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Treatment Acceptability and Cultural Sensitivity of Standard Behavioral Therapies among Latinx and non-Latinx White College Students

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Abstract

It is generally regarded that therapies ought to be culturally sensitive. However, the precise meaning of this phrase and the extent and substance of cultural tailoring of therapies are unclear. 173 Latinx and non Latinx college students were shown 4 videos of culturally untailored behavior therapy and were asked to imagine themselves as the recipient of the therapy from the therapist depicted in the video. They were then asked to rate these videos on a variety of dimensions including offensiveness, insensitivity, effectiveness, ability to build rapport, meeting personal needs, and willingness to return. Results indicated no differences in the ratings of Latinx and non-Latinx students and both groups rated the therapy positively. Thus, there is not evidence that this sample found untailored standard behavioral therapies as culturally problematic. Limitations include a sampling of only one subgroup (college students) and one minority population (Latinx).

Key words: Latinx, Hispanic, Treatment Acceptability, Behavioral Therapy .

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Novelty and Significance

What is already known about the topic?

- Ethnic minorities seek mental health services at lower rates than their non-ethnic minority white counterparts.
- Once in treatment, ethnic minorities have higher attrition rates and poorer mental health outcomes.
- Treatment acceptability should be examined among ethnic minorities so as to explore whether cultural adaptations should be considered when providing treatment to these populations, in order to make the therapy culturally sensitive.

What this paper adds?

- Latinxs rated evidence-based therapies as sensitive and effective indicated that they would return to subsequent sessions of therapy if they were a client.
- The results suggest that generally speaking Latinxs find evidence-based treatments acceptable.

Historically, ethnic minorities seek mental health services at lower rates than their non-ethnic minority white counterparts (Lorenzo Blanco & Delva, 2012). These findings are hypothesized to be a result of a variety of internal (e.g., stigma, mental health literacy, attitudes) and external (e.g., cost, geographical proximity) barriers (Clement et alii, 2015). Further, once in treatment, ethnic minorities have higher attrition rates and poorer mental health outcomes (Lester et alii, 2010). One possible explanation for these findings may be that the intervention or the therapist may be not be seen as culturally sensitive (see, e.g., Chu, et alii, 2016). The possible implications of this include decreased therapeutic effectiveness and a higher likelihood that ethnic minority clients will drop out of treatment.

Treatment acceptability is defined as "judgements of treatments by actual or potential consumers of the treatments" and can be interpreted to cover several key dimensions

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of treatments (e.g., fairness, reasonability; Carter, 2007, pg. 13). The judgments are clinically relevant in that these provide information as to which populations find which treatments appropriate for targeting their problems, as well as how well the treatment aligns with a patient's unique expectations based on their cultural backgrounds (Chu, et alii, 2016). Assessing treatment acceptability of empirically-supported psychotherapies is particularly important as these have the best evidence of general efficacy and effectiveness but also need to examined for what modifications might be necessary when delivering these therapies to ethnic minorities (Huey, et alii, 2016). Currently there is little research utilizing a "bottom up" approach whereby potential consumers of empirically supported psychotherapies are asked to what degree they find a therapy sensitive; rather the field has been driven largely by a top-down approach in which experts argue that cultural modifications need to be made to enhance outcomes (see for example Chu et alii, 2016). Thus, the perceptions that minority individuals hold towards empirically supported psychotherapies as culturally sensitive is widely unknown.

One argument for the need to examine treatment acceptability among ethnic minorities is to explore whether cultural adaptations should be considered when providing treatment to these populations, in order to make the therapy "culturally sensitive" (e.g., Chu, et alii, 2016). Cultural sensitivity can be defined as "awareness of how cultural variables may affect the treatment process" (Sperry, 2010, p. 316), and includes a clinician's attitudes, beliefs and understanding of cultural differences. Cultural competence is the translation of this awareness into clinical skills and can be examined by exploring a variety of dimensions including whether a client feels offended, that their needs as a member of a minority cultural group have not been met, and many other self-reported responses of clients. Research on the topic of cultural sensitivity of mental health treatments may help guide efforts by determining which, if any, components of therapies require cultural adaptations, thereby increasing the likelihood of minority clients' willingness to engage in treatment.

In a study by Jones, Lee, Zigarelli, and Nakagawa (2017), examining training clinicians to incorporate culturally responsive components into cognitive behavior therapy for depression treatment was found to yield higher client satisfaction than traditional cognitive behavior therapy. However, the construct of cultural sensitivity has been regarded as poorly defined, as being too broad (e.g., Latinx covers a number of distinct cultures) and it is unclear what behaviors or adaptations actually constitutes "sensitivity" (see O'Donohue & Benuto, 2010 as well as Frisby and O'Donohue, 2018 for extended analysis of the construct). Benuto and O'Donohue (2015) reviewed the literature on culturally modified versions of Cognitive Behavioral Therapy and determined that there was no consensus regarding how mainstream cognitive behavior therapies ought to be adapted as well as mixed evidence regarding whether these adaptations resulted in any improved outcomes. Huey and colleagues (2014) also found that cultural adaptations often did not produce improved outcomes for minority patients. Despite this small body of research indicating that culturally modified (i.e., adapted, tailored etc.) therapy may not improve outcomes for ethnic minority clients, as illustrated above, little is known about the degree to which ethnic minority client's rate or perceive existing therapies as culturally sensitive or culturally insensitive. Because there is a hypothesized link between treatment acceptability and preference and client outcomes (Jaeger, Echiverri, Zoellner, Post, & Feeny, 2010; Milosevic, Levy, Alcolado, & Radomsky, 2015) and the literature hypothesizes that cultural modifications to treatments may be necessary, we examined how the largest minority group in the United States (Latinxs) rated video depictions of

a variety of standard, untailored behavioral therapy interventions.

Method

Participants

Participants consisted of 93 Latinx and 80 non-Latinx college students. While participants ranged in age from 18 to 34 (M= 19.79; SD= 2.43), 93% of the sample (n= 161) were between the ages of 18 and 22. The majority of participants were women (n= 119), college freshman (n= 107), and single (n= 139).

Measures and Procedure

Demographic Information. Participants completed a basic demographic questionnaire that included questions about their ethnicity, gender, age, income, education, and relationship status.

Videos. Participants watched four videos that depicted a white non-Latinx therapist administering four different empirically supported behavioral therapy treatments. Both the clients and the therapists were NLWs in the videos that were depicted. Participants were asked to imagine themselves as the recipient of the therapy from the therapist depicted in the video:

Acceptance and Commitment Therapy (ACT). This video was 3 minutes and 27 seconds long. This video depicts a non-Latinx White (NLW) male therapist (Steven Hayes) advising a NLW male client to place his hand in a cup and describe his physical sensations. The client describes the adversity he experiences in touching the cup. The therapist advises him to perform a certain task involving the cup while separating himself from his own thoughts by describing his thinking process out loud. At the conclusion of the video the therapist describes how exposure from an ACT perspective is about establishing flexibility in the presence of the feared stimulus. This video can be viewed at: https://www.youtube.com/watch?v=I2Zv4Wn6qec&feature=youtu.be.

Behavioral Activation (BA). This video was 9 minutes and 45 seconds long. In this video the NLW female therapist (Heather Brundrett) asks a NLW male client to describe his thoughts in relation to his actions and feelings. They review a worksheet completed in a previous session that shows the relationship between thoughts, actions, and feelings. The therapist describes to the client that if he engages in behavioral activation, mood will improve. Together they develop a weekly activity schedule where the client will engage in activities and then assign a score to the activity based on his sense of achievement and enjoyability. The video can be viewed at: https://youtu.be/O1dxNCiU92U.

Dialectical Behavior Therapy (DBT). This video was 2 minutes and 16 seconds long. It depicted a NLW female therapist (Marsha Linehan) and a NLW female suicidal client. The therapist asked the client to talk through the event of her cutting herself and asks her how she ended up cutting herself. The client expresses that she was thinking about killing herself and that she thought the therapist would help her but she didn't; the client expressed dissatisfaction with how her life is not getting better, that the therapist is not helping her, and that the is not available to her. The client indicated that she cut herself deeply because the therapist was not available to her. The video can be viewed at: https://www.youtube.com/watch?v=x0Iky4NWN2U&feature=youtu.be.

Exposure Therapy (ET). This video was 8 minutes 38 seconds long and was specifically focused on exposure therapy for Obsessive Compulsive Disorder. Both the unnamed therapist and the client are NLW females. The therapist asks the client to take out an item of a bag that she brought with her (a

dog leash) and to rate her level of distress and share her thoughts while she is holding the object. The therapist asks the clients to touch the dog leash where there are stains; the client is distressed and states that she feels that she may get sick. The therapist rubs the leash on her body and asks the client to do the same thing. The client's self-rated distress rises throughout the session and then decreases. The therapist offers the client praise and encouragement. The video can be viewed at https://www.youtube.com/watch?v=x0Iky4NWN2U&feature=youtu.be.

Intervention Evaluation

Participants were asked to imagine themselves as the recipient of the therapy delivered by the therapist depicted in the video. Participants were then asked nine questions to assess their impression of the therapy and therapist that was presented in the video. They were asked to answer the questions about the mental health treatment modality they watched using a four-point Likert scale ranging from 1 (Strongly Disagree) to 4 (Strongly Agree). The items on which they rated the video were:

- The therapy would be good
- The therapist would be offensive
- The therapist would be insensitive
- The therapist would not meet my needs
- The therapist would not build good rapport
- The therapist would not be effective
- The therapist would not be efficient
- The therapist would not really understand me
- I would probably not come back for another session

Participants were recruited through the university's subject pool. After registering for the study, participants came to the lab to complete the study measures. Participants completed the study measures using Qualtrics, a software system for administering study materials. Specifically, participants watched a video that illustrated an empirically supported treatment and then answered a series of questions about the therapy and the therapist. Participants received 3 SONA credits for their completion of the study measures.

Data Analytic Plan

The central research question that guided this study was, *What is the difference, if any, between Latinx and non-Latinx Whites (NLWs) appraisal of empirically supported treatments?* A secondary research question was *How to Latinx and NLWs appraise empirically supported treatments?* It was hypothesized that if standard behavior therapies was viewed as culturally problematic then Latinx subjects would rate the therapy lower than Non-Latinx subjects. Moreover, their ratings on dimensions taping judgements of cultural sensitivity would be significantly different. The results are presented below and organized by therapy type. Various CBT therapy types were included to better sample the domain of modern standard behavior therapy. We conducted four Hotelling's T^2 tests (one for each empirically supported therapy that was assessed) as we had one independent variable that only had two groups (ethnicity: Latinx vs. NLWs) and had more than two dependent variables (each of the rating items about the therapy or therapist were considered an independent variable). We also examined mean ratings on each of the nine items for each ethnic group and the sample as a whole.

Results

We ran four separate Hotelling's T^2 (one for each type of therapy). We examined the data for each therapy to ensure that assumptions were met. To avoid redundancy, the assumptions for all of the data are presented here. Preliminary assumption checking revealed that data was normally distributed per visual inspection of the Normal Q-Q plot; there were no univariate outliers as assessed by an exanimation of the mean and standard deviation and frequency of scores (i.e., no single score fell above three standard deviations about the mean); there were linear relationships, as assessed by scatterplot; and multicollinearity was absent ($|r| < .9$). Finally, there was homogeneity of variance-covariance matrices, as assessed by Box's M test for ACT ($p = .031$), BA ($p = .002$), ET ($p = .003$), and DBT ($p = .010$). There were multivariate outliers so we ran the data both with and without the outliers included in the analysis; there was no bearing on the results, thus we left the outliers in the final analysis.

We ran four Hotelling's T^2 (one for each type of therapy) to determine if therapy and therapist ratings (across the nine items detailed in the methodology), differed by ethnicity (Latinx and NLWs).

Hotelling's T^2 was run to determine if Latinx and NLWs appraised ACT differently. There was not a statistically significant difference between Latinx and NLWs on the combined dependent variables that evaluated ACT, $F(9, 163) = 1.172$, $p = .316$; Wilks' $\Lambda = .939$; partial $\eta^2 = .061$. An examination of mean ratings for the ACT video (see Table 1) indicated that the evaluation of ACT across both Latinx and NLW participants was approximately neutral. Both Latinx and NLW participants indicated that they (approximately) agreed that the therapy would be good ($M = 2.58$). Both types of participants ratings were in the direction of indicating that they disagreed that the therapist would be offensive, would not meet their needs, would not build rapport, would not be effective or efficient, and would not really understand them. Participants indicated that they approximately disagreed that they would probably not come back for another session.

Table 1. Means and Standard Deviations for Acceptability of ACT (ratings were on a 4-point scale ranging from strongly disagree to strongly agree).

	Latinx		NLW		All	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
The therapy would be good	2.59	0.70	2.58	0.69	2.58	0.69
The therapist would be offensive	2.10	0.74	1.93	0.52	2.02	0.65
The therapist would be insensitive	2.35	0.76	2.20	0.70	2.28	0.74
The therapist would not meet my needs	2.56	0.80	2.38	0.83	2.47	0.82
The therapist would not build good rapport	2.53	0.76	2.39	0.74	2.46	0.75
The therapist would not be effective	2.39	0.82	2.26	0.76	2.33	0.79
The therapist would not be efficient	2.41	0.76	2.26	0.76	2.34	0.76
The therapist would not really understand me	2.62	0.81	2.40	0.79	2.52	0.80
I would probably not come back for another session	2.57	0.79	2.55	0.88	2.56	0.83

There was not a statistically significant difference between Latinx and NLWs on the combined dependent variables, that evaluated BA $F(9, 163) = .853$, $p = .569$; Wilks' $\Lambda = .955$; partial $\eta^2 = .045$. An examination of mean ratings for the Behavioral Activation video (see Table 2) indicated that participants agreed ($M = 3.01$) that the therapy would be good. Participants generally strongly disagreed that the therapist would be offensive or insensitive and disagreed that the therapist would not meet their needs, be efficient and effective, and would not really understand them. Participants also disagreed that they would probably not come back for another session and that the therapist would not build good rapport.

Table 2. Means and Standard Deviations for Acceptability of BA (ratings were on a 4-point scale ranging from strongly disagree to strongly agree).

	Latinx		NLW		All	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
The therapy would be good	3.00	0.86	3.03	0.81	3.01	0.84
The therapist would be offensive	1.42	0.50	1.45	0.55	1.43	0.52
The therapist would be insensitive	1.51	0.62	1.50	0.57	1.50	0.60
The therapist would not meet my needs	2.05	0.88	2.14	0.98	2.09	0.92
The therapist would not build good rapport	1.82	0.72	1.76	0.78	1.79	0.75
The therapist would not be effective	2.01	0.85	2.05	0.91	2.03	0.88
The therapist would not be efficient	1.94	0.82	2.03	0.89	1.98	0.85
The therapist would not really understand me	2.06	0.82	2.06	0.92	2.06	0.86
I would probably not come back for another session	1.92	0.90	2.09	1.01	2.00	0.95

There was not a statistically significant difference between Latinx and NLWs on the combined dependent variables that evaluated ET, $F(9, 163)= .519$, $p= .859$; Wilks' $\Lambda= .972$; partial $\eta^2= .028$. An examination of mean ratings for the Exposure Therapy video (see Table 3) indicated that participants agreed ($M= 3.17$) that the therapy would be good and generally disagreed that the therapist would be offensive, insensitive, not meet their needs, not build good rapport, not be effective or efficient, and not really understand them. Participants also disagreed ($M= 2.06$) with the statement I would probably not come back for another session.

Table 3. Means and Standard Deviations for Acceptability of Exposure Therapy (ratings were on a 4-point scale ranging from strongly disagree to strongly agree).

	Latinx		NLW		All	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
The therapy would be good	3.15	0.85	3.20	0.68	3.17	0.77
The therapist would be offensive	1.72	0.73	1.75	0.63	1.73	0.68
The therapist would be insensitive	1.95	0.84	1.91	0.75	1.93	0.80
The therapist would not meet my needs	1.81	0.81	1.86	0.79	1.83	0.80
The therapist would not build good rapport	1.77	0.80	1.78	0.69	1.77	0.75
The therapist would not be effective	1.77	0.80	1.74	0.69	1.76	0.75
The therapist would not be efficient	1.77	0.78	1.76	0.68	1.77	0.73
The therapist would not really understand me	1.86	0.85	1.84	0.74	1.85	0.80
I would probably not come back for another session	2.06	0.96	1.93	0.76	2.00	0.88

There was not a statistically significant difference between Latinx and NLWs on the combined dependent variables that evaluated DBT, $F(9, 163)= .479$, $p= .887$; Wilks' $\Lambda= .974$; partial $\eta^2= .026$. An examination of mean ratings for the DBT video (see Table 4) indicated that participants disagreed ($M= 1.72$) that the therapy would be good. They also generally agreed that the therapist would be offensive, insensitive, not meet their needs, not build good rapport, not be effective or efficient, and not really understand them.

Table 4. Means and Standard Deviations for Acceptability of DBT ratings were on a 4-point scale ranging from strongly disagree to strongly agree).

	Latinx		NLW		All	
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*
The therapy would be good	1.72	0.81	1.80	0.77	1.76	0.79
The therapist would be offensive	2.73	0.93	2.68	0.87	2.71	0.90
The therapist would be insensitive	2.87	0.85	2.84	0.85	2.86	0.85
The therapist would not meet my needs	3.22	0.72	3.16	0.75	3.19	0.73
The therapist would not build good rapport	3.08	0.82	3.11	0.76	3.09	0.79
The therapist would not be effective	3.12	0.79	3.10	0.82	3.11	0.80
The therapist would not be efficient	3.06	0.80	3.09	0.80	3.08	0.80
The therapist would not really understand me	3.23	0.80	3.15	0.87	3.19	0.83
I would probably not come back for another session	3.29	0.77	3.20	0.79	3.25	0.78

Discussion

The results from this study indicated an absence of differences between the ratings of Latinx and NLW participants with regard to several dimensions related to the sensitivity, appropriateness and effectiveness of standard, untailored behavior therapy. More specifically, when asked to imagine themselves as the recipient of the therapy from the therapist depicted in four videos, Latinx and NLW provided similar ratings for videos that depicted ACT, behavioral activation, exposure therapy, and DBT. It is noteworthy that participants (regardless of ethnicity) rated the therapies and therapists fairly positively, with the exception of DBT; in response to the item The therapy was good participants indicated that they agreed with this statement in reference to ACT, BA, and ET but that they disagreed with this statement with regard to DBT.

Moreover an examination of the ratings more directly taping treatment acceptability and cultural sensitivity ratings also indicated no substantial differences between Latinx and NonLatinx participants suggesting no need for cultural adaptations for standard behavior therapies with population.

This study is not without its limitations. Certainly generalizability to participants who are not college students is questionable. Also, the videos that were used in this study were not standardized and varied in terms of length, presenting concern, and therapist. Thus, it is possible that the results were influenced by the characteristics of the videos. Also this is dependent on the participants ability to actually imagine themselves as clients -perhaps actually being a client their reactions would be different.

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