

# **CBT+ and Culturally Responsive Practice**

Sponsored by

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# Introduction

In today's progressively global world, professional health and mental health care providers are increasingly required to interact with families whose race, culture, national origin, living circumstances, and family composition are different from their own. This is particularly true in almost any urban clinic in the U. S., but especially so in public contexts, where providers routinely encounter multiethnic and multiracial populations. (Alegría, Atkins, Farmer, Slaton, & Stelk, 2010, p. 48)

The US is an increasingly diverse country. It is estimated that there will be no majority racial or ethnic group by 2050. This shift will come far sooner for children. Currently, first generation immigrants make up about 10% of the population and 43% of children in the US are from racial or ethnic minorities: 20% are Latino, 15% are African American, and almost one fifth is immigrants. In contrast, the mental health work force is primarily white, female, highly educated, and better off economically than many. This overall difference creates the possibility of a disconnect between clients and providers that can affect aspects of the delivery of mental health services including engagement in services, acceptance of treatment approaches and expectations, and actual or perceived benefits.

Insuring that all children with mental health needs and their families are able to access needed care and that the care is acceptable and beneficial requires efforts on many levels. This is especially true for diverse communities that face disproportionate socioeconomic burden and persisting racism, and for whom there is a long history of disparities in access to and engagement in health care. The purpose of this report is twofold: 1) to briefly summarize the current state of knowledge on mental health services and mental health interventions with respect to racial and ethnic minorities and 2) to describe how CBT+ can contribute to culturally responsive practice.

The second section of the report contains specific practice-based evidence suggestions generated by minority-serving mental health organizations and minority providers in Washington State. Practice-based evidence in the context of culturally responsive practice has been defined as:

...a range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice-based evidence services are accepted as effective by the local community, through community consensus, and address the therapeutic and healing needs of individuals and families from a culturally-specific framework. (Isaacs, Huang, Hernandez, & Echo-Hawk, 2005, p. 16)

This knowledge derived from direct experience can be incorporated into the delivery of evidence-based practices (EBPs) in public mental health.

This report is intended to be embedded into the much larger context of efforts to promote a culturally responsive mental health system of care. The purpose is to provide practical strategies to help EBP providers effectively and respectfully deliver evidence-based interventions in ways that are consonant with and responsive to cultural/ethnic values, attitudes, and beliefs.

## **SECTION I**

# **Summary of the Research on Cultural Responsiveness**

## I. Health and Mental Health Disparities

Increasing attention has been paid to racial and ethnic disparities in access, acceptability, and effectiveness of health and mental health service systems. The Institute of Medicine published an important report in 2003: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. The report confirmed that disparities are widespread and harmful to minorities across health care problems including mental health. Disparity is defined as differences in treatment or access not justified by the differences in health status or preferences of the groups. Another very influential report and call to action, *Mental Health: Culture, Race, and Ethnicity*, was published in 2001 by the U.S. Department of Health and Human Services (DHHS) as a Supplement to *Mental Health: A Report of the Surgeon General* (DHHS, 1999). The report reviewed the relevant mental health issues and documented “the existence of striking disparities for minorities in mental health services and the underlying knowledge base” (p. 3). The report concluded that: “A major finding of this Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and thus suffer a greater loss to their over-all health and productivity” (p. 3).

These disparities extend to children. In a review of racial and ethnic disparities in health and health care, Flores and the Committee on Pediatric Research (2010) found lower rates of mental health use compared to Whites for African American, Latino, Asian, and American Indian children. Many studies find lower rates of mental health use by minorities, with most studies focusing on African American and Latino children relative to White youth. African American and Latino children are less likely to have used any mental health services compared to Whites (Coker, 2009; Garland et al., 2005; Zimmerman, 2005), although other child characteristics are associated with disparities as well; for example, girls are less likely to receive treatment (Zimmerman, 2005). Not all studies find disparities or find them only for some groups or types of service (see Lester et al., 2002 for a review), but the overall picture is that even when need is taken into account, racial and ethnic minorities are less likely to attend therapy and tend to have lower engagement or therapy completion rates. Alegría, Valles, and

Pumariega (2010), in their review, concluded that minority children have the highest unmet need and are undertreated compared to White children.

Numerous studies have investigated the underlying explanations for the disparities. The relationships between the contributing factors and the disparities in care are complicated and vary among studies depending on which factors are being examined, including those at an organization level (lack of public or private insurance, location of services, availability of linguistically matched providers or interpreters, organizational climate), at the provider level (bias, lack of cultural competence), and knowledge or attitudes among clients (stigma about mental health, poor health education, perceived or actual conflict with cultural values). Some factors may be more relevant for certain groups. For example, one study (Alegría, Lin, Chin, et al., 2012) showed that increasing the availability of insurance and expanding the availability of community clinics where minorities are more likely to seek care reduced service disparities between Whites and Latinos, but African Americans with mental health needs continued to be less likely to access care.

Additionally, mental health service disparities for children vary by racial/ethnic group and mental health needs. In a large national study, Alegría, Lin, Green, et al. (2012) found that there were no racial or ethnic differences in the identification of mental health problems among adolescents or in encouragement to seek care. On the other hand, identification through systematic assessment and specific encouragement to seek mental health care was associated with increased likelihood of receiving services for all racial and ethnic groups. Despite this, even when children do attend services, most have relatively few visits; racial and ethnic differences are sometimes but not always found in the number of sessions attended. These findings suggest that identification of mental health needs may not be a strong locus of disparity.

The pathways to mental health services reveal additional disparities, particularly in the relationships between race/ethnicity, type of disorder, type of mental health symptoms, and service settings. For example, in a study of depressed youth, Cummings and Druss (2011) found

that only 38% of all depressed youth received any mental health care, but African American, Latino, and Asian youth had even lower rates after accounting for family income and insurance, with Asians having the lowest rates (White: 40%; African-American: 32%; Latino: 31%; Asian: 18%). Similarly, in a large nationally representative sample, Merikangas et al. (2011) found that disparities vary by type of disorder: Latinos were less likely than other groups to receive treatment for mood and anxiety disorders, African Americans were less likely to receive treatment for mood disorders, and other/multiracial ethnic youth were less likely to receive treatment for anxiety and ADHD. In studies of youth in juvenile justice (Gudiño, Lau, Yeh, McCabe, & Hough, 2009) or child welfare (Martinez, Gudiño, & Lau, 2013), both internalizing and externalizing problems were related to White children receiving services whereas only externalizing problems were related to African American children accessing services, which reveals an interaction with the type of mental health symptoms. For children with substance abuse and co-morbid problems, African American youth are less likely to use both formal and informal services (e.g., AA), whereas the disparity only extends to informal services for Latino children (Alegría, Carson, Gonçalves, & Keefe, 2011). In a large national study of adolescents, Cummings, Ponce, and Mays (2010) reported significant disparities for minority youth with clinical need in attending specialty clinics, but no racial or ethnic differences for school-based services. These findings suggest that it is not just race/ethnicity that matters; instead, there may be an interaction between type of problem, type of service, and service setting.

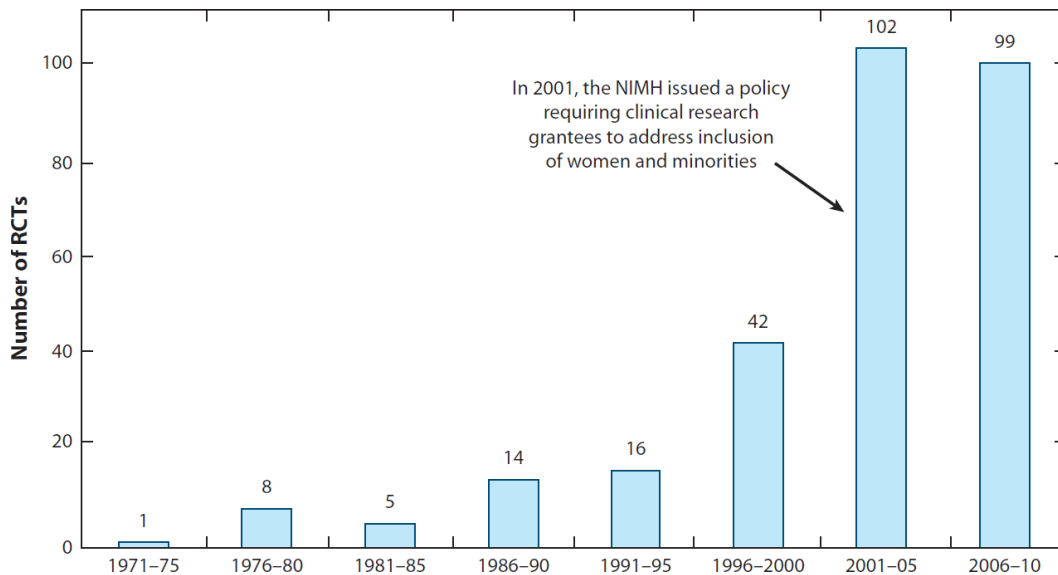
Overall, the body of literature finds racial and ethnic disparities in access to—and use of—mental health services, with disparities found most consistently for African American youth compared to other youth. However, differences are not found in all areas and are moderated, or even eliminated in some cases, when mental health need, setting, insurance, or other factors are taken into account. In some cases, the differences involve an interaction among factors. These findings highlight the fact that disparities may occur differentially among ethnic groups and that various strategies at different points will be required.



## II. Treatment Effectiveness and Racial and Ethnic Minorities

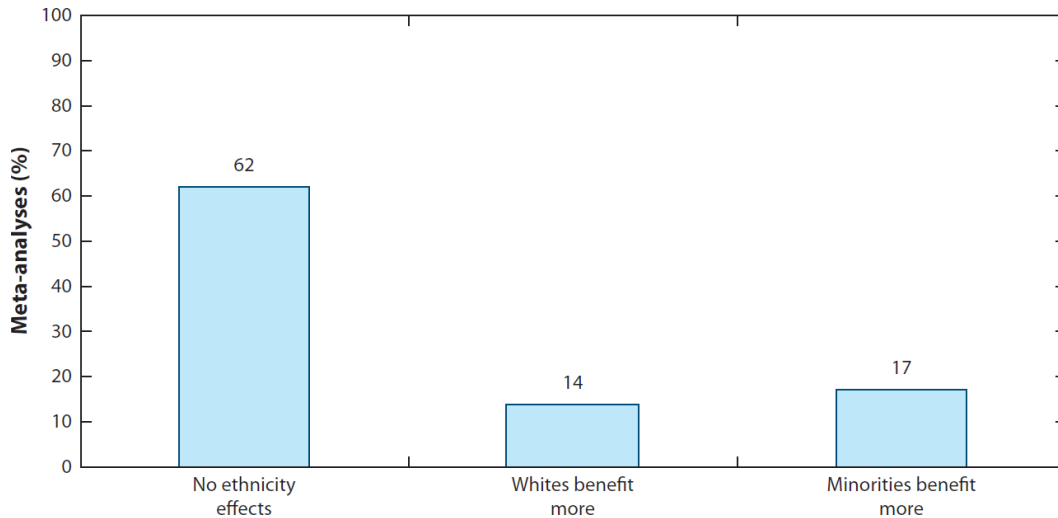
Research has also investigated outcomes for racial and ethnic minority children who do receive mental health services. In recent years, there has been a substantial increase in the number of randomized controlled trials that are minority-focused. These are studies in which the children are predominantly minority, studies that specifically assess the impact of minority status on outcomes, and studies that assess treatment outcome by race/ethnicity. Most studies involve African American and Latino children, but increasingly there are studies focused on Asian families (Lau, Fung, Ho, Liu, & Gudiño, 2011). The treatments cover a broad range of conditions in youth including ADHD, externalizing behavior problems, anxiety, and depression. Few differences are found in outcomes across minority groups for those receiving treatment. The results showed that minority youth benefit by therapy in general (Bernal, Jiménez-Chafey, & Rodríguez, 2009; Bernal, Sáez-Santiago, & Galloza-Carrero, 2009; Hodge, Jackson, & Vaughn, 2010; Huey & Polo, 2008; Miranda et al., 2005).

*Figure 1.* Number of randomized trials of psychosocial interventions with an ethnic minority focus, in 5-year intervals. Retrieved from Huey, Tilley, Jones, & Smith, 2014, p. 311.



More recently, there has been specific focus on evidence-based treatments (EBTs) and whether they are effective for racial and ethnic minorities. This is a very important question as policy makers and payers increasingly promote or preferentially reimburse EBTs. One method of evaluating the effectiveness of EBTs with minorities is conducting studies that have sufficient numbers of minority youth and that compare outcomes for minority and non-minority youth. Huey and Polo (2008) reported that the majority of studies with sufficient numbers of minority children to conduct analyses showed no ethnicity effects (62%), whereas 15% had stronger effects for White youth and 23% had stronger effects for minority youth. Huey et al. (2014) cited a more recent review that he and a colleague conducted on ethnicity effects showing essentially the same pattern.

Figure 2. Percentage of treatment outcome meta-analyses ( $N = 29$ ) showing no ethnicity effects, White advantage, or ethnic minority advantage (adapted from S. J. Huey Jr. & C. Smith, unpublished manuscript). Retrieved from Huey et al., 2014, p. 314.



### **III. Cultural Responsiveness to Address Disparities**

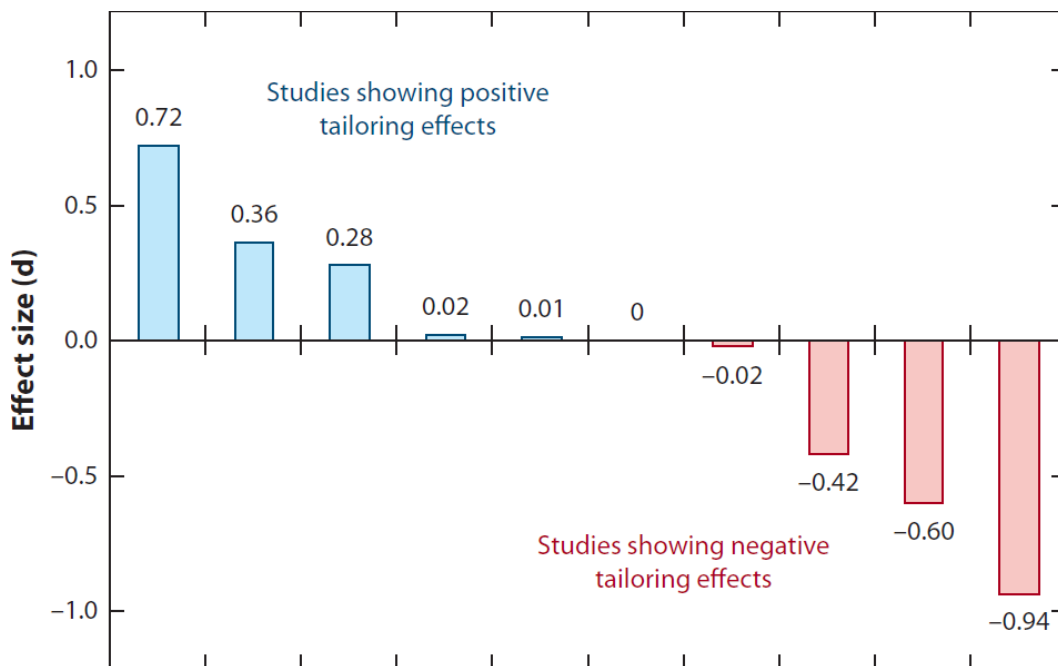
A variety of terms are used to describe culturally-specific modifications in the delivery of treatments: culturally sensitive, culturally adapted, and culturally tailored. Huey et al. (2014) state that most minority-focused treatments involve some amount of tailoring to the specific client group that is targeted. The modifications generally have the goal of increasing the acceptability and meaningfulness of the treatment program. The adaptations may be informal and woven into treatment delivery or they may be full models that are specifically designed for a particular racial or ethnic group.

Many commentators (Alegría et al., 2010; Huey et al., 2014; Kataoka, Novins, & Santiago, 2010; Pumariega, Rothe, Song, & Lu, 2010; Sue, Zane, Hall, & Berger, 2009) describe the various strategies for creating culturally adapted versions of standard EBTs. The most common focus is on incorporating culturally relevant and congruent concepts, metaphors, and analogies into the models. The goal is to make the interventions more acceptable and meaningful to diverse groups. These modifications or adaptations are frequently developed in collaboration with diverse community representatives using focus groups, consultants, or advisory groups. Extensive investment is made in cultivating ongoing relationships with minority-serving organizations to support referral pathways and coordinate care. It is common to use culturally or linguistically matched therapists to deliver the interventions. Additionally, more time may be expended in engagement before beginning active therapy. Huey et al. (2014) noted that adjustments specific to racial or ethnic group are more likely to be successful than generic modifications.

Very few studies have addressed whether cultural tailoring of EBTs produces superior results; a few have noted that cultural tailoring can potentially undermine treatment effects. It is possible that too much focus on cultural elements reduces the therapy time spent on what are presumed to be the active core ingredients for change. Huey et al. (2014) directly tested this question by comparing 10 studies in which the only difference between treatments was the

cultural tailoring. In this meta-analysis, there were no differences for treatment engagement or treatment outcome between the standard and the tailored versions. On average, when moderator analyses were conducted, implicit tailoring (adjustments made outside of patient awareness) was associated with better outcomes, whereas explicit tailoring (adjustments that were discussed openly with patients) was associated with poorer outcomes. An example of implicit tailoring is an Asian cultural adaption of an exposure treatment that involved more directive therapist commands (Huey & Pan, 2006). Potential reasons offered for this moderator effect include patients feeling stereotyped; feeling that race/ethnicity was not relevant to treatment-related goals, or again feeling that time spent discussing culture-related topics may have reduced time spent on other important treatment tasks.

Figure 3. Individual effect sizes for 10 randomized trials comparing culturally tailored vs. generic treatments for ethnic minorities (adapted from Huey, 2013). A positive effect size means that outcomes favor the culturally tailored condition; a negative effect size means that results favor the “generic” condition. Retrieved from Huey et al., 2014, p. 327.



## **IV. Cultural Competence to Address Cultural Disparities**

There is an extensive and rich literature on culturally competent practice. Cultural competence generally refers to the treatment context including organizational climate and provider awareness and attitudes. Leading commentators (Alegría et al. 2010; Kataoka et al., 2010; Huey et al., 2014; Pumariega et al., 2010; Sue et al., 2009; Whaley & Davis, 2007) have reviewed the literature and noted that there are a variety of terms used to define the concept. Cultural competence can include a broad range of organizational and individual provider activities. Activities at the organizational level might include locating programs in areas where racial and ethnic minorities live or embedding mental health in primary care community clinics, maintaining strong collaborative relationships with diverse community groups, having a work force that reflects the racial/ethnic makeup of the clients, and proactively addressing the importance of linguistic access considerations.

At the provider level, cultural competence refers to knowledge, attitudes, and skills. As cited by Sue et al. (2009), cultural competence at the provider level consists of three components:

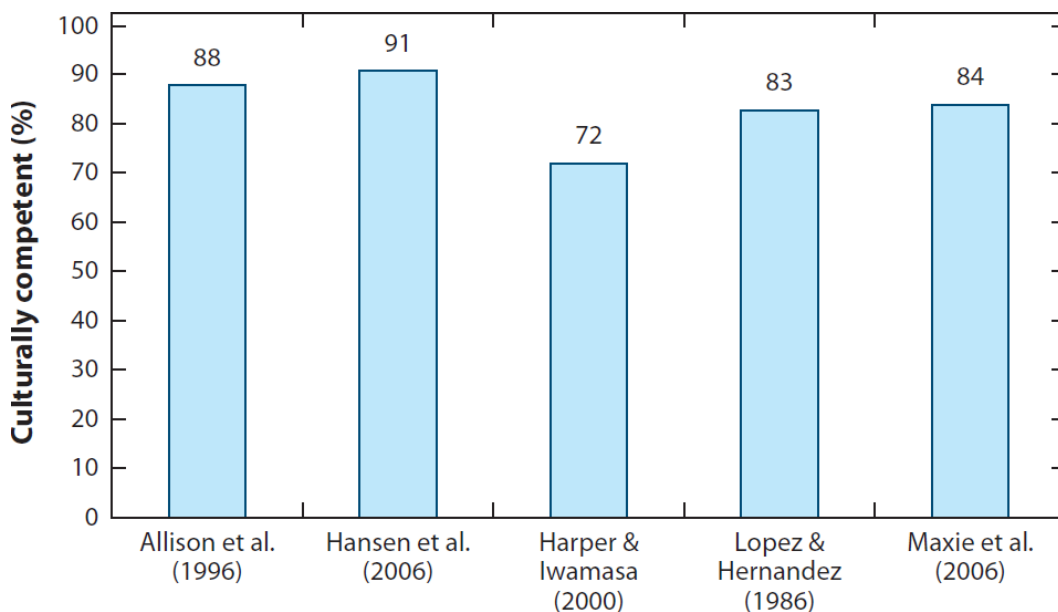
- Cultural awareness and beliefs: The provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem and the counseling relationship.
- Cultural knowledge: The counselor has knowledge of the client's culture, worldview, and expectations for the counseling relationship.
- Cultural skills: The counselor has the ability to intervene in a manner that is culturally sensitive and relevant. (p. 529)

Racial or ethnic matching of clients and providers is considered an important form of culturally competent practice. However, the evidence for its relevance is more complicated. Cabral and Smith (2011) conducted a meta-analysis of research on racial matching. While racial and ethnic minorities tended to prefer providers of the same background and had moderately more favorable views of racial/ethnically matched providers, no differences in outcomes were found.

In other words, there are perceptual differences in acceptability but no actual impact on outcomes. These results are helpful given that it would be impossible to create a service system in which matching across all ethnic/racial groups was a necessary factor in achieving positive outcomes. The findings do suggest that it is likely important to have a diverse work force that reflects the community served to both increase engagement and to create a more positive view of the organization and the services offered. An emphasis on racial/ethnic matching may not improve outcomes nor, interestingly, is it always client preference. When possible, it is desirable to offer choices and respect strong preferences as might be done in other instances (e.g., female rape victim preferring female therapist).

It would seem that the recent emphasis on cultural competence has had significant penetration among mental health providers. Huey et al. (2014) reported that across studies of mostly White providers, a majority consider themselves to be culturally competent and to engage in activities (e.g., openly discuss race/ethnicity) that are often considered a part of culturally competent practice.

Figure 4. Percentage of clinicians who self-report competence in working with ethnic minority (or diverse) clients. Retrieved from Huey et al., 2014, p. 324.



However, provider self-report may not reflect actual practices and provider perceptions may not extend to their clients nor have any relationship to outcomes. In a large study of substance abuse treatment, Imel et al. (2011) directly addressed the question of general competence and cultural competence by comparing the outcomes of providers across racial and ethnic groups. The results showed that some therapists were more effective than others, but general competence did not always extend to competence with racial or ethnic groups. Some therapists were more effective with minority groups. From this perspective, cultural competence would be defined by the outcomes achieved by providers with diverse groups, not the perceptions of either providers or clients. More investigation is needed into the factors that are associated with successful outcomes for different ethnic/racial groups.

## **V. Summary of Research on Cultural Responsiveness and Treatment Outcomes**

Overall, there is good news about the effectiveness of psychosocial interventions for racial and ethnic minorities across a broad range of conditions. Research suggests that standard EBTs are generally as effective for minorities as they are for White clients. Culturally sensitive adaptations show benefit for racial and ethnic minorities, especially when the treatment approaches are bona fide or evidence-based and when the focus on culture does not overtake the presumed active ingredients of the intervention. In addition, for some conditions, there are specific culturally tailored versions available. Given these findings, Lau (2006) argued that adaptations or tailoring should be “selected and directed.” In this approach, instead of assuming that clients from diverse backgrounds prefer or will benefit more by a culturally modified approach or racial/ethnic matching, decisions can be made on a more systematic and specific basis.

The convergence of the evidence suggests that a variety of approaches with evidence-based interventions for ethnic/racial minorities will be effective. Results from studies of evidence-based parenting programs provide an illustration. Chaffin, Bard, BigFoot, and Maher (2012) found equivalent outcomes for Native Americans and other groups for a standard evidence-based parenting program (SafeCare). Importantly, ratings by Native American and other groups for working alliance, satisfaction, and cultural competence did not differ and were higher for the evidence-based intervention versus usual care. Lau et al. (2011) tested another evidence-based parenting program (Incredible Years) compared to waitlist control with Chinese immigrant parents in a randomized trial. Although providers made some adjustments in initial engagement strategies, by and large the standard model was delivered. However, the investigators worked closely with community organizations to recruit families and used bilingual, bi-cultural therapists. In this case, the cultural adjustments primarily involved the setting and the providers, not the intervention model per se. The evidence-based intervention was effective for the Chinese immigrants. In another example, McCabe, Yeh, Lau, and Argote



(2012) developed a Mexican-American adaptation (GANA) of a well-established parenting program (PCIT) and compared it to the standard model and to treatment as usual. The results showed that the culturally modified version performed the best in terms of effect sizes, with the standard evidence-based version having results between the cultural adaptation and treatment as usual. However, the cultural adaptation only outperformed the standard evidence-based version on one outcome (internalizing scores). Importantly, for all three conditions, the therapists were bilingual and presumably brought a culturally sensitive approach to whatever intervention they delivered.

These studies exemplify the results of the scientific research for cultural responsiveness. One conclusion is that evidence-based interventions produce better outcomes and may be perceived as culturally responsive compared to usual care by minorities as well as Whites even when no adjustments are made. However, being culturally responsive by having close working relationships with local community agencies serving the cultural group, being a culturally-specific mental health organization, having a diverse work force, using bi-lingual and bi-cultural therapists, or making specific cultural adjustments within the evidence-based models may increase engagement and—in some cases—improve outcomes.

## **SECTION II**

### **Cultural Responsiveness in CBT+**

## VI. What is CBT+

CBT+ is model for training public mental health providers in EBPs using a modified Learning Collaborative approach that involves an in-person learning session and expert case consultation. CBT+ teaches four specific EBTs within the program. The interventions are Cognitive Behavioral Therapy (CBT) for anxiety, CBT for depression, Trauma-Focused (TF) CBT for trauma impact, and parent management training (PMT). These intervention targets are relevant for approximately three-fourths of children in public mental health. All four interventions are on the Washington State Institute for Public Policy (WSIPP) Inventory as evidence-based or research-based (WSIPP, 2013). The CBT+ program consists of the CBT+ training/consultation, ongoing support for CBT+ supervisors, advanced training, and special projects related to implementation and sustainment of EBP in public mental health in Washington. This report is a special project of CBT+.

Of the four treatments included in CBT+, TF-CBT has the most empirical support for effectiveness with minority groups, primarily African American children. Two culturally responsive adaptations of TF-CBT exist. A Native American version has been developed by Dolores Subia BigFoot (<http://www.icctc.org/>). Michael de Arellano has developed a Latino version of TF-CBT ([http://academicdepartments.musc.edu/ncvc/about\\_us/faculty/dearellano\\_bio%2008.htm](http://academicdepartments.musc.edu/ncvc/about_us/faculty/dearellano_bio%2008.htm)). CBT for depression has generally been found to be effective for racial and ethnic minorities and cultural adaptations exist (e.g., Duarté-Vélez, Bernal, & Bonilla, 2010). There are numerous PMTs and many of the brand names have been found effective across racial and ethnic groups. The non-brand name version used in CBT+ is presumed to be effective even though specific studies of diverse groups have not been carried out. Similarly, CBT for anxiety is considered highly effective but insufficient representation of minorities in studies preclude making definitive statements about effectiveness with diverse racial and ethnic groups.

CBT+ teaches the underlying principles and practices of CBT. Key principles are that the relationship between the provider and the client is transparent and collaborative; that therapy is active, structured, and time-limited; and that the essential ingredient of therapy is teaching new skills that are used in real life. The practices that are taught include engagement and motivational enhancement strategies, methods to change untrue or unhelpful cognitions, coping skills for intense negative emotions, and practicing new and more effective behaviors to reduce distress and achieve goals that are specific to the clinical targets outcomes (e.g., exposure for anxiety, activation for depression, selective attention for behavior problems).

## VII. Practical Suggestions for Cultural Responsiveness with CBT+

The CBT+ framework is highly consistent with cultural responsiveness as described by Pumariega et al. (2010):

Psychological interventions should be congruent with the values and beliefs of culturally diverse children and their families. More traditionally acculturated children and families may be more accepting of and responsive to therapeutic approaches with a practical problem-focused, here-and-now orientation. Clinicians must be realistic about the acceptability of therapeutic interventions that may not be consonant with the family's cultural values. At the same time, clinicians must advise families about naturalistic parenting approaches that may be acceptable in their culture of origin but may be considered unacceptable or illegal in mainstream culture, such as the use of corporal punishment. (p. 746)

Not only does CBT+ emphasize engagement and a collaborative approach with clients, but it is also practical and problem-focused. CBT+ delivers evidence-based interventions that are likely to produce the best outcomes for clients and allows for adjustments or adaptations to insure that the specific clinical strategies are meaningful and acceptable to minority clients.

### **Engagement**

CBT+ emphasizes the explicit use of specific engagement strategies as explicated by McKay et al. (1998). The steps include beginning the mental health encounter (on the phone or in person) with inquiry about the problems and needs *as described by the client*. The client is encouraged to describe their concern(s) in their own words and from their own perspective. Providers then explicitly communicate that help is available and that a positive outcome is possible. Following these steps, providers inquire about attitudinal barriers such as beliefs about mental health or

prior experiences with mental health (e.g., cognitions that might be barriers to utilization) and provide corrective information. They also proactively ask about concrete barriers to attendance (e.g., finances, child care, transportation) and proactively problem solve. CBT+ teaches that these strategies should *precede* asking questions that are mainly for the purpose of establishing eligibility or obtaining contact or other demographic information to the extent practicable.

By using a specific step-by-step initial engagement approach, providers can learn clients' treatment-relevant general and culturally-specific beliefs and attitudes at the outset. This step is most relevant for the parents/caregivers who bring the children to treatment, although it also matters for the children themselves. For example, recent immigrants or traditional families may have culturally-specific views about mental health treatment. Undocumented families may be worried that attendance at therapy could jeopardize their legal circumstances. Differences in degrees of acculturation between parents/caregivers and their children may be relevant to perceptions of what constitutes an emotional and behavioral problem as well as expectations of therapy. When parents/caregivers and children are encouraged to describe their views about mental health problems and mental health therapy, insight is gained into the views on the nature of the problem and how to best engage the family.

With racial and ethnic minority clients, the engagement phase creates an ideal opportunity to listen very carefully to how parents/caregivers describe their children's problems, including the specific words they use for behavior that brings them to therapy, how and why the children's mental health is of concern, and what their goals are. In addition, elicitation of attitudes about mental health problems and mental health treatment, as well as prior experiences with mental health services, provides invaluable clues about cognitions that are relevant to service engagement. For example, providers will learn how the family perceives the mental health problems (e.g., he needs to show more respect [behavior problem], she needs to be quiet because she has brought shame on our family [traumatic stress]). Cultural views that might pose a barrier to engagement can be surfaced (e.g., only crazy people go to therapy). Inquiring about concrete barriers and proactively problem solving these barriers signifies recognition of

the difficulties associated with the economic disparities that disproportionately affect racial and ethnic minorities. By making an effort to anticipate, overcome, or work around the concrete barriers, providers do not just make it possible for economically disadvantaged clients to attend but contribute to shifting cognitions toward a more favorable view of the organization and/or the provider.

By attending to what clients have to say about the mental health concerns that bring them in and eliciting their attitudes and beliefs about mental health and therapy, providers are better equipped to address cultural or other barriers to engagement in active therapy. They can immediately begin to consider ways to present therapy that are congruent with client and family values and beliefs. They can identify areas where there may be a need to counter negative prior experiences in ways that make sense to clients. It is also an opportunity to actively encourage clients to share culturally important or relevant input into the therapy process.

Another engagement consideration is the question of *who* is being engaged. The primary target of engagement activities should be the parents/caregiver. Parents/caregivers are needed to bring children to therapy, support therapy goals and treatment activities, and in the case of some conditions such as externalizing problems, parents/caregivers are the primary treatment participants. Focusing engagement on parents/caregivers is also a culturally responsive practice. It has been noted by many commentators on cultural competence that racial and ethnic minorities tend to prioritize a family orientation over an individual one. Meeting with parents/caregivers first, establishing a collaborative relationship with them, insuring that their beliefs and values are known and incorporated into the process, is a culturally sensitive practice.

## **Assessment**

CBT+ adheres to the Evidence-Based Assessment (EBA) approach. In addition to the clinical interview, EBA incorporates the use of standardized checklists to identify and quantify the clinical target. In this model, a specific clinical target is selected for the focus of treatment. Even though comorbidity is common, most evidence-based interventions argue for a systematic, concentrated focus on a specific target until there is improvement versus having multiple treatment targets at the same time. Parents/caregivers and children complete standardized checklists for the target conditions (behavior problems, anxiety, posttraumatic stress, depression) and receive feedback about the results from their provider.

The use of standardized checklists in assessment can contribute to a culturally responsive approach. Checklists compare the clients' answers to those of many others. Although most checklists do not provide norms for specific racial or cultural groups, the key quality they share is that the results reflect a comparison to another group of respondents, not a particularized judgment by the provider. This allows providers to present clients with information comparing their responses to those of many others and comment on it from their own perspective. Use of standardized checklists can serve as a non-judgmental mechanism for measuring a clinical problem. The key to making this process clinically meaningful is providing feedback and discussion. Of course, a comprehensive diagnostic interview and clinical assessment does not rely entirely on standardized checklists.

## **Psychoeducation**

Psychoeducation is the term for information that is provided in the course of mental health therapy. Psychoeducation is intended to support and promote the therapy experience by educating clients about the clinical condition (e.g., anxiety, depression, behavior problems, posttraumatic stress), the principles and practices underlying the therapy (e.g., transparent and collaborative, structured and skill oriented), and the treatment process (e.g., number of sessions, treatment expectations such as homework) and relationship (e.g., confidentiality). In many cases in public mental health, there may be other important topics for psychoeducation



such as accurate information about the child protection system or the criminal justice process when relevant.

The goal of psychoeducation is to influence cognitions so that providers and clients are on the same page about the process, expectations, and goals of therapy. The psychoeducation step of therapy is another opportunity to incorporate culturally relevant information. Culturally competent providers can incorporate what they already know about diverse cultural and ethnic groups and what they have learned from specific clients into the psychoeducation. For example, if a cultural group describes anxiety as “*ataque de nervios*,” then this is addressed during psychoeducation. Similarly, if a family labels child's misbehavior as disrespect, PMT is described as a program to teach children to respect their elders. It is incumbent on providers to translate what they have learned into their psychoeducational content. Psychoeducation is also a very important opportunity to normalize, validate, and instill hope.

In summary, the CBT+ practices of explicit engagement steps, use of standardized assessment measures, and systematic psychoeducation can all be capitalized on to promote culturally responsive practice. These steps precede and set the stage for the evidence-based active therapy process where change is the goal. Culturally competent therapists will endeavor to learn about the concerns from the perspective of the diverse clients, incorporate culturally relevant ways of describing child emotional and behavioral problems and family goals, and provide normalizing and corrective information that is culturally—as well as individually—meaningful.

## VIII. Results of the Culturally Responsive Applications of EBP Meeting

The purpose of the Culturally Responsive Applications meeting held on September 9, 2013 was to bring together evidence-based supervisors and racially and ethnically diverse providers to elicit practice-based evidence from their clinical context related to certain aspects of the CBT+ interventions. The focus was on potential cultural beliefs and attitudes that might collide with several of the core active ingredients of the four CBT+ models. The meeting was not intended to address the larger issues of disparities in access to mental health treatment, organizational or provider cultural competence, or engagement per se.

Participants represented 16 organizations, of which 5 are specialized racial/ethnic minority-serving organizations: Consejo Counseling Services, Asian Counseling and Referral Services, *beda?chelh* serving the Tulalip Indian Tribe, and Odessa Brown Children's Clinic and Atlantic Street Center serving a primarily African American population. KSARC has a program, Dando Voz, which provides therapy, case management and legal advocacy for Latino and Spanish speaking victims and their families. Supervisors and providers generated examples of client/family attitudes and beliefs they had encountered in their work that represented potential collisions with elements of the CBT+ interventions. Then they brainstormed strategies for overcoming these collisions and engaging clients in active evidence-based therapy.

Three specific active components across the CBT+ interventions were identified for focus: *parenting practices*, *emotional expressiveness*, and *dealing with trauma and adversity*. Within CBT+ *parenting* is the primary intervention for a behavior problem target, and positive parenting is part of the parent component of TF-CBT. PMT or evidence-based parenting approaches generally oppose coercive practices including corporal punishment or authoritarian approaches, promote explicit praise for desirable behaviors, and recommend rewards over consequences. All four CBT+ interventions teach skills for *management of emotions* (identifying negative emotional states, rating intensity, appropriate expression, specific coping skills). The

goal of TF-CBT is to help children and families *overcome the impact of trauma* by creating a new and more helpful perspective.



3. Obedience is respect/disagreement is disrespect.

4. Cultural clash between immigrant parents and more acculturated children

- Can lead to CPS involvement—educate regarding state definitions of abuse;
- Often has not solved the problem—explore this parent’s experience;
- Only changes behavior when parent is present to deliver the consequence (can use adult examples such as speeding when police not present);
- Parent will need other strategies when child is older/stronger.
- Point out that other parenting strategies are more effective at changing child behavior than corporal punishment. Would parent be willing to try out something new that might work better, even if it feels new/strange at first?
  - Can ask if parents have experience trying something new that felt strange at first but turned out to be a good change.
- Elicit views on respect and explore difference between respect and fear or submission: *“How do you define respect?”* AND/OR *“How do people earn those respects without physical coercion?”* AND/OR *“What authorities earn your respect? Police? Priest? How do they do it?”*
- Explore views on disagreement: *“Are there times you would WANT your child to disagree with adults/authorities?”* AND/OR *“Can you ever disagree with someone you respect?”* AND/OR *“Are there acceptable ways for a child to express disagreement in your family?”* AND/OR *“Did you ever disagree with your parents?”*
- Reframe unhelpful behaviors (parents’ nagging as caring; normative US child behaviors as learning to be successful in this country).

5. Why should a child be promised something for behavior they should know how to do?

Children should just do what they are told.

Punishment is what the child needs, not praise/reward.

- Elicit view on praise or rewards with open-ended questions: *“How were you raised? How did you know if you did something right growing up?”* AND/OR *“What do you think about praise?”* AND/OR *“What feedback do you give your children?”* AND/OR *“How does he know you are pleased with his respectful behavior?”* AND/OR *“How does your child know you are happy with him/his behavior?”*
- Identify a culturally-congruent way to talk about the process of communicating that the child is behaving well (e.g., “honor” or “recognition” vs. “praise”).
- Elicit descriptions of consequences of praise: *“What does your face look like when you are pleased that your child is learning from your teaching?”* AND/OR *“What does it feel like when you are told ‘good job’ by someone that matters?”*
- Brainstorm alternative ways to show praise (non-verbal). Align praising with behavioral goal (obedient, more respectful).
- Get child’s perspective on how caring or approval is shown in the family.
- Do a reward chart first if it is more acceptable, then teach praise.
- See if parents are willing to do an “experiment”/try something a little different. Have them identify an urgent behavior and ask: *“Would you be willing to try a little change to see if it makes difference?”* AND/OR *“Try it and pay attention to what your child does with this week. Just notice.”* Then follow up: *“How did it go?”* AND/OR *“How are you feeling?”*
- Elicit feedback even before having them try it at home – *“How does it feel to be doing this skill? What feels comfortable and what doesn’t?”* Be flexible within the general principles of behavior management.
- Elicit concerns: How do they think other people in community will

6. In a family, the oldest female is responsible for doing chores. Older female children should take responsibility for caring for younger children. Children should help their parents pay bills/provide interpreting.

7. Children are an economic asset; intimacy/fun/warm feelings are not important goals for the parent.

judge them for using these new skills? Positive or negative?

- Highlight drawbacks of punishment as primary strategy:
  - Only changes behavior when parent is around to catch them;
  - Does not teach child what TO do (i.e., a more appropriate way to act in the problem situation), so other problem behaviors may replace the first;
  - Often does not feel as good to child or parent;
  - Stick is more likely to escalate a situation compared to carrot;
  - Use adult example—would they feel better about changing their behavior (e.g., at work) for a reward or punishment? How would they feel about their job/their boss?
  
- Help parents identify alternative ways to get critical needs met (e.g., connect with interpreters/ESL support in school or other systems, connect to relevant social services).
- Explore the costs of relying on children in this way, particularly in US cultural context. Explore alternatives and potential costs/benefits of trying them.
- Explore whether there are ways to meet the needs of children within familial expectations (e.g., can oldest daughter look after children AND carve some time for other needs). Help parents see how these changes may serve their interests as well (e.g., do they have goals for this daughter other than current caregiving?).
  
- Identify goals the parent *does* have that may be consistent with helpful behavior change (e.g., parent wants child to be successful in US; parent wants to decrease conflict at home).
- Contrast pathways to success in the US with the pathways that were predominant in the parents' home country (e.g., completing

8. It's the father's job to discipline.

9. The child is "cursed or bad spirit"; treatment of the child to address this will improve behavior.

an education for economic success; social development for social/career success; etc.) when this supports helpful parenting changes.

- Explore costs/benefits to this approach. Are there downsides when mother cannot effectively discipline on her own? Are there downsides for father to be the sole discipliner? Explore costs/benefits of a different arrangement.
- Seek consultation from someone familiar with/from the culture if possible.
- Learn more about cultural practices for this understanding of the problem. Discuss openly, as family may well pursue culturally-endorsed remedies whether or not you ask about them.
- Benign practices may be encouraged, but suggest that if they do not resolve the problem you have other very effective strategies to offer.
- If the cultural understanding of the problem is problematic (e.g., they believe child cannot be helped; the culturally-endorsed remedy is potentially harmful), see if parents would be interested in trying what you have to offer first. Educate parents when cultural practices may conflict with US law.



EMOTIONAL EXPRESSION	POSSIBLE STRATEGIES
<p>1. Showing feelings is sign of weakness. Not talking about feelings is better. Anger is very acceptable in our family.</p>	<ul style="list-style-type: none"> <li>• Link emotional expression to achieving client/family goal in a clear and convincing way. (And if the link isn't clear to you, perhaps emotional expression should not be a primary intervention for this case...)</li> <li>• Ask clients to talk about feelings and feelings expression to assess clients' feeling vocabulary.</li> <li>• Learn from clients how emotions are expressed in their family.</li> <li>• Ask client to describe how what they may experience internally is different from what they exhibit externally.</li> <li>• Describe feeling in the room; use reflection.</li> <li>• Ask client to describe or show feeling states connected to situations: <i>"How do you normally handle?"</i></li> <li>• Explain benefits that come from emotional expression.</li> <li>• Inquire about indirect expressive strategies.</li> <li>• Normalize feelings and explain feeling expression as something we learn.</li> <li>• Practice emotion expression together in session (i.e., model, role play)</li> </ul>
<p>2. Certain feelings are risky to express in public due to racism/stereotypes (e.g., anger for African Americans).</p>	<ul style="list-style-type: none"> <li>• Acknowledge the real (and/or perceived) consequences of emotional expression.</li> <li>• Explore for socially/culturally more acceptable means of getting their needs met in problem situations (e.g., <i>"OK, so you don't feel comfortable saying it that way. What is something you COULD say to them that might still help with the situation?"</i>)</li> <li>• If appropriate, consider an experiment to see if the feared</li> </ul>

3. Men should not express certain feelings.

consequences are realistic in this situation. Role play and identify in advance how they will gauge the success of the strategy/interaction.

- Explore why not (what will happen? what does it mean?) and the potential costs/benefits of doing so anyway.
- Do they think a restriction on men's feeling expression is fair (to men, their families)?
- Explore alternative acceptable ways to express or otherwise manage the problem situation.
- Consider an experiment to see what actually happens when they try expressing these emotions (does the strategy work? do feared consequences follow?).

## DEALING WITH TRAUMA & ADVERSITY

## POSSIBLE STRATEGIES

1. If they don't talk about it, they'll forget about it.  
If they talk about trauma, they'll cement it in their mind.  
If I think about it, it'll make it worse for me.  
If I don't talk about it, it'll get better.

2. If you talk about sex, the child will act out sexually.

3. The child's traumas/behaviors bring shame upon family.

- Acknowledge feelings and validate that avoidance is working on some level.
- Highlight that avoidance has not actually resolved trauma-related symptoms (e.g., by reviewing CPSS/other measure).
- Elicit concerns regarding talking about trauma: *"What is your fear of talking about trauma?"*
- Give psychoeducation about why/how exposure works.
- Elicit experiences: *"How have you handled difficult feelings in the past?"* AND/OR *"Have you ever overcome a fear in the past?"* See if there are examples of exposure working.
- Find out how does the culture "let things go" or move on after a trauma or adversity.
- Find out what is a source of strength in family's culture.
  
- Discuss how talking about sex and the child's experiences openly can help to counteract unhelpful beliefs/experiences, thereby preventing sexual acting out/risky behavior. This also ensures it is parents' values the child hears (vs. peers or those of an abuser).
- Refer to research showing sex education/knowledge decreases sexually risky behavior and unwanted outcomes (and the reverse—lack of knowledge increases risks).
  
- Explore with them why this is considered shameful in their culture (if there are reasons, such as blame for the victim, these may be challenged Socratically).
- Find out what are the consequences within their community for individuals who have experienced this trauma (how are people

4. Shouldn't talk about family problems or issues with outsiders.  
*Ropas sucias se lavan en la casa.*

5. Intergenerational trauma – “ongoing despair.”  
The whole community is affected and connected by the legacy of the past.

6. Child is broken/ruined.

treated differently, are there known exceptions, can these consequences be overcome).

- Explore who is considered responsible (by family/community) and Socratically challenge cognitions/beliefs that are unhelpful or inaccurate (e.g., blaming the victim or family).
- Consider involving a respected authority from the community (e.g., priest) to learn more about the community's true views on the matter. If you have spoken to this person and know they would reinforce healthy views (e.g., not blaming the victim), it may be valuable to include them in a treatment session, with family's permission, to correct misperceptions.
- Acknowledge that preference and also use motivational strategies (learn about and reflect back to them the important problems that have not been solved within the family) to build motivation for trying outside help. Provide information about the effectiveness of the treatment program you have to offer and, if possible, tie this treatment directly to goals important to the family members with greatest authority to continue or discontinue treatment.
- Recognize that an individual's depth of pain is informed by historical cultural experiences. Acknowledge how this can impact reactions to more recent and personally experienced traumas. Encourage the client to think about how to change the intergenerational legacy of trauma for themselves and their community.
- Find out why they think this. (If this is a parent belief, have this conversation without child present.) What are the reasons they

7. Buddhist belief – “this is our fate.”

It was karma, the result of wrongs from a past life (e.g., rape happened because client did something bad to dad in previous life).

8. Change or acceptance.

think so? Use Socratic questioning to challenge their reasoning and identify and highlight counter-evidence.

- Ask questions to better understand the belief system/cognition. What are the potential consequences of this thought? Identify ways it is helpful as well as ways it may be unhelpful moving forward. Are there other ways to think about this that might result in better recovery or functioning?
- “This is our fate/the result of wrongs from a past life.” - Draw a triangle to explore the impact this has on feelings and behavior. For some, this thought might contribute to healthy acceptance of painful past events and decreases in self-blame and anger. For others, it might result in increased self-blame and contribute to a sense of deserving this and other negative circumstances. When expressed by a family member or offender, it may deflect blame and responsibility where it does not belong or contribute to continued unsafe circumstances for the victim. Might there be alternative thoughts or statements, also true or more helpful, that could be used to promote recovery and wise behavior moving forward?
- Support an acceptance approach as long as it is does not involve thoughts that might maintain emotional distress (e.g., life has hardships that we all must endure versus I must have deserved what happened).

## Conclusions and Recommendations

Racial and ethnic disparities in health and behavioral health access and engagement exist. However, the disparities vary among racial and ethnic groups, the step in the process of identification and engagement in services, and the type of problem. On the other hand, when it comes to effectiveness of therapy, including evidence-based treatments, racial and ethnic minorities gain equivalent benefits compared to White children and families. Disparities can be reduced and good outcomes achieved through culturally competent organizational and individual provider practices and thoughtful culturally responsive applications of evidence-based interventions.

1. Culturally competent practice is the standard at the organizational and provider level. Multiple specific activities can be undertaken to promote culturally competent practice including organization location, service setting, diversity of the work force, linguistic access, relationships with key community organizations and leaders, and awareness and knowledge about the experience and perspectives of diverse groups.
2. Evidence-based programs should be widely used, including for culturally diverse populations to insure that the benefits are available across all racial and ethnic groups.
3. Cultural responsiveness or adaptations of evidence-based interventions should be “specific and directed,” focus primarily on engagement, acceptability, and meaningfulness, and not detract from the core active ingredients.

# CBT+ Cultural Meeting Attendees

## ***Asian Counseling & Referral Service***

Han, Yoon Joo  
Yamazaki, Junko  
Vispo-Cuba, Terri

## ***Atlantic Street Center***

Chu, Justin  
Contreras, Hereri  
Plummer, Caroline

## ***Behavioral Health - Tulalip Tribes beda?chelh***

McCormick, Kathryn

## ***Central Washington Comprehensive***

### ***Mental Health***

Gengler, Ron  
Lopez, Vicente  
Kramer, Harry  
Petre, Dawn

## ***Children's Home Society***

Cabrera, Marisol  
Karpenko, Kristi

## ***Compass Health***

Lin, Lea

## ***Consejo Counseling***

Arauz, Celia  
Lopez, Maria  
Turner, Morgan

## ***DSHS - Department of Behavioral Health and Recovery***

Endler, Gregory  
Payton, Lin

## ***Greater Lakes Mental Health***

Price, Astrik  
Rambo, Laura

## ***Harborview Center for Sexual Assault & Traumatic Stress***

Potuzak, Chrys

## ***Institute for Family Development***

Alexander, Linda  
Lovely, Melody

## ***King County Sexual Assault Resource Center***

Lynch, Lorraine  
Santisteban, Juancarlos

## ***Navos***

Fisher, Roy  
Mejias, Melissa

## ***Ryther***

Barrett, Rachel  
Hooks, Michelle  
Ortiz, Jessica

## ***Seattle Children's Hospital/Odessa Brown***

Fadool, Mark  
Ingram, David

## ***Sound Mental Health***

Ligasín, Beng  
Winston, Susie

## ***Yakima Valley Farm Workers Clinic***

Gurtler, Michele  
Reyes, Martha

## ***Youth Eastside Services***

Halela, Debbi  
Mazariegos, Lydia

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