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THERAPEUTIC ALLIANCE AND TREATMENT OUTCOMES IN CLIENTS OF COLOR AT A UNIVERSITY-BASED TRAINING CLINIC

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THERAPEUTIC ALLIANCE AND TREATMENT OUTCOMES IN CLIENTS OF COLOR AT A UNIVERSITY-BASED TRAINING CLINIC

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ABSTRACT

THERAPEUTIC ALLIANCE AND TREATMENT OUTCOMES IN CLIENTS OF COLOR AT A UNIVERSITY-BASED TRAINING CLINIC

Aimée Baez

This study examined the differences between diverse and Caucasian clients in their ratings of the therapeutic alliance and therapeutic outcomes. Data were collected from 166 participants from a University-Based training clinic in a metropolitan section in the northeastern, United States. Multiple regression analyses were used to test the relationship between ethnicity and the therapeutic alliance. Treatment outcomes included session frequency, working alliance, motivation to change in treatment, and overall quality of life. Results showed that ethnicity is positively related to working alliance, quality of life, and client's motivation to treatment. In some cases, ethnicity was confounded by age and/or gender when considering the predictors of the motivation to change, quality of life and working alliance. Theoretical and practical implications are discussed.

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Introduction

Statement of the Problem

In the United States mental health disorders are one of the leading causes of disabilities, surpassing Cardiovascular and Circulatory Diseases (World Health Organization, 2010). One in every five adults, over the age of 18 years, has a diagnosed mental health disorder (SAMHSA, 2017). This is of particular importance as the United States population is becoming increasingly diverse (U.S. Census, 2015). Data demonstrate that 19% of Caucasians experienced a mental illness in the past year when compared to 16.8% of African Americans, 22.7% of Native Americans, 13.4 of Asian Americans, and 15.3 % of Latinos (SAMHSA, 2015). While these statistics show some slight differences between racial/ethnic groups, the fact is that people of color experience mental illnesses that may be long lasting (SAMHSA, 2015). For the purposes of this study, "people of color" will be defined as racial and ethnic minorities that include Black, African Americans, Latinos, Native Americans, Asian Americans, Pacific Islanders, Middle Eastern Americans, and Multiracial Americans.

Despite a similar existence of mental health disorders across racial backgrounds, unlike Caucasians, people of color are less likely to seek and persist with mental health care. It is likely that the history of racial and ethnic disparities in mental health services has negatively impacted communities of color, including African-Americans, Latinos, Native Americans, and Asian Americans. These disparities show that people of color are less likely to have access to mental health care (Office of the Surgeon General, 2001). Although more people of color are now seeking mental health services, they are still not seeking the

services at the same rate as Caucasian clients (Fortuna et al., 2010). Evidence also suggests that people of color are less likely to receive quality care (Office of the Surgeon General, 2001). As reported in numerous studies, African Americans are less likely to receive adequate services when compared to Caucasian clients (Fortuna et al., 2010). Although it is the ethical responsibility of the mental health service providers to adequately care for all their clients, regardless of their ethnic background, these disparities persist (Fortuna et al., 2010).

Mental health service utilization is still the highest amongst Caucasian individuals despite gender, age, and socio-economic status (SAMHSA, 2015). Caucasian male and female adults, regardless of socio-economic status, are more likely to utilize mental health services when compared to African American, Latino, and Asian American regardless of socio-economic status (SAMHSA, 2015).

There are many issues that arise regarding the utilization of psychotherapy among clients of color. Even though people of color disproportionately experience mental illnesses, they attend therapy at a lower frequency. This is problematic since we know that for therapy to work, regular attendance is necessary. Data suggest that people of color seek therapy at a significantly lower rate, and terminate therapy at a higher rate than Caucasian clients (U.S. Department of Health and Human Services, 2001, Fortuna, 2010).

Numerous studies have confirmed that the therapeutic alliance is linked to treatment outcomes in both adults and youth in therapy (Ardito & Rabellino, 2011). Another factor that relates to negative treatment outcomes among African American, Latino and Asian-American clients are their negative reports of their mental health providers (Zane et al., 1994). It has been hypothesized that clients of color may be experiencing issues with the

establishment of the therapeutic alliance such as ruptures in the relationship with their therapist. This disruption might then lead to poorer treatment outcomes, dissatisfaction with treatment and the potential for cultural mistrusts and misunderstandings (American Psychological Association, 2003).

It is crucial to understand the reasons as to why clients of color underutilize and have greater dissatisfaction with mental health treatment. One way to potentially answer this longstanding question is to further investigate the hypothesis regarding the establishment of the therapeutic relationship between the clients of color and the therapist. The therapeutic alliance, defined as a "cooperative working relationship between client and therapist" (American Psychological Association, 2020), has been shown to influence treatment outcomes regardless of the orientation of therapy (Wampold & Imel, 2015, Warwar & Greenberg, 2000, Horvath & Luborsky, 1993).

Scientific research in psychology has become increasingly more inclusive; however, the need to study the experiences of people of color is still present. Not many studies have considered the experiences of clients of color in therapy and throughout the therapeutic relationship (Kim et al., 2005). There is a need for research in this area, so that solutions aimed at increasing the rate at which clients of color seek out mental health services, persist in therapy, and report successful treatment outcomes. Specifically, since the power of the therapeutic relationship has been demonstrated in the literature repeatedly, this research should be targeted towards understanding and improving the therapeutic relationship when working with clients of color (Kim et al., 2005). Although there exist difficulties in studying the topic of therapeutic alliance, it is still of grave importance to study the therapeutic alliance between client-therapist, particularly for clients of color

given the multitude of issues that arise with the utilization of psychotherapy (Horvath & Luborsky, 1993) .

The present study aims to investigate the impact of the therapeutic alliance on the outcome of treatment for clients of color when compared to their Caucasian counterparts. This study will also examine the demographic differences among clients in therapy and the differential factors in the development of the therapeutic alliance between clients of color and their therapists in comparison to Caucasian clients within an outpatient population from a University-based training clinic in a major metropolitan area. In next chapter, a review of the literature that considers the impact of the therapeutic alliance in regard to the treatment outcomes among clients of color will be provided.

Chapter 2

Literature Review

The Therapeutic Alliance

History of the Therapeutic Alliance. The study of the therapeutic alliance can be traced back to the days when Sigmund Freud introduced the concept of transference (Ardito & Rabellino, 2011). Later, Rogers defined the essentials of client-centered therapy around the strong foundation of the therapeutic relationship that included empathy, congruence, and unconditional positive regard (Ardito & Rabellino, 2011). While many therapies highlighted the gravity of the therapeutic relationship, Luborsky was one of the first to present a theoretical framework (Ardito & Rabellino, 2011). In Lubrosky's framework of 1976, he defined the therapeutic alliance as something more fluid and dynamic, as opposed to stagnant. In his description, the alliance could be seen as supportive, early on in therapy and collaborative, later on in the therapy. Similarly, another theorist, Bordin, defined the alliance as collaborative and structured mostly around alignment on therapeutic goals (Ardito & Rabellino, 2011).

The Phases of Therapeutic Alliance. There are some misconceptions in regard to the manner in which the alliance between clients and therapists should proceed (Safran et al., 1990). According to Safran and colleagues (1990), the therapeutic relationship is not linear and should not be measured in such a manner. Instead, Safran and collogues suggest that the relationship be measured during points of rupture; are the therapist and the client able to overcome ruptures and move forward? Typically, successful transitions lead to more positive therapeutic alliances (Safran et al., 1990). Further, the strong alliances at the

beginning and end phases of treatment are the best predictors of positive therapeutic outcomes (Horvath & Symonds, 1991).

Therapeutic Modalities. Research has not demonstrated that there are significant differences in the role that the therapeutic alliance plays in relation to various therapeutic modalities (Ardito & Rabellino, 2011). One study found that the alliance was rated significantly higher by clients involved in cognitive-behavioral therapies as opposed to psychodynamically oriented therapies (Ardito & Rabellino, 2011). While there is agreement that the therapist-client alliance is pivotal in varying therapeutic modalities, the framework where it lives can differ. The nuances that exist between frameworks are considered, as they can affect the outcome of therapy (Shirk & Russell, 1996). On one hand, non-behavioral therapies consider the therapeutic alliance as part of the change mechanism or process (Shirk & Russell, 1996). On the other hand, behavioral therapies emphasize the role of the therapist-client alliance within the motivation and collaboration of treatment (Shirk & Russell, 1996). These slight but significant nuances can lead to differences within the role that the alliance plays in treatment and potentially impact treatment outcomes.

Not surprisingly, there exist varying viewpoints about the exact role of the therapeutic alliance in psychotherapy. Some researchers argue that the alliance is somewhat valuable, but not necessary for creating a positive therapeutic outcome (Huppert et al., 2006). This argument stands on the premise that a strong clinical orientation has a stronger impact on the alliance (Huppert et al., 2006). The rationale behind this hypothesis is that the relationship between client-therapist will continue to strengthen as a byproduct

of the strong treatment technique (Huppert et al., 2006). This hypothesis introduces the notion that the relationship is a result of strong treatment as opposed to being more of a factor or target in therapy (Huppert et al., 2006).

Therapeutic Alliance & Treatment Outcomes. Research has shown that the therapeutic alliance is considered a positive predictor of outcomes for therapy (Horvath & Bedi, 2002). Research has shown a moderate relationship between satisfactory therapeutic alliance and positive therapeutic outcome (Horvath & Symonds, 1991). In fact, the quality of the therapeutic alliance is more of a predictor of the outcomes in psychotherapy than other factors (Martin et al., 2000). It is considered an independent predictor despite the type of psychotherapy (Norcross, 2002). Others have found similar results, as the therapeutic alliance was more of a predictor of positive outcomes than the intervention (Martin et al., 2000). Often the rating of the relationship amongst the therapist and client will differ (Castonguay et al., 2006). The client's perception of the relationship more accurately represents the direction in which the outcome of the therapy is headed (Castonguay et al., 2006).

The Measurement of the Therapeutic Alliance. Work is still being conducted toward accurately defining the therapeutic alliance between client and therapist. Research often collects information from both the process and the outcome of psychotherapy. There are important nuances to distinguish here as they look at different stages in the treatment process. Outcome research considers the final result of the therapy for the client, and process research considers the progress made throughout the therapeutic process. Both outcome and process research data are important to consider, as they relate to the overall outcome of therapy and can provide insight about the development and impact of the

therapeutic relationship. Unfortunately, these terms are often used interchangeably in the literature. It would be helpful to parse apart the distinctions when considering the therapeutic relationship between client and therapist during the treatment process versus at the final stages of treatment. This information can be particularly useful to consider during times of alliance ruptures (Ardito & Rabellino, 2011).

Research aimed at analyzing the factors that contribute to the development of an adequate therapeutic alliance is still underway. There has been progress in the creation of measures that purport to provide an understanding of the alliance from various viewpoints/perspectives (e.g. client, therapist, observer). Research with varying analytic approaches allow for the collection of multiple pieces of information. Single-case studies, meta-analysis, and in some cases even longitudinal studies have been conducted to attempt to identify the factors that accurately represent and capture the therapeutic alliance. A vast number of scales and instruments have been created to measure the therapeutic alliance (Ardito & Rabellino, 2011).

Moreover, many of the instruments are proven to be strong predictors of the alliance (Fenton et al., 2001). One study analyzed the effectiveness of six instruments (the California Psychotherapy Alliance Scale (CALPAS), Penn Helping Alliance Scales (PHAS), the Vanderbilt Alliance Scale (VTAS), Working Alliance Inventory- Observer Form (WAI-O), Working Alliance Inventory- Client Form, Working Alliance Inventory- Therapist Form) used to measure the therapeutic alliance. All six instruments were found to be strong predictors of the relationship and as equally effective (Fenton et al., 2001). Scales of this nature also hold good generalization between each measure, as they appear to measure the same factors and produce similar results (Martin et al., 2000). While the

scales measure similar factors, they are constructed differently. Some scales measure multiple perspectives, while others are limited to one; some are shorter in nature, while others appear to be rather lengthy (Martin et al., 2000). The most widely utilized therapeutic alliance scales for individual therapy are the WAI, CALPAS, PHAS, VTAS, the Toronto Scales (TARS), and the Therapeutic Bond Scales (TBS) (Martin et al., 2000).

Predictors of the Therapeutic Alliance

Since the therapeutic alliance is linked to treatment outcomes, we want to consider the predictors related to the therapeutic alliance. In understanding these predictors, we can better control for a positive outcome.

Racial/Ethnic Background of the Client and Therapist. Research suggests that matching the racial background of the client and the therapist does not yield a strong positive relationship to clinical outcomes (Meyer & Zane, 2013). Another study found similar findings and reported that the racial match of the client and therapist was unrelated to treatment outcomes (Meyer & Zane, 2013). Not surprisingly, others have noted that there are no differences in the measurement of treatment outcomes when clients share the same racial/ethnic background as their therapist (Cabral & Smith, 2011). In fact, authors explain that there is often a misconception that a shared racial match means similar worldviews. Nonetheless, clients do report a preference in working with therapists of their own race/ethnicity and generally view this experience as positive (Meyer & Zane, 2013). Factors that have been shown to impact the effects of racial matching are age, gender, and level of education (Cabral & Smith, 2011).

***Demographic Attributes*.** The establishment of trust and credibility seems to drive the interpersonal relationship between client and therapist. Demographic factors such as

age, gender, and socioeconomic status may impact the client's notion of trust in their therapist, which then may affect the development of the alliance. Early on in therapy, the client is more reliant on overt demographic characteristics when others might not be apparent. Overall, findings indicate that gender, age, and income do not have a significant impact on the therapeutic alliance (Behn et al., 2018).

Gender. The findings on the impact of gender matching in the client and therapist relationship on treatment outcomes is mixed. Overall, it seems that gender matching may positively impact the therapeutic alliance at the beginning of therapy. This can lead to varied findings depending on when measurement of the therapeutic alliance between therapist and client occurs (Behn et al., 2018). Interestingly, one study found that a female therapist tends to receive more positive ratings for working alliance and empathetic resonance. This point aligns with other research that supports the notion that female therapist build stronger therapeutic alliances (Bhati, 2014).

Age. There is not sufficient research pertaining to age and therapeutic alliance, as it is still a developing field. There is no reported significant association between age matching and therapeutic alliance. However, same aged groups provide an additional growth in the alliance, particularly during the initial sessions and decrease after each session (Behn et al., 2018).

Income. Unlike other variables, not much research has focused on the socioeconomic status of the client and therapist. This is an important variable to consider as individuals from low-income communities are highly affected by mental health disorders (Behn et al., 2018).

The Importance of Cultural Competence For the Therapist

The client's perception of the therapeutic relationship carries the most weight, as this factor has been found to be cor 10 l with positive treatment outcomes (Horvath & Bedi, 2002). The cultural competence of a therapist impacts the therapeutic relationship when working with clients of color (Constantine, 2002). The therapist's cultural competence trumps other important factors, such as general competence, expertness, trustworthiness (Constantine, 2002). Culturally insensitive therapists have been found to negatively impact the experience of clients of color (Sue et al., 2007).

A therapist has to do the work to be able to understand culturally diverse individuals (APA, 2003). The therapeutic alliance is fostered through the work a therapist does toward understanding their client's perspective (APA, 2003). There are evidence-based approaches and practices that positively influence the therapeutic alliance. Two researchers found that specific techniques, such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience and personal attributes, such as flexible, honest, respectful, trustworthy, confident, warm, interested, and open positively influence the therapeutic alliance regardless of the therapist's orientation (Ackerman & Hilsenroth, 2003).

There is not a one size fits all model or framework. It is of the utmost importance to individualize techniques and practices upon work with culturally diverse individuals (Comas-Diaz, 2006). This requires consistent reflection and growth on the therapist's part to remain aware of their own bias and limitations of practice (Comas-Diaz, 2006). Proven frameworks exist which allow the therapist to do the internal work and provide them with an exemplar model of effective culturally responsive pedagogy. One framework can be

referred to in the multicultural guidelines set forth by the APA from their 2003 model which emphasizes the role of the therapist in understanding of individuals' diversity and values (APA, 2003). This particular framework also encourages the therapist to spend time understanding the intersectionality of the client's multiple identities (APA, 2003). Another framework is Sue's model from 2003 which emphasizes the role of the therapist in acknowledging that racism exists (Sue & Sue, 2003). Their model is built on a nonracist stance where everyone (no matter what your racial or ethnic background) must actively fight against racism and oppression (Sue & Sue, 2003).

The therapist is advised to address culturally specific issues in therapy to build alliance and effectively treat their client. This includes the discussion of racism and oppression in sessions when treating clients of color. In addition to teaching clients strategies on how to deal with racial stress management. Being aware of the systematic oppression in society and addressing this in session builds a relationship on trust and empathy, while strengthening the alliance (Comas-Diaz, 2006).

Premature Termination

A weak therapeutic alliance appears to be a reliable predictor of premature termination (Andersen et al., 2019). This is consistent with findings that there exists a moderately strong relationship between psychotherapy dropout and therapeutic alliance (Sharf et al., 2010). The relationship between the therapeutic alliance and premature termination appears to be stronger than client demographic variables (Sharf et al., 2010). Nonetheless, it is important to pay attention to some of the other demographic variables. While the racial matching of the client and therapist is unrelated to treatment outcomes, it

still plays an important role. Some research suggests that clients are more likely to drop out of therapy and attend fewer sessions with a therapist who does not share their racial or ethnic background (Sue et al., 1995). This is of much importance considering that the number of treatment sessions is associated with treatment outcomes (Cabral & Smith, 2011). Other researchers indicate that there are mixed findings presented in the literature and that some studies have not found an effect of racial/ethnic matching on premature termination (Sharf et al., 2010).

The length of treatment is also an important variable in treatment outcomes. Longer treatments led to stronger associations between alliance and dropouts (Sharf et al., 2010). While the therapeutic alliance and premature termination do show a relationship across various outpatient settings, an outpatient clinic showed a stronger effect when compared to a counseling center. Certain factors may contribute to greater premature termination, although little is known about the effect size. These factors include low education, low socioeconomic status, and being a person of color. Opposing information is presented regarding gender, as some studies report that men are more likely to drop out of therapy prematurely, while others report that women are more likely to drop out. Age can also be considered a factor, as younger clients are more likely to drop out prematurely (Anderson et al., 2019).

There is a lack of information available regarding premature termination and the reasons as to why clients drop out of therapy. Few studies have examined the reasons as to why clients terminate services early, possibly due to the difficulties associated with contacting clients after they have terminated therapy. Nonetheless, the client's perspective is valuable and considered more accurate. 30-35% of clients report terminating services

early because of dissatisfaction. No further elaboration is provided in regard to what entails the clients' dissatisfaction (Anderson et al., 2019).

Conclusion

In conclusion, there is clear evidence calling for the study of the client-therapist relationship as it is a good predictor of outcomes in therapy. While we have made many gains in this area, there is still much that is unknown. One consistent limitation throughout the literature is that the quality of the therapeutic relationship is typically measured in a subjective way. We have begun to tease apart the factors that contribute to the alliance, but much is still unknown. We do know that establishing an alliance between a therapist and a client of color requires some cultural awareness and work on the therapist's part. Understanding the therapeutic alliance is a relatively new topic, but so far, the information we have points us in the same direction: the alliance between client-therapist is important no matter who you are, how old you are, or where you come from.

Chapter 3

Research Questions

The present study will explore variables that may contribute to differences in the reported development of the therapeutic alliance and treatment outcomes among clients of color. The study will attempt to explore differences between racial/ethnic groups in their ratings of the therapeutic alliance and therapeutic outcomes. Based on the examination of the related literature, the following hypotheses are proposed:

1) Ultimately, in comparison to Caucasian clients, clients of color will attend fewer sessions and will report a higher occurrence of a poor therapeutic alliance and a greater dissatisfaction with treatment.

2) Caucasian clients will persist in therapy longer than clients of color.

3) Caucasian clients will report stronger therapeutic alliances.

4) Caucasian clients will have better outcomes.

Chapter 4

Proposed Methods

Location

Data from a University-Based training clinic that is located in a metropolitan setting in the north-eastern United States was utilized for this study. This clinic was established to provide psychological services to the highly diverse community that surrounds the University. The clinic allows for approximately 80 students enrolled in the doctor of philosophy clinical psychology program, and the doctor of psychology school psychology program to provide short-term therapeutic services (among other services) centered around a Cognitive-Behavioral framework to adults under the supervision of licensed psychologist supervisors. These services are offered to the community and range from low to moderate costs via a sliding scale basis.

Sample

The sample consisted of adult clients who sought individual therapy at the clinic. Informed consent for research purposes was obtained from adult participants at the onset of therapy services as per the clinic's already established research agreement with all clientele. Since this is an archival study, no interactions took place with live participants. Participant names were removed from the data set to ensure confidentiality, and client data were identified by client IDs.

Procedure

Data were collected from the initial consultation through the discharge of services was analyzed. Ongoing client ratings of treatment outcomes focused on symptoms distress and

therapeutic alliance was analyzed. Client data will include demographic information such as race/ethnicity, gender, age, education level, and socioeconomic status.

Measures

Treatment Outcomes. Treatment outcomes information was obtained from the clinic's intake data collection and from a Working Alliance and a Motivation scale. The intake information focused on demographic criteria such as ID number, ethnic background, and age. The Working Alliance and Motivation scales are utilized as ongoing measurements of client progress and the therapeutic relationship throughout the therapy process. The collection of measures are shortened versions of various scales that demonstrate strong reliability and validity including: the Ten Item Personality Inventory (TIPI; Gosling, Rentfrow, & Swann, 2003), a measure that is based on the Big Five personality traits (McCrae & Costa, 1997), State Hope Scale (Snyder et al., 1996), Gratitude Questionnaire (McCullough, Emmons, & Tsang, 2002), Quality of Life assessment (World Health Organization, 1996), Session Rating Scale (Duncan et al., 2003), Client Motivation for Therapy Scale (Pelletier et al., 1997). The internal consistency reliability was estimated from our sample for each subscale: Quality of Life (α=.85), Working Alliance (α=.95), and Motivation (α=.45).

In the present study, we analyzed the client's total scores on items such as motivation for treatment, quality of life, and working alliance. The Motivation scale considers the client's commitment to therapy and their understanding of what they are getting out of therapy. The Working Alliance scale focuses on the client feeling supported in therapy by the therapist, and reporting a good match between client and therapist. The

Quality of Life scale focuses on the client's satisfaction with their life, physical appearance, and interpersonal relationships.

Therapeutic Alliance. The client's therapeutic alliance was measured by an ongoing self-report from the BIL (adult assessment) assessment. The particular questions will assess the client's perception of their relationship with their therapist, relating to feeling heard, valued, motivated, successful and clear on therapeutic gains. The measure focuses on questions, such as: "I feel heard and understood in my therapy sessions, "My therapist's approach is a good fit for me."

Potential Significance of The Findings

The study aimed to make significant contributions to the understanding of the therapeutic alliance on treatment outcomes for clients of color. The study sought to provide needed information to mental health practioners on the main factors that impact the relationship between client and therapist. Ideally, this will draw conclusions as to how to best care for clients of color in the field of mental health services, in addition to providing us with ideas for further research.

Chapter 5

Results

The present study considered the influence of the therapeutic alliance on treatment outcomes and its relation to demographic factors, such as ethnic background. It was predicted that measurement of poorer therapeutic alliance would be associated with lower levels of session rate and treatment outcomes. Multiple regression analyses were used to test the relationship between length of services, client's ethnic background, age, and gender. It was predicted that there would be a relationship between the therapeutic alliance and treatment outcomes that include: session frequency, motivation to change in treatment, and overall quality of life. Furthermore, we predicted that certain variables would impact the treatment outcomes of clients of color in comparison to Caucasian clients.

Demographics

A total of 166 participants were included in this study. Sixty-two participants, who had a significant amount of missing data, were removed including those that did not identify their ethnicity. The average age of participants that were included in the study was 35.31 (SD = 14.25). The youngest participant was 18 years old and the oldest participant was 88 years old, indicating a range of 70 years. The majority of participants were female (68%; male, 32%). The ethnic breakdown of the participants included: 74 (44%) Caucasian, 34 (21%) Hispanic or Latino, 16 (10%) Black or African-American, 18 (11 %) Asian, 8 (5%) Mixed or Multiracial, and 16 (10%) Other. Overall, the participants in the study were majorly Caucasian, females, with an average of 35 years old. There was a strong representation of

clients of color, as they accounted for 42% out of the total number of participants, inclusive of Hispanic/Latino, Black, and Asian.

Table 1

Demographic, Clinical, and Baseline Characteristics of Client Participants

Demographic Characteristics	Total Number of Participants/Percentages
Total	166
Male	53 (32%)
Female	113 (68%)
Age- Youngest	18
Age-Oldest	88
Age-Average	35
Ethnicity- Caucasian	74 (44%)
Ethnicity- Hispanic or Latino	34 (21%)
Ethnicity- Black or African American	16 (10%)
Ethnicity- Asian	18 (11%)
Ethnicity- Mixed	8 (5%)
Ethnicity- Other	16 (10%)

Hypothesis #1: Caucasian clients will persist in therapy longer than clients of color.

While there were no set number of sessions required for each client, we utilized a mean score of sessions attended as a comparison factor. This was derived by averaging the number of sessions attended by the participants between March 2013 and September 2021. The average number of attended sessions was 10.53 (SD = 12.19). The smallest number of sessions attended was 1, and the highest number of sessions attended was 69. It was important to consider the therapeutic alliance and its impact on ethnicity.

A One-way ANOVA revealed no statistically significant differences between session frequency and the ethnicities of the participants [F (5, 155) = 1.831, p = .110]. Therefore,

the hypothesis that Caucasian clients will persist in therapy longer than clients of color was rejected.

Table 2
Session Frequency

Session Demographic	Fact
Earliest Session Date	March 2013
Last Session Date	September 2021
Average Number of Sessions	10.53
Standard Deviation Number of Sessions	12.19
Lowest Number of Sessions in Attendance	1
Highest Number of Sessions in Attendance	69

Hypothesis #2: Caucasian clients will report stronger therapeutic alliances.

A one-way ANOVA shows that there is a statistically significant difference between working alliance and ethnicity [$F (5, 2185) = 8.648$, $p < .001$]. Upon further analysis from Tukey's HSD Test, there was a statistically significant difference between Caucasian participants and Hispanic/Latino [$p = .007$] and between Caucasian and Asian American participants [$p < .001$]. Caucasian clients report a stronger working alliance than Hispanic or Latino clients. Caucasian clients also report a stronger working alliance than Asian American clients. No statistically significant difference was found between Caucasians and African Americans [$p = .964$], Caucasians and Multiracial participants [$p = .677$], and

Caucasians and Others [p = .291]. The hypothesis that Caucasian clients will report stronger working alliance in comparison to Latinos and Asian Americans is supported.

When controlling for age, gender, and ethnicity, it was found that these factors predict working alliance. The overall regression model (MANOVA) was significant, [F (3, 2157) = 19.181, p < .001, R2 = 0.26]. All three predictors explained a significant amount of the unique variance in working alliance (Age, p < .001; Gender, p < .000; Ethnicity, p = .002). This tells us that the hypothesis is supported and thus, age, gender, and ethnicity can be considered predictors of the working alliance between client and therapist.

Hypothesis #3: Caucasian clients will have better outcomes as defined by quality of life.

A one-way ANOVA demonstrates that there is a statistically significant difference between quality of life and ethnicity [F (5, 2353), p < .001]. This significant difference exists between Caucasian and Hispanic or Latino individuals [p < .001] and between Caucasian and Mixed or Multiracial individuals [p = .039]. Hispanic or Latino individuals report a better quality of life outcomes than Caucasian clients. Mixed or Multiracial individuals report a better quality of life outcomes than Caucasian clients. The hypothesis that there is a statistical difference between quality of life and ethnicity is supported, as Latinos and Mixed individuals report a better quality of life.

A multiple analysis of variance model (MANOVA) was significant, [F (3, 2315) = 20.8, p < .001, R^2 = 0.26]. When looking at factors such as age, gender, and ethnicity of the client within a group, these factors predict quality of life significantly. Age did not explain a significant amount of unique variance in quality of life (p = .408) and neither did the ethnicity of the client (p =.966). However, the gender of the client did explain a significant

amount of the unique variance in quality of life ($p < .001$); thus, in this case the hypothesis is supported. The gender of the client is related to quality of life. Ethnicity appears to be confounded with gender, as a factor that predicts motivation to therapy.

Hypothesis 4: In comparison to Caucasian clients, clients of color will attend fewer sessions and will report a higher occurrence of a poor therapeutic alliance and will have less motivation to attend therapy.

A one-way ANOVA displayed a statistically significant difference between client's motivation in regard to treatment and ethnicity [$F (5, 2347)$, $p < .001$]. In comparing Caucasian and Asian American clients, there is a statistically significant difference ($p < .001$). Asian American clients demonstrate greater motivation to attend therapy sessions when compared to Caucasian clients. Other ethnic groups did not display a statistically significant difference [Latinos, $p \geq 1.00$; African Americans, $p = .255$; Multiracial, $p = .991$; Other, $p \geq 1.00$]. Asian American clients demonstrate a greater motivation to attend therapy in comparison to Caucasian clients.

When controlling for age, gender, and ethnicity, these factors predict motivation to therapy. The overall regression model (MANOVA) was significant, [$F (3, 2310) = 32.87$, $p < .001$, $R2 = .041$]. Specifically, age and ethnicity did not explain a significant amount of the unique variance in motivation to attend therapy (Age, $p = .088$; Ethnicity, $p = .227$). Gender does predict a significant amount of the unique variance in motivation to attend therapy ($p < .001$). Gender serves as a predictor of motivation to therapy, while age and ethnicity do not serve as predictors. Ethnicity appears to be confounded with gender, as a factor that predicts motivation to therapy.

Table 3- Multiple Regression Linear Model
Working Alliance

R Square	Standard Error of Estimate	F	Sig.
0.26	.81223	19.181	.000

Variable	Beta	t	Sig.
Age	-.109	-.4.957	.000
Gender	.093	4.271	.000
Ethnicity	-.067	-3.127	.002

Table 4- Multiple Regression Linear Model

Quality of Life

R Square	Standard Error of Estimate	F	Sig.
0.26	1.11	20.803	.000

Variable	Beta	t	Sig.
Age	-.018	-.827	.408
Gender	.157	7.453	.000
Ethnicity	.001	0.42	.966

Table 5- Multiple Regression Linear Model

Motivation

R Square	Standard Error of Estimate	F	Sig.
0.41	.88789	32.872	.000

Variable	Beta	t	Sig.
Age	-.036	-1.705	.088
Gender	.187	8.904	.000
Ethnicity	.025	1.209	.227

Chapter 6

Discussion

This study made an attempt to evaluate the therapeutic alliance and its impact on therapeutic outcomes for people of color. Variables that were believed to be correlated with the therapeutic alliance were considered.

Session Frequency. We considered if there is a difference between session frequency and the clients' ethnic background. Data suggest that clients who attended sessions more frequently had faster and greater outcomes (Erekson et al., 2015). We found no difference between the frequency of sessions and ethnic backgrounds within this dataset. This leads us to believe that all ethnic groups are attending therapeutic sessions at the same rate within setting utilized for this study. Clients of color are attending therapeutic sessions at the same rate as Caucasian individuals. Contrary to the proposed hypothesis, racial and ethnic groups attended sessions at the same frequency.

Previous research suggests that Clients of Color discontinue mental health services more frequently and earlier in treatment when compared to Caucasian clients (Smith & Trimble, 2016). While there was no significant difference between session frequency and the clients' ethnic background in this study, it is important to consider the context of treatment within this study. The site of this study provides affordable care that is based on the client's income, and thus, could be a potential factor as to why clients continue with services. It provides accessibility to clients of various income levels, including clients from low- income backgrounds. Another factor that is important to consider is that the analyses conducted considered an average rate of sessions. For further considerations, one should

examine if there is an effect on attendance rate and clients' ethnic background with less than or more than ten sessions (given that ten sessions were the average rate).

Motivation to Treatment. When we discuss motivation to therapy, we consider the clients' motivation for the particular session, the clients' motivation to their own therapy, and the clients' understanding of what they are getting out of therapy. When controlling for ethnicity, gender does display a statistically significant effect on motivation to therapy. Thus, ethnicity is confounded with gender. Asian American clients demonstrate greater motivation to attend therapy sessions when compared to Caucasian clients. Results did not show the same statistical significance for other ethnic backgrounds of clients, suggesting that African American, Latino/Hispanic, and Multiracial clients attended therapy at the same rate as Caucasian clients. This study considers a specific Asian American population that came in for therapy. Research focuses largely on the general Asian American population and shows that Asian Americans are three times less likely to seek mental health services than Caucasians (Spencer et al., 2010). Often Asian Americans seek support from personal networks such as close friends, family, and the religious community largely due to the stigma related to mental health services. Other factors that impede Asian Americans from seeking mental health services is due to the lack of awareness and resources, in addition to a lack of bilingual mental health services.

Therapeutic Alliance. In an analysis, we found significant group differences in therapeutic alliance. Working alliance considers factors such as the client feeling heard, understood, and respected in sessions, talking about what the client wants, the client feeling that the therapist's approach is a good fit for them, and feeling that the sessions are going well. The working alliance mean was stronger for Caucasian clients than Hispanic or

Latino clients. The working alliance mean was also stronger for Caucasian clients than Asian American clients. For this particular study, Caucasian clients reported feeling more heard and respected in sessions and feel that the therapist is a good fit for them. No significant differences were found among other ethnic groups, such as African-Americans and Multiracial individuals. This information calls for further studies on the potential factors that can contribute to the lower therapeutic alliance for Latino and Asian American clients. Potential factors may indicate that there is a greater emphasis placed on the working alliance for Latino and Asian American clients. Barriers may include the stigma of mental health services, the overreliance of support from family members and religion, and the accessibility of resources, and bilingual services. It is important to note that age and gender uniquely explain a significant variance related to the working alliance and are confounded with ethnicity. Future research should be focused on the impact of age and gender and its role in the working alliance.

Better Treatment Outcomes. Quality of life considers factors such as enjoyment of life, finding meaning in life, satisfaction with physical appearance, inner self and outer relationships. Significant group differences were discovered on the quality-of-life scale. Latino individuals report a stronger quality of life in comparison to Caucasian clients. Previous research suggests that Latinos are generally upbeat about their reporting of quality of life (Pew Research Center, 2007). In fact, Latinos with high social economic status, those that are born in the United States, and English dominant are more satisfied with their lives and report a higher quality of life. Mixed or multiracial individuals also rated themselves as having a stronger quality of life in comparison to Caucasian clients. No significant results were found amongst other ethnic groups, such as Asian American clients

and African American clients when compared to Caucasian clients. Gender explains a significant amount of unique variance when related to quality of life and appears to be confounded with ethnicity.

Lower results for clients of color. We predicted that clients of color would attend fewer sessions, report a lower therapeutic alliance, display less treatment outcomes, and show greater dissatisfaction with treatment. The particular data shows that clients of color attend sessions at the same rate as Caucasian clients. There is a lower working alliance amongst Latinos and Asian Americans in comparison to Caucasian clients. Latinos and Multiracial clients had reported stronger quality of life. Asian American clients had a stronger motivation to treatment in comparison to Caucasian clients.

Conclusion. In sum, there is a difference between the therapeutic alliance as reported by clients of color and those of Caucasian clients. Limited research is available in the area of therapeutic alliance. There are limitations to this study, as therapeutic alliance is difficult to define and is comprised of many variables. Subscales pertaining to working alliance, motivation to change, and quality of life were used as indicators. The reliance on a self-report can skew the information, as clients may feel the need to respond in a more positive manner in order to avoid uncomfortability with their therapist.

The scales measure one or several aspects of the therapeutic alliance but not all. It is difficult to separate the effects of other confounding variables, such as age and gender. In some cases, analyses showed that ethnicity was confounded by gender and/or age. Future research should focus on the impact of age and gender in order to be able to draw

conclusions about the data. It is difficult to truly know the exact role of ethnicity and its impact on working alliance, quality of life, and motivation to treatment.

While Caucasian clients do report a stronger working alliance, the impact on other variables including treatment outcomes is difficult to determine. There are many drawbacks to the attempt of trying to understand the complexity of the therapeutic alliance. Further research would need to be conducted to determine how best to capture the therapeutic alliance in therapy with regard to treatment outcomes. It is just as difficult to determine treatment outcomes, and therefore, having two large concepts that include multiple factors can be difficult to investigate.

We do not have information available regarding the ethnic background of the therapist. This precludes us from making any assumptions if that is a major factor in the reporting of the therapeutic alliance. We also do not have any ratings from the therapist in regard to the therapeutic alliance from their perspective.

Further research on the impact of the therapeutic alliance on Latino or Hispanic and Asian American clients is needed. Given that Latino clients rated lower working alliance scores, we would want to know why this is the case. What was their experience with their therapist? Why did they not feel as valued or heard? Why did they report not feeling that their therapist was a good fit? Similarly, we would want to know why Asian American clients also report a lower therapeutic alliance?

When we think about cultural diversity, we have to think about the differences within the groups. Therefore, further research should consider the impact of the therapeutic alliance across ethnic groups, as was found in this study. This study did not find a major difference in the reporting of therapeutic alliance among African American clients and

Caucasian clients. Why is this the case and has this been observed in other studies? Is this finding generalizable? One interesting factor to consider is the lower number of African American clients in comparison to Latinos and Asian Americans clients. If there were more African American clients would we have the same results or would the data say something different?

There was a small sample size that limits the generalizability of the results. Furthermore, the data was taken solely from one psychological training clinic that provides services to clients of diverse backgrounds. While this is an advantage of the study, this high level of diversity may not be present in all geographical locations. Another drawback is that all the therapists are considered students working toward their doctoral degrees. Looking at data from established therapists may conclude different results.

As we consider implications to treatment, therapist should consider speaking to their clients, particularly clients of color about the therapeutic alliance. Early in treatment planning, the therapist and the client should define what it means to feel supported and valued in sessions. Discussing culture is key in therapy, as literature proves the importance of establishing a strong therapeutic alliance (Taber et al., 2011). This requires training for the practitioner that is focused on cultural competence. Evidence demonstrates that clients perceive the working alliance to be related to the cultural competence of their provider (Owen, 2011). Providing a space for the client to discuss their culture, values, goals of therapy, and work in collaboration with the therapist, is imperative. These actions are believed to yield a positive therapeutic alliance and better outcomes for the client.

Appendix

Working Alliance Measure on the BIL

1. I feel heard, understood, and respected in my therapy sessions.

2. In therapy, we work and talk about what I want.

3. My therapist's approach is a good fit for me.

3. Overall, my sessions go well.

Quality of Life Measure on the BIL

1. I enjoy life.

2. My life is meaningful.

3. I am able to concentrate.

4. I accept how my body looks.

5. I am satisfied with myself.

6. I am satisfied with my personal relationships.

7. I am satisfied with my sex life.

8. I am satisfied with the support I receive from my friends.

Motivation Measure on the BIL

1. I am personally motivated for my therapy session today.

2. I am here for my session primarily because others want me to be here.

3. I do not understand what I am getting out of therapy.

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