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Bridging Diversity and Family Systems: Culturally Informed and Flexible Family Based Treatment for Hispanic Adolescents

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Abstract

There is growing interest in identifying interventions that have been tested and found efficacious with minority families. This interest is fueled in part by the growth of Hispanics in the U.S. as well as by research findings that suggest that Hispanics have better outcomes when treatments are adapted to their unique experiences, and risk and protective factors. Family-based treatments for culturally diverse populations require the integration of advances from both the cultural and family systems domains. Current intervention research has begun to move towards developing and advancing individualized interventions for patients/clients. Adaptive interventions, tailored interventions, adapted interventions, and targeted interventions have all been identified in the literature as appropriate for addressing distinct cultural characteristics which generic interventions may not address effectively. To date, research has focused less on tailored or adaptive interventions partly due to the fact that they require decision rules, more careful implementation, and measurement of individualized outcomes. In this article we present evidence for the usefulness of adaptive interventions that can address not only subgroup variability but within group variability as well. Culturally Informed and Flexible Family-Based Treatment for Adolescents is presented as an adaptive treatment that allows for the tailoring of treatment to the unique clinical and cultural variations of individual adolescents and families, but that does so in a systematic and replicable fashion. By building decision-making processes into the manualized treatment, the transportability of the treatment may be enhanced as family therapists appreciate it's flexibility to address the complexity of clinical work.

There is a growing interest in determining just how effective evidence-based interventions are for minority families (Griner & Smith, 2006; Huey & Polo, 2008). Some treatments tested with Hispanics may have been developed especially for Hispanics, while other treatments developed for a non-Hispanic populations may have been tested with Hispanics with or without adaptations (Bernal & Scharron-del-Rio, 2001). This interest in

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documenting which treatments work for Hispanic youth and families is fueled in part by the large increase in Hispanic population over the past decade (U.S. Census Bureau, 2010) and the large proportion of Hispanics that are under the age of 18 (35%) compared to 22% for the non-Hispanic population (U.S Census Bureau, 2011). Even more critical, however, is the steady and alarming rise in risk indicators within the population of young Hispanics. When compared to both their White and African American peers, Hispanic youth have: 1) disproportionately high rates of illicit drug use in 8^{th} and 10^{th} grades, particularly marijuana (Johnston, O'Malley, Bachman, & Schulenberg, (2011), 2) higher rates of risky sexual behavior (CDC, 2011), and 3) higher rates of both suicidal ideation (16.7%) and suicide attempts (10.2%; CDC, 2012).

The interest in how well treatments work for Hispanic youth and their families is also fueled by studies that show the relevance of culture-related variables and ethnic matching to treatment outcomes and symptom development. Halliday-Boykins, Schoenwald, and Letourneau (2005) have reported that ethnic similarity between adolescent caregiver and therapist can predict important outcomes such as length of treatment and successful discharge. Likewise, when Hispanic adolescents in substance abuse treatment, are matched to Hispanic therapists they report greater decreases in substance use than when they are paired with Anglo therapists (Flicker, Waldron, Turner, Brody, & Hops, 2008).

Simply matching patient and psychotherapist/assessor on ethnicity, however, may be less important than ensuring that they reflect positive attitudes toward and understanding of minority experiences (Sue, Zane, and Young, 1994). Many minority families have unique life experiences that contribute to their symptom picture. For example, one of the most widely studied of the minority experiences is acculturation, that is the process by which an individual's values and behaviors are changed when he or she migrates to a different sociocultural environment. Research has linked the acculturation process to symptom development in a number of domains such as drug use, depression, and other health indicators (Abraido-Lanza, Armbrister, Florez, & Aguire, 2006; Gil, Wagner, & Vega, 2000; Gonzales, Deardorff, Formoso, Barr, & Barrera, 2006; Schwartz, Unger, Zamboanga & Szapocznik, 2010; Tonin, Burrow-Sanchez, Harrison, & Kircher, 2008). Taken together these findings suggest that therapists must have an appreciation of the unique values and life experiences of the Hispanic client and be prepared to use those as a starting point in the conceptualization of both symptom emergence and return to healthier functioning.

The inherent complexities of applying family-based treatment with diverse populations requires that the family therapist be informed by both the theories and research findings emerging from the family systems field and those emerging from work focused on the unique cultural factors that are prominent in the group of interest. These valuable bodies of knowledge often emerge and are considered as separate, but the real challenge for the therapist is to understand how they intersect and interact and especially, not to ignore one over the other. As Lopez (2003) argues in an analysis of the Surgeon General's report on Culture, Race and Ethnicity, too often the position is taken that "studying ethnicity or culture was not significant, did not address general processes, was too political, and was too complex" (p. 420). Two of these positions are particularly common to discussions of culture, race, and ethnicity. First, it is often argued that culture-related processes have little to do

with the more established core concepts related to risk factors, symptom emergence, and therapy process. Those who champion the importance of cultural characteristics have not always effectively articulated the relevance of culture related factors to key established concepts. Second, critics present the counterargument that diversity exists not only between ethnic groups but also *within* ethnic groups, and that this is a level of complexity that can never be accounted for and addressed effectively. Fortunately, family systems therapists embrace rather than shy away from complexity.

This article extends the dialogue around these and related concerns, illustrating just how meaningful and necessary each of these bodies of literature is to the other when planning and evaluating family-based prevention and treatment interventions for multicultural populations. The richness of family systems concepts is most evident when considering the diversity of experiences and relationships encountered by individuals of different backgrounds. Likewise, the complex relationships and contextual interactions that can be so powerful in minority individuals' lives can be better appreciated through the lens of systemic principles. The remainder of this article is organized into three sections. In the first section we examine the systemic nature of two broad areas commonly researched and targeted by family psychologists and therapists, "within family relationships and processes" (e.g., parenting practices and family functioning; Henderson, Rowe, Dakof, Hawes, & Liddle, 2009; Minuchin & Fishman, 1981) and the "family in the larger context" (e.g., social-ecological or eco-developmental contexts; Bronfrenbrenner, 1979; Falicov, 1998; Szapocznik & Coatsworth, 1999). In covering both of these themes we will consider important findings that have emerged from research on culture-related processes, and show how these processes interact with the more "mainstream" systemic concepts. We illustrate how these two streams (cultural and family systemic principles) work together and enhance each other to create a more complete picture of culturally informed interventions with diverse multicultural patient groups. It is not possible to outline or understand how all possible aspects of a culture or subculture interact with family systems concepts, so we have chosen to emphasize "*only those differences that make a difference* to the family therapist's evaluation of and approach to clients" (Falicov, 1998). In the second section we present different approaches to modifying treatment so that the treatment can account for cultural variations. We present strategies and methods that include treatment adaptations, tailoring and adaptive treatments and attempt to highlight their unique characteristics. In the third and final section we present Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA: Santisteban & Mena, 2009), developed as part of a Stage 1 Treatment Development effort meant to enhance the "ecological validity" (Bernal & Scharron-del Rio, 2001) and outcomes of treatment for Hispanic adolescents and families. CIFFTA was developed as an adaptive treatment that could capitalize on the integration of family systems and cultural diversity findings through the systematic tailoring of interventions to the unique clinical and cultural aspects of individual families.

Linking Systemic and Culture-Related Findings

Before discussing specific areas of "within-family" and "family in context," it is worth noting a general framework for deciding when a treatment should be modified to better account for culture-related variability. Castro, Barrera, & Holleran Streiker (2010) outline

four conditions that justify cultural adaptations of evidence-based interventions. The first condition is when the intervention does not appear to effectively engage a particular subgroup into treatment. Research that only examines outcomes among fully engaged participants is obviously biased and overlooks the treatments inherent failure to attract minority participants. The second condition is when there appear to be unique risk or resilience factors. Unique factors for Hispanic populations may include experiences such as acculturation and immigration related stressors (Cervantes, Fisher, Cordova, & Napper, 2011). The third condition is the situation in which the population exhibits unique symptoms of a common disorder that the original evidence based intervention was not designed to influence. Finally, the fourth condition is when research highlights poor intervention effectiveness with a particular cultural group. In the next section we present key findings that, along with those already presented on acculturation and ethnic matching, have led to recommended adaptations to treatment content and process.

Within Family Relationships and Processes

There are a number of well-developed family systems concepts that have been empirically linked to the emergence and treatment of adolescent mental health and drug use symptoms. The literature on adolescent behavior problems has linked parenting practices such as weak limit setting and effective monitoring to the emergence and/or maintenance of externalizing and other delinquent behavior (Dishion, Bullock, & Granic, 2002; Gayles, Coatsworth, Pantin, & Szapocznik, 2009; Kiesner, Dishion, Poulin & Pastore, 2009; Wagner et al., 2010). Likewise, low family support and conflict have been shown to be related to the emergence of behavior problems in youth (Coatsworth et al., 2000). An empirical literature also exists documenting how cultural beliefs and values about parenting as well as actual parenting practices vary between different countries and cultural traditions (Domenech Rodriguez, Donovick, & Crowley, 2009). The question these two research areas raise in tandem is how the understanding of unique cultural-related experiences can help us to appreciate the family systems concepts in a more meaningful way.

Attachment and Parent-child separations—The quality of attachment that a parent and child create, beginning at infancy and progressing throughout life, has important implications for individual development and healthy family processes (Bowlby, 1979; Liddle & Schwartz, 2002; Sroufe, Egeland, Carlson & Collins, 2005). The attachment system was originally conceptualized as a universal, genetically programmed process of forming a special bond between infant and caregiver. In her original studies, Mary Ainsworth observed similar processes of attachment formation between infant and caregiver in Uganda and the United States (Ainsworth, 1963; Ainsworth, Blehar, Waters & Wall, 1978). Although different cultures may have distinct patterns of childrearing practices, the underlying phenomenology of creating a secure relationship appears to be universal across cultures (Cassidy & Shaver, 1999; van IJzendoorn & Sagi, 1999). Attachment is important not only in terms of those characteristics that are internalized by the child and adolescent and that shape personality, but also in terms of the quality of support and connection that will be evident in the family over the person's lifetime. Family therapists consistently confront the challenges of understanding and interpreting the complexities of the intra and interpersonal transactions that occur between two individuals' internalized working

attachment models (for example, parent's and youth's) and the pattern of interactions that are created by overt behaviors that are interpreted through the veil of their internal working model.

The realities of immigrant life may magnify these complexities making it even more challenging to understand the attachment processes across a child's development. One such experience occurs when one or both parents migrate to a new country at an earlier date than their children in order to establish a home prior to reuniting with the child. Despite the good intentions of the migration, this can also be a powerfully disruptive process for the child and family (Suarez-Orozco, Todorova, & Louie, 2002). Our work in South Florida has provided opportunity to work with mothers who came to the United States from Central America and the Caribbean to establish a home, sent money back to the family, and, only later when the family was more economically secure, brought their children to the new country. The impact of the separations was revealed when the children arrived in the U.S. and problems emerged in their behavior. Upon reunification, children often suffered greatly due to their inability to accept and express the feelings of abandonment they had experienced when the initial separation occurred, but also the sense of loss due to being removed from an attachment figure for a second time; this time from the family member who remained in the country of origin and had become the primary caregiver during the separation. Mothers may also suffer from guilt over leaving a young child with another relative and fear that she has been replaced as the primary caregiving figure for her child. These internalized feelings of abandonment and loss on the child's part, and guilt and fear on the mother's part, influence mother-child interactions and make it difficult to re-establish a loving harmonious relationship. In this situation, parenting is more difficult because the quality of the relationship has suffered due to the separation. Parenting also becomes complicated by the fact that the parents have not adjusted to their children's natural development that occurred during the separation and may treat their children as younger than their actual ages. Sometimes there may also be blended family issues if the parent has a new partner and/or stepchildren and so a dual loyalty now exists between the new family and the separated children. In short, these immigration-related disruptions in the family can have profound influences on the family interactional patterns that family researchers and therapists study and target for treatment. If these consequences of migration and separation remain unresolved, they may contribute to family interactions that are recalcitrant to change.

Communication, conflict resolution, and parent-adolescent acculturation differences (gaps)—The quality of parent adolescent communication and the ability of the family to resolve conflicts are both key components in a well functioning family (Snyder, Cozzi & Mangrum, 2002). Good communication allows parents to guide and nurture the adolescent while good conflict resolution skills validate the experiences of the family members while reaching healthy resolution to the disagreement. Different rates of acculturation within the family, however, may disrupt communication and conflict resolution and lead to behavior problems in youth (Martinez, 2006; Unger, Ritt-Olson, Wagner, Soto, & Baezconde-Barbanati, 2007). The natural variability in the trajectory of acculturation is dependent on such factors as generation, gender, and type of contact with the host community but can disrupt healthy family processes. Youngsters tend to acculturate

faster than parents, which means that normal intergenerational gaps in values and behaviors are multiplied by the differences in acculturation. An adolescent's normal striving for independence which may have gone more slowly in the family's country of origin, is accelerated through assimilation into a culture of individualism and becomes increasingly incompatible with the parent's preference for the traditional cultural value of parental control (hierarchical/lineal relations). Such discrepancies in middle-school-aged children and their parents have been linked to youth intentions to use substances, less effective parenting practices, and an increase in family stress (Martinez, 2006). Increases in parent-child Hispanic acculturation discrepancies from the ninth to tenth grade are associated with increased risk of substance use (Unger et al., 2007). These studies demonstrate the complex way in which acculturation processes within a family require tremendous adaptation from the family. They also exemplify the way in which the cultural process of immigration and acculturation can negatively impact natural developmental and family systems processes of parent and adolescent attachment, conflict and support.

Hierarchy in Families: In groundbreaking work Kluckhohn and Strodtbeck (1961) identified the diversity of basic assumptions held by different ethnic cultures which are keys to understanding how different people view the world. The Relational Orientation Dimension these authors describe may be the dimension that is most clearly linked to family theory and constructs. This dimension refers to the expectations regarding a person's relation to other people -- with a range of a) hierarchical (vertical relationships), b) collateral (i.e. horizontal network) and c) individualistic (i.e., autonomy) relationship. These dimensions are seen as universal but will differ in degree by ethnic group. Hispanics have been shown to be more hierarchical in their relationships with a preference toward lineal non-egalitarian relationships (Szapocznik, Scopetta, Aranalde, & Kurtines, 1978).

The extent to which parents have a preference for markedly hierarchical family relations has powerful implications for parenting an adolescent, for strategies used in resolving conflicts, and often for how couples choose to function. When caregivers in the family view good family functioning as consisting of marked levels of authority and non-egalitarian relationships, there may be clear expectations about who is "in charge" and "most powerful" in the family and challenges to that individual's authority may lead to severe conflicts. When the blueprint is that parents are clearly in charge, challenges by the adolescent are not easily processed. Open disagreements between parents and adolescents violate the Hispanic value of "respeto" (respect) and are perceived as disrespectful and counterproductive. Respeto often leads families to diffuse rather than address conflict to keep harmony in relationships. It may be evident to the experienced family therapist that this view may clash with a mental health culture in which full conflict emergence with resolution is valued. It suggests that cultural values must be reflected not only in the content of therapy but also in the process of therapy. The question must be asked whether negativity and its full emergence is expected and more easily tolerated. In the highly hierarchical minority family, interventions that openly encourage the youngsters to "speak their mind" and "tell parents what they really think" may be seen as incompetent or misguided therapy. The "intervention" may be seen as exacerbating and not ameliorating the presenting family problem (i.e., the disrespectful child), by encouraging what is perceived to be the

dysfunctional behavior (questioning and challenging). As will be presented below, this hierarchical perspective extends beyond the family to outside social spheres and influences how Hispanic parents interact with others in those spheres;, teachers or administrators in a youth's school for example.

Familism in Hispanic Families—Familism is often cited as a core construct among Hispanics and other ethnic minority cultures and has been shown to have three components: 1) perceived obligations toward helping family members, 2) reliance on support from family members, and 3) the use of family members as behavioral and attitudinal referents (Marin & Marin, 1991). Individuals who strongly endorse this characteristic are motivated to behave in ways that benefit the family, but may not benefit themselves. Those who give such priority to the family may find that their views are consistent with the assumptions of a family therapy model. Problems can be discussed in family terms and it is expected that family will be involved. In this sense, familism may be consistent with many of the processes of family therapy.

A high degree of family orientation has pros and cons that must be viewed through the lens of the symptoms and the health of the family's functioning. One strength of families that are very close and attuned to each other is that they are aware of each other's problems and needs and are often available for support. However, if taken to an extreme, these families may not tolerate uniqueness so that those who do not "fit in" can be ostracized. Clinical anecdotal evidence points to the fact that this value, combined with well-defined gender roles often lead to female adolescents being prematurely rejected by the family for behavior that goes against "family norms" (Vega, 2013). As Hispanic youth move away from cultural values, such as familism, the risk for conflict in the family increases (Lorenzo-Blanco, Unger, Baezconde-Garbanati, Ritt-Olson, & Soto, 2012). Further, as youth acculturate they tend to reject traditional gender roles and this appears to impact girls and boys differently. Lorenzo-Blanco et al. (2012) found that when girls retained traditional gender roles they reported higher family cohesion; the same was not true for boys. Evidence suggests that female adolescents who incorporate familism into their value system at an early age may accept their parents' strict parenting style and rule setting and in turn receive more approval from their parents (Pena et al., 2011). When female adolescents behave in ways that are culturally in sync with their parents, it is likely that family conflict will be lower (Pena et al., 2011).

In addition, these types of families may engender dependency and delay the emotional development of some of their members. For example, an adolescent's need to individuate may be interpreted as rebelliousness when it conflicts with a family's tendency toward emotional and psychological closeness. Clinically, this conflict needs to be addressed with the recognition that separation/individuation is culturally syntonic in the dominant culture whereas closeness is culturally syntonic in the Hispanic culture. Therefore, therapists must always be attentive to personal and cultural values and be careful not to undermine either the need for self-sufficiency or the reliance on other family members in those individuals for whom this is important and adaptive. Families that are at the other end of the continuum also show costs and benefits. In families that are not highly family-oriented, members may learn to be competent and independent at an earlier age. The cost may be that in difficult times

family members may not be available to support one another or may not even be aware of each other's emotional needs. The degree of closeness and family orientation that is found in a Hispanic family is typically greater than that found in White-European families (Marin & Marin, 1991). The therapist must be careful not to pathologize this as enmeshment too quickly while maintaining the ability to question whether the closeness is hindering the well-being of the family's youngest members.

Youth responses to and interpretation of parenting practices: An interesting and less frequently conducted line of research investigates the role of ethnicity in influencing the emotional, behavioral and cognitive responses and outcomes of children and adolescents to a given parenting practice or message (Mason, Walker-Barnes, Tu, Simons, & Martinez-Arrue, 2004). The importance of this research lies in the fact that while parenting has received substantial attention in the prevention and treatment literature, much less is known about the factors that might lead adolescents to systematically respond differently to the same parenting strategies and techniques. The work of Mason et al. (2004) for example, found that parenting "Control through Guilt" messages were interpreted by African American and Hispanic youth as reflecting more "loving and cared for" than "coercion" but the interpretation was inverse for White youth. Further research is needed to continue to identify and tease apart the contextual factors and family characteristics that may contribute to the differential effectiveness of different types of parenting. Investigation of the culture-bound meaning that youth may attribute to specific types of parenting practices will be useful given the evidence that youth from different ethnic/race backgrounds may give substantially different affective meaning (i.e., caring/loving vs. controlling/manipulating) to their parent's parenting practices.

Family Responses to Immigration: When working with immigrant families, therapists must identify the circumstances that led them to leave their country (e.g., war, famine, persecution, desire for upward mobility), the meaning that immigration holds for them (e.g., loss), the process of the immigration itself, and its impact on the family (e.g. parent-child separations, attachment disruptions, trauma). Migration is a major life event for most families arriving in the U.S. but it can be particularly traumatic for some families that have dangerous and perilous paths here (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). After arriving, many families are forced to adjust quickly to the new environment and do not have the opportunity to process those painful family experiences. Often, family members suffer in silence, even when experiencing symptoms of trauma related to the immigration stress. After the initial migration stress has past, families may undergo a long and complex process of acculturation that requires them to adjust the assumptions, belief systems, and behavior patterns that had guided the family but that had been taken for granted. Both the immigration and acculturation processes can have powerful impacts on family systems and family functioning.

Parenting and Guidance around Adolescent Sexual Behavior—Adolescents involved with severe drug use are at high risk for Sexually Transmitted Infections (STIs) and HIV. Family factors such as high levels of parental involvement and good parent-adolescent communication have been consistently linked to healthy youth behavior

including having less unprotected sex (Hutchinson, Jemmot, Jemmot, Braverman, & Fong, 2003). Development of sexuality and sexual behavior is a universal aspect of human development, but its expression is closely tied to cultural values. A number of factors make open and honest communications about sexuality particularly difficult and complex in more traditional Hispanic families (Villarruel, 1998). These include Hispanic parents' beliefs that discussion of sexuality is taboo, and that "good girls" don't initiate sexual activity, and their lack of exposure to media presentations about safe sex. Our own research showed that Hispanic parents were less likely to have these conversations when they were concerned with possible negative reactions from their adolescent and when they felt they were not knowledgeable and confident regarding the facts of STIs and the role of birth control (Mena, Dillon, Mason, & Santisteban, 2008). This pattern in which parents lack information about, or feel it is taboo to discuss, sexually risky behavior and protection is not unique to Hispanic families but is prominent enough in this population that therapists should always consider whether it might impede the types of honest family communication that may help their kids practice safer sex. As a process issue for family-based interventions, these findings are meaningful because interventions can target all of these factors (e.g., level of parent-youth involvement, quality of communication, handling negative reactions) around the content issue of safer-sex. However, with Hispanic parents who have not had a history of these types of communications and who feel that they lack the breadth of knowledge regarding safer sex practices, it may be very helpful to provide them with facts about STIs, HIV/AIDS, the added risks for drug abusing youth, the high rates of HIV/AIDS found in Hispanics, and information on safer sex practices, so that they can feel confident enough to lead such a conversation.

Although this is not an exhaustive list of the ways in which culture-related variables can be conceptualized as influencing core within-family processes, these examples emphasize the need for greater understanding of the interactions between these two bodies of work.

The Ethnic Family Within its Larger Context

In working with minority families it is also important to assess the contextual/societal variables that shape daily interactions and contribute to their ease or difficulties of daily living. A useful framework for conceptualizing the key domains in the lives of children and families and in the interaction of these families with the larger context is Uri Bronfenbrenner's Social Ecological model of Human Development (1979) and the more recent research focused on the ecodevelopmental correlates of behavior problems (Coatsworth et al., 2000). The Social Ecology framework helps to organize risk and protective factors that impact the lives of youngsters. Using this model one can conceptualize the development of an adolescent as naturally "nested" within a number of domains such as the: family system, the school system, the neighborhood system, and the peer system. As the child develops, different parts of the system may become more strongly activated and influential. For example very young children depend almost exclusively on the family system for their emotional and physical well-being. The young child's health and development are determined primarily by the interactions between parents and the child. But as she/he reaches school-age, the school system becomes increasingly important and peers begin to take a prominent role. When children are able to spend time in the neighborhood

with decreased supervision, the influence of the neighborhood system also increases. In adolescence, the influence of the peer system and the manner in which peer values may begin to challenge or conflict with those of the family. When the child-family relations are supportive and strong, they may help steer youngster away from deviant peers. Family therapists spend a good amount of time focused on the interactions that take place in these important systems and in the interactions between children/adolescents and the important figures in the systems.

Another important focus of the family therapist, however, is the way in which microsystems interact with each other. In fact it may be a healthy and productive relationship between parents and the adolescent's peers (or "Family-Peer system") that helps promote the child's healthy development. Likewise, when the systemic functioning between parents and school is adaptive and supportive, the child is much more likely to be successful. Culture-related variables and lack of familiarity with the social settings outside the family may influence how powerful or powerless parents feel interacting with the school or peer group.

The well-being of the minority family is impacted in large part by how their ethnic group and race is perceived and how well they are accepted by the host community and society. Individuals that are treated poorly or discriminated against due to language, race, or class will likely have much more difficulty in major social domains including school, peers, work, neighborhoods, and healthcare systems. Skin color and linguistic characteristics make group membership clearly evident and help make these individuals easier targets of discrimination. Further adding insult to injury is the frequent inability of the majority population to accept, understand, and validate the discrimination that is experienced by the minority individual. All of these contextual race and culture-related factors can become daily stressors and directly impact health and symptom development.

A special situation arises for those families who are in the United States but are undocumented or do not have the formal permission to be in the U.S. For these individuals and families there is a special fear of being identified and deported. When families experience this awkward relationship with their country of residence and live in fear of being identified, they cannot avail themselves of many of the safeguards that most families take for granted. For example, victims of domestic violence may feel unable to report the violence for fear that they or the perpetrator may be deported. Similarly, families may feel the need to keep delinquent or criminal behavior by a son or daughter hidden to avoid deportation. In short, many of the reporting guidelines a family therapist would turn as a natural way of helping families may be rejected or even lead to premature termination of treatment if suggested. These are further examples of the contextual issues that directly and powerfully impact family and family-therapist dynamics.

Even when the Hispanic family is in the U.S. legally, there may be pressures that make it difficult to effectively interact with their ecology. Hofstede's (1980) concept of Power-Distance describes how some societies favor marked power differentials in which some persons (e.g., those highly intelligent or educated or of higher social class) or formal institutions must be treated with great respect, conformity and deference. The same hierarchical relationship expectations that shape children's conforming and deferring

behavior toward parents, help to shape families' expectations with highly respected institutions (e.g., juvenile justice systems and schools) and individuals (e.g. judges and psychiatrists). Families characterized by this orientation often favor hierarchical doctor-patient relationships (expert-patient) in which the doctor tells the patient what to do and the patient complies with little or no questioning. This is not uncommon among many of our Hispanic families but may differ from the process seen in non-Hispanic families that may feel more comfortable in asking questions and challenging authority when necessary. Programs that include multisystemic interventions that attempt to help parents become partners with the school or juvenile justice systems, for the sake of their children, may also be impacted by this phenomenon. Hispanic parents often look upon these institutions with such high respect and awe that they are unable to view themselves as having the ability to influence them. Even when language barriers that further disempower Hispanic parents do not exist, these other factors can shape their behavior and make it easy to label the parents as passive, dependent and lacking motivation. Work that focuses on the interactions between ethnic minority parents and large institutions would do well to consider the influence of Hofstede's power-distance orientation in their work and be prepared to assess this issue with families.

Approaches for Adapting and Tailoring Treatments for Diverse Populations

Current intervention research has begun to move towards developing and advancing individualized interventions for patients/clients. Adaptive interventions, tailored interventions, adapted interventions, and targeted interventions have all been identified in the literature as appropriate for addressing distinct characteristics which generic interventions may not effectively address. The goal of these types of interventions is to improve outcomes but there are important differences between them. The literature distinguishes targeted from tailored interventions (Beck et al., 2010; Kong, Singh, & Krishnan-Sarin, 2012). A "targeted" intervention is defined as an intervention developed to address one distinct characteristic of an entire group (Beck et al., 2010). In much the same way, "adapted" interventions typically involve modifications made for an entire group- such as treatments that are adapted to the needs of Hispanics patients (Castro, Barrera, & Holleran Steiker, 2010). Tailored interventions focus more on individuals and their unique characteristics. The treatment may be modified to address the individual characteristics of persons within a group in order to improve outcomes (Beck et al., 2010). The tailoring process requires that individual characteristics relevant to the intervention be selected and measured in order to best address the needs of the individual patient/client. An adaptive intervention is an intervention developed to address the individual treatment needs of a patient/client (Collins, Murphy, & Bierman, 2004) and often involve two steps. The first is that the intervention be focused on the individual needs and characteristics of patients/clients and the second is that the intervention adapts over time in response to the patient/client's response to the intervention and to how their needs change throughout the treatment process (Collins, Murphy, & Bierman, 2004; Nahum-Shani et al., 2012). Adaptive interventions use specific decision rules that guide therapists on when the intervention should take a particular shape and/or change its course and/or intensity depending on the participant's response to the intervention or their changing needs. Adaptive interventions use "tailoring variables" to

individualize the intervention for a patient/client and the type, amount, or intensity of treatment for an individual depends on how they score on measurement of the chosen tailoring variables.

To date, research has focused more heavily on targeted and adapted interventions than on tailored or adaptive interventions partly due to the fact that tailored and adaptive interventions require more careful implementation, measurement of individualized outcomes, and analyses (Beck et al., 2010). Adapted interventions for Hispanics have sought to take into account variables such as “familism” (Marin & Marin, 1991) and have recommended that when working with a Hispanic family, the family therapist may want to consider how the level of familism may help or hinder the presenting symptoms. It also means that a non-Hispanic therapist may want to check his/her assumptions to make sure they are not overly biased by an individual orientation. To assume that these dimensions are central to the life of a specific Hispanic without probing, however, moves quickly away from cultural competence and toward stereotyping. Although familism may be more common among Hispanics as a group, there is considerable variability in the orientation toward familism and individualism within the overall Latino population. The prominence of the specific values can sometimes be directly influenced and predicted by the individual’s level of acculturation, but even that is not always the case. Research has shown for example that certain components of familism change with acculturation and others do not (Sabogal, Marin, Otero-Sabogal, & Marin, 1987) and that individuals may be able to hold seemingly conflicting values and behaviors and alternate between them depending on the context (LaFromboise, Coleman, & Gerton, 1993).

As is described in the next section, the CIFFTA intervention utilizes the adaptive framework by measuring carefully chosen tailoring variables, such as acculturation, family conflict, co-occurring psychiatric disorders, and sexual risk, to assist in the initial tailoring of the intervention for a specific adolescent/family. Part of the tailoring process involves the decision-making process around the selection of CIFFTA psycho-educational modular interventions. After the modules are delivered, the individual and family therapy sessions integrate the material from the modules into the family systems work. The CIFFTA therapists also monitor new issues that emerge or problems that are resistant to change and may select additional modules to be administered. Although we currently do not systematically measure these tailoring variables throughout the course of therapy in order to make mid-treatment corrections this is the next step in CIFFTA’s development. Currently these mid-therapy adjustments are made in a more fluid clinical manner and only the pre-treatment tailoring is based on specific tailoring variables data.

Culturally Informed and Flexible Family-Based Treatment for Adolescents: An Adaptive Approach to Handling Diversity in a Systematic and Manualized Fashion

Rationale for Creating CIFFTA

CIFFTA is based on the assumption that Hispanic families enter treatment with behavioral and symptom profiles and experiences that are both common across ethnicities (e.g., clinical

presentation of depression, family conflict, blended family issues) and unique to their life experiences (e.g., cultural elements of immigration and acculturation stress, traditional family views, and sociopolitical experiences such as discrimination-related stress). CIFFTA seeks to help the family therapist adequately appreciate and work through the families' unique experiences in the process of changing core individual and family issues that they present (e.g., parenting practices, attachment issues, understanding of diagnostic symptoms). The competent handling of these different issues should increase the likelihood of full engagement and retention in treatment and of a positive outcome. We believe that an adaptive treatment is particularly well suited to address this array of themes. Although any manualized treatment can claim to be flexible, the problem occurs when a therapist must make idiosyncratic adjustments to the manual that includes little information on cultural variability. The clinician who is required to tailor the treatment to an individual family via "clinical improvisation" can later be criticized for showing low adherence/fidelity to a manualized treatment that is designed with high specificity. Further, the activity is unlikely to be replicable because the manual was designed with little specificity regarding the types of changes/tailoring that should be considered. The same is true for adjustments made due to co-occurring psychiatric disorders. During an initial training period, adjustments to the manual can be guided by an expert or treatment developer, but this process is more likely to fall apart when the therapist is no longer supervised directly by the expert. This loss of a supervisory and consultation structure may help to explain why the effect sizes seen in efficacy trials are rarely duplicated in effectiveness trials. When intense and ongoing supervision/consultation is required, it may not be sustainable financially. Modular interventions that have cultural and clinical nuances built into the content and process of treatment and which are delivered within a framework that articulates decision-making processes may help to achieve effects more similar to those achieved in efficacy trials. In describing a flexible approach in the treatment of anxiety in children, Kendall and Beidas (2007) state that the exposure experience can be flexibly tailored to the child regardless of whether it is separation anxiety or social phobia, however they also provide guidance by stating that parental involvement might be expected in separation anxiety treatment while parental involvement may not be expected in social phobia. This guidance on decision-making processes helps in the replicable implementation of this flexible treatment. Modular interventions such as those developed for CIFFTA allow the treatment to be tailored to the important family themes while ensuring that the interventions for the unique conditions can be more highly specified. In addition to content adjustments, there are also adjustments made to therapy process based on family styles and preferences. The more tradition/hierarchical family will be more sensitive to adolescent negativity and challenges to authority. The family therapist must be prepared to modulate what the parents may describe as "disrespectful" behavior and help the family negotiate in a way that is more acceptable to the family characteristics. It is not sufficient to merely talk about these differences during a discussion about acculturation but it is also necessary to ensure that the therapy processes is one that can be effective and not counter-therapeutic.

Other core assumptions guiding CIFFTA are that to be most effective, a treatment should be 1) culturally informed; 2) family based; 3) responsive to co-occurring disorders, and 3) adaptive with a built-in decision-making logic for systematic implementation. CIFFTA was

developed as an adaptive treatment that would be attractive to family therapists who had concerns about inflexible manualized treatments that did not acknowledge the complexity of their clients. By addressing this concern directly, and creating a treatment that more closely mimicked the decisions made by a good clinician, we hope to increase CIFFTA's transportability. A description of the adaptive approach to handling co-occurring psychiatric disorders is beyond the scope of this article as is a description of how and why a substantial individual treatment component was developed for CIFFTA. This latter point is described in some detail in Santisteban and Mena (2009). In this section we focus primarily on CIFFTA's adaptive and flexible decision-making approach to handling culture-related diversity by creating psycho-educational modules focused on content that responds to cultural variation and its impact on core family processes.

CIFFTA's Empirical Foundation

CIFFTA is the culmination of a formal and systematic treatment development effort (Santisteban, Mena, & Suarez, 2006; Santisteban & Mena, 2009; Santisteban, Mena, & McCabe, 2011) funded primarily by the National Institute on Drug Abuse. In its development, we followed the Stage model for the development and testing of behavioral treatments, which specifies the steps from a creative concept, through manualization and testing, and all the way to dissemination (Rounsaville, Carroll & Onken, 2001). The work consisted of: 1) integrating the most recent findings in the areas of culture, family processes, developmental factors, and the treatment of drug and behavior problems; 2) conducted our own cross-sectional research on Hispanic youth and families to learn more about the intersection of cultural factors and risky sexual behaviors (e.g., Mena et al., 2008) and parent-child immigration-related separations and psychological symptoms (Mena, Mitrani, Mason, Muir, & Santisteban, 2013); 3) creating psycho-educational modules that linked cultural influences and family processes; 4) designing a systematic process of assessing important tailoring variables and creating a profile that can be easily used by clinicians; and 5) utilizing a series of pilot cases in which the feedback from adolescents, families, and therapists were used to create the final refinements of the model (Santisteban, Mena, & Suarez-Morales, 2006).

CIFFTA has Structural Family Therapy (Minuchin & Fishman, 1981) as its foundation, integrates lessons learned from our previous work with behavior problem adolescents (Santisteban, Suarez-Morales, Robbins, & Szapocznik, 2006), and introduces new ideas related to culture-related themes and an adaptive and modular treatment delivery framework (Santisteban & Mena, 2009). CIFFTA integrates: 1) individual interventions (e.g., Motivational Interviewing and skills training), 2) psycho-educational modules (e.g., parenting, drug education, depression, risky sexual behavior, acculturation-related stressors) and 3) family therapy. CIFFTA has been tested in various forms from a less intensive (i.e., 12–16 session) prevention oriented intervention (Santisteban, Czaja, Nair, Mena, & Tulloch, 2013) to a more intensive (i.e., 24 session) drug treatment intervention (Santisteban, Mena, & McCabe, 2011). Family therapy and select psycho-educational modules are delivered to individual families in a conjoint format. Individual treatment and select psycho-educational modules (e.g., drug education) are delivered to the adolescent alone. Parenting modules are delivered only to parent figures in each individual family.

Following Falicov's idea of focusing our attention on "differences that make a difference" CIFFTA sought to continue to emphasize the family and therapy processes important to adolescent treatment, to adjust that process to the unique preferences families bring with them to treatment, and to ensure that our psycho-educational modules weave culture-related material into the fabric of these family components. For example, effective parenting is considered to be at the core of our work with adolescents that display behavior problems and drug use. Monitoring, attachment, support, and conflict resolution are all important in well-functioning families and are the targets of family treatment when major symptoms emerge in adolescents. CIFFTA includes a parenting module that all parent figures receive when they seek treatment for a youth with a behavior or drug use problem. The module provides the basic information and frame that will facilitate the conjoint family therapy work. Within that parenting module, we have integrated the types of acculturation and culture-related material that should be incorporated into treatment to more effectively address the unique challenges experienced by Hispanic parents. So, the manual guides the therapist through considering the role of acculturation differences between parents and adolescents and its possible effect on parenting effectiveness. Likewise, the therapist is guided in considering how monitoring is more difficult when parents feel they are out of touch with the world the adolescent lives in. If the gap in acculturation is extreme, as measured for example by the Hispanic Stress Inventory (Cervantes et al., 2011) acculturation gap scale, then whether to implement the additional "Acculturation" module is considered. The family's presentation on other important issues such as immigration-related separations, parents' perceptions of their place in and acceptance by society, comfort or discomfort with discussions of sexuality, and other stressors experienced by Hispanics (e.g., marital stress or discrimination stress) may also lead to modules that can address those issues more directly. The family's profile of critical issues at intake guides this tailoring and gives the therapist direction by identifying important therapeutic themes that are likely to influence the treatment process.

One of the more important contributions of our work is to emphasize that not all of these issues are relevant to all Hispanic families. This perspective is supported by research that shows that there may be improved outcomes resulting from tailored or adaptive interventions when working with minority populations but that the improvement is most visible in patients that are not highly acculturated (Griner & Smith, 2006). Interestingly, a client-family may seem very non-Hispanic in some domains and very Hispanic in others. In short, an assumption underlying the CIFFTA model is that even a treatment designed primarily for Hispanics is unlikely to have a "one size fits all" solution.

CIFFTA in Practice: Using an Adaptive Manual with Decision Rules

Following the groundbreaking efforts at creating "adaptive" interventions and decision-rules (Collins, Murphy, & Bierman, 2004; Chorpita, 2007; McHugh, Murray, & Barlow, 2009) CIFFTA identifies "tailoring variables" that can be measured and linked to decision rules that lead to the tailoring of the intervention to the unique adolescent/family characteristics. The challenge is to delineate procedures for identifying those unique characteristics that will serve as tailoring variables, and to describe steps for using this information to select modules and to shape treatment processes. CIFFTA's tailoring work is based on both a comprehensive semi-structured interview conducted by the therapist and a set of self-report

and interview items from standardized instruments administered at baseline. The types of data we deem essential from the two part assessment include: 1) immigration history – including such information as where the family is from, when and why the family came to the U.S. or for those who had been in the U.S. for many years – how much they felt a sense of belonging in their communities, whether family members were separated due to immigration and if so, what were the conditions of the separations, 2) comorbid psychiatric diagnoses such as those that can be derived from the Diagnostic Interview Schedule for Children, 3) profile of sexually risky behavior, 4) stressors found to be prominent in Hispanics such as acculturation gaps between parents and youth, immigration stressors (e.g., Hispanic Stress Inventory), 5) traumatic experiences including immigration, 6) behavior problem profiles including drug use, and 7) family conflict (e.g., Family Environment Scales). We also ask parents how comfortable they are with their knowledge and their ability to communicate with their adolescent about drugs, alcohol, co-occurring psychiatric symptoms, sexually transmitted infections, and safer sex options. A report is generated automatically for the therapist with the information on the specific tailoring variables listed above. Based on this information the therapist – together with the family – formulates a treatment plan.

Within a modular therapy, psycho-educational modules can easily be integrated into the treatment process if their scores on a particular measure trigger a decision or the therapist uncovers information that the theme of the module is of particular relevance to the family. Modules can also be implemented in different sequences depending on the unique needs of the family. For adolescents with severe drug use problems, we consider modules on parenting practices for parents, drug education for youth, and HIV/STI risk reduction education for youth as core interventions for every family. We typically also offer the information on drug education and HIV/STI to parents so that they feel sufficient mastery of the areas to engage in productive conversations with the adolescent. When parents do not feel they have sufficient knowledge about a topic to allow them to confront the adolescent or to provide leadership in a family session, we will modify the therapy sequence to prepare the parent ahead of the family session. CIFFTA's flexibility is complemented by a set of decision-making guidelines that facilitate tailoring without an expert's supervision. Decision-making guidelines suggest which pre-treatment characteristics and issues should be considered in module selection and which treatment processes may be monitored to consider mid-treatment adjustments. For example, when there are co-occurring psychiatric disorders (which have been shown to be the rule and not the exception in adolescent drug abuse treatment) modules for parents and adolescents on specific disorders such as depression, ADHD, and conduct disorder can be used. When parent figures are clashing around their parenting and being ineffective, that observation may trigger a return to the parenting module and specifically to the section on how parent figures must work together. By providing structured modules and a set of decision-making guidelines, CIFFTA facilitates a higher level of fidelity to the overall treatment and the ability of other therapists to replicate the delivery of the treatment with diverse families. Additional modules that are optional and selected based on the needs identified in the initial clinical interview focus on things such as co-occurring psychiatric disorders modules including depression, conduct problems, and ADHD, interpersonal effectiveness skills for youth, teen dating violence,

issues in blended and single parent families, working with a psychiatrist around medications for children, working through parent-child immigration separations, working with the juvenile justice system, and understanding acculturation-related stressors and their possible impact on the family.

As is evident from the description of the CIFFTA process, psycho-educational modules are meant to be connected directly to the individual and family components of the therapy. CIFFTA targets individual and family level factors that can promote or hinder healthy adolescent development, and the psycho-educational modules are created to facilitate that work. Although the modules are a key component of the CIFFTA approach because of their role in the tailoring process, it is a mistake to believe that the presentation of this didactic material alone has the impact necessary to ameliorate recalcitrant symptoms. It is an important assumption of our work that the modules create the “therapeutic frames” for the work that occurs in the family and individual therapy sessions. For example, following the parenting and acculturation modules, it is expected that a family will use their greater appreciation for complex and normative acculturation processes and understand that much of the conflict can be attributed to these processes and not to the rejection of parental authority. The therapist facilitates the use of this new perspective in the family sessions to orchestrate more adaptive interactions. Similarly, the use of the parent-child immigration-related separations module can normalize the feeling of abandonment, betrayal and lost time and help the family to improve attachment and move beyond those feelings to catch up on lost time and create a new family. Individual sessions may utilize motivational interviewing while using the new drug and HIV/STI module information in making personal decisions and in setting goals. The full impact of the therapy can only be realized if the therapist is able to create synergy between the different treatment components (i.e., family work, individual work and psycho-educational modules) around the selected cultural, clinical and family themes. Three case examples may help to describe the process that is the foundation of the CIFFTA approach.

Case 1—In the Ramirez family the one-page family intake/tailoring profile shows the therapist that the adolescent is sexually active and that the parents have never spoken to the youngster about safe sex practices. Had the profile shown that this conversation had taken place, the therapist might feel comfortable bringing it up naturally in a family session. Seeing that the discussion has never taken place, the therapist might review the score indicating the level of acculturation of the parents and consider whether the lack of communication may be due in part to a low level of parent acculturation or perhaps parental lack of a vocabulary for speaking about safe sex. The therapist decides to offer the parents the “safer sex and STD risk” module separately so that the parents gain some mastery of the material before entering the family session with the adolescent. The module content and coaching by the therapist serves to empower the parent to take a leadership role in promoting safe sex in the family therapy session that focuses on this topic and which seeks to shape the parental leadership role. It should be noted that this psycho-educational component emerged from research that showed that Hispanic parents who did not communicate with their adolescent around these issues often did not do so because they

either felt the adolescent knew more than they did about the topic and/or they felt the adolescent would ridicule them for bringing up the topic (Mena et al., 2008).

Case 2—In the Perez family the intake/tailoring profile showed two high-points (i.e., peaks) on the Hispanic Stress Inventory (Cervantes et al., 2011) “Acculturation Gap” scale and on the “Family-Cultural Stress” subscale. The therapist realizes that in most cases this means that the adolescent is highly acculturated while the parent is not, and that these differences may be disrupting family communication and relationships. During the mandatory “Parenting Practices” module the therapist emphasizes the sections that talk about the different types of parenting seen in different cultures and family types (e.g., more highly involved and perhaps hierarchical families as opposed to more egalitarian family structures). The therapist may also consider the implementation of the stand-alone “Acculturation” module that presents a framework for thinking about the normative process of acculturation and the consequences of differing rates of acculturation. This module content explains how an adolescent can be expected to move away from the culture of origin and that this normative process is not a rejection of the parents or family values. It also allows the parents to consider their expectations regarding adolescent communications style (e.g., speaking their mind in a health way vs. being disrespectful of authority). In the family therapy session that follows and that “generalizes” the module content, the family therapist helps the family discuss the normative acculturation process, how this may impact family functioning, and how communication should take place so that it is effective and not deemed disrespectful of parental authority.

Case 3—In the Gonzalez family the intake/tailoring profile indicated that there has been an extended parent-child separation due to immigration. The therapist inquires about this separation and considers the utilization of the “Separation” module. This module is administered to the family together and describes the many normal feelings (e.g., abandonment, hope, disappointment, loss, sadness) that may emerge from such an experience (Mitrani, Santisteban, & Muir, 2004). It covers the difficulties that are inherent in trying to “reunite” with a family member that has changed so much and who is experiencing a sense of loss. Sometimes the loss has to do with the weakened parent-child relationship while at other times it is the loss of the most recent parent figure in the country of origin, left during the reunification process. The normalization of the complex process allows for the family to start the next family therapy session from a point of better understanding and less blame, allowing for the validation of sadness and sense of loss.

Conclusion

With the growing diversity of the U.S. population and the increasing evidence that there may be inferior engagement and treatment outcomes when treatments are not designed to address issues of cultural diversity, there is an interest in integrating the best of the family systems and cultural diversity literatures. Family-based treatment for culturally diverse populations requires that the therapist be informed by theories and research findings emerging from the family systems field as well as those emerging from work focused on the unique cultural factors that are prominent in the group of interest. Neither a “culture-free”

systemic intervention nor a “systems theory-free” culturally-focused intervention appears to be optimal for addressing substance abuse in Hispanic youth and families.

The key to success may be in identifying, measuring and utilizing the culture-related experiences and factors that can be shown to directly impact the relevant family systems constructs. In our CIFFTA family-based intervention, we have concentrated on those links we found most meaningful between culture-related factors, within-family systemic functioning, and family-in-context interactions. We have used this integrative thinking in our program of research focused on the development and testing of the Culturally Informed and Flexible Family-Based Treatment for Adolescents (CIFFTA). This adaptive framework allows the tailoring of the intervention based on the cultural and clinical uniqueness of the adolescent and family has proven to be highly promising in a recent set of randomized trials. In this article we presented our work with Hispanic families as one exemplar of the model, but we believe that this framework can be used similarly with other ethnic groups (e.g., African Americans and Asians) and other diverse populations (e.g., LGBT) that have not always seen the issues important to them integrated into culturally-informed treatments. It is our long term plan that CIFFTA will expand beyond Hispanic populations through the process of identifying key tailoring variables that can inform treatment with increasingly diverse populations. Our previous (Santisteban et al., 1997) and current success with African American adolescents and families have been important preliminary steps in this direction.

One of the advantages of a truly adaptive treatment is that it can be manualized in a way that articulates the treatment framework and therapy components, and facilitates replication, but does so without a loss of flexibility and without disregarding the clinical complexity of diverse patient groups. Although some non-adaptive treatment manuals may be general enough to provide a wide range of techniques for the therapist’s use, it may fail to articulate the expected complexity of most patients and to provide guidance on how that complexity should be handled within the theoretical framework and without expert consultation. Adaptive manualized treatments that build in decision processes that facilitate the tailoring of the treatment to the unique individual characteristics are fairly new to the field (Collins, Murphy, & Bierman, 2004; Chorpita, 2007) but are promising in their ability to deal with complexity in a replicable manner.

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References

Abraido-Lanza AF, Armbrister AN, Florez KR, Aguirre AN. Toward a theory-driven model of acculturation in public health research. American Journal of Public Health. 2006; 96(8):1342–1346.10.2105/AJPH.2005.064980 [PubMed: 16809597]

Ainsworth, MDS. The development of infant-mother interaction among the Ganda. In: Foss, BM., editor. Determinants of infant behavior. New York: Wiley; 1963. p. 67-104.

Ainsworth, MS.; Blehar, MC.; Waters, E.; Wall, S. Patterns of attachment: A psychological study of the Strange Situation. Hillsdale, NJ: Erlbaum; 1978.

Beck C, McSweeney JC, Richards KC, Roberson PK, Tsai P, Souder E. Challenges in tailored intervention research. Nursing Outlook. 2010; 58(2):104–110.10.1016/j.outlook.2009.10.004 [PubMed: 20362779]

Bernal G, Scharron-Del-Rio MR. Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. Cultural Diversity & Ethnic Minority Psychology. 2001; 7:328–342.10.1037/1099-9809.7.4.328 [PubMed: 11759270]

Bowlby, J. The making and breaking of affectional bonds. New York: Tavistock; 1979.

Bronfrenbrenner, U. The Ecology of Human Development: Experiments by Nature and Design. Cambridge, MA: Harvard University Press; 1979.

Cassidy, J.; Shaver, PR. Handbook of attachment: Theory, research, and clinical applications. New York: Guilford Press; 1999.

Castro FG, Barrera M, Holleran Steiker LK. Issues and challenges in the design of culturally adapted evidence-based interventions. Annual Review of Clinical Psychology. 2010; 6:213–239.10.1146/annurev-clinpsy-033109-132032

Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2011. MMWR. 2012; 61:11–12. [PubMed: 22695458]

Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-United States, 2011. Surveillance Summaries. MMWR. 2012; 2012:61. (No. SS-4).

Cervantes RC, Fisher DG, Cordova D Jr, Napper LE. The Hispanic stress inventory—Adolescent version: A culturally informed psychosocial assessment. Psychological Assessment. Sep 26; 2011 24(1):187–196. Advance online publication. 10.1037/a0025280 [PubMed: 21942232]

Chorpita, BF. Modular cognitive-behavioral therapy for childhood anxiety disorders. New York: Guilford Press; 2007.

Coatsworth JD, Pantin H, McBride C, Briones E, Kurtines W, Szapocznik J. Ecodevelopmental correlates of behavior problems in young Hispanic females. Applied Developmental Science. 2000; 6(3):126–143.

Collins LM, Murphy SA, Bierman KL. A conceptual framework for adaptive preventive interventions. Prevention Science. 2004; 5:185–196. [PubMed: 15470938]

Dishion T, Bullock B, Granic I. Pragmatism in modeling peer influence: Dynamics, outcomes and change processes. Development and Psychopathology. 2002; 14(4):969–981.10.1017/S0954579402004169 [PubMed: 12549712]

Domenech Rodriguez M, Donovick M, Crowley S. Parenting styles in a cultural context: Observations of ‘protective parenting’ in first-generation Latinos. Family Process. 2009; 48(2):195–210.10.1111/j.1545-5300.2009.01277.x [PubMed: 19579905]

Falicov, C. Latino Families in Therapy: A Guide to Multicultural Practice. New York: The Guilford Press; 1998.

Flicker SM, Waldron HB, Turner CW, Brody JL, Hops H. Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. Journal of Family Psychology. 2008; 22(3):439–447. [PubMed: 18540772]

Gayles J, Coatsworth J, Pantin H, Szapocznik J. Parenting and neighborhood predictors of youth problem behaviors within Hispanic families: The moderating role of family structure. Hispanic Journal of Behavioral Sciences. 2009; 31(3):277–296.10.1177/0739986309338891

Gil AG, Wagner EF, Vega WA. Acculturation, familism, and alcohol use among Latino adolescent males: Longitudinal relations. Journal of Community Psychology. 2000; 28(4):443–458.10.1002/1520-6629(200007)28:4<443::AID-JCOP6>3.0.CO;2-A

Gonzales NA, Deardorff J, Formoso D, Barr A, Barrera MR. Family mediators of the relation between acculturation and adolescent mental health. Family Relations. 2006; 55(3):318–330.10.1111/j.1741-3729.2006.00405.x

Griner D, Smith TB. Culturally adapted mental health intervention: A metaanalytic review. Psychotherapy: Theory, Research, Practice, Training. 2006; 43:531–548.

Halliday-Boykins CA, Schoenwald SK, Letourneau EJ. Caregiver-therapist ethnic similarity predicts youth outcomes from an empirically based treatment. Journal of Consulting and Clinical Psychology. 2005; 73:808–818. [PubMed: 16287381]

Henderson CE, Rowe CL, Dakof GA, Hawes SW, Liddle HA. Parenting practices as mediators of treatment effects in an early-intervention trial of Multidimensional Family Therapy. The American Journal of Drug and Alcohol Abuse. 2009; 35:220–226.10.1080/00952990903005890 [PubMed: 20180674]

Hofstede, G. Culture's Consequences: International Differences in Work-related Values. Beverly Hills, CA: Sage Publications; 1980.

Huey S, Polo A. Evidence-based psychosocial treatments for ethnic minority youth. Journal of Clinical Child and Adolescent Psychology. 2008; 37:262–301.10.1080/15374410701820174 [PubMed: 18444061]

Hutchinson MK, Jemmot JB, Jemmot LS, Braverman P, Fong GF. The role of mother-daughter sexual risk communication in reducing sexual risk behaviors among urban adolescent females: A prospective study. Journal of Adolescent Health. 2003; 33:98–107. [PubMed: 12890601]

Johnston, LD.; O'Malley, PM.; Bachman, JG.; Schulenberg, JE. Monitoring the Future national results on adolescent drug use: Overview of key findings, 2010. Ann Arbor: Institute for Social Research, The University of Michigan; 2011. p. 77

Kendall PC, Beidas RS. Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. Professional Psychology: Research and Practice. 2007; 38:13–20.

Kiesner J, Dishion T, Poulin F, Pastore M. Temporal dynamics linking aspects of parent monitoring with early adolescent antisocial behavior. Social Development. 2009; 18(4):765–784.10.1111/j.1467-9507.2008.00525.x [PubMed: 19966920]

Kluckhohn, FR.; Strodtbeck, FL. Variations in value orientations. Evanston, IL: Row, Peterson; 1961.

Kong G, Singh N, Krishnan-Sarin S. A review of culturally targeted/tailored tobacco prevention and cessation interventions in minority adolescents. Nicotine and Tobacco Research. 2012; 14:1394–1406.10.1093/ntr/nts118 [PubMed: 22614548]

La Fromboise T, Coleman HL, Gerton J. Psychological impact of biculturalism: evidence and theory. Psychological Bulletin. 1993; 114(3):395–412. [PubMed: 8272463]

Liddle HA, Schwartz SJ. Attachment and family therapy: clinical utility of adolescent-family attachment research. Family Process. 2002; 41(3):455–476. [PubMed: 12395569]

Lopez SR. Reflections on the surgeon general's report on mental health, culture, race and ethnicity. Culture, Medicine and Psychiatry. 2003; 27:419–434.

Lorenzo-Blanco EI, Unger JB, Baezconde-Garbanati L, Ritt-Olson A, Soto D. Acculturation, enculturation, and symptoms of depression in Hispanic youth: the role of gender, Hispanic cultural values, and family functioning. Journal of Youth and Adolescence. 2012; 41:1350–1365.10.1007/s10964-012-9774-7 [PubMed: 22627624]

Marin, G.; Marin, BV. Research with Hispanic populations. Newbury Park, CA: Sage; 1991.

Martinez CR. Effects of differential family acculturation on Latino adolescent substance use. Family Relations. 2006; 55:306–317.10.1111/j.1741-3729.2006.00404.x

Mason CA, Walker-Barnes CJ, Tu S, Simons J, Martinez-Arrue R. Ethnic differences in the affective meaning of parental control behaviors. The Journal of Primary Prevention. 2004; 25(1):59–79.

McHugh RK, Murray HW, Barlow DH. Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: The promise of transdiagnostic interventions. Behaviour Research and Therapy. 2009; 47:946–953.10.1016/j.brat.2009.07.005 [PubMed: 19643395]

Mena MP, Dillon F, Mason CA, Santisteban DA. Communication about sexually-related topics among Hispanic substance-abusing adolescents and their parents. Journal of Drug Issues, Special Issue: Explaining Contemporary Hispanic Drug Use/Abuse: Issues and Challenges. 2008; 38:215–234.

Mena, MP.; Mitrani, V.; Mason, C.; Muir, JA.; Santisteban, DA. Unpublished Manuscript. University of Miami; 2013. Extended parent-child separations: Impact on adolescent functioning and possible gender differences.

Minuchin, S.; Fishman, CH. Family therapy techniques. Cambridge: Harvard University Press; 1981.

Mitrani VB, Santisteban D, Muir JA. Addressing immigration-related separations in Hispanic families with a behavior-problem adolescent. American Journal of Orthopsychiatry. 2004

Moras K. The use of treatment manuals to train psychotherapists: observations and recommendations. Psychotherapy. 1993; 30:581–586.

Nahum-Shani I, Almirall D, Fabiano GA, Yu J, Qian M, Pelham WE, Gnagy B, Waxmonsky JG, Murphy SA. Experimental design and primary data analysis methods for comparing adaptive interventions. Psychological Methods. 2012; 17:457–477.10.1037/a0029372 [PubMed: 23025433]

Pena JB, Kuhlberg JA, Zayas LH, Baumann AA, Gulbas L, Hausmann-Stabile C, Nolle AP. Familism, family environment, and suicide attempts among Latina youth. Suicide and Life-Threatening Behavior. 2011; 41(3):330–341. [PubMed: 21463357]

Rounsaville BJ, Carroll KM, Onken LS. A stage model of behavioral therapies research: Getting started and moving on from stage I. Clinical Psychology: Science and Practice. 2001; 8:133–142.

Sabogal F, Marin G, Otero-Sabogal R, Marin B. Hispanic familism and acculturation: What changes and what doesn't? Hispanic Journal of Behavioral Sciences. 1987; 9(4):397–412.10.1177/07399863870094003

Santisteban DA, Coatsworth JD, Perez-Vidal A, Mitrani V, Jean-Gilles M, Szapocznik J. Brief Structural/Strategic Family Therapy with African- American and Hispanic high-risk youth. Journal of Community Psychology. 1997; 25(5):453–471.10.1002/(SICI)1520-6629(199709)25:5<453::AID-JCOP6>3.0.CO;2-T

Santisteban, DA.; Czaja, S.; Nair, S.; Mena, MP.; Tulloch, A. Unpublished Manuscript. University of Miami; 2013. A Randomized Trial Testing Computer Assisted Culturally Informed Flexible Family Based Treatment for Adolescents: Testing Treatment Impact on Behavior Problems and Family Functioning.

Santisteban D, Mena M. Culturally informed and flexible family-based treatment for adolescents: A tailored and integrative treatment for Hispanic youth. Family Process. 2009; 48:253–268.10.1111/j.1545-5300.2009.01280.x [PubMed: 19579908]

Santisteban DA, Mena MP, McCabe BE. Preliminary results for an adaptive family treatment for drug abuse in Hispanic youth. Journal of Family Psychology. 2011; 25(4):610–614. Advance online publication. 10.1037/a0024016 [PubMed: 21639636]

Santisteban, DA.; Mena, MP.; Suarez-Morales, L. Using treatment development methods to enhance the family-based treatment of Hispanic adolescents. In: Liddle, H.; Rowe, C., editors. Adolescent Substance Abuse: Research and Clinical Advances. Cambridge University Press; 2006.

Schwartz SJ, Unger JB, Zamboanga BL, Szapocznik J. Rethinking the concept of acculturation: Implications for theory and research. American Psychologist. 2010; 65(4):237–251.10.1037/a0019330 [PubMed: 20455618]

Santisteban DA, Suarez-Morales L, Robbins MS, Szapocznik J. Brief strategic family therapy: Lessons learned in efficacy research and new research directions on blending research and practice. Family Process. 2006; 45:259–275. [PubMed: 16768022]

Silove D, Sinnerbrink I, Field A, Manicavasagar V, Steel Z. Anxiety, depression and PTSD in asylum-seekers: associations with pre-migration trauma and post-migration stressors. British Journal of Psychiatry. 1997; 170:351–357. [PubMed: 9246254]

Snyder, DK.; Cozzi, JJ.; Mangrum, LF. Conceptual issues in assessing couples and families. In: Liddle, H.; Levant, R.; Santisteban, DA.; Bray, J., editors. Family Psychology Intervention Science. Washington, D.C: American Psychological Association Press; 2002. p. 69-88.

Sroufe, LA.; Egeland, B.; Carlson, EA.; Collins, WA. The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood. New York: Guilford; 2005.

Suárez-Orozco C, Todorova I, Louie J. "Making up for lost time": The experience of separation and reunification among immigrant families. Family Process. 2002; 41:625–643. [PubMed: 12613121]

Sue, S.; Zane, N.; Young, K. Research on psychotherapy with culturally diverse groups. In: Bergin, AE.; Garfield, SL., editors. Handbook of Psychotherapy and Behavior Change. New York: John Wiley & Sons; 1994.

Szapocznik, J.; Coatsworth, JD. An ecodevelopmental framework for organizing the influences on drug abuse: A developmental model of risk and protection. In: Glantz, MD.; Hartel, CR., editors. Drug abuse: Origins and interventions. Washington, DC: American Psychological Association; 1999. p. 331-366.

Szapocznik J, Scopetta MA, Aranalde MA, Kurtines WM. Cuban value structure: Clinical implications. Journal of Consulting and Clinical Psychology. 1978; 46(5):961–970. [PubMed: 701575]

Tonin SL, Burrow-Sanchez JJ, Harrison RS, Kircher JC. The influence of attitudes, acculturation, and gender on substance use for Mexican American middle school students. Addictive Behaviors. 2008; 33:949–954.10.1016/j.addbeh.2008.02.014 [PubMed: 18343041]

Unger JB, Ritt-Olson A, Wagner KD, Soto D, Baezconde-Garbanati L. A comparison of acculturation measures among Hispanic/Latino adolescents. Journal of Youth and Adolescence. 2007; 36:555–565. 10.1007s10964-007-9184-4.

U.S. Census Bureau Estimates. U.S. Census Bureau; 2010. http://www.factfinder.census.gov

Van IJzendoorn, MH.; Sagi, A. Cross-cultural patterns of attachment: Universal and contextual dimensions. In: Cassidy, J.; Shaver, PR., editors. Handbook of attachment: Theory research and clinical applications. New York: Guilford Press; 1999. p. 713-734.

Vega, WA. Caribbean Basin and Hispanic Addiction Technology Transfer Center. Universidad Central del Caribe; 2013. Cultural elements in treating Hispanic populations: Dialogue on science and addiction.

Villarruel A. Cultural influences on the sexual attitudes, beliefs, and norms of young Latina adolescents. Journal of the Society of Pediatric Nurses. 1998; 3:69–79. [PubMed: 9670168]

Wagner K, Ritt-Olson A, Chou C, Pokhrel P, Duan L, Baezconde-Garbanati L, Soto DW, Unger JB. Associations between family structure, family functioning, and substance use among Hispanic/Latino adolescents. Psychology of Addictive Behaviors. 2010; 24(1):98–108.10.1037/a0018497 [PubMed: 20307116]