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Associations between Cultural Identity and Attitudes Toward Routine Progress Monitoring in a Sample of Ethnically Diverse Community Therapists

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Abstract

Community mental health services are increasingly embracing evidence-based interventions (EBI), and the professional workforce is diversifying to meet the needs of historically underserved groups. As such, it is increasingly important to understand how psychotherapist cultural factors may be associated with attitudes toward EBI. The use of standardized assessments within routine progress monitoring is a cornerstone of EBI, yet therapist attitudes remain an obstacle to implementation. The current study examines the associations between therapist cultural identity and attitudes toward and use of routine progress monitoring. An online survey was used to gather data from 229 ethnic minority community therapists delivering EBIs in a large public mental health system serving children and families. Therapists were 35.2 years of age on average (SD=7.7), 86.5% female, 69.9% Hispanic/Latinx (30.2% Other ethnic minority), 36.2% licensed, 90.8% held a Master's Degree, and 76.4% of participants reported being able to deliver services in a non-English language. Hierarchical multiple regression analyses revealed that stronger heritage cultural identity was related to perceptions of potential harm with routine progress monitoring. In addition, more favorable views of standardized assessment instructions were associated with positive attitudes toward routine progress monitoring. We discuss how findings point to the need for additional user centered research with diverse community therapists to learn how assessment and progress monitoring can be better designed to address their cultural and racial-based concerns.

Keywords

Routine progress monitoring; evidence-based assessment; cultural identity; psychotherapist attitudes; implementation; children's mental health

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Introduction

After decades of concern about the lack of availability of culturally-responsive mental health services, there has been significant progress in diversifying the mental health workforce. The American Psychological Association's Center for Workforce Studies report shows increases in ethnic minority psychologists, including 47.4% among Hispanic/Latinx, 79.5 % among Asian American, and 100% among African American psychologists from 2005 to 2013 (Lin, Nigrinis, Christidis, & Stamm, 2015). As one example, in California, trends are more pronounced among masters-level clinicians, with reported increases of 133% among Latinx students graduating from master's programs in social work and counseling between 2003 and 2012 (Bates, Blash, & Chapman, 2014). Recent findings from California also indicate that ethnic minority counselors and social workers now make up half of the community mental health workforce in the state (Bates et al., 2014). Ethnic minority psychotherapists (referred hereafter as therapists) are also likely to serve ethnic minority clients, who represent a majority of recipients of public mental health services (U.S. Department of Health and Human Services, 2015).

There has been a growing movement in state and local mental health authorities to introduce evidence-based interventions (EBIs) to improve quality of care and client outcomes in community mental health settings (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006; Beidas et al., 2013). Evidence-based assessment (EBA) is an integral component of delivering EBIs and entails the use of psychometrically valid *standardized assessment measures* for the purposes of diagnostic clarification, treatment planning, and outcome assessment. *Routine progress monitoring* employs standardized assessment measures in the provision of ongoing feedback to guide therapist and client decision-making (Borntrager & Lyon, 2015; Jensen-Doss, 2011). Research has demonstrated a clear link between EBA use and improvement in clinical outcomes (Bickman, Kelley, Breda, de Andrade, & Riemer, 2011; Jensen-Doss et al., 2016; Lambert et al., 2003), underscoring the importance of understanding the association between therapist attitudes and use of routine progress monitoring.

Yet, recent data suggest that EBA for the purposes of routine progress monitoring is generally not used in community settings (Jensen-Doss et al., 2016). A recent survey suggests that less than two-fifths of practicing psychologists report using EBA for routine progress monitoring (Wright et al., 2017). Rates appear even lower among master's level providers in community mental health contexts (Frauenhoffer, Ross, Gfeller, Searight, & Piotrowski, 1998; Palmiter, 2004). The emergent literature indicates that therapist background characteristics (e.g., training background, age, level experience) are associated with attitudes toward EBA. For example, psychologists compared to other disciplines, as well as cognitive-behavioral therapists compared to psychodynamic therapists, express more favorable views in implementing EBA with clients (Jensen-Doss & Hawley, 2010). Additionally, therapists in private practice have shown to perceive less benefit of EBA compared to therapists in other settings (Jensen-Doss & Hawley, 2010). Relatedly, there is evidence that more favorable attitudes toward EBA are associated with increased use of standardized assessment among community therapists (Jensen-Doss & Hawley, 2010; Lyon,

Dorsey, Pullmann, Silbaugh-Cowdin, & Berliner, 2015). Yet, little is known about how therapist cultural, ethnic, and racial diversity may be related to EBA attitudes and use.

Cultural factors among the therapist workforce may be especially relevant to understanding attitudes toward EBA and routine progress monitoring. Community therapists commonly raise the concern that EBIs developed by researchers in university settings may not fit cultural needs of the diverse clients they serve (Aarons, et al., 2010; Addis & Krasnow, 2000). Likewise, therapists have expressed reservations about the cultural relevance or sensitivity of standardized measures used in EBA (Garland, Kruse, & Aarons, 2003). For example, the administration of standardized measures may be experienced as intrusive if too much information is requested, if the content does not feel directly relevant to a client's presenting concern, or if questions inquire about areas that are a source of shame (Cabassa, 2016; Cabassa & Baumann, 2013).

Relatedly, the regular provision of personal clinical data of symptoms or life functioning, key elements of EBA and routine progress monitoring, may elicit experiences with historically-based racism among ethnic minority groups and mistrust of American structural or institutional systems (Benkert, Peters, Clark, & Keves-Foster, 2006; Ojeda & McGuire, 2006). Experiences of racism may underlie some of the therapists' or their clients' reluctance to use EBA and routine progress monitoring in diverse community mental health settings. Thus, beyond cultural concerns that EBA focuses on diagnostic criteria that do not characterize the prominent forms of distress nor the key domains of adaptive functioning valued in ethnic communities, the sharing of this information in written or electronic form may prompt concerns about misuse of personal data by historically oppressive institutions. This is plausible given the robust literature linking high cultural and racial mistrust to negative client-provider interactions (Benkert et al., 2006; Whaley, 2001). To the extent that Latinx and other ethnic minority therapists and clients hold these concerns, therapists may hold negative attitudes about the administration of standardized assessments and sharing these results with clients within routine progress monitoring.

Findings from a single study to date demonstrate that ethnic minority therapists are more likely to view standardized assessment as being impractical compared to non-Latinx White therapists (Jensen-Doss & Hawley, 2010). Jensen-Doss and Hawley (2010) specifically examined clinicians' attitudes toward standardized assessments and their relations to self-reported use of these tools. Results generally showed that clinicians held neutral views toward these tools, with most favorable views about their psychometric properties and less positive views about their practicality and incremental benefit over using clinical judgment alone. Subsequently, Jensen-Doss and colleagues (2016) found that therapists' perceptions of potential benefit of routine progress monitoring were associated with more frequent use (Jensen-Doss et al., 2016). However, therapists that perceived routine progress monitoring as having more potential for harm also reported more frequent use (Jensen-Doss et al., 2016). More research is needed to understand how perceptions toward standardized assessment are related to views of harm and benefit in routine progress monitoring. Given the large heterogeneity within and between ethnic minority groups, it may be instructive to consider aspects of cultural identity that might be more proximal determinants of attitudes toward EBA among an ethnically diverse mental health workforce. Our study is novel in that it

extends beyond therapist ethnicity/race categories to cultural identity as it pertains to therapist attitudes toward routine progress monitoring.

Therapist cultural identity may have some bearing on attitudes toward standardized assessment or routine progress monitoring. It may be useful to consider an aspect of acculturation, the extent to which an individual identifies with mainstream U.S. culture or the language, norms, or customs associated with European/White American culture (Berry, 1997; Yoon, Langrehr, & Ong, 2011). A recent study showed that patterns of cultural identity among ethnic minority therapists related to types of adaptations to evidence-based interventions they reported making (Saifan, Brookman-Frazee, Barnett, Gonzalez, & Lau, 2018). The findings suggested that highly enculturated therapists (more aligned with heritage culture) may be more adherent to EBI training compared to bicultural therapists who may be more aware of the ways in which western-developed EBIs are unaligned with ethnic values and norms.

The existing literature on acculturation among foreign-born mental health professionals shows contradictory findings regarding the plausible impacts of acculturation on some aspects of psychotherapy processes. Relevant research has focused on foreign-born counselors' cultural transition to the U.S., wherein counselors from non-Western countries in the U.S. report greater conflict and challenges in understanding Western approaches to treating mental health compared to their counterparts (Ng, 2006). At the same time, levels of acculturation may relate to therapists' critical reflection on the cultural appropriateness of evidence-based practice for diverse clients. Nilsson and Anderson (2004) found that more acculturated international counseling trainees reported higher levels of self-efficacy and more discussion of cultural issues in supervision than trainees who were less acculturated. These findings indicate a possible link between diverse therapists' acculturation experiences and perceptions of individualistically-oriented EBI. Standardized EBA conventions and progress monitoring strategies are highly-structured, goal-oriented, person-centered, and symptom-focused, which may represent practices that are most aligned with individualistic values. Furthermore, ethnic minority therapists who identify more with their heritage culture of origin may be more likely to question the fit between EBA tools and processes for their ethnically diverse clients (e.g., viewing process as too intrusive, confusing, and impersonal). Given the novelty of this area of research, and some inconsistent findings across studies (e.g., Ng, 2006; Saifan et al., 2018), we aim to explore the relationship between ethnic minority therapists' acculturation and their perceptions of EBA.

The primary aim of this study was to examine the relationship between therapist cultural identity and their perceptions of the benefit, harm, and burden associated with routine progress monitoring (Aim 1). We also examined the relationship between other therapist background/professional characteristics and perceptions of routine progress monitoring. In our secondary aim, we assessed therapist-reported training, use, and perceptions of standardized assessment measures and the association with therapist perceptions of the benefit, harm, and time-burden of routine progress monitoring (Aim 2). Consistent with previous studies (Jensen-Doss, 2011; Jensen-Doss et al., 2016; Jensen-Doss & Hawley, 2010), we predicted that cognitive-behavioral therapy (CBT) orientation, psychology

discipline, doctoral degree, current use, and more favorable views of EBA would be associated with more positive attitudes towards routine progress monitoring.

Method

Study Context

This study examined therapist cultural identification and attitudes toward the use of EBA in routine progress monitoring in a large sample of ethnically diverse, predominately Latinx, community therapists in the Los Angeles County Department of Mental Health (LACDMH) who were trained to deliver multiple evidence-based interventions (EBIs) in the Prevention and Early Intervention (PEI) initiative in children's mental health services. PEI promoted EBI and EBA through contracting with community-based agencies for the delivery of specific EBIs for reimbursement and required the collection of standardized assessment measures at pre- and post-treatment (Department of Mental Health Program Support Bureau, 2016). Although PEI did not mandate routine progress monitoring during the episode of care, one specific widely-implemented EBI emphasizes routine progress monitoring in therapist decision-making. As such, in this implementation context, many community therapists in this study are knowledgeable about a variety of standardized assessment measures, yet may not routinely engage in routine progress monitoring.

Participants and Procedures

An online survey concerning perceptions of outcome measurement was administered as part of a larger study examining therapist experiences with the PEI initiative in children's mental health services in LACDMH (*Masked for Review*). Specifically, 98 agencies that were directly operated or contracted by the LACDMH to deliver at least one of the six EBPs of interest to children or transition-age youth were eligible for inclusion in the study. We identified eligible participants through agency management at these organizations. The research team requested contact information for all eligible staff from the management at the 98 eligible agencies. Contact information for staff from 69 agencies (70.4% of eligible agencies) was obtained for recruitment. Of those 69 agencies, 62 agencies provided email contacts for staff and seven forwarded an email to staff that allowed them to opt-in to provide their email contact to the research team. The county-wide survey was fielded between March 2015 to July 2015 and resulted in 726 therapist participants, of which 376 therapists completed the survey (51.8% response rate). Respondents received a $20 gift card for completion of the survey.

Of the 376 respondents, 35 (9.3%) participants who identified with a U.S. culture of origin were excluded, and of those, 112 (32.8%) who identified as Non-Hispanic White/Latinx were excluded. This resulted in a subset of 229 ethnic minority respondents that endorsed identification with a non-U.S. culture of origin. The subset of 229 consisted of the following endorsed cultures: Latin-American (65.9%; e.g., Mexico), European (3.5%; e.g., Spain), and Asian or Pacific Island (19.7%; e.g., China, Philippines). The racial/ethnic breakdown comprised of 69.9% Hispanic/Latinx, 18.8% Asian and Pacific Islander, 7.0% African American, and 4.4% Multiracial/Other. The racial/ethnic breakdown comprised of 69.9% Hispanic/Latinx, 18.8% Asian and Pacific Islander, 7.0% African American, and 4.4%

Multiracial/Other. Participants were on average 35.2 years of age (SD=7.7), 86.5% female, 36.2% licensed, 90.8% held a master's degree, and 76.4% of participants reported being able to deliver services in a non-English language. All therapists reporting a Marriage and Family Therapy discipline held a master's degree, most Social Workers held a master's Degree (98.8%; one held a doctorate), and most Psychology clinicians held a doctorate degree (85%; two held master's degree and one held a bachelor's degree). See Table 1 for therapist characteristics.

Measures

Background and professional characteristics—Therapists were asked to complete a background questionnaire, which asked them to report on sociodemographic and professional training information including gender (female, male, other), race/ethnicity, level of education, licensure status, discipline, theoretical orientation, number of years as a practicing clinician, and client caseload.

Acculturation—We adapted items from the Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB; Zea, Asner-Self, Birman, & Buki, 2003) to produce two subscales from the original AMAS-ZABB (U.S. Cultural Identity or American Identity and Culture of Origin Identity). Therapists were first asked whether they identified with a heritage culture of origin other than U.S. American. If indicated "yes", they identified their heritage culture of origin and were then asked to rate a series of questions about their cultural identity on a scale from 1 (strongly disagree) to 4 (strongly agree). Therapists rated the extent to which they identified with the U.S. majority culture (3-items; e.g., "Being U.S. American plays an important part in my life."), and the extent to which they identified with their non-U.S. culture of origin (3-items; e.g., "I feel good about being a member of my culture of origin"). The two scales demonstrated good internal consistency: U.S. Cultural Identity (α=.88) and Culture of Origin Identity (α=.85).

Use of EBA in treatment—We generated three dichotomous variables to capture therapist use of EBA at the Beginning, During, and End of treatment phase to classify EBA users ('1') and non-users ('0') of standardized assessment at each of the three phases of treatment.

Perceptions of EBA clinical utility and practicality—The Attitudes towards Standardized Assessment Scale- Monitoring and Feedback (ASA-MF; Jensen-Doss et al., 2016; Jensen-Doss & Hawley, 2010) was used to examine therapist attitudes toward administering standardized assessment measures and using them for clinical decision-making. For this study, we included two subscales from the original ASA-MF: Clinical Utility (8-items; e.g., "Assessment measures don't tell me anything I can't learn from just talking to clients.") and Practicality (5- items; e.g., "Standardized assessment measures can efficiently gather information."). Standardized was defined for therapist participants as client self-report measures with standard items and scoring procedures. Mean scores were computed for each subscale. Providers rated items on both subscales using a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Negative items were reverse coded

such that higher scores indicated more favorable attitudes. Scales had adequate internal consistency: Clinical Utility (α=.78) and Practicality (α=.74).

Perceptions of confidence in using EBA—We generated four items to examine therapist sense of self-efficacy in utilizing EBA measures for clinical decisions (e.g., "I feel confident scoring and interpreting standardized assessment measures.") on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). Mean scores were computed for the Confidence scale. The scale demonstrated good internal consistency (α=.82).

Perceptions of routine progress monitoring—The Monitoring and Feedback Attitudes Scale (MFA; Jensen-Doss et al., 2016) was used to examine therapist attitudes toward routine progress monitoring and providing feedback to clients about treatment progress. In this study, 14 items were used from two subscales: Harm (4-items; e.g., "Providing clients with negative feedback about their progress would decrease their motivation for and/or engagement in treatment.") and Benefit (10-items; e.g., "Providing clients with feedback about treatment progress can increase their insight."). Therapists were asked to indicate the extent of agreement with each statement using a 5-point Likert scale where 1 was Strongly Disagree and 5 was Strongly Agree. Routine Progress Monitoring was defined as the administration of measures to therapy clients every 1–2 sessions in order to monitor progress in treatment. The Cronbach's alpha indicated the Harm (α=.84) and Benefit (α=.89) scales had good internal consistency in the current sample.

In addition to the Harm and Benefit subscales, we generated four items to assess therapist perceptions of burden associated with implementing routine progress monitoring and providing feedback to clients (e.g., "Routinely providing clients with feedback on their progress takes too much time within sessions."). The Burden scale was scored by averaging the items within the scale. Items were rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The Cronbach's alpha indicated Burden had good internal consistency (α=.77) in the current sample.

Analytic Plan

To address our primary aim of exploring the relationship between therapist cultural identity and their perceptions of routine progress monitoring, we conducted three separate hierarchical multiple regression analyses to examine predictors of the three dimensions of therapist attitudes towards routine progress monitoring – perceived Benefit, Harm, and Burden. Predictors in Step 1 of each model included therapist gender (female [reference], male), race/ethnicity (Hispanic/Latinx [reference], other ethnic minority group), educational level (master's degree [reference], bachelor's degree, doctorate), licensure status (yes, no [reference]), discipline (marriage and family [reference], psychology, social work, other), theoretical orientation (cognitive/behavioral [reference], other), years of clinical experience, client caseload count, and cultural identity scores (U.S., culture of origin). Predictors in Step 2 included therapists' current use of EBA (Beginning, During, End) and three types of perceptions of EBA (Clinical Utility, Practicality, Confidence).

The use of EBA measures, wherein therapists were asked to rate the proportion of their client caseload with whom they use EBA measures, was entered into each model as a

dichotomous variable rather than using the original survey 6-point Likert scale range given the distribution of the data. On the survey, therapists were asked to report on their use of EBA at three time points of treatment: Beginning, During, and End by rating twelve items meant to capture various steps of EBA use (i.e., administration of measures, scoring and interpreting of measures, provision of feedback to clients, and use to plan treatment) where 0 was “no use of EBA with clients” and 5 was “use with all clients.” Therapists provided these ratings for each of the three phases of treatment, allowing us to generate three mean scores for each phase. The mean scores were calculated based on respective items for each phase in treatment. The subscales demonstrated good internal consistency: Beginning (α=.84), During (α=.89), and End (α=.84). Given the highly skewed data for each subscale wherein the majority of therapists reported using EBA with few clients during treatment, we computed dichotomous variables to classify therapists into EBA users (‘1’) versus non-users (‘0’) of standardized assessment at each of the three phases of treatment. Those with mean scores greater than two were categorized as users of EBA (i.e., EBA use with some clients) on the Beginning (38 %) and End (32.3%) subscales, while those with mean scores > 1 were categorized as users (i.e., EBA use with very few clients) for the During scale (69.4%). This process resulted in three dichotomous scales capturing use of EBA at the Beginning, During, and End of treatment phases.

Results

Aim 1: Therapist Cultural Identity and associations with attitudes toward Routine Progress Monitoring

Aim 1 sought to assess the extent to which therapist acculturation (i.e., American identity, culture of origin) influences perceptions about the benefit, harm, and burden of routine progress monitoring. Therapist cultural identity was associated with perceptions of Harm, but not Burden or Benefit. Stronger identification with culture of origin was associated with perceiving routine progress monitoring as potentially harmful (β=0.22; p<0.01). This finding was retained in Steps 1 and 2 of the Harm models and accounted for 28% of the Step 2 model.

Contrary to our prediction, no therapist background variables emerged as significant predictors of perceptions of routine progress monitoring. These results are shown in Table 2, Step 1 columns.

Aim 2: Associations between Current Use and Perceptions of EBA and Attitudes toward Routine Progress Monitoring

Predictors of the perceived benefits of routine progress monitoring—When EBA use and perceptions were entered into step 2 (step 2 columns in Table 2), only therapist EBA practicality perceptions emerged as significantly related to benefits, such that therapists with more favorable perceptions about the practicality of EBA also viewed routine progress monitoring as more beneficial (β=0.24; p<0.05). Professional characteristics, current use of EBA, and other perceptions of EBA were unrelated to perceptions of benefit. Step 2 accounted for 13% of the variance in the Benefit scale, as opposed to 5% in Step 1.

Predictors of the perceived harm of routine progress monitoring—Therapists with a bachelor's degree educational level were more likely to view routine progress monitoring as harmful compared to those with a master's degree (β=−0.26; p<0.05), accounting for 12% of Step 1. Education level was no longer significant when EBA attitudes were entered into the model at Step 2, and instead EBA attitudes and use factors emerged as significant. Specifically, therapists with less favorable attitudes about the practicality of EBA (β=−0.32; p<0.001) and who reported less confidence in using EBA (β=−0.27; p<0.001), also perceived routine progress monitoring as more harmful. Therapists using EBA *during* treatment perceived less harm in routine progress monitoring (β=−0.13; p<0.05). Step 2 accounted for 28% of the variance compared to only 12% in Step 1.

Predictors of the perceived burden of routine progress monitoring—Consistent with our predictions, therapists who held more favorable attitudes about the practicality (β=−0.48; p<0.001) and clinical utility (β=−0.17; p<0.051) of EBA perceived routine progress monitoring as less burdensome. Step 2 accounted for 41% of the variance in perceived burden, as opposed to 9% in Step 1.

Discussion

In the present study, we examined the impact of therapist-level factors on attitudes toward routine progress monitoring in an ethnically diverse, majority Latinx, sample of community therapists. Three broad findings emerged. First, therapist cultural identity was associated with reported attitudes toward routine progress monitoring, such that affiliation to culture of origin was related to less favorable views of routine progress monitoring. Second, only education level emerged as a therapist professional background characteristic significantly predicting attitudes toward routine progress monitoring. Third, and consistent with the literature, favorable attitudes toward EBA and use of EBA were related to more favorable attitudes toward routine progress monitoring. Given the low base rates of EBA use and routine progress monitoring among community mental health providers for youth, our findings point to targets for supporting implementation within an increasingly diverse workforce (Bates et al., 2014; Lin et al., 2015).

With regard to our first objective, a notable finding emerged which underscores the potential importance of therapist cultural identity in the implementation of routine progress monitoring. Therapists with strong affiliation to their culture of origin perceived routine progress monitoring as more harmful, regardless of their level of acculturation toward U.S. culture. One interpretation might be that perhaps more enculturated therapists also serve more ethnically diverse caseloads and thus are more vigilant to concerns about the cultural (mis)fit of EBA, a theme raised previously by community therapists working with ethnically diverse populations (Garland et al., 2003). There is value in examining the cultural sensitivity of EBA tools that therapists are required to use with ethnically diverse clients in community settings (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010). Although some EBA models have expanded to be more culturally inclusive and consider input on content from multiple stakeholders including clients (e.g., Child and Adolescent Needs and Strengths; Anderson, Lyons, Giles, Price, & Estle, 2003; Top Problems Checklist; Weisz et al., 2011), EBA and routine progress monitoring approaches require further input on appropriateness

from diverse therapist end-users and clients. A second possible interpretation stems from the literature on historically-based racism and cultural mistrust (e.g., Benkert et al., 2006; Ojeda & McGuire, 2006) such that experiences of racism may underlie some diverse therapists or clients reluctance to use EBA or routine progress monitoring. Items on the Harm subscale related to potential negative impacts on the client-provider relationship, and not directly to concerns about institutional use of EBA data. Future research should disaggregate cultural versus race-based concerns about potential harm associated with EBA. Overall, further investigation on perceptions of potential harm among therapists with strong ethnic identity is warranted to understand and accommodate their concerns in use of EBA and routine monitoring with their diverse clients.

Consistent with previous study findings, therapist education level emerged as a significantly related to attitudes toward routine progress monitoring (Jensen-Doss & Hawley, 2010; Jensen-Doss et al., 2016). Specifically, therapists with lower education were more likely to perceive routine progress monitoring as taking up valuable session time in ways that created a burden. This finding was washed out, however, when standardized assessment attitudes and use were accounted for in the model, highlighting its more distal influence over routine progress monitoring attitudes. It could be argued that non-PhD programs focus less on the implementation of EBA or routine progress monitoring strategies, and that results in providers perceiving the practice as more time-burdensome. It is also possible that therapists self-select into different professions and program types (PhD versus non-PhD) based on their affinity for various approaches. It stands to reason, therefore, that the use of EBA and routine progress monitoring could be in conflict with personal provider values. More work is warranted to better understand the meaning of this finding to inform therapist training efforts that balance between mandates for use of EBA and therapist-centered training goals and values. No other professional background characteristics emerged as significant, despite previous studies linking therapist professional factors (discipline and theoretical orientation) with EBA attitudes (Jensen-Doss et al., 2016; Jensen-Doss & Hawley, 2010). It is possible that the characteristics of our particular sample may help to explain why we did not replicate previous findings about associations between therapist background characteristics and attitudes toward assessment. For example, a CBT orientation and psychology discipline have previously been linked to more favorable views of EBA (e.g., Jensen-Doss et al., 2016), but the samples upon which those findings were based have consisted of majority non-Hispanic white, U.S.-born therapists (e.g., ~90% non-Hispanic White; Jensen-Doss et al., 2016; Jensen-Doss & Hawley, 2010) with doctoral-level education (e.g., 56.3%; Jensen-Doss & Hawley, 2010) and more years of clinical experience (e.g., 22 years on average; Jensen-Doss et al., 2016). It is possible that those professional factors are not as important predictors of attitudes toward routine progress monitoring for a sample of culturally and ethnically diverse therapists relative to less diverse groups. In terms of how use of standardized assessments impacts attitudes toward routine progress monitoring, use of EBA *during* treatment was related to more favorable perceptions of routine progress monitoring in terms of lower perceived potential for harm. This suggests that therapists who are currently engaged in some progress monitoring to inform ongoing care decisions do not feel that this has introduced problems in care.

The most consistent findings pertained to therapists' perceptions of standardized assessment. Perhaps not surprisingly, therapists who perceived standardized assessment as practical (e.g., time efficient), perceived routine progress monitoring as more beneficial, and less harmful and burdensome. Second, those with more self-reported confidence in implementing standardized assessment perceived routine progress monitoring as less harmful. Third, therapists who perceived EBA to have clinical utility, also perceived routine progress monitoring as less burdensome. Together, these findings hold promise for effective change through therapist training geared towards building self-efficacy in standardized assessment by way of education, supported administration, and ongoing implementation. In particular, active learning training methods for therapists have proven to be an important vehicle for therapist behavior change (Beidas & Kendall, 2010; Cross, Matthieu, Cerel, & Knox, 2007; Herschell, C. B. McNeil, & D. W. McNeil, 2004). In addition to therapist training and supports, scale up efforts should include pragmatic methods that simplify and minimally disrupt therapist practice given the competing demands of community systems of care (Bickman et al., 2016; Boswell, Kraus, Miller, & Lambert, 2015). Perhaps most critical is the need for methods that ensure assessment data are provided to therapists and presented to clients in a useful way; that is, to drive clinical process, as opposed to fulfilling an administrative requirement. Research shows that community-based therapists who administer EBA to clients do not use results to inform treatment (Garland et al., 2003), which underscores the importance of appropriate framing for therapists.

The present study has some limitations that warrant consideration. First, the sample consisted of therapists from one county in California. Although Los Angeles County is a large and diverse area with both urban and more rural populations, these findings may not be representative of therapists in other California counties or regions of the United States. In addition, we included only therapists who identified with a non-US, non-Hispanic/Latinx White culture of origin, and as such our findings may not generalize to general population of therapists in the service context. Relatedly, therapist cultural identity may be a proxy for extraneous variables that might be most pronounced among diverse and/or therapists with a strong heritage cultural identity, such as vigilance about the cultural responsiveness of EBI or EBA. Qualitative studies are necessary to uncover clearer mechanistic relationships between therapist cultural identity and attitudes toward routine progress monitoring. Although several predictors of attitudes were identified across the three subscales of routine progress monitoring, variability in attitudes remained unexplained, suggesting additional predictors exist (e.g., organizational supports; Jensen-Doss, Hawley, Lopez, & Osterberg, 2009). It is important to note that therapists' attitudes toward routine progress monitoring and standardized assessment might vary based on the intervention or specific assessment tools introduced. Finally, measurement was limited to the survey administered in the larger study, which at times included only subscales of original measures. This was intended to reduce participant burden and to focus only on measurement relevant to the main study aims. As always, replication of the findings is needed with more comprehensive measures to support the interpretations presented here.

Conclusion

These findings provide useful information about predictors of attitudes toward routine progress monitoring within real-world EBI and EBA implementation contexts with a culturally- and ethnically-diverse workforce. Findings built upon previous work and indicated that, in addition to therapist educational level, therapist cultural identity was related to attitudes toward routine progress monitoring. Therapist attitudes toward standardized assessment were also linked to views of routine progress monitoring. Together, these findings suggest that therapists who identify more with an ethnic minority culture may need support to maximize the clinical utility of EBA through engagement strategies, involvement in instrument selection, and implementation support. There is a need for the development of culturally-responsive EBA processes and tools for use among culturally-diverse clients and therapists. To date, much of the work has focused on psychometrically-strong tools, with little to no attention to how these processes and tools might fit with the growing ethnically-diverse workforce and consumer base. It is critical that our findings be replicated, perhaps through the use of qualitative methods to understand the specific nature of concerns endorsed by diverse therapists. This information could better inform directions for improvement of measurement systems in children's mental health system to promote high quality services.

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Table 1:

Therapist Characteristics

Characteristic	Mean (SD) or %	N
Gender (Female)	86.5%	198
Race/Ethnicity		
Hispanic/Latinx	69.9%	160
African American	7.0%	16
API	18.8%	43
Multiracial	2.6%	6
Other	1.7%	4
Cultural Identity [a]		
U.S.	3.6(.53)	229
Culture of origin	3.6(.54)	229
Bilingual	83.0%	190
Education Level		
BA Degree	1.3%	3
Master's Degree	90.8%	208
Doctoral Degree	7.9%	18
Discipline		
Marriage and Family Therapy	54.6%	125
Social Work	35.8%	82
Psychology	8.7%	20
Other	0.9%	2
Orientation		
Cognitive/Behavioral	59.8%	137
Other	40.2%	92
Clinical Experience (years)	5.8(4.8)	229
Licensed	36.2%	83
Language Services Delivery		
English only	23.7%	54
Spanish	67.6%	154
Other	8.8%	20
Client caseload count	15.7(9.4)	229
Client Caseload Ethnic Composition % [c]		
Hispanic/Latinx	76.8(27.5)	229
Non-Hispanic/Latinx White	6.1 (10.5)	229
African American	11.4(19.0)	229
API	2.1(9.1)	229
Other	3.8 (15.4)	229
Use of standardized assessment in treatment		
At the beginning	38%	87
During	69.4%	159

Characteristic	Mean (SD) or %	N
At the end	32.3%	74
Perceptions of standardized assessment [b]		
Clinical Utility	3.3(.58)	229
Practicality	3.3(.69)	229
Confidence	4.0(.68)	229

Note.

[a] U.S. Cultural Identity and Culture of Original subscales range between 1 (strongly disagree) and 4 (strongly agree)

[b] Clinical Utility, Practicality, and Confidence subscales range between 1 (strongly disagree) and 5 (strongly agree)

[c] Multicultural % = 0

Table 2:

Summary of Hierarchical Regression Analysis for Variables Predicting Therapist Perception on Routine Progress Monitoring (n=229)

	Benefit						Harm						Burden					
	Step 1			Step 2			Step 1			Step 2			Step 1			Step 2		
Parameter	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***
Sociodemographic																		
Female	.03	.10	.02	.03	.10	.02	.15	.16	.06	.14	.14	.06	.09	.16	.04	.17	.13	.07
Race/ethnicity [a]																		
Other Minority	.04	.07	.04	.07	.07	.06	.11	.11	.07	.03	.11	.02	.09	.11	.05	.07	.10	.04
Cultural identity [b]																		
U.S.	.09	.07	.10	.06	.07	.07	−.06	.11	−.04	.01	.10	.007	−.19	.11	−.13	−.07	.09	−.05
Culture of origin	.05	.07	.05	.04	.07	.04	.33	.11	**.23****	.32	.10	**.22****	.08	.11	.05	.11	.09	.08
Professional																		
Education level [c]																		
BA	.02	.57	.003	−.01	.56	−.003	1.81	.89	**.26***	1.54	.83	.22	1.18	.89	.17	.51	.74	.07
Doctorate	.20	.30	.11	.25	.30	.14	−0.32	.48	−.11	−.44	.45	−.15	.12	.48	.04	−.19	.40	−.07
Licensed	−.07	.08	−.07	−.10	.08	−.10	−.13	.13	−.08	−.08	.12	−.05	.006	.13	.004	.02	.11	.01
Discipline [d]																		
Psychology	−.06	.30	−.04	−.12	.29	−.07	−.24	.47	−.09	−.02	.43	−.008	−.52	.47	−.19	−.15	.39	−.05
Social work	−.02	.07	−.02	−.03	.07	−.03	−.08	.11	−.05	−.10	.11	−.06	−.11	.11	−.07	.05	.10	.03
Other	.06	.67	.01	.09	.66	.02	−2.06	1.05	−.25	−1.97	.98	−.23	−.12	1.06	−.01	.74	.88	.09
Cognitive/Behavioral [e]	.13	.07	.13	.10	.07	.10	−.01	.10	−.006	.07	.10	.05	−.08	.10	−.05	−.04	.09	−.03
Years as practicing therapist	.005	.008	.05	.002	.008	.02	−.01	.01	−.07	−.002	.01	−.009	−.02	.01	−.13	−.01	.01	−.08
Client caseload count	.001	.004	.01	.001	.004	.03	.001	.006	.02	−.001	.006	−.007	.006	.006	.07	−.004	.005	−.05
Use of standardized assessment in treatment																		
At the beginning [f]	---	---	---	−.13	.10	−.13	---	---	---	−.04	.14	−.03	---	---	---	−0.18	0.13	−0.11
During [g]	---	---	---	−.006	.07	−.006	---	---	---	−.23	.11	**−.13***	---	---	---	−0.03	0.10	−0.02
At the end [f]	---	---	---	.000	.10	.000	---	---	---	−.16	.15	−.10	---	---	---	0.26	0.13	0.15

	Benefit						Harm						Burden					
	Step 1			Step 2			Step 1			Step 2			Step 1			Step 2		
Parameter	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***	***b***	***SE b***	***β***
Perceptions of standardized assessment in treatment [h]																		
Clinical utility	---	---	---	−.08	.08	−.10	---	---	---	.10	.12	.07	---	---	---	−0.22	0.10	**−0.17***
Practicality	---	---	---	.17	.07	**.24***	---	---	---	−.36	.10	**−.32*****	---	---	---	−0.54	0.09	**−0.48*****
Confidence	---	---	---	.07	.06	.10	---	---	---	−.31	.08	**−.27*****	---	---	---	0.14	0.07	0.12
R^2		.05			.13			.12			.28			.09			.41	
ΔR^2		.05			.08			.12			.16			.09			.32	
ΔF		.09			**3.14****			**2.31****			**7.73*****			1.63			**18.62*****	

Note.

*p <.05

**p <.01

***p <.001

[a]Hispanic/Latinx is the REF

[b]U.S. Cultural Identity and Culture of Original subscales range between 1 (strongly disagree) and 4 (strongly agree)

[c]Master's Degree is the REF

[d]MFT is the REF

[e]Other orientations are the REF=Humanistic, Family Systems, Psychodynamic and Eclectic

[f]Therapist use with few or no clients is the REF

[g]Therapist use with no clients is the REF

[h]Clinical Utility, Practicality, and Confidence subscales range between 1 (strongly disagree) and 5 (strongly agree)