

Demystifying the Concept of Ethnicity for Psychotherapy Researchers

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ABSTRACT

At a time when ethnic minority populations are increasing in the United States, few psychotherapy studies are including minorities in their samples. To include ethnic minorities in psychotherapy studies, the complex construct of ethnicity must be carefully measured. In this article, practical advice is offered for conceptualizing, measuring, and interpreting ethnic factors in psychotherapy studies. Also discussed are identifying pathways from ethnicity to psychotherapy outcomes. Pathways that may influence ethnic differences in psychotherapy outcome include cultural factors, minority status, socioeconomic status, acculturation, and immigration experiences.

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Recent decades have spawned an increased awareness of ethnic minority issues. Unfortunately, this awareness may have paradoxically led to a decrease in research with ethnic minority populations. In an analysis of community psychology journals from 1965 to 1985, [Loo, Fong, and Iwamasa \(1988\)](#) found that only 11% of articles were about U.S. minorities. Similarly, [Graham \(1992\)](#) found that only 3.6% of empirical articles in six major American Psychological Association (APA) journals from 1970 to 1989 were on African Americans, with a steady decline in proportion of articles after the early 1970s. Additionally, [Jones, LaVeist, and Lillie-Blanton \(1991\)](#) examined articles in the *American Journal of Epidemiology* and found that inclusion of ethnic minority populations in research decreased over time, whereas articles reporting exclusion of non-White individuals increased. At a time when minority

populations are increasing in the United States ([U.S. Bureau of the Census, 1994](#)), fewer studies are being conducted to understand their treatment needs. If this trend continues, gaps in knowledge about treating an increasingly large segment of the population will occur.

The zeitgeist of recent decades, focusing on ethnic and cultural differences, may have inadvertently led to an exclusion of ethnic minorities from research, including psychotherapy studies. This may be due to several factors. First, researchers may believe that because of ethnic and cultural differences, new and different therapies must be developed for each ethnic group. Empirical research has not supported this position (for a recent review, see [Atkinson & Lowe, 1995](#)). Only by including ethnic minority groups in psychotherapy studies can treatments that are most culturally appropriate and effective be identified. Researchers may also exclude minorities from their studies because they believe that ethnic minority issues can only be examined by cross-cultural psychologists or ethnic minority researchers. Unfortunately, far too few ethnic minority investigators are available to adequately address the research needs of this population ([Bernal & Castro, 1994](#)). Finally, researchers may be aware of ethnic and cultural differences but experience general confusion regarding how to measure these issues and how to interpret differences if they are found. In this article, we provide information necessary to help researchers consider ethnic factors in psychotherapy studies.

To include ethnic minority individuals in psychotherapy studies, three major factors should be considered: (a) recruitment and retention of ethnic minority individuals in research, (b) the adaptation and administration of culturally and linguistically sensitive measures and interventions, and (c) a conceptualization of ethnicity that furthers knowledge about the role of ethnic factors in psychological processes. The ethnicity-focused articles in this special section consider the first two issues. In this article, we focus on the third, and perhaps most complex, factor: conceptualizing, measuring, and interpreting ethnic and cultural factors.

We begin by discussing the measurement of race and ethnicity. Next, we discuss ways to measure the pathways from ethnicity to outcome. Finally, we discuss feasibility of this measurement within psychotherapy research.

Defining and Measuring Ethnicity

Race

[Beutler et al. \(1996\)](#) , in this issue, and others ([Heath, 1991](#) ; [Zuckerman, 1990](#)) have pointed out that race as a biological category is generally not supported by scientific evidence. Racial groupings, therefore, operate more as social and political categories, and the effects of such groupings, such as discrimination based on skin color or ethnic identification based on shared characteristics, should be subsumed by other categories. Therefore, we recommend, as do others ([Betancourt & Lopez, 1993](#)) that race not be used as an explanatory variable in psychotherapy research. Researchers finding any differences should seek to understand and explain them rather than implicitly suggest that such

differences are inherent. (For an in-depth discussion of race and race-related variables, see [Helms, 1995](#); [Casas & Pytluk, 1995](#); and [Sodowsky, Kwan, & Pannu, 1995](#).)

Ethnic Status

The article in this special section by [Beutler et al. \(1996\)](#) clearly identifies the problem common to much research that includes ethnicity; that is, a lack of consistent definition or delineation of ethnicity. As a first step in solving this problem, we recommend that researchers clearly identify the particular definition they use in their studies. Researcher-identified ethnic classifications, using broad categories such as African American, Asian American, Latino, and Native American is an appropriate way for initially identifying ethnic status. However, because these terms are often inaccurate and include heterogeneous groups, other descriptors should be added. We recommend simple questions measuring self-identification, country of origin of participant or parents of participant, and geographic residence. The more dimensions that investigators can provide in their descriptions of the sample, the less the likelihood of glossing over the diversity and variety of subcultures within each ethnic group ([Sasao & Sue, 1993](#)).

In any one study, an ethnic sample may not be large enough to address subgroup differences. For example, a sample of Asian Americans may not be large enough to carefully examine treatment outcome differences between recent refugees from Tibet and second-generation Chinese Americans. However, the sample composition should be clearly identified in the article. In addition, any information found about differences between subgroups could be useful for future studies that would be designed specifically to look at such differences.

These recommendations pertain to defining ethnic status and defining ethnic populations. They should not be seen as explaining or causing differences between groups. The next section examines the ways in which ethnic groupings can have psychological significance and lead to ethnic differences in psychotherapy research.

Identifying Pathways From Ethnicity to Outcome

Once ethnicity has been defined, the next task is to include appropriate constructs to help interpret and explain ethnic differences. Although most research handles ethnicity as if it were directly linked to outcome variables, ethnicity is better conceptualized as a distal variable that works through a variety of proximal variables to affect outcomes ([Lopez, in press](#)). Important proximal variables include minority status, socioeconomic status, acculturation, immigration history, and cultural factors. These variables have been used to explain both intra- and interethnic differences in such outcomes as prevalence of psychiatric disorders ([Roberts & Vernon, 1984](#) ; [Warheit, Vega, Shimizu & Meinhardt, 1982](#)), etiology or expression of psychopathology ([Aldwin & Greenberger, 1987](#) ; [Lefley, 1990](#)), help-seeking behaviors ([Neighbors & Jackson, 1984](#) ; [Wells, Hough, Golding, Burnam, & Karno, 1987](#)), attitudes toward mental health services ([Leaf, Bruce, Tischler, & Holzer, 1987](#) ; [Takeuchi, Leaf, & Kuo, 1988](#)), and therapist preference ([Ridley, 1984](#)).

Cultural Factors

Because it is such a complex concept, culture is among the most difficult topics to study in psychology. Much research treats culture as a global factor that acts on outcome variables in unspecified ways (e.g., traditional Native American culture acts as a risk factor for suicide; traditional Asian culture acts as an impediment to help seeking, etc.) or speculates about the role of particular cultural factors to explain findings post hoc. For meaningful contributions to knowledge about the role of culture in any particular phenomenon, a priori hypotheses about the relationship of culture to outcome should be developed and directly measured ([Lopez, in press](#)).

To generate cultural hypotheses, researchers must learn about the culture of interest. We recommend three possibilities for learning about cultures of interest. First, literature is often available to help educate investigators about a specific culture, such as the ethnic-focused articles in this special section and ethnicity-focused work in anthropology and psychology. ¹Second, collaborating or consulting with other researchers familiar with the culture is often useful. Finally, focus groups can be very useful in learning about cultural attitudes about specific issues under study. For example, a focus group of young African American women may be useful in understanding attitudes toward child rearing before conducting a parenting intervention. The results of focus groups could be used to develop culturally specific hypothesis about the response of young African American women to a parenting intervention. [Hughes and DuMont \(1993\)](#) and [Morgan \(1993\)](#) provide information about using focus groups in research.

In some studies, culture may not be predicted as a factor in psychotherapy outcome. For example, we may predict that African American patients are as likely as White patients to respond to short-term therapy for treatment of depression if the treatments are offered in culturally appropriate ways. However, when differences are suggested, the predictions should be clear and the culturally related variables studied. For example, a randomized trial of directive versus collaborative treatment for anxiety may include both White and Filipino patients. The hypothesis that Filipinos are more likely to participate in therapy with a directive therapist rather than a collaborative therapist could be generated based on traditional Asian cultural values of deference to and respect for authority ([Leong, 1986](#)). The best test of this hypothesis would be to study Filipinos and non-Filipinos randomly assigned to directive or collaborative therapy. In addition, both Filipinos and non-Filipinos should complete measures of deference to and respect for authority. The hypothesis should be tested by examining the relationship of deference to and respect for authority to participation in directive versus collaborative treatment. In addition, the frequency with which Filipinos drop out of both directive and collaborative treatment may be studied, as well as the relationship of acculturation to drop out.

Minority Status

The experience of ethnic populations in the United States is strongly effected by minority status (for an in-depth review, see [Ogbu & Matute-Bianchi, 1986](#)). By minority status, we refer to the designation of members of particular groups as inappropriate, unwelcome, or inferior, that justifies and perpetuates their

systematic exclusion from full participation in society or access to its rewards. For ethnic minorities, personal or collective experience of discrimination and marginalization will have an impact on their beliefs, attitudes, and behaviors. Therefore, some differences between majority and minority groups, such as a greater level of mistrust of therapists and reluctance to self-disclose in therapy among African Americans than Whites ([Ridley, 1984](#)) may be more indicative of minority status than adherence to cultural values. For example, [Sussman, Robbins, and Earls \(1987\)](#) found that, among depressed Whites and African Americans who failed to seek professional help for their depression, African Americans were more likely to cite fear of hospitalization as a factor in their decision. This belief is consistent with the reality that African Americans are much more likely to be involuntarily hospitalized than Whites with similar levels of psychopathology ([Adebimpe, 1994](#)).

We recommend that researchers measure perceived discrimination among participants in psychotherapy trials. Although more work in this area clearly needs to be done, several possible measures are available, including the Perceived Discrimination subscale of the cultural identity measure by [Felix-Ortiz, Newcomb, and Meyers \(1994\)](#). In addition, we recommend that perceived discrimination be considered as a possible explanation for ethnic differences found in studies. For example, if African Americans are less likely than Whites to agree to participate in a study, perceived discrimination in past research may account for those differences.

Socioeconomic Status

Minority populations are more likely to be poor than majority populations. Regardless of the culture to which they belong, poor individuals are likely to think, believe, and act in ways consistent with their life circumstances. For instance, differences in the level of perceived control over life circumstances result in differences between poor and more advantaged groups on a number of psychological constructs, such as locus of control ([Heller, Quesada, & Chalfant, 1983](#)) and coping style ([Neighbors, Jackson, Bowman, & Gurin, 1983](#)). Ethnic minority populations are more likely to be poor than majority populations; therefore, sociodemographic factors may account for ethnic differences.

Many studies that include ethnic minorities either fail to measure socioeconomic status or address class-culture confounds. Some studies have made comparisons between African Americans and Whites using low-income African Americans and middle-class Whites ([Graham, 1992](#)). Such practices can lead to class factors being inappropriately attributed to culture. One example of the class—culture confound is the long-standing assumption that, because ethnic minorities are crisis oriented and nonintrospective, they are less appropriate candidates for insight-oriented psychotherapy than majority populations ([Rogler, Malgady, Constantino, & Blumenthal, 1987](#)). Clearly, the multiple day-to-day problems faced by poor individuals, such as unemployment, homelessness, poor health, and single parenting responsibilities, could lead to a crisis-oriented perspective in any individual regardless of cultural background.

To avoid class—culture confounds, researchers should include in their study designs (a) measures of

socioeconomic status, including personal and household income and occupational status of individuals and their parents, and (b) a stratified sample of all groups, in particular, more economically advantaged ethnic minority individuals and economically disadvantaged white individuals. If this is not possible, researchers should alert readers of the potential limits of the generalizability of their findings to the particular subgroups they studied.

Acculturation

Acculturation refers to the process of psychosocial change that occurs when a group or individual comes into contact with another culture. Acculturation is an important factor to measure in psychotherapy studies with minority individuals. Acculturation has been measured by assessing the use of language values, beliefs, attitudes, psychological frame of references, skills, preferences for music or television, leisure activities, observance of holidays, and cultural self-identity. Language accounts for much of the total variance in acculturation. However, multiple domains of assessment are necessary because acculturation may not occur at the same rate across domains. For example, among Latinos, men tend to become acculturated faster in occupational domains, whereas women tend to acculturate faster in gender role domains ([Vazquez-Nuttal, Romero-Garcia & DeLeon, 1987](#)).

Interpreting findings in light of acculturation is important. As [Lopez \(in press\)](#) points out, acculturation is often used as a proxy variable for culture. However, low levels of acculturation may indicate either adherence to traditional culture or lack of exposure to the dominant culture. Acculturation, rather than being considered as a simple continuum, is better conceptualized as consisting of independent or orthogonal dimensions, exposure—adherence to traditional culture and exposure—adherence to the dominant culture, rather than as a single dimension ([Felix-Ortiz, et al., 1994](#) ; [Oetting & Beauvais, 1991](#)). For example, [Loo, Tong, and True \(1989\)](#) reported that mental health service use in San Francisco's Chinatown is extremely low. They found that this pattern was explained not by the avoidance of services because of the stigma of being labeled as mentally ill (adherence to traditional culture) but by a lack of knowledge about what services were available (lack of exposure to dominant culture). We recommend use of measures that capture both adherence to traditional culture as well as exposure to new culture. Several scales measuring multiple domains are available (for review, see [Marin & Marin, 1991](#)).

Because lack of education, segregation, marginalization, and geographic isolation can also contribute to lowered exposure to White middle-class society for all populations, acculturation and exposure to the mainstream culture should be measured for all groups participating in cross-cultural research. Questions can be asked about beliefs about particular values, knowledge about particular issues, and degree of contact with white populations, such as the ethnic composition of the neighborhood where individuals grew up or currently reside. A brief ethnic identity scale has been developed by [Phinney \(1992\)](#) for use with any ethnic group, including majority populations.

Immigration Experience

Immigrants often exhibit particular views of behaviors that differ from those seen in native populations.

These differences may not be cultural but actually stem from experiences leading up to, during, or after migration. To a greater extent than native groups, immigrants experience separation from their social networks, families, material belongings, and familiar cultural environment and face changes in economic and social status and cultural shock. Immigrants from underdeveloped countries may have particular difficulty adjusting to all of the different lifestyles changes, compared with immigrants from more industrialized or urban areas ([Ben-Porath, 1991](#)). Adjustment may also be more difficult for individuals who did not play a role in the decision to migrate, including children or women who migrate with their husbands ([Espin, 1987](#)).

Refugees often experience trauma from preflight persecution, including the death of a loved one, torture, and rape, as well as difficult migration, including perilous travel and detainment in overcrowded refugee camps. Refugees, particularly those who are from right-wing dictatorships, and thus often not recognized as refugees or provided with legal avenues of immigration by the U.S. government, may have a more difficult time during the period of resettlement than other immigrants ([Ben-Porath, 1991](#)). Clearly, refugee status should be assessed among all immigrant groups.

A Cautionary Note

In the previous sections, we have presented the proximal factors associated with ethnicity that are potential pathways to outcome as separate categories. We do not mean to imply that these are distinct constructs that act on outcomes independently. These factors are complex; they overlap and interact with one another. For example, minority status is likely to be experienced differently by individuals from different socioeconomic backgrounds. Similarly, the adherence to traditional cultural beliefs and practices by a recent immigrant may have different psychological significance than it would for a third-generation individual who has recently renewed ties with his or her ethnic community. In addition, what can be described as culture is shaped not only by traditional values and teachings but also by current experience and environment. Thus, in addition to traditional Latino or Asian culture, for example, there is also the culture of poverty, of oppression and marginalization, of living in a particular geographic area, or of any number of factors.

We realize, therefore, that the presentation of these categories may be construed as an oversimplification of a very complex issue. We offer these guidelines not as a definitive guide for conducting cross-cultural research but as a starting point to facilitate the inclusion of ethnicity into mainstream psychotherapy research. As more ethnic populations are included in psychotherapy research, our knowledge about ethnic issues and the tools we use to measure them in this context will become more sophisticated, and, we hope, this simplified model of ethnicity will become obsolete.

Feasibility

In this article, we have made a number of recommendations about how to include ethnicity in psychotherapy research. Clearly, we are not suggesting that researchers must overhaul their research

designs or add extensive batteries to their assessments or make cultural factors their main focus of study. On the contrary, we are suggesting that a relatively small set of questions may be sufficient to make results easier to interpret.

We provide a hypothetical example to illustrate our point. Suppose we are interested in testing the effectiveness of family therapy for treatment of depression in young mothers in a public hospital setting. Our primary goal is to determine whether this form of therapy will be effective in a disadvantaged population of medical patients. The hospital serves a primarily low-income population, and half the women are Latinas. First, we determine the country of origins of our sample and learn about their culture. Next, we hold focus groups with Latinas and non-Latinas seen in the clinics and discuss their views regarding treatments. This leads us to a variety of hypotheses about cultural factors and family therapy. On the basis of our cultural assessment, we predict that Latinas will benefit more from family therapy than will non-Latinas because of the emphasis on the family in a Latina's sense of well being. We use four items from the Familism Scale ([Sabogal, Marin, Otero-Sabogal, Marin, & Perez-Stable, 1987](#)) assessing the importance of family and family obligations for Latinas and non-Latinas.

We also consider Latinas' minority experience of discrimination. We feel that Latinas may be harder to engage in therapy because of distrust of service providers. We use the three items from the Perceived Discrimination subscale of [Feliz-Ortiz et al.'s \(1994\)](#) Cultural Identity Scale.

We feel that our Latina and non-Latina groups may be similar in terms of socioeconomic status because they are all public sector patients. However, undocumented Latinas are excluded from most welfare programs and may have much greater concerns about livelihood than do non-Latinas. As a result, we measure income for both groups, as well as eligibility for entitlements.

We are also interested in acculturation. Our sample includes both recent immigrants and second-generation Latinas. Therefore, we include a short acculturation scale ([Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987](#)). We also hypothesize that Latinas may be less likely to agree to participate in the study than Whites because they are recent immigrants and unlikely to be familiar with psychotherapy. However, the non-Latinas in this sample of public sector patients may also be unfamiliar with psychotherapy. We include in our initial assessment interview two questions about whether the individual has ever been in therapy or if her friends or family have ever been in therapy ([Yokapenic, Clark, & Aneshensel, 1983](#)). We also include three questions about perceived usefulness of psychological interventions ([Fischer & Turner, 1970](#)).

Finally, many of the Latinas in this sample are from war-torn Central American countries. They may have also had traumatic migration experiences. To assess this, we include a screen for posttraumatic stress in our intake assessment. We hypothesize that those women with posttraumatic stress will be helped less by the family therapy than those women without these symptoms.

In this hypothetical example, we add, at most, about 15—20 min to our assessment battery by asking these questions. These simple steps allow us to interpret ethnic differences more accurately, if found, in

our data. We believe that this cultural assessment also adds richness to our interpretation of treatment outcome data, including adding to knowledge about the impact of cultural beliefs on treatment outcome.

Conclusion

The purpose of this article was to help researchers to conceptualize ethnicity in a way that makes it a more manageable component to incorporate into their research. Identifying how ethnicity and culture are operationalized and considering the variety of ways that ethnicity can impact on outcome variables are concrete strategies researchers can use to make this task easier. Specifically, we recommend that researchers (a) identify the definition of ethnicity that they are using; (b) provide additional descriptive information beyond ethnic status (i.e., language, national heritage, self-identification, geographic residence, etc.) to further describe ethnic samples; (c) include measures of social class, minority status, acculturation and exposure, and immigration experience to help clarify the meaning of ethnic differences; (d) identify specific cultural variables hypothesized to affect outcome variables and measure them; and (e) avoid making unwarranted conclusions about the role of ethnicity, race, or culture in explaining differences between groups.

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For recent reviews regarding ethnic and cultural issues for a number of ethnic minority groups, see [Atkinson and Lowe \(1995\)](#) and [Leong, Wagner, and Tata \(1995\)](#). For introductions to traditional cultural values of particular ethnic groups, sources include [Ho \(1976\)](#) and [Leong \(1986\)](#) with respect to Asian Americans, [Marin and Marin \(1991\)](#) for Latinos, [Hill \(1972\)](#) for African Americans, and [Red Horse \(1988\)](#) and [LaFromboise \(1988\)](#) for Native Americans.