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ETHNICITY AND THERAPEUTIC ALLIANCE

A Doctoral Research Project
Presented to
The School of Graduate Studies
Department of Psychology
Indiana State University
Terre Haute, Indiana

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Psychology

by
Victor M. Huertas

December, 1992

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APPROVAL SHEET

The doctoral research project of Victor Mario Huertas, Contribution to the School of Graduate Studies, Indiana State University, Series IV, Number 45, under the title Ethnicity and Therapeutic Alliance is approved as partial fulfillment of the requirements for the Doctor of Psychology Degree.

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ABSTRACT

The therapeutic alliance, defined as a relationship between the therapist and patient in which they work together in a realistic collaboration based on mutual respect, liking, trust, and commitment to the work of the psychotherapeutic treatment, is thought to be an important component of successful therapeutic interventions and may also serve to reduce premature terminations. The concept of therapeutic alliance, however, has not been addressed directly in the ethnic minority literature. Literature pertaining to the psychotherapeutic treatment of ethnic minorities was reviewed with an emphasis on therapeutic alliance. Factors that may influence the development of an adequate therapeutic alliance with ethnic minority patients are identified and discussed. In addition, recommendations for integrating into clinical psychology training programs the process of building therapeutic alliances with ethnic minority clients are made.
ACKNOWLEDGEMENTS

My sincere gratitude is extended to my doctoral research committee members without whom this project would not have been possible. I especially want to thank Dr. Don Nelson, first for giving me the chance to prove myself by accepting me in the doctoral program, and secondly, for his continual confirmation that I was both intelligent and capable of progressing through the program. His emotional support and constant encouragement gave me the "ganas" and motivation to persevere in my quest to obtain the doctorate. I am also indebted to Dr. Martin Krugman, who painstakingly reviewed and edited this project, and taught me to write professionally. I also wish to thank him for the emotional support he provided me throughout this process. I owe a tremendous thanks to Dr. Veanne Anderson for stepping in and "pinch hitting" when I lost my second committee member.

To my wife, Denise Ann Harris Huertas, who has shown me unconditional love and devotion, and constant encouragement. I owe you more than I can put into words--I love you.

I owe special thanks to my parents, Tony and Diana Huertas, for making my dreams possible and never allowing me to think I was incapable of achieving my highest academic aspirations. Their unyielding emotional support and encouragement many times prevented me from giving up my academic career. Thanks to my sisters, Linda, Wilma, and Maggie, for being available when I needed them.
Finally, I wish to honor the memory of my brother, Jose A. Huertas, Jr., by dedicating this doctoral research project to him.
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Chapter 1

INTRODUCTION

Recent years have seen the development of a growing body of literature on the mental health and therapy needs of ethnic minorities (Sue, 1981; Sue & Sue, 1977). This research has focused on personality and cultural differences among ethnic groups. In particular, differences between the white majority (about whom most of the personality theories and therapeutic techniques have developed) and other ethnic groups (about whom little has been written) have been highlighted. The thrust of these studies has largely been to evaluate the use of different treatment modalities with various ethnic populations, to reveal cultural biases, and to encourage sensitivity by non-ethnic minority psychotherapists to various aspects of different cultures. These contributions have been very valuable, and awareness of ethnic issues by mental health professionals has been greatly enhanced. However, to date no consistent theoretical framework has been advanced to organize the literature and provide a structure within which empirical studies can be evaluated.

Ethnic minorities bring special needs into the therapy
situation, and these needs often present obstacles for mental health professionals who work with the culturally different (Padilla, Ruiz, & Alvarez, 1975). However, the basic issue is not that people are different, but that means must be found to work with people in need, no matter who they are. It will be argued that the essential ingredient for psychotherapeutic success is the establishment of a therapeutic alliance, by whatever means possible, and that other cultural considerations can be regarded as secondary issues that help to understand different approaches to this goal.

A strong therapeutic alliance is likely to minimize the effects of cultural differences between patients and therapists. Thus, the therapist does not necessarily have to be a member of the same or similar cultural group to achieve therapeutic success. Fortunately, a substantial literature on therapeutic alliance already exists, and can be used as a conceptual framework with which to approach the therapeutic treatment of ethnic minorities.

The literature has neglected to emphasize the development of the therapeutic alliance as a conceptual framework for conducting psychotherapy with culturally diverse groups. In addition, the importance of a successful therapeutic alliance for positive psychotherapy outcomes with ethnic minorities has not been emphasized. Thus, it will be argued that increased focus on the development of successful therapeutic alliances with ethnic minority clients is
important and necessary to therapeutic success. Specific elements of this alliance to be addressed include the components of cultural sensitivity, rapport building, the utilization of empathy to facilitate effective treatment, the establishment of credibility, and understanding the ethnic minority patient's family background. In addition, suggestions for teaching alliance-building skills in clinical psychology training programs will be discussed.

The chapter on therapeutic alliance reviews articles that: (1) discuss the historical evolution of therapeutic alliance, (2) delineate concept definitions, and (3) investigated the concept of therapeutic alliance in clinical settings. This review will examine the relationship between therapeutic alliance and its relation to psychotherapy.

The chapter on ethnicity and therapeutic alliance reviews the psychotherapy literature pertaining to the treatment of ethnic minorities with an emphasis on therapeutic alliance. Factors that may influence the development of therapeutic alliance with ethnic minority patients will be delineated and discussed. Research articles that examine: (1) therapeutic alliance as it relates to ethnic minorities, (2) the relationship between the therapist and ethnic minority patients, (3) the historical evolution of psychotherapy with ethnic minorities, and (4) factors thought to improve psychotherapy with ethnic minorities are reviewed and summarized. Greater attention is given to those articles which presented literature reviews. These articles
were drawn from psychological and psychiatric journals.

The chapter on establishing therapeutic alliance discusses establishing and maintaining a therapeutic alliance with ethnic minority patients. Specifically, the chapter discusses guidelines of cultural sensitivity, rapport, credibility, empathy, and understanding the ethnic minority patient's family background.
Chapter 2

THERAPEUTIC ALLIANCE

Therapeutic alliance has been discussed in the literature for many years; however, interest in this construct increased following the publication of treatment efficacy studies by Eysenck (1952), and more recently by Smith and Glass (1977). Eysenck's (1952) study, the first to question psychotherapy's efficacy, reported that psychotherapy was no more effective than no treatment. Eysenck reviewed 24 studies of psychoanalytic and "eclectic" psychotherapy. He compared controls and people receiving treatment on discharge rates of recovered or improved neurotic patients from New York state hospitals and patients who were seeking insurance claims while being treated by general physicians. The results of Eysenck's (1952) study indicated that 72% of those patients who received minimal custodial care, or care by a general physician, were judged to have improved, while only 64% of the patients who received eclectic psychotherapy and 44% who received psychoanalytic psychotherapy evidenced improvement. This research created much controversy within the profession and led some investigators to ask questions about the process and ingredients of psychotherapy.
One of the first responses to Eysenck's research criticized his methodology (Luborsky, 1954). First, the scale Eysenck used to determine treatment efficacy was ambiguous and was applied in an inconsistent manner. There was no differentiation between the scale items as evidenced by his collapsing four categories into two overall categories. This led to the concern that Eysenck may have interpreted or manipulated the data in an inconsistent and idiosyncratic manner to suit his hypothesis (Bergin, 1971; Garfield, 1981; Phares, 1979).

A second criticism was that Eysenck's (1952) study lacked adequate control procedures. Specifically, the comparison groups that were used were not adequately matched with the psychotherapy patients on variables such as education, social class, gender, and income level. Moreover, in the sample of state hospital patients, it was not possible to determine whether or not the patients who were discharged as improved received some form of psychotherapy as part of the hospital treatment regime. In the second "control" study, the quality of the interaction between the patient and the physician was not measured. Furthermore, the criteria by which the evaluation of "improved" was made were not specified. These patients may have derived therapeutic benefit from those professionals with whom they were in contact, hence making a comparison with the psychotherapy groups improper.

Despite the criticisms, Eysenck's (1952) study was
important because it raised questions about the effectiveness of psychotherapy and led to the study of factors leading to its enhancement. In addition, Eysenck's (1952) study helped to elucidate the difficulty in conducting psychotherapy treatment outcome research. Bergin (1971) reanalyzed Eysenck's original data and found problems with the original studies including methodological errors, calculation errors, and evaluator subjectivity. Despite these problems, Bergin's reanalysis indicated that the rate of effectiveness dramatically changed from 44% to 83% improvement for the psychoanalytic therapy. In addition, he found the eclectic psychotherapy group to have 65% improvement, which was essentially equivalent to Eysenck's result of 64% improvement. Bergin (1971) reported that the difference between his calculations and Eysenck's for the psychoanalytic psychotherapy group may have been due, in part, to how patient dropouts were treated. Eysenck considered the dropouts as failures, whereas Bergin did not because Bergin suspected that the dropouts may have actually benefitted from therapy before they terminated. In addition, Bergin recalculated the spontaneous remission or "control" subjects and found a 52% improvement rate instead of the 72% reported by Eysenck. Bergin (1972) arrived at the lower figure because the rules Eysenck used to evaluate the treatment data were not applied equally to the "control" data. Eysenck found that researchers had categorized subjects into three categories: "cured," "improved," and "not improved."
He determined that improved could mean either "slightly" or "significantly" improved. Eysenck divided the subjects equally and placed half into the "improved" and half into the "slightly improved" category. However, the "slightly improved" category was then collapsed into the "unimproved" category. Bergin found, however, that Eysenck did not use the same procedures with control subjects.

Bergin's (1971) conclusions pointed to the unreliability of Eysenck's findings and this led to improvements in research and refinement of the research questions on the efficacy of psychotherapy. Moreover, later research, assessing the effectiveness of psychotherapy, found additional support for psychotherapy. Luborsky, Singer, and Luborsky (1975), for example, reviewed 40 studies comparing psychotherapy and found no differences between methods of psychotherapy, but psychotherapy was found to be more effective than no treatment.

One criticism of the previous research on psychotherapy efficacy is the small number of studies reviewed. Smith and Glass (1977), in an attempt to correct the problem, used meta-analysis to evaluate 400 controlled studies of psychotherapy and counseling. Their results suggested that patients who received psychotherapy or counseling fared better than those who did not receive treatment. They found no difference between "behavioral therapies (systematic desensitization and behavior modification) and non-behavioral therapies (Rogerian, psychodynamic, rational
emotive, transactional analysis, etc.)" (p. 752). These results supported the Luborsky et al. (1975) finding that no differences existed between methods of psychotherapy.

The results of the Luborsky et al. (1975) and Smith and Glass (1977) research suggest that patient and/or therapist factors may contribute strongly to the efficacy of psychotherapy and called for a reexamination of the research question used to evaluate psychotherapy efficacy. Garfield (1981) argued that whether or not psychotherapy is effective is not a good research question because too many variables are involved. Rather, the question that should be posed is "what type of therapeutic procedures carried out by what type of therapist on what type of client with what particular clinical problem can produce effective results?" (Garfield, 1981, p. 174). Embedded within this type of inquiry is the question of which therapist and patient variables are necessary to produce effective psychotherapeutic results.

In an attempt to delineate relevant qualities of patients, therapists, as well as interactions between patients and therapists, Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) evaluated 166 studies that examined psychotherapy outcomes with adults. Their results indicated that the patient factors of adequate premorbid functioning, intelligence, high level of discomfort or distress, youthfulness, likability, and motivation were predictive of positive psychotherapy outcome. The therapist factors that
were of predictive value included experience level, skill level, interest level, and empathic ability. Luborsky et al. (1971) also found that similarities between the patients and therapists, in terms of values, attitudes, interests, and social class influenced the outcome of psychotherapy positively. Finally, they also found that the more motivated the patient and the more empathic the therapist, the more effective treatment tended to be.

Based on the treatment outcome studies, and studies of therapist and patient factors, researchers began formulating more specific questions about psychotherapy that led, in turn, to findings of increased treatment efficacy and greater positive outcomes (Luborsky et al., 1971; Luborsky et al., 1975; Smith & Glass, 1977). These researchers provided the impetus to establish factors essential for improving treatment efficacy and outcome rather than spending time, energy and money developing new or different types of psychotherapy.

Hartley and Strupp (1983) suggested that if a large variety of treatments produce similar benefits, there are likely to be common elements responsible for these benefits. One factor that is widely believed to affect treatment efficacy and outcome is the therapeutic alliance (Bordin, 1974; Gaston, 1990; Gomes-Schwartz, 1978; Hartley & Strupp, 1983; Luborsky, 1976; Marmar, Horowitz, Weiss, & Marziali, 1986; Marziali & Alexander, 1991). The construct of therapeutic alliance is thought to be a necessary factor within
most treatment models for obtaining positive results in treatment outcome (Bordin 1979; Gaston, 1990; Marziali & Alexander, 1991).

The development of a therapeutic alliance is an important aspect of the therapeutic process because it stresses the collaboration between therapist and patient (Frieswyk et al., 1986). Its importance has been noted by various schools of psychotherapy (Gaston, 1990), particularly cognitive behavior therapy (Bordin, 1979) and psychodynamic therapy (Dickes, 1975).

The concept of therapeutic alliance is not new. The construct has its origins in the theory of psychoanalysis and has been discussed by others under different names such as ego alliance (Sterba, 1934) and working alliance (Greenson, 1965).

Originally, Freud (1912) alluded to the alliance between the analyst and the patient when he emphasized the importance of building rapport with the patient during the initial stage of therapy. Freud (1912) also believed that transference played an important role in the development of the therapeutic relationship. Transference refers to the re-experiencing of feelings, drives, attitudes, fantasies, and defenses from the past in response to the therapist, in the present. This emotional response is inappropriate to the therapist, and is a repetition and a displacement of reactions originating in regard to a significant person or persons from the patient's childhood. Freud believed that
the therapist must foster the transference by developing rapport with the patient and thereby enhancing therapeutic success.

Freud reasoned that without adequately establishing rapport with the patient, transference could not be established and therapy would be hindered. He believed that the patient should be made a collaborator such that he or she may gain insight and overcome resistances. Freud (1913) also thought that prior to the analyst making any interpretations, the patient first needed the sympathetic understanding and interest of the analyst. He thought that the interest and understanding provided by the analyst should be of the kind to which the patient was accustomed; namely, that afforded by people who have treated the patient with serious affection in the past. Moreover, Freud believed that without achieving such a relationship, patient resistance to interpretation would hinder therapeutic outcome and insight would be delayed, if achieved at all. In psychoanalysis, transference is thought to foster the expression of the patient's neurosis within the therapeutic setting so the clinician may interpret the interaction and relate it to the patient's past, and help the patient change current behavior.

Sterba (1934) defined transference as the therapeutic interplay between the analyst and analysand, where the analysand's id, ego, and superego attempts to fulfill the patient's needs, wishes and desires. He stated that as a
function of transference, the id attempts to cathect the object-choice, while at the same time, the superego attempts to resist it on moral grounds. The duration of the resistance is determined by the patient's unconscious motivation. The analyst is responsible for addressing these resistances through an alliance with the patient's ego against the defense mechanisms in place. Sterba thought that the method by which the therapist aligns with the patient's ego was through explanations and interpretations of the transference and resistance. The willingness of the analysand to accept interpretations is determined by the level of transference established in the therapeutic situation.

Sterba believed that there had to be a certain amount of positive transference through identification with the analyst by the analysand before the transference was ripe for interpretation. Throughout the therapy, through the use of interpretation, the analyst influences and collaborates with the analysand to uncover and understand the patient's unconscious which will ultimately be changed. The process is continual throughout the treatment. Although Sterba did not identify the process as the therapeutic relationship or therapeutic alliance, he, like Freud (1913), was certainly addressing the relationship between the patient and the therapist and attempted to establish its importance in psychoanalysis.

The term "therapeutic alliance" was first introduced by Zetzel (1956) with the idea of transference in mind. She
loosely defined therapeutic alliance as an identification and attachment to the therapist. Zetzel believed that patients who presented problems in becoming engaged in psychotherapy needed therapists who were sensitive to their needs and those who had trouble trusting therapists needed more supportive interventions. Greenson (1965; 1967) anecdotally reported that in his clinical work, patients seemed to terminate treatment prematurely because clinicians failed to establish and maintain an adequate relationship with the patient which he labeled "working alliance."

Greenson (1965; 1967) believed that the working alliance often developed imperceptibly, without specific direction by the therapist. He suggested further that if the therapist did not gain the patient's trust, a successful therapeutic relationship would not be established. Moreover, Greenson suggested that therapists needed to develop an interactive style with a goal of creating and maintaining the working alliance. He also thought that therapists should attempt to establish a working alliance through compassion, concern, and therapeutic intent, rather than by just being an observer or blank screen.

Greenson (1965) acknowledged that the concept of a working alliance was derived from the concept of transference and is similar to Freud's definition of transference, wherein the experience of a patient's feelings, attitudes, defenses, and fantasies toward the therapist in the present are inappropriate and related to the patient's early child-
hood experiences. However, the therapeutic or working alliance differs from the concept of transference because it stresses the willingness or capacity of the therapist and patient to work together in a realistic, collaborative relationship based on mutual respect, liking, trust, and commitment to the work of psychotherapeutic treatment (Foreman & Marmar, 1985; Greenson, 1965). In addition, the therapeutic alliance refers to the level to which the therapist and patient have bonded and represents the patient's perception of the therapist's ability to provide help (Luborsky, 1984).

Kanzer (1975) noted that the process of establishing a therapeutic alliance with the patient is accomplished by the therapist in a disciplined manner, which allows the patient to gain insight through experience. Kanzer (1975) acknowledged a need for the modification of the process of transference because neutrality did not always foster the development of transference and provide the desired gateway from present to past. He suggested that establishment of a therapeutic alliance is done on "hierarchical levels in a complex and ever-changing context of past and present determinants" (p. 66).

Bordin (1979) has argued that the quality of the therapeutic alliance is the degree to which patient and therapist agree about the goals and tasks of psychotherapy. Furthermore, Greenberg and Pinsof (1986) have suggested that Bordin's (1979) conceptualization of alliance eliminates the distinction between general relationship factors and specif-
ic technical factors, and combines them within a theoretical framework. Safran, Crocker, McMain, and Murray's (1990) conceptualization is that "the impact of the therapist's behavior on the client must ultimately be understood in terms of the client's perception of that behavior, and this perception is ultimately determined by the client's unique learning history" (p. 155).

Thus, the techniques used to establish therapeutic alliance with one patient may not work as well with another patient who may have a similar problem. An active and domineering therapist, for example, may work well with a passive patient, but may find difficulty working with a patient who is also active and domineering, despite the fact that both patients have a similar problem (e.g., depression). The therapist must be attuned to the needs of the patient and their ability to perceive and receive the therapist's intentions. The important point here is that the interactions between patient and therapist have far-reaching implications and require an in-depth investigation and attention to increase therapeutic success and reduce premature termination.

Currently, most therapists and researchers, acknowledge that a positive relationship between the therapist and patient is an important, if not essential, aspect of effective psychotherapy. The importance of enhancing therapeutic alliance in psychotherapy is to improve treatment effectiveness and ultimately outcome (Egan, 1982; Gaston, 1990; Marziali & Alexander, 1991). The relationship between
the therapist and patient should be established and facilitated so that the patient will be more receptive to the therapist's interventions.

Therapeutic alliance has undergone extensive study. In a review of the therapeutic alliance literature, Gaston (1990) found a basic disagreement with the definition of therapeutic alliance. She pointed out, for example, that some researchers believed therapeutic alliance to be a bonding between therapist and patient (Luborsky, 1984) while others believed it to be an active collaboration between the therapist and the patient (Frieswyk et al., 1986). Gaston observed that this problem seemed to be resolved by Bordin's (1979) operationalization of the construct. Bordin divided the construct into three components: a) the bond between the therapist and the patient, b) the agreement of goals for therapy, and c) the agreement of tasks necessary to achieve the goals of therapy.

Gaston (1990) found that four dimensions could be derived from Bordin's (1979) components, which served to resolve the disagreement in the literature regarding the definition of therapeutic alliance. The four dimensions included (1) the affective response of the patient to the therapist, (2) the empathic understanding by the therapist, (3) the patient's ability to work purposefully in therapy, and (4) the agreement of goals and tasks of therapy by the patient and therapist.

The research on therapeutic alliance has been focused
on the development and use of treatment efficacy instruments that identify and measure components of therapeutic alliance. These studies have, at times, focused on portions of therapy sessions, and on the perceptions of the therapist, patient or an objective third party. A number of inventories have been used to measure the relationship between the patient and therapist. The Relationship Inventory, for example, was developed by Barrett-Lennard (1962) to measure the patient's perception of relationships. The Therapy Session Report developed by Orlinsky and Howard (1986) was designed to assess the patient's experience in therapy and measure the quality and outcome of psychotherapy treatment (Saunders, Howard, & Orlinsky, 1989). The Vanderbilt Psychotherapy Process Scale (VPPS) was developed by Strupp, Hartley, and Blackwood (1974) to assess the patient-therapist relationship and to measure treatment outcome as a function of good therapeutic relationship (Gomes-Schwartz, 1978; Moras & Strupp, 1982; O'Malley, Suh, & Strupp, 1983).

Generally, a strong association between therapeutic alliance and psychotherapy outcome has been found (e.g., Gomes-Schwartz, 1978; Hartley & Strupp, 1983) and suggests that therapeutic alliance appears to be an important factor in the efficacy of psychotherapy. Foreman and Marmar (1985), for example, investigated psychotherapy treatment outcome based on improvements in therapeutic alliance. They found a strong relationship between treatment outcome and therapeutic alliance. Another example which may illustrate
a relationship between therapeutic alliance and treatment outcome is the research by Gaston, Marmar, Thompson, and Gallagher (1988). These researchers were looking at success rates using exploratory methods with patients based on alliance level attained and treatment outcome. They found that the better the alliance the more effective the treatment method tended to be.

Delineating factors that influence psychotherapy outcome is important to improve psychotherapy techniques and provide optimal treatment to psychotherapy patients. In general, therapeutic alliance has been established as a significant factor in successful psychotherapy outcome; however, most studies have not involved ethnic minorities. It is worthwhile, then, to determine the extent to which psychotherapy with ethnic minorities is influenced by therapeutic alliance and to apply this concept as a theoretical framework within which to improve psychotherapy effectiveness with these patients. In addition, the following chapter presents a review of the psychotherapy literature pertaining to the psychotherapeutic treatment of ethnic minorities with an emphasis on therapeutic alliance.
Chapter 3

ETHNICITY AND THERAPEUTIC ALLIANCE

The literature on psychological treatment of ethnic minorities has generally focused on determining cultural and personality differences between ethnic minorities and whites and on finding the reasons mental health services have been underutilized (Sue, 1977; Sue, 1981). The research has also focused on culture bias and sensitivity by non-ethnic minority psychotherapists to various aspects of different cultures and on discussions of optimal treatment modalities to use with ethnic minority patients (Boyd-Franklin, 1989; Comas-Diaz, 1988). The research has delineated issues with respect to different ethnic groups and the role that culture and cultural techniques play in psychotherapy (Rogler, Malgady, Costantino, & Blumenthal, 1987; Sue & Zane, 1977). However, the literature did not reveal evidence of definitive differences between ethnic minorities and majority whites in terms of either personality or the manifestation of psychopathology.

The focus of the current literature review was on psychotherapeutic treatment of ethnic minority clients. Emphasis was placed on factors that improved psychotherapy
effectiveness and in determining whether or not a relationship existed between therapeutic alliance and treatment effectiveness with ethnic minorities.

The current project was in response to reports that services for ethnic minorities were "inappropriate, demeaning, irrelevant, and oppressive" (Sue, 1981, p. xi). During the early 1980's efforts were made to develop new methods, concepts, and services more appropriate to the life experiences of ethnic minorities. A consolidated theoretical basis in conducting psychotherapy with the culturally different in the United States, however, never materialized (Sue, 1981). A theoretical foundation was needed because most research had been narrow in scope, often filled with conjecture, clinical anecdotes, or case reviews (Cobb, 1972; Sue, 1981). A theoretical foundation would allow researchers to develop new methods, concepts, and services more appropriate to the experiences of minority clients and provide a strong empirical base which would make treatment more relevant and less demeaning and oppressive for ethnic minorities (Sue, 1981).

To develop such a theoretical foundation, researchers investigated problems in mental health service delivery and interactions between the psychotherapy provider and recipient. Counseling and psychotherapy have been defined by Sue and Sue (1977) as a "... process of interpersonal interaction and communication. For effective counseling to occur, the counselor and client must be able to appropriately and
accurately send and receive both verbal and nonverbal messages" (p. 420). In the patient-therapist relationship many non-ethnic minority therapists are not able to relate well to their ethnic minority and low socioeconomic status (SES) patients, and this factor appears to be a primary reason many ethnic minority patients leave treatment prematurely (Ponterotto, 1988).

Some researchers have postulated that because within group communication breakdowns often occur between members who share the same culture, it is only logical to assume that breakdowns in communication will magnify and produce greater alienation, less trust and less rapport between cultural/racial groups (Sue & Sue, 1977). This reasoning suggested that an increase in alienation and reduction in trust and rapport would likely prevent good therapeutic alliance and possibly increase premature treatment termination. In short, the counseling or psychotherapy would end prematurely due to the inability of the therapist to establish a good working relationship or therapeutic alliance.

The importance of therapeutic alliance in relation to improved treatment effectiveness and a reduction of early treatment termination has been discussed by many researchers (Acosta & Sheehan, 1976; Carkhuff & Pierce, 1967; Lerner, 1972; Padilla, Ruiz, & Alvarez, 1975; Sue, 1977; Sue, 1981; Torrey, 1986). Although therapeutic alliance has been discussed as a potentially useful therapeutic tool in working with ethnic minorities (e.g., Sue, 1981; Sue & Zane,
1987), it has not been regarded as an essential or important psychological issue for the treatment of ethnic minorities, as it has in the mainstream psychotherapy literature. Perhaps this has been because researchers have focused, instead, on developing alternative methods of treating ethnic minorities. Sue (1981) has argued, however, that a major stumbling block to effective psychotherapy with ethnic minorities has been the failure to build the factor of therapeutic alliance and not necessarily the lack of adequate treatment modalities.

Failure to establish a therapeutic or working alliance with ethnic minorities may be a reason that well-established therapeutic modalities have not been used successfully with ethnic minorities. In fact, evidence for the lack of success with common therapeutic modalities was reported by Sue and Zane (1987) who noted that no improvement has been observed after 20 years of studying the problem of increasing the effectiveness of mental health treatment with ethnic minority populations. In an attempt to explain the lack of effectiveness, Sue and Zane (1987) suggested that "the single most important explanation for the problems in service delivery involves the inability of therapists to provide culturally responsive forms of treatment" (p. 37). Moreover, Sue (1977) has suggested that because most therapists are trained in the style of mainstream American psychotherapy, they are not attuned to cultural factors affecting treatment efficacy which may consequently lead to a higher
dropout rate for ethnic minority patients than for white patients.

Sue and Zane (1987) have suggested an alternative method for improving treatment effectiveness with ethnic minorities. They argue that rapport between ethnic minority patients and their therapists may be improved by increasing the qualities of "credibility" and "giving" in the therapist. In essence, they argue that it is necessary to effect change in the interactive style of the therapist, rather than in the treatment modality, to enhance therapeutic effectiveness with minority patients. Their suggestion is to increase or enhance the therapeutic alliance with the patient. Thus, by focusing increased attention on the relationship between the therapist and patient, that is, the therapeutic alliance, it may be possible to improve therapy outcomes with ethnic minority patients.

The research that led to this conclusion stemmed from studies of the influence of race on psychotherapeutic treatment (e.g., Griffith & Jones, 1978; Yamamoto, James, Bloombaum, & Hattem, 1967). The studies on ethnicity or race, however, were not always forthcoming and research that was available often had methodological flaws or poor theoretical foundations, or were anecdotal or case history reports.

Ponterotto (1988), who reviewed 934 articles and brief reports published between 1976 and 1986 in the Journal of Counseling Psychology, found only 53 (5.7%) articles
pertaining to racial or ethnic minority issues. Of those, only 49 articles were empirical studies. His analysis of these studies revealed, in part, "a lack of conceptual or theoretical framework to guide research" (p. 410) and lack of hard scientific data. Based on his review, Ponterotto (1988) recommended that researchers stop focusing solely on cultural variables and consider other variables that transcend culture and that are experienced by all people (e.g., economic deprivation). He also suggested that research focus on the strengths of ethnic minorities and those characteristics of positive mental health rather than focusing on the negative aspects. Nevertheless, the point is that research conducted with ethnic minorities must be done carefully without overgeneralization. At the same time, researchers must be attuned to the discrepancies observed in the psychotherapeutic treatment of ethnic minorities. They must delineate factors that will enhance treatment effectiveness and outcome.

The differential treatment of ethnic minorities may be a starting point from which one can determine what factors lead to poor treatment utilization, effectiveness, and outcome. These factors may in turn lead to clues about how to improve relationships between the therapist and patient. Yamamoto, James and Palley (1968) attempted to determine factors leading to poor treatment utilization. They administered questionnaires to 594 patients and their therapists. Of the 594 patients 65% were Caucasian and 35%
were ethnic minorities, including 25% Black, 9% Mexican American and 1% Asian. There was no systematic breakdown of the ethnicity of the therapists. Yamamoto et al. (1968) found that ethnic minority patients were discharged from treatment or seen for minimal supportive psychotherapy more often, and received less intensive therapy than their white counterparts. Generally, these researchers interpreted their results to mean that ethnic minority patients were more difficult to work with and less understood by their white therapists.

Cobb (1972), in a review of 34 studies of delivery of service, also found that ethnic minorities were less understood and that treatment was often inappropriate and irrelevant. In addition, he found that patients from higher socioeconomic status (SES) levels were more often recommended for treatment than low SES or ethnic minority patients.

Cobb (1972) suggested two possible reasons for this difference: (1) therapists may be prejudiced toward ethnic minorities and unknowingly treat ethnic minorities in a differential manner, and/or (2) therapists may recognize the inappropriateness of the treatment for ethnic minority patients and not refer them for treatment. Whatever the reason, it appears clear that differential treatment of ethnic minority and lower class patients was a constant problem, and factors contributing to this problem appeared to be in the characteristics therapists and patients possess. In addition, the interaction between the patient and
therapist based on these individual variables appeared to be a contributing factor to problems of poor treatment effectiveness.

Other studies pointing to the differential treatment of ethnic minorities with a wider population served to illuminate at least some factors that may be contributing to this problem. After reviewing records of almost 14,000 patients (90.2% White, 7.3% Black, 1.2% Native American, .7% Asian-American, and .6% Chicano) from 17 community mental health centers in Seattle, Washington, researchers found that ethnic minority group members who sought psychotherapy received discriminatory treatment from white therapists (Sue, 1977; Sue, McKinney, Allen, & Hall, 1974).

Specifically, the researchers found that African-Americans received differential treatment and had poorer outcomes than whites. Asian Americans, Chicanos, and Native Americans who received equal treatment to Whites also had poorer treatment outcomes as measured by premature treatment termination rates. These researchers hypothesized that because ethnic minorities and lower class patients are thought to be difficult to work with, therapists may unknowingly refuse or may be unable to work with ethnic minorities. They may convey this message on an unconscious level and in subtle ways such as expecting the patient not to make improvement or even to drop out of treatment prematurely.

The idea that unconscious communication may occur was suggested by Cobb (1972) who thought that therapists, be-
cause they have been traditionally whites from upper or middle SES, were unable to relate to lower class and ethnic minorities due to their lack of experience. He thought that the inability to relate had to do with those variables that ethnic minorities and low SES patients had that were different from the therapists. Therefore, the therapists' problems relating to ethnic minority and low SES patients resulted in an inability to establish a therapeutic alliance.

The problem of relating to the ethnic minority patient has been noted by Sue (1977) who reported that the effects of racism and differential treatment of ethnic minorities on service delivery were both direct and subtle, and cited the YAVIS syndrome (Schofeld, 1964) as a reason for whites being unwilling or unable to provide adequate treatment to minority patients.

The YAVIS syndrome (Schofeld, 1964) was described as the middle class therapist's inclination to work with young, attractive, verbal, intelligent, and successful (YAVIS) individuals who were likely to benefit maximally from treatment. The patient in this case was very similar to the therapist in culture, class, and worldview. The therapist was more than likely able to relate well to the patient because she or he was more often than not white, middle class, and from the same or similar cultural background as the patient.

In addition, the therapist may perceive the patient as
being able to benefit from treatment because of the similar backgrounds whereas she or he may not have had the same perception of the ethnic minority or low SES patient. The perception clinicians may have of the ethnic minority or lower class patient as too different from themselves may hinder or prevent them from being able to adapt their psychotherapy styles in order to accommodate the ethnic minority patient. Clearly this variable of therapist expectation appears to be a contributing factor that interferes with establishing a working or therapeutic alliance with the ethnic minority or lower class patient, and may in turn affect patient selection.

Patient selection is an important issue because if therapists select out those patients who are different from themselves or with whom they cannot relate, then services will not be available to ethnic minority and lower class patients. Alternatively, if therapists reluctantly accept ethnic minorities and lower class patients, subtle messages may be given and premature treatment termination will be hastened by the therapist. If the therapist cannot overcome this problem and adjust adequately, the problems of treatment efficacy with ethnic minorities may become more prevalent.

Acosta (1980) interviewed 74 patients who had terminated treatment prematurely to ascertain their reasons for leaving treatment. He found no differences between Mexican-American, African-American, and lower SES Anglo-Americans in
their reasons for terminating treatment prematurely when compared to whites who were of low socioeconomic status (SES). The reasons for premature treatment termination included: (1) negative attitude toward the therapist, (2) treatment was of no benefit, (3) environmental constraints, (4) self-perceived improvement, (5) appointment mix up, (6) situational impediments, and (7) perceived therapist's termination (Acosta, 1980). The two main reasons for patients leaving treatment were: (1) negative attitude toward therapists and (2) treatment was of no benefit.

Acosta (1980) could not point to specific factors the patients reported about the therapists that caused them to have a negative attitude, but strongly suspected that something occurred in the interaction between the patient and therapist to cause the patients to have negative experiences. Acosta's (1980) results suggested that, since the therapists were mostly white middle class (82%), the differences between the therapist and the patient were class issues that middle class or high SES clinicians were not well-equipped to handle.

In fact, an earlier study supported the hypothesis that therapists treat ethnic minorities and low SES patients in a subtle, but differential manner (Sue, 1977). In a study described earlier (Sue et al., 1974; Sue, 1977) which examined data from 17 community mental health centers, it was found that white patients from high SES levels dropped out less often than ethnic minorities, even after controlling for
education and income. These results suggested that therapists are likely to have viewed the high SES patients as similar to themselves especially if they were white. Consequently, they were better able or more willing to provide treatment which produced fewer premature treatment terminations for high SES white clients in comparison to ethnic minorities from similar SES levels. Sue (1977) also found that therapists often perceived ethnic minorities as looking for quick care of the medical model type, or lacked psychological awareness. This suggested that white, middle class therapists may have held negative attitudes toward the minority patients, and may have treated them differentially. Sue (1977) found it difficult to verify this conclusion, however, because the clinicians never really knew the true reasons for treatment termination due to the patient's failure to return for follow-up appointments.

Acosta's (1980) conclusion that ethnic minority patients held negative attitudes toward their therapists, as well as patient reports of poor treatment outcomes, strengthened the hypothesis that therapists may be giving subtle negative messages to their minority patients. Negative messages from the therapist, subtle though they may be, are likely to result in the development of poor therapeutic alliance which, in turn, may lead to poor treatment efficacy.

The issue of therapist variables hindering treatment efficacy for ethnic minorities has been discussed for the
past two decades. The consensus is that stereotypes exist for middle class therapists who work with low income and ethnic minority patients (Acosta, 1977, 1980, 1982; Lorion, 1974; Thomas & Sillen, 1972). In addition, the literature suggests that therapists' biases affect their view of the patient in terms of diagnosis, disposition, and treatment, and that therapists choose patients who are more like themselves in SES, verbal fluency, and ethnicity (Acosta, 1982; Ponterotto, 1988; Schofeld, 1964; Sue, 1977; Yamamoto et al., 1967, 1968).

Furthermore, because therapists look for similar characteristics in their patients, they may give subtle indications that they do not want to treat ethnic minority patients or are disinterested in their welfare (Acosta, 1982; Rogler et al., 1987; Sue, 1977; Sue, 1981). Subsequently, another factor that may contribute to poor therapeutic alliance is that therapists may erroneously attribute stereotypic knowledge about an ethnic group(s) to the patient with whom they are working (Acosta, 1979; Comas-Diaz & Griffith, 1988) and view the typical ethnic minority patient's objectives as limited and simple. Ethnic minorities may have difficulty communicating their needs which may, in turn, lead therapists to incorrect understandings of the patient's needs (Acosta, 1982).

Additionally, Rogler et al. (1987) have argued that clinicians perceive non-ethnic minority patients along a continuum that ranges from uneducated to educated, but they
do not perceive ethnic minority patients similarly. To improve treatment efficacy with ethnic minorities, Rogler et al. (1987) suggested that minorities be recognized as existing along a similar continuum ranging from unacculturated to acculturated. Clinicians tend to use any available means to reach the majority white client of the YAVIS type (Schofeld, 1964), and it is important that clinicians similarly utilize whatever means necessary to reach ethnic minority clients.

The resolution may be for therapists to focus on the patient's life style rather than the ethnicity of the patient. Acosta (1980, 1982) suggested that ethnic minority patients are similar to low socioeconomic status (SES) non-minority patients. It appears that the ethnic issues, SES issues, and other environmental issues are similar and treatment should fit the patient, not the therapist's wishes for the patient's success.

Acosta (1982) conceptualized the therapeutic needs of patients as dual in nature. These needs include psychotherapy, as well as psychosocial therapy which allows for an understanding of social circumstances of patients and leads to the development of more appropriate treatment plans. He found that minority patients, in particular, do not generally benefit from insight therapy alone and often require a mixture of therapies to meet their dual needs. Further, Acosta (1982) stated that the comprehensiveness of treatment requires therapists to look at real life situations of
patients. Therapeutic objectives must be clear and acceptable to both patient and therapist, and the therapist must acknowledge prejudice and racism if it is recognized by the therapist. This can be accomplished through peer consultation and specific training designed to increase awareness of, and sensitivity towards, ethnic minority and low SES patients. Through these efforts a proper establishment of therapeutic alliance between the therapist and patient may be achieved. Furthermore, flexible treatments may be tailored to the individual needs of each patient regardless of the patient's SES, ethnic background, or environmental situation (Comas-Diaz & Griffith, 1988; Boyd-Franklin, 1989; McGoldrick, Pearce & Giodano, 1982; Sue, 1981).

Sue (1977) called for training programs to teach clinicians about ethnic minority issues to improve not only interactions between therapists and clients by fostering the development of an adequate therapeutic alliance, but to improve treatment efficacy as well. He suggested making clinicians aware of procedures that would make treatment more responsive and meaningful for ethnic minorities and low SES patients. As a result, subsequent research began investigating methods to achieve this goal. Evans, Acosta, Yamamoto & Skilbeck (1984) trained 29 beginning psychotherapists in a special program to increase awareness and sensitivity of ethnic minorities and low SES patients. The therapists were 26 second-year psychiatric residents and three clinical psychology interns. A baseline of pre-
training work with ethnic minorities and low SES whites was obtained prior to training the therapists. The patients were 171 adults including 62 Hispanics, 51 Blacks, and 60 Whites. Therapist training included seven weekly seminars of instruction and assigned readings. The therapists were evaluated through a cultural awareness questionnaire, patient ratings of therapist sensitivity to cultural issues, and an analysis of audiotape recordings of psychotherapy sessions.

Evans et al. (1984) found that the training helped psychotherapists to become more aware and sensitive to ethnic minority and low SES patient issues. Moreover, patients reported significantly more favorable responses toward the trained therapists than untrained therapists. The subjective evaluations were confirmed by analysis of the audiotapes of sessions which revealed that "oriented therapists provided significantly more explanation and discussion of patient problems and intended therapeutic regimen than non-oriented therapists" (p. 95). In effect, trained therapists were able to develop greater therapeutic alliance with their ethnic minority patients resulting in more favorable responses by the patients toward their therapists. On follow-up four to six weeks later, the patients continued to report significantly favorable responses and reported better coping skills to handle problems and expressed a greater willingness to return to the therapist if the need arose.
Evans et al.'s (1984) research demonstrated that psychotherapy is facilitated and treatment efficacy and outcome are improved when a clinician has established an adequate therapeutic alliance.

Patient variables, like therapist variables, affect the establishment of therapeutic alliance and treatment efficacy, and contribute to premature treatment termination. Patient expectations of therapeutic encounters are likely to make patients wary of therapists because the former may have preconceived notions of the ability of the latter to understand them (Ponterotto & Benesch, 1988). One reason may be that ethnic minority and low income patients may place great emphasis on immediate resolution of problems through some action and de-emphasize long verbal interactions (Acosta, 1982).

Patients may have such expectations because they are accustomed to receiving action-oriented treatment from physicians. When ethnic minority patients visit physicians, they are often prescribed medications for a malady. This prescription functions as an action-oriented curative resolution (Cobb, 1972; Padilla, Ruiz, & Alvarez, 1975). Ethnic minority patients often have similar expectations when they enter therapy, and when they do not receive such treatment, they tend to terminate treatment prematurely. As discussed previously, the treatment the therapist may be using is often viewed by the patient as irrelevant to the presenting problem (Sue, 1977). Patient expectations of
psychotherapy must be dealt with in a sensitive and educational manner so that the patient gains an understanding of the therapeutic interaction.

The ethnic minority patient's world view is another characteristic that influences the therapeutic alliance. Sue (1981) defines world view as the way "a person perceives his/her relationship to the world (nature, institutions, other people, things, etc.)" (p. 73). He believes that the world view is developed and influenced by the patient's cultural experience. In addition, he suggests that the manner in which one is raised will determine or influence interactions between people, in this case psychotherapists.

If a patient learns to interact in a passive manner through his or her cultural experience, a therapist's attempt to teach the patient assertiveness skills, for example, may prove to be antithetical to the patient's cultural experiences. Furthermore, this may present greater problems for the patient when she or he attempts to utilize the newly acquired skills. Additionally, the patient may terminate treatment because she or he finds the therapist's attempts too foreign and confusing, irrelevant, and/or oppressive (Sue, 1981). While ethnic minorities and therapists have their different world views, problems may occur if the therapist is not aware of or sensitive to such differences.

When differences between the therapist and the ethnic minority and low SES patient are acknowledged, however, it
is the responsibility of the trained professional to make necessary adjustments and bridge the gap to obtain a therapeutic alliance that will lead to improved treatment efficacy and ultimately positive treatment outcome. To determine the direction one must proceed to achieve a good therapeutic alliance, the clinician must: (1) obtain a sound clinical assessment to determine the nature of the problem, (2) incorporate the knowledge of therapist and patient variables, (3) educate the patient to the therapeutic process, and (4) approach the patient with cultural sensitivity and awareness. Moreover, the therapist must have a recognition of his or her own biases and prejudices and be willing to discuss these issues with ethnic minority patients in an open, honest, and non-threatening fashion (Ruiz, 1985). These efforts are likely to facilitate the process of establishing rapport — that is, the therapeutic alliance — with the ethnic minority and low income patient. Although many issues minorities face are economic in nature (Cobb, 1972), it is important to take into account that all individuals have a unique socio-cultural background. These socio-cultural differences, however, are more prevalent with ethnic minorities and low SES people (Evans et al., 1984; Minuchin et al., 1967; Padilla & Ruiz, 1973; Ruiz, 1985).

The effort to increase cultural awareness and sensitivity towards ethnic minorities and low SES patients and establish an adequate therapeutic alliance would serve to make treatment more relevant, culturally sensitive, less
demeaning, and less oppressive. It would also increase confidence and establish a positive reputation within the ethnic minority and low SES community. Through these efforts, utilization rates would more than likely rise to more appropriately proportional levels. In fact, several interventions have successfully improved the reputation and increased the utilization rates of mental health centers incorporating these guidelines (Abad, Ramos, & Boyce, 1974; Acosta, Yamamoto, Evans, & Skilbeck, 1983; Normand, Iglesias, & Payn, 1974; Rodriguez, 1971).

Rodriguez (1971), for example, used a group format with 21 male Hispanic patients who met once a week. He believed that the identification and support the patient received from the group members, as well as the willingness of the therapist to understand and work through problems, served to enhance the therapeutic process and increase utilization. Rodriguez believed the patients found the group non-threatening and useful.

In a second study, Abad et al. (1974) set up a community mental health center in the Hispanic section of New Haven, Connecticut, incorporating bilingual/bicultural staff members. The community mental health center provided education of the therapy process, worked closely with Hispanic religious groups, and provided consultation services to Hispanic agencies and organizations. In addition, they worked closely with hospital emergency rooms for referrals. Through these efforts these researchers increased their
hours of operation from one afternoon a week to five days a week to accommodate the increased numbers of patients using the clinic. The researchers reported that the reputation of the clinic was strictly by word of mouth and there had been no formal opening or advertising.

In a third study, Normand et al. (1974) treated 55 (13 males and 42 females) Hispanic patients in brief group therapy. The therapy was conducted by bilingual/bicultural staff. The group served an educative function to prepare the patients for longer term therapy. The researchers reported that although the patients were uncomfortable with each other at the beginning of the group, they gradually found that they had common problems and were able to support each other. The researchers found that 40 patients had improved with brief group therapy. Of 55 patients, 13 dropped out of treatment and 31 of 42 referrals for long-term treatment followed through with the referral.

In a fourth study, Acosta et al. (1983) developed an orientation program to help patients understand the process of psychotherapy. Specifically, the program was designed to help patients better express the nature of their problems, needs, and expectations of the therapist. The orientation was also designed to help the patients become more active in psychotherapy. The project included 62 Hispanic, 51 black, and 60 white psychiatric outpatients. Results indicated that patients who received the orientation were more knowledgeable about psychotherapy than those patients who did not
receive the orientation. In addition, the oriented patients had better attitudes toward therapy than non-oriented patients. These results suggested that with training, ethnic minority and low income patients can benefit a great deal from treatment. Moreover, orientation can serve to improve therapeutic alliance and reduce negative expectations patients may have about therapy or therapists.

In general, these studies illustrated successful efforts by clinicians to increase cultural awareness and sensitivity, establish an adequate therapeutic alliance, increase positive attitudes towards the clinic or clinicians, approach the process of therapy in an open and non-threatening manner, and ultimately improve treatment efficacy and outcome. In fact, studies specifically investigating utilization rates of mental health facilities found that these rates doubled following implementations of innovations such as these (Bloom, 1975; Trevino, Bruhn, & Bunce, 1979).

Another patient characteristic thought to affect the therapeutic alliance is language differences between non-English speaking clients and therapists (Marcos, 1976; Padilla, Ruiz, & Alvarez, 1975). These differences may also prevent establishment of a therapeutic relationship and possibly hinder treatment efficacy, which could ultimately lead to premature treatment termination (Marcos, 1976; Rogler et al., 1987; Rozensky & Gomez, 1983; Schumacher, Banikiotis, & Banikiotis, 1972). One resolution to this
problem was studied by Acosta and Cristo (1981) who developed a program to use specially trained interpreters for those Spanish-speaking patients whose primary language was not English. The program was found to be successful and did not create a distraction from the therapy process (Bloom, 1975; Trevino, Bruhn, & Bunce, 1979). Innovative programs may facilitate the therapeutic alliance and increase credibility with the patient. However, in instances where interpreters are not available or necessarily needed, what is important is that the therapist exhibit the willingness to understand and work with the patient. Efforts put forth by the therapist will serve to enhance therapeutic alliance and increase treatment efficacy and outcome.

The concept of therapeutic alliance is imbedded in the ethnic minority research on culture bias, cultural sensitivity, and demeaning or oppressive treatment. Therapeutic alliance, when emphasized and used appropriately, can be useful in providing services to ethnic minorities and can serve to: (a) increase mental health utilization; (b) obtain a proper clinical assessment (Ruiz, 1985); (c) address unique socio-cultural differences of ethnic minority populations such as focusing on the patient's life style rather than the ethnicity of the patient (Acosta, 1982); (d) look at real life situations of patients (Acosta, 1980, 1982); (e) enhance therapeutic objectives in a clear and acceptable manner (Acosta, 1982; Sue, 1981); (f) help the therapist acknowledge prejudice and racism if she or he
notices it (Boyd-Franklin, 1989; Comas-Diaz, 1988); and (g) provide adequate assessment of the client's level of acculturation (Cuellar, Harris, & Jasso, 1980).

In summary, psychologists are strongly encouraged to focus on increasing therapeutic success by returning to therapeutic basics and developing a conceptual framework from which to establish a more productive and positive therapeutic alliance with minority patients. Thus, the therapist does not necessarily have to be a member of the same or similar cultural group to achieve therapeutic success.

The literature has neglected the development of the therapeutic alliance as a useful conceptual framework for conducting psychotherapy with culturally diverse groups. Furthermore, the importance of a successful therapeutic alliance for positive psychotherapy outcomes has not been sufficiently recognized. Thus, it has been argued that increased focus on the development of successful therapeutic alliances with ethnic minority clients is both important and necessary. Specific elements of this alliance to be addressed in the next chapter include the components of cultural sensitivity, rapport building, establishment of credibility, understanding the individual's family background, and the utilization of empathy to facilitate effective treatment. In addition, suggestions for teaching alliance-building skills in clinical psychology training programs will be discussed.
Phares (1979) believed all psychotherapies have common elements and the goal of each is to help the patient adjust to his or her life circumstance and become happier. All psychotherapies appear to have the elements of warmth, empathy, and acceptance; however, the manner in which each one manifests these elements may be different. The goals for psychotherapy are dependent on factors that include the problems identified by the patient, the patient's life circumstances, the nature of the patient's personality, the training of the therapist, and the patient's cultural background (Phares, 1979). The current discussion has not been an attempt to introduce a new or different psychotherapy. In addition, the argument for an alternative psychotherapeutic technique for ethnic minorities has not been made. Rather, it has been the aim of the current discussion to describe therapeutic alliance as an important and necessary element in psychotherapy and to emphasize it as an aid to enhance psychotherapy.

Establishing therapeutic alliance with ethnic minorities should not be any more difficult to achieve than with
non-ethnic minority patients. Clinicians often use whatever means necessary to understand a patient and gain a good therapeutic alliance with the individual (Schofeld, 1964). The same effort must be made with ethnic minorities and low SES patients. The process can be accomplished by following guidelines designed to facilitate a good working or therapeutic alliance.

The first of these guidelines is cultural sensitivity. Cultural sensitivity is the awareness one has for the individual's ethnic origin (McGoldrick, 1982). The clinician must be sensitive to the patient's needs, problems, and experiences within the framework of the patient's cultural background. Obtaining a complete and proper assessment is one method to ascertain these needs and to determine the patient's cultural background. The clinician must take care to obtain the necessary information in a non-threatening and non-offensive manner; acknowledging cultural differences with a presentation that shows respect for the patient and does not offend the individual with whom the clinician is working.

The process of establishing the therapeutic alliance usually begins within the first session. The first session is thought to be the most important session and will determine the outcome of the therapeutic experience (Jalali, 1988). Many patients enter into psychotherapy ignorant of the psychotherapy process and they may have negative expectations of the therapist's motives, evaluations, and
interpretations (Comas-Diaz, 1988). One of the first steps in establishing the therapeutic alliance is to explain the psychotherapeutic process to the patient. In so doing, the clinician may help the patient to understand his or her problem and express it in a way that helps them understand the nature of their problem.

It is important to note that all patients come from some ethnic origin whether it is the majority white or ethnic minority from an upper class environment or a from a lower class environment. Each has his or her unique view of the world. Most often the patient's world view (Sue, 1981) is different from that of the clinician performing the interview. Although most clinicians are not trained as cultural anthropologists, it is suggested that one take the approach of curiosity and interest of a cultural anthropologist (Jalali, 1988).

Pathological behavior, when present, should be diagnosed without hesitation; however, nuances that are often mistaken for pathology must equally be recognized without hesitation. For example, the patient who does not make eye contact or who may make inquiry into the therapist's credentials may not lack the ability to relate to others or have a problem with authority. Rather, this patient may simply be expressing a polite gesture or seeking reassurance that she or he is in the company of the proper health care provider (McGoldrick, 1982). So often in our haste to complete the interview the necessity of using cultural sensitivity
escapes us and we are left wondering about the poor response with which our efforts are met. Acknowledgement of the difference in ethnicity between the patient and the therapist may help to bridge the gap between the cultures.

McGoldrick (1982) suggests that therapists should become aware of their own ethnicity and struggle with their own subjective view of the world in order to help them become cognizant of their own biases and help them become more sensitive to other's cultural backgrounds. Training programs may aid this process by instituting instruction and exercises designed to increase awareness of one's own ethnicity. The training should begin during the initial stages of graduate study and continue throughout the student's tenure. Constant focus on cultural sensitivity must be a requirement so that issues of ethnicity become second nature and do not seem foreign to the therapist. The more comfortable the clinician is with ethnic issues the easier it may be for him or her to observe a problem the patient may be experiencing without fear of making a mistake and possibly alienating the patient further (Evans et al., 1984). The role of the therapist requires keen observation and knowledge of the dynamics within the patient or patients.

Jalali (1988) suggested that therapists must become mediators between the patient and the culture. The therapist must be observant of the problems the patient is having with the environment and help him or her understand and deal with it effectively or help the patient appropri-
ately accept the situation. An open mind and willing curiosity may be one key to acquiring and maintaining cultural sensitivity.

Problems establishing therapeutic alliance may arise without the therapist's knowledge. The clinician may, at times, inadvertently show disrespect, become threatening, or be offensive toward the patient, even though precautions to the opposite have been taken. This may lead to an initially poor therapeutic alliance, but this does not mean that the patient will necessarily leave treatment. Initially poor therapeutic alliances can be recovered and a strong therapeutic alliance may be subsequently established by acknowledging and directly addressing the problem (Foreman & Marmar, 1985). The patient will more than likely view the effort by the clinician as a desire to understand the patient and participate to a greater degree with the therapist.

The second guideline for establishing a therapeutic alliance is the concept of rapport. Rapport is the relationship a therapist establishes with a patient which includes mutual trust or emotional affinity (Benjamin, 1981). Rapport building is a skill used by clinicians to establish a therapeutic relationship with the patient (Egan, 1982). The manner in which the clinician attempts to establish the relationship with the patient determines whether the interaction is successful or not. In addition, the level of rapport one establishes with patients may vary
according to the patient's interpersonal style and ethnicity (Benjamin, 1981; Egan, 1982). Some patients need a greater degree of rapport than others and it is the clinician's responsibility to determine the necessary level of rapport that will be most effective with a particular patient (Egan, 1982).

The awareness the clinician has of the patient's cultural background can help him or her determine the degree of rapport to establish. Placing emphasis on rapport is important because doing so allows the patient to feel comfortable, cared for, and allows the patient to recognize that the clinician is attempting a basic understanding of their problem or situation. It also allows the therapist to invite the patient to participate in the therapeutic relationship. Rapport allows the clinician to express himself or herself in a manner that conveys openness, honesty, caring and understanding (Benjamin, 1981; Egan, 1982). Moreover, it allows the therapist to express interest and understanding which the patient may be accustomed to receiving from others in the past as Freud (1913) has suggested. In this case the rapport that is established is not necessarily to foster transference, but to enhance the therapeutic alliance and to improve treatment outcome. The idea of establishing rapport has been discussed in the literature by various authors (e.g., Sue & Zane, 1987) and it is a technique that is often taught in basic interviewing courses (Benjamin, 1981; Egan, 1982). However, it is often
not discussed in relation to it's importance in working with ethnic minority patients. In addition, techniques for achieving rapport are often only alluded to in the literature (e.g., Sue & Zane, 1987).

An example of establishing good rapport can be seen in the work of Acosta and Cristo (1981). These researchers developed a treatment program using Spanish-speaking interpreters to work with Hispanic patients. The therapeutic intervention was successful and appeared to have had positive treatment outcome after rapport was achieved. In this case, rapport was achieved by the clinician's willingness to use any means necessary to gain an understanding of the patient's problems. This willingness was viewed by the patients as a genuine attempt to understand and help them and served to increase the therapist's credibility and the patient's willingness to participate in the therapy. This type innovation is one example of the many techniques therapists can use to establish rapport with the ethnic minority patients.

A third guideline to consider when establishing a good therapeutic alliance is the concept of empathy. Empathy is defined as the understanding of another's feelings, situation, or motives or the willingness to view a situation from the perspective of the patient (Benjamin, 1981; Egan, 1982). This may be one of the more difficult skills to use with ethnic minorities because of the difference in cultural backgrounds between clinicians and patients. Although a
clinician may not have the same or similar experiences as the ethnic minority patient, empathy may be achieved through moderate effort. In this case, the clinician's cultural sensitivity, rapport building skills, and self-understanding of ethnicity may allow the him or her to probe the patient in a manner that elicits experiences with which one can relate. A therapist may never know exactly what it feels like to be the patient, but she or he may estimate with some accuracy the feelings, emotions or experiences of the patient (Egan, 1982). In addition, the therapist may be able to encourage the patient to help him or her understand the patient's experience, if an adequate therapeutic alliance has been established.

It is most important that the clinician convey willingness and an honest attempt to understand the patient's problem, feelings, emotions, and experiences, because this effort may be the single most important factor in establishing a strong therapeutic alliance. The therapist may not have extensive knowledge or experience working with a particular ethnic minority patient, but if he or she can communicate empathic understanding and a desire to help, achieving a therapeutic alliance will be facilitated. More importantly, the ethnic minority patient may not only be more willing to work with the clinician, but may be willing to teach him or her about their ethnicity.

The fourth guideline for establishing a therapeutic alliance is that of credibility. Credibility is not
something that the clinician can overtly attempt to achieve. Instead, the therapist's credibility should be enhanced if the three previous guidelines are followed. However, if it appears that the therapeutic alliance has not been established, lack of achieved credibility may be part of the problem. Sue and Zane (1987) define credibility as "the client's perception of the therapist as an effective and trustworthy helper" (p. 40). Some credibility is achieved prior to the patient attending the first session simply by the fact that the clinician is a professional and has had a certain level of education. This type of credibility is referred to as ascribed credibility (Sue & Zane, 1987). However, credibility is maintained and hopefully enhanced by one's skill and effectiveness in understanding the patient's problems and helping him or her to resolve them. This type of credibility is known as achieved credibility (Sue & Zane, 1987).

Credibility is important because without it, not only will there likely be a rupture in the therapeutic alliance (Safran et al., 1990), but the process of psychotherapy may produce a poor outcome. Sue and Zane (1987) believe that therapists often lack ascribed credibility with ethnic minorities because they are viewed to not be well-equipped to deal with ethnic minority issues, thus leading to low utilization rates. Moreover, these researchers believe that if ethnic minority patients present for services they tend to leave treatment early because of poor achieved credibili-
ty. The patient does not believe the therapist is able to help them.

To maintain an adequate level of credibility Sue and Zane (1987) suggest that therapists: (1) gain a thorough understanding of the patient's problem, (2) help find solutions to the patient's problem which do not run counter to his or her culture, and (3) identify and establish compatible goals with the patient. The clinician must periodically assess his or her credibility based, in part, on the progress of the treatment and incongruities in one or more of the above goals. Continual monitoring of these processes will help to maintain adequate credibility and therapeutic alliance.

Training programs may instruct their students on the concept of credibility through role-playing exercises with college students of all ethnicities. Progress may be measured by evaluations performed by the student, patient, and experienced clinician. Through these exercises and evaluations the student clinician can gain experience and knowledge on the subtleties of both ascribed and achieved credibility. In addition, the student clinician may hopefully gain experiences with ruptures of credibility and learn to deal with improving those ruptures.

The last guideline to consider for establishing therapeutic alliance is the ethnic patient's family background. When the therapist obtains a good understanding of the patient's family of origin he or she will be able to gain a
good understanding of the patient. Just as in non-ethnic minority patients, the family of origin gives the clinician a window into the dynamics of the individual patient. An understanding of the person's world view will determine the level of cultural sensitivity, rapport, and credibility one must utilize. The general descriptions of ethnic families in the literature (e.g., Boyd-Franklin, 1989) are helpful, but they can not possibly capture each and every family. The characterizations of non-ethnic minority families are also based on general descriptions and differ with respect to region of the country and each family, but serve to provide a basic understanding of the family. However, because most therapists are not ethnic minorities, they may have a tendency to rely more on these general literature descriptions, instead of gaining a thorough understanding of their patient's family background. Thus, they must make a concentrated effort not to rely heavily on stereotypes. Analogously, the characterizations of ethnic minority families are general descriptions and it is incumbent on the clinician to ascertain the unique family style within which the patient grew up. The effort the therapist places on understanding the patient's family dynamics, and subsequently the patient's dynamics, will facilitate rapport, cultural sensitivity, and credibility.

The preceding guidelines provide a general overview to help the therapist achieve an adequate therapeutic alliance with ethnic minority and low SES patients. These guidelines
should be considered as a whole process working in tandem to improve treatment effectiveness and outcome. The reader is cautioned not to use these guidelines as a panacea for working with ethnic minorities or low SES patients, but as a starting point in learning the process of psychotherapy with minority clients. Clinicians are encouraged to modify and add to the current guidelines as deemed necessary given the nature of the situation. However, continued work to increase awareness and sensitivity of ethnic issues is also strongly encouraged.

Research in the area of therapeutic alliance with ethnic minorities is needed to lend credence to these ideas. It is believed that a theoretical foundation has been laid from which sound research can be generated. Research to investigate the teaching techniques incorporating the concept of therapeutic alliance with ethnic minorities is suggested. In addition, research using actual ethnic minority and low SES patients emphasizing therapeutic alliance is also suggested. Finally it is suggested that training programs continue their efforts to incorporate ethnic issues in every facet of the training curricula so that clinicians are accustomed to dealing with similar issues out in the field and do not hesitate to tackle these issues in the initial stages of therapy.
Chapter 5

CONCLUSIONS

Therapeutic alliance has been discussed as a theoretical framework to enhance psychotherapy effectiveness and outcome with patients, in general, and ethnic minority patients, in particular. Although the relationship between the therapist and the ethnic minority patient has been addressed in the past, the importance of therapeutic alliance for successful treatment of the minority patients in psychotherapy had not been clearly set forth until now. In this review, factors that can be incorporated in the treatment of ethnic minority and low SES patients which would enhance the therapeutic alliance were discussed. These factors included: (1) obtaining a good clinical assessment to determine the patient's ethnicity and worldview, (2) incorporating knowledge of therapist and patient variables that affect psychotherapy effectiveness, (3) educating the patient to the process of psychotherapy, (4) increasing cultural sensitivity and awareness, and (5) recognizing and addressing personal biases, prejudices, and racism which may impact the therapeutic process. In addition, guidelines for the establishment of a therapeutic alliance with ethnic minority and
low SES patients were delineated. These guidelines included cultural sensitivity, rapport, credibility, empathy, and knowledge of the patient's family background.

This review of the literature regarding ethnic minorities generated three recommendations to improve psychotherapy effectiveness with ethnic minority patients. First, cultural or racial issues should be addressed at the outset of and during psychotherapy. Addressing cultural or ethnic issues can give the ethnic minority patient permission to discuss related concerns without fear of violating some unspoken rule. Second, clinicians would benefit from gaining as much experience working with ethnic minorities as possible. Research has suggested that clinicians with more ethnic minority experience feel more comfortable with, achieve greater psychotherapy effectiveness with, and are more willing to spend additional time explaining the process of psychotherapy to minority patients than inexperienced therapists (Evans et al., 1984). Third, training programs should stress the importance of establishing an adequate therapeutic alliance using the components listed above, no matter what the ethnicity of the client.

As presented in this paper, therapeutic alliance is a theoretical concept with limited empirical support, particularly as it relates to ethnic minorities. Additional research is needed to provide a more in depth understanding of the concept and verify its potential to enhance psychotherapy effectiveness with ethnic minorities. Examples of
such research might include comparing experienced and non-experienced psychotherapist's effectiveness in establishing therapeutic alliance with ethnic minority patients or surveying patients to determine what defines an effective working relationship with their psychotherapist. Much work also remains to delineate the most effective ways to teach beginning clinicians to establish therapeutic alliances with ethnic minority patients.
REFERENCES


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes?" Archives of General Psychiatry, 32, 995-1008.


