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A First Look at the Working Alliance in Psychotherapy With American Indians

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We could find no published studies measuring the working alliance in outpatient psychotherapy with American Indians. Given that the working alliance has been shown to be one of the most reliable and robust predictors of outcome across psychotherapeutic modalities, we sought to understand the working alliance in this population. Eight psychotherapists in an urban outpatient clinic rated their working alliance with American Indian patients (n = 112) immediately after treatment delivery using the Working Alliance Inventory, 12-item short form (Tracey & Kokotovic, 1989). Working alliance data from 112 sessions were collected and compared with data from the Working Alliance Inventory, 12-item short form, normative sample (Busseri & Tyler, 2003). Therapist-rated working alliance in psychotherapy with American Indian patients was higher than a comparison sample. Alliance was unaffected by patient, therapist, or therapy-related variables in this sample. The working alliance is likely to be an important construct in psychotherapy with American Indian patients. Replication with a larger, representative group of therapists as well as the collection of patient and observer ratings are important next steps.

Clinical Impact Statement

Question: As it has not been investigated previously, we wondered what the working alliance is like in psychotherapy with American Indian outpatients. ***Findings:*** Therapist-rated working alliance was high, compared with a normative sample, and unaffected by potential covariates in 112 psychotherapy sessions with American Indian outpatients. ***Meaning:*** The working alliance appears to be an important ingredient in psychotherapy with this understudied and underserved population. ***Next Steps:*** Multiple raters and settings should be investigated to create a more comprehensive picture of the working alliance in psychotherapy with American Indian patients.

Keywords: psychotherapy process, working alliance, American Indians

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The working alliance, as conceptualized by Bordin (1979) and measured by the Working Alliance Inventory (WAI; and other instruments),[1] has been shown to be a consistent and robust predictor of psychotherapy outcome across different schools of psychotherapy (Castonguay, Constantino, & Holtforth, 2006; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).[2] Bordin's trans-theoretical model included the emotional bond between therapist and patient, the agreement on in-session tasks, and the agreement on treatment goals. Horvath and Greenberg (1986, 1989) operationalized Bordin's model with the WAI, a 36-item, self-report measure. Subsequently, Tracey and Kokotovic (1989) introduced an abbreviated, 12-item version of the WAI, which was shown to be psychometrically interchangeable (Busseri & Tyler, 2003).

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[1] In their review, Horvath, Del Re, Flückiger, and Symonds (2011) identified more than 30 alliance measures. Four measures appear to be most widely used: California Psychotherapy Alliance Scale, Helping Alliance Questionnaires, Vanderbilt Psychotherapy Process Scale, and the WAI.

[2] See Hausner (2000) for a review of the origins of the working (and therapeutic) alliance.

Race/Ethnicity Status and Alliance

Ethnoracial status can impact psychotherapy process (see Carter, 1995; Muran, 2007, for reviews)[3]; however, few studies have examined its relationship with alliance. Studies have shown, for example, that patients' experience of racial microaggressions in psychotherapy is significantly, inversely related to patient-rated working alliance (Constantine, 2007; Owen et al., 2011). In a study of psychotherapy patients with severe mental illness (Walling, Suvak, Howard, Taft, & Murphy, 2012), White patients exhibited reliable, steady increases in working alliance (as measured by therapist-rated WAI) but ethnoracially underrepresented participants did not. Chao, Steffen, and Heiby (2012) found that patients who perceived an ethnic match with their therapists reported higher working alliance ratings relative to patients who perceived an ethnic mismatch. In a meta-analytic study (Flückiger et al., 2013), the relationship between working alliance and outcome decreased as the percentage of underrepresented participants per sample increased. Unfortunately, none of these studies contained an adequate number of American Indian patients about which to draw inferences.

American Indians in Psychotherapy

American Indians are at high risk of medical (Indian Health Service, 2014) and psychological conditions (Gone & Trimble, 2012) that might be addressed productively with psychotherapy. However, some researchers have raised concerns that psychotherapy as usual may not be culturally appropriate for many American Indian patients[4] (see Gone & Trimble, 2012, for a review), and there are very few empirical studies of psychotherapy process and outcome to guide intervention with this group (see Pomerville, Burrage, & Gone, 2016, for a review). An early study of American Indian psychotherapy patients (Sue, Allen, & Conaway, 1978) showed that retention was low relative to White patients. More recently, Fickenscher, Novins, and Beals (2006) explored predictors of treatment completion and demonstrated empirical associations with age (older adolescents), treatment readiness, help seeking, and legal involvement in a sample of adolescent American Indian patients in a specialized, American Indian operated residential treatment for substance use disorder. Current evidence suggests that American Indians avail themselves of psychotherapeutic services when offered (Gone, 2004; Levinson, 2011) and can receive benefits comparable with White participants in a variety of settings, including outpatient college counseling (Lambert et al., 2006), culturally adapted residential substance abuse treatment (Beckstead, Lambert, DuBose, & Linehan, 2015), and court-mandated multimodal substance abuse treatment (Dickerson et al., 2010).

Some scholars have suggested that the working alliance might be an important construct with respect to psychotherapeutic treatment for American Indian patients (Lee, 1997; Running Bear, Beals, Novins, & Manson, 2017). However, PsycINFO and MEDLINE searches of *Indigenous Populations* and (*Therapeutic Alliance or Working Alliance*), conducted in December, 2019, produced no published empirical studies of the working alliance in individual outpatient psychotherapy with American Indians[5] Only one published study measured the working alliance among 202 American Indian parents involved in the child welfare system and their trained home visitors posttreatment (Chaffin, Bard, Bigfoot, & Maher, 2012). In this study, the WAI-12 mean total score was 5.75 (on a 7-point scale),[6] which was somewhat lower than mean total score rating ($M = 5.96$) at the final session provided by 54 voluntary, individual psychotherapy patients (Busseri & Tyler, 2003). Two studies assessed working alliance between patients and therapists in Canadian Aboriginal samples (Clarkson et al., 2013; DeSorcy, Olver, & Wormith, 2016).[7]

To address this gap in the literature, we investigated therapist-rated working alliance in an urban American Indian behavioral health clinic.[8] Understanding the nature of the working alliance in this underserved and understudied population will move the field one step forward in determining the safety and efficacy of psychotherapy for American Indians. Given the lack of research in this area, we regarded our investigation as preliminary and did not craft strong a priori hypotheses. Part of the goal was simply to demonstrate feasibility, that is, that standardized psychotherapy process measures could be implemented in a busy, urban American Indian clinic. We imagined that the working alliance ratings provided by professional therapists working in an urban American Indian clinic would be similar to those reported in a previous study of therapists in a comparison sample (Busseri & Tyler, 2003),[9] especially given the high alliance ratings that American Indian child-welfare parents awarded their home visitors (Chaffin et al., 2012). We set out to examine the effects of a variety of potential covariates (patient, therapist, and therapy variables) on working alliance. We did not expect to see large effects on working alliance from patient demographic or diagnostic variables because previous research has identified working alliance as a predictor of psychotherapy outcome in large samples of heterogenous patients (Horvath et al., 2011). We did expect higher working alliance ratings in sessions provided by American Indian therapists (given that this indicates an ethnoracial therapist–patient match in our data set) compared with White therapists. We did not anticipate that therapist orientation would affect alliance, as ratings tend to be similar across schools of therapy (Horvath et al., 2011). As previous research has indicated that the therapeutic alliance can increase linearly or quadratically as psychotherapy unfolds (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004), we investigated the relationship between therapist-rated alliance and number of previous therapy sessions.

[3] However, the effects of race and ethnicity on psychotherapy therapy outcome are less clear cut (Cabral & Smith, 2011; Karlsson, 2005; Maramba & Nagayama Hall, 2002).

[4] We do not distinguish between patients and clients, therapists and counselors, or psychotherapy and counseling in this article.

[5] Whitehorse Lopez (2006) developed a native-adapted therapeutic alliance measure for a doctoral dissertation.

[6] Note that the authors computed the WAI-12 on a 0–6 scale rather than a 1–7 scale, so we added one point to their reported mean total score of 4.75 to rescale it for comparison purposes.

[7] Owing to the nonvoluntary, residential status of their participants, as well as problem severity, these studies do not provide adequate points of comparison for the current study of adult outpatients and are reviewed herein primarily for comprehensiveness.

[8] We have also investigated therapist-rated technique use at this clinic in a separate line of research (Beitel et al., 2018 for review).

[9] This foundational study established the validity of the WAI-12 vis-à-vis its parent instrument and provided norms for comparison; therefore, it was selected as the comparison sample for the current study.

Method

Participants

The eight therapists included in this study provided individual outpatient psychotherapy to American Indian adult patients in an urban American Indian health clinic. All of the therapists were female; four identified as American Indian and four identified as White. American Indian therapists provided 41 sessions, and White therapists provided 71 sessions. The therapists ranged in age from 26 to 50, with a mean of 35 years ($SD = 7$). Two of the therapists held doctoral degrees, and six held master's degrees. Seven therapists were licensed in their state; one was a clinical psychology trainee. On average, the therapists had 7 years of clinical experience ($SD = 5$) and provided an average of 27 sessions per week ($SD = 8$). Four of the therapists were supervisors and reported 1 to 5 years of supervisory experience, with 1 to 2 hr of supervision provided weekly. The therapists identified their primary theoretical orientation as family systems ($n = 3$), humanistic ($n = 2$), cognitive or cognitive–behavioral ($n = 1$), eclectic ($n = 1$), and narrative/postmodern ($n = 1$). Thirty-five sessions were delivered from a family systems orientation and the rest were from other orientations.

The therapists rated 112 psychotherapy sessions. Of the 112 separate patients whose sessions were rated, 73 were female and 39 were male. The mean age was 38 years ($SD = 14$); all were American Indian. Depression and anxiety were the most frequently occurring primary diagnoses ($n = 57$ and $n = 49$, respectively). The next most common primary diagnoses were posttraumatic stress disorder ($n = 40$), substance use disorder ($n = 22$), substance use disorder in remission ($n = 17$), and bipolar disorder ($n = 16$). Nine patients had a diagnosis of adjustment disorder, and five had a diagnosis of attention deficit disorder. In total, the 112 patients had 233 separate psychiatric diagnoses, and 66% had more than one diagnosis. Therapists rated 26% of patients as having mild psychological problems ($n_{\text{patients}} = 29$), 42% as having moderate psychological problems ($n_{\text{patients}} = 47$), and 32% as having severe psychological problems ($n_{\text{patients}} = 36$).

Measures

Working Alliance Inventory—Short Form. The WAI—Short Form is a 12-item measure of three facets (bond, task, and goal) of the therapeutic relationship as articulated by Bordin (1979) and initially operationalized by Horvath and Greenberg (1986) with the 36-item WAI (Tracey & Kokotovic, 1989). Items are rated on a 1 (*never*) to 7 (*always*) point scale. Forms exist for therapists, patients, and observers: Therapist ratings were used in this study. Scale reliabilities have been estimated as good to excellent (Busseri & Tyler, 2003; Samstag et al., 2008; Tracey & Kokotovic, 1989).

Demographic questionnaire. Each participating therapist filled out a brief questionnaire to assess age, gender, race/ethnicity, degree/license type, and years of experience. Treatment-relevant variables were also collected for each rated session, including patient age, gender, ethnicity, number of psychotherapy sessions provided to date, primary diagnosis, and level of functioning (low, medium, and high).

Procedure

The clinic was located through an Internet search initiated by the first author, Mark Beitel.[10] All eight of the available therapists were invited to rate psychotherapy sessions immediately after service delivery. Specifically, we asked each therapist to rate 25 consecutive individual sessions, representing work with 25 different adult American Indian patients. Three therapists were able to do so: The remainder rated three, six, seven, eight, and 13 sessions, respectively. The patients whose sessions were rated had, on average, 15 sessions with their therapist before the rated session ($Mdn = 7.5$, $SD = 17$). The number of previous sessions ranged from two to 75. The modal number of sessions was four, indicating that most cases were concentrated at the lower end of the range. This study received an exemption from the Human Investigations Committee at Yale School of Medicine. The Board and Directors of the clinic authorized this research as well. Directors at the participating clinic reviewed this article in advance of its submission for publication.

Data Analysis

Data analytic strategies appropriate for continuous and categorical data were used (Pearson and partial correlation, regression, and multivariate analysis of variance [MANOVA]). Statistical significance was set to $p < .05$. Statistical analyses were performed with SPSS Version 25 for Windows.

Results

Descriptive statistics for therapist-reported alliance variables are presented in Table 1. The variables were approximately normally distributed. Neither univariate nor multivariate outliers were detected. Estimates of internal consistency for the Task, Goal, and Total scales (see Table 1) were comparable with published norms, which ranged from .68 to .87 (Tracey & Kokotovic, 1989). However, the Bond scale produced a lower than expected coefficient α of .57. Removing Item 5 "I am confident in my ability to help" would increase the coefficient α to .66, but this measure was not taken to avoid rendering the scale incomparable with established normative data.

Mean elevations on all therapist-rated working alliance domains (see Table 1) exceeded those from a comparison sample of fourth-session therapist ratings (Busseri & Tyler, 2003), as assessed by one-sample t test: Bond ($M_{\text{comparison}} = 5.79$, $t = 1.99$, $p < .05$), Task ($M_{\text{comparison}} = 5.22$, $t = 4.48$, $p < .001$), Goal ($M_{\text{comparison}} = 5.36$, $t = 3.65$, $p < .001$), and Total ($M_{\text{comparison}} = 5.46$, $t = 3.79$, $p < .001$). The WAI Total score did not differ significantly from the Chaffin et al. (2012) sample ($M_{\text{Chaffin}} = 5.75$, $t = -1.79$, $p = .08$).

Neither patient age nor level of functioning was related to therapist-rated working alliance variables, as assessed through Pearson product-moment correlations (all rs $\leq .25$ and all ps $> .05$). Patient gender did not affect working alliance, $F = 0.38$, $p =$

[10] The clinic director (and coauthor, Laurelle L. Myhra) is an enrolled American Indian tribal member, a doctoral-level clinician, and a seasoned clinical investigator. The clinical staff share a desire to increase psychotherapy research for this underserved and understudied population.

Table 1
Scale Descriptive Statistics and Intercorrelations

Subscale	*M*	*SD*	α	1	2	3	4
1. Bond	5.90	0.61	.57	—			
2. Task	5.48	0.60	.71	.63**	—		
3. Goal	5.59	0.67	.74	.55**	.80**	—	
4. Total	5.66	0.55	.87	.82**	.92**	.90**	—

** $p < 01$.

.77, as assessed through MANOVA. We conducted a MANOVA to determine if patient diagnostic status affected working alliance. Neither main effects for posttraumatic stress disorder ($F = 2.24$, $p = .09$) nor current substance use disorder, $F = 0.57$, $p = .63$, were significant. The interaction Posttraumatic Stress Disorder × Substance Use Disorder was not significant, $F = 1.62$, $p = .19$.

The eight therapists differed from one another on all working alliance variables, as assessed by MANOVA (all $Fs > 4.0$, all $ps < .01$).[11] Five of the therapists produced WAI Mean Total scores between 5.6 and 5.8, whereas three produced scores between 5.0 and 5.2. All of the therapists in this sample were female, so the effects of therapist gender on alliance could not be assessed. Therapist ethnoracial status (American Indian vs. White) did not exert a significant effect on working alliance, as assessed through MANOVA, $F = 1.65$, $p = .18$. There were too many therapeutic orientation categories in this sample, with too few participants in each category, to test the effects of therapist theoretical orientation on working alliance.

The distribution for number of previous sessions was positively skewed and leptokurtotic, so a logarithmic transformation was applied to improve normality. The transformed variable showed the same pattern of relationship to the study variables as the original variable, so it was not used in subsequent analyses. The relationship between the number of previous therapy sessions and therapist-rated alliance measures was tested with linear and quadratic regression models. Neither linear nor quadratic relationships were found to be significant (all $ps > .05$).

Discussion

This is one of the first studies to explore the working alliance in outpatient psychotherapy with American Indian patients. We anticipated that working alliance ratings would be similar to WAI-12 normative data from therapists practicing in outpatient settings, given that we focused on professional therapists who were working in an urban treatment setting and deploying standard psychotherapeutic techniques. Contrary to our predictions, however, therapist-rated working alliance exceeded ratings from a comparison study of outpatient therapists (Busseri & Tyler, 2003). In their case study of an urban American Indian health care organization, Wendt and Gone (2012) summarized respondents' descriptions of the clinic as "(a) a vital place to be with other American Indians and feel connected with Native culture, (b) a home-like place where one feels welcome and comfortable, and (c) a place where health care is especially relational and hospitable" (p. 1031). Given that the clinic in this study specifically serves American Indians, it may similarly place a high value on providing culturally responsive care, such as heightened sense of connection, comfort, and hospitality, which in turn increases the quality of the working alliance.

We investigated the effects of potential covariates (patient, therapist, and therapy variables) on working alliance ratings. None of the patient variables (age, gender, problem variables, and diagnosis) were related to therapist alliance ratings in this admittedly small sample. As one might expect, the individual therapists differed in their therapeutic alliance ratings. Controlling for this variable made little difference, so it was not included in subsequent analyses. We were unable to test for differences by therapist gender or therapeutic orientation. No significant difference between American Indian and White therapists on therapeutic alliance was detected. This is an unexpected finding because research suggests that working alliance is affected by ethnoracial match (Chao et al., 2012; Flückiger et al., 2013). However, having an ethnoracial match may be more significant for patients' sense of alliance and linked outcomes than the therapists' alliance ratings. The therapists working in this specialized setting receive training and supervision to provide culturally responsive care. High alliance ratings may be in line with clinical training and supervision that values acceptance, nonjudgmental care, and cultural humility (Tervalon & Murray-García, 1998). Finally, the number of previous therapy sessions was unrelated to therapists' alliance ratings. Previous research (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004) has indicated that alliance, at least for clients, increases linearly or quadratically as psychotherapy progresses. However, we were unable to detect this phenomenon in our data set. This is not surprising because we were dealing with a single time-point alliance measurement.

Limitations

At this stage of our research, we do not have patient or observer alliance ratings to corroborate our findings. Including additional rater perspectives was deemed too complex for an initial investigation with new clinical partners, particularly given the history of abuse and mistrust between American Indians and university-based clinical investigators (see Hodge, 2012, for a review). The relatively small number of therapists, drawn from a single clinic, limits generalizability and prompts us to be cautious in interpreting our findings. Therapeutic orientation might also exert an influence on alliance, but we were unable to control for this variable in this study. In addition, it is possible that the degree of cultural com-

[11] Partialing out the effects of therapist ID on working alliance variables through partial correlation had virtually no effect, so therapist ID was not controlled in subsequent analyses.

mitment in therapists and patients might influence therapeutic alliance but was not assessed in this study.

Future Directions

It will be important to extend this line of research to include more therapists and clinics, including reservation-based clinics, as American Indians are diverse in terms of culture, history, and geography. Linking process variables to outcome (e.g., symptom reduction, functional improvement) will also be an important next step in this nascent line of research. Routine assessment of alliance and related constructs might help therapists serving American Indian patients practice more intentionally and self-reflectively. Finally, more rater perspectives should be included.

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