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Parent Involvement Enhances CBTs for Anxiety Disorders in Hispanic/Latino Youth: Acculturation as a Moderator

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Objective: Although cognitive behavioral treatments (CBTs) are well-established evidence-based interventions for anxiety disorders in youth, there is long-standing underrepresentation of Hispanic/Latino (H/L) families in youth anxiety clinical trials research. The impact of such underrepresentation is that clinicians who work with H/L youth have minimal evidence-based guidance on best practices. The present study moves toward informing best practices for working with H/L youth with anxiety disorders by examining H/L parents' acculturation and enculturation as moderators of youth anxiety outcomes following CBTs. ***Method:*** Two hundred eleven H/L youths ages 6–16 ($M = 9.41$ years, $SD = 2.39$ years; 43.8% female) and their parents were assigned to individual-youth CBT or one of two parent involvement CBTs: one targeted decreasing parent psychological control, the other targeted decreasing parent use of negative reinforcement. Parent acculturation and enculturation were measured at pretreatment; youth anxiety severity was measured at pretreatment, posttreatment, and 12-month follow-up evaluations. ***Results:*** Youth anxiety outcomes were enhanced in both parent involvement CBTs compared with individual-youth CBT. Parent acculturation, but not enculturation, significantly moderated outcomes. At lower levels of parent acculturation, youth anxiety outcomes were enhanced in the parent involvement CBT that targeted negative reinforcement. At higher levels of parent acculturation, youth anxiety outcomes were enhanced in the parent involvement CBT that targeted psychological control. ***Conclusions:*** These findings further support the efficacy of CBTs for anxiety disorders in H/L youth and suggest guidance for tailoring parent involvement treatments based on parent acculturation levels.

What is the public health significance of this article?
This study advances best practices for treating Hispanic/Latino (H/L) youth with anxiety disorders by demonstrating that (a) parent involvement in cognitive behavioral treatments enhances youth anxiety outcomes and (b) parent acculturation levels moderate outcomes. For low-acculturated parents, targeting decreases in negative reinforcement enhances outcomes; for high-acculturated parents, targeting decreases in psychological control enhances outcomes.

Keywords: anxiety, cognitive behavioral therapy, Hispanic/Latino, youth, acculturation

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Cognitive behavioral treatments (CBTs) are well-established, evidence-based interventions for anxiety disorders in children and adolescents (hereon referred to as "youth"; Higa-McMillan et al., 2016; Silverman et al., 2008). Despite extensive evidence supporting the efficacy of CBTs, there is long-standing underrepresentation of racial and ethnic minority families in youth anxiety clinical trials research, particularly Hispanic/Latino (H/L) youth (Pina et al., 2003, 2019). The impact of this underrepresentation is magnified by data showing that H/L youth experience anxiety disorders at higher rates than other ethnic groups (e.g., Roberts et al., 2006).

We know of six randomized controlled trials (RCTs) for youth anxiety disorders where at least 50% of the sample was H/L (Chavira et al., 2018; Pina et al., 2012, 2020; Silverman et al., 2009, 2019, 2022). The fact that only six prior RCTs—out of well over 100 RCTs for youth anxiety (Higa-McMillan et al., 2016)—have included samples with at least 50% H/L participants is strong evidence for the severe underrepresentation of H/L families in CBT trials, a critical issue of concern highlighted almost two decades ago by Pina et al. (2003). An important implication of this severe underrepresentation is that clinicians working with H/L youth with anxiety disorders have minimal evidence-based or—informed guidance on best practices.

In the present study, we move toward informing best practices for working with H/L youth with anxiety disorders and refining culturally responsive treatments for youth anxiety by examining key candidate variables related to culture and anxiety in H/L families: parenting and acculturation. We examine these candidate variables in relation to youth anxiety outcomes following CBTs.

Parent Involvement to Enhance CBT for Anxiety in H/L Youth

Evidence suggests that treatment experiences that are congruent with treatment preferences lead to improved outcomes (Langer & Jensen-Doss, 2018). Direct involvement of H/L parents with their anxious youth's treatment is a viable approach to enhance CBT outcomes among youth given data showing H/L parents prefer involvement compared with noninvolvement (Dumka et al., 1998; Pina, Villalta, et al., 2009; Seligman et al., 2020). This parental preference may relate to the cultural value of *familismo*, which refers to the importance of family as a key source of support and loyalty (Stein et al., 2014), wherein family interests are placed above individual interests (Rosselló et al., 2008). In our work on parent involvement CBT, parents participate in their child's treatment in the same sessions and are taught specific strategies to help their child reduce their anxiety (e.g., Silverman et al., 2009, 2019, 2022).

Only five studies of CBTs have examined the influence of parent involvement on youth anxiety outcomes in H/L families (Pina et al., 2012; Silverman et al., 2009, 2019, 2022; Vaclavik et al., 2017); and only one of these examined parent acculturation and parent enculturation (Vaclavik et al., 2017). These studies provide a mixed picture of enhancement effects of parental involvement in part because there was no examination of parent acculturation or parent enculturation, with the exception of Vaclavik et al. (2017). Leveraging Silverman et al. (2019), in 139 H/L youths with anxiety disorders, Vaclavik et al. (2017) compared a parent involvement CBT that targeted decreasing parent psychological control and parent–youth relationship conflict with a peer-group CBT that targeted increasing youth social skills and peer–youth relationships. Although comparable youth anxiety outcomes were found for parent involvement CBT and peer-group CBT, parent acculturation but not enculturation significantly moderated outcomes. Specifically, youth anxiety scores at posttreatment were lower in parent involvement CBT than peer-group CBT at high but not low parent acculturation. This novel and intriguing finding suggests parent involvement enhancement effects in H/L families vary with parents' acculturation. Of note, we do not know whether enhancement effects depend on parenting behavior targeted (e.g., whether youth of low-acculturated parents had improved outcomes in the peer-group CBT due to incongruence with the parenting behavior targeted in the parent involvement CBT), when compared with individual CBT. We build on and extend this finding in the present study by examining parent acculturation and enculturation as moderators of H/L youth anxiety outcomes in two parent involvement CBTs that targeted distinct parenting behaviors, in comparison with individual CBT.

Parent Acculturation to Inform Parent Involvement in CBT

Acculturation occurs as a result of interactions with a culture different than one's own. Such interactions may lead to changes in attitudes, values, customs, language use, and behaviors (Berry, 2005). Acculturation, the sense of belonging and identifying with the majority culture, is distinct from enculturation, the sense of belonging and identifying with the heritage culture. The process of acculturation is bidimensional because individuals incorporate majority culture's practices and beliefs while maintaining identity from the heritage culture (Berry, 2005; Williams et al., 2017). Thus, in this study, we examined both acculturation and enculturation. Acculturation may be more relevant than enculturation to youth anxiety outcomes because CBT draws upon values that reflect the dominant society. Guided by this notion, and further guided by Vaclavik et al.'s (2017) findings that acculturation but not enculturation moderated outcomes, our hypothesis rested on finding the former as a moderator, not the latter (see below).

Eighty-eight percent of H/L youth residing in the United States have at least one parent who was born outside the United States (U.S. Census Bureau, 2019). Among H/L parents, there are differences in levels of acculturation based on country of origin and time living in the United States. H/L parents' acculturation levels are related to their parenting behaviors (Buriel, 1993; Smokowski et al., 2009, 2014; Varela et al., 2004). H/L parents born on the U.S. mainland or living in the United States longer (proxies for higher acculturation) are more likely to practice parenting styles congruent with those of the majority culture, characterized by providing warmth, acceptance, and promoting independence (e.g., Buriel, 1993), whereas H/L parents born off the U.S. mainland practice parenting behaviors characterized by higher levels of control and use of reinforcement than typical in majority U.S. culture (Martinez & Eddy, 2005; Varela et al., 2004).

As we elaborate in the following sections, differences in acculturation and parenting behaviors may require differential emphasis to optimize outcomes when involving parents in CBT (Vaclavik et al., 2017). In this study, we focus on two key parenting behaviors relevant to youth anxiety and acculturation that can be emphasized

in treatment to optimize outcomes: psychological control and use of reinforcement.

Parent Acculturation and Psychological Control

Parent psychological control is characterized by parental demands and restrictions that put pressure on children to behave, think, or feel in certain ways (Barber, 1996; Halgunseth et al., 2006). Higher parent psychological control is associated with higher youth anxiety in non-H/L samples (see McLeod et al., 2007, for a meta-analysis). Findings are mixed in H/L samples: High parent psychological control is associated with high youth anxiety in some studies (e.g., Manongdo & García, 2011; Varela et al., 2013) and low youth anxiety in others (Gonzalez & Weersing, 2014; Varela & Hensley-Maloney, 2009). Researchers have suggested that the mixed findings may depend in part on levels of parent acculturation (Halgunseth et al., 2006; Ispa et al., 2004; Varela et al., 2004).

Parent psychological control may be experienced as congruent with the cultural values of *respeto* (conformity to role expectations within the family, encouraging obedience, and respect for adult's authority; Stein et al., 2014) and *educación* (moral education and development); both of which are prominent among low-acculturated families (Halgunseth et al., 2006; Vaclavik et al., 2017; Yau & Watkins, 2018). Low-acculturated families' emphasis on *respeto* and *educación* is evident in statements high in psychological control such as, "We work hard to send you to a private school, and you have to appreciate that, and you have to earn the sacrifices that we make" (Yau & Watkins, 2018, p.141), and "You must look adults in the eye and answer when they speak to you to show you have good manners. If you don't, they will think we didn't raise you correctly." Viewed through the lens of *respeto* and *educación*, H/L youth from low-acculturated families may interpret parent psychological control as a demonstration of love, care, and concern, not unwanted intrusions, because it is a culturally expected parenting style (Varela et al., 2013; Yau & Watkins, 2018).

Only two studies have examined parent involvement CBT that targeted-parent psychological control in H/L families. In a sample of 341 youths with anxiety disorders (82% H/L), Silverman et al. (2022) conducted an RCT of parent-involvement CBTs, one of which targeted-parent use of psychological control (see below under The Present Study section, for further details of the study's arms and parent components targeted). This parent-involvement CBT resulted in enhanced youth anxiety outcomes compared with individual youth CBT but it did not examine parent acculturation or parent enculturation. As noted above, however, Vaclavik et al. (2017) found that involving H/L parents in CBT for anxiety disorders in youth and targeting decreases in parent psychological control produced enhanced outcomes among high-acculturated families, but not low-acculturated families.

While targeting decreases in parent psychological control is relatively congruent with the parenting styles and values of high-acculturated families, the same is not necessarily true for low-acculturated families. This is because targeting decreases in parent psychological control may provide a poorer fit to low-acculturated H/L parents than high-acculturated parents because psychological control is a culturally expected parenting style (Varela et al., 2013).

Parent Acculturation and Negative Reinforcement

Parent negative reinforcement is characterized by allowing youth to escape from or avoid anxiety-provoking events (Fisak & Grills-Taquechel, 2007; Rapee, 2002). Higher parent negative reinforcement of youth's anxious behaviors is associated with higher youth anxiety in non-H/L samples (Fisak & Grills-Taquechel, 2007). Only two studies examined parent reinforcement skills for anxious youth in H/L families. In a sample of 341 youths with anxiety disorders (82% H/L), Silverman et al. (2022) conducted an RCT of parent involvement CBTs, one of which targeted parent negative reinforcement of youth anxious avoidance behaviors. This parent involvement CBT arm produced enhanced youth anxiety outcomes compared with individual youth CBT. In a sample of 88 youths (59% H/L) with anxiety symptoms or diagnoses, Pina et al. (2012) conducted an indicated comparative prevention RCT of a parent involvement CBT that focused on "reducing parental reinforcement of the child's anxious behavior and guiding the parent to help the child practice the skills learned in session" (p. 942) with individual youth CBT. The parent-involvement CBT resulted in enhanced anxiety outcomes. Parent acculturation and parent enculturation were not examined in either study.

We propose that targeting negative reinforcement in H/L parents may provide a better fit for low-acculturated families relative to high-acculturated families. This is because teaching parents to reduce negative reinforcement to manage their children's anxious avoidance behaviors is likely congruent with cultural values of *respeto* and *educación*, prominent among low-acculturated families, which emphasize child obedience to parent instructions. For example, an H/L child who is reluctant to order food at a restaurant may comply if parents instruct them to do so and refuse to order for them. These same cultural values may be incongruent though with training H/L parents in reinforcement strategies that involve ignoring misbehaviors such as back-talk or name calling, because ignoring may be seen as an unacceptable, passive discipline strategy when expectations of *respeto* and *educación* are violated (Calzada et al., 2010). Of note, however, in CBT of anxiety, reinforcement strategies emphasize parents providing clear instructions to their child to face anxiety-provoking situations, not allowing the child to avoid or escape these situations. In CBT, targeting parents' use of reinforcement is therefore congruent with cultural values of *respeto* and *educación* because it may leverage their child's more general stance toward obeying and complying with parents' commands.

The Present Study

In the present study, we move toward informing best practices for working with H/L youth and refining culturally responsive treatments for youth anxiety disorders by extending findings on H/L families' participation in CBT, and by examining H/L parents' acculturation and enculturation as moderators of youth anxiety outcomes. We aim to identify which parent involvement CBTs produce enhanced outcomes for subgroups of H/L youths with anxiety disorders using data from a subset of participants who identified as H/L from Silverman et al.'s (2022) RCT. In this RCT, participants were randomly assigned to one of three arms: individual-youth CBT or parent involvement CBT that targeted either (a) parent–child relationship skills building (decrease parent psychological control; increase parent acceptance) or (b) parent

reinforcement skills (decrease parent use of negative reinforcement; increase parent use of positive reinforcement). In all arms, emphasis was placed on practicing the skills learned in session to reduce children's anxious behaviors to mitigate anxiety disorders and symptoms. Findings from Silverman et al.'s RCT showed reductions in parent psychological control and parent use of negative reinforcement were central to youth anxiety reductions. We therefore focus on parent psychological control and parent use of negative reinforcement in the present study. Further details of the RCT that the present study leverages appear in Silverman et al. (2022).

As noted in the preceding section, the utility of targeting parent psychological control and negative reinforcement likely depends on the congruence between these parent targets and parents' acculturation levels. Based on this congruence and the above literature, we hypothesized that parent acculturation will moderate outcomes in two ways. One, we hypothesized that when parent acculturation is high, youth anxiety severity at posttreatment and 1-year follow-up evaluations would be lower in a parent involvement CBT that targets decreasing parent psychological control compared with individual CBT. Two, we hypothesized that when parent acculturation is low, youth anxiety severity at posttreatment and 1-year follow-up evaluations would be lower in a parent involvement CBT that targets decreasing parent use of negative reinforcement compared with individual CBT. Guided by Vaclavik et al.'s (2017) findings, we had no basis to expect that parent enculturation would moderate outcomes.

Method

Participants

Participants were 279 H/L youths ages 6–16 years (M = 9.40, SD = 2.39, 43.8% female) and their parents (mostly mothers) drawn from a larger RCT conducted in an urban area where the majority of the population identified as H/L (for details on larger RCT, including inclusion and exclusion criteria and the measures used to establish them, see Silverman et al., 2022; https://ClinicalTrials.gov identifier: NCT00620958).

We present parent and youth demographic characteristics in Table 1. As shown in the Table, most parents were married (81.4%) and about two-thirds (64.9%) of parents were born off the U.S. mainland. Of those born off the U.S. mainland, the mean number of years living on the U.S. mainland was 20.45 (SD = 12.46 years) for parents and 7.27 (SD = 2.46 years) for youths. Most parents born on (93.2%) and off (83.3%) the U.S. mainland attained a high school degree. Families were given the option to complete measures and treatment in English or Spanish. Slightly more than one-fifth (21.3%) of families opted to complete measures in Spanish and treatment primarily in Spanish and/or a mix of Spanish and English (see Procedure section).

Table 1
Parent and Youth Demographic Characteristics

Demographic characteristic	N (%)
Parent marital status	
Married	171 (81.4)
Divorced	21 (9.9)
Single	8 (3.7)
Cohabitating with partner	4 (1.8)
Separated, widowed, or remarried	4 (1.8)
Did not report	3 (1.4)
Parent annual household income	
Less than $40,999	78 (37.0)
Between $41,000 and $99,999	86 (40.8)
Between $100,000 and $150,000	25 (11.8)
Over $150,000	8 (3.8)
Did not report	14 (6.6)
Parent birthplace if off United States mainland	
Cuba	44 (20.9)
Colombia	21 (10.0)
Venezuela	13 (6.2)
Nicaragua	11 (5.2)
Puerto Rico	7 (3.3)
Dominican Republic	8 (3.8)
Mexico	8 (3.8)
Other Latin American Country	25 (11.9)
Youth birthplace if off United States mainland	
Cuba	3 (1.4)
Colombia	4 (1.9)
Venezuela	8 (3.8)
Other Latin American Country	12 (5.7)
Did not Report	6 (2.8)
Treatment delivered primarily in Spanish	45 (21.3)

Measures

Outcome Measure Completed by Parents and Youths

Revised Children's Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). The RCMAS parent (RCMAS/P) and youth (RCMAS) versions are 37-item rating scales that assess anxiety symptom severity. Total raw scores range from 0 to 28, with higher scores indicating higher levels of anxiety severity. In the absence of gender- and age-based norms for H/L samples, and to permit comparison of our findings with prior youth anxiety studies with H/L samples (e.g., Pina et al., 2012; Pina, Little, et al., 2009; Silverman et al., 1999, 2009, 2019, 2022; Vaclavik et al., 2017; Varela et al., 2008), we report raw scores in the present study. The RCMAS parent and child versions have extensive validity and reliability data (Reynolds & Richmond, 1978) and are sensitive to change in clinical trials (e.g., Etkin, Lebowitz, et al., 2021; Etkin, Shimshoni, et al., 2021; Silverman et al., 2019, 2022; Silverman & Ollendick, 2005). The Spanish versions of the RCMAS have demonstrated comparable psychometric properties to the English versions (Pina, Little, et al., 2009; Varela et al., 2008). In the current sample, McDonald's (1999) total ω was 0.84, 95% CI [0.80, 0.87], for parent report and 0.86, 95% CI [0.83, 0.88], for youth report.

Parent Acculturation and Enculturation Measure Completed by Parents

Stephenson Multigroup Acculturation Scale (SMAS; Stephenson, 2000). Parent acculturation level was assessed using the Dominant Society Immersion (DSI) subscale and parent enculturation was measured using the Ethnic Society Immersion (ESI) subscale of the SMAS. The DSI includes 15 parent self-rated items measuring acculturation to the majority culture and the ESI includes 17 items measuring identification with country of origin (enculturation) based on a broad range of behaviors, attitudes, and knowledge related to language (use at home, fluency), familiarity with cultures

(history, current affairs), interaction with cultures (e.g., food, customs, social interactions), and level of comfort interacting with cultures. Examples of DSI items include "I feel totally comfortable with (Anglo) American people" and "I am familiar with important people in American history." Examples of ESI items include "I like to speak my native language" and "I am familiar with the history of my native country." Items are rated on a 4-point scale, indicating whether a statement is *false, partly false, partly true,* or *true.* Higher scores on the DSI and ESI subscales represent higher acculturation and enculturation, respectively. Convergent validity of English and Spanish versions has been supported by significant associations with other measures of acculturation (Stephenson, 2000), language spoken, and country of origin (Vaclavik et al., 2017). In the current sample, McDonald's (1999) total ω was 0.91, 95% CI [0.89, 0.93], for DSI and 0.88, 95% CI [0.86, 0.91], for ESI.

Procedure

Study procedures were approved by the university's institutional review board. Prior to completing a pretreatment assessment, parents and youths provided written informed consent and assent. RCMAS and RCMAS/P were completed at pretreatment, posttreatment, and 12-month follow-up and the SMAS was completed at pretreatment. Youths who met inclusion criteria were randomly assigned to one of the two parent involvement treatment arms (CBT + Relationship [CBT + Relat], $n = 50$; or CBT + Reinforcement [CBT + Reinf], $n = 80$) or CBT ($n = 81$) using a random numbers table in equal ratios. A naturally occurring sampling imbalance in random assignment resulted in fewer participants assigned to the CBT + Relat arm (see Silverman et al., 2022). Each treatment arm consisted of 12–14 weekly sessions of 60 min. In both parent involvement treatment arms, youth and parents were seen together in dyadic format, and in CBT only the youth was seen while parents were involved in three brief meetings. All arms targeted youth anxious symptoms using in- and out-of-session exposures and cognitive strategies. Therapists were doctoral and master's level psychology graduate students who were trained in all treatment manuals and participated in weekly clinical supervision meetings with a licensed-clinical psychologist. As noted, parent involvement treatments were administered in Spanish for families who preferred and we often conducted treatment in bilingual format to accommodate parent preference for Spanish and youth preference for English. Copies of written materials and assignments were translated into Spanish and were given to Spanish-speaking parents and youths. Translation of these materials were completed by bilingual therapists who paid careful attention to word meanings and the description of anxiety-related symptoms in Spanish. For example, terms such as "nervios" and "ataque de nervios" are common words used in the H/L communities to describe fears and anxiety. Materials were then back translated and adjustments were made as indicated. Detailed descriptions of the treatments are provided in Silverman et al. (2022); in the following sections, we describe cultural adaptations for H/L families.

CBT + Relationship

In addition to targeting youth anxious symptoms, the focus of this treatment arm was to decrease parent psychological control and increase parent acceptance. Parent control and autonomy granting were discussed within a cultural framework (e.g., differentiating parent control from care and protection), and presenting alternatives to parent psychological control that fostered in children a sense of personal competency while also maintaining *respeto* and *educación*. Components relevant to psychological control and acceptance were introduced in Session 6, and then practiced in every session with both parents and youths until treatment ended. CBT + Relat involved no instruction on variables targeted in CBT + Reinf.

CBT + Reinforcement

In addition to targeting youth anxious symptoms, the focus of this treatment arm was to decrease parent use of negative reinforcement and increase use of positive reinforcement. Reinforcement was discussed within a cultural framework (e.g., fostering concepts of *respeto* and *educación* to parents and obedience by parents not providing negative reinforcement of their child's anxious behaviors and providing rewards for youth facing their fears). Components relevant to positive and negative reinforcement were introduced in Session 6, and then practiced in every session with both parents and youths until treatment ended. CBT + Reinf involved no instruction on variables targeted in CBT + Relat.

Individual–Child CBT

The focus of this treatment arm was to reduce youth anxiety in individual format by delivering psychoeducation and conducting in- and out-of-session behavioral exposures and training youth in coping cognitive strategies (Silverman & Kurtines, 1996). CBT contained only three parent meetings (beginning, middle, and end of treatment) to provide information about their child's goals and to request parents' assistance with exposure tasks (e.g., dropping off child at a friend's house). CBT involved no parent training.

Results

Preliminary Analyses

Of 279 H/L families, 211 (75.6%) completed treatment. Completion rates are similar to rates reported in past efficacy trials (e.g., Kendall, 1994; Silverman et al., 2019). Because this was an efficacy trial, and intent-to-treat analyses confound efficacy, implementation, and adherence to treatment protocol (Dallal, 2012; Feinman, 2009; Gross & Fogg, 2004), we used the per protocol sample of families in the current analysis, like in past work (Silverman et al., 2009, 2019, 2022). There were no statistically significant differences with noncompleters and no correlation with variables of interest, except for parent marital status. More completers (81.52%) than noncompleters (66.18%) were from married parents. There were no statistical differences in marital status by treatment arm, and marital status was not significantly associated with outcome measures at pre- or post-treatment.

Data for continuous variables were evaluated for multivariate outliers using both model and nonmodel-based analyses. There were no outliers found. Analyses were conducted in the MPlus 7.4 statistical software program (Muthén & Muthén, 1998–2015) in a structural equation modeling (SEM) framework. Missing data bias was assessed by creating a dummy variable reflecting the presence or absence of missing data for each variable and then correlating it with all other variables. No meaningful bias was observed. Missing

data were accommodated using full-information maximum-likelihood estimation.

Means of and correlations between variables are presented in Table 2. Based on past research using the same measures of acculturation and enculturation (Stephenson, 2000), the present sample's mean acculturation score (48.65) and mean enculturation score (56.43) were between first- and second-generation immigrants. Linear probability models were used to examine probability differences for dichotomous variables (Hellevik, 2009). Parents born off the U.S. mainland were more likely to receive treatment in Spanish ($b = 0.42$, $SE = 0.05$, $p < .001$) and had lower levels of acculturation ($b = -7.71$, $SE = 1.02$, $p < .001$) and higher levels of enculturation ($b = 7.74$, $SE = 1.52$, $p < .001$) compared with parents born on the U.S. mainland. In addition, parents who were born off the U.S. mainland (83.3%) were less likely than parents born on the US mainland (93.2%) to have received at least a high school degree ($b = -0.098$, $SE = 0.044$, $p < .03$). Given this difference, we included parent education status (high school or lower vs. at least some college or higher) as a covariate in tests of moderation.

Outcomes Analyses

Table 3 presents means and standard deviations (*SDs*) on the RCMAS and RCMAS/P by treatment arm. When we collapsed across treatment arms, there were statistically significant pretreatment to posttreatment mean changes on the RCMAS (pretreatment mean = 12.14, posttreatment mean = 7.12, $z = 10.27$, $p < .001$, $d = 0.84$) and RCMAS/P (pretreatment mean = 13.21, posttreatment mean = 8.31, $z = 10.96$, $p < .001$, $d = 0.94$). There were also statistically significant mean changes on the RCMAS from posttreatment to follow-up across treatment arms (posttreatment mean = 7.12, follow-up mean = 5.40, $z = 3.96$, $p < .001$, $d = 0.33$), and on the RCMAS/P from posttreatment to follow-up (posttreatment mean = 8.31, follow-up mean = 7.38, $z = 2.32$, $p < .05$, $d = 0.21$).

In between-arms contrasts, youth anxiety severity was significantly lower at posttreatment in both of the parent involvement arms compared with CBT. Specifically, at posttreatment RCMAS mean scores were significantly lower for youth in the CBT + Relat arm than youth in the CBT arm (mean difference = −2.44, $z = -2.51$, $p = .012$, $d = 0.28$) and significantly lower for youth in the CBT + Reinf arm than youth in the CBT arm (mean difference = −1.98, $z = -2.56$, $p = .011$, $d = 0.35$). At follow-up, RCMAS/P scores were significantly lower for youth in CBT + Relat arm than youth in CBT arm (mean difference = −3.44, $z = -3.23$, $p = .001$, $d = 0.56$) and showed a nonsignificant trend toward being lower for youth in the CBT + Reinf arm than youth in the CBT arm (mean difference = −1.61, $z = -1.72$; $p = .085$, $d = 0.21$). There were no significant mean differences between the two parent involvement arms at posttreatment or follow-up.

Moderation Analyses

A series of multiple regression analyses were conducted in an SEM framework that predicted youth anxiety scores at posttreatment and follow-up, respectively, from treatment arm (CBT, CBT + Relat, CBT + Reinf), pretreatment parent acculturation scores, and the interaction between treatment arm and parent acculturation. Of interest was whether differences between treatment arms on youth anxiety scores varied as a function of parent acculturation. Prior to running analyses, continuous variables were mean centered to reduce the potential for multicollinearity and to facilitate interpretation of parameter estimates. We defined dummy variables for the three treatment arms (CBT, CBT + Relat, CBT + Reinf), entering two of them into the model for each SEM analysis. Product terms were generated to examine moderation by multiplying the treatment condition by the mean-centered parent acculturation scores (Jaccard & Turrisi, 2003). All predictor variables were entered into each regression equation simultaneously. Pretreatment anxiety scores were included as a covariate in all analyses. As in the RCT upon which this study leverages (Silverman et al., 2022), child age, sex, and parent education were added to the model as covariates. Results are presented without the inclusion of covariates (age, sex, education) for ease of presentation. The same approach was used to examine pretreatment parent enculturation as a moderator, replacing acculturation scores with enculturation scores.

At posttreatment, parent acculturation significantly moderated treatment outcomes on the RCMAS for the contrast between the CBT + Reinf arm and the CBT arm (coefficient = 0.18, $z = 2.25$, $p = .02$). The Johnson–Neyman regions of significance test indicated that RCMAS levels were significantly lower for youth in the

Table 2
Means of, Standard Deviations of, and Correlations Between Study Variables

Measure	1	2	3	4	5	6	7	8	9
1. DSI	—								
2. ESI	−.380**	—							
3. RCMAS PRE	.031	−.001	—						
4. RCMAS/P PRE	.064	−.087	.281**	—					
5. RCMAS POST	−.027	.034	.543**	.185**	—				
6. RCMAS/P POST	.223**	−.133	.222**	.556**	.278**	—			
7. RCMAS 12M	.010	.061	.478**	.261**	.603**	.305**	—		
8. RCMAS/P 12M	.051	.024	.342**	.468**	.343**	.599**	.444**	—	
9. Youth age	.003	.070	.077	.026	−.002	−.029	.153	−.028	—
M	48.65	56.43	12.10	13.21	7.07	8.32	5.52	7.25	9.40
SD	8.81	8.19	6.36	5.61	6.14	5.57	5.54	5.43	2.39
Observed range	17–60	23–68	0–26	1–26	0–24	0–22	0–23	0–23	6–17

Note. DSI = Dominant Society Immersion; ESI = Ethnic Society Immersion; RCMAS = Revised Children's Manifest Anxiety Scale–Child Version; RCMAS/P = Revised Children's Manifest Anxiety Scale–Parent Version; PRE = pretreatment; POST = posttreatment; 12M = 12 month follow-up.
** $p < .01$.

Table 3
Means (and Standard Deviations) for Anxiety Severity, Acculturation, and Enculturation by Treatment Arm

Measure	CBT	CBT + Relat	CBT + Reinf
RCMAS/P			
Pretreatment	13.46 (5.95)	13.32 (5.54)	12.89 (5.35)
Posttreatment	8.51 (5.81)	8.54 (6.08)	8.02 (5.04)
Follow-up	8.37 (6.06)	5.40 (4.62)	7.19 (4.99)
RCMAS			
Pretreatment	11.87 (6.33)	13.19 (6.79)	11.68 (6.12)
Posttreatment	8.29 (6.33)	6.52 (6.30)	6.18 (5.72)
Follow-up	5.73 (5.70)	4.91 (4.28)	5.66 (6.05)
DSI	47.52 (9.63)	50.47 (7.03)	48.73 (8.8)
ESI	57.47 (7.75)	54.5 (9.53)	56.51 (7.74)

Note. CBT = individual cognitive behavioral therapy; Relat = relationship skills; Reinf = reinforcement skills; RCMAS = Revised Children's Manifest Anxiety Scale–Child Version; RCMAS/P = Revised Children's Manifest Anxiety Scale–Parent Version; DSI = Dominant Society Immersion; ESI = Ethnic Society Immersion.

CBT + Reinf arm than youth in the CBT arm when parent acculturation scores were at or below 53 (i.e., one-half standard deviation above the mean). No other moderation effects were statistically significant at posttreatment.

At follow-up, parent acculturation significantly moderated treatment outcomes on the RCMAS (coefficient = 0.24, $z = 2.17$, $p = .03$) and the RCMAS/P (coefficient = 0.26, $z = 2.78$, $p = .006$) for the contrast between the CBT + Reinf arm and the CBT arm. The Johnson–Neyman regions of significance tests indicated that RCMAS levels were significantly lower for youth in the CBT + Reinf arm than youth in the CBT arm when parent acculturation scores were at or below 38 (i.e., about one standard deviation below the mean), and that RCMAS/P levels were significantly lower for youth in CBT + Reinf arm than youth in the CBT arm when parent acculturation scores were at or below 47 (i.e., about the mean).

An additional significant moderation effect was found at follow-up on the RCMAS for the contrast between the CBT + Reinf arm and the CBT + Relat arm (coefficient = 0.28, $z = 2.42$, $p = .02$). The Johnson–Neyman regions of significance test indicated that RCMAS levels were significantly lower for youth in the CBT + Reinf arm than youth in the CBT + Relat arm when parent acculturation scores were below 26 (i.e., about three standard deviations below the mean), and that RCMAS levels were significantly lower for youth in CBT + Relat arm than youth in the CBT + Reinf arm when parent acculturation scores were above 52 (i.e., about one-half a standard deviation above the mean).

Parent enculturation did not significantly moderate treatment outcomes on the RCMAS or RCMAS/P at posttreatment or follow-up.

Ancillary Analysis

We examined country of origin as a moderator in ancillary analyses to gain insight into whether moderation effects could be driven by country of origin. We dummy-coded country of origin (0 = born on U.S. mainland; 1 = born off U.S. mainland) and generated product terms to examine moderation by multiplying the treatment condition by country of origin (Jaccard & Turrisi, 2003). Country of origin did not significantly moderate treatment outcomes on the RCMAS or RCMAS/P at posttreatment or follow-up.

Discussion

The present study extends findings on H/L families' participation in CBTs and provides novel data that can inform best practices for working with H/L youth with anxiety disorders. To summarize our key findings: parent involvement CBTs significantly enhanced youth anxiety outcomes compared with individual youth CBT and this enhancement was moderated by parent levels of acculturation, not enculturation. In addition, when parent acculturation was low, youth anxiety outcomes at posttreatment and 12-month follow-up were enhanced in a parent involvement CBT that targeted decreasing parent use of negative reinforcement. By contrast, when parent acculturation was high, outcomes at 12-month follow-up were enhanced in a parent involvement CBT that targeted decreasing parent psychological control. Below, we consider each finding in turn, focusing on their implications for practice.

Our finding that youth anxiety outcomes were enhanced in both parent involvement CBTs compared with individual-youth CBTs is in line with prior findings in H/L families that parent involvement CBTs emphasizing parent use of reinforcement or parent psychological control enhanced youth anxiety outcomes relative to individual-youth CBT (e.g., Pina et al., 2012; Silverman et al., 2022). The cumulative data thus support parent involvement in CBT as a best practice when working with H/L youth with anxiety disorders. H/L parents may prefer to be involved in their youth's treatment and contribute by implementing skills themselves to help decrease their youth's anxiety. The data also support the notion of clinical flexibility in that similar outcomes will be attained whether targeting parent use of negative reinforcement or psychological control when involving H/L parents in treatment.

In examining influences of parent involvement, this study is only the second to examine parent acculturation as a moderator of youth anxiety outcomes in H/L families. Consistent with the one prior study (Vaclavik et al., 2017), we found parent acculturation moderated outcomes. We build upon and extend these findings by demonstrating that when parent acculturation was low (i.e., parents were not as integrated to mainstream U.S. culture and values), youth anxiety outcomes were enhanced in a parent involvement CBT that targeted -parent use of reinforcement. This finding supports our notion that targeting parent use of reinforcement is likely to be congruent with the cultural values of *respeto* and *educación* prominent in low-acculturated H/L families. While targeting reinforcement, parents are provided with skills to decrease negative reinforcing behaviors (i.e., not allowing youth to avoid anxiety-provoking stimuli, such as not allowing youth to miss school to avoid giving an oral presentation) and increasing positive reinforcers (such as rewards or praises) for facing fears. Youth are also taught to follow through with directions via agreed-upon tasks and reinforcers (i.e., rewards). Low-acculturated H/L parents in particular may view these skills as relatively culturally congruent because they foster respect and obedience without diminishing parental control.

Also consistent with Vaclavik et al. (2017), when parent acculturation was high, youth anxiety at follow-up was enhanced in a parent involvement CBT that targeted decreasing parent psychological control. This finding similarly supports our notion that

targeting decreasing parent psychological control is likely to be congruent with the parenting styles and values of high-acculturated families (Vaclavik et al., 2017). High-acculturated families in particular may be receptive to decreasing psychological control as a means to reduce youth anxiety because they view psychological control as intrusive and restrictive, and not as a sign of care and concern (e.g., Varela et al., 2013).

Altogether, these findings inform best practices for working with H/L youth with anxiety disorders and extends the current literature by showing that differences in parent acculturation levels require tailoring CBT to optimize outcomes when involving H/L parents. Although there is need for further research including empirical evaluation of the congruence between targeted-parent variables and cultural values, the cumulative data support the practice of assessing parent acculturation and using parent acculturation to tailor treatment approaches for H/L youth with anxiety disorders. Of note, in ancillary analyses we found that parental country of origin (whether parents were born on or off U.S. mainland) did not moderate youth outcomes. This nonsignificant finding, together with the nonsignificant findings for parent enculturation, suggests that parent acculturation levels are central to H/L response to parent-involved treatments, perhaps because CBT draws upon values that reflect the dominant society.

As found in past youth anxiety research (Settipani et al., 2013; Silverman et al., 2009, 2019) and Silverman et al.'s (2022) RCT, the statistical significance of findings varied by informants and measurement waves. Statistically significant enhancement and moderation effects were found by posttreatment on youth self-ratings of anxiety, whereas such effects were statistically significant only at 12-month follow-up on parent ratings of youth anxiety. It is possible that youth are better able to notice changes in their parents' concrete behaviors (e.g., parent not allowing youth to avoid anxiety-provoking situations), relative to less concrete behaviors such as psychological control (e.g., parent use of guilt induction). Additionally, from the parents' perspective, it is possible that parents became more aware of reductions in their youth's anxiety symptoms during the year following treatment as they continued applying the skills learned in treatment sessions. These changes may occur more quickly when practicing concrete behavioral skills such as reinforcement relative to less concrete, psychological control but more research is needed to test this idea and the others raised above.

Strengths, Limitations, and Future Research

Our findings need to be considered in light of the study's strengths and limitations. A notable strength is the large and diverse sample of H/L families that included families from diverse nationalities such as Cubans, Colombians, Venezuelans, and other underrepresented nationalities in the literature. Additional strengths include the use of manualized treatment approaches that prescribed strategies that targeted specific and distinct parenting behaviors, and administration of rating scales to parents and youth at pretreatment, posttreatment, and 12-month follow-up evaluations. Limitations include the reliance on rating scales when examining youth anxiety outcomes and parent acculturation, and the absence of data on parent and youth cultural values such as *respeto* and *educación* and treatment preferences. As noted, collection of such data represents an important direction for future research because it will permit evaluation of the congruence between cultural values and treatment components. Another limitation is that despite diverse nationalities noted as a study strength, we had inadequate statistical power to analyze for differences between subgroups based on families' countries of origin or descent. Finally, as in prior RCTs (Pina et al., 2012; Vaclavik et al., 2017), parent involvement focused almost exclusively on mothers. Given the prominence of *familismo* as a cultural value (i.e., a strong sense of family orientation, obligation, and cohesion; e.g., Baumann et al., 2010; Vega, 1995), further evaluation of H/L families' preferences for inclusion of fathers, siblings, and even extended family members may further inform practices for treating youth anxiety, especially considering the different roles that each family member plays in raising H/L youth (Kapke & Gerdes, 2016; Moreno et al., 2008).

In addition to parental acculturation, future work could examine whether youth acculturation and enculturation potentially moderate which treatment modality works best for them. Further, consideration of generational differences in level of acculturation (i.e., high-acculturated child, low-acculturated parent, or vice versa) is another intriguing area for future research. It is possible that targeting H/L parents' psychological control or reinforcement skills may yield different outcomes when anxiety stems from generational differences in acculturation levels. Another avenue for future work is to identify and incorporate H/L families' unique cultural practices of healing anxiety, building upon prior work toward understanding H/L families' perspectives about ways to deliver CBT for anxiety (e.g., Chavira et al., 2017). Conducting focus groups with H/L families about their customs and preferred healing practices may provide insight into ways to enhance treatment by incorporating these practices.

Our sample was drawn from an urban area in South Florida where the majority of the population identifies as H/L. Pressure to acculturate to mainstream U.S. culture may be lower compared to other regions of the United States, and thus the generalizability of the present findings to other regions of the United States is unknown. In addition, most families who completed treatment came from married households. Perhaps single-parent households face barriers that interfere with attendance, such as childcare for siblings or work-related responsibilities, and other ways of involving parents in treatment may be warranted (e.g., telehealth; Khanna & Carper, 2022; Norman et al., 2022).

As further research on parent involvement advances, of key importance will be to investigate how parent involvement might be better targeted for greater treatment enhancement and outcomes in H/L families. This is an issue worth investigating as researchers have suggested that H/L families prefer involvement in their child's treatment compared with noninvolvement (Dumka et al., 1998; Pina, Villalta, et al., 2009; Seligman et al., 2020), and congruence between families' preferences and treatments may enhance outcomes in part through greater engagement with treatment activities (Langer & Jensen-Doss, 2018).

In summary, the present study provides evidence to inform best practices for treating anxiety disorders in H/L youth, a population severely underrepresented in clinical trials research (e.g., Pina et al., 2003). Accumulating evidence supports parent involvement in CBT as a best practice; and consistent with Vaclavik et al. (2017), the present study supports the utility of parent acculturation levels to inform selection of treatment targets. We encourage future research to identify additional potential targets and evaluate strategies for tailoring CBTs within culturally responsive frameworks to further

guide best practices for working with H/L families (e.g., Consoli et al., 2018).

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