.e., African American clients seen by 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 outcome as reported on the measure used. The investigators speculated that perhaps the GAS is not a very sensitive measure or that ethnic match may influence interpersonal attraction, which results in a greater number of sessions but fails to affect outcomes. There is no consistent evidence from studies of actual clients that ethnic match enhances outcomes among African Americans. Another neglected issue is that the preferences for therapist ethnicity by clients were not assessed. It is unknown if the African American clients preferred to have African American therapists.

The previous study failed to find consistent evidence in support of a therapist-client ethnic match. However, other more recent studies have found supportive evidence. Recent data from the same Los Angeles County Mental Health System (Yeh, Eastman, & Cheung, 1994) suggest that therapist-client ethnic matching in general may have beneficial effects on treatment utilization and outcome. African American adolescents who were ethnically matched with therapists were less likely to drop out of treatment after a single session, attended more treatment sessions, and were judged to have better psychological functioning at discharge than those who were ethnically mismatched with therapists. Moreover, African American adults who were ethnically matched with therapists were judged to have better psychological functioning following treatment than those African American adults who were ethnically mismatched (Russell, Fujino, Sue, Cheung, & Snowden, 1996). In a national study of Veterans Administration outpatient settings, African

American veterans had higher rates of early termination and received fewer treatment sessions when treated by White therapists, but not when treated by African American therapists (Rosenheck, Fontana, & Cottrol, 1995). When African Americans had White therapists, they failed to return for a second session 29% of the time. However, the premature termination rate was only 14% when African Americans had African American therapists. African American clients averaged 17 sessions with White therapists versus 25 sessions with African American therapists. African American therapists also appeared to positively impact White clients, as premature termination rates were lower and number of sessions higher when White clients were treated by African American therapists versus White therapists. In none of these studies, however, were actual client preferences for therapist ethnicity assessed.

Contrary to the findings in the mental health and Veterans Administration settings, ethnic matching of therapists and African American clients in outpatient substance abuse programs has not been associated with better outcomes (Fiorentine & Hillhouse, 1999; Sterling, Gottheil, Weinstein, & Serota, 1998). Although ethnic match was associated with perceived counselor credibility (Fiorentine & Hillhouse, 1999), ethnic matching was not associated with longer treatment utilization or better outcomes. Effective substance abuse treatment may be particularly critical for African Americans, for there is evidence that more African Americans may seek substance abuse treatment than Whites do (Nebeker, Lambert, & Huefner, 1995). It is possible that other variables, such as therapist competence in drug abuse treatment or high rates of recidivism, were more influential than ethnic match. For instance, evidence suggests that a method to enhance counselor communication with African American substance abusers involving individually tailored diagrams results in fewer drug-positive urine tests and clients missing fewer scheduled counseling sessions relative to clients who underwent a standard drug treatment program (Dansereau, Joe, Dees, & Simpson, 1996). These diagrams represent interrelationships among personal issues and related plans, accompanied by alternatives or solutions. For example, a diagram of a choice to do drugs leads to a need for money, which leads to stealing and a dependence on one's mother. Stealing leads to jail, and a dependence on one's mother may interfere with future opportunities for independent functioning. Conversely,

a diagram of a choice not to do drugs leads to positive consequences, including feeling good about oneself and getting a job. Such individualized efforts to enhance communication through illustrative interpretation of the problem and its related consequences and alternatives were more effective for African Americans and Mexican Americans than for European Americans.

A recent meta-analysis of the previously cited and other therapist-client ethnic match studies suggested that the statistically significant effects of ethnic match are small and in some of these studies may be a function of the large sample sizes (Maramba & Hall, in press). These small effect sizes may reflect weak outcome measures or the possibility that an ethnic match is not necessarily a cultural match (Sue & Zane, 1987). Components of cultural match include a shared language, understanding the client's cultural background, and openness to modifying treatment. Cultural match and ethnic match are not necessarily synonymous. Some therapist-client ethnic matches are also cultural matches, but others are not, which may account for the statistically significant but small effect sizes for outcome differences in the ethnic match studies. In the Sue et al. (1991) study, although large effect sizes were found for ethnic match and dropout, the base rates for dropping out were low for ethnically matched and ethnically mismatched therapist-client pairings. However, the study did provide evidence that ethnic match may be beneficial for certain kinds of ethnic clients, such as those who are less acculturated to the mainstream culture or who have limited English proficiency.

Other Therapist Variables

Although ethnic match has dominated the pertinent literature (and in some respects, could be considered a therapist variable), other therapist variables have also been studied. These therapist variables include 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. For example, the Cross-Cultural Training Institute for Mental Health Professionals, developed by Lefley (1985), was designed to enhance the diagnostic, therapeutic, and administrative skills of mental health professionals in providing culturally responsive services to African American and Latino/a communities. The intensive eight-day training program 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 effecting positive changes in mental health agencies, but its effects on individual clients were not assessed.

In a similar study, Wade and Bernstein (1991) investigated the effects of therapist cultural sensitivity training on African American clients. These researchers assigned experienced African American or White therapists to either a cultural sensitivity training program or a control group (with no additional training given). Therapists then saw female African American clients from the community who presented for 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, particularly because the training program only lasted *four* hours. If the results are replicated, the implications for programs and policies may be immense. It is surprising that there has not been a published replication over the ensuing 10 years since this study was published.

In another study, D'Andrea, Daniels, and Heck (1991) assessed the efficacy of three approaches to multicultural training with graduate students, based on the same content but varied by time format. In the first condition, the effects of a multicultural training course were examined, in which the three-hour class met once a week during a 15-week semester. In the second condition, a multicultural training course that took place twice weekly for three hours per session over a six-week period was examined. Finally, a third condition focused on a weekend workshop format involving intensive weekends of training for three consecutive weekends. The results of the three conditions indicate that each multicultural training format led to significant improvement in therapists' self-reported cross-cultural knowledge, awareness, and skill acquisition between pre- and post-test administration (D'Andrea et al., 1991). These findings suggest that the specific

length of multicultural training programs is not influential in determining the effectiveness of these programs.

In contrast to the previous study, Pope-Davis, Prieto, Whitaker, and Pope-Davis (1993) and Pope-Davis and Dings (1995) both found limited gains from workshops, and the gains that were made were in multicultural awareness but not in knowledge or skills. Thus, these researchers asserted a need for longer training programs. However, the studies by Pope-Davis and colleagues were retrospective and asked about any workshop training the respondents had, whereas D'Andrea et al. (1991) evaluated programs with similar content, structure, and length. The findings of D'Andrea et al. suggest that perhaps as long as the training is sufficiently intense, the specific length and number of sessions will have little or no effect on outcome. They also demonstrated that the acquisition of the multicultural skills component, though significantly improved across all conditions, was generally less affected than the knowledge and awareness components. This finding suggests that the skills component may be more difficult or time-consuming to promote. None of these studies tested to see if training had any effect on therapeutic outcome.

At a minimum, cultural sensitivity may involve therapists' willingness to address issues of race and ethnicity. For example, two African American female and two White female counselors were trained to increase their levels of awareness of African American clients and of the experiences of African Americans (Thompson, Worthington, & Atkinson, 1994). These counselors addressed issues of being an African American woman with some clients and did not with others. Ratings of videotapes suggested that African American college women were more willing to reveal intimate information to female counselors who addressed issues of being an African American woman than to those who avoided these issues. Moreover, the women were more willing to return to see counselors who addressed these issues.

Rather than simply examine preferences for African American or White therapists, Helms and Carter (1991) assessed how racial identity and demographic variables of African Americans and Whites predicted preferences for therapists who differed according to race and gender. Using African American male and female and White male and female therapists, a large number of variables and analyses were conducted. Only a

brief presentation of the results pertinent to our discussion is given. For White participants, 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 participants, predictors of preference for African American therapists failed to reach significance, although racial identity attitudes 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 participants and therapists. Research on ethnic preferences has become increasingly systematized and specific. Several conclusions seem appropriate: (1) Research has evolved from simply ascertaining the 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; and (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. Most psychotherapy studies have not examined this within-group heterogeneity along dimensions such as ethnic identity.

In summary, the research literature on therapist variables has yielded mixed findings. Ethnic matching of clients with therapists in the case of African Americans results in more favorable outcomes in general mental health and Veterans Administration settings, but not in substance abuse settings. However, the positive effect sizes of ethnic match are small, and it is possible that cultural match is more predictive of positive outcomes than ethnic match per se. Finally, a few studies demonstrate success in 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

Have certain situations or types of programs or therapies been found to be especially effective with African Americans? Many scholars have discussed the kinds of mental health services that

may be culturally appropriate for African Americans. For example, Lefley and Bestman (1984) established a comprehensive mental health program with staff that included personnel indigenous to the community and who were headed by a cultural broker. A cultural broker is someone familiar with two cultures who can serve as a liaison between the two cultures. The investigators reported that dropout rates in this program were low and that consumer satisfaction and treatment outcomes were high when a cultural broker was involved as an interpreter during therapy. However, further research on this program has not been forthcoming since the original report. Still others have recommended that ethnic-specific services (i.e., those that are specifically designed for African Americans) or services provided by indigenous healers be more fully incorporated into the mental health system (Sue, 1977; White, 1984). Although most scholars have offered suggestions regarding psychotherapy with African Americans, few have empirically tested the effects of such suggestions.

One important modification, which appears to be very helpful in the provision of services, is pre-therapy intervention. Ethnic minority clients may not know what psychotherapy is, how psychotherapy can help, what to do in therapy, or what to expect from therapy. Some pre-therapy interventions may be beneficial. Acosta, Yamamoto, and Evans (1982) have devised client orientation programs aimed at familiarizing clients with psychotherapy. By using slides, audiotapes, or videotapes, the investigators showed clients the process of seeing a therapist, means by which to express problems and self-disclose, and possible ways of communicating needs. Acosta, Yamamoto, Evans, and Skilbeck (1983) conducted an evaluation of the effectiveness of the orientation program. They presented, prior to the first treatment session, low-income African American, Latino/a 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 with ethnic minority clients. Reviews of client and therapist preparation programs have been favorable (see Jones & Matsumoto, 1982). However, pre-therapy training, though effective,

has not been studied since the mid-1980s, and it is not widely employed despite its apparent value.

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.

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). The American Indian population in 2000 was 2.4 million. Between 1990 and 2000, the population grew by 7%. The nation's American Indian, Eskimo, and Aleut resident population is relatively young, with an estimated median age of 27.6 years, which is nearly eight years younger than the median of the U.S. population as a whole (U.S. Census Bureau, 2001).

As a group, when compared to the U.S. population at large, American Indians and Alaska Natives are economically impoverished and educationally disadvantaged. American Indians tend to be unaffected by national economic cycles, as their unemployment tends to be chronically high (LaFromboise, 1988). From 1997 to 1999, 26% of the nation's American Indian, Eskimo, and Aleut households had incomes that placed them below the poverty line (U.S. Census Bureau, 1999b). Unemployment ranged from 20% to 70%, depending on the community; their 9.6 mean years of formal education was the lowest of any ethnic group in the United States. Social and psychological problems within 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 including post-traumatic stress (Manson, Walker, & Kivlahan, 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 in use 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. Furthermore, significant within-tribe differences include whether individuals live on or off a reservation. Thus, generalizations about the population need to be qualified.

Although generalizations about American Indians and Alaska Natives are difficult to make because of the diversity of these groups, it appears that American Indian and Alaska Natives differ from Whites in world views and value orientations. Such value differences have included American Indians' and Alaska Natives' preferences for sharing and redistribution rather than acquisition, cooperation instead of competition, noninterference instead of intervention, harmony with nature instead of controlling nature, present time orientation rather than future planning, and promotion of an extended family network instead of promotion of a nuclear family network (Sue & Sue, 1999; Trimble & LaFromboise, 1985). Other differences, which have been suggested as relevant in psychotherapy with American Indians and Alaska Natives, include culturally based faith in tribal rituals, ceremonial practices, Indian medicine and traditional healing practices, causes of mental health problems, and ways such problems should be solved. In addition, culturally specific mental disorders and culturally specific manifestations of mental disorders are salient issues (Manson, Shore, & Bloom, 1985; Neligh, 1988; Trimble & LaFromboise, 1985).

Treatment Outcome

Very few empirical studies have been conducted 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 Alaskan Natives. Given these efforts, the lack of research on outcomes must be considered a serious problem.

The most researched American Indian mental health problem has been drug and alcohol use and abuse, although even here few treatment evaluation studies of this problem have been conducted. A comparative study (Query, 1985) between White and American Indian youth in an inpatient chemical dependency treatment program at a North Dakota State Hospital found that Ameri-

can Indian youth were disproportionately represented in the unit as would be expected by their percentage in the population. The youths received an unspecified form of "reality therapy" for four to six weeks. Before treatment, 64% of the White youth and 55% of the American Indian youth had contemplated suicide. Thirty-two percent of the White youth and 30% of the American Indian youth had actually attempted suicide. Upon followup six months after release from treatment, Whites were found to be functioning much better than American Indian youth on various outcome measures. Since their discharge from treatment, 42% of the American Indian youth had contemplated suicide and 25% had attempted suicide, compared to 21%, and 16%, respectively, of the White youth. Findings from this study suggest that the treatment program had resulted in more positive change in White than in American Indian youth.

Other alcohol and drug abuse programs have been studied. For instance, a substance abuse program for American Indians has been developed that combines family systems approaches, individual and group counseling, and Alcoholics Anonymous and Narcotics Anonymous meetings with Indian cultural and spiritual methods of healing. Two common methods include the sweat lodge and talking circle (Gutierres & Todd, 1997). The sweat lodge—a ritual in which participants sit near hot rocks sprinkled with water and subsequently experience sweat while engaging in fasting and prayer—promotes a feeling of kinship with all living things and the universe as the participants are exposed to the steam. The talking circle is a form of group therapy focused on the circle as a symbol of physical and psychological connectedness among individuals, a connectedness that requires that members are heard and not criticized. When evaluated relative to a no treatment control group, this culturally enhanced program increased the likelihood of treatment completion and significantly decreased depression (Gutierres, Russo, & Urbanski, 1994; Gutierres & Todd, 1997). The effects of the program on additional substance abuse, however, were not reported.

Substance abuse and suicide prevention programs for American Indians also have been advocated (see Manson, 1982; and Moncher, Holden, & Trimble, 1997, for reviews of the prevention programs). Although prevention programs are not normally discussed in terms of treatment outcome, because of the dearth of treatment outcome research with American Indians and Alaska

Natives, and because 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, which included extensive collaboration within the American Indian community and in which researchers delivered the program to six groups of American Indian youth. Even highly traditional parents consented to their children's participation. In addition, the youth themselves evaluated the program favorably. However, of the six outcome variables (drug use opinions, drug knowledge, alcohol use identity, tobacco use identity, inhalant use identity, marijuana use identity), only one, "alcohol use identity," which was a measure of self-identification as a current or future alcohol user, was found to have changed significantly following the prevention program. Bobo et al. (1988) attributed this lack of statistically significant change on all but one variable to a small sample size ($N = 35$) and resulting insufficient power to detect change. Also, these researchers speculated that American Indian culture in general has a resistance to outside influences. Thus the study's design may have confounded the results.

Social skills training for client bicultural competence is another prevention approach. LaFromboise and Rowe (1983) outlined the process of culturally adapting an assertiveness training program for American Indians. The training combined general assertiveness skills (e.g., refusing an unreasonable request, presenting an idea to a superior) with assertiveness skills in dealing with racism (e.g., challenging employers who stereotype Indians, maintaining composure when called derogatory names). Behavioral skills (e.g., eye contact, timing, loudness of voice) were emphasized for interactions with Whites, whereas cultural appropriateness (e.g., the impact of assertiveness on the group) was emphasized in interactions with Indians. The authors contended that skills training is less culturally biased than other approaches in that it is less prescriptive in its conceptualization of appropriate behaviors. The approach can be tailored to the context 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 presumably facilitates culturally appropriate modifications of the program.

Schinke and colleagues (1988) compared a bicultural competence skills training approach, which taught competence in American Indian and mainstream U.S. cultures, with a no-treatment control condition for preventing substance abuse in American Indian adolescents. They found that there were greater post-test and followup improvements with the bicultural skills program than with the no-treatment group on measures of knowledge about the health and social effects of substance use, self-control, assertiveness, and substance use rates.

In addition to substance abuse prevention, suicide prevention programs have been developed for American Indians. The Zuni Life Skills Development Curriculum was designed to prevent suicide among American Indian high school students (LaFromboise & Howard-Pitney, 1995). The program involved: (a) building self-esteem; (b) identifying emotions and stress; (c) increasing communication and problem-solving skills; (d) recognizing and eliminating self-destructive behaviors such as pessimistic thoughts or anger reactivity; (e) receiving suicide information; (f) receiving suicide intervention training; and (g) setting personal and community goals. Zuni students who were exposed to this curriculum had better suicide intervention skills as measured by a role-play assessment, and significantly lower suicide probability and hopelessness ratings, as measured by self-report, than did students who did not receive the intervention. Unfortunately, no followup data have been published showing that it affected suicide rates.

It is apparent that research on interventions with American Indians for problems such as substance abuse and suicide has proceeded very slowly, and it would be premature to try to address the question of the efficacy of mental health interventions.

Treatment Process
Client Variables

In terms of expectancy and preferences, it has often been stated that American Indians distrust non-Indian therapists (LaFromboise, 1988). However, the empirical investigation of such a claim, especially as it relates to American Indian expectancy and preferences for ethnically similar therapists, has yielded mixed results (see Atkinson, 1983, for a review). For example, 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 of qualities of a helpful person. The ethnicity of a

person, in terms of being an American Indian, was found to be relatively less important than other qualities such as trustworthiness. No differences in ratings were found between 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 previously 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. (1981) found that students gave more positive ratings on the Counselor Effectiveness Scale to counselors who were introduced as American Indian. Furthermore, the culturally oriented counseling style was rated as more credible than the nondirective approach, but not the directive 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% American Indian blood quantum, with nearly 70% of the sample having lived on a reservation some time during their lives. The researchers found that American Indian students showed a strong preference for an ethnically similar counselor, and that students' willingness to use a counseling center where an American Indian was on staff related directly to students' preferences for an ethnically similar counselor. Furthermore, Havilland et al. (1983) found that American Indian students tended to report a preference for an American Indian counselor for personal, educational, and vocational problems. Blood quan-

tum and percentage of life spent on a reservation were not found to influence students' preferences.

Bennett and BigFoot-Sipes (1991) found that, although therapist-client ethnic match 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, having a counselor who shared similar attitudes and values was even more important for both American Indians and Whites. These findings were supported in a subsequent study (BigFoot-Sipes, Dauphinais, LaFromboise, Bennett & Rowe, 1992).

Cultural commitment may also influence American Indians' attitudes toward mental health services. In a study of American Indian college students, those strongly committed to their native Indian culture displayed more negative attitudes toward counseling and mental health professionals than those strongly committed to White culture or to both cultures (Price & McNeill, 1992). American Indian women in all groups showed more positive attitudes toward counseling than did men.

The studies to date on American Indian expectancies and preferences have been analogue studies and have yielded mixed results. However, inconsistent results may have been caused by the method employed. Thus, it would be useful for future expectancy and preference research to take into account the type of problem with which a client presents and counselor characteristics other than ethnicity alone. These could include client and therapist attitudes, personality, education, and especially American Indian ethnic identity or cultural commitment (Bennett & BigFoot-Sipes, 1991; BigFoot-Sipes et al., 1992). Finally, a pragmatic factor to consider is that ethnic preference studies may not reflect what services are actually available to the American Indian and Alaska Native population. For example, many American Indians and Alaska Natives simply have few therapist choices available to them, despite the preferences they may have. In 1993, only 22 American Indians received a doctoral degree in psychology (Commission on Ethnic Minority Recruitment, Retention, and Training in Psychology, 1997). Findings that American Indians prefer American Indian therapists may provide additional justification for funding the education of American Indian and Alaska Native researchers and therapists, for there currently are so few American Indian and Alaska Native mental health professionals. However, further research is needed to

clarify American Indian expectancies and preferences within the therapeutic setting.

Therapist Variables

The paucity of empirical research also is evident with respect to the impact of therapist variables, and what has been evaluated to date has yielded mixed results. Dauphinais, LaFromboise, and Rowe (1980) surveyed American Indian eleventh and twelfth grade students (from a variety of tribal affiliations such as Choctaw, Creek, Kiowa, Chickasaw, Comanche, Cherokee, Sioux, Cheyenne/Arapahoe) attending Bureau of Indian Affairs boarding schools and urban and rural public schools in Oklahoma. These researchers 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. Treatment outcome was not assessed in these studies. Thus, the effects of therapist variables may be obscured by client preferences.

Another line of research suggests that American Indians may initially turn to community support systems for help. Similar to White students, Zuni high school students were more likely to seek help from a friend, parent, or relative than professional sources for personal problems (Bee-Gates, Howard-Pitney, LaFromboise, & Rowe, 1996). When Zuni students did seek professional help, it was primarily for academic and career issues. Thus, academic and career counselors should be alert to potential psychological problems among American Indian youth, as these problems are not likely to come to the attention of mental health clinicians.

Situational or Treatment Variables

There is little empirical evidence that validates the effectiveness of specific modes of psychotherapy with American Indian or Alaska Native populations, and no information was found 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 group treatment. 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 a 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 has described work utilizing the extended family in a therapeutic setting.

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 its geographical range across the United States, including varied locations such as cities, rural areas, and reservations. Another problem (which is not, by any means, unique to American Indian research) is the tendency for researchers to use nonclinical populations, a methodology that limits the generalizability of findings. In addition, there have been so few empirical psychotherapy studies on American Indians, and none on Alaska Natives, that those that have been conducted do not allow for broad generalizations. The literature on psychotherapy with American Indians and Alaska Natives predominantly consists of descriptive reports and theoretical program suggestions. However, the recent trend in American Indian research, which utilizes and extends the methodologies developed to study other ethnic groups, appears to have potential to further the field. Because the methodologies are similar, comparisons now can 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.

As a whole, the Asian American population grew by 45% between 1990 and 1999 to 11.2 million (U.S. Census Bureau, 2001). This increase can be attributed largely to immigration to the United States from China, the Philippines, India, Korea, Southeast Asia, and secondarily to natural increases (births minus deaths and departures from the United States). The largest groups are Chinese Americans (22%), Filipino Americans (19%), Japanese Americans (12%), South Asians or Asian Indians (11%), Korean Americans (11%), Vietnamese Americans (8%), and Hawaiian Americans (3%) (U.S. Bureau of the Census, 1993). Most Asian Americans (70%) live in just five states—namely, California, Hawaii, New York, Illinois, and Texas.

Asian Americans have a higher median household income ($45,248) than Whites ($40,576). However, this is probably because 14% of European American households have no income earners versus only 9% in Asian American households (U.S. Census Bureau, 1999). In addition, 20% of Asian American households have three or more income earners versus 12% of European American households. Per capita median income for Asian Americans ($22,398) is somewhat lower than it is for European Americans ($23,191). Moreover, Asian Americans have more persons living in their households than do other groups. Whereas 47% of European Americans have two-member households, only 28% of Asian Americans do (U.S. Census Bureau, 1999). Forty-eight percent of Asian American households have four or more members versus 31% for European Americans. In addition, over 90% of Asian Americans live in metropolitan areas, where the cost of living is highest (Lee, 1998). Thus, living expenses are higher for Asian Americans than for other groups who are less densely populated in metropolitan areas.

An important characteristic of the Asian American population is the diversity among groups (U.S. Census Bureau, 1993). 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. 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 variation also exists among Asian groups in educational attainment and achievement. The high school dropout rates for Filipinos are substantially higher than those for 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 of them are American born (37%). Moreover, foreign-born Chinese come from different parts of the world (e.g., mainland China, Taiwan, Hong Kong) and speak different dialects of Chinese, 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 Chinese and Japanese and have primarily used student samples that 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 (i.e., it is unclear which Asian American groups are being studied).

Treatment Outcome

Few studies have directly examined psychotherapy outcomes for Asian American clients. Zane, Enomoto, and Chun (1994) assessed White and Asian outpatients at a community mental health center at the first and fourth sessions using both client self-report (Symptom Checklist) and therapist-rated (Brief Psychiatric Rating Scale) outcome measures. The results indicated poorer short-term treatment outcomes for Asian American outpatients relative to their White American counterparts after controlling for pre-treatment level of severity. Asian clients reported greater depression ($\beta = .20$), hostility ($\beta = .44$), and anxiety ($\beta = .15$) after four sessions of treatment and were less satisfied than White clients on five satisfaction indices ($\beta s = -.29$ to $-.40$). There was also a tendency for therapists to evaluate Asian clients as having lower levels of psychosocial functioning ($\beta = -.14$) than White clients after short-term treatment. 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 terms of differential outcome, two studies have examined clinical outcome among Asian outpatients using the Global Assessment Scale (GAS), a measure of general psychosocial functioning as rated by the client's therapist. Zane, Hatanaka, Park, and Akutsu (1994) found no differences between Asians and Whites on post-treatment GAS scores, adjusted for pre-treatment GAS. 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. Lee and Mixson (1995) asked clients at a university counseling center to rate the effectiveness of counseling and of their therapists and to indicate the reasons they sought treatment. Despite presenting with a similar number of concerns prior to treatment, Asians rated both the counseling experience and therapists as less effective than did Whites. Statistically significant differences were found between Asian Americans and Whites on ratings of helpfulness for personal problems (Asian American mean = 4.03, White mean = 4.63 on a 7-point scale), therapist competence (Asian American mean = 4.01, White mean = 4.57 on a 5-point Scale), and likelihood of returning to the therapist (Asian American mean = 4.28, White mean = 4.87 on a 7-point scale).

An intervention to enhance parent-child relationships and to reduce parental overcontrol was examined among Chinese American parents who were not necessarily experiencing psychological distress (Chau & Landreth, 1997). Parents in two metropolitan churches were assigned either to a filial therapy intervention or a no-treatment control group. Parents in the intervention group significantly increased in their empathic interactions and acceptance of their children and experienced a significant decrease in stress. However, it is unknown if group assignments were random, and children's outcomes were not assessed.

Any conclusions about the effectiveness of treatment for Asians would be premature given the limited data, but several empirical trends should be noted. First, some evidence suggests that certain Asian groups improve with psychotherapy. Second, with respect to differential outcomes, 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 stud-ies 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. It is highly reliable if raters are extensively trained in its use (Endicott, Spitzer, Fleiss, & Cohen, 1976), but there appeared to be no such training conducted with the therapists in either study. In sum, Asian clients appear to derive 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).

Treatment Process

The empirical work that has addressed psychotherapy issues has focused primarily 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 exits between and within Asian American groups, client variables presumably would be an important area of focus for process research on Asian Americans. To date, the major empirical efforts have addressed acculturation influences and client preferences and expectancies. At times, these variables have been examined concurrently.

Asian American Ethnic Group Differences

Combining Asian Americans as a single group may obscure important between-group differences in psychopathology. Ying and Hu (1994) examined public outpatient mental health services for Chinese, Japanese, Filipino, Korean, and Southeast-Asian American adults in the San Francisco area. Filipinos were underrepresented in the system, whereas Southeast Asians were overrepresented and had higher utilization rates, but showed less improvement than did the other groups. It is possible that Southeast Asians had more acculturation stressors as a function of refugee status and had less community coping resources than the other groups, though this hypothesis was not studied.

In a study of inpatient and outpatient mental health facilities in Hawaii, Leong (1994) found that Chinese and Japanese Americans underutilized both types of facilities. It was suggested that this general underutilization was partially a func-

tion of the stigma associated with mental health problems for both ethnic groups. However, Filipino clients tended to underutilize outpatient facilities somewhat less than they did inpatient facilities. It was suggested that Filipinos may feel less stigma regarding mental health services than other Asian American groups.

In a study of outpatients in the public mental health system in Seattle, the percentages of all Asian Americans and European Americans diagnosed with schizophrenia and with major affective disorders (e.g., major depression, bipolar disorder) were approximately the same (Uehara, Takeuchi, & Smukler, 1994). However, an analysis of individual Asian American ethnic groups revealed striking differences. Japanese and Chinese American clients were diagnosed with significantly greater rates of schizophrenia than major affective disorders. The opposite was true for Laotian Americans and Filipino Americans. Rates of diagnoses for schizophrenia and major affective disorders for Vietnamese Americans were approximately the same. These findings may reflect a reluctance of Japanese and Chinese Americans to seek public mental health services for major affective disorders. The findings also suggest that those Japanese and Chinese Americans who do seek public mental health services may be more psychologically disturbed than other groups of Asian American or European American clients. Japanese and Chinese Americans who are less psychologically disturbed may seek support from family or community sources other than the public mental health system. The Japanese and Chinese American communities in Seattle and in other areas of the West Coast and Hawaii have existed longer and are better established than many of the other Asian American ethnic communities. These well-established communities may be better able to provide alternative sources of support for mental health problems than other less established Asian American communities.

Thus, it appears that Asian Americans generally tend to underutilize mental health services, although utilization rates vary across specific Asian American ethnic groups. However, the reasons for different rates of utilization are unknown. Investigation of potential cultural mechanisms or environmental stressors such as acculturation is needed.

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. This research has primarily relied on nonclinical samples of Asian American or foreign Asian students. There is recent evidence that Asian Americans may not prefer traditional psychotherapy methods. Atkinson, Kim, and Caldwell (1998) have identified eight counselor helping roles for work with ethnic minority clients: adviser, consultant, counselor, psychotherapist, advocate, change agent, facilitator of indigenous support systems, and facilitator of indigenous healing methods. For problems of external etiology (e.g., a Korean immigrant being taken advantage of by an employer), Asian American students preferred a counselor in a consultant role. For problems of internal etiology (e.g., depressed thoughts), the students preferred a counselor who facilitated indigenous support systems. The psychotherapist role was perceived by the students as the least helpful of the eight roles for internal and external problems. Thus, effective interventions with Asian Americans may involve therapists who engage in methods other than traditional psychotherapy. However, this conclusion is based on analogue research with nonpatient samples.

Similar to the pretherapy interventions discussed above in the section on African Americans, a pretherapy intervention was developed for immigrant clients at a community mental health center in Hawaii (Lambert & Lambert, 1984). Clients in the intervention condition listened to a recorded message that explained role expectations for therapy, therapy processes, expectations for verbal disclosure, problems encountered by clients in psychotherapy, misconceptions about psychotherapy, and the need for regular attendance. Clients in the control condition listened to a recorded message about why people have trouble coping with problems and demands in their lives. Relative to the clients in the control condition, clients in the experimental condition had lower dropout rates, were more satisfied with therapy, rated themselves as more changed, and became less dependent on the therapist for support, advice, and direction.

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 (Sue & Morishima, 1982). In one of the

few studies of Asian clients, Tracey, Leong, and Glidden (1986) examined the presenting problems of Whites and of seven Asian groups (Chinese, Filipino, Hawaiian, Korean, Japanese, Asian-White, and Asian-Asian Americans) 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 relationships") and less likely to perceive their major presenting problem as involving 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 than those from 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 (Sue, Wagner, Ja, Margullis, & Lew, 1976). On the other hand, Asians were more likely to believe that mental health is enhanced by the avoidance of negative thinking and/or using self-discipline (Lum, 1982; Sue et al., 1976). 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 stage of psychotherapy which relies most heavily on these processes (cf. Meichenbaum, 1976), inconsistent with their conceptualization of positive mental health benefits (Zane & Sue, 1991).

In addition to causal attributions and conceptualizations of illness, symptom patterns of Asian clients in treatment have been examined. Asians (particularly those with depressive disorders) tend to present with more somatic complaints than non-Asian 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 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 very similar to the White responses. Some research suggests that these somatic tendencies have resulted from help-seeking practices in which Asians have tended to use medical services for psychological disorders (Cheung, 1982; Cheung & Lau, 1982). One study suggests that Asian Americans are no more likely to experience somatic discomfort than are Whites (Zhang, Snowden, & Sue, 1998). However, when considering somatic symptoms, including the culture-bound syndrome such as neurasthenia (a disorder similar to Chronic Fatigue Syndrome and characterized by persistent and distressing mental fatigue or bodily weakness with symptoms of muscular pain, dizziness, tension headaches, sleep disturbance, extreme tenseness, irritability, or dyspepsia), it appears that Asian Americans are more likely to show somatic symptoms (U.S. Surgeon General's Supplement to the Report on Mental Health, 2001). Regardless of the causal pathway, the process by which basic psychological problems are presented and/or experienced appears to be somewhat different for Asians.

Culture-specific symptom presentation suggests that culture-specific psychotherapy methods may be most useful for many Asian Americans. Western psychotherapy relies on verbal expressiveness and open self-disclosure as the primary means for resolving psychological problems. These aspects can conflict with the tendency of Asians to be less verbal and to refrain from the public expression of feelings (Kim, 1973). Indeed, Asian Americans have been found to be more reticent than White Americans to discuss psychological problems with professionals, family, or friends (Zhang et al., 1998). 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 and their possible relationship to outcomes.

Therapist Variables
Match Between the Client and Therapist

The match between client and therapist has been considered to be an important factor in psychotherapy. For those Asian American clients who are non-English speaking, language match would also be crucial.

Sue et al. (1991), in the previously described study of Los Angeles County Mental Health System, found that ethnic match between client and therapist was associated with increased use of mental health services and a lower 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 indices of treatment efficacy, ethnic match exerted a significant influence with 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.

Language match may be a lowest common denominator for effective communication in psychotherapy (Rogler, Malgady, Costantino, & Blumenthal, 1987). However, a language match does not necessarily ensure that the therapist is culturally competent. As with other aspects of ethnic matching, language match has shown statistically significant but small effects on mental health services utilization and outcome among Asian Americans. Thus, language match is a starting point rather than an endpoint for culturally competent mental health services. Considering that the growth of the Asian American population in the United States is due, in 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 as Asian American clients is important for service utilization and, to some extent, treatment outcome. However, further research is needed to replicate Sue et al.'s (1991) findings and to investigate potential differences in the significance of match among Asian American groups.

Situational or Treatment Variables

It has often been hypothesized that modifications in the approach to psychotherapy are needed to adequately treat Asian American clients (Chin, 1998; Lee, 1997). For example, Lee (1997) and others have noted important differences in family structure, value orientation, and beliefs about mental health and illness between Asian and White American cultures. Compared with Western culture, which typically focuses on the nuclear family unit, involves 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 that 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.

Despite the extensive amount 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 culturally specific treatments or culturally modified treatments themselves. Most research has focused on aspects of "culturally sensitive services" for Asian Americans, such as ethnic and language match discussed in the previous section.

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

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. Lau and Zane (2000) compared patterns of the cost-utilization and outcomes of 3,178 Asian American outpatients using ethnic-specific services (ESS) to those Asians using mainstream services. Consistent with earlier studies, cost-utilization for ESS Asian clients was higher than that for mainstream Asian clients. However, better treatment outcome was found for ESS clients compared to their mainstream counterparts after controlling for certain demographics, pre-treatment symptom severity, diagnosis, and type of reimbursement. Moreover, there was a significant relationship between cost-utilization and outcome for ESS clients, whereas for mainstream clients, this relationship was not significant. Nevertheless, statistically significant effects in a large database are not necessarily substantive. Overall, these studies suggest that parallel services have increased the utilization and, in some cases, the effectiveness of mental health services with some Asian American groups.

Although these studies are limited in that treatment outcome was not often measured, the impact of parallel services on indirect indices 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, but there are no outcome studies on interventions for psychological disorders and very little research conducted in the 1990s.

RESEARCH ON LATINO/A AMERICANS

Latino/a Americans number 32.4 million and make up approximately 12% of the United States population (U.S. Census Bureau, 2001). They are the second largest ethnic minority group in the United States, preceded only by African Americans. However, the Latino/a American population is projected to become the nation's largest ethnic minority group by 2005 and to comprise 24% of the population by 2050 (U.S. Census Bureau, 2000a). The nation's Latino/a population increased by 10.1 million people between 1990

and 2000 (U.S. Census Bureau, 2001). The tremendous growth in the Latino/a population has been due to the high levels of Latino/a immigration into the United States. Nearly two-thirds (63%) of Latino/a Americans in 1997 were of Mexican origin, whereas 14 percent were of Central or South American origin, 11 percent of Puerto Rican origin and 4 percent of Cuban origin (U.S. Census Bureau, 1998). California (10.5 million) and Texas (6 million) are home to over half of the Latino/a's in the United States (U.S. Census Bureau, 2000b). Latino/a Americans are relatively young, with the median age of the population being 27 years.

Compared to the non-Latino/a White population of the United States, Latino/a's have lower levels of income, education, and occupational status, although their disadvantage varies greatly by Latino/a group. In 1998, approximately 26% of Latino/a Americans were poor, as defined by individual annual earnings of less than $8,500 (U.S. Census Bureau, 1999). The reasons for these differences are partly attributable to 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, whereas some Latino/a groups come from impoverished economic backgrounds (Gurak & Rogler, 1983).

Although the general question of the degree of psychotherapy effectiveness with Latino/a's remains, research in this area has attempted to clarify this question. Specifically, what kinds of psychotherapy are most effective with Latino/a's? What are the client, therapist, and situational factors that influence psychotherapy with Latino/a's? 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 increase treatment effectiveness?

Treatment Outcome

It is generally assumed that mainstream mental health therapies are less effective with Latino/a's. This assumption, though not always tested directly, has been supported by indirect measures of treatment outcome such as treatment utilization, premature termination, and treatment duration of Latino/a's 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/a values or cultural orientation, modifying current therapies for Latino/a's, and developing therapies that utilize elements of Latino/a culture (Rogler et al., 1987).

Much emphasis has been given to investigating the efficacy of therapies, which have been modified to fit Latino/a culture. These studies will be discussed. However, research focusing on the treatment outcomes of Latino/a's, given current Western modes of treatment, has received less attention. One large-scale study in Los Angeles County (described earlier) measured treatment outcome using pre- and post-treatment scores on the GAS; Mexican Americans were found most likely to improve after treatment when compared to Whites, African Americans, and Asian Americans (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, Mexican Americans tend to underutilize services, so at this time it is unclear what the effect of underutilization may have been on the sample. Thus, conclusions drawn from this study must be interpreted with caution.

Treatment Process
Client Preferences

Client preference studies among Latino/a Americans have explored (1) the relationship between client ethnicity and acculturation, (2) ratings of therapists of similar and different ethnicities, and (3) client ratings of therapeutic style. In a review of the research on the role of ethnic similarity in psychotherapy, Atkinson (1983) concluded that for Latino/a's, there did not appear to be a preference for therapist ethnicity. Likewise, no therapist ethnicity effect on therapy process variables was found. These variables included perceived therapist credibility, perceived therapist effectiveness, and client verbal behavior.

Ruelas, Atkinson, and Ramos-Sanchez (1998), in an analogue study, found that perception of therapist credibility among Mexican American community college students was positively associated with therapist adherence to Mexican cultural attitudes and behavior. Conversely, acculturation to North American culture was not associated with ratings of counselor credibility. These findings contradict the "cultural barrier" hypothesis that Latino/a cultural values prevent Latino/a Americans from help-seeking. The aspects of Latino/a cultures that may facilitate help-seeking require additional investigation.

Therapist Variables
Match Between Client and Therapist

In a previously discussed study of clients in Los Angeles County, Sue et al. (1991) found that ethnic match predicted a greater number of sessions for Mexican American clients. The Mexican American clients were divided into two groups based on whether English was 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 more positive treatment outcomes in terms of therapist ratings. Thus, it appears that ethnic and language matches are important factors in the psychotherapeutic process, especially for Mexican Americans whose primary language is not English. These findings have been replicated in subsequent analyses of the clients at the same Los Angeles clinics (Russell et al., 1996; Yeh et al., 1994). In a previously 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 non-dropout status. As discussed previously, the effect sizes of the ethnic match studies have been small. This suggests that ethnic matching is not a guarantee that mental health services will be effective for Latino/a's (Maramba & Hall, in press).

In addition to ethnic match, language match is a particularly important factor in the treatment of monolingual Spanish-speaking Latino/a 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 were found to feel more helped and understood than bilingual Mexican American clients who spoke to the therapist in English (Kline, Acosta, Austin, & Johnson, 1980). More research needs to be conducted in this area. However, available evidence suggests that language match is important in understanding psychotherapy and its outcomes among Latino/a's.

In other studies, variables in addition to ethnic match have been examined. Similar to the results with African Americans, Latino/a Americans who were matched with substance abuse counselors on gender and ethnicity did not utilize services more frequently or have better outcomes than those who were not matched on these variables (Fiorentine & Hillhouse, 1999). Nevertheless, individually tailored methods to enhance

counselor communication with Mexican American substance-abusing clients have been found to be more effective in reducing positive drug urine tests and enhancing treatment attendance (Dansereau et al., 1996). These methods were described previously in the section on African Americans. Individual tailoring of treatment methods may be a means of increasing the therapist-client cultural match (Sue & Zane, 1987).

Therapist Style

The effect of therapist style is a more recently investigated area in Latino/a psychotherapy research. Preliminary evidence supports the claim that Latino/a's prefer a directive counseling style over a nondirective style. Ponce and Atkinson (1989) found that Mexican American students gave more positive ratings to a directive counseling style than a nondirective style. Pomales and Williams (1989) found Puerto Rican and Mexican American students to have an overall preference for a directive counseling style. This preference for a directive style was found to exert a stronger influence than acculturation on the ratings of the counselor's knowledge of psychology, on counselor willingness to help, and on the students' own willingness to see a counselor.

Cultural Sensitivity Training

As mentioned earlier, development of cultural sensitivity training for therapists has been an important trend in providing effective services to minority populations (Acosta, 1984; Acosta et al., 1982; Lefley, 1985). In reviewing clinical and empirical findings on psychotherapy with Mexican Americans, Acosta (1984) described a research project that investigated 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 with topics drawn from the book *Effective Psychotherapy for Low-Income and Minority Patients* (Acosta et al., 1982). Post-program evaluations showed that therapists significantly increased their knowledge and sensitivity in dealing with low-income and minority patients, and patient followup data suggested that therapists may have been more effective, according to self- and patient reports, as a result of the orientation program (Yamamoto, Acosta, Evans, & Skilbeck, 1984). Another brief, intensive training program mentioned earlier in the section on African Americans—Cross Cultural Training for

Mental Health Professionals, also has been evaluated positively in increasing the effectiveness of therapists in servicing Latino/a's (Lefley, 1985). Thus preliminary research supports the efficacy of cultural sensitivity training. However, further empirical research needs to be conducted to replicate the findings of these studies. Moreover, the effects of cultural sensitivity training on psychotherapy outcome also need to be evaluated.

Situational or Treatment Variables

The need for culturally sensitive treatments for minority populations has been argued. However, research on the effectiveness of services for Latino/a's has been limited to indirect indices. No direct comparisons between the effectiveness of mainstream services and culturally sensitive services were found. Previous research has focused either on mainstream treatments or on culturally sensitive treatments. However, recent studies on cultural modification of treatments have begun to bridge the gap between mainstream and culturally sensitive treatments.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) has been found to be an effective, well-established treatment for depression in European American adults (DeRubeis & Crits-Christoph, 1998). Three studies in medical centers and outpatient university settings that have focused specifically on Latino Americans have reported similar results, suggesting that cognitive behavioral therapy reduces depression in Latino/a American adults and adolescents. One study did not include a control group (Organista et al., 1994), but two others demonstrated superior effects for CBT versus no-treatment control groups (Muñoz et al., 1995; Rossello & Bernal, 1999). A class for groups of clients based on CBT principles reduced Beck Depression Inventory (BDI) scores by 2 points but did not impact Center for Epidemiological Studies depression scores (Muñoz et al., 1995). This small effect on BDI scores may be a function of the class format without individualized attention. In the Rossello and Bernal (1999) study involving Puerto Rican adolescents, the effect size for cognitive behavioral therapy was .43. The evidence from the latter two studies qualifies CBT as a probably efficacious treatment for depression among Latino/a American groups by EST standards. CBT has also been found to reduce panic symptoms among Latino/a American adults in a community medical center setting

(Sanderson, Raue, & Wetzler, 1998). All 30 clients experienced two or more panic attacks before treatment. However, 15 clients were panic free at the end of treatment, and 24 experienced one or no panic attacks per week following treatment. However, this study did not include a control group. Cognitive behavioral therapy clearly shows promise in treating depression among Latino/a Americans and could become an effective, well-established treatment with one more well-designed outcome study.

Interpersonal Therapy

Another effective, well-established treatment for depression in European American adults is interpersonal therapy (DeRubeis & Crist-Cristoph, 1998). Rossello and Bernal (1999) compared the effects of CBT, interpersonal therapy, and a waiting list control group on depressed Puerto Rican adolescents. Cognitive behavioral therapy and interpersonal therapy were equally effective in reducing depression, and both treatments were more effective than no treatment. It is possible that the two treatments were equally effective because components of Puerto Rican culture, including *respeto* (respect for elders) and *familismo* (emphasis on family), were incorporated into both treatments. Rossello and Bernal (1999) suggested that the interpersonal approach is more consistent with Puerto Rican values and hence is the more culturally sensitive of the two treatment approaches. Because interpersonal therapy was not demonstrated to be superior to CBT, it awaits additional validation as a probably efficacious treatment by EST standards.

Family Therapy

A number of scholars believe that the family plays an essential role for Latino/a's as a source of help and support (Acosta, 1984; Padilla & Salgado de Snyder, 1987; Rogler et al., 1983; Rogler, Malgady, & Rodriguez, 1989). Nonetheless, in a study comparing structural family therapy, individual psychodynamic child therapy, and a recreational control condition for Latino/a boys with behavioral and emotional problems, Szapocznik et al. (1989) found that both structural family therapy and individual psychodynamic child therapy were more effective than the control condition in terms of limiting therapy dropout. During the study's duration, no significant differences were found in the reduction of emotional and behavioral problems between the treatment conditions. However, upon followup, families whose child had been in the individual psychodynamic child therapy condition were found to have deteriorated with regard to family functioning. In direct contrast, those families in the structured family therapy condition displayed improvement in family functioning. Those families in the control condition remained the same in terms of family functioning.

Group Therapy

The group therapy format has been advocated as useful with Latino/a's 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, which did compare different types of group interventions, have demonstrated the efficacy of a group format (Costantino, Malgady, & Rogler, 1986; Malgady, Rogler, & Costantino, 1990b). Kay, de Zapien, Wilson, and Yoder (1993) randomly assigned elderly Mexican American widows to a no intervention control group or to a support group conducted primarily in Spanish. The support group also incorporated Mexican American cultural elements. Women in the support group showed significant decreases in anxiety, somatization, and affective symptoms, whereas the control group did not. Because there was no comparison treatment, it is unclear if the treatment effects were a function of the group format or of the cultural elements. Thus group therapy appears to be beneficial for Latino/a's, but it is unclear if group therapy is more effective than individual therapy.

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 Latino/a's. Acosta, Evans, Yamamoto, and Wilcox (1980) developed a brief audiovisual orientation program for low-income clients to enable clients to understand the process of psychotherapy and act upon that understanding in therapy (e.g. an open expression of problems and needs). As noted earlier, low-income, Latino/a, 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). Little research on this

topic has been published in the last 20 years, despite the positive effects reported earlier.

Culturally Specific Treatments

One of the most innovative areas of psychotherapy research with Latino/a's has been the development of culturally sensitive treatment modalities. Although the effectiveness of many of these culturally-specific treatments remains to be determined, some of them have been subject to empirical study and 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 was compared with art/play therapy and with no intervention for high-risk kindergarten through third grade Puerto Rican children (Costantino et al., 1986). There was a significant effect due to cuento therapy treatment, and a significant interaction between treatment and grade level, with differences between treatments only at the first grade level. First grade children who received cuento therapy showed significantly less trait anxiety than those in the other groups after 20 weeks of treatment. Cuento therapy was more effective in reducing trait anxiety than no intervention but did not significantly differ from art/play therapy. In addition, cuento therapy significantly increased scores on the Wechsler Intelligence Scale for Children-Revised (WISC-R) comprehension subtest compared to art/play therapy and the no intervention controls.

In a study supporting the effectiveness of cuento therapy for Puerto Rican children, Malgady, Rogler, and Costantino (1990a; 1990b) found that cuento therapy significantly decreased anxiety and aggression, and significantly increased social judgment. Relative to an attention control group, cuento therapy has also been found to reduce anxiety and phobic symptoms, and results in better school conduct among Puerto Rican, Dominican, and Central American children, and adolescents (Costantino, Malgady, & Rogler, 1994).

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 Puerto Rican adolescents who were at high risk for mental health problems. This social learning-based intervention used biographies of famous Puerto Rican historical individuals to convey appropriate adult role models. Although there was no significant treatment effect on distress symptoms, treatment did significantly affect eth-

nic identity. Interestingly, the effect of treatment on adolescents' self-concept (which is different than ethnic identity) varied as a function of gender and with the presence or absence of the adolescent's father in the household. In household where the father was absent, self-concept was increased by treatment. However, for adolescents whose father was present, treatment did not affect the self-concept for boys but adversely affected the self-concept for girls. Malgady et al. (1990a; 1990b) speculate that the presentation of heroic figures may have resulted in negative outcomes because those who did have parental role models in the home may have compared their parents to the heroic figures, which resulted in subsequent feelings of inadequacy.

The effect sizes in the above studies of cuento therapy versus a control condition were generally in the medium range. These studies qualify cuento therapy as a probably efficacious therapy for Puerto Rican children according to EST criteria. One more controlled outcome study with children demonstrating the superior effects of cuento therapy versus another treatment, similar to the Costantino et al. (1986) study, but conducted by investigators other than Costantino and his colleagues, would qualify cuento therapy as a well-established treatment.

Social skills training has been adapted for Latino/a's by translating patient and therapist manuals and videos into Spanish and by having participants' families integrated into the treatment process in order to increase sensitivity to Latino/a cultural values of *respeto* and *familismo* (Kopelowicz, 1998). Adult Latino/a schizophrenics who received this culturally sensitive treatment exhibited better acquisition of social skills and a reduction of schizophrenic symptoms relative to a group who had monthly visits to psychiatrists. However, it is unknown if the cultural adaptation of the social skills training approach would have been superior to social skills training that was not culturally adapted. Moreover, the specific Latino/a groups in the study were not specified.

SUMMARY OF FINDINGS FOR AFRICAN AMERICANS, AMERICAN INDIANS, ASIAN AMERICANS, AND LATINO/A AMERICANS

Across the four ethnic groups discussed above, there are some common findings. Many ethnic

minority persons tend to prefer therapists of their own ethnicity. In mental health service settings, ethnic matching of clients and therapists has been associated with longer service utilization and better outcomes, as measured by clinician ratings. These results have been found in large studies and are not necessarily substantive. It is possible that ethnic matching is an imperfect measure of cultural match (e.g., same language, similar values, similar world views) between clients and therapists, and that cultural matching is more substantively associated with positive treatment outcomes. There is some evidence that cultural sensitivity training for therapists and pre-therapy orientation for clients may help improve client-therapist cultural match.

Cognitive behavioral and interpersonal therapy appear to have promise in treating depression among African Americans and Latino/a Americans. The interpersonal approach may be more consistent with the interdependent cultural characteristics of ethnic minority cultures (Rosello & Bernal, 1999). Additional comparative studies are needed to determine the effects of cognitive behavioral versus interpersonal therapy with ethnic minority groups. The results of research on specific psychotherapy approaches with American Indians and Asian Americans are equivocal.

An overall conclusion is that much more psychotherapy research is needed with ethnic minority populations. Much of the published literature on psychotherapy with ethnic minorities is conceptual without actual hypothesis testing (Hall, 2001). A notable exception is the empirical work on cuento therapy, which utilizes cultural folktales to convey morals and models of adaptive behavior to children. Cuento therapy appears to be effective in reducing children's anxiety. In general, the potential benefits of integrating conceptually based, culturally relevant treatment into treatments established for Whites remain to be investigated (Hall, 2001).

EVALUATION OF RESEARCH METHODS AND THEORIES FOR CULTURALLY DIVERSE POPULATIONS

Numerous methodological difficulties complicate any empirical inquiry into the process and efficacy of psychotherapy, and these have been well documented elsewhere (e.g., Kazdin, 1994). These problems include inadequate sample selection, inappropriate outcome criteria, ambiguity

over the types of therapists and treatments used, nonconvergence among outcome criteria, observational biases, incorrect statistical analyses of change, inappropriate designs for the outcome question being addressed, inadequate control groups, uncertainty over the clinical and social value of the treatment-produced magnitude of change, and inadequate power in terms of design sensitivity. We now focus on 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

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 has often 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 *imply* differences in culture. Cultural differences refer to variations in actual attitudes, values, and perceptual constructs that result from different cultural experiences. As Zane and Sue (1991) have noted,

> Whereas the former simply involves group membership, the latter constitutes a host of cognitive variables that 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, although important, has not directly tested the cultural difference hypothesis of treatment (p. 52).

Ethnic differences are only indirect indices of the more important cultural differences, which 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 the 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

There has been a great reliance on analogue studies involving: (a) the use of simulated rather than actual treatment sessions, (b) the sampling of students instead of clients, (c) the assessment of change over one treatment session rather than over the course of many sessions, and (d) the examination of client preferences for certain personal characteristics of the therapist (e.g., ethnicity, professional status, attitude similarity) and for certain types of therapist approach (directiveness, trustworthiness, pro-assimilation versus pro-pluralism, culture-salience vs. culture-blind). Excellent discussions of the advantages and disadvantages of using analogue strategies have been presented elsewhere (Kazdin, 1986).

Related to these issues are specific problems that result from the examination of cultural influences. First, it is questionable whether 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 of Latino/a's have found few ethnic effects in therapist credibility (e.g., Furlong, Atkinson, & Casas, 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 of this process, the rating of one's therapist in credibility 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 the treatment process. 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 to cultural effects as operationalized by these two variables.

Finally, analogues may curtail the range of clinical problems that are typically presented by ethnic clients suffering from real problems. Issues such as racism, cultural adjustment, ethnic identity conflicts, and intergenerational difficulties are more frequently presented by ethnic clients. These areas may also be the most problematic for nonethnic therapists who likely would be less familiar with these experiences. These are complex issues that may not be discussed by ethnic clients until trust and rapport have been established (Ridley, 1984). Again, the brevity and focus on initial sessions of analogues tend to exclude many clinical situations in which cultural differences may have their most impact. The reliance on analogue studies stems partially from the earlier tendency in psychotherapy research to concentrate on efficacy issues. In efficacy studies, the focus is primarily on the intervention and on the rigorous evaluation of intervention effects under highly controlled conditions (Barlow, 1996). To optimize internal validity and replicability, the effects of factors that may obscure treatment effects are minimized. For example, factors such as differential treatment expectations, variations in therapist behaviors and skills, and client heterogeneity are controlled as much as possible through the use of nonspecific control groups, treatment manuals, and very restrictive inclusion and exclusion criteria for client selection (Nathan, Stuart, & Dolan, 2000).

Within this approach, analogue studies can be useful in that they can examine, under very controlled conditions, the specific aspects of the treatment that may account for some of its effects. Although much has been learned from efficacy studies about which particular treatments actually improve client symptoms and functioning, there is growing appreciation for the need for effectiveness research to complement efficacy investigations. Effectiveness studies determine whether treatments have favorable and useful effects with clients who typically use mental health services in real-life community settings and circumstances. A major interest in the study of effectiveness centers on how certain contextual and individual difference variables moderate the effects of treatment. Factors often considered sources of error in efficacy studies are allowed to vary or are systematically varied to assess their impact. It should be noted that sociocultural factors essentially constitute a subset of these variables. Much of the research reviewed here points to the importance of determining how variables that map onto important ethnic and cultural differences on the part of clients and/or therapists can moderate the effects of treatment and services.

Samples Selected

The heterogeneity within each ethnic minority group has often been noted by researchers (e.g., Clark, 1972; Leong, 1986). For each group there are important variations in sociodemographic and psychosocial characteristics that include country of origin, immigration history (length of stay in refugee camps, immigrant versus refugee status), place of residence (urban versus rural, urban versus reservation), education level (both in the United States and the country of origin), motivation for leaving country of origin, acculturation level, socioeconomic level, English proficiency, ethnic identification, and preferred language. Despite this documented diversity, few studies have 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/a and Anglo American culture. In responding to a directive or nondirective style, Latino/a-acculturated students rated the non-directive 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/a-acculturated students regardless of therapist style. By not identifying subgroup characteristics (e.g., level of acculturation, tribal affiliation, different Asian groups, and different Latino/a 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 population of ethnic minority groups. Small population size creates problems in trying to find not only representative samples for study but also adequate numbers of participants. 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; evaluations based on norms developed on White populations; conceptual and scale nonequivalence of measures across different cultural groups; difficulties in administering instruments to limited-English speaking clients or in making adequate translations; and cultural differences in approaching assessment tasks (Okazaki & Sue, 1995). 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 ethnic groups because another, more recent, and sophisticated measure is developed for the rest of the country and may also be used with ethnic minority groups without validation. This results in the situation in which the assessment of ethnic minority populations frequently lags behind, and ethnic minorities are given new 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 minorities 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 of 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. 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, type of living environment, 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 often has 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 cultural differences that should serve as the focus of process and outcome studies. Ethnicity and race often are used as proxies or as distal variables for a set of other, not explicitly measured, variables (Walsh, Smith, Morales, & Sechrest, 2000). The focus on the broad concept of ethnicity has frequently obscured important variations that could be related to treatment outcome within both the ethnic minority *and* White groups. Moreover, intervening cultural variables tend to exist 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 variables (e.g., coping styles) also have been the focus of previous studies on process and outcome. Ultimately, the meaningfulness of race or ethnicity and of more proximal cultural variables is an empirical/theoretical issue.

CONCLUDING COMMENTS

We now know that ethnic and cultural group variations are related to certain processes and outcomes in psychotherapy. However, the exact nature of these effects seems less clear. 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. Questions have been posed by researchers, such as: (1) Is psychotherapy effective for ethnic minority clients; (2) what are utilization and dropout rates; (3) which kind of individual differences affect treatment; and (4) 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 have implications for programs and policies. Nevertheless, there is a need for programmatic research that focuses on more theoretical issues. For instance, why do we see underutilization of services by some ethnic groups, and why are culturally responsive or culturally congruent forms of treatment effective? A more theoretical focus is occurring in some areas. For example, we do see some research issues in which descriptive and theoretical advances are being made by groups of researchers (e.g., 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 that helps to improve ideas, theories, and methodologies and to stimulate other research.

Second, many researchers and practitioners believe that psychotherapy is relatively ineffective with members of ethnic minority groups. Subsequently, they believe that providing a definitive answer based on research findings is not possible. The reason for this is that only a few empirical studies are available and the question of psychotherapy effectiveness is complex, requiring more than an affirmative or negative response. If we put aside the subtleties and complexities involved in the question of overall effectiveness, we have some reason to believe that certain conditions are related to aspects of effectiveness: ethnic similarity for clients and therapists of some ethnic minority groups; the use of some culturally responsive forms of treatment; pre-therapy intervention with ethnic clients; and the training of therapists to specifically work with members of culturally diverse groups. It is yet unclear if the

therapies that have been proven efficacious are actually effective with ethnic minority individuals. Although they may well be beneficial for all groups, the paucity of rigorous research findings leaves open the question of whether the empirically supported therapies (ESTs) for major depression such as cognitive behavioral therapy or interpersonal psychotherapy actually are effective with most ethnic minority individuals. Clearly, more effectiveness studies are needed to address these basic questions of generalizability before these ESTs can be considered as "best practice" interventions for minority clientele. It should be noted that we are not suggesting that ethnic minority clients avoid the use of psychotherapy, even in the absence of rigorous empirical research on outcomes. Our position includes the following: that therapy can be very helpful, but the factors underlying culturally competent services should be identified, and more research should be conducted on treatment outcomes.

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. Ethnic researchers must often confront additional methodological and conceptual problems that other researchers do not encounter to the same extent. 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 current research is going beyond the evaluation of treatment issues for African Americans, American Indians, Asian Americans, and Latino Americans 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 researchers who study ethnic issues. 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 improved substantially because of the pioneering work of many scholars, and the viewpoints of "insiders" to the groups (i.e., those who

conduct ethnic minority research) have increasingly been expressed. In closing, we offer some personal comments and observations about ethnic minority research.

Ethnic minority research in general, and ethnic psychotherapy research in particular, were largely initiated on African Americans because of the long oppressive history of African Americans by Whites in this country and the need to address these relations. This early 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/a 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 greater 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 government agencies that control mental health services is of concern for African Americans. The nature of services is also of concern to the other groups, but other additional issues such as the underutilization of services among Asian Americans and Latino/a Americans are especially salient for these ethnic groups. Unlike African Americans and American Indians, Asian Americans and Latino/a 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 factors to consider. American Indians who live on reservations are more isolated from mainstream American culture than are, say, Latino/a Americans living in urban ethnic communities. Many have experienced cultural genocide—the destruction of traditional folkways. Using culturally based psychotherapy approaches may serve not only to increase treatment effectiveness, but also to reaffirm the cultural folkways. As indicated previously, much research on the role of ethnic identity in psychotherapy among African Americans has been conducted by Helms and her colleagues (e.g., Helms & Carter, 1991; Parham & Helms, 1981). For Latino/a Americans, ethnic identity is also important but it is part of a larger issue—acculturation and assimilation (Padilla, 1980). With the continuing immigration of

Latino/a's to this country, there is a constant source of cultural values coming from Latino/a "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/a 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.

Finally, there has been a move away from population-focused studies in which research has examined ethnic or cultural between-group differences on psychotherapy process and outcome. Although this parameter-based research has provided important information about the treatment experiences of ethnic minorities, the focus on between-group differences has obscured important variations among members of a particular minority group. More significantly, the descriptive nature of this research has precluded determining exactly how culture affects the treatment experience and eventual outcomes. Recently, greater emphasis has been placed on variable-focused studies in which the research examines how specific psychological elements associated with ethnic or cultural group differences (namely, the specific aspects of culture) affect treatment or moderate treatment effectiveness. This shift to studying culturally based variables such as cultural value orientation, cultural identity, control orientation and shame and stigma, allows us to better explain and understand the specific effects of cultural influences.

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