

## Response Paper

**Cognitive-Behavior Therapy for Ethnic Minority Adolescents:  
Broadening Our Perspectives**David J. Hansen, Byron L. Zamboanga, and Georganna Sedlar, *University of Nebraska–Lincoln*

*Adolescents are a burgeoning, and sometimes challenging, section of the population. In addition, a reality for cognitive-behavior therapists is the rapidly increasing culturally diverse client base. While cognitive-behavioral procedures have been shown to be effective for a variety of problems experienced by adolescents, these treatments often lack consideration of the role of ethnicity in adolescent development and mental health problems. Thus, the increasing number of both ethnic minority and adolescent populations in combination with the challenges involved in providing treatment to these populations emphasize the need for efforts to improve the relevance and effectiveness of cognitive-behavior therapy with ethnic minority adolescents. This article discusses the complexity of the developmental and cultural context of treating ethnic minority adolescents and the utility of cognitive-behavioral procedures for providing a strong basis for advancing our treatment efforts.*

**I**N THEIR VALUABLE ARTICLE on cognitive-behavior therapy with ethnic minority adolescents, Harper and Iwamasa (2000) have helped to advance a dialogue on important issues of therapeutic practice. While cognitive-behavioral approaches have begun to address issues pertaining to adolescents as well as the complexities of treating ethnic minorities, examination of cognitive-behavioral

Cognitive-behavior therapy is increasingly recognizing that it must expand its own cultural competence.

treatment of individuals who are both an ethnic minority and an adolescent remains limited. We are pleased to have an opportunity to participate in this discussion.

The field of cognitive-behavior therapy is increasingly recognizing that it must expand its own cultural competence (Harper & Iwamasa, 2000; Iwamasa, 1996; Tanaka-Matsumi, Seiden, & Lam,

1996). A reality for therapists practicing in the new millennium is a rapidly increasing culturally diverse client base. While minority groups comprise 25% of the U.S. population today, this number is expected to more than double by 2050 (Sleek, 1998). As Harper and Iwamasa suggest, ethnic minority adolescents' mental health status and service utilization definitively points to the need for interventions that are both pertinent and useful for this population.

In addition, as Harper and Iwamasa (2000) duly note,

adolescents are a burgeoning section of the population. While cognitive-behavioral treatments have been found effective with adolescents (e.g., Kendall, 1993; Werry & Wollersheim, 1989), these treatments often lack proper consideration of the role of ethnicity in adolescent development and mental health problems. The growing number of ethnic minority and adolescent populations, and the complexities involved in treating these populations, point to an immediate need for continued exploration and examination of effective treatments for ethnic minority adolescents.

The purpose of this paper is to expand on some of the issues and ideas put forth by Harper and Iwamasa (2000), as well as to provide additional perspectives and information on the effectiveness and relevance of cognitive-behavior therapy with ethnic minority adolescents. In the following sections we will briefly examine the complexity of context of treating ethnic minority adolescents, as well as how what we know about cognitive-behavioral procedures provides a strong basis for moving forward.

**Complexity of the Context****Developmental Context**

Understanding the maturational course and development of adolescents is an intricate process. Adolescents are developing cognitive and verbal abilities, as well as experiencing physical and emotional changes associated with puberty. In addition, there are changes in family relationships, school settings, peer relations, and alterations in societal and community expectations. Due to such complexities, consideration of the various possible developmental and contextual factors is particularly valuable when treating adolescents.

During the normative course of adolescent maturation and personal identity development, many minority

youths undergo additional developmental tasks such as formation of an ethnic identity (Bernal, Knight, Ocampo, Garza, & Gota, 1993; Pañiagua, 1998; Spencer & Markstrom-Adams, 1990). A general understanding of the concept is that "ethnic identity is a construct or set of self-ideas about one's own ethnic group membership. The emphasis in defining ethnic identity is on knowledge about one's own ethnic group and on the sense of self as a member" (Bernal et al., p. 33). As minority children reach the middle childhood stages of cognitive development, they begin to gain a better understanding of their social milieu (Ho, 1992). In turn, these children learn about discriminatory practices and messages, and acquire knowledge pertaining to the sociopolitical infrastructure and the economic resources of their cultural group in the context of the larger society (Ho). Such factors play a key role in the self-concept formation by minority adolescents in that many may perceive limited opportunities for themselves compared to majority children, which, consequently, may lead to feelings of inferiority, frustration, and resentment (Rivers & Morrow). In addition, native or traditional cultural values and belief systems, which may be strongly imposed by parents, that conflict with or differ considerably from those of the larger society may potentially give rise to dual identity conflicts or struggles for many minority adolescents (Ho; Rivers & Morrow). Another complexity, as noted by Ho, is that "as youth become more aware of their own ethnicity, their ethnicity also is more evident to other children" (p. 16). Hence, there may be added social pressures that accompany the identity conflicts minority adolescents are likely to endure. These potentially conflicting values and belief systems, whether they stem from parental and/or societal influences, raise issues with respect to minority adolescents' ability to achieve bicultural competency (successful adjustment in both cultures) and flexibility (Ho; Rivers & Morrow). Although the task of contending with two disparate cultures may pose challenges for many minority children, there is also evidence that suggests that bicultural involvement and flexibility facilitates psychological adjustment (Ramirez, 1983; Szapocnik & Kurtines, 1980a, 1980b).

#### **Therapeutic Needs, Motivation, and Alliance**

It is no surprise that a mutually trusting relationship and solid therapeutic alliance between the minority adolescent client and the therapist are considered vital in fostering motivation for change (Rivers & Morrow, 1995). In this context there are a few culturally relevant points worth noting when treating minority youth. As Ho (1992) points out, "many minority youth have been negatively warned by their family and friends that mainstream helping professionals are not very helpful in terms of meeting

their needs" (p. 132). Furthermore, the acculturation level of minority youth may differentially impact communication styles with authority figures and adults, and any language proficiencies or barriers will have a direct effect on a therapist's ability to establish a therapeutic alliance (Ho; Rivers & Morrow). A cultural background that does not sanction the open expression of feelings may also provide therapeutic challenges as well (Paniagua, 1998; Rivers & Morrow). Establishing a trusting relationship and a collaborative working alliance with a minority youth's parents is also central in reducing the likelihood that minority parents will prematurely terminate their child from treatment (Ho). Thus, language barriers and level of acculturation, mutual trust, and a working alliance play a vital role in therapists' accurate conceptualization and effective treatment of minority adolescents.

Many may perceive limited opportunities for themselves compared to majority children, which may lead to feelings of inferiority, frustration, and resentment.

#### **Ethnicity as a Heterogeneous and Distal Variable**

Overall, U.S. ethnic minority groups vary substantially, not only in terms of their nationality, but also as a function of generational status, ethnic and cultural identity, religiosity, acculturative modalities and degree of acculturation into mainstream society, language use and proficiency, socioeconomic status, geographical residence, and family structure. Such variables have been shown to play a significant role in moderating various mental health processes, psychological outcomes, and well being among minority populations (e.g., Aponte & Crouch, 1995; Ho, 1992; Paniagua, 1998). The complexities surrounding the heterogeneity of minority populations raise important issues with respect to assessment, case conceptualization, and treatment of diverse populations. The diversity, complexity, and heterogeneity of ethnic minority populations pose many challenges with regard to external validity and generalizability of treatment procedures.

By itself, ethnicity provides very little information with respect to the attitudes, belief and value systems, cultural identity, and behaviors of the adolescent client or the therapist. There are notable within-groups variations among different ethnic and cultural groups. Client-therapist ethnic matching can result in a mismatch if the client and the therapist differ on factors such as ethnic identity, acculturation level, socioeconomic background, beliefs, and value systems. On the other hand, client-

Language barriers and level of acculturation, mutual trust, and a working alliance play a vital role in therapists' accurate conceptualization and effective treatment of minority adolescents.

therapist ethnic mismatching may not necessarily result in cultural mismatches because clients and therapists from different ethnic backgrounds, conceivably, may share similar life experiences, cultural values, and belief systems (Sue, 1988). However, research has found that client preferences for ethnically or culturally similar therapists may vary with acculturation level, ethnicity and cultural identity (e.g., Atkinson, Furlong, & Poston, 1986; Atkinson, Maruyama, & Matsui, 1978; Sanchez & Atkinson, 1983). Sue (1988) eloquently described ethnicity as a distal variable, noting, "Ethnicity per se tells us very little about attitudes, values, and experiences and behaviors of individuals, therapists, clients, who interact in a therapy session" (p. 306).

#### **Dynamic Interactive Nature of the Complexity of the Context**

The dynamic and interactive nature of the adolescent's developmental context, ethnic identity, treatment motivation and alliance, client-therapist perspectives, and the heterogeneity of minority populations is highly complex. Such individual, familial, and sociocultural factors may mutually influence each other's occurrence and impact, compounding the complexities faced by cognitive behavior therapists in providing effective treatment approaches to ethnic minority youths.

#### **Beyond Learning From Therapists: Learning From Theory and Research**

##### **Contributions of the Core Features of Cognitive-Behavioral Approaches**

Fortunately, cognitive-behavioral approaches appear well suited for offering effective treatments for diverse populations and addressing many of the complexities noted for ethnic minority adolescents. A basic strength of cognitive-behavioral approaches is that the treatment procedures are grounded in theory (e.g., social learning, operant, etc.) that should have, hopefully, some universal basis across populations. An additional source of fit between cognitive-behavioral treatment and ethnic minority youth involves cognitive-behavior therapy's emphasis on functional analyses. As recently noted by Tanaka-Matsumi et al. (1996), a functional assessment assists therapists in developing culturally appropriate and effective

interventions, in part through proper identification of the relationships between a client's presenting problems and his or her sociocultural environment. Thus, functional consideration of the client's cultural experiences and context can enrich the therapist's understanding of the client's ecology and guide a culturally appropriate treatment plan. Finally, a thorough and repeated functional assessment examining the relationship of antecedents, consequences, and behaviors for an individual serve to avoid applying simplistic and universal notions about ethnic minorities in treatment planning and evaluation.

As discussed earlier, there is a great deal of heterogeneity within various ethnic minority groups. Such heterogeneity may include differences in subgroup type (e.g., Puerto Rican, South American, etc.), socioeconomic status, level of acculturation, and immigrant status. The idiographic, objective, and contextual emphases of cognitive-behavioral assessment are ideal for facilitating a culturally sensitive, competent, and appropriate assessment, without reliance on norm-based and subjective procedures that may have interpretative limitations or inaccuracies. The use of multiple measures, methods, and informants (e.g., youth, parents, teachers, etc.) also facilitates completion of a relevant and informative assessment. For example, in a review of assessment strategies for culturally diverse populations, Paniagua (1998) rank ordered various types of assessment strategies according to their likely degree of cultural bias. Along with psychophysiological assessment, cognitive-behavioral approaches of behavioral observations, self-monitoring, and behavioral self-report rating scales were the highest ranked approaches (i.e., the least likely to be biased). Norm-based approaches (e.g., self-report personality or psychopathology inventories) were considered more susceptible to cultural bias. Direct assessment of specific targeted events or behaviors, also common in cognitive-behavioral approaches, can also reduce the likelihood of bias (Paniagua). In addition, the broad focus of cognitive-behavioral assessment on the functioning of the youth in the context of the environment is valuable, and may include an adolescent's broader culture of origin and ethnic identification, the more immediate family and community cultures (which may or may not be synonymous with the broader culture), as well as other influential "cultures" such as the adolescent's expanding peer culture.

Another reason that cognitive-behavioral approaches are, in theory, well suited for treating diverse populations is that many approaches are compatible with ethnic minorities' views, beliefs, and expectations about therapy (Paniagua, 1998). Depending on a particular culture's values, seeking mental health treatment may be a shameful, stigmatizing, or embarrassing process. Therefore, cognitive-behavior therapy's focus on current behavior and promotion of change (as opposed to hypothetical

underlying causes), its tendency to be directive and time-limited, and its goal-oriented, problem-solving approach may be agreeable to, and consistent with the expectations of, at least some ethnic minorities. Therapists should be aware, however, that cultural factors influence client judgments about the acceptability of different behavioral treatment procedures (e.g., Kazdin, 1980).

Further, cognitive-behavior therapy's involvement of families in the treatment of youth has natural applications to interventions with ethnic minority adolescents. Although there can be substantial differences across individuals and families, extended families may often have an active and central role in the lives of ethnic minority adolescents. These family members can provide valuable information about the adolescent's environment, including culturally specific values and norms, as well as offering perspectives on developmental, family, and social context. In addition, in many cognitive behavioral interventions for youth, parents or other family members may play an integral role in treatment planning and delivery.

Finally, the emphasis that cognitive-behavior therapy places on continuous evaluation of treatment corresponds with recognition that adolescence and ethnicity are both dynamic and interactive contextual factors. For example, clients may initially present to therapy for adjustment difficulties unrelated to ethnicity, but as treatment progresses cultural stressors and issues may surface and need to be addressed in therapy. In addition, as adolescence is marked by significant changes on many levels, continuous monitoring and evaluation allow the therapist to accommodate treatment approaches accordingly. The core features of cognitive-behavioral approaches should, in theory and practice, result in strengthening the therapist's capabilities for providing effective treatment within a culturally competent and culturally sensitive framework.

#### **Learning From Strategies for Enhancing the Effectiveness of Intervention**

There is much we can learn from the cognitive-behavioral literature on enhancing the effectiveness of interventions. For example, the concepts of treatment adherence, social validity, and generalization have been addressed in literature examining various populations and clinical problems (e.g., Hansen, Nangle, & Meyer, 1998; Kazdin, 1977; Lundquist & Hansen, 1998; Stokes & Osnes, 1989). There is significant overlap among these concepts. For example, the more socially valid the goals and procedures, the more likely the youth will adhere to treatment. The more likely the youth is to participate in treatment, the more likely the effects will generalize and maintain. Finally, the more the effects generalize and maintain, the more socially valid and functional the ef-

fects. Across all types of clients, problems, and settings, systematic consideration at the onset of assessment of strategies to enhance adherence, social validity, and generalization and treatment can increase the effectiveness of services provided. By their very nature and purpose, these concepts clearly provide guidance for working with ethnic minority populations.

*Treatment adherence.* Treatment adherence has been defined as the "active, collaborative, voluntary involvement of a client in a mutually acceptable course of behavior to produce a desired preventative or therapeutic result" (Meichenbaum & Turk, 1987, p. 20). Adherence problems with adolescents are believed to be relatively common, as they may be reluctant participants in therapy (Hansen et al., 1998; Hansen, Watson-Perczel, & Christopher, 1989). At least three types of behaviors need to occur for successful treatment. Youth, and possibly their parents or other family members, must (a) attend sessions regularly, (b) participate within sessions, and (c) complete out-of-session assignments. Resistance or adherence problems can be evidenced at both micro and macro levels (Lundquist & Hansen, 1998). At the micro level it is evidenced by challenges, disagreements, disqualifications, and other negative verbal responses by clients to therapist suggestions. At the macro level it is evidenced by clients not completing homework assignments, missing appointments, and dropping out of treatment.

Adherence can be influenced by a variety of setting events and contextual factors (Hansen et al., 1998). At times, failure to participate in treatment may not be because of resistance or uncooperativeness, but because family or other circumstances push clients in other, more demanding directions. Such stress factors or setting events may include marital or other family discord, substance abuse problems, financial problems, and so forth. In addition, a variety of specific problems can arise, such as transportation problems, illness, forgetting, lack of access to a phone to cancel or reschedule appointments, and parent or family concerns about obtaining mental health services. Adherence responses are likely to be under the control of multiple contingencies operating simultaneously.

When therapists are frustrated by resistant attitudes and nonadherence responses, it is important that they

Functional consideration of the client's cultural experiences and context can enrich the therapist's understanding of the client's ecology and guide a culturally appropriate treatment plan.

control their exasperation and tendency to arrive at general, but perhaps ill-informed, attributions for the client's behaviors (Newman, 1994). Therapists must take an idiographic approach to the assessment of each client's resistance and must examine the unique etiological and maintaining factors for each client (Hansen et al., 1998;

Therapists need to consider whether the goals are what the minority youth, the family, significant others, and/or society wants and whether achieving the goals would actually improve the adjustment and effectiveness of the youth.

Newman). Adopting a proactive approach toward adolescents and their families who do not adhere to treatment is valuable; a functional analysis of the conditions that elicit, maintain, and prevent adherence responses is essential. For example, Newman suggested that therapists consider assessment questions such as the following: "What is the function of the client's resistant behaviors?" "How does the client's current resistance fit into his or her developmental/historical pattern of resistance?" "What might be some of the client's idiosyncratic beliefs that are feeding into his or her resistance?" "How might the client be

characteristically misunderstanding or misinterpreting the therapist's suggestions, methods, and intentions?" "What skills does the client lack that might make it practically difficult or impossible at this point for him or her to actively collaborate with treatment?" and "What factors in the client's natural environment may be punishing the client's attempts to change?" (pp. 51–55). These questions were written from the perspective of working with an individual "client," but one could easily apply them to families, including ethnic minority youth and their families.

In addition to a specific functional analysis of each client's treatment adherence, there are a number of valuable antecedent and consequent strategies available to therapists for facilitating adherence. For example, some antecedent strategies include the following: having an empathic and skilled therapist; involving the client in goal and procedure selection; obtaining a private or public commitment from clients; providing clear and detailed written instructions; providing additional stimuli such as reminder cards; beginning with small homework requests and gradually increasing assignments; providing specific training for tasks to be implemented; and identifying cognitions that precede or accompany nonadherence responses (Hansen et al., 1998; Lundquist & Hansen, 1998; Newman, 1994; Shelton & Levy, 1981).

While these strategies overall have received little direct empirical evaluation, conceptually and practically they make sense. There is no reason to believe that they are universally effective across populations, ages, or clinical problems, however; a proactive approach to preventing adherence problems seems universally valuable.

Along with antecedent strategies, there are several consequent strategies that may facilitate adherence, such as basic behavioral techniques including feedback, shaping, and positive reinforcement. Several approaches use both antecedent and consequent strategies, such as working with referral sources (e.g., schools, court, child protective services), advocating for the client (e.g., providing support for interactions within school or other involved agencies), using cognitive rehearsal strategies (e.g., self-management and self-reinforcement); problem-solving for potential obstacles to adherence; and anticipating and reducing the negative effects of compliance (e.g., concerns that behavioral changes will result in ridicule from peers). Again, practically speaking, such approaches should have widespread applicability.

*Social validity.* Social validity, according to Schwartz and Baer (1991), refers to the acceptability and viability of an intervention both to individuals and to groups (e.g., subcultures). Kazdin (1977) described three general areas in which social validity should be established: the goals, procedures, and outcomes of intervention.

In order to enhance the social validity of treatment, therapists need to consider whether the goals are what the minority youth, the family, significant others (e.g., peers, teachers), and/or society wants and whether achieving the goals would actually improve the adjustment and effectiveness of the youth. Most interventions have consisted of teaching behaviors to clients that therapists assumed were important, to levels that therapists assumed were appropriate (Hansen et al., 1989). Therapists must consistently consider contextual factors (e.g., cultural influences and values, family stressors or conflict, etc.) that may take precedence as priorities for clients. The goals of the therapist (e.g., increase the youth's participation and performance at school) may not match those of the youth or family (e.g., due to different "priorities" for the youth or family). Considering specific youth and family goals can enhance social validity because they are more likely to be satisfied with the results of therapy when treatment is targeted toward areas of their lives they deem as important.

Therapists also need to consider whether the youth and family members consider the assessment and treatment procedures, including the therapy setting, acceptable. Consideration of culturally influenced client concerns, as well as the psychological and practical barriers to participating in treatment, is valuable. Perhaps attempts to make direct mental health services more

readily available through less stigmatizing agencies or centers (e.g., ethnic-specific local community centers, churches, etc.) may help reduce some of the concerns and doubts that some minority families and adolescents espouse toward the general practice of mental health and helping professionals in the field.

Finally, therapists need to consider whether clients and relevant others are satisfied with all of the effects of treatment. Evaluation is needed regarding whether behavior changes of individual, clinical, social, or applied importance have been achieved. An important question to address is whether clients are benefitted by treatment to functional (i.e., useful) levels in their environment. For example, an individual's acculturation level has important implications for treatment interventions and outcome and certainly could be considered a central aspect of an ethnic minority adolescent's ecology (Paniagua, 1998). Conflict within a family could center around the behavioral manifestations of significant discrepancies in cultural values and belief systems between parents and their adolescent children (e.g., parents may think their child is acting in ways that contradict the culture of origin's values).

Strategies to enhance social validity are dependent on assessing social validity targets including goals, methods, and outcomes. Hansen et al. (1989) suggested that investigations sensitive to social validity should include: (a) selection of socially valid behaviors, (b) documentation of the need for and criterion levels for training, (c) demonstration of socially valid improvements in performance, and (d) evaluation of the acceptability of treatment goals, procedures, and effects by the clients and others. With an idiographic approach to enhancing social validity, professionals consider whether clients' rates of target behaviors show significant (e.g., functional) improvements following intervention, and they consider how individual clients or family members rate a variety of factors related to the intervention (e.g., satisfaction with goals, procedures, and effects). Such idiographic approaches are particularly valuable when working with ethnic minorities, where reliance on a nomothetic approach (e.g., norm-based assessment) may not be as valuable and relevant.

*Generalization.* Achieving generalization was previously viewed as a passive phenomenon until a classic paper by Stokes and Baer (1977) emphasized the need for actively programming for the generalization of intervention effects. Generalization can be defined as "the outcome of behavior change and therapy programs, resulting in effects extraneous to the original targeted changes" (Stokes & Osnes, 1989, p. 338). Stimulus generalization refers to demonstration of behavior gains in settings other than the therapy setting, or with people other than the therapist. Response generalization refers to changes in behaviors that have not been targets of inter-

vention, while temporal generalization refers to maintenance of effects posttreatment.

Categories of programming strategies suggested by Stokes and Osnes (1989) included the following: (a) exploit current functional contingencies, (b) train diversely, and (c) incorporate functional mediators. There are several subcategories subsumed within these three general categories. A fourth type of strategy is to target contextual factors (Hansen et al., 1998; Lundquist & Hansen, 1998).

Functional contingencies refer to the arrangement of antecedents, behaviors, and consequences that affect frequency, magnitude, and duration of relevant behavior (Stokes & Osnes, 1989). Relevant approaches for exploiting current functional contingencies include strategies such as contacting and recruiting natural consequences within their environment (e.g., include peers in the environment in efforts to improve social interactions) and reinforcing occurrences of generalization outside of treatment (e.g., reinforcement of desired behaviors by significant others).

A strategy offered by Stokes and Osnes (1989) that may be particularly relevant for cognitive-behavioral interventions with ethnic minority youth is training diversely. The basic premise is that when the goals and procedures of training are more widespread, so are the outcomes. Training diversely includes using sufficient culturally relevant stimulus and response exemplars, a relatively common practice in most skills training and other cognitive-behavioral interventions.

Another strategy to enhance generalization is to incorporate functional mediators into the intervention (Stokes & Osnes, 1989). A mediator acts as a discriminative stimulus and facilitates or mediates generalization. This category includes use of common salient physical and social stimuli (e.g., extended family in the home, peers in the school) as well as self-mediated physical and verbal stimuli (e.g., self-instruction, self-monitoring, problem-solving strategies).

A fourth overall strategy is to target contextual factors (e.g., attitudes toward mental health services, language barriers, economic or other stressors) that interfere with skill acquisition or use (Hansen et al., 1998; Lundquist & Hansen, 1998). Many cognitive-behavioral interventions with youth and their families focus on discrete procedures and behaviors (e.g., teaching parenting skills to in-

Therapists need to consider whether the youth and family members consider the assessment and treatment procedures, including the therapy setting, acceptable.

crease compliance) and have failed to consider the importance of contextual factors (e.g., living conditions and stressors, participation in culture of origin, cultural values and beliefs). More efforts to address such contextual factors may prove valuable for improving the generalization and maintenance of treatment (e.g., via stress management, problem solving, involvement of significant others in treatment).

Through the development and evaluation of procedures to facilitate treatment adherence, social validity, and generalization, cognitive-behavior therapists have learned much about achieving lasting and meaningful behavior change (Hansen et al., 1998; Lundquist & Hansen, 1998; Stokes & Osnes, 1989). These strategies should have significant implications for enhancing the appropriateness and effectiveness of our procedures for the treatment of ethnic minority youth.

### Conclusion

Fortunately, the core practices and features of cognitive-behavior therapy provide a strong foundation for work with clients of all types and ages. In addition, it is fortunate that cognitive-behavior therapists have done much to teach us how to enhance the effectiveness of our interventions. However, it is also clearly not the case that we know all we need to about cognitive behavior therapy with any population. This is especially the case, as Harper and Iwamasa (2000) note, for a group as complex and heterogeneous as ethnic minority adolescents. It is our hope that cognitive-behavioral researchers and clinicians will continue to search for the most relevant and effective procedures for treating ethnic minority youth, building on our foundation and strengthening and expanding our techniques.

### References

- Aponte, J. F., & Crouch, R. T. (1995). The changing ethnic profile of the United States. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp. 1-18). Needham Heights, MA: Allyn & Bacon.
- Atkinson, D. R., Furlong, M. J., & Poston, W. C. (1986). Afro-American preferences for counselor characteristics. *Journal of Counseling Psychology, 33*, 326-330.
- Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian-Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology, 25*, 76-85.
- Bernal, M. E., Knight, G. P., Ocampo, K. A., Garza, C. A., & Gota, M. K. (1993). Development of Mexican American identity. In M. E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formation and transmission among Hispanics and other minorities* (pp. 31-46). Albany, NY: State University of New York Press.
- Hansen, D. J., Nangle, D. W., & Meyer, K. (1998). Enhancing the effectiveness of social skills interventions with adolescents. *Education and Treatment of Children, 21*, 489-513.
- Hansen, D. J., Watson-Perzel, M., & Christopher, J. S. (1989). Clinical issues in social-skills training with adolescents. *Clinical Psychology Review, 9*, 365-391.
- Harper, G. W., & Iwamasa, G. Y. (2000). Cognitive-behavioral therapy with ethnic minority adolescents: Therapist perspectives. *Cognitive and Behavioral Practice, 7*, 37-53.
- Ho, M. K. (1992). *Minority children and adolescents in therapy*. Newbury Park, CA: Sage.
- Iwamasa, G. Y. (1996). Introduction to the special series: Ethnic and cultural diversity in cognitive and behavioral practice. *Cognitive and Behavioral Practice, 3*, 209-214.
- Kazdin, A. E. (1977). Assessing the clinical or applied importance of behavior change through social validation. *Behavior Modification, 1*, 427-452.
- Kazdin, A. E. (1980). Acceptability of alternate treatments for deviant child behavior. *Journal of Applied Behavior Analysis, 13*, 259-273.
- Kendall, P. C. (1993). Cognitive-behavioral therapies with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology, 61*, 235-247.
- Lundquist, L. M., & Hansen, D. J. (1998). Enhancing treatment adherence, social validity, and generalization of parent-training interventions with physically abusive and neglectful families. In J. R. Lutzker (Ed.), *Handbook of child abuse research and treatment* (pp. 449-471). New York: Plenum.
- Meichenbaum, D., & Turk, D. C. (1987). *Facilitating treatment adherence: A practitioner's guidebook*. New York: Plenum.
- Newman, C. (1994). Understanding client resistance: Methods for enhancing motivation to change. *Cognitive and Behavioral Practice, 1*, 47-69.
- Paniagua, F. A. (1998). *Assessing and treating culturally diverse clients: A practical guide* (2nd ed.). Thousand Oaks, CA: Sage.
- Ramirez, M. (1983). *Psychology of the Americas: Mestizo perspective on personality and mental health*. New York: Academic Press.
- Rivers, R. Y., & Morrow, C. A. (1995). Understanding and treating ethnic minority youth. In J. F. Aponte, R. Y. Rivers, & J. Wohl (Eds.), *Psychological interventions and cultural diversity* (pp. 164-180). Needham Heights, MA: Allyn & Bacon.
- Sanchez, A. R., & Atkinson, D. R. (1983). Mexican-American cultural commitment, preference for counselor ethnicity, and willingness to use counseling. *Journal of Counseling Psychology, 30*, 215-220.
- Schwartz, I. S., & Baer, D. M. (1991). Social validity assessments: Is current practice state of the art? *Journal of Applied Behavior Analysis, 24*, 189-204.
- Shelton, J. I., & Levy, R. L. (1981). *Behavioral assignments and treatment compliance*. Champaign, IL: Research Press.
- Sleek, S. (1998). Psychology's cultural competence, once "simplistic," now broadening. *APA Monitor, 29*, 1, 27.
- Spencer, M. B., & Markstrom-Adams, C. (1990). Identity processing among racial and ethnic minority children in America. *Child Development, 61*, 290-310.
- Stokes, T. F., & Baer, D. M. (1977). An implicit technology of generalization. *Journal of Applied Behavior Analysis, 10*, 349-367.
- Stokes, T. F., & Osnes, P. G. (1989). An operant pursuit of generalization. *Behavior Therapy, 20*, 337-355.
- Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*, 301-308.
- Szapocnik, J., & Kurtines, W. (1980a). Acculturation, biculturalism, and adjustment among Cuban Americans. In A. Padilla (Ed.), *Acculturation: Theory, models, and some new findings* (pp. 27-42). Boulder, CO: Westview.
- Szapocnik, J., & Kurtines, W. (1980b). Bicultural involvement and adjustment in Hispanic American youths. *International Journal of Intercultural Relations, 4*, 353-365.
- Tanaka-Matsumi, J., Seiden, D. Y., & Lam, K. N. (1996). The Culturally Informed Functional Assessment (CIFA) Interview: A strategy for cross-cultural behavioral practice. *Cognitive and Behavioral Practice, 3*, 215-233.
- Werry, J. S., & Wollersheim, J. P. (1989). Behavior therapy with children and adolescents: A twenty-year overview. *Journal of the American Academy of Child and Adolescent Psychiatry, 28*, 1-18.

Address correspondence to David J. Hansen, Clinical Psychology Training Program, Department of Psychology, University of Nebraska-Lincoln, Lincoln, NE 68588-0308.

Received: April 25, 1999

Accepted: June 25, 1999