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The process of change in ethnic minority males undergoing psychodynamic psychotherapy: a detailed comparison of two cases

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Better understanding of the connection between therapeutic processes and outcomes in minority groups can help design and use culturally adapted treatments. To explore the active ingredient in the therapeutic process, the present case study compared two ethnic minority male clients, recruited as part of a randomized controlled trial, one with a good outcome, the other with a poor one. The 12-item Working Alliance Inventory-Observer (S-WAI-O) coding system was used to capture the process of change, alongside a qualitative analysis of content. The cases were identified based on their change in pre- to post-treatment scores on the Beck Depression Inventory and the Hamilton Rating Scale for Depression. The findings suggest a rupture-resolution process in the good outcome case, including a process of negotiation of the alliance and work on issues of trust. In contrast, the poor outcome case showed strong and steady alliance, but context analysis pointed to withdrawal ruptures. Although it is difficult to generalize from a two-case study analysis, the present work suggests that building and negotiating alliance with minority clients has a potential for treatment success.

Keywords: alliance; therapeutic process; case studies; ethnic minority groups; psychodynamic treatment; rupture resolution processes

Most of alliance research to date has not focused on minority clients. Therefore, more research is needed to examine the relationship between minority status and alliance (Castonguay, Constantino, & Holtforth, 2006). Freud was first to discuss the therapeutic relationships, in his early papers on transference (Freud, 1920). Emphasizing the importance of the personal bond between client and therapist, he noted that these bonds help clients remain in therapy and effectively participate in it. The term 'alliance' was later coined by Zetzel (1956) and elaborated by Greenson (1965). Subsequently, Bordin (1979) developed the working alliance framework, suggesting that an effective and positive alliance between clients and

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therapists comprises three components: the emotional bond within the therapeutic dyad, agreement on the goals of therapy, and agreement on the tasks involved in achieving these goals. Over the years, the topic of therapeutic alliance has received a great deal of attention. Researchers commonly recognize that stronger therapeutic alliance correlates positively with greater symptomatic changes (Martin, Garske, & Davis, 2000). Furthermore, meta-analyses have shown that therapeutic alliance is a predictor of positive outcome in therapy, regardless of differences in treatment conditions (Horvath, Del Re, Flückiger, & Symonds, 2011).

The client–therapist alliance has been noted to be a dynamic construct (de Roten et al., 2004; Stiles & Goldsmith, 2010). Several distinct patterns of alliance development, associated with positive outcomes, have been identified (Stiles & Goldsmith, 2010). Some studies have shown a linear increase in alliance as therapy progresses (Patton, Kivlighan, & Multon, 1997), whereas others have shown a U-shaped pattern (strong alliance in early sessions, decrease during intermediate sessions, and strong alliance in the concluding sessions) and patterns of alliance ruptures and repairs (Safran & Muran, 1996). When predicting positive outcome alliance patterns were found to vary, and to be affected by the rater, whether it was client or therapist rated (Bachelor, 2013). This leaves open the question whether different clients or groups of clients are associated with different and distinct patterns of alliance in successful treatments. In particular, the relationship between therapeutic alliance and symptom change is less clear regarding members of minority groups, where fewer studies have been conducted. Adapting treatment to individual clients has been slower than expected because not enough is known about various groups of clients (Hall, 2001). Several studies have suggested that minorities and non-minorities experience similar benefits from therapy (Blom et al., 2010; Cruz et al., 2007; Lambert et al., 2006), with mixed results in the outcome with mixed and same-race dyads (Imel et al., 2011; Karlsson, 2005). This further underlines the need to examine the processes involved in therapy involving ethnic minority clients.

Of the few studies that have examined differences in therapeutic processes with ethnic minority clients, some discuss the changes that need to be made to the therapeutic process to achieve culturally competent psychotherapy (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Gaztambide, 2012). Cultural skepticism has been used as a perspective in examining therapeutic sessions (Earl, Alegría, Mendieta, & Linhart, 2011). For example, African Americans have been found to harbor cultural distrust of the psychological field, which may account for an often-noted hesitation to seek treatment, and for the difficulties encountered in it (Brown, Blackmon, & Schumacher, 2013). Racial aspects are present in many treatments, but whether or not they are specifically addressed in therapy does not predict client satisfaction. It has been argued that a humble, empathic, and non-judgmental response from the therapist is of great importance for the success of treatment of ethnic minorities (Chang & Berk, 2009; Owen et al., 2015). In a meta-analysis, therapists' multicultural competence was found to be positively associated with the working alliance (Tao, Owen, Pace, & Imel, 2015). Therefore,

it has been argued that it is crucial to adapt psychotherapy to minorities for it to be successful (Pieterse, Todd, Neville, & Carter, 2012).

Consistent with general alliance research, good alliance with minority clients appears to be associated with better outcomes and with higher rates of treatment completion (Cordaro, Tubman, Wagner, & Morris, 2012). Only a few studies, however, have examined the association between alliance, ethnicity, and treatment outcomes in minorities, and these yielded mixed results. For example, some did not find any differences in alliance rating between mixed and same ethnic dyads (Cruz et al., 2007), whereas others found higher therapist- and client-rated alliance, and better outcome in same than in mixed ethnic dyads (Wintersteen, Mensinger, & Diamond, 2005). In a study examining changes in alliance over time, white clients reported a linear increase in alliance over time, whereas ethnic minorities showed no significant changes (Walling, Suvak, Howard, Taft, & Murphy, 2012).

The alliance might be experienced differently by ethnic minority clients, and may inhibit negative reactions toward others, specifically toward the therapist (Vasquez, 2007). A study that examined therapeutic alliance in the treatment of ethnic minorities stressed the importance of addressing the ethnic component and attempting to bridge the ethnic gap (Chang & Berk, 2009). Similar findings were reported in a case study analysis (Knight, 2013). It has been further found that clients who perceived microaggression (subtle forms of racism; Sue et al., 2007) during treatment reported a lower alliance, suggesting that it is important to explore and discuss cultural aspects in treatment and attend to the therapeutic relationship (Owen et al., 2011). To achieve a better understanding of such aspects, it is critical to investigate the therapeutic alliance in individual case studies involving minority clients, which can shed light on the unique processes taking place in the alliance, and on the effect of such processes on treatment outcome. In a case example, Altman (1995) examined how his own feelings of shame as a therapist treating an African American man held him back from bringing up racial content.

In light of the sparse literature on therapeutic alliance with minority clients and of the many open questions that remain in this field, the present study examined the active ingredients in therapeutic process involving minority clients in two cases, one with a good, the other with a poor outcome. We sought to identify the individual-level processes that led to the therapeutic change, and to examine the effect of addressing cultural aspects in treatment. The literature stresses the importance of addressing race-related content and of building trust, but it has not focused specifically on the effect of the dynamic of alliance on outcome involving ethnic minorities. In the present study, we hypothesize that the relationship between the ethnicity of the client and therapist may facilitate racial processes that may need to be carefully attended to. Case study methodology offers an excellent opportunity to investigate mechanisms of change in individual client–therapist dyads and to isolate the mechanisms of change (Hill, Carter, & O'Farrell, 1983). Whereas in large samples researchers can generalize their findings, in case studies it is possible to look deeper into the individual clients and specific changes, enabling the findings to inspire future research of large samples. Use of similar cases

treated by the same therapist provides an opportunity to focus on the client and on dyadic variables rather than on the therapist (O'Farrell, Hill, & Patton, 1986).

The two cases reported in the present study were selected from a larger randomized controlled trial (RCT) of short-term psychodynamic psychotherapy, medication, and pill placebo, conducted on 156 clients with major depression disorder (MDD) (Barber, Barrett, Gallop, Rynn, & Rickels, 2012). The RCT found that race and gender moderated outcome. Psychotherapy was found to be more efficacious for minority men than medication and pill placebo. These findings led to the present study, in which we looked deeper into the treatment of this subpopulation to find the active ingredient in psychotherapy that led to the efficacious outcome among minority men. We used a mixed method approach of inquiry that combines qualitative and quantitative tools, one method shedding light on the other to advance clinical knowledge (Dattilio, Edwards, & Fishman, 2010).

Method

The present study relied on an RCT conducted by Barber et al. (2012), in which 156 clients, who had all met the DSM-IV criteria for MDD based on the Structured Clinical Interview (First, Spitzer, Gibbon, & Williams, 1995), were randomized into one of three treatment groups: supportive-expressive therapy (SET), pharmacotherapy, or pill placebo. The clients signed a consent form allowing videotapes of their sessions to be used for research, and were assured that no identification information would be included in any publication. For the purpose of the present study, the therapies of two ethnic-minority males were compared. The clients who were selected had completed the full active phase of SET treatment in the above-mentioned study and had been treated by the same therapist, so that the focus of the study was on clients and dyads rather than on therapists. From among the clients with the most extensive and available record of therapy sessions, two clients were chosen. A single client with the best outcome was selected, he was then matched, based on intake Beck Depression Inventory (BDI) scores and demographic similarities, with a poor outcome case treated by the same therapist. Good and poor outcome cases were identified based on their change in pre- to post-treatment scores on the BDI and the HRSD.

Participants

Client 1

An African-American male in his late thirties, single, father of two children from two women, with 13 years of education, a full-time position in the field of finance, and a moderate annual salary (median, according to the US Census; Webster & Bishaw, 2007). The client claimed that he had been in a depressed state for a few years, which had affected him both socially and professionally. In particular, he noted that his work capacity and professional involvement

had decreased, affecting his salary, and that in recent years he had become less active and more withdrawn socially. He sought therapy to address this long-term depressive condition.

Client 2

An African-American male in his late forties, married, father to one child, with 10 years of education, previously employed as a service provider, but unemployed at the time of the study. While employed, the client's annual income had been below the median (according to the US Census; Webster & Bishaw, 2007). The client described a variety of social and mental problems he had faced in the last few years. He felt that he had become withdrawn from his family and friends, that he was not contributing as much as he would have liked to them, and was not as involved as he would have liked to be in the relationships with them. He had sought therapy to address this long-term depressive state.

Therapist

A white female, with over 15 years of clinical experience and over 10 years of experience in SET, who served as a therapist in prior SET studies.

Treatment

Both clients were treated with SET – a time-limited, manualized psychodynamic treatment adapted for depression, using supportive and expressive components (Luborsky et al., 1995). The active treatment lasted 16 weeks. Therapy sessions were provided twice a week during the first four weeks (for a total of 8 sessions), and weekly for the remainder of the treatment, consistent with the process described by Barber et al. (2012). The treatment focused on understanding the clients' negative relationship patterns and helping them cope with core relational difficulties, with the use of supportive techniques aimed at establishing positive relationships (Luborsky, 1984). Expressiveness refers to the therapist using that which is expressed by the client to frame interpretations of the main relationship themes. Clinical formulation was based on the Core Conflictual Relationship Theme (CCRT), a method that comprises three components: a wish (W), a response from the other (RO), and a response from the self (RS). CCRT helps track the clients' experiences and can be used to direct therapy sessions to focus on the wishes and hopes of clients within the context of therapy (Luborsky et al., 1995). The treatment manual emphasizes the importance of transference and countertransference work. It has been suggested that therapists should explore cultural issues that may affect the therapeutic work in SET and other psychodynamic treatments (Leichsenring & Schaunburg, 2014); that therapists should be aware of their own and their clients' cultural background and explore the differ-

ences between them; and that they should make an effort to become familiar with their client's cultural background, and distinguish between what is normal and what is perceived as impaired in the client's cultural context (Connolly Gibbons et al., 2012).

Measures

The measures of the RCT used in the present study were the BDI (Beck, Ward, & Mendelson, 1961), the Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1960), the Inventory of Interpersonal Problems-Circumplex (IIP-C) (Alden, Wiggins, & Pincus, 1990; Horowitz, Rosenberg, Baer, Ureño, & Villaseñor, 1988), and the Working Alliance Inventory-Short Form: Client and Therapist versions (WAI) (Horvath & Greenberg, 1989) (described in detail in Table 1).

Two further measures were the Segmented Working Alliance Inventory Observer form, and the qualitative analysis of content, described below.

Segmented Working Alliance Inventory Observer form (S-WAI-O) (Berk, 2013)

A 12-item observer-scored inventory, based on Bordin's (1979) conceptualization of the working alliance, consisting of three subscales: bond, task, and goal. In the S-WAI-O only two of the subscales were used: bond and task. The goal subscale was removed because of high correlations and an overlap between the goal and the task items (Berk, 2013). The score is calculated as an average for each subscale, and an overall score for each 5-min segment, measuring change in the quality of the working alliance throughout the therapy session. Higher scores indicate a stronger alliance; a dip or a decline in the alliance rating is considered a rupture. In the present study, two undergraduate students served as independent observers and received training for two intensive weeks, 64 h in total, until agreement between them was achieved. Thirty-four videotaped therapy sessions and 300 segments were coded and analyzed. Inter-judge reliability by the two coders, as assessed by intraclass correlation (ICC [2, 1]; Shrout & Fleiss, 1979), was .93.

Qualitative analysis of content (Braun & Clarke, 2006)

Four researchers analyzed all the therapy sessions of both cases; two of the four researchers were more closely involved in the analysis than the others. Analysis was based on watching the videotaped sessions and looking for interpersonal interactions in the treatment. The aim was to explore the processes taking place in interpersonal interactions between the therapist and the client in the therapy room. The clinical formulation of the treatment (CCRT) was used to identify the patterns of recurrent themes and interpersonal problems in the thematic analysis. We focused on the client's interpersonal patterns and the ways they were or

Table 1. Measures used in the current study.

Measure	Description	Time of assessment in current study
Beck Depression Inventory (BDI) (Beck et al., 1961)	A 21 item self-reported inventory assessing the severity of depression. Higher scores indicate more severe depression	Intake and final session
Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1960)	A 17 item Clinician-based evaluation of depressive symptoms. Higher scores indicate more severe depression	Intake and final session
Inventory of Interpersonal Problems-Circumplex (IIP-C) (Alden et al., 1990; Horowitz et al., 1988)	A 64-item self-reported inventory assessing behaviors related to interpersonal problems. Clients are assigned an overall score indicating their angle with respect to the circumplex as well as a score for each of the eight octants (domineering, vindictive, cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive)	Intake, week eight and final session
Working Alliance Inventory-Short Form: Client and Therapist versions (WAI) (Horvath & Greenberg, 1989)	A 12-item self-reported inventory based on Bordin's (1979) conceptualization of the working alliance. Higher scores indicate stronger alliances	Week two, four, eight, and final session

were not repeated in the interaction with the therapist, in light of the theoretical and empirical expectation that the client's interpersonal problems and interactions are important in maintenance and persistence of depression (Luborsky & Mark, 1991). The detailed analysis enabled us to become familiar with the narrative and the themes in each treatment, provided a better understanding of the therapy process, and led to the identification of unique phases of treatment for each client. Based on these phases, we segmented the treatments into three periods, each period consisting of different processes and themes, to better investigate the various processes.

Results

Client 1: the good outcome case

Background

At intake, the client was found to have moderate-to-severe depression (BDI: 31, and HRSD: 16). The client met criteria for personality disorder not otherwise specified, with narcissistic, borderline, and depressive tendencies. The client did not present comorbidity with any DSM-IV-Axis I anxiety disorders. Based on self-report questionnaires at intake, the client showed high interpersonal distress (IIP-64: 0.80 SD above the norm), in particular, a tendency to be cold or distant in interpersonal relationships, and difficulties in maintaining long-term interpersonal relationships. The client also reported a need to be in control (IIP Angle: 173.38).

Course of treatment

The client's therapy process was divided into three phases: initial, intermediate, and concluding. The decision which sessions were included in each phase was determined based on changes in processes, patterns, and themes, as identified in the coding of the S-WAI-O data (Figure 1(a)). The changes in alliance coding were consistent with the qualitative analysis of content identification of different processes and themes for each phase.

The initial phase consisted of the first six sessions, in which the client described his main interpersonal problems with his mother, with the mother of his son, and with one of his friends. Issues of trust, disrespect, and betrayal were evident. The first source of difficulties in interpersonal relationships to be reported, and the most dominant, had to do with the client's mother. The client noted his disappointment with the way his mother had raised him. Because he would often be left with other family members, he felt neglected. The client described an incident of feeling mistreated and underappreciated when his mother had forgotten to pick him up from school: 'I waited for 13 hours because my mom didn't come to pick me up.' The therapist's response communicated to the client that he should feel free to share his feelings with her, that she had understood his feelings and
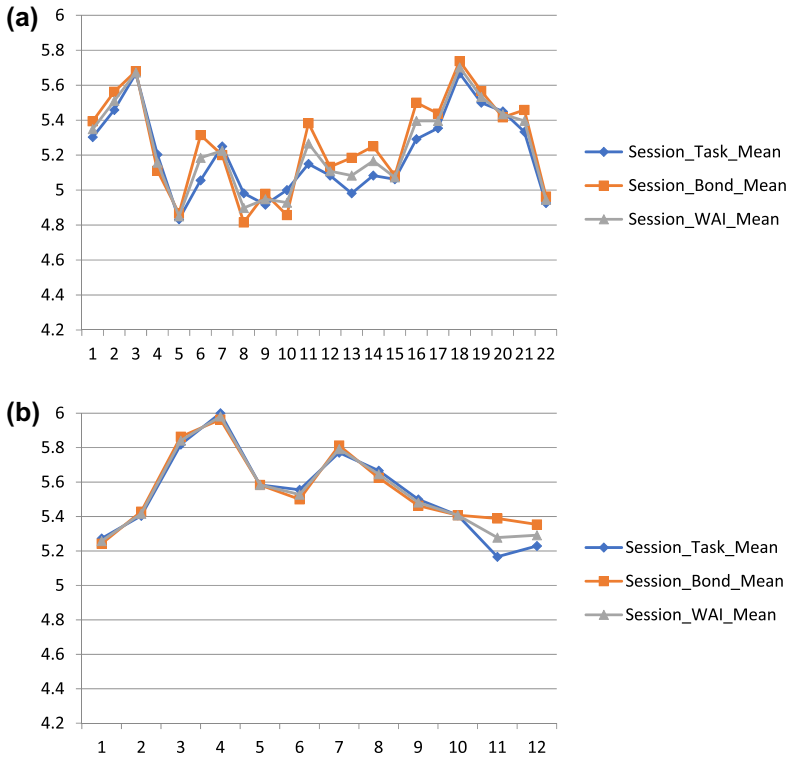
Figure 1. Changes in the ranking of observer coded alliance throughout the therapy sessions. Higher scores indicate a stronger alliance in each of the components of the alliance (task, bond, overall alliance score). Values for 5-min segments were averaged to yield a single score per session. (a) Changes in observer coded alliance values for the 22 sessions of the good outcome case. (b) Changes in observer coded alliance values for the 12 sessions of the poor outcome case.

was supportive of him and critical of the mother for having let him wait for many hours. Following this session, the client's self-reported WAI scores showed that his alliance with the therapist had significantly improved, from WAI: 4.58 at the time of intake, when alliance expectation was lowest, to WAI: 5.41 at the end of the second week of therapy. As is often the case, the therapist's self-reported WAI was lower than the client's WAI (week 2, WAI: 4.25).

Another source of interpersonal problems mentioned by the client in the course of the initial sessions was the mother of his son, to whom he attributed feelings of rejection and disrespect toward him. According to the client, at the beginning of his relationship with his son's mother he had failed to appreciate the relationship they had, and had seen it as temporary. When he realized that he wanted to be with her, she had already 'moved on' and had rejected him. The

client voiced many complaints about the way she was raising their son. The client's manner of speech suggested that he might be masking feelings of rejection with complaints about money (for instance, such feelings became apparent when the client complained that when he did not give their son money, the mother would become angry, reject him, and speak ill of him to their son). Further evidence of the sense of being underappreciated emerged when the client described being at a party where the son's mother ignored his presence. He noted a similar pattern with reference to another woman he had dated. In this case, too, the client reported that he had felt rejected by the woman once she realized that he did not have enough money. In both cases, as well as when referring to his mother, the client expressed a strong response from the other (RO) of rejection and disrespect (as conceptualized in the CCRT method, Luborsky (1995)). The therapist showed empathy, and tried to understand and reflect back the client's feelings.

Other than references to the above two women, the client also referred to one of his male friends as disrespectful and as a source of disappointment. He recalled a period when he and the friend had been writing songs together, and was upset by the friend's later behavior, noting that the friend had taken advantage of an opportunity to work on his own and to become successful. The client felt he had been abandoned by him and that the friend had failed to acknowledge the client's part in this musical success. As a result, the client felt hurt and disrespected.

Issues concerning the client's feelings of belonging to a minority came up throughout the initial phase. The client spoke of authority figures who, he felt, had harassed him or had made him feel incompetent because of his race. For example, the client described a previous workplace where he had been late to work and was subsequently fired. He noted that he could not understand the reason for his dismissal and blamed his former boss of racism. Although race-related considerations may indeed have led to his dismissal, and although the client's on-the-job actions may have stemmed from a race-related need to manage his self-esteem defensively, the client directed his anger exclusively at what he viewed as a racist action, and was unable to see any alternative reasons for his dismissal, even with the therapist's guidance.

As a consequence of the above-cited relationship representations, the client initially expressed a strong aversion to needing others. He cited his need for independence as the reason behind his current preference for being self-employed. In the course of the initial therapy sessions, the client came to understand that he had arranged his life in a way that minimized his need for others. However, the client did acknowledge needing his son, and noted that he felt betrayed when the son would not visit him or call him on Fathers' Day. His daughter was not mentioned in this context.

The second phase comprised nine sessions, during which the issue of intimacy emerged. Three themes related to intimacy became evident: the client's need for intimacy with others; the challenges of developing intimacy with the therapist; and, as a result of these challenges, ruptures in the alliance with the therapist (deterioration in the alliance or tension between the client and the therapist

(Safran & Muran, 2006)). During these sessions, a reduction in the client's IIP dominance score (week 8, DOM octant of the IIP: 0.02) indicated that the client had become less domineering.

The client seemed slow to warm up in the interaction with the therapist, and had a difficult time starting almost all sessions, as reflected in the low observer-rated S-WAI-O scores (information obtained from the segmented coding, not the average single session score). It was during these intermediate sessions that the client started to test the client–therapist relationship, questioning the right degree of intimacy for such a bond. The client noted his fear, which may in part have been realistic, of being misunderstood by the therapist. At that point, the client seemed reluctant to open up and talk about relationships with women he was dating, or about issues related to his son. For example, in one of these intermediate sessions, the client commented: 'I have children and we haven't discussed that yet. Hopefully we can avoid that subject for a couple of months.' At the same time, the client expressed the belief and hope that he would be able to open up to the therapist in the future. Later, but during the same phase, when the client was just beginning to open up to the therapist and wanted the therapist to be there for him, he stated: 'I wish I had somebody in my corner.' Similarly, the client's need for greater support from people around him was frustrated by trust issues and by his difficulties in opening up to them, exemplified by his comments about his fear of being used. The client was able to talk about these fears and about his hopes for more intimate relationships. He mentioned several past experiences that highlighted those feelings. In one example, he referred to having 'a yet-undefined relationship' with a woman. In later sessions, during the same intermediate phase, the client realized that he wanted to be with that woman, but after he had approached her, she rejected him. In another instance, the client referred to a woman whom he had been dating and with whom the relationship failed because he felt she had been using him, and had been interested mostly in his money.

As noted above, the intermediate sessions contained many ruptures in the therapeutic relationship. For example, a power-related rupture occurred in week 4, with a meaningful decrease in both bond and task, as demonstrated by S-WAI-O observer coding (Figure 1(a)), with the observer-rated alliance mean reaching its lowest point in the therapy (S-WAI-O: 4.85). This rupture also affected the therapist-reported WAI for the same week (week 4, WAI: 4.17). During this rupture, the client said that he felt it was expected of him to be the first to speak at the opening of the session. He believed that this expectation put him at a disadvantage, as it would, in his opinion, in the case of business relationships. Note that the client was smiling while discussing these feelings, a gesture that may have moderated the effect of his words and provided a sense of hope for the future of their relationship. The therapist responded: 'But we are not in sales, I'm quiet to see where you will pull from.' In an effort to resolve the rupture, the therapist explained the reasons for letting the client speak first, but the client responded that he was not persuaded. Nevertheless, in a subsequent intermediate-phase session, the client no

longer viewed himself as inferior to the therapist but rather as an equal contributor to the therapy because he was contributing to research. Additional ruptures with the client had to do with the fact that as he sought respect and equality with the therapist, he had started asking questions about the therapist's personal life, and was trying to mimic the therapist's manner of speaking, saying: 'So, how are you? Did you have a good week?'

Subsequent rupture resolution processes, in which the therapist explicitly addressed the rupture between them, appear to have helped the client open up to the therapist and feel respected. In one example, the therapist inquired whether the client had been abusing drugs: 'Are you on any substances that are making it hard for you?' The client was offended and stated: 'It's possible that I'm like this without chemical use.' However, after the therapist apologized: 'Sorry if I had offended you,' the apology seemed to have a positive effect on the client. The same event also provided an example of a micro-aggression. The client said: 'Well you accused me of being a pot head.' Following this encounter, the atmosphere between the therapist and the client seemed to become more comfortable, with both adopting a more relaxed posture and smiling more frequently at each other.

The means by which the ruptures were resolved, through empathy and openness of the therapist, appeared to promote a facilitating environment, which in turn, allowed the alliance between the client and therapist to grow stronger in the following sessions, as the client started to share and open up more. The therapist accomplished this by choosing not to avoid starting a direct discussion when the client raised racial concerns. This resolution of ruptures was also reflected in the client's reported WAI, which was lower, but still above his average alliance of 5.11 (Week 4: WAI: 5.25). Throughout this phase, the therapist was active, giving concrete advice and using supportive techniques, consistent with the model of SET, and the client appeared to follow her advice. The client also seemed more content with his relationships with his son and family. His depression symptoms were similarly improving, with the lowest score noted for session 15, BDI: 15.

The third phase comprised the last seven therapy sessions, during which the client recognized the work and commitment he had invested in the therapy, in particular with regard to the interpersonal relationship with the therapist: 'I don't think I did anything that required a commitment before this one.' The client attended all sessions and understood their significance. This recognition was further evident in the overall client IIP score, which decreased to its lowest value on week 16 (week 2-IIP: 0.80; week 16-IIP: 0.48). The therapist also praised the client's hard work during the course of the therapy, and demonstrated a high degree of empathy toward him. During this phase, the client felt comfortable discussing his difficulties beyond his financial problems, and was beginning to understand, with the help of the therapist, that his happiness was not dependent upon financial success, as he had thought earlier. The client was also able to acknowledge that earning more money would not make him happier and became aware of his

need for significant relationships in his life. In particular, he acknowledged that he was looking for more meaningful relationships with women. In another development, the client's son came to visit for the summer, and their relationship became stronger, as they spent more time together and jointly visited the client's family. Congruent with the above findings, the observer WAI scores for this phase showed an increase in both task and bond. The therapist's self-reported WAI also increased, from WAI: 4.25 on week 8 to its highest point, WAI: 4.75, on week 16.

The observer S-WAI-O scores (Figure 1(a)) show a jagged pattern in the last sessions. This occurred simultaneously with an increase in the client's self-reported WAI scores on week 8 (WAI: 5.08) and week 16 (WAI: 5.25). In the final session, however, the client felt that he had not progressed enough, and ruptures appeared, associated with the end of the therapy and the upcoming separation from the therapist and with the confidentiality of the therapy. The therapist tried to reassure the client, and her attempts appeared to be successful.

External observation of alliance (S-WAI-O)

Fluctuations in the observer S-WAI-O, with a significant number of low rupture points, were noted mostly in the intermediate sessions (Figure 1(a)), corresponding to the period when the alliance and the relationship between client and therapist were being negotiated, in particular issues related to trust and self-disclosure.

Self-report data

The self-reported data suggest a process similar to that reflected by the S-WAI-O. Throughout the course of the therapy, both the client's and therapist's self-reported WAI values were moderate (Table 2). Changes in client–therapist alliance rating in the course of the therapy reflected a strengthening of the alliance, with a decrease in week 8 for the client. IIP scores at intake indicated a cold tendency and problems in the areas of trust (vindictive octant of the IIP: 1.19) and of

Table 2. All available client and therapist rated WAI.

Client 1 WAI			Client 2 WAI		
Week	Client self-reported WAI	Therapist self-reported WAI	Week	Client self-reported WAI	Therapist self-reported WAI
Intake	4.58		Intake		
Week 2	5.42	4.25	Week 2		5.25
Week 4	5.25	4.17	Week 4	6.75	
Week 8	5.08	4.25	Week 8	6.58	5.75
Week 16	5.25	4.75	Week 16	6.50	6.00

Note: WAI = working alliance inventory.

the establishment of close relationships with others (cold octant of the IIP: 2.57). In later sessions, a history of being taken advantage of by others was revealed, which had not been referred to in the client's self-report (exploitable octant of the IIP: −1.00). This omission may indicate a need to appear strong and to not need others. Overall angle scores pointed to a cold orientation (173.38), but in the course of therapy a change toward less cold and more vindictive (159.75) was noted. The most significant improvements over the course of the therapy were noted in the domineering and non-assertive octants. Improvement was shown in both BDI and HRSD outcome measures over the course of the treatment. Change was most prominent in the second and third phases of therapy.

Client 2: poor outcome case

Background

At intake, the client was diagnosed with major depressive disorder (BDI: 33 and HRSD: 28, indicating severe depression). The client showed no comorbidity with any Axis-I or personality disorders. Based on the self-report questionnaires at intake, the client showed very high interpersonal distress (IIP-64: 1.26 points above the norm). A cold and social avoidant interpersonal orientation was noted. In particular, he reported being anxious in the presence of others, not initiating social interactions, and lacking self-confidence (Angle: 193.25).

Course of therapy

Similar to the good-outcome case, this client's therapy sessions can be divided into three phases: initial, intermediate, and concluding, based on the identification of different processes, patterns, and themes, as rated on the S-WAI-O (Figure 1(b)). Changes in alliance coding were consistent with the qualitative processes and themes noted for each phase.

The initial phase: The first five sessions were characterized by the client's idealization of his own 'previous self,' before becoming depressed. Two years prior to therapy, he saw himself, as a social person, close to his friends and family, active and respected at work, and always employed in fulfilling jobs. Since then, the client reported that he had been depressed, unable to sleep or to form social interactions. During one of the early therapy sessions, he commented: 'I have been avoiding people for a long time, haven't been socializing at all.' He was unable to identify a specific incident that had led to these feelings of depression and low self-worth. Although acknowledging these feelings to the therapist, the client felt a need to hide them from others. He thought that by acknowledging such feelings he would be letting down his friends and his family. The client also felt that he was not meeting his social obligations, such as playing with his daughter or participating in family events. He noted a particular family event in which he had not wanted to participate so as not to draw attention to his problem, and stated:

'I haven't even told my own people.' The client explained that he avoided social contact because he did not want others to feel sorry for him and because of a need to appear as if he was doing well. The client appeared to try to maintain a sense of self-worth. The therapist was empathic and reported a relatively high WAI at week 2 (WAI: 5.25).

The client's apparent fear to let others down was noted in several of his comments, and was reflected by his high IIP scores at intake (IIP nonassertive octant: 0.85). For example, the client reported that when offered a new employment opportunity, he was afraid to accept it so as not to let the boss down if he turned out to be unable to fulfill the requirements of the position. Another example had to do with his concern about his sexual performance with his wife. Similarly, in the course of the therapy, the client often asked the therapist to reassure him that he was doing a good job. Throughout this phase, the therapist was helpful, reassuring the client and giving him concrete advice, to which the client responded either by nodding or with statements of passive agreement (e.g. 'Yeah, you're right').

The alliance between the client and the therapist appeared to grow as the sessions progressed, as evidenced by an increase in observer S-WAI-O scores, for both task and bond. The client participated actively in the therapy, agreed with the therapist, echoed her words, and seemed to follow all her suggestions. This acceptance may have been the reason for the noted increase in the therapist's WAI scores. Ruptures were not apparent on the surface during the early therapy sessions, but the increase in alliance was not followed by a corresponding improvement in the client's depression symptoms, as evidenced both by his self-report (week 3, BDI: 28) and his restless sleep. The client was still seeking reassurances from the therapist, and would often ask: 'So you think I should do it?'

The second phase consisted of four sessions. Examination of the data recorded at these sessions showed that the client often seemed to agree with the therapist's advice, but later would not act upon it. For example, the therapist advised him to see a specialist for the headaches he had been reporting, and the client agreed to do so, but in the end did not. The same pattern was apparent in the client's relationship with his wife: he promised his wife that he would go with her to church, but failed to do so. In yet another instance, the therapist recommended some nutritious beverages and healthy foods that she thought would improve the clients' appetite and energy levels. After some initial hesitation, the client did try the beverages, but two weeks later he stopped using them. The client's WAI scores during these sessions increased from the expected alliance at intake (WAI: 5.66) to their highest rating in the fourth week (week 4, WAI: 6.75). The S-WAI-O observer graph (Figure 1(b)) shows that the strong alliance with the therapist, noted already in the initial phase of therapy, persisted, but content analysis demonstrated the client's lack of commitment to following the therapist's suggestions. The client may have pretended to accept the therapist's suggestions only to avoid disagreements. The client's self-reported depression symptoms were lowest during these sessions (BDI: 16), although Hamilton scores remained high (HRSD: 27).

One of the themes brought up by the client during this phase was the subject of trust. When, on one occasion, the therapist mentioned having children, the disclosure seemed to please the client, who said: 'It makes me happy to know you have kids,' and appeared to bolster the bond between the two, allowing the client to open up more about his own daughter. Therapist self-disclosure during this phase of therapy may have contributed to a high self-reported WAI scores by the client (week 8, WAI: 6.58) and the therapist (week 8, WAI: 5.75). In another instance, the subject of trust was discussed following the client's visit to his doctor. The client claimed that the doctor was withholding some medical information pertaining to his case, and shared feelings of being mistreated and lied to. The therapist responded with concrete advice, recommending that the client look for a doctor he trusts.

The third phase consisted of the last three therapy sessions. The themes that emerged during these sessions were similar to the ones noted during the second, intermediate phase of therapy. The client stated that the therapist had helped him a great deal, and even revealed that he had been keeping her phone number in his wallet. At the same time, he still felt that he was not helping enough at home and was not being appreciated for the things he was trying to do. In one case, feelings of worthlessness arose again when the client's wife thought that he should not accompany his daughter on a school field trip, and had asked her brother, the daughter's uncle, to do it instead. The client's overall IIP scores decreased during these last sessions to IIP: 0.42 (as compared with IIP: 1.26 at intake).

During this phase, the topic of the final sessions was discussed. The client found it difficult to adjust to the approaching conclusion of the therapy sessions. Asked by the therapist how he felt about ending the therapy, he said that he had no bad feelings about it, 'but I just figured, that for as long as I can just keep seeing somebody, I will get it done.' The client's reaction was passive, but his disappointment was visible. This pattern was also evident in the decrease in the S-WAI-O (Figure 1(b)) scores during the concluding sessions, as well as in the client's self-reported WAI scores, which decreased in week 16 (WAI: 6.50). The therapist self-reported WAI scores increased, and were highest in week 16 (WAI: 6.00).

During the very last therapy session, the client stated that although he had not wanted to attend this session, he also did not want to disappoint the therapist. In this, as well as in other comments, the client's fear of disappointing others and his seeking of therapist's approval emerged as recurring and persisting themes. Neither the therapist nor the client addressed cultural content, the alliance seemed strong on the surface, and they did not actively work on strengthening the alliance.

External observation of alliance (S-WAI-O)

A high, steady alliance, with no apparent ruptures, was noted throughout the entire treatment (Figure 1(b)). External observations suggested less work on issues of

trust and on negotiating the client–therapist relationships. The client made no reference to issues of race at any point in the treatment.

Self-report data

Both the client's and the therapist's self-reported data reflected a strong, steady alliance (Table 2), similar to that revealed by the S-W-AI-O scores. In his IIP questionnaire, the client did report difficulties in establishing close relationships with others (cold octant of the IIP: 1.26), and high levels of anxiety in the presence of others (socially avoidant octant of the IIP: 2.18). Although lack of confidence and some self-doubt were also noted (nonassertive octant of the IIP: 0.85), the client did not see himself as easily persuaded by others (exploitable octant of the IIP: 0.18). With respect to this last element, however, some evidence from the therapy sessions suggested otherwise. Evidence from the client's self-reports also suggests a highly apparent need to please others and to win their approval (overly nurturant octant of the IIP: 1.36). A change from a cold and social avoidant orientation in the client's overall IIP scores (193.25) at intake to a more nonassertive and less cold orientation (260.28) at the end of therapy was noted. The most significant improvement in IIP scores was noted for the vindictive octant. Only an insignificant decrease in the client's BDI, and an even smaller one in his HRSD, was noted over the course of treatment, despite the client's statements to the therapist, during the therapy sessions, that he had seen an improvement in his state.

Discussion

The present study compared in detail two cases to explore and identify potential active ingredients that contribute to the outcome of treatment for minority clients, in particular African-American men, in psychodynamic psychotherapy using a mixed model design. All available records from the clients' therapy sessions were coded using the S-WAI-O, taking into consideration the self-reported WAI scores of the clients and the therapist, as well as other client self-report measures (e.g. the IIP). These data were analyzed in conjunction with a qualitative assessment of the content of the therapy sessions. The mixed method approach used in the present study combines self-reported data and clinically administered measures, with qualitative analysis of content making possible an important comparison between different perspectives of the relationship (client, therapist, and observer). This, in turn, enabled us to observe in-depth the narrative of each client and the dynamics of each treatment, and to carry out an integrative comparison of the two clients. Both clients were African-American males of similar age and depression severity at intake. Both were treated by the same therapist, and both reported interpersonal problems and feelings of incompetence in their interpersonal relationships at the beginning of treatment. Both clients showed a decrease in self-reported interpersonal distress at the end of treatment. There is an open question about the

degree of conscious change in the clients regarding their interpersonal problems. The results of the current study may indicate what degree of conscious ability is needed to be able to report difficulties. During treatment, the awareness of difficulties may come up and lead the client to rank higher levels of interpersonal difficulties.

We selected the two clients who differed markedly in their BDI and HRSD outcome scores, with improvement on both measures for the good outcome case, and a much smaller decrease in BDI and almost no change in HRSD for the poor outcome case. The clients differed also in their observer-coded alliance, demonstrating fluctuations in the alliance in the good outcome case, and strong and steady alliance in the poor outcome case. Content analysis, however, revealed that the steady alliance in the poor outcome case included withdrawal ruptures. This became noticeable even when the therapist and client appeared to be working together. Although the client appeared to accept the therapists' suggestions, he also tended to withdraw and avoid disagreements in a way that seemed overly deferential (a behavior pattern previously noted by Safran and Muran (2006); see also Eubanks-Carter, Muran, and Safran (2010)).

We found that the good-outcome client had negotiated his interpersonal needs with the therapist, leading to increased self-disclosure and a stronger alliance. They seemed to be working together and the client opened up emotionally to the therapist. In contrast, the poor-outcome client presented a general façade of well-being, refrained from revealing most of his problems, and was unwilling to negotiate his alliance with the therapist, thus not fully addressing his needs and not raising racial issues, which have been found to be important in working with many minority clients (Chang & Berk, 2009). Underneath the good alliance, the client appears not to have felt that he could raise issues of race and reveal his true feelings about the therapist. These findings confirm the important role of the rupture-resolution process in the therapeutic alliance. Ruptures have been defined as a deterioration, or tension in the alliance (Safran & Muran, 2006), and can describe either a major break in therapy or minor tensions between client and therapist (Safran, Muran, & Eubanks-Carter, 2011). Earlier studies have stressed the importance of the rupture-resolution process for therapy outcomes with non-minority clients. Successful resolution of ruptures can contribute to emotional changes during therapy and to better outcomes (see also Eubanks-Carter et al., 2010). Previous studies found significant correlation between rupture-repair episodes and outcomes, and have shown that the presence of such episodes predicted better outcomes (Safran et al., 2011). The present findings suggest that the benefits from rupture-resolution processes apply to minority clients as well.

A rupture-resolution process was evident in the good outcome case, where a negotiation of the alliance and joint work on issues of trust and self-disclosure were noted. The good outcome case also involved ruptures caused by the racial differences between client and therapist, which were then resolved. By contrast, the poor outcome case showed strong alliance during treatment, but at the same

time masking unresolved withdrawal ruptures: the client was overly agreeable and made efforts to draw closer to the therapist and seek her approval, but at the same time he concealed certain personal experiences from her.

The present findings are consistent with previous reports on issues of trust in psychotherapy, regardless of other client characteristics, as well as with previous documented cases in which minority clients were reported to show their distrust of psychotherapy (Brown et al., 2013). In the present study, the therapist and the good-outcome client addressed the multicultural component openly and explicitly, attempting to overcome the ethnic gap, which proved beneficial to the formation of a strong and genuine alliance. In previous studies, such a process was found to be an important factor in the negotiation of the therapeutic alliance for minority clients (Chang & Berk, 2009). In the poor outcome case, the topic of race did not come up. We suggest that the development of trust may be jeopardized and fail if conscious and unconscious culturally specific elements are not brought to awareness during psychoanalytic psychotherapy.

One aspect of the present findings is inconsistent with some previous research: a strong and steady alliance has been previously associated with better outcomes in minority clients (Cordaro et al., 2012), in the present study the poor-outcome client showed a high and steady alliance, which may be attributed to the lack of race-related discussion in treatment, whereas the good-outcome client displayed fluctuating alliance levels. Addressing the cultural aspect in the good outcome case appears to have led to the resolution of ruptures, whereas in the poor outcome case the cultural aspect and the withdrawal ruptures were not addressed. The different outcomes of the two cases attest to the importance of addressing ruptures and resolving them in treatment, and of discussing cultural aspects. Not all clients are able to identify and report on ruptures and various cultural characteristics may mask them. If our finding is replicated in a larger sample, therapists treating minority clients may wish to identify and examine subtle nuances in the therapeutic alliance, and negotiate the therapeutic alliance with their clients, showing responsiveness and sensitivity when clients raise racial issues. In turn, such attention and routine monitoring by the therapist may help elucidate the effect of alliance-focused training for therapists on the outcome of treatment.

The current study highlights the importance of trust in relationships between therapists and minority clients, and the need to boost such trust by means of open discussion and alliance negotiation. If the results are replicated in samples of a larger size, they may suggest that therapists should keep in mind that good alliance may mask withdrawal ruptures. Therapists should note that some minority clients may need more open negotiations of trust and higher levels of self-disclosure about race to form genuine alliances. As suggested by the present findings, these could then lead to better outcomes. To examine cultural sensitivity, a comparison of mixed and non-mixed dyads may be needed. Note, however, that the findings of the present study are consistent with the literature on mixed dyads, showing that the alliance did not increase linearly (Walling et al., 2012).

Limitations

In a case study many factors may be examined, each one leading to a different analysis of the findings. The present study focused mainly on client–therapist alliance as an active ingredient in the therapy. The research data, however, may also be examined from other perspectives. For example, it is possible to examine the therapy processes presented here and the corresponding outcomes from the perspective of the CCRT method, arguing that in the good outcome case CCRT had been formulated and negotiated with the client, whereas in the poor outcome case these steps were less evident for the poor outcome client. Other therapy approaches may have treated race and culture differently leading to different outcomes. Additional perspectives on the two cases may also look into the coding of culture processes of the clients in relation to outcome, exploring macro-aggression and cultural identity. Examining the alliance from multiple perspectives, based on client and therapist self-reports and on observer coding, can shed light on the therapy process. The design of the present study, however, leaves the important question of causality unanswered. Future studies are needed, using the hermeneutic single-case efficacy design (HSCED, Elliott, 2002), which can be useful in evaluating treatment causality in single therapy cases, especially to establish a causal link between the therapy process and outcome.

The two clients presented in this study differed from one another in many ways, including marital status and income, and these differences may have contributed to differences in their behavior and in the outcomes. The clients differed from the therapist in gender and ethnicity, whereas matched therapist–client dyads may lead to different outcomes. This limitation, however, is mitigated by the fact that in our study the therapist was the same in both cases, and their pretreatment depression symptoms were matched. In larger sample sizes, it is also important to disentangle differences between clients based on trait-like characteristics (such as the baseline differences in symptomatology and comorbidity between cases) and the effect of the dynamic nature of the alliance within each client, such as rupture and repair processes (Zilcha-Mano, 2017). Such analyses will help better identify dynamic processes in the alliance. In addition, conscious and unconscious processes relating to cultures play an important role in therapy, and this separation should be explored in future studies. Finally, we are not able to explain some of the findings, such as the decrease in IIP in both clients; examining other characteristics might elucidate these findings, and using a clinical interview about interpersonal problems may bring up difficulties of which the client is not aware.

Conclusion

Based on two case studies, the present research adds to the growing knowledge regarding alliance with minority clients. Although it is difficult to generalize based on the analysis of two case studies, the present work draws attention to the

importance of negotiating both the alliance and other aspects of the relationship between black clients and white therapists, for the success of the treatment.

References

Altman, N. (1995). *The Analyst in the inner city: Race, class, and culture through a psychoanalytic lens*. Hillsdale, NJ: The Analytic Press.

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the inventory of interpersonal problems. *Journal of Personality Assessment, 55*, 521–536. doi:10.1207/s15327752jpa5503&410

Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology & Psychotherapy, 20*, 118–135. doi:10.1002/cpp.792

Barber, J. P., Barrett, M. S., Gallop, R., Rynn, M. A., & Rickels, K. (2012). Short-term dynamic psychotherapy versus pharmacotherapy for major depressive disorder: A randomized, placebo-controlled trial. *The Journal of Clinical Psychiatry, 73*, 66–73. doi:10.4088/JCP.11m06831

Beck, A. T., Ward, C., & Mendelson, M. (1961). Beck depression inventory (BDI). *Achieves of General Psychiatry, 4*, 561–571. doi:10.1037/t00741-000

Berk, E. (2013). *Detecting alliance ruptures and rupture repair with the Segmented Working Alliance Inventory – Observer Form (S-WAI-O)* (Unpublished dissertation). New York, NY: The New School for Social Research.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research and Practice, 40*, 361–368. doi:10.1037/a0016401

Blom, M. B., Hoek, H. W., Spinhoven, P., Hoencamp, E., Haffmans, P. J., & van Dyck, R. (2010). Treatment of depression in patients from ethnic minority groups in the Netherlands. *Transcultural Psychiatry, 47*, 473–490. doi:10.1177/1363461510374561

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*, 252–260. doi:10.1037/h0085885

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. doi:10.1191/1478088706qp063oa

Brown, D. L., Blackmon, S., & Schumacher, K. (2013). Exploring clinicians attitudes toward the incorporation of racial socialization in psychotherapy. *Journal of Black Psychology, 39*, 507–531. doi:10.1177/0095798412461806

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice, Training, 43*, 271–279. doi:10.1037/0033-3204.43.3.271

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*, 521–536. doi:10.1037/a0016905

Connolly Gibbons, M. B., Thompson, S. M., Scott, K., Schauble, L. A., Mooney, T., Thompson, D., … Crits-Christoph, P. (2012). Supportive expressive dynamic psychotherapy in the community mental health system: A pilot effectiveness trial for the treatment of depression. *Psychotherapy, 49*, 303–316.

Cordaro, M., Tubman, J. G., Wagner, E. F., & Morris, S. L. (2012). Treatment process predictors of program completion or dropout among minority adolescents enrolled in a brief motivational substance abuse intervention. *Journal of Child & Adolescent Substance Abuse, 21*, 51–68. doi:10.1080/1067828X.2012.636697

Cruz, M., Scott, J., Houck, P., Reynolds, C., Frank, E., & Shear, M. K. (2007). Clinical presentation and treatment outcome of African Americans with complicated grief. *Psychiatric Services, 58*, 700–702. doi:10.1176/appi.ps.58.5.700

Dattilio, F. M., Edwards, D. J., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training, 47*, 427–441.

de Roten, Y., Fischer, M., Drapeau, M., Beretta, V., Kramer, U., Favre, N., & Despland, J. N. (2004). Is one assessment enough? Patterns of helping alliance development and outcome. *Clinical Psychology & Psychotherapy, 11*, 324–331. doi:10.1002/cpp.420

Earl, T. R., Alegría, M., Mendieta, F., & Linhart, Y. D. (2011). 'Just be straight with me:' An exploration of Black patient experiences in initial mental health encounters. *American Journal of Orthopsychiatry, 81*, 519–525. doi:10.1111/j.1939-0025.2011.01123.x

Elliott, R. (2002). Hermeneutic single-case efficacy design. *Psychotherapy Research, 12*, 1–21.

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). Alliance ruptures and resolution. In J. Muran & J. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 74–94). New York, NY: Guilford Press.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. (1995). *Structured clinical interview for DSM-IV Axis I Disorders (SCID)*. New York, NY: Biometrics Research.

Freud, S. (1920). *A general introduction to psychoanalysis*. Oxford: Horace Liveright.

Gaztambide, D. J. (2012). Addressing cultural impasses with rupture resolution strategies: A proposal and recommendations. *Professional Psychology: Research and Practice, 43*, 183–189. doi:10.1037/a0026911

Greenson, R. R. (1965). The working alliance and the transference neuroses. *Psychoanalysis Quarterly, 34*, 155–181.

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502–510. doi:10.1037/0022-006X.69.3.502

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery, and Psychiatry, 23*, 56–62. doi:10.1136/jnnp.23.1.56

Hill, C. E., Carter, J. A., & O'Farrell, M. K. (1983). A case study of the process and outcome of time-limited counseling. *Journal of Counseling Psychology, 30*, 3–18.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureño, G., & Villaseñor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology, 56*, 885–892. doi:10.1037/0022-006X.56.6.885

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9–16. doi:10.1037/a0022186

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223–233. doi:10.1037/0022-0167.36.2.223

Imel, Z. E., Baldwin, S., Atkins, D. C., Owen, J., Baardseth, T., & Wampold, B. E. (2011). Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural competence. *Journal of Counseling Psychology, 58*, 290–298. doi:10.1037/a0023284

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology, 11*, 113–129. doi:10.1037/1099-9809.11.2.113

Knight, Z. G. (2013). Black client, white therapist: Working with race in psychoanalytic psychotherapy in South Africa. *The International Journal of Psychoanalysis, 94*, 17–31.

Lambert, M. J., Smart, D. W., Campbell, M. P., Hawkins, E. J., Harmon, C., & Slade, K. L. (2006). Psychotherapy outcome, as measured by the OQ-45, in African American, Asian/Pacific Islander, Latino/a, and Native American clients compared with matched Caucasian clients. *Journal of College Student Psychotherapy, 20*, 17–29. doi:10.1300/J035v20n04_03

Leichsenring, F. & Schauenburg, H. (2014). Empirically supported methods of short-term psychodynamic therapy in depression–Towards an evidence-based unified protocol. *Journal of Affective Disorders, 169*, 128–143.

Luborsky, L. (1984). *The principles of psychoanalytic psychotherapy*. New York, NY: Basic Books.

Luborsky, L. (1995). Supportive-expressive dynamic psychotherapy of depression: A time-limited version. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders* (pp. 41–83). New York, NY: Basic Books.

Luborsky, L. & Mark, D. (1991). Short-term supportive-expressive psychoanalytic psychotherapy. In P. Crits-Christoph & J. P. Barber (Eds.), *Handbook of short-term dynamic psychotherapy* (pp. 110–136). New York, NY: Basic Books.

Luborsky, L., Mark, D. Hole, A. Popp, C. Goldsmith, B., & Cacciola, J. (1995). Supportive-expressive dynamic psychotherapy of depression: A time-limited version. In J. P. Barber P. Crits-Cristoph (Eds.), *Dynamics therapies for psychiatric disorders* (pp. 13–83). New York, NY: Basic Books.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438–450. doi:10.1037/0022-006X.68.3.438

O'Farrell, M. K., Hill, C. E., & Patton, S. M. (1986). A comparison of two cases of counseling with the same counselor. *Journal of Counseling & Development, 65*, 141–145. doi:10.1002/j.1556-6676.1986.tb01261.x

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research, 11*, 204–212.

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2015, October 12). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice*, *47*, 30–38. doi:10.1037/pro0000046

Patton, M. J., Kivlighan, D. M., Jr., & Multon, K. D. (1997). The Missouri psychoanalytic counseling research project: Relation of changes in counseling process to client outcomes. *Journal of Counseling Psychology, 44*, 189–208. doi:10.1037/0022-0167.44.2.189

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology, 59*, 1–9. doi:10.1037/a0026208

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*, 447–458. doi:10.1037/0022-006X.64.3.447

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness?. *Psychotherapy: Theory, Research, Practice, Training, 43*, 286–291. doi:10.1037/0033-3204.43.3.286

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy, 48*, 80–87. doi:10.1037/a0022140

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86*, 420–428. doi:10.1037/0033-2909.86.2.420

Stiles, W. B., & Goldsmith, J. Z. (2010). The alliance over time. In J. Muran & J. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 44–62). New York, NY: Guilford Press.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist, 62*, 271–286. doi:10.1037/0003-066X.62.4.271

Tao, K. W., Owen, J., Pace, B. T., & Imel, Z. E. (2015). A meta-analysis of multicultural competencies and psychotherapy process and outcome. *Journal of Counseling Psychology, 62*, 337–350. doi:10.1037/cou0000086

Vasquez, M. J. (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*, 878–885.

Walling, S. M., Suvak, M. K., Howard, J. M., Taft, C. T., & Murphy, C. M. (2012). Race/ethnicity as a predictor of change in working alliance during cognitive behavioral therapy for intimate partner violence perpetrators. *Psychotherapy, 49*, 180–189. doi:10.1037/a0025751

Webster, H. B., & Bishaw, A. (2007). *Income, earnings, and poverty data from the 2006 American Community Survey*. Suitland, MD: US Department of Commerce, Economics and Statistics Administration, US Census Bureau.

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology: Research and Practice, 36*, 400–408. doi:10.1037/0735-7028.36.4.400

Zetzel, E. R. (1956). Current concepts of transference. *International Journal of Psychoanalysis, 37*, 369–376.

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist, 72*, 311–325. doi:10.1037/a0040435.