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A Qualitative Study Examining the Quality of Working Alliance as a Function of the Social Identifies of Clients and Therapists During the Mental Health Intake

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A qualitative study examining the quality of working alliance as a function of the social identifies of clients and therapists during the mental health intake

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Abstract

Therapists are faced with the challenge of developing effective ways to advance cross-cultural engagement with a rapidly growing diverse client population. In this qualitative study, we characterized the way clients and therapists described the quality of working alliance during the mental health intake and examined whether these descriptions vary as a function of their social identities. We conducted in-depth interviews with Ashkenazi (socially advantaged group; $n = 22$) therapists and their Mizrahi (socially disadvantaged group $n = 29$) or Ashkenazi ($n = 26$) clients immediately following their intake session in four mental health clinics in Israel. We performed a thematic analysis. Overall, interrater reliability among three raters who coded the narratives was high ($\kappa = 0.72$, therapist; 0.70 , client). Across all client and therapist interviews, we

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identified eight central themes detailing different qualities of the working alliance: (1) feeling understood, (2) feeling comfortable, (3) openness and cooperation, (4) trust, (5) empathy and identification, (6) frustration and disappointment, (7) anger and hostility, and (8) emotional disengagement. On average, clients reported 2.56 (standard deviation = 1.17) and therapists described 2.65 (standard deviation = 1.45) themes in each session. Overall, concordant and discordant dyads described similar themes with few exceptions. In particular, being part of a discordant dyad may affect the client's interpretation of non-verbal communication as well as the therapist's evaluation of the client's openness and trustworthiness. Although less frequent, when anger and hostility were described by therapists, these characterized the interaction with Mizrahi clients. We discuss implications to care including the need to promote a culturally humble approach to providing care for minorities.

Keywords

Working alliance, intake, mental health, ethnic minorities

Therapeutic alliance refers to the degree to which the client and therapist are engaged in collaborative work (Bordin, 1979; Hatcher and Barends, 2006; Horvath et al., 2011). A pan-theoretic definition of the alliance includes an agreement on the goals and tasks of therapy in the context of a positive affective bond between the client and therapist (Bordin, 1979; Horvath, 2001). The therapist's ability to form a good alliance is considered a core ingredient of psychotherapy (Flückiger et al., 2018; Norcross and Lambert, 2018), with studies documenting a moderate but stable correlation between early alliance and treatment outcomes regardless of therapy orientation, alliance measure, and time of assessment (Flückiger et al., 2018; Horvath et al., 2011; Norcross and Lambert, 2018). Strong therapeutic alliance directly affects improvement in symptoms and health status as well as satisfaction with care (Falkenström et al., 2013; Horvath et al., 2011; Nienhuis et al., 2018).

The increasing ethnic/racial diversity of the client population in many Western countries has compelled health-care systems to identify ways to promote effective engagement in cross-cultural encounters. When interacting with someone whose cultural background differs from one's own, processes pertaining to different social categorization may impact the ability to form a good alliance. First, different social identities might generate difficulties in understanding and correctly interpreting the client's information (Alegria et al., 2008), also known as a cultural dysfluency effect (Oyserman, 2011). Second, given that such discordant encounters often involve a therapist from an advantaged group and a client from a disadvantaged group, processes pertaining to intergroup bias and intergroup power might further come into play. Therapists may be prone to use social categorization and bias in their decision-making processes (Cooper et al., 2012). For example,

Green et al. (2007) found that when presented with vignettes about clients with symptoms of myocardial infarction, physicians higher in implicit racial bias were less likely to recommend appropriate treatment recommendations for African American clients when compared with White clients. Therapist bias can also impact the quality of clinical interaction. Nakash and Saguy (2015) examined the quality of working alliance as a function of the social identities of clients and therapists. Their findings showed that while socially advantaged therapists reported worse working alliance with clients belonging to disadvantaged (relative to advantaged) groups, there were not significant differences in the clients' rating of the working alliance as a function of their social group.

Findings related to social identities of clients and therapists have led multiple investigators to test the hypothesis that improved outcomes may result from working in concordant (same group) dyads (Chu et al., 2016; Cooper and Powe, 2004; Karlsson, 2005; Maramba and Nagayama Hall, 2002). This "matching" hypothesis suggests that the best quality of care is provided when the therapist comes from the same cultural or ethnic/racial background as their client. "Matched" dyads are assumed to have both the language and cultural competency to engage effectively during clinical encounters (Thornton et al., 2011).

Research pertaining to the "matching" hypothesis provided inconsistent answers as to whether shared social identities between clients and therapists are related to outcome variables. A meta-analysis (Cabral and Smith, 2011) of 154 studies documented a moderately large effect for clients' preference of a therapist of the same ethnicity/race but almost no benefit of ethnic/racial matching to the outcomes of mental health treatment. Studies focusing on quality of interaction during mental health visits found that ethnic/racial match promoted clients centered communication among some minority groups (e.g., Latinos; Alegría et al., 2013). This is supported by findings that minority clients may have reason to mistrust health-care providers based on the expectation of being stereotyped and receiving lower quality care (Burgess et al., 2004).

Here, we conducted a qualitative study to examine the quality of working alliance as reported by therapists and clients during interviews following the mental intake session. Therapists have multiple goals to the intake, including but not limited to establishing diagnosis, facilitating rapport, and planning treatment (Nakash et al., 2009a, 2009b; Rosen et al., 2012). Clients' goals may focus on their wish to feel understood and supported by their therapists (Nakash et al., 2014b). Despite the documented importance of early sessions in client retention and outcome, limited research exists examining the quality of clinical interaction during the initial intake. The challenges of the intake, and particularly establishing rapport, are likely to be amplified when social/ethnic differences exist given the unfamiliarity and discomfort often associated with such encounters (Nakash et al., 2009a; Nakash and Saguy, 2015). In this study, we aimed to characterize the way clients and therapists described the quality of working alliance during the mental health intake and examined whether these descriptions vary as a function of their social identities.

We focused on differences between encounters involving an Ashkenazi (socially advantaged ethnic group that includes Jews of European/American descent) therapist with either a Mizrahi (socially disadvantaged ethnic group that includes Jews of Middle Eastern/North African descent) or Ashkenazi clients. Since only a small minority of therapists self-identified as Mizrahi, we were not able to examine discordant dyads with ethnically disadvantaged therapist. Mizrahi and Ashkenazi ethnic groups make up the majority of the Jewish population in Israel and both mostly migrated during the early years of the foundation of the State of Israel. Consistent evidence from research in public health and the social sciences (Israel Central Bureau of Statistics, 2017; Nakash et al., 2013a, 2013b; Saguy et al., 2008) shows that persistent gaps between these groups is apparent in levels of education (Ashkenazim have three additional years of education on average compared with their Mizrahi counterparts), average income (Mizrahi families earn 85% of the income of their Ashkenazi counterparts), and mental health status (prevalence rates of mood and anxiety disorders are twice higher among first- and second-generation Mizrahi respondents compared to their Ashkenazi counterparts). Also, Mizrahi group members tend to experience more prejudice, negative stereotyping and discrimination compared to their Ashkenazi counterparts (Nakash et al., 2012; Saguy et al., 2008).

Method

Setting

The study was conducted in four community mental health clinics in Israel. All four participating clinics offer free mental health services to an ethnically and socioeconomically diverse adult client population. All clinics offer a variety of mental health services, including assessment, psychotherapy (including different treatment modalities tailored to client's presenting problem, such as cognitive-behavioral therapy, psychodynamic therapy, crisis intervention, group therapy, and family and couples therapy), and psychopharmacology. Access to care does not necessitate medical referral. The primary goal of the intake session at all participating clinics was to gather information about the presenting problem and psychosocial history of the client to inform diagnosis and treatment plan. None of the participating clinics used a structured intake protocol. At each of the clinics, clients were consecutively allocated to therapists to conduct the intake based on therapist availability. All intake sessions are conducted in person with no prior screening.

Sample

A convenience sample of therapists and clients participated in the study. We recruited therapist participants at the clinics through introductory informational meetings. Thirty-eight therapists agreed to take part in the study, five therapists

declined participation. To ensure the diversity of the sample, we invited therapists to participate only up to five times (with five different clients; $M = 3.8$, standard deviation (SD) = 1.3). We recruited client participants through direct person-to-person solicitation as they presented for the intake visit. Clients were informed that all information gathered would be kept confidential and that no identifying information would be collected. As part of the informed consent process, research assistants also informed clients that they were free to decline participation and/or withdraw participation at any point with no consequences to the quality of care they received from the clinic. Client inclusion criteria were adults (18 years and above) who did not require interpreter services. Exclusion criteria included people whom the therapists identified as psychotic or actively suicidal. Only clients of clinicians that agreed to participate were invited to the study. Of the 184 clients who were invited to participate in the study, 122 agreed to participate (31 clients declined to participate: 21 were not able to stay for additional time following their intake to complete the research protocol, 3 did not feel well enough to participate, and 7 did not want to have the intake session recorded). Five clients did not complete post intake interview and five additional clients were excluded from analyses due to poor recording quality. In this study, we included only therapists that self-identified as Ashkenazi ($n = 22$) and their clients that self-identified as Mizrahi ($n = 29$) or Ashkenazi ($n = 26$).

The majority of therapists were females (75%), ages ranged from 28 to 63 years ($M = 42.9$, $SD = 10.97$) and approximately two-thirds of therapists were born in Israel (72.7%); 50% were psychologists, 10% psychiatrists, and 40% social workers, with the approximately half of therapists (47.36%) having more than 5 years of clinical practice ($M = 9.94$, $SD = 9.77$). All participating clients were Israeli Jews who were fluent in Hebrew. Of the 55 clients who participated in the study, the majority were females (76.9%), ages ranged from 19 to 72 years ($M = 39.73$, $SD = 14.41$) who were born in Israel (78.4%). Half of the sample (51.1%) had 12 or less years of education and 59.7% were unemployed. Approximately, 60.8% reported a personal yearly income of less than US\$15,000.

Procedure

These data are part of a larger study aimed to examine the mental health intake with diverse client population (for full study description, please see Nakash et al., 2014a, 2015a, 2015b, 2015c; Nakash and Saguy, 2015). Immediately following the intake session, trained research assistants conducted semi-structured, in-depth interviews face to face with clients and therapists. Interviews lasted approximately 30 minutes (see Online Appendix 1 for interview guides). We audiotaped and fully transcribed all interviews. Clients' interviews included questions about their presenting problem, rapport with the therapist, significance of sociocultural factors in the presenting problem, and their expectations from care. Therapists' interviews included questions about their understanding of the client's main problem, their evaluation process, their rapport with the client, and their views of the role of

sociocultural factors in the client's presenting problem. Trained graduate students in clinical psychology who received weekly supervision conducted all interviews. All aspects of the study were approved by the appropriate Institutional Ethics Committees at each participating clinic, and all clients and therapists completed informed consent prior to participation.

Qualitative analysis

We performed thematic analysis (Braun and Clarke, 2006) to identify major themes in clients' and therapists' accounts of the quality of their interaction during the mental health intake using ATLAS.ti version 7. The research team who coded and analyzed the data included three graduate students in clinical psychology.

The thematic analysis involved a series of steps (Braun and Clarke, 2006). First, we developed two codebooks, for clients' and therapists' interviews using the following three steps. We initially performed open coding which refers to inductive coding process which is achieved by having each member of the analytic team independently read the each interview line by line to identify codes (Corbin and Strauss, 2008). We then grouped and labeled key categories. In the second stage, we separately reread the accounts to perform axial coding. Axial coding refers to qualitative research technique that involves relating data together in order to identify the relationship among categories and to organize them into themes within participants' voices in the collected data. In other words, axial coding is a way to construct linkages between codes to provide a meaningful account of the data (Corbin and Strauss, 2008).

The development of the codebooks lasted approximately three months and formalized when we reached saturation. The development of the codebooks was based on 15% ($n = 25$) of the interviews which were randomly selected. Once we established interrater reliability, all remaining interviews were divided among the coders and coded using the codebooks. To prevent coders' drift at this stage of the analysis, we assessed interrater reliability using ATLAS.ti. The program allows for comparison across coders of selected transcripts and provides a measure for interrater reliability (Kappa). Kappas were calculated by having all raters code four randomly selected interviews (two for providers and two for patients) at three time points as follows: after coding 25% ($n = 30$; therapist: kappa = 0.82; client: kappa = 0.82), 50% ($n = 60$; therapist: kappa = 0.71; client: kappa = 0.71), and 75% ($n = 90$; therapist: kappa = 0.70; client: kappa = 0.71) of the total recorded interview. Overall, interrater reliability among all three raters in the different time points (based on total of 12 interviews) was good (therapist: kappa = 0.72; client: kappa = 0.70).

We organized all the information in the interviews under these emerging themes. In addition, we allowed data excerpts to be placed under more than one category and/or code depending on their relevance. In this study, we focused on the larger category of "working alliance" which included themes related to the quality of the interaction between the client and therapist. Throughout the analysis process, the

team met on a weekly basis. Team discussions focused on the developing coding scheme to ensure consistency between coders and validity of the emerging findings. The team continuously reviewed questions related to coding and considered new codes if emerged (under the themes that have been identified in the codebook). Constant comparison was used to examine relationships within and across codes and categories. Team meetings also included invitation for reflexivity, and members of the team were encouraged to reflect on sources for potential bias stemming from their intersecting social locations. When disagreement regarding coding arose, the source of the discrepancy and coded sections were reviewed again until consensus was reached (Corbin and Strauss, 2008).

Results

Across all client and therapist interviews, we identified eight central themes detailing different qualities of the working alliance as follows: five themes portrayed positive qualities: (1) feeling understood, (2) feeling comfortable, (3) openness and cooperation, (4) trust, and (5) empathy and identification; three themes portrayed negative qualities: (1) frustration and disappointment, (2) anger and hostility, and (3) emotional disengagement. On average, clients reported 2.56 ($SD = 1.17$) and therapists reported 2.65 ($SD = 1.45$) themes describing the quality of their working alliance during the intake session. Overall, although specific categories did not always match between clients and therapists, the themes that emerged were similar and the overall tone of the quality of the interaction (positive/negative) was by and large congruent between the depiction of clients and therapists when describing the quality of their interaction during the intake. Overall, 26 concordant and 29 discordant dyads described similar themes with few exceptions. In the paragraphs below, we expand on the themes we identified while highlighting ethnic differences when these emerged. We provide a measure of the frequency of occurrence of the identified themes in the data set (number and percentage of interviews). The measure of frequency is merely descriptive and not an estimate of population parameter. Finally, we include specific examples for illustration.

Feeling understood

Clients from both ethnic groups reported that feeling understood was a critical element characterizing the relationship with their therapists ($n = 48$; 94.1%). Clients described different therapist behaviors that fostered feeling understood. These included: asking the right questions, knowing how to direct the session, offering appropriate advice, and, primarily, listening in a way that encouraged a sense of safety and openness:

She understood, she got what I meant. Her speech, and the experience in directing the conversation... she asked questions that were really important. Because of this, I continued to openly speak to her in an open manner. (3415CL)

Other clients emphasized the therapist's clinical training and practice as well as other personal attributes that contributed to their experience of being understood:

I think that if she learned how to be a good therapist, and she has experience... I believe that she's smart, educated, cultured, and intelligent enough in order to be in the place she's in. For sure, this helped her understand me. (2196CL)

Non-verbal communication was also key to enhancing feeling understood particularly among Mizrahi clients. These included behavioral gestures such as speech tone, facial expression, and head nodding: "His eyes spoke to me... he basically said this is really hard. He showed that he understands" (2247CL).

In contrast to clients, close to half of the therapists ($n = 10$; 45.5%) and a third of the therapists' total interviews ($n = 18$, 32.7%) described understanding their client as a key characteristic of the interaction with their client. The therapists who did mention this highlighted similar cultural background as a key factor contributing to their ability to better understand their client:

This [similar background] primarily influences my confidence in my ability to understand, because if someone comes from a totally different culture, I won't know if this is socially acceptable or not... With someone who is more [socio-culturally] similar, the answers to these questions will be clearer to me. (2199PR)

Feeling comfortable

About half of the clients of both ethnic groups ($n = 27$; 52.9%) described a sense of comfort when interacting with their therapist. Comfortable alliance was primarily promoted by their therapist's non-verbal communication, which included soft speech tone, maintaining eye contact, as well as sympathetic facial expressions and smiles from the therapist:

She asked questions in an understanding, pleasant, accepting way. The smile was pleasant, the way in which she spoke wasn't pretentious. I just felt comfortable. (1113CL)

The client's perception of the therapist sincere wish to help was also key in promoting a sense of ease and comfort particularly among Mizrahi clients:

She simply was great, very comfortable... she gave me the best feeling there is... she gave me the feeling that she wants to and can help me. (4410CL)

More than three quarters of therapists ($n = 18$, 81.8%) and more than half of total therapist interviews ($n = 32$, 58.2%) described a sense of pleasantness and comfort

when describing the quality of the interaction with their client. Factors that contributed this experience of comfort were client participation and openness:

It was comfortable for me to talk to her because she cooperated in an open way, she was able to connect emotionally. (4412PR)

The therapist ability to identify with and relate to clients experience was also important. This was often prompted by the degree of similarity between them and their clients:

There were points of similarity. I can really identify with her feelings... A lot more pleasant for me, I feel that I am more attentive and a lot less critical. (2119PR)

Other therapists described that the use of humor also contributed to a comfortable interaction:

In total, it was very pleasant, flowing, open... I think that there were a few times that perhaps I, a bit, joked with him. I think this helped. (1171PR)

Respect toward the client also contributed to a sense of comfort, but interestingly this came up only for therapists who saw Ashkenazi clients:

There was a pleasant interaction. She's impressive... I respected her and the way she managed her life so far. (2199PR)

Openness and cooperation

Less than fifth of the clients of both ethnicities ($n = 9$, 17.6%) described a sense of cooperation and openness when describing the quality of the clinical interaction with their therapists during the intake. Clients highlighted their therapist ability to guide the dialogue and ask questions that helped them "open up":

She touched on the heart of the problem; she really nailed it. She asked me the most essential questions in my perspective and I immediately responded and told her the whole background. (2124CL)

In contrast, approximately three quarters of the therapists ($n = 16$, 72.7%) and half of the total therapists' interviews ($n = 29$, 52.7%) described a sense of cooperation and openness when characterizing their interaction with clients of both ethnicities. Therapists highlighted the client's ability to speak openly and honestly:

To achieve the goals with her, this was pretty easy... she is very honest and she is really cooperative... she was very open. (2199PR)

Trust

More than a third of the clients of both ethnicities ($n = 22$; 43.1%) mentioned trust when describing the quality of the interaction with their therapists. Trust was primarily fostered by the perception of therapist professional demeanor and clinical experience:

She gives a sense of a person that is very trustworthy, responsible, and serious. She understands what she's doing, she is very skilled in what she does. (4407CL)

An additional factor that helped clients trust their therapists was the feeling that “finally there's someone that listens” to their concerns and pains:

First of all, I was a person that most of the time was closed within myself, that I didn't open up to anyone . . . I also had a lot of anger towards society . . . and thank G-d I see that there are people in the world that want to help and to give. (3411CL)

An additional factor that fostered trust was related to therapists' non-verbal communications and, primarily, eye contact and welcoming body language:

The moment a person looks at another person in the eyes and he doesn't deal with different things during the conversation is when you know they speak with honesty. (4404CL)

Approximately, a third of the therapists ($n = 8$, 36.4%) and one-fourth ($n = 14$, 25.5%) of the total therapist interviews reported trust when describing the interaction. Therapists mentioned trust primarily with Ashkenazi clients with whom they felt an emotional connection, largely relying on non-verbal communication during the session:

I saw her emotional flooding . . . primarily the mimicry of the face, more than all the words. It seemed to be very authentic . . . the pain in [her] face seemed to me very truthful, and this really encouraged me. (4404PR)

Empathy and identification

About one-tenth of the clients of both ethnicities ($n = 6$, 11.8%) mentioned empathy and identification when describing the quality of the therapeutic relationship during the intake. Non-verbal communication, which included behavioral gestures (e.g., speech tone, facial expression, and nodding), was key to signal that their therapist was empathic:

He simply seemed to me a pleasant, gentle, empathic person . . . speech tone, speech character, everything felt very pleasant, and welcoming. . . In contrast to this, there are people that I simply feel unpleasant with, that there's something aggressive in their

speech, that they speak in a very loud voice, and his tone was very calm and quiet. (1122CL)

Other clients mentioned similarity in sociocultural characteristics (e.g., religiosity/gender/age) between them and their therapist that enabled their therapist to empathize with their experience:

When the background is similar this can encourage me to feel more that they can feel my pain... or that they identify with me... I am primarily speaking about the religious background. (2199CL)

In contrast, more than half of the therapists ($n = 14$, 63.6%) and in little over a third of the total therapist interviews ($n = 21$, 38.2%) reported a sense of empathy and identification. Therapists highlighted their emotional connections with the clients of both ethnicities, particularly with their emotional pain:

There was something very appealing about her. I felt very empathetic towards the terrible life that she describe and how this woman coped with all of this. I had a lot of appreciation for her. (2205PR)

Frustration and disappointment

Approximately one-fourth of the clients of both ethnicities ($n = 12$, 23.5%) described frustration and disappointment when they characterized the interaction with their therapist. Frustration was mainly provoked when clients felt the treatment recommendations were not appropriate and/or when the clinic did not offer services they needed:

I didn't leave satisfied because I didn't get what I needed... she didn't want to speak about the topic of the pills because this isn't her field. I was very disappointed. (4412CL)

Approximately half of the therapists ($n = 10$, 45.5%) and in less than fifth of the total therapist interviews ($n = 10$, 18.2%) described a sense of frustration and disappointment when they characterized the interaction with their clients. These therapists, who treated clients of both Mizrahi and Ashkenazi background, described a sense of disappointment during the session because they neglected to ask certain questions or because they felt they did not fully probe certain points that, in hindsight, they understood to be important:

I felt difficulty with the questions that I am required to ask. I felt that this could intimidate her in some way. I am sorry that I didn't ask this. I didn't find the words or the timing to ask about this, it was frustrating. (1091PR)

Other therapists described disappointment when interacting with clients who did not “open up” and were not openly disclosing information:

There was something very disheartening working with him, a feeling that he isn't open enough and he wasn't able to see his vulnerability . . . it seemed that he doesn't allow himself to touch these parts of himself. . . It was frustrating during different point of the meeting. (2231PR)

Anger and hostility

Only a few clients of both ethnicities described anger or hostility ($n = 4$, 7.8%) when characterizing the quality of the clinical interaction. The primary factor that provoked anger and hostility toward therapists was the feeling that the therapist is insensitive, does not dedicate enough thought to understanding the client's problem, and tends to rush to conclusions and offer treatment recommendations that were not acceptable to client (e.g., recommend psychopharmacological treatment):

The psychiatrists don't understand the soul of the person . . . if the psychiatrist straight away comes and gives me a pill it just shows how they don't care . . . I think that one needs to try other ways of help. I felt she didn't understand me. What type of doctor is she? She's a witch, she's not a doctor. I was really upset. (3407CL)

Similar to clients, only few therapists ($n = 5$, 22.7%) and in few interviews ($n = 5$, 9.1%) described anger and hostility. Interestingly, these were primarily interactions with Mizrahi clients. Therapist described feeling angry with clients they perceived as critical toward them and/or resistant to receiving the help they offered:

This isn't nice to say but he kind of annoyed me . . . because of the concealments; that he comes for help but doesn't really want to receive it. (2191PR)

Emotional disengagement

Only few clients of both ethnicities ($n = 3$, 5.9%) mentioned emotional disengagement from their therapists. When it was apparent, it was primarily influenced by the personality and character of the therapist:

One needs to be a very specific type of person in order to succeed in being empathic . . . It depends on personality . . . it could be that I would open-up a bit more or that it would be easier for me to feel connected with her in general if she was a little nicer, not so judgmental. (1322CL)

In contrast, half of the therapists ($n = 11$; 50%) and approximately a third of total therapist interviews ($n = 17$, 30.1%) described emotional disengagement toward their clients. Often, they attributed it to the client's personality characteristics, particularly to the clients' difficulty developing an emotional connection and/or clients that seem disengaged or emotionally detached:

The interaction with him was formal. I simply got information from him. There was no emotional range to what he was saying, no feeling. I understood his problem, and I didn't really emotionally connect to his problem. (3302PR)

Other therapists disengaged from clients they perceived as hostile and/or entitled:

She's that type of person that thinks that the more they ask they'll get more and I don't feel that a good relationship developed... I don't think that she likes me... there was something aggressive and angry about her. She was very negativist. I was really hard to connect with her. (2092PR)

Finally, some therapists reported disengagement with clients who either were not able to give a coherent account or clients whose affect did not match their narrative:

I didn't succeed in getting a coherent story, also because of her embarrassment and also because of her personality which carries many disconnections. Meaning, she can't really tell a story in sequence. It was just hard to relate to her. (1030PR)

Discussion

Developing good alliance can be challenging when cultural/racial/ethnic differences exist between clients and their therapists. Unfamiliarity and/or discomfort with a client's beliefs, practices, understanding of etiology, acceptable approaches of treatment, and communication style may create additional levels of complexity in the clinical encounter (Nakash et al., 2009b, 2012). In this study, we aimed to characterize the quality of the working alliance during the mental health intake as reported by clients and their therapists in post intake qualitative interviews. We set out to examine the "match" hypothesis which suggests that therapeutic dyads that share ethnic background will report better quality of working alliance compared with discordant dyads (Alegria et al., 2013).

Our findings show that clients and therapists in this study used more positive than negative categories to describe the quality of working alliance during the intake. Furthermore, the overall valence (positive/negative) of the session was congruent between clients and therapists. Specifically, we identified five positive valence descriptions of the quality of the alliance in both therapist and client interviews including feeling understood and/or comfortable, openness, trust, and

empathy/identification. Over half of the clients highlighted feeling understood and comfortable during the intake. Therapists similarly emphasized feeling comfortable while also highlighting openness and empathy in their interactions with clients. These findings are congruent with previous research that documented that a large majority of clients report wanting to feel understood by their therapists during the initial intake session.

Previous research has also documented the role of client's openness and willingness to disclose to the therapist's empathy and connection with them (Levontin et al., 2019; Nakash and Alegría, 2013; Nakash et al., 2009a). Self-disclosure is an essential factor in interpersonal relationships, and it is crucial to intimate relationship development including therapeutic relationships (Cozby, 1973; Derlega et al., 1993). Indeed, a central premise of most modern mental health treatments is that disclosure of personal information as well as problems, traumas, and transgressions has positive effects on both psychological and physical markers (Pennebaker, 2012).

Interestingly, although the data included minimal differences in the overall positive depiction of the clinical interaction as a function of the social identity of clients and therapists, the characteristic of these interactions varied to some degree between Mizrahi and Ashkenazi clients. Most notable was the role of non-verbal communication (including tone of voice, eye contact, physical gestures, etc.). Mizrahi clients tended to highlight the role of non-verbal communication in feeling understood by their therapists as well as evaluating the sincerity of the therapist's motivation to help them. Ashkenazi therapists also reported feeling more respectful toward Ashkenazi clients as well as greater openness and trust with Ashkenazi clients. Non-verbal communication played an important role during these interactions as well. Integrating multiple sources of information which rely heavily on non-verbal communication can be an important tool in making judgments about how to relate to a certain client and how to facilitate rapport (Chaffey et al., 2010; Nakash and Alegría, 2013). However, they can also contribute the therapist bias especially when interacting with minorities (Ashton et al., 2003; Hausmann et al., 2011).

Although less prevalent, clients and therapists also described negative valence of the working alliance for some clinical encounters. We identified three major themes including disappointment and frustration, anger and hostility, and emotional disengagement. Notably, more therapists described emotional disengagement with clients—primarily with those who were less emotionally available and connected. Furthermore, although not frequent, when anger and hostility were described by therapists, these characterized the interaction with Mizrahi clients.

Taken together, our findings suggest that the quality of the working alliance during the mental health intake can vary in some ways according to of clients' and therapists social identifies. In particular, concordant or discordant identities can affect the interpretation of non-verbal communication as well as the therapist's evaluation of the client's openness and trustworthiness. These findings suggest

underlying processes that can contribute to therapist bias that manifest in the more favorable quality of care provided to clients who belong to a similar ethnic group as their therapists (i.e., socially advantaged social groups).

Yet, the application of cultural match approach to mental health care is limited. First, cultural matching is rarely possible for all clients, particularly in places like Israel, which is ethnically and culturally diverse. Clients are assigned to their therapist based on their illness profile or availability, rather than on their social/ethnic backgrounds. Thus, all therapists, regardless of whether they are matched with their clients' cultural/ethnic background, need to know how to communicate and interact with clients about mental health distress. Second, the cultural match approach as it is practiced often assumes that social identities are based only on one dimension and disregards the body of literature on intersectionality (Adames et al., 2018). For example, an Arab, Christian, homosexual male client may have little in common with an Arab, female, heterosexual, Muslim social worker. Social identities are far more complex and nuanced; however, it is possible that one dimension of a client's social identity (e.g., sexual orientation) may be more salient than another (e.g., ethnic background) for promoting effective communication and forming a rapport.

For these reasons, the field of cross-cultural communication has expanded in recent years toward encouraging therapists to learn cultural competent communication skills with their clients regardless of their own ethnic/cultural background and whether it matches their clients (Cooper et al., 2012; Saha et al., 2008). This approach has proven to be an effective strategy and shown to improve client's satisfaction and retention in care (Beach et al., 2005; Cooper et al., 2012; Saha et al., 2008). In this context, observing culturally appropriate non-verbal communication etiquette and avoiding stereotypes as well as avoiding making assumptions about a clients' preference based on ethnicity/race, nationality, and culture are critical.

Raising awareness to cultural differences in client–therapist communication is an important first step in improving cross-cultural interactions. Yet, it will not be complete without acknowledgment of the role of social power in cross-cultural encounters and the potential harmful consequences that may arise when power differentials are not addressed. Social power, defined as the ability to influence the outcomes of others through control over material (e.g., money) or social (e.g., knowledge) resources, has been shown to fundamentally impact human behavior (Keltner et al., 2003). Any client–therapist interaction is by definition hierarchical because the therapist is the one with the knowledge and expertise (Goffman, 1963). However, in ethnic/race/culture-discordant encounters between a therapist from a privileged group and a client from a minority group, another layer of power is added, namely, power by virtue of social group membership. This layer adds to the already existing amount of power-by-social-role, resulting in a therapist from a privileged group having overall more social power in the discordant encounter than in a concordant encounter (Nakash et al., 2012).

In order to address these uneven power dynamics that are inherently part of the therapeutic relationship, scholars have offered to move beyond the cultural competence framework, which emphasizes a “way of doing” to embracing a cultural humility approach, which refers to the therapist’s “way of being” with the client (Hook et al., 2016; Ndiwane et al., 2017). Cultural humility is guided by values that promote diversity and equity while being attentive to structures of power and hierarchy in cross-cultural interactions. In their landmark paper, distinguishing between cultural competence and cultural humility in therapist training, Tervalon and Murray-García(1998) summarized that “cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the therapist–client dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations” (p. 123). Maintaining a culturally humble stance requires a degree of openness to others. It is centered on a humble approach that maintains respect and lack of superiority when communicating with the client (Hook et al., 2013).

Our study has several limitations. First, we included a convenience sample which may be subject to selection bias. Second, since only a small minority of therapists self-identified as Mizrahi, we were not able to examine the quality of the working alliance in clinical encounters with ethnically advantaged therapists.

Advancing effective cross-cultural communication is a challenge faced by therapists in an increasingly diverse and interconnected world. Raising awareness and promoting knowledge about mental health needs and care preferences including communication styles is an important first step in addressing communication gaps. However, on its own, these steps may overlook power differentials and important structural factors that contribute to the communication gaps. Promoting a culturally humble approach to providing care acknowledges that one can never fully know the *other*, and thus any communication should be based on curiosity and respect for the other. Asking and actively listening to clients’ needs and preferences are essential.

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Supplemental material

Supplemental material for this article is available online.

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