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Cultural Difference and the Therapeutic Alliance: An Evidence-Based Analysis

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The research on positive psychotherapy outcome consistently indicates that the quality of the alliance is important across different models of psychotherapy (D. E. Orlinsky, M. H. Ronnestad, & U. Willutzki, 2004; B. E. Wampold, 2000). Social psychological research has documented how "unintentional bias" can produce barriers to university admissions, employment, and advancement of well-qualified members of ethnic minority groups (J. F. Dovidio, S. L. Gaertner, K. Kawakami, & G. Hodson, 2002). Neuroscience is further confirming social psychological responses associated with race (J. L. Eberhard, 2005). Unintentional bias identified in social psychological research may be part of the psychotherapist/client interaction, interfere with the therapeutic alliance, and partly account for the high dropout rates and underutilization of psychotherapeutic services by people of color. The purpose of this article is to provide an evidence-based analysis of how

psychologists in practice may unintentionally interfere with development of quality alliances with culturally different clients or patients and thus contribute to the barriers to effective multicultural counseling and psychotherapy. Principles from the American Psychological Association's (2003) multicultural guidelines and a review of relevant research are applied in suggesting strategies to reduce bias and to develop culturally appropriate skills in psychological practices.

Keywords: multicultural counseling, therapeutic alliance, evidence-based analysis, multicultural guidelines, unintentional bias

Psychotherapy is a change process designed to provide symptom relief, personality change, and prevention of future symptomatic episodes and to increase the quality of life, including the promotion of adaptive functioning in work and relationships, the ability to make healthy and satisfying life choices, and other goals arrived at in the collaboration between client/patient and psychotherapist (APA Presidential Task Force on Evidence-Based Practice, 2006). Unfortunately, ethnic minority populations underutilize psychotherapy services and have high rates of dropping out of treatment (Casas, Vasquez, & Ruiz de Esparza, 2002; Center for Mental Health Services, 1998; U.S. Department of Health and Human Services, 2001). One of the purposes of this article is to identify variables that could potentially interfere with as well as enhance the outcome of psychotherapy with ethnic minority populations. The working alliance is a particular focus, and this evidence-based information is applied to psychotherapy with ethnic minority populations.

The Effectiveness of Psychotherapy

The APA Presidential Task Force on Evidence-Based Practice (2006) provided a definition of evidence-based practice in psychology as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). The task force also concluded that psychologists must attend to a range of outcomes that may sometimes suggest one strategy and sometimes another, and they must also attend to the strengths and limitations of available research regarding these different ways of measuring success.

The empirical evidence on the outcomes of counseling and psychotherapy informs psychotherapists that, generally, treatment is effective for a broad range of problems, difficulties, and psychopathology, regardless of the therapeutic approach of the clinician (Lambert & Archer, 2006; Wampold, 2000). That is, in most control group studies in counseling and psychotherapy, treated persons are found to be more functional and less distressed than are untreated persons as a result of treatment (Wampold, 2000). In a review of hundreds of studies, both qualitative and quantitative,

Lambert and Ogles (2004) found that about 75% of clients who enter treatment show some benefit. Only with those diagnosed with severe biological-based disturbances, such as bipolar disorder and the schizophrenias, were psychological treatments secondary to psychoactive medications (Lambert & Archer, 2006). Overall, however, psychological interventions have been found to be equal to or to surpass the effects of medication for psychological disorders. Psychological interventions are less dangerous and less intrusive, and when psychotherapy and medication are offered together, psychotherapy reduces the likelihood of relapse once medications are withdrawn.

In a review of studies examining outcomes of individual counseling and psychotherapy, Lambert and Archer (2006) and Wampold (2000) concluded that various psychotherapy treatments intended to be therapeutic are beneficial, regardless of approach; when all available meta-analytic reviews comparing different psychotherapies were collected, these studies usually indicated little difference between treatments (Lambert & Ogles, 2004). However, some analyses found that some disorders (e.g., phobias, panic disorder) respond to treatment more easily than others (e.g., obsessive-compulsive disorder), and some require longer and more intense interventions (Lambert & Archer, 2006). Under some limited circumstances, certain methods (such as applying behavior techniques that rely on systematic exposure to fear-provoking situations with anxiety disorders) are superior in outcome. Even then, surprisingly small differences between the outcomes were found (Lambert & Archer, 2006).

Wampold (2000) further suggested that evidence supports the common factor model as opposed to the specific ingredient model. That is, specific ingredients in treatments do not produce superior outcomes to others; rather, the "ritual," with a set of procedures and common factors, seems necessary and sufficient for therapeutic change. Those specific ingredients are indeed necessary, Wampold suggested, to develop a coherent treatment that provides a convincing rationale to clients and in which therapists have faith. Carter (2006) also identified common factors and components of all forms of psychotherapy. Both Carter (2006) and Wampold (2000) cited Frank and Frank's (1991) position to further articulate the common factors. Frank and Frank believed that the success of all techniques depends on the patient's sense of alliance with the healer. They suggested that therapists should learn as many approaches as they find congenial and convincing and then select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem. Frank and Frank further stated that "creating a good therapeutic match may involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take

into account the concepts the patient brings to therapy" (p. xv).

Wampold (2000) agreed. He suggested that

the evidence strongly favors letting clients select a psychological treatment that makes sense to them and permitting therapists to adapt treatments to be consonant with the attitudes, values, and culture of the client, rather than having third-party payers or health maintenance organizations mandate a particular treatment. (pp. 735–736)

Wampold (2000) and Frank and Frank (1991) proposed that therapists must select among models and interventions and apply them as appropriate to each client. Marcia Hill (2004), author of *Diary of a Country Therapist*, stated, "One really has to be a chameleon, oneself always, but changing with the emotional tone, needs, and personal style of the other individual. Thirty clients, thirty different therapies, thirty different therapists" (p. 45). Martha Stark (1999) described how the

optimal therapeutic stance is one that is continuously changing. . . . Moment by moment, the therapist's position shifts. How the therapist decides to intervene depends on both what she has come to understand about the patient by virtue of the listening position she has assumed and what she believes the patient most needs—whether enhancement of knowledge, a corrective experience, or interactive engagement in relationship. (p. 5)

The Therapeutic Alliance

The therapeutic alliance has been identified as one of the most important of the common factors in therapeutic effectiveness (Warwar & Greenberg, 2000). Ahn and Wampold (2001), for example, concluded that training models should focus on the common factors as the bedrock of skills necessary to become an effective practitioner, including the importance of interviewing skills, establishment of a therapeutic relationship, and the core facilitative conditions such as those that have historically interested humanistic, dynamic, and relational researchers and clinicians.

The *therapeutic alliance* may be defined as the quality of involvement between therapist and client or patient, as reflected in their task teamwork and personal rapport, and the therapist's contribution to the alliance is an important element of that involvement (Orlinsky, Ronnestad, & Willutzki, 2004). Carter (2006) suggested that both clinicians and researchers should attend to the *therapeutic relationship* and the *working alliance* (often referred to synonymously). The role and impact of the alliance, as well as the ways in which the alliance as a relationship can be enhanced, should be the foci of attention. Given that the therapeutic relationship has strong evidentiary support as an essential factor in successful outcomes, clinicians should devote considerable attention to building and maintaining a strong therapeutic relationship in the implementation of

evidence-based practice. The relationship rests on agreement of goals, tasks, and processes and is positively related to outcomes.

Huppert, Fabbro, and Barlow (2006) provided a challenge to the interpretation of the outcome research; they suggested that although the therapeutic relationship is necessary, it may not be a sufficient factor in producing positive therapeutic outcomes. Given the difficulty in identifying specific mechanisms that produce a good alliance, Huppert et al. suggested that the outcomes of psychological treatments are also determined by the manner in which therapists execute specific techniques. They proposed that because some studies suggest that a positive alliance leads to better treatment compliance, the more powerful the treatment strategies, the greater the benefit from a strong alliance. Thus, the reverse is also possible: The more effective the strategy, the better developed the alliance may become. There are indications that with some types of problems (e.g., cocaine abuse), the alliance is not correlated with outcome within structured treatments, although it was strongly related to outcome in supportive psychotherapy (Carroll, Nich, & Rounsaville, 1997). Indeed, the quality of the alliance may be a phenomenon, or result, of positive treatment change. However, many studies do show evidence for the therapeutic alliance as a mediator of change; evidence has been collected showing that outcomes can be predicted from early alliance ratings (Salvio, Beutler, Wood, & Engle, 1992). Continued research will provide more clarity about these complex variables. Regardless of cause and effect, it is important to identify issues related to the therapeutic alliance with ethnic minority clients.

Threats to the Alliance for Ethnic Minority Clients/Patients

Attention to the therapeutic relationship and the working alliance with clients/patients of color may require special considerations. What are the unique issues that may interfere with the therapeutic alliance of clients different from psychotherapists? Ethnic minority populations underutilize psychotherapy services and have high rates of dropping out of treatment (Casas et al., 2002; Center for Mental Health Services, 1998; U.S. Department of Health and Human Services, 2001). Multiple reasons most likely account for these unfortunate findings, but one possibility may be that many ethnic minority clients do not experience the alliance as described by Carter (2006), Frank and Frank (1991), M. Hill (2004), Lambert and Archer (2006), Stark (1999), and Wampold (2000). Related causes include cultural misunderstandings and miscommunications between psychotherapists and clients (American Psychological Association [APA], 2003).

Psychologists who provide psychotherapy services have a responsibility to work only with those who are within the boundaries of their competence (APA, 2002). Standard 2 of the APA Ethics Code focuses on competence, and the implication is that psychologists refer clients with whom they do not think they can provide effective services. One issue is that psychologists may not always be aware of when the potential for developing an effective therapeutic alliance may be compromised.

C. E. Hill, Thompson, Cogar, and Denman (1993) and others have suggested that psychotherapists need to be sensitive to the tendency for clients to defer and conceal negative reactions by creating opportunities for clients to express their reactions. Clients may hide reactions out of fear of rejection if they express negative feelings to the therapist, as well as out of deference to the therapist's authority. Concealment of negative reactions is a normal human process. However, if the therapeutic alliance is one of the most important aspects in therapeutic effectiveness (C. E. Hill & Nutt Williams, 2000), then it would be helpful to be aware of potential negative reactions on the part of clients that interfere with the development of a positive alliance or cause alliance ruptures. Psychologists would potentially enhance effectiveness if they focused on the development of skills and processes that promote a positive therapeutic alliance. People of color experience slights and offenses so regularly that there is a tendency for them to "edit" their responses on a regular basis. That reality, combined with cultural values, may further inhibit negative reactions.

Although there is mixed evidence, most clients of color are more comfortably matched with therapists similar to them (Casas et al., 2002). More specifically, clients working with clinicians of similar ethnic backgrounds and languages tend to remain in treatment longer than do clients whose therapists are not ethnically or linguistically matched (S. Sue, 1998). However, such matches are not always possible. In addition, matches do not guarantee a healthy therapeutic alliance.

Social psychological research that sheds light on racial and ethnic minority relationships with White members of society may help psychologists understand more about the risks in interactions between groups, such as biases in general, and in the psychotherapy process in particular.

Social Psychological Research: Implications for Psychotherapy

One assumption of this article is that the same interpersonal dynamics that occur in everyday life may also occur in the psychotherapeutic office. Indeed, psychotherapy is often a microcosm of interactions out in the world except insofar as the psychotherapist is providing helpful interventions and working to ensure that destructive interactions do not occur in the process. *Microaggressions* is a term coined to convey power dynamics in interactions in cross-cultural encounters that convey attitudes of dominance, superiority, and denigration: that a person with privilege is

better than the person of color, who is less intelligent, capable, worthy, and so forth (Fouad & Arrendondo, 2007; D. W. Sue, 2003). Microaggressions are often perpetrated by well-meaning people who hold egalitarian beliefs but who have not become aware of their negative attitudes and stereotypes about people of color and/or who have not had sufficient contact with people different from themselves (Fouad & Arrendondo, 2007). To what degree do these microaggressions occur in psychotherapy between White clinicians and clients of color? To what degree do they occur for any psychotherapist with those clients different from him or her by virtue of differences based on any factor that is negatively socially constructed without privilege in society? In addition to race and ethnicity, differences may include gender; age; gay, lesbian, bisexual, or transgender identity; socioeconomic status; religious affiliation; and disability status.

The nature of the role of psychotherapist confers power that can be beneficial in facilitating constructive change (D. W. Sue & Sue, 2003). Practitioners must be careful to understand and remember this power and take care to not abuse it. The privilege that is conferred upon practitioners by virtue of possessing a doctorate is often unspoken but is a central dynamic in the psychotherapeutic relationship. Historically, power has also been a factor in cross-cultural encounters (Fouad & Arredondo, 2007; D. W. Sue & Sue, 2003).

Steele's (1997) "stereotyped threat" research indicates that when ethnic minorities are asked to perform a task in which ethnic minorities stereotypically underperform, they end up underperforming, due to the threat, fear, and anxiety of underperforming. Ethnic minority clients may be particularly sensitive to the experiences of negative judgment, rejection, and criticalness on the part of White therapists, without the White therapist being aware of this sensitivity. Because of a history of oppressive and rejecting experiences, many if not most ethnic minorities are easily shamed. Therapists may not always know when they convey negative judgments in body language, including facial expressions, voice tone, and eye contact.

Greenwald and Banaji (1995) suggested that social structure influences cognitive judgment and leads to implicit attitudes and unconscious effects. Human social structures have compounding effects on people's cognitive structures and ultimately on their social attitudes and beliefs about others. The way society constructs societal representations of groups affects the social order and has a tremendous impact on the identities of individuals in various groups, both ethnic minority and White majority.

Social psychological research (Dovidio et al., 2002) has continued to document how unintentional bias can produce barriers to university admissions, employment, and advancement of well-qualified members of ethnic minority groups. As much as people perceive themselves to be egal-

itarian, they are not subconsciously so as individuals in this society. Dovidio et al. (2002) demonstrated in a series of studies that contemporary racism among Whites is subtle, often unintentional, and unconscious. Many Whites often give off negative body language (less eye contact, voice tone not as warm or natural) in response to those different from themselves. Whites who demonstrate these behaviors report not being aware of this negativity. Members of ethnic minority groups were aware of negative attitudes toward them in those studies that examined these interactions.

Neuroscience is further confirming social psychological responses associated with race. The use of functional magnetic resonance imaging is a noninvasive means of examining the functioning of healthy brains. Eberhardt (2005) demonstrated the process by which ideas about racial groups produce physical changes in the brains of individuals; these come to shape who those individuals are. Social variables can influence biological brain development (Siegel, 1999). Essentially, studies reviewed by Eberhardt indicated that Whites exhibit more positive evaluation bias (greater amygdala response habituation) to in-group White faces than to out-group Black faces. Blacks exhibit a more positive evaluation bias to Blacks than do Whites. Eberhardt reported optimism in believing that seeing pictures of the brain may lead people to understand that their own race-based perceptions have the capacity to change and shape who they are themselves in ways never before thought possible.

The implication of these studies is that even psychotherapists may exhibit unintentional bias in their work with clients or patients who are culturally different from them.

Overcoming Psychotherapist Bias

Some, if not most, ethnic minority clients have experiences of discrimination to address in psychotherapy, usually in addition to other issues. What happens in psychotherapy when an ethnic minority conveys the perception of an unfair evaluation or that a lack of promotion has to do with prejudice and discrimination? What if the facial expression of the therapist reflects disbelief? What if the client may be struggling with a failure experience/event, without perceiving the possibility of discrimination, when discrimination is in fact a part of the process? What happens for that individual client when the therapist fails to suggest bias/discrimination as a possible factor?

The White therapist who has negative stereotypes about the competency of marginalized group members may have a difficult time staying present and empathic with the person of color who is struggling with a painful discriminatory event or a cultural experience foreign to the psychotherapist. One study (Nelson & Baumgarte, 2004) demonstrated that individuals experience less emotional and cognitive empathy for a target experiencing distress stemming from an incident re-

flecting unfamiliar cultural norms and that this reduction of empathy is mediated by a lack of perspective taking on the part of the observer. These findings suggest that representations of prior experience as well as lack of similarity between self and other can have a negative impact on the ability to mediate perspective taking or empathy on the part of the observer.

Comas-Díaz (2006) discussed how cross-cultural encounters are frequently rife with "missed empathetic opportunities." They include those moments when a client reports emotional issues and the clinician changes the topic without addressing or reflecting the client's feelings. Comas-Díaz contended that these missed empathetic opportunities are subtle but more frequent when clinicians work with those different from them on the basis of racial, ethnic, gender, sexual orientation, socioeconomic, ideological, and political differences.

The reality is that, given the sociopolitical context in which people exist, they are all influenced by racism, ethnocentrism, sexism, heterosexism, and other -isms whether they are conscious of those or not. The APA (2003) *Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists* (hereafter referred to as *multicultural guidelines*) include various assumptions and guidelines that address this reality. The first multicultural guideline exhorts psychologists to "recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (p. 382). Thus, psychologists are encouraged to continually engage in activities that promote self-awareness and self-exploration in becoming aware of unconscious beliefs and bias and to reduce stereotypic attitudes.

Developing the Therapeutic Alliance With Ethnic Minority Clients/Patients

Ackerman and Hilsenroth (2003) identified therapists' personal attributes and in-session activities that positively influenced the therapeutic alliance from a broad range of psychotherapy orientations. Personal attributes found to contribute positively to the alliance included being flexible, honest, respectful, trustworthy, confident, warm, interested, and open. Techniques such as exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the patient's experience were also found to contribute positively to the alliance.

Although these attributes and techniques may very well work with clients of color, Comas-Díaz (2006) suggested the careful application of any evidence-based findings, given the dearth of research with populations of color. Individuals of one cultural group may require a form of psychotherapy and a stance by the therapist different from others. For example, cognitive behavior therapists may need to assess the role of racism and oppression in their client's ability to achieve mastery and agency. Racial stress management may be an additional empowering technique for clients who have experienced oppression systemically. The therapeutic relationship may be even more important with immigrants who feel distrustful of authority figures in this country. Some culturally diverse clients may be unsettled with the egalitarian and nondirective interaction styles of some therapists. Others may be put off by an authoritarian stance. These are factors and issues that must be continuously assessed, as cultural groups vary and as individuals within those groups are heterogeneous, based on acculturation, language, generational status, and other related factors (APA, 2003).

APA's second multicultural guideline encourages psychologists "to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals" (APA, 2003, p. 385). The more psychologists understand about those with whom they work, including understanding their worldview and perspective, the more likely they are to promote a therapeutic alliance. This implies learning as much as possible about the various values, norms, and expectations of various ethnic and racial group members with whom one works. The challenge in learning about cultural groups is to avoid stereotyping; rather, the knowledge is to be used to assess the degree of application of various cultural values, behaviors, and expectations. Comas-Díaz (2006) suggested that although the therapeutic relationship requires special attention in multicultural dyads, clinicians need to tailor the relationship to the client's interpersonal and developmental needs, a suggestion in keeping with that of Frank and Frank (1991), M. Hill (2004), Stark (1999), and Wampold (2000). A very good suggestion is to learn the client's uses of words to facilitate and guide learning of a new common language, as well as to teach the client concepts in the therapeutic dialogue.

Comas-Díaz (2006) explored the role of culture within the therapeutic relationship and provided recommendations for addressing the cultural components of the client/therapist relationship to increase psychotherapy effectiveness. She especially suggested modification of the therapeutic relationship to the client's culture, special attention to understanding the client's voice, development of trust and credibility, and the promotion of cultural empathy.

In addition, a culturally sensitive psychotherapist would use a variety of interventions that take into account the needs of clients. This assessment process is complex and is informed by self-awareness, cultural knowledge, and familiarity with the evidence base of treatments, preferably those that include ethnic minority populations in the research samples. Not only must psychotherapists possess sophisticated and ongoing self-awareness, but they must continuously evaluate their theories, assumptions, practices, and clinical skills to correctly apply culturally resonant

interventions to accommodate the needs of the wide variety of clients with whom they work. The abilities required to engage in integration of this evidence-based knowledge and processes are often what distinguishes a doctoral-level clinician from others.

Ponterotto, Fuertes, and Chen (2000) summarized several models of multicultural counseling. All are helpful in potentially providing knowledge, skills, and awareness in improving effectiveness in counseling and psychotherapy with ethnic minority populations. In the multicultural guidelines, the APA (2003) also promotes valuable guidelines with which to promote effective treatment, and others (Constantine, 2007; Constantine & Sue, 2005; de las Fuentes, 2007; Fouad & Arrendondo 2007; D. W. Sue, 2003; Vasquez, 2005) have applied the multicultural guidelines to psychotherapy in particular.

Other suggestions include D. W. Sue's (2003) contention that one develops a nonracist White identity by first acknowledging that one's racism exists. As long as one denies racism, the greater the difficulty in developing an authentic and positive White identity. In addition, D. W. Sue (2003) suggested that every individual is responsible to combat racism, not only in themselves but in society at large. He encouraged people of color to also continue to fight for dignity and humanity, regardless of how tired, impatient, or angry they feel. D. W. Sue (2003) also suggested that hope is an important antidote to surrender bitterness and blind hatred.

De las Fuentes (2007) and Hardy and Laszloffy (1995) suggested the use of a "cultural genogram" as a didactic/ experiential training tool to promote awareness of how the family is the principal mode by which people learn and develop an understanding about their cultures and ethnicities. Clinicians can learn about their own unique values, transmitted through their families and experiences, as well as learn better how to assess those for their clients, especially those different from them.

A hopeful note is that the psychotherapeutic process generally provides the opportunity, if the psychotherapist is open to it, to become intimately acquainted with the strengths and resilience of one's clients. Feminist and multicultural approaches in particular, but also others, emphasize the empowerment of individuals and work toward the increased quality of life for all people. *Cultural mutuality*, as defined by the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (APA, 1990), describes, in part, the importance of relating to clients of color, women, and other oppressed groups in a respectful, connecting manner based on psychotherapists' knowledge of clients' culture and also tuning in to aspects of the clients' needs that their therapeutic processes may help. This is an important value for psychotherapists who wish to promote alliances with persons of color and others who have been historically disenfranchised.

Conclusion

The social construction of race and ethnicity in this country means that everyone suffers from unintentional biases, resulting in discriminatory, oppressive behaviors that result in microaggressions and other offenses. It is highly likely that these attitudes and behaviors extend to the process of psychotherapy. Change involves awareness of biases, and the ability for psychotherapists to promote knowledge, attitudes, and skills important to the cultures of those with whom they work. The therapeutic alliance, of significant importance in a positive therapeutic outcome, may be positively or negatively affected by the choices that psychotherapists make in overcoming those *-isms*. Various activities and experiences are suggested in the literature, and all practitioners have a responsibility to engage in those endeavors. The APA (2003) and others (Constantine, 2007; Constantine & Sue, 2005; de las Fuentes, 2007; Fouad & Arrendondo 2007; D. W. Sue, 2003; Vasquez, 2005) have suggested a variety of strategies to reduce bias and to promote a healthy and constructive therapeutic alliance. The first and most critical is constant awareness of attitudes. Other strategies involve effort and practice in changing the automatic favorable perceptions of the White privileged group and negative perceptions of those whose historical roles in society have been left with negative perceptions (Vasquez, 2005). According to Dan Siegel (1999), psychotherapists can rewire their circuitry through explicit processing of their biases, immersion with different groups and individuals, readings, training, and practice in behaving in ways to change their subconscious perceptions in the psychotherapeutic process (staying attuned to clients, demonstrating cultural empathy, being respectful and open to worldviews). They can change their neural pathways developed through negative biases and stereotypes in society (Eberhardt, 2005; Siegel, 1999).

More research is recommended to assess the quality of the therapeutic alliance and how that affects outcome for clients of color. This would be a complicated endeavor, as results of studies investigating the therapeutic alliance often consider different treatment modalities, with mostly heterogeneous groups of patients with various disorders. However, it is an important goal, both to determine the degree to which it is a problem in the psychotherapeutic underutilization of services for clients of color, as well as to identify unique factors related to the promotion of the therapeutic alliance in cross-cultural dyads.

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