The Influence of Cultural Factors in Psychotherapy: Avoiding Racial/Psychological Profiling

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Cultural Factors in Treatment

The main objective of this talk is to discuss some ideas on how cultural factors may influence the development of treatment interventions. I will illustrate these ideas with some of my clinical work and research projects.
Self-Orientation: Is the way people define themselves and the world

**Individualism/idiocentrism:**
1) People define themselves and others through self attributes.
2) People pursue individual goals.
3) People emphasize boundaries with others.
4) They soothe in isolation from others (IIE).

**Collectivism/allocentrism/relationalism:**
1) People define themselves and others through relational terms.
2) People pursue group goals.
3) Boundaries with others are fluid.
4) They soothe in relationship to others (AIE).
The Treatment Match Model assumes that patients benefit more from interventions that match their individual characteristics (Barlow, 2004; Blatt & Felsen, 1993). The idea is that some treatments work better for some individuals with particular characteristics (e.g., personality traits).

This model is increasingly used by EBPs.
Cultural Match Theory

- The basic premise of the cultural match theory is that interventions are more effective when they are more compatible with patients’ cultural characteristics.
- The cultural match theory is one of the key assumptions of the cultural competence literature which has led to the development of culturally sensitive psychotherapies. However, it has rarely been empirically examined.
Definition: Culturally Sensitive Therapy (CST)

- CST is the tailoring of psychotherapy to specific cultural groups, so that persons from one group may benefit more from a specific type of intervention than from interventions designed for other groups (Hall, 2001).
Three Implications of CST

1) Constructs such as race, ethnicity, or culture are used to classify individuals into different groups.

2) Some constellation of characteristics are unique or more prominent in certain cultural groups relative to others.

3) CSTs are developed according to the characteristics or needs of culturally diverse groups.
1) Constructs such as race, ethnicity, or culture are used to classify individuals into different groups (e.g., Hispanics, Asians).

2) EBPs are increasingly categorizing SS according to racial or ethnic characteristics.

3) Doyle (1998) found that race and ethnicity had only been assessed on 15% of the studies and of these 92% were Whites.

4) The Revitalization Act (NIH, 1993) mandated that ethnic minorities be included on all research projects sponsored by NIH.

5) Recent data shows some improvements but we still have a long way to go.
1) CST Classification System (Operational system)

1) Race is often defined by observing SS physical characteristics.
   1.1) It is fast and reliable
   1.2) It is meaningless; It reveals more of researchers’ biases than SS’ characteristics (Helms, Jernigan & Mascher, 2005).
   1.3) It is a sociopolitical construct that can be used to perpetuate an oppressive hierarchy.

2) Ethnicity is often assessed by inquiring about SS background (e.g., where were you born?)

3) Culture is often measured as specific constellation of meanings that are more frequent within one group than others (often measured through multicultural and contextual variables). For more information see (La Roche & Christopher, 2008; 2009).
2) Assumptions of Unique Group Characteristics

- It can be assumed that some ethnic/racial or cultural groups are characterized by the presence of constellations of characteristics that are more prominent or unique in certain cultural groups than others.
- Researchers who have assumed higher levels of universalism often overlook measuring and conceptualizing cultural differences.
- However, there is much variability within ethnic groups.
2) Assumptions of Unique Group Characteristics (Recommendations)

Given the many cultural differences within ethnic/racial groups we encourage researchers to conceptualize and measure:

1) Multicultural Variables (ethnic identity, self-orientation, perceived levels of discrimination, spirituality).

2) Contextual variables (SES, levels of neighborhood violence, unemployment rates, education levels).
3) Translations of Culture Into Interventions

- The culturally adapted intervention must reflect the cultural characteristics of the SS as suggested by the Cultural Match Theory.
- Based on this idea we developed the Culturally Competent Relaxation Intervention (CCRI) and the Asthma Culturally Competent Intervention. The CCRI used allocentric guided imagery exercises and the Asthma Intervention used allocentric interventions.
The Culturally Competent Relaxation Intervention (CCRI)

1) The overall goal of the CCRI was to provide a relaxation intervention that is consistent with Latino’s allocentric world view (La Roche, D’Angelo, Gualdron & Leavell, 2006). The CCRI utilized an allocentric imagery exercise, while most relaxation interventions employ IIEs (La Roche et al, Under submission) (AIE &IIE).

2) Also consistent with this allocentric self-orientation, participants met in a group setting (La Roche, Mitchell, & Gualdron, 2006b) as they socialized in an informal manner and reviewed psycho-educational information (e.g., identifying anxiety triggers, sleep, and exercise).

3) An allocentric relaxation exercise was taught during the last 30 minutes. The same format and topics were addressed in all groups.

4) In this intervention we measured levels of individualism and relationalism/allocentrism and anxiety.
1) A positive relationship would exist between levels of allocentrism and the frequency participants (Latinos) practiced the AIE (index of treatment adherence). A significant relationship ($r=.36, p=.04$) was found between levels of allocentrism and times they practiced the AIE.

2) A positive correlation would exist between the frequency in which participants practiced the AIE and their reductions in anxiety levels ($\beta=-.36, p=.001$).
The Culturally Competent Relaxation Intervention (CCRI). Additional Results

1) Individuals who were more individualistic dropped out of the intervention more frequently.

2) Furthermore, one year after the intervention as anxiety levels decreased, ER visits also decreased significantly and fewer medications were needed intervention in comparison to one year before the intervention.

3) The CCRI findings are similar to our previous asthma psychoeducational studies (La Roche, Koinis-Mitchell & Gualdron, 2006) in which participants of the culturally adapted intervention visited the ER 50% less often than the non-adapted intervention, while the no intervention group had a 25% increase of ER visits.
Cultural Content Analyses of Guided Imagery Scripts

The question is: are guided imagery scripts relational or individualistic?

Using a theoretical review we created three categories to analyze the guided imagery scripts according to the levels of allocentrism/relationalism or individualism/idiocentrism. We revised these categories on all APA and American Psychiatric Associations articles published from 1989-2008 that included guided imagery scripts (n=123)
Why Conduct a Cultural Study with Guided Imagery Scripts?

1) It is an inexpensive opportunity to objectively study what, in fact, happens within the psychotherapy session (we have written guided imagery scripts).

2) Guided imagery is practiced not only by psychologists of different orientations (CBT, DBT, psychoanalysis, Gestalt, etc) but also by different health professionals (e.g., PCPs, SWs).

4) It is one of the most frequently assigned types of psychotherapeutic homework.

5) Their cultural assumptions have rarely been questioned.
Cultural Content Analyses of Guided Imagery Scripts

1) The self is distinct from the non-self - there are clear and firm boundaries between self and others/nature and we found that self-separation was 53.3 times more frequent than absence with others.

2) The self is composed of internal attributes (e.g., intelligence, self-esteem) or traits (e.g. personality) that are understood to be stable over time, contexts, and make up an individual’s sense of identity. The absence of others was 2.4 times more frequent in scripts than the presence of others.

3) As a result of these internal attributes people have a sense of agency, internal locus of control, autonomy, and competence (Kagitcibasi, 1994; Triandis, 1995). More precisely, internal agency was 1.5 times more frequent than relational agency.
Current CCRI Research Project

1) We are currently conducting an RCT in which we are randomly assigning SS to AIE and IIE treatment conditions. This study not only includes Latinos, but also Whites and African Americans. The idea is to assess if self-construal predicts treatment adherence and outcome more effectively than ethnicity and race.

2) We have included additional variables (acculturation stress, familism, spirituality).
Conclusions/Recommendations

1) It is necessary to emphasize that ethnicity or race do not define psychological attributes (Helms, Jernigan & Mascher; 2005). There are many cultural differences within all cultural groups. Thus, cultural characteristics need to be examined not assumed.

2) Culturally competent interventions should be based on the predominant characteristics of each group and it is important to measure interventions’ cultural characteristics. In our study we only analyzed the guided imagery literature finding many individualistic biases. **How many other interventions (such as ESTs) are unknowingly reflecting traditional cultural values?**
Conclusions/Recommendations

3) Discrepancies between treatment and patients’ cultural characteristics may explain therapeutic outcomes and it would be useful to measure both and their interactions as means to have more information of the cultural match theory.

4) There are many cultural variables (e.g., spiritualism, familism) and we have only started to systematically study a few (i.e., individualism/relationalism).

5) It is important to employ multi-methods (e.g., quantitative, qualitative, clinical) to measure different cultural and outcome variables.
Conclusions/Recommendations

6) It is important to frame the cultural competence literature within the current health care debate and emphasize that culturally competent interventions are beneficial not only reducing human suffering but also medical costs.

7) These recommendations are not only applicable to ethnic minorities but to all. There is much cultural variability within Whites too (some or many Whites may also adhere to relational assumptions). Some could also benefit from relational strategies.

8) We must continue to listen to our patients’ narratives rather than to assume socially constructed categories that have oppressed and marginalized ethnic minorities; we need to avoid psychological racial profiling in which we define differences as deficits.
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