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Psychotherapy dropout : the influence of ethnic identity and stigma on early termination.

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PSYCHOTHERAPY DROPOUT: THE INFLUENCE OF ETHNIC IDENTITY AND
STIGMA ON EARLY TERMINATION

By
Le'Keldric Jawon Thomas
B.A. Morehouse College, 08/2006
M.Ed. University of Louisville, 05/2012

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A Dissertation Approved on

01/11/16

by the Following Dissertation Committee:

_____
Jesse Owen, Ph.D., Committee Co-Chair

_____
Patrick Hardesty, Ph.D., Committee Co-Chair

_____
Stephanie Budge, Ph.D., Committee Member

_____
Ron Van Treuren, Ph.D., Committee Member

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exist within their minds gave me the motivation to persist. Last, but certainly not least, I would like to thank my wife and best friend, Quand, for allowing me to pursue my dreams and dare to be my best self.

ABSTRACT

PSYCHOTHERAPY DROPOUT: THE INFLUENCE OF ETHNIC IDENTITY

AND STIGMA ON EARLY TERMINATION

Le'Keldric J. Thomas

01/11/16

Although clients continue to drop out of psychotherapy, researchers have made few inroads into understanding the dropout phenomenon. Clinical studies have reported client dropout rates based on demographic factors (e.g., race, socioeconomic status, educational status). However, few studies have investigated the cultural correlates that may underlie these demographic factors and affect client termination. Furthermore, none have provided an empirically driven explanation as to why some clients drop out more often than others. In two studies, I explore dropout in two settings: a community mental health center and a university counseling center. Guided by current theory and research, I will examine the association between clients' ethnic identity, the stigma they experience, and their decision to terminate therapy. Through logistic regression, I will seek to explore these cultural influences on the dropout process. It is expected that the study will contribute to current research and assist practitioners in preventing dropout.

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CHAPTER 1: INTRODUCTION

Psychotherapy is an effective approach in treating a wide range of conditions. However, client dropout is a well-documented occurrence within the practice of psychotherapy. Estimates of the psychotherapy dropout rate range from 20% to 60% (Clarkin & Levy, 2004; Hamilton, Moore, Crane, and Payne, 2011; Sparks, Daniels, & Johnson, 2003; Swift & Greenberg, 2012; Wierzbicki & Pekarik, 1993). Client dropout can affect the clients, as well as therapists and society as a whole. Clients who drop out experience fewer treatment gains, fewer positive mental health outcomes, and report more dissatisfaction with treatment, which may lead to repeated treatment episodes (Björk, Björck, Clinton, Sohlberg, & Norring, 2009; Klein, Stone, Hicks, & Pritchard, 2003; Lampropoulos, 2010). Additionally, therapists may experience client attrition as demoralizing and destructive to their morale (Sledge, Moras, Hartley, & Levine, 1990). For agencies, dropout has been associated with high staff turnover (Klein, Stone, Hicks, & Pritchard, 2003) and wasted resources, including lost revenue and inefficient use of available resources (i.e., less time spent in service delivery, longer waiting lists, limiting the number of clients who can receive care) (Armbruster & Kazdin, 1994; Barrett, Chua, Crits-Christoph, Gibbons, & Thompson, 2008; Reis & Brown, 1999). The social effects of client attrition are numerous and are still being fully understood. Clients who drop out of therapy may require additional and more expensive mental health services in the future (Farmer & Burns, 1997). The experience of living with untreated mental illness can also

have detrimental effects on the individual as well as the individual's family and community (Barrett, 2008).

Within psychotherapy research, dropout has primarily been measured in four different ways: therapist judgment, number of sessions, clinical change, and client report. Therapist judgment relies upon the decision of the therapist to determine whether the client has indeed ended treatment prematurely. This method is considered to have face validity. It is the most widely used among practicing clinicians, and it is often preferred since the therapist is considered to be intimately familiar with the case (Pekarik, 1985; Swift & Greenberg, 2012). Although therapists are equipped to make an informed decision about whether dropout did or did not occur, there could be some biases in their judgment (Garb, 1998). For instance, therapists may experience pressure to lower their dropout rate and be motivated by this pressure to indicate fewer dropouts. Conversely, a therapist's own countertransference reactions to the client or case could influence whether the client is deemed to have dropped out prematurely or not. This method also suffers from issues of inter-rater reliability for what is judged to be dropout.

A second criterion is to measure dropout via failure to attend therapy for a set number of sessions (e.g. dropout is based on a client not attending through the 3rd or 5th session; Warnick, Gonzalez, Weersing, Scahill, & Woolston, 2012). This method is easily quantifiable, but it does not account for the fact that clients experience results at different rates (Baldwin, Atkins, Olsen, & Nielsen, 2009). Third, Hatchett and Park (2003) introduced the idea of clinically significant change as a means of understanding the construct of dropout. Based on this method, a client is considered to have dropped out of therapy only if they did not make significant improvements as evidenced by outcome

measures. This method holds promise since it provides practice-based evidence for a client's well-being at the time of termination, which may speak to the effectiveness of therapy (see Swift, Callahan, & Levine, 2009). However, this method does not account for the fact that some clients drop out because they are no longer distressed, even if improvements in their functioning may not be captured by their last session scores.

Fourth, client judgment is based on the idea that clients are best positioned to determine when dropout has occurred. Measuring dropout in this way honors the client's voice in the psychotherapy decision-making process. Clients who make the decision to end therapy without discussing it with their therapists are said to have unilaterally terminated (Owen, Imel, Adelson & Rodolfa, 2012). Callahan, Aubuchon-Endsley, Borja, and Swift (2009) identified through client judgment that 45% of clients who ended therapy did so unilaterally, a number that rose to 77% with trainee clinicians' judgment. In general, clients who unilaterally terminate demonstrate worse treatment outcomes (Owen, Smith, & Rodolfa, 2009; Vandereycken & Vansteenkiste, 2009). This gives credence to the viability of using client judgment in order to more effectively understand the dropout phenomenon.

There is little agreement as to which method of measuring dropout is the most effective or reliable. It is likely that each method has its merits based on a variety of factors including treatment modality and treatment setting. The current study will explore dropout as it occurs in family therapy at a community mental health center and individual therapy at a college counseling center. Guided by the literature and practical concerns, I have decided that using therapist judgment and client judgment to assess dropout offers the most insight into understanding dropout for these two populations in this study.

The current body of research has explored factors related to dropout that can be placed within three broad categories: process factors, therapist factors, and client factors. Process factors such as the working alliance have been linked to dropout (Sharf, Primavera, Diener, 2010). Further, therapists vary in their ability to retain clients (Owen, et al., 2012); retention rates also vary based on client factors such as race/ethnicity. Indeed, client factors tend to hold great promise in understanding what works in treatment. According to Wampold (2001), client factors are most closely associated with psychotherapy outcome and account for as much as 87% of the variance. Thus, the current study will examine client factors, in particular, clients' race/ethnicity, racial/ethnic identity, and stigma of attending therapy.

Race/Ethnicity and Dropout

Therapy has historically been considered an institution of the privileged (Schofield, 1964), which excluded many racial/ethnic minority (REM) individuals. Thus, the relationship between REM individuals and the institution of psychotherapy had been largely nonexistent until approximately 35 years ago. Additionally, physical and social barriers, including service accessibility, affordability, and language issues, have prevented the delivery of quality mental healthcare for many REM individuals (Leong, 2011). This exclusion, as well as ongoing devaluing experiences such as racism, discrimination, and stereotyping within the practice of psychology, has contributed to a cultural mistrust of psychotherapy among many REM individuals (David, 2009; Terrell & Terrell, 1981).

This negative perception may be a salient factor that keeps REM clients from entering therapy at all (Richman, Kohn-Wood, & Williams, 2007). REM individuals seek

mental health support at different rates than Whites. They may overuse services due to more severe diagnoses and greater distress or, conversely underuse care relative to their mental health needs. REM clients may also seek support from a broader network— including pastors, doctors, and other informal sources of support—than is typical for Whites (Abe'Kim, 2002; Breaux & Ryujin 1999; Mills, 2010).

Unfortunately, negative experiences based on REM status do not disappear upon entering into therapy. REM individuals who do seek treatment may encounter additional problems, including smaller treatment gains or discrimination from their therapists, particularly in the form of microaggressions (Constantine, 2007; Owen, Imel et al., 2011), that reinforce their previous perceptions of therapy. These negative experiences may lead to worse treatment outcomes, including premature termination (Owen et al., 2012 Owen, et al., 2013; Terrell & Terrell, 1984).

Sue, et al. (1976) was among the first to investigate race/ethnicity in psychotherapy. In a retrospective analysis of archival data, they found that REM clients prematurely terminated therapy more frequently than Whites, even when controlling for other demographic variables. In 1991, Sue, et al. replicated their original study and found that dropout rates remained higher for Black clients than for White clients. Swift and Greenberg (2012) conducted the most comprehensive meta-analysis to date, which included 669 studies representing 83,834 clients. Their meta-analysis followed the meta-analysis conducted by Wierzbicki & Pekirak (1993) nearly 20 years prior. Both meta-analyses reported similar effect sizes for the association between client race/ethnicity and drop out ($d = 0.20$ and $d = 0.16$), indicating some consensus on the impact of this client factor on dropout rate (Swift & Greenberg; 2012 Wierzbicki & Pekirak, 1993). Further,

there are other variables where REM clients are overrepresented that were significantly

associated with dropout, including low education ($d = 0.28$) and low socioeconomic

status ($d = 0.37$; Swift & Greenberg, 2012; Wierzbicki & Pekirak, 1993).

Of course, not all REM individuals report experiencing racism, discrimination,

and stereotyping. Furthermore, not all who have these experiences are affected in the

same way. One's experience of these acts prior to therapy and/or within therapy may

have important implications for treatment outcomes. The effects of perceived negative

cultural interactions may also differ depending upon an individual's self-other processes.

Indeed, how clients make sense of their experiences may play a greater role in their

decision-making regarding treatment than objective circumstances. A therapist's lack of

attention to negative cultural interactions may damage the therapeutic alliance (Owen,

Tao, Imel, Wampold, & Rodolfa, 2014; Whaley & Davis, 2007), which is a robust

predictor of psychotherapy dropout (Horvath et al., 2011).

It is difficult to disentangle race/ethnicity from other variables like education level

and socioeconomic status. This suggests that we should take a nuanced approach to

exploring the ways that racial/ethnic identity interacts with other aspects of individual

experience. Guided by current research, I posit that racial/ethnic identity and stigma are

two constructs that may underlie clients' experience of the psychotherapy and provide

new insight into the decision-making process of remaining in or dropping out of

treatment.

Racial/Ethnic Identity and Dropout

Research into psychotherapy has demonstrated the need for therapists and the

therapeutic process to attend more effectively to clients' cultural concerns (American

Psychological Association, 2003; Arredonde, 1992; Sue & Sue, 2003; Whaley & Davis, 2007). However, empirical research directly connecting cultural variables to dropout is virtually nonexistent. Most attempts to capture cultural aspects within the dropout literature have used REM status as a demographic variable. Using REM status as a proxy for culture oversimplifies culture in a way that is not beneficial. It also fails to connect the social construct of race to other more robust constructs like REM members' worldviews, perceptions, and values that may also be related to treatment outcome and underlie decisions to terminate therapy (Helms & Talleyrand, 1997). Thus, while using REM status is helpful in assessing for disparities, it is a "what" question, insufficient in helping clinicians understand dropout status in a more integral way; it cannot answer the question of "why." Owen et al. (2012) shows that while REM clients drop out more frequently, a client's cultural processes related to race/ethnicity, and the way in which they are attended to within the therapeutic process, may be more relevant than a client's racial/ethnic identification status.

Ethnic identity models have been developed in order to more effectively acknowledge and account for the diversity within members of various racial/ethnic groups. These models are conceptualized as an attempt to move away from biologically-based identifications of race, to understanding race/ethnicity as a dynamic and multidimensional construct that refers to an individual's self-concept or perceived racial/ethnic group membership based in genealogy or ancestry (Phinney, 2003). According to Phinney (2007), racial/ethnic identity is a multifaceted construct that involves a sense of belonging to a group along with a process of learning about one's group. It includes affective attachment, sense of pride, awareness of one's history,

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cultural practices and values, attitudes toward one's group, and responses to discrimination (Phinney, 1992; Phinney & Ong, 2007). Developing ethnic identity is a dynamic process as individuals acquire knowledge and understanding of their in-group affiliations, gain experiences, and make decisions. Individuals' ethnic identity may vary in its salience and importance over time and with respect to different social contexts, suggesting that understanding broader social context is an integral part of understanding ethnic identity (Phinney, 1992; Phinney, 2003).

Phinney's ethnic identity model is appropriate for this study because of its origin and its nature. The ethnic identity model is rooted in the developmental life-stage model of Erik Erikson (1968), which postulated that exploration of one's identity can lead to the eventual development of a positive identity that is consistent across various contexts. Erikson's empirical basis can be traced to the work of Marcia (1966), who discussed 'crisis' (an opportunity to examine values) and 'commitment' (decision among various beliefs) as the central underpinnings to identity achievement. Secondly, as a cyclical, two-dimensional, and process model, Phinney's ethnic identity model acknowledges that each individual's and group's ethnic identity process may be different, while still permitting exploration of the commonalities within the ethnic identity development process. Ethnic identity is thus a fluid construct, subject to vary along with one's awareness over time (Phinney, 2003).

To date, only one published study has investigated the impact of client racial identity on psychotherapy dropout. Schaumann (1998) used a sample of 22 self-identified African American adult female patients who presented for psychotherapy outpatient services. Dropout was defined as not returning after the initial session. The author found

that the relationship between dropout and racial identity status did not reach statistical significance but reported that dropouts were more likely to display higher "internalization" scores than those who remained in treatment. This suggests that those who dropped out presented with a tendency toward higher racial salience and centrality. These results suggest that racial/ethnic identity may be positively associated with dropout, in that those who have stronger racial/ethnic identity may be more likely to drop out of therapy. However, given the small sample size it is difficult to know whether the non-statistically significant findings were askew.

In spite of the paucity of studies directly examining the link between ethnic identity and dropout, a few studies have discussed the role of ethnic identity in seeking mental health treatment and treatment engagement. Richman, Kohn-Wood, & Williams (2007) found that identity variables, including ethnic identity, offer a more robust explanation than structural variables (socioeconomic status, accessibility to services, and education) as a predictor of utilization of mental health services. Ethnic identity has also been positively associated with feelings about one's own heritage, and a preference for informal sources of support such as friends or relatives (Hyppolite, 2012). These findings indicate that ethnic identity may be a critical aspect of the therapy decision-making process, affecting both the decision to enter into therapy and the decision to continue in therapy.

Ethnic identity seems to have solid theoretical connections to dropout in psychotherapy. Clients bring with them various cultural assets, including their ethnic identity. Since ethnic identity is a construct that informs beliefs about interpersonal relationships and interactions (Smart-Richman & Kohn-Wood 2007), it have merit within

the therapeutic context. The degree to which ethnicity is a salient factor in how individuals make meaning of events may be affect treatment-related behaviors, including how the individual ends treatment. For example, an individual with an unexamined ethnic identity status who also does not experience high ethnic saliency subsequently may not feel that their racial/ethnicity heritage is a particularly relevant factor in interpreting therapeutic events, while a person who has an achieved ethnic identity status might experience high ethnic saliency, which may lead him/her to be more inclined to understand therapy in terms of their ethnic identity status. Given that therapy is generally seen as more stigmatizing for REM clients (Owen et al., 2013), those with an achieved identity may experience therapy as more threatening to their ethnic identity than those who have not examined or who are exploring their ethnic identity. Based on this theory and the Shaumann (2008) study, I hypothesize that ethnic identity status will be positively associated with psychotherapy dropout.

Stigma and Dropout

Stigma has generally been conceptualized into three types: public, social, and self-stigma. The public stigma of seeking help relates to one's perception that a person who seeks help is undesirable or socially unacceptable (Vogel, Wade, & Haake, 2006). Clients who present with high public stigma may believe that they would be judged negatively by society based on their decision to seek treatment. Social stigma of seeking help is the perception that those within clients' social support systems would judge them based on the decision to seek help (Owen et al., 2013). Self-stigma relates to one's internalized feelings related to seeking help. Clients with high self-stigma may evaluate themselves negatively based on their decision to seek treatment (Vogel, et al., 2006).

While there is overlap between these types of stigma, they each may factor differently into a person's approach to the decision to enter treatment. Since social stigma and self-stigma have been most closely associated with therapeutic outcome (Owen et al., 2013), the current study will explore their impact as it relates to dropout.

Researchers have postulated a connection between ethnicity and stigma. Coker (2005) noted that cultural and societal beliefs may influence an individual's perception of stigma. Leong, Wagner, and Tata (1995) reported that some ethnic minority groups may avoid seeking treatment because of concerns about stigmatization. Goldston et al. (2008) and Shea & Yeh (2008) found that individuals from collectivist cultures experience higher self-stigma of seeking help than those from individualist cultures. Owen, Thomas, et al. (2013) reported that REM clients perceived higher self-stigma than White clients. Cheng, Kwan, and Sevig (2013) used an ethnically diverse sample of African American, Asian American, and Latino college students to explore the stigma of seeking help. They found that higher levels of perceived racial/ethnic discrimination related to higher levels of perceived social stigma for seeking help. Among African American students, higher ethnic identity status related to lower self-stigma.

More recent research has considered stigma as a client factor that is likely influenced by the therapeutic process. That is, some clients who are currently in therapy still present with stigma, and that stigma negatively affects the treatment process. Wade, Post, Cornish, Vogel, and Tucker (2011) explored the impact of a single group session on self-stigma in college students. The participants were 263 students, 86% of whom self-identified as European American, 2% as African American, 4.5% as Asian American, and 3% as Latin American, with 12% not responding. 55% of participants identified as male

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and 45% as female. The study found that perceptions of self-stigma were negatively associated with alliance and session depth. This study is consistent with findings from Owen, Thomas, et al. (2013) who explored the impact of self-stigma and social stigma on the therapeutic process of college counseling center clients. Clients who perceived higher self-stigma were more likely to report lower working alliances with their therapists. This indicates that self-stigma may affect the ability of the client and therapist to build or maintain an affective bond and agree on the goals and tasks of therapy. Additionally, those who perceived higher social-stigma were more likely to report more positive session outcomes. This suggests that clients who experience higher social stigma may use therapy as social support, or they may use therapy in ways that improve their relationships within their existing support system. Self-stigma also indirectly affected session outcome via the alliance – a point which will be addressed in more detail below.

There has also been some exploration of stigma's effect on mental-health treatment dropout. To date, five published studies have explored this relationship. Two of these investigated pharmacological mental health treatment discontinuation. Sirey et al. (2001a) explored the relationship between public stigma and treatment adherence. Two hundred patients who met the criteria for depression were treated with medication at an initial appointment and assessed at a 3-month follow-up. The authors found that clients' perceptions of public stigma were positively related to early termination. In a similarly designed study, Sirey et al. (2001b) explored this same relationship in younger adults (ages 18-64) and older adults (ages 65+). Ninety-two participants who met criteria for major depressive disorder were prescribed medication at an initial interview and assessed at a 3-month follow up. "Older adults" who perceived higher stigma were more likely to

discontinue treatment. However, no relationship between stigma and treatment discontinuation was found for "younger adults". In both studies dropout was defined as treatment discontinuation within 3 months.

The remaining three studies specifically examined dropout in psychotherapy. Wade et al. (2011) investigated the effect of a single session of group counseling on self-stigma. The participants were 263 undergraduate students who met a clinical cutoff for overall psychological symptomology. Dropout was defined as those who had "no intent to seek counseling." This study found that self-stigma predicted interest in seeking therapy beyond the single session; those who reported higher self-stigma reported lower interest in seeking counseling after the session. This study is critical to understanding the dropout process by indicating the impact that stigma may have on clients' decisions to continue in therapy after an initial session. Reece (2001) explored the influence of HIV-related stigma on psychotherapy dropout. The sample of 132 HIV-diagnosed clients (51% Black and 46% White) were assessed for HIV-related stigma and monitored for attendance throughout therapy. Dropout was defined by the client failing to return for a session after the initial appointment. Reece found that a higher perceived HIV-related stigma was associated with dropout. In contrast, McCabe (2002) investigated premature termination in a sample of Mexican-American families. Fifty parents whose children presented for therapy were assessed for stigma at intake and tracked as to their therapy attendance beyond one session. Dropout was defined as "nonattendance beyond the initial session." The study found that perceived stigma was not a significant predictor of dropout. Overall the literature suggests that stigma is positively related to dropout.

However, the evidence is inconclusive as to whether stigma predicts dropout greater for REM clients than for White clients.

It is likely that stigma, ethnic identity, and dropout are related. However, since clients may filter their experiences through various cultural assets, the relationship between these three elements may be more nuanced. Potentially, stigma may be more strongly related to dropout for those who have a strong ethnic identity. Theoretically, ethnic identity may filter the experience of stigma. In other words, the experience of stigma may have different meanings for clients based upon their ethnic identity status. Clients who have higher ethnic identity may be more reactive to stigma while in treatment because going to therapy would be threatening to an integral aspect of their identity, which could be associated with greater dropout. Contrastingly, clients who have lower ethnic identity should be less reactive to feelings of stigma for attending therapy and therefore be less likely to drop out.

The Alliance, Stigma, and Dropout

While stigma and ethnic identity may affect dropout in a variety of ways, ingredients within the therapeutic process remain an active influence on clients. For clients, the therapeutic alliance is one such ingredient, which may counteract the effect of stigma on dropout. This makes sense because the alliance is the degree to which the client and therapist are engaged in collaborative, purposive work (Bordin, 1979; 1994). It consists of three interconnected parts: the affective bond that occurs between client and therapist, the agreement between client and therapist on the goals of therapy, and the strategies needed for goal attainment (Bordin, 1979). Conceptually, Bordin (1994) describes the alliance as mutually developed, dynamic, interpersonal, and reciprocal in

nature. Empirically, the alliance is a robust predictor of treatment outcome (Horvath et al. 2011). A meta-analysis by Sharf et al. (2010) reported a moderate effect size ($d = 0.55$) for the association between alliance and dropout, indicating that clients who perceived lower working alliances were more likely to dropout. Thus, the alliance may be a salient element in understanding client dropout.

The alliance may share a reciprocal relationship with both good technique and effective therapy (Hatcher & Barends, 2006). A solid alliance provides trust and a quality base from which psychotherapeutic work can be done. Thus, for clients who perceive high stigma, a strong alliance may be a catalyst for or the result of therapeutic work and a buffer against the effects of stigma. For instance, clients who enter therapy with high stigma but persist to develop a strong working alliance with their therapists may invest more in therapy and experience it as beneficial. These clients may remain in treatment in spite of their perceived stigma (Owen, et al., 2013). Additionally, when issues occur within the therapeutic process, a client who perceives a high alliance may be more willing to remain in therapy to work through the issues as opposed to ending therapy. Clients with high alliances who consider dropping out may feel more comfortable discussing their concerns with their therapists prior to making a decision. This may be even more important when cultural concerns like stigma arise. Accordingly, I will statistically control for the alliance as a factor within the dropout process.

Social stigma, self-stigma, and session outcome

Psychotherapy dropout reflects one potential end of a course of therapy. However, there are many moments across the therapeutic process and many ways within the process wherein stigma's impact may manifest. These moments could occur before

dropout occurs, yet still have an immense effect on a client's therapy experience. Clients' session outcomes may be one opportunity that allows us to capture the impact of stigma while the therapy process remains ongoing. Relatively little psychotherapy research explores stigma's effects on therapy outcome. One such study, by Owen et al. (2013) found that clients who perceived high self-stigma reported fewer session gains, which were moderated by the alliance, while those who perceived high social stigma reported more session gains. This finding lends support to the notion that the effects of stigma likely show up even before a decision to end therapy is made.

The findings of this study contain two interesting elements. First, self-stigma, a client-factor, was observed to have differential impact based on the alliance (a client-reported process variable). This suggests that as clients experience change during the therapy process, their experience of self-stigma may change as well. Wade, Post, Cornish, Vogel, and Tucker (2011) explored the impact of a single group psychotherapy session on clients' self-stigma, finding a post-session decrease in client-reported levels of self-stigma. Furthermore, self-stigma was noted to predict clients' intention to see help after the session. This finding supports the theory that clients' level of stigma may change due to in-session experiences, as well as the notion that this change may relate to the decision whether to continue receiving therapy. The findings also suggest that clients' support systems are active in the therapy process. Slone and Owen (2015) concluded that clients who perceived higher systemic alliances (a sense of agreement between the clients' social network and the therapy process) reported better session outcomes. Together, social stigma and systemic alliance may reflect the level of clients' social support related to their decision to attend therapy and the degree to which their social

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support system buys into their therapy process. Per these findings, the current study will also examine the influence of stigma on session outcomes.

Hypotheses

Study 1

H_1: Client report of stigma will be positively related to dropout.

H_2: Clients' ethnic identity will be positively related to dropout.

H_3: Clients' ethnic identity will moderate the relationship between stigma and dropout with clients who report higher ethnic identity and higher stigma demonstrating greater dropout.

Study 2

H_4: Client report of self-stigma will be negatively related to session outcome.

H_5: Client report of systemic alliance will be positively related to session outcome.

H_6: Clients' racial/ethnic status will be negatively related to session outcome—clients who report a REM status will experience fewer positive session outcomes. The original hypothesis could not be tested because the measure of ethnic identity was not able to be included in the protocol prior to data collection. REM status was included as a proxy for this study and the hypothesis was revised accordingly.

H_7: Clients' ethnic status will moderate the relationship between stigma and session outcome—clients who report an REM status and higher stigma will demonstrate fewer positive session outcomes.

CHAPTER 2: METHOD

This dissertation consists of two studies, one that is longitudinal and one that is cross-sectional. These studies explore the influence of stigma, ethnic identity, and therapeutic alliance on psychotherapy dropout/session outcomes. This section will describe the design and methodology for each of these studies.

Study 1

Participants. This sample consisted of 24 parent/guardian clients who presented for family therapy services with their children. Only one parent/guardian per child participated in the study. Three of the 24 parents/guardians returned significantly incomplete surveys and were excluded from the statistical analysis. Of the 21 participants included in the analysis, most self-identified as women (17 women, 4 men) and the mean age of participants was 37 (*SD*=8.93). 52.4% self-identified as REM and 47.6% self-identified as White. Specifically, 10 participants reported their ethnicity as White/Caucasian American, 8 as African American/Black, 2 as Mixed, and 1 as Hispanic/Latino. Per self-report, participants mostly had annual incomes below $30,000 (87%), described their sexual orientations as heterosexual (83%), were unmarried (67%) and reported having at least attended some college (73.6%). The setting was a community-based mental health center in a large city in the Midwest. The study and its instruments have been created and validated for English-speaking adult populations; those under the age of 18 or those who speak languages other than English were excluded from participation.

Measures

     Self-stigma. The Self-Stigma of Seeking Help Scale (Vogel et al., 2006) was originally created to assess clients' perceptions of self-stigma associated with seeking help. The original SSOSH is a 10-item self-report instrument, and the items are rated on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Example items include, "It would make me feel inferior to ask a therapist for help," and "My self-confidence would not be threatened if I sought professional help." Vogel et al. (2006) found a one-factor structure and demonstrated support for the internal consistency of the measure (alphas ranging from .86 to .90). Vogel (2006) reported support for concurrent validity by significant associations with other stigma measures and attitudes toward seeking help. Internal consistency estimates of community samples ranged from .81 to .91 (Hammer & Vogel, 2010; Wester, Arndt, Sedivy, & Arndt, 2010).

     Whereas the SSOSH was developed to measure the self-stigma for potential clients (those who have yet to enter treatment), this study used the Self-Stigma of Seeking Help Scale-Therapy (SSOSH-T), a measure adapted from the original to more appropriately reflect self-stigma for clients who are currently in therapy. In adapting the SSOSH-T, Owen, Thomas, and Rodolfa (2013) changed the verb tense (from conditional tense to present participle) and the total number of items on the scale. For instance, the item "It would make me feel inferior to ask a therapist for help" was changed to "My decision to go to therapy has made me feel inferior." A second item, "If I went to a therapist I would be less satisfied with myself" was changed to "My decision to go to therapy has made me feel less satisfied with myself." A third item, "I would feel okay about myself if I made the choice to seek psychological help," was changed to "My

decision to seek psychological help has made me feel okay with myself." In adapting the scale, Owen and colleagues (2013) consulted three content experts. They also conducted an exploratory factor analysis, finding that the items on the SSOSH-T consisted of a single factor, which accounted for 47.91% of the variance. Owen et al. (2013) reported that the Cronbach's alpha for SSOSH-T was .89.

Owen et al. (2013) validated the SSOSH-T on a sample of college counseling clients. It had not been used in a community mental health sample, and thus its validity for this specific population is not known. However, it was included because it is the only known measure able to yield information regarding self-stigma in clients who have already made the decision to enter therapy. The Chronbach alpha for the current study is .79.

Social Stigma. The Perceptions of Stigmatization by Others of Seeking Help (PSOSH) (Vogel et al., 2009) was used in this study to assess the degree to which clients perceive that their social network would view going to therapy as stigmatizing. The PSOSH is a 5-item self-report measure, which is rated on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Example items include, "If you sought services for an academic or vocational issue, to what degree do you believe that the people you interact with would react negatively to you?" and "If you sought services for an academic or vocational issue, to what degree do you believe that the people you interact with would think of you in a less favorable way?" Vogel et al. (2009) found support for the reliability and validity, with correlations with other stigma measures (Stigma of Seeking Professional Help Scale, Komiya et al., 2000 and Self-stigma of Seeking Help, Vogel et al., 2006), a one-dimensional factor structure, and an internal consistency estimate of .88.

Owen et al. (2013) reported a Cronbach alpha of .91 in their clinical sample of college students. The Cronbach alpha for the current study is .85

    Ethnic Identity. Participants completed the Multigroup Ethnic Identity Model (MEIM) (Phinney, 1992). The MEIM was developed to assess affective and cognitive components of ethnic identity development across diverse samples. It is a 14-item self-report measure that is rated on a four-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Higher scores indicate higher ethnic identity. Example items include, ¨I have a clear sense of my ethnic background and what it means to me¨ and ¨I am active in organizations and social groups that include mostly members of my own group¨. Research has shown support for a two-factor structure: ethnic identity exploration and ethnic behaviors and a sense of commitment, belonging, and affirmation. Only the first 12 items are used to calculate a person´s ethnic identity score. There are three additional items (items 12-14) that are only used to yield information related to a person´s ethnic categorization. Phinney (1992) reported Cronbach's alphas for the overall MEIM-EI scale (.90), the Ethnic Identity Achievement (.80), and the Affirmation and Belonging (.86) subscales in a diverse college student sample. Concurrent validity was demonstrated between the MEIM-EI scores with ethnic self-concept (Phinney, Chavira, & Tate, 1993) and self-esteem (Phinney, 1992). Phinney (1992) reported a reliability estimate of .90 in the original college student sample. The Cronbach alpha for the current study is .89.

    Dropout. "Dropout" was defined by therapist judgment. When therapy ends, therapists reported whether or not their clients dropped out based on their own knowledge of the therapy process with their clients. The dropout rate for the current sample was

28.6%. This is consistent with the overall rate of dropout reported in the literature (Wierzbicki & Pekarik, 1993; Swift & Greenberg, 2011).

Procedure. Prior to data collection, researchers met with therapists and staff at the community mental health site. They were informed that the study's purpose was to understand how their pre-treatment thoughts, feelings, and attitudes influence treatment outcome. Therapists were included in brainstorming ways to ensure the research process does not affect treatment. The research team also met with staff and trained them on the informed consent process. A member of the research team was available to answer client questions regarding the study.

Clients were informed of the study by advertisements in the lobby of the center and by the office staff prior to completing the initial paperwork for intake. The office staff was instructed to ask clients if they would be open to participating. If the clients agreed to participate, the office staff was instructed to hand a packet to the client containing information about the study and consent forms. Each packet was numbered to obscure client information. The packet numbers were matched to an anonymous ID number in an electronic file. The office staff was also instructed to refer any questions to the research team member on site.

Patients were informed that their participation in the study could help improve services at the center. They were also informed that the purpose of the study is to determine how therapy ends. Clients were assured that declining to participate in the study will not affect their treatment or mental health care coverage. Clients received no compensation for their participation in the study.

Clients provided their consent to treatment by signing the consent form in the packet, completing the included questionnaires, and returning the packet to the administrative assistant. Subjects were instructed that participation will take about 15-20 minutes. Participation included completing the questionnaires in the packet and consenting to allow the therapists to inform the research team whether or not the client dropped out of treatment. The research packet consisted of a copy of the consent form, a copy of the research authorization form, a demographic form, the SSOSH-T, the PSOSH, and the MEIM.

All instruments were administered prior to the first therapy session. This method was determined to be the most noninvasive and practical approach to obtaining information from the clients in this particular setting while also respecting the treatment process. Since each packet was numbered at the time of intake, the only information that the research team reviewed is the packet information, an anonymous number in the system, and how the client ended therapy.

Aside from the initial questionnaires (the demographic form, the SSOSH-T, the PSOSH, and the MEIM) and the client's status as "dropout" or "not", no information about the actual clients was gathered. However, this particular mental health center focuses on brief treatment. Thus, the families who are treated at this site generally present with mild to moderate symptomology. Clients typically attend 5-15 sessions prior to discharge.

Study 2

Participants. The sample consists of 79 clients who presented for individual therapy services at a large West Coast college counseling center. The clients in this

sample were currently in treatment, and their scores on the session outcome measure reflect their most recent session. Participants reported a mean age of 23.00 (*SD*=5.146). Participants described sexual orientations of heterosexual/straight (69.6%), lesbian/gay (3.8%), bisexual (3.8%), pansexual (1.3%), queer (6.3%), and non-heterosexual (1.3%). One person did not report a sexual orientation. Participants self-identified genders of woman/female (70.8%), male (13.9%), Trans (2.5%), and fluid (1.3%). 11.5% reported no gender. Of the 79 clients, approximately 35.4% self-identified their race/ethnicity as White/Caucasian American, 51.9% as REM, and 12.7% did not report a race/ethnicity. Specifically, 21.5% described their ethnicity as Asian/Asian American, 12.7% as Hispanic/Latino, 11.4% as Multiracial/Biracial, 3.8% as African American/Black, and 2.5% as of Middle Eastern descent. Participants were solicited prior to intake for participation in the study.

The study and its measures were created and validated for English-speaking adult populations; therefore those under the age of 18 and who speak a language other than English were excluded from participation. The study also excluded clients who completed therapy prior to the beginning of the study, did not attend individual therapy (e.g., clients seeking psychiatric services only or those attending only group or couples therapy) or did not complete the full survey.

Measures

Self-Stigma. The SSOSH-T (Owen et al., 2013) was used to measure clients' perception of self-stigma related to making the decision to attend therapy. A description of the measure is provided above. The Cronbach alpha for the current study is .90.

Ethnic Identity. The MEIM (Phinney, 1992) was to be used in this study. However, it was not included due to restrictions in further data collections. Racial and ethnic status was included in the analysis as a proxy variable for ethic identity. Ethnic status was dichotomized into clients who identify as White/Caucasian American and those who identify as Racial and Ethnic Minorities. Accordingly, the hypothesis was also changed to reflect the use of this variable.

Alliance. The Individual Treatment Alliance Scale Revised Short-Form (ITASr-SF) is a 15 item client-report measure rated on a 7-point scale ranging from 1 (completely disagree) to 7 (completely agree), with higher scores indicating stronger alliance. Owen (2012) concluded that it was useful in predicting psychotherapy termination status and therapy outcome. The ITASr-SF (Owen, 2012) assesses alliance amongst two client subsystems reflected in the two subscales of the measure. The Self- subscale measures the perception of the alliance between client and therapist, and the Other-subscale measures the perception of the alliance between clients' support systems and their therapists. In order to capture client perceptions of their alliance with their therapists the Self subscale of the ITASr-SF was used. The items reflect client agreement on the goals of therapy and the tasks for reaching those goals, as well as the bond between the client and therapist. An example item from this subscale is "The therapist does not understand me". Owen (2012) reported a Cronbach alpha of .78. The current study has a Cronbach alpha of .91.

Systemic Alliance. In order to assess clients' perceptions of systemic alliance, the Other-subscale of the ITASr-SF was used. An example of an item on this subscale is "The people who are important to me would feel accepted by the therapist". Slone and

Owen (2015) reported a Chronbach alpha of .85 and found that clients who perceived

higher systemic alliance also had better therapy outcomes. The Cronbach alpha for the

current study is .87.

       Session Outcomes. The Client Task Specific Change Measure–Revised (CTSC-

R) (Watson et al., 2010) was used to assess clients' perceptions of overall therapy

outcomes. The CTSC-R is a 16-item client-report measure, which includes items that

reflect changes across a variety of theoretical orientations (Watson et al., 2010). The scale

consists of two subscales which measure Behavior Change (13 items) and Awareness and

Understanding (3 items). The items are rated on a 7-point scale ranging from 1 (strongly

disagree) to 7 (strongly agree), with higher scores indicating more post-session change.

Example items include, "I was able to challenge my negative automatic thoughts," and "I

reconciled two opposing aspects of myself and felt more integrated inside." Watson et al.

(2010) found "that the measure is useful to assess change overall" (p. 231) and that it was

a unique predictor of outcome (Watson et al., 2010). Additionally, support for the

reliability and validity of the CTSC-R was found with Cronbach alphas of more than .90.

Clients' total scores on the CTSC-R were significantly associated with a strong working

alliance and positive therapy outcomes in process-experiential and cognitive-behavioral

therapies (Watson et al., 2010). Furthermore, the CTSC-R has also been related to client-

rated cognitive-behavioral and psychodynamic-interpersonal techniques along with

alliance in naturally occurring therapies (Owen & Hilsenroth, 2011). In the current study,

the Cronbach alpha is .92.

Number of Sessions. Although the number of sessions is not a central variable of interest to the study, it was included as a control variable because it has been associated with session outcomes in previous research (Owen et al., 2013).

Procedure. Clients received an email asking if they would be willing to take a survey about their therapy experience. They were informed that the purpose of the study was to improve service at the college counseling center. Those who agreed were able to access the anonymous survey measures online. Clients were given an opportunity to decline participation and were assured that declining to participate in the study would have no impact on their treatment. After clicking a link to the survey, all information entered by the clients was anonymous. On the first page of the link, clients were provided a brief description of the study. Subjects were instructed that participation would take about 20-30 minutes and that participation would include completing the questionnaires. On the second page, clients were asked whether they consented to participate by clicking "Yes, I consent" or "No, I don't consent".

Formal diagnoses were not assessed at this counseling center; however, clients reported a range of presenting problems, including adjustment issues, anxiety, relationship issues (family, romantic, and peer), eating disorders, depression, and impulse control. Clients at this site typically report mild symptomology and receive brief therapy (6 to 10 sessions). Owen, Thomas, Rodolfa (2013) reported a median of four sessions for this particular site, which is consistent with other university/college counseling centers (Barr, Eells, Jones, Colbs, & Meyer, 2008). In addition, it is common practice at this counseling center for the therapist who conducts the intake to continue to see the client for therapy.

Information about the therapists has been obtained to provide context to the study, but will not be used in the analysis. At this counseling center, therapists have a range of professional backgrounds including practicum students, pre-doctoral interns, postdoctoral fellows, staff psychologists, and staff therapists. Prior open-ended format assessments at this counseling center revealed that all therapists indicated that they practiced some form of integrative therapy (e.g., psychodynamic/cognitive-behavioral, relational/systems/cultural; see Owen, Quirk, Hilsenroth, & Rodolfa, 2012).

Study 1 Hypotheses and Method of Analysis

Hypothesis H₁: Stigma will be positively related to dropout. To test this association, point biserial correlation analysis was conducted.

Hypothesis H₂: Ethnic identity will be positively related to dropout. To test this association, point biserial correlation analysis was conducted.

Hypothesis H₃: Ethnic identity will moderate the relationship between stigma and dropout, with clients who report higher ethnic identity and higher stigma demonstrating greater dropout. To test for moderation, a test for interaction effects of stigma and ethnic identity on dropout was conducted via a logistic regression analysis.

Study 2 Hypotheses and Method of Analysis

Hypothesis H₄: Self-stigma will be negatively related to session outcomes. To test this association, bivariate correlation analysis was conducted.

Hypothesis H₅: Systemic alliance will be positively related to session outcomes. This test was also conducted via bivariate correlation.

Hypothesis H₆: Ethnic status (REM status) will be negatively related to session outcomes. This test was conducted via a point bi-serial correlation analysis.

Hypothesis H₇: Ethnic status will moderate the relationship between stigma and session outcomes, with clients who report a REM status and higher stigma demonstrating fewer positive session outcomes. To test for moderation, a test for interaction effects of stigma and ethnic status on session outcomes was conducted via multiple regression analysis.

Prior to testing the hypotheses, preliminary data analysis was conducted to inform the hypothesis testing process. First, descriptive statistics were examined to test for parametric assumptions and to understand the nature of the data. Based on these statistics, appropriate tests were used.

CHAPTER 3: RESULTS

Study 1

This study examined three central variables: ethnic identity, self-stigma, and social stigma. Participants reported a mean level ethnic identity of 2.99 (SD= 1.05), which reflects an average ethnic identity exploration on the 5-point Likert scale used to measure this variable. There was no statistically significant difference in mean levels of reported ethnic identity for White clients (2.78; SD = 1.11) and REM clients (3.20; SD = 0.99), p > .05. Participants reported a mean level of self-stigma of 2.09 (SD = 0.67). Similarly, participants reported a social stigma mean of 2.1 (SD = 0.74). Table 1 provides a descriptives for the ethnicities of participants in Study 1.

Table 1

Ethnicity of Participants	n
African American/Black	8
Biracial/Multiracial	2
Hispanic/Latino	1
White/Caucasian	10

Assumptions

Binary logistic regression was used in this study to model the relationship between termination status and the independent variables. The most important assumption in logistic regression is that the binomial distribution of errors is equal to the difference between the predicted outcome and the actual outcome. Peng, Lee, and Ingersoll (2002) consider this assumption to be robust as long as the observations are independent and the sample is random. This assumption was also checked and upheld using the Hosmer and Lemeshow test. The result was not statistically significant ($X2 = 5.67$, $p = .68$), suggesting that the logistic regression model is a good fit for this data. Since data collection in this study was conducted through a convenience sampling approach, the assumption of random selection was violated. Data will be interpreted taking into account this statistical assumption violation. Logistic regression also assumes that the data are relatively independent. Hair, Anderson, Tatham, and Black (1995) suggested that a Variable Inflation Factor (VIF) below 10 is acceptable in moving forward with using regression analysis. The VIFs were checked and revealed no high correlations among the variables in the study, with Ethnic Identity (VIF=1.03), Social Stigma (VIF= 4.55) and Self-Stigma (VIF=4.52) all with VIF's below 10. Consistently, Tolerance values were checked and found to be .22 or greater, which is near or above other recommended minimum values of .10 (Tabachnick & Fidell, 2001), .20 (Menard, 1995), and .25 (Huber & Stephens, 1993) Values were centered to permit a better interpretation of the unique contributions of each of the variables.

Hypotheses

H_1: Clients' report of self- and social- stigma will be positively related to treatment dropout. The first analysis was conducted to test self- and social- stigma as predictors of treatment dropout via a point bi-serial correlation. The results demonstrated that self-stigma was not statistically significantly associated with dropout ($r = -.01$, $p = .98$), that is, a client's level of perceived self-stigma was not a statistically significant predictor of their dropout status. Similarly, results for the association between social-stigma and dropout was not a statistically significant ($r = -.02$, $p = .92$), that is, a clients' level of perceived social stigma was not a significant predictor of their dropout status. This hypothesis was not supported (see Table 2).

H_2: Clients' reported level of ethnic identity will be positively related to client dropout. The next analysis was conducted to test ethnic identity as a predictor of treatment dropout. The results demonstrated that ethnic identity was a statistically significant predictor of dropout ($r = -.61$, $p<.01$). That is, that the higher the client's ethnic identity, the less likely they were to drop out of treatment. Although this variable was statistically significant, it was in the opposite direction of the hypothesis. The hypothesis was therefore not supported (see Table 2).

Table 2

Correlations of Social Stigma, Self-Stigma, Ethnic Identity, and Outcome
(N=21)(Dropout=1, Remained in Treatment=0)

	Outcome	Overall Social Stigma	Overall Self-Stigma	Overall Ethnic Identity
Outcome	--	--	--	--
Overall Social Stigma	-.02	--	--	--
Overall Self-Stigma	-.01	.88**	--	--
Overall Ethnic Identity	-.61*	.09	.01	--

*Note. *p=.003, **p<.001*

H₃: Clients' level of ethnic identity will moderate the relationship between self- and social- stigma and dropout with clients who report higher ethnic identity and higher stigma demonstrating greater dropout. The fourth analysis conducted focused on ethnic identity as a moderator of the relationship between self-stigma and treatment dropout. A logistic regression model was fitted to the data in order to assess the relationship between the likelihood of dropping out of treatment and the interaction of self-stigma with the client's level of ethnic identity. The independent variable was the interaction of the centered variables of ethnic identity and self-stigma. The results demonstrated that the interaction of ethnic identity and self-stigma was not a statistically significant predictor of dropout (b = 1.02, SE = 1.29, p=.43).

The fifth analysis focused on ethnic identity as a moderator of the relationship between social stigma and psychotherapy dropout. A logistic regression model was fitted to the data in order to assess the relationship between dropping out of treatment and the interaction of social stigma with the client's level of ethnic identity. The independent variable was the interaction of ethnic identity and social stigma. The analysis reflects that the interaction of ethnic identity and social stigma was not a statistically significant predictor of dropout (B=-.30, SE= 1.08, p=.78). Thus, the finding does not support this hypothesis.

Table 3

Variables in the Equation (Dropout=1, Remained in Treatment=0)

	B	*S.E.*	*Wald*	*df*	*Sig.*	*Exp(B)*
Overall Social Stigma	.84	1.40	.36	1	.55	2.31
Overall Self Stigma	-.57	1.45	.16	1	.69	.57
Overall Ethnic Identity	-2.47	1.16	4.51	1	.03	.09
Constant	-1.89	1.00	3.55	1	.06	.15

Given the study's low sample size, conducting correlational analysis was chosen as a more statistically appropriate way to understand the influence of each of the variables on treatment dropout. However, correlational analysis does not allow for exploration of the impact of all three variables' potential on treatment dropout when considered collectively. Thus, in order to capture the influence of all of the variables, the interaction effects were dropped, and logistical regression analysis was conducted. This analysis has limitations within the constraints of the low sample size, although some summary interpretation of all the available data was possible.

Direct logistic regression was performed to assess the impact of factors that might affect the likelihood that respondents would drop out of treatment. The final model contained all three independent variables (social stigma, self-stigma, and ethnic identity), with ethnic identity contributing the most statistical weight to the equation. This model was statistically significant, χ^2 (3, N= 21) = 10.06, p <.05, indicating that the model was able to distinguish between respondents who remained in treatment and those who dropped out. Ethnic identity was associated with an odds ratio of .085. This indicated that respondents who dropped out were .15 times more likely to remain in treatment for every 1-point increase in ethnic identity. The final model correctly classified 81% of participants, which is an increase from 71.4% for the model with no predictors.

Study 2

Self-stigma, ethnic status, and systemic alliance were the central variables in this study. Participants reported a mean level self-stigma of 2.26 (*SD* = .78). This level reflects a lower than average level of client perceived self-stigmatization on the 5-point Likert scale used to measure this variable. Participants reported a mean level of systemic alliance of 5.47 (*SD* .90). This suggests an overall sample size with a high level of systemic-alliance. Of the 79 participants, 35.4% self-identified their race/ethnicity as White/Caucasian American, 51.9% as REM, and 12.7% did not report a race/ethnicity. Table 4 provides the descriptives of the self-identified ethnicities of the participants included in Study 2.

Table 4

Race/Ethnicity of Participants	*N*
African American/Black	3
Asian/Asian American	17
Biracial/Multiracial	9
Hispanic/Latino	10
Middle Eastern	2
White/Caucasian	28
Did not Report	10

Assumptions

In this study, bivariate correlations were used to assess the influence of each of the independent variables on session outcomes. However, multiple linear regression was used to model the relationship between session outcomes and the collective influence of the independent variables. Several assumptions must be met in order to use multiple linear regression.

Linear relationship between the independent and dependent variables. A Normal P-Plot of Regression Standardized Residuals was checked and no violations of this assumption were observed. Also, since multiple linear regression is sensitive to outliers, the scatterplots were checked and no outliers were revealed in the data. Collinearity statistics reflect that the data is linear. However, since data collection in this study was conducted through a convenience sampling approach, the assumption of random selection was violated. Data will be interpreted taking into account this statistical assumption violation.

Independence of Observations (Residuals). The Durbin Watson Statistic of 1.96 indicates that the size of one residual has no impact on the size of another; there is no serial correlation of the observations in the data.

Multicollinearity. Reviewing the correlation matrix reveals that correlations amongst the independent variables to each other and the dependent variable session outcomes is well below .70. Also, the Tolerance coefficients (lowest=.59) suggests an appropriate amount of collinearity amongst the variables in the study. Additionally, the Variance Inflation Factors are <10, consistent with Hair, Anderson, Tatham, & Black's (1995) recommendation.

Normality. A histogram generated in the data output reflects that the data has a normal shape.

Homoscedasticity. A scatterplot of the regression standardized residuals versus the regression standardized predicted value reflects that the residuals are approximately equal for all session outcome scores. Standardized normal probability plots confirm homoscedasticity of the data.

Hypotheses

H_4: Client reported stigma will be negatively related to session outcomes. The first analysis focused on self-stigma as a predictor of session outcomes. A bivariate correlation was used to assess the relationship between the likelihood of clients reporting fewer positive session outcomes and the client reported level of perceived self-stigma. The result indicated that self-stigma shares a significant negative correlation to session outcomes ($r = -.29$, $p<.01$). This result indicates support for this hypothesis.

H₅: Systemic alliance will be positively related to session outcomes. The second analysis focused on systemic alliance as a predictor of session outcomes. The bivariate correlation was used to assess the relationship between the likelihood of clients reporting more positive session outcomes and the client's level of perceived systemic-alliance. The results indicate that systemic alliance was statistically significantly positively correlated with session outcomes ($r=.50$, $p<.001$).

H₆: Clients' racial/ethnic status will be negatively related to therapy outcome, such that clients who report a REM status will experience fewer positive session outcomes. The third test focused on racial/ethnic status as a predictor of session outcomes. The point bi-serial correlation was used to assess the relationship between the likelihood of clients reporting fewer positive session outcomes and their report as a REM. The results indicate that REM status was positively correlated with session outcomes, though not statistically significantly associated ($r = .11$, $p=.18$). This hypothesis was not supported by the findings.

Table 5

Correlations of REM status, Systemic Alliance, Self-Alliance, Self-Stigma, # of sessions, and Outcome (N=67)

	Outcome	REM	Systemic Alliance	Self Alliance	Self-Stigma	# of Sessions
Outcome	--	--	--	--	--	--
REM	.11	--	--	--	--	--
Systemic Alliance	.50***	-.14	--	--	--	--
Self-Alliance	-.63***	.00	.53***	--	--	--
Self-Stigma	-.29**	.15	-.52***	-.38**	--	--
# of Sessions	.44***	.18	.20	.47***	-.25*	--

Note. *p<.05, **p<.01, ***p<.001

Hypothesis 7: Client ethnic status will moderate the relationship between stigma and session outcomes with clients who report a REM status and higher stigma demonstrating fewer positive session outcomes. The first multiple regression model focused on REM status as a moderator of the relationship between self-stigma and session outcomes. While REM status was not statistically significant associated with session outcomes (p=.18), stigma demonstrated a statistically significant negative correlation to session outcomes (p<.01). In testing for moderation, their interaction did not demonstrate statistical significance (B = -.10, SE = .188, p=.60), such that clients who identified as of a REM status and those who perceived higher self-stigma did not

experience fewer positive session outcomes. This hypothesis was not supported by the findings.

Bivariate correlations were used to assess the influence of ethnic status, self-stigma, and systemic-alliance on session outcomes. However, these analyses do not capture the collective influence of all of the variables of interest on session outcomes. To provide a summary of this, a multiple regression analysis was conducted and interpreted within the context of the statistical limitations of the study. In conducting this analysis, number of sessions and self-alliance were included as control variables in the final predictive model. The control variables (number of sessions and self-alliance) collectively accounted for 41% (adjusted-R^2) of the variance in session outcomes. Once the predictor variables (ethnic status, self-stigma, and systemic alliance) were included, the model accounted for 46.7% (adjusted-R^2) of the variance, which was statistically significant F (5, 61) =12.58, p < .05. This means that the final predictive model, which includes all of the variables, accounted for an additional 5.7% of the variance, above and beyond that which is predicted by the control variables (number of sessions and self-alliance) alone.

As shown in Table 6, the control variables made the largest statistically significant unique contribution to session outcomes (self-alliance B= .37; number of sessions B= .25). Of the predictor variables, systemic alliance made the largest statistically significant unique contribution variable (B=.31), followed by REM status (B=.19). Self-sigma (B=.05) did not make a statistically significant unique contribution, but it was included in the predictive model.

Table 6

Variables in the Equation

	B	S.E.	Sig.
# of Sessions	.25	.02	.02
REM Status	.19	.15	.05
Systemic Alliance	.31	.10	.01
Self Stigma	.05	.11	.68
Self-Alliance	.37	.11	.00
Constant	.25	.02	.02

CHAPTER 4: DISCUSSION

Between 20 and 60% of clients who start psychotherapy drop out before the end of treatment (Hamilton et al., 2011; Swift & Greenberg 2012; Wierzbicki & Pekarik, 1993). The consequences of this rate are multilayered and have consequences for clients, therapists, businesses, and communities (Barrett et al., 2008; Björk, et al., 2009; Farmer & Burns, 1997; Klein et al., 2003; Sledge et al., 1990). Racial/ethnic minorities are even more at risk of experiencing these consequences, with disparities in outcome including dropout reported throughout the literature (Owen, Imel et al., 2011; Owen et al., 2012; Owen et al., 2013; Terrell & Terrell, 1984; Wierzbicki & Pekarik (1993). While a precise understanding of dropout is still elusive, research has suggested that client factors— including client cultural factors—may be significant to understanding the phenomenon (Wampold, 2001). Empirical research on the role of client cultural constructs in the dropout process is minimal, so this project aims to explore empirically-supported cultural factors related to clients' decisions to end therapy. Guided by prior research and theory, hypotheses were generated related to the roles of stigma, ethnicity, and systemic alliance on psychotherapy outcome (understood as treatment dropout in Study 1 and session outcomes in Study 2). In two distinct clinical samples, clients completed self-report measures related to these constructs and the outcomes of their therapy processes were measured. This chapter summarizes these findings, and their

implications. Afterwards, clinical recommendations are offered, followed by a discussion of the studies' limitations as well as recommendations for further research.

This project was conceptualized as an attempt to improve understanding of psychotherapy dropout by observing the phenomenon across two distinct settings (a community mental health center and a college counseling center). The goal was to use very similar measures in both settings and to interpret the findings of each study in an integrated way. However, administrative hurdles occurred during the project's execution that prevented the inclusion and analysis of similar variables across both studies. This limitation notwithstanding, both studies share key links that allow for some jointly informed interpretation of the findings. For instance, both studies are psychotherapy outcome studies involving clients who were attending psychotherapy at the time of the study. Also, both studies involved significant REMs and explored similar variables of interest (stigma and ethnicity/ethnic identity). Their findings are interpreted and discussed with the scope of this limitation.

Stigma

The stigma associated with attending therapy is rooted in a complex matrix of factors in which cultural identity does play a significant role (Coker, 2005; Goldston et al., 2008; Leong et al., 1995; Shea & Yeh, 2008). Recent research suggests that some clients continue to perceive stigma surrounding psychotherapy treatment even after making the decision to attend therapy (Owen et .al, 2013; Wade et al., 2011). In this project, such a continuing stigma could be seen in both Study 1 (Social Stigma 2.1, SD=.75; Self-stigma 2.09, SD=.67) and Study 2 (Self-stigma=2.26, SD .78). While these numbers (on a 5-point scale) may seem somewhat low, the presence of any stigma among

clients in therapy is notable. Owen et al., (2013) found that client perceived self-stigma was negatively associated with session outcomes and was mediated by the working alliance. In that same study, social stigma, on the other hand, was positively associated with session outcomes. It is, then, surprising that neither self-stigma nor social-stigma demonstrated statistical significance on treatment dropout in Study 1. Although statistical significance was not reached, those with higher self-stigma showed a trend toward dropping out of treatment, while those with higher social stigma showed a trend toward remaining in treatment. These tendencies are consistent with the previous study (Owen et al., 2013).

The levels of stigmatization reported by clients in these two studies were unexpected—clients seemed to have lower rates of stigmatization than in previous studies. For instance, Wade et al. (2011) reported a mean self-stigma perception of 2.89 (SD=.78). This level of perceived self-stigmatization is consistent with that reported by clients who are not in treatment. In their study of individuals who were not in therapy, Cheng et al. (2013) reported a mean level of stigma of 2.21-2.73 (SD=.74-.79), while Vogel et al. (2006) reported a mean stigma level of 2.73 (SD=.66). On the other hand, the clients in Study 1 reported a higher level of social stigma than that reported in Cheng et al's. (2013) study of individuals not in treatment, which showed social stigma of 1.27-1.72 (SD=.45-.81). This could be explained by the existence of certain levels of social stigma observed in clients who attend therapy that are not observed in clients outside of therapy. This in turn may point to there being two types of clients: those who are kept from therapy by social stigma and those who enter therapy with social stigma. Although this is an interesting avenue of inquiry, the nuanced relationship between social stigma

and the decision to begin or remain in psychotherapy is beyond the scope of this current project.

Taken together, these findings suggest that self-stigma may be an active factor within therapy for some clients, potentially more important than social stigma. Given its correlation with therapeutic outcome, it could be that clients' perceived self-stigma was a barrier to achieving more positive session outcomes. It could also be that achieving few positive session outcomes increased clients' level of self-stigma or did not make it easy to tolerate their existing self-stigma. However, self-stigma's association with the self-alliance as reported in the findings of Owen, Thomas, and Rodolfa (2013) may be stronger than reported since its effects are filtered through the therapeutic alliance in its association with outcome. It could be that clients in this study who perceived self-stigma were able to build a working alliance with their therapists that buffered against it or reduced it. Thus, while clients entered with self-stigma, their alliances with their therapists were protective factors, keeping the stigma from affecting their achievement of session outcomes (in Study 2). This is consistent with Kendra et al., (2014) who theorized that attending therapy may provide a corrective emotional experience for clients who perceive self-stigma yet are validated for making the decision to come to therapy by their therapist (someone who has the potential to perpetuate their stigmatization).

Social stigma (included only in Study 1) was not statistically significantly correlated with dropout (r=-.02). The low correlation and lack of statistical significance in the current study may be due to the small sample size or it could be that social stigma has very little influence on degree to which clients remain in treatment. Further evidence is needed to better understand the role of social stigma. Interestingly, this null finding

coupled with Owen et al. (2013) who found that higher levels of social stigma was related to greater session outcomes, may suggest that we need to better understand the potentially paradoxical or insignificant role that social stigma may have on the therapy process.

While social stigma was not included in Study 2, a measure of systemic alliance was included as a proxy. The systemic alliance captures clients' perceptions of the alliance between themselves, their support systems, and their therapists regarding the therapy process. For clients in Study 2, systemic alliance was significantly associated with session outcomes (r=.50). Systemic alliance was also a statistically significant contributor to the final predictive equation (B= .31). In other words, clients who perceived high alliances between themselves, their therapists, and their social networks, experienced more gains from their therapy sessions. It could be that clients who reported higher systemic alliances were able to commit to therapy process, invest in it more, and use it in a different way that lead to more gains. In this way the systemic alliance may have functioned differently than social stigma, yet had a similar impact. Whereas social stigma may underlie clients' level of commitment to invest in the process due to a perceived disconnection between their social support system and their decision to attend therapy, the systemic alliance may underlie clients' level due to the agreement between their social support system and therapy. This finding is consistent with previous research that demonstrated positive effects on session outcome by a strong systemic alliance (Owen, 2012; Slone & Owen, 2015).

The unique characteristics of each of these studies may contribute to the understanding of the findings on stigma. Clients in Study 1 were attending family therapy at a Community Mental Health Center, while clients in Study 2 were attending individual

therapy at a College Counseling Center. Attending therapy as a family suggests the presence of a support system, and possibly some agreement from their support system with the decision to attend therapy. It could also be that attending therapy with at least one other individual, as is typically the case in family therapy, reduces one's experience of stigma or buffers against its effects. This support system may not be readily present when attending individual therapy. Furthermore, attending therapy in a community setting of permanent residence may differ from attending therapy in a collegiate setting where residents are more transient and often away from their social support systems. These factors may suggest that clients in this setting may have experienced social support in a way that clients in Study 2 did not. This is also supported by the aforementioned finding that clients in Study 1 perceived a lower level of stigma than is typically found in the stigma and psychotherapy literature.

Results of both studies imply that therapy has the potential to be advantageous even when clients enter the process with perceived stigma. Specifically, the results of Study 2 imply that client-factors with cultural bases (such as social or self-stigma) are not necessarily deterministic of therapeutic outcome. Rather, they rather shape and are shaped by things that actually happen within therapy. This was, perhaps, most evident in the finding that self-stigma was individually related to session outcomes, but not a contributor to the overall predictive equation. In the same study, systemic alliance was positively associated with session outcomes. This suggests that therapists, social support systems, and clients all have ability to influence the therapy process, as clients who perceived more alliance within their support system were able to experience more

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positive outcomes. Indeed, clients' social support systems may affect outcomes achieved in therapy in a way that is unique from therapists or the clients themselves.

Ethnic Identity

Ethnic identity was included as a variable to capture clients' sense of ethnic self (e.g., exploration and commitment of ethnic group). This is among the first known psychotherapy outcome studies to explore the influence of clients' ethnic identity on therapeutic outcome in a clinical sample. In Study 1, ethnic identity was negatively related to dropout (r=-.61). That is, clients who reported higher levels of ethnic identity (a more clarified and developed sense of ethnic self) were less likely to drop out. This finding was contrary to the study's hypothesis. Ethnic identity was not measured in Study 2. However, ethnic status was used as an imperfect proxy in an attempt to capture the impact of one's ethnicity on session outcomes. Ethnic status was not statistically significantly associated with session outcomes, however it was a statistically significant contributor to the overall predictive equation (B=.19) and accounted for 2.7% of the variance in session outcomes.

These findings, when considered in the context of each other, offer a nuanced understanding of ethnicity and the impact of one's internal sense of ethnicity on therapy outcome. Study 2's finding that one's ethnic status plays a role in the context of other variables is informative. However, Study 1's finding highlights a potentially unexpected manifestation of ethnic identity in therapy. The fact that higher ethnic identity is associated with less likelihood of dropout is consistent with the positive psychological health outcomes that have been reported of those with higher levels of ethnic identity, including improved social support and as a buffer against perceived stress (Greene, Way,

& Pahl, 2006; Torres & Ong, 2010; Umaña-Taylor, Diversi, & Fine, 2002). Indeed, having greater clarity about one's ethnicity, a more developed sense of ethnic self, and a realistic assessment of one's own ethnic group may have served as a buffer against dropping out of therapy.

Additionally, the contextual variables of clients in Study 1 is distinct from that of clients in Study 2, offering a richer understanding of the findings. For instance, clients in Study 1 self-identified mostly as either African American or White and in their mid to late 30's. The broader community that the sample is situated is a large urban Southern City, and reflects the mostly Black and White ethnic diversity of clients in the sample. The finding of the influence of ethnic identity on therapy dropout for clients in Study 1 could reflects gains from lived experiences within urban Southern racial/ethnic dynamics and their lived experiences at their developmental phase within the lifespan.

One possibility is that the experience of ethnic minorities within therapy may be fundamentally different than the experience of those who self-identify as White. This could be because REM status is not only a client-factor within the therapy process, but also becomes a therapist-perceived factor within the therapy context. Thus, one's REM status gains in its salience and influence when considered within a relational context. In this way, one's REM status becomes an active part of therapy and likely interacts with relationally-based factors, including the systemic-alliance, to actually influence session outcomes. Since therapy is culturally-laden and relational in nature, more attention to and integration of cultural constructs may have created opportunities for additional session gains. Clients in Study 2 with strong systemic alliances may have been able to take advantage of these opportunities in ways that improved their process. In this way, an

REM status may have facilitated cultural conversations in a way that may not have been as readily available to White clients. This is supported by the fact that though REM status was not a significant predictor by itself, for REM clients who perceived agreement with their therapists and between their therapists and their support systems (as measured by the systemic alliance), their REM status related to positive session outcomes in the final predictive equation.

Another possibility lies within resiliency factors related to race and ethnicity. For example, the resulting resiliency gained from navigating the world as a REM may have been implemented in a way that increased the alliance with therapists, or prevented a low alliance from impeding the achievement of positive session outcomes. It could be that ethnicity and one's sense of it creates the lens through which experiences in therapy are filtered. In this respect, one's sense of ethnicity may offer insight into the cultural framework that shapes clients' internal worlds.

These relationships become even more complex when considering that ethnic identity is conceptualized as a more dynamic and interactional variable than REM status. In fact, it could be that through ethnic identity development, clients gained skills (greater resources, positive feelings about oneself, a connection to stories of resilience and strength) that allowed them to effectively navigate the psychological rigors of therapy. This might have allowed them to remain in the process, whether they experienced the process as beneficial or not. This is consistent with Sellers and Shelton (2003) who theorized that ethnic identity provides individuals a repertoire of ways to deal with stress. Others have concluded that ethnic identity serves as a buffer for ethnic minorities against mental health concerns (Mossakowski, 2003; Shelton, Yip, Eccles, Chatman, Fuligini, &

Wong, 2005). In this way, a high ethnic identity may have been protective against many negative therapy experiences (e.g. microaggressions) that can arise during therapy (Owen et al., 2014; Owen et al., 2011).

Phinney and Ong (2007) noted that ethnic identity is likely to fluctuate over time and context. Thus, it is also important to understand the findings on the influence of ethnicity and ethnic identity in the context of the therapy. Though the practice of psychotherapy has made strides toward increasing diversity, the centrality of whiteness remains pervasive via cultural norms related to the racial/ethnic demographics of who attends therapy, therapeutic approaches, the racial/ethnic demographics of therapists, and the cultural symbols and that are present. Thus, the spaces in which therapy takes place may relate to how clients benefited from therapy. For instance, it would make sense that the experience of REM clients may have differed in Study 2, as accessing cultural validation and connection to the process would have been more difficult. Similarly, those who reported a lower level of ethnic identity may experience more challenges navigating these spaces, as the spaces may not be congruent with their cultural needs.

It is important to interpret the findings of Study 1 within the context of the ethnic make-up of the study's sample. Nearly half of the sample self-identified as ethnically White. Thus, while a higher level of ethnic identity was negatively related to dropout across all clients in the study, White and REM clients may have differed in their process of identity development and resources acquired throughout their developmental process. For instance, Hickling-Hudson and Ahlquist (2003) point out that the Eurocentric nature of the US education curriculum exposes all students to traditions, cultures, and practices that are common to individuals from European backgrounds. The findings of ethnic

identity, as captured by the MEIM, could mean that a higher level of ethnic identity for White clients in the study reflect an achieved status based on years of this type of systemic exposure, while higher levels of ethnic identity for REM clients reflect the product of a more active ethnic identity search and exploration.

Clients in Study 2 were students at a large urban West-coast college who were in their early 20's and self-identified mostly as predominantly White or Asian/Asian American, with significant minorities identifying as Biracial/Multiracial and Hispanic/Latino. The broader college community and community in which the college is situated mirrors the ethnic diversity of clients in the sample. Although an ethnic identity measure was not included in Study 2, the proxy variable of ethnicity was related to session outcomes only in the context of the other study variables. This finding of the way race/ethnicity functions within the psychotherapy context may reflect the functioning of race/ethnicity in interpersonal contexts outside of psychotherapy context for clients in this study. Indeed, writings that illuminate these interactions have pointed to the dynamics of interpersonal experiences such as REM invisibility and the model minority myth (Sun & Starosta, 2006; Wing, 2007). Though no measure was provided to assess these dynamics directly, these social realities could have indirectly influenced client experiences and been observed in the findings.

There are a few notable implications of these findings on clinical practice and the broader literature. First, racial/ethnic status is an important construct to consider in the overall therapy process. However, one's ethnic identity may be equally as important, and potentially more impactful on the outcome of therapy and decisions to remain in treatment or drop out. Secondly, racial/ethnic disparities in psychotherapy, including

treatment dropout, are able to be influenced at the client-therapist level. A client's ethnicity and ethnic sense of self may not be deterministic of outcome; they might instead be factors among others that relate to how therapy ends. Lastly, while racial and ethnic disparities in healthcare exist, these findings call into question whether differences in dropout exist based on ethnic identification, ethnic identity, and other cultural variables.

Clinical Recommendations

Reading about racial/ethnic disparities in outcome and experiencing them first-hand can be a disheartening experience for those who work with or desire to work with ethnic minority clients. Thus, it is my hope that these findings may be clinically useful in several ways. First, the fact that dropout is not necessarily simply correlated to demographic variables may be empowering to therapists who are often a first point of contact for clients. Therapists may want to consider the complexity of cultural factors in the lives of their clients and within the therapy process. One way of doing this is to conceptualize clients within the context of broader systems, including their social support network, their experience of ethnic group membership and sense of ethnic self, and their cultural norms related to attending therapy. Clients of various backgrounds often bring cultural assets, which if connected to a therapy process that honors them may lead to more treatment engagement and more effective therapy use. This may also yield a more culturally-informed and culturally attuned clinical process. Within this perspective, therapists are able to consider ethnicity and the many cultural factors that may underlie it. Indeed, interventions that have roots and personalized relevance within this broader client cultural framework may be more meaningful to clients and thereby may improve outcomes and reduce dropout.

The finding that clients continue to report stigma after entering therapy and that it can influence therapy in different ways is not a new one (Owen, Thomas, et. al, 2013), but it warrants repetition due to its importance on therapy outcome. It is recommended that therapists assess clients' level of stigma from the outset of therapy and be attentive to it throughout the process as needed. This is crucial, as the effects of stigma could counteract the therapy work of facilitating change. Additionally, as both ethnic identity and stigma likely interact with other factors within therapy itself, therapists may find in beneficial to frame interventions with these constructs in mind. For instance, assessing clients' ethnic sense of self and perception of stigma could be done formally (through measures similar to the ones used in these studies) or informally by asking questions such as "What was it like for you to make the decision to go to therapy?", "How does your social support system feel about you going to therapy?", and "How did you envision receiving support prior to coming to therapy and does the way I've supported you fit with that vision?" Interventions related to these variables would depend on their relevance to the clients. However, assisting clients in exploring their ethnic identity, bolstering clients' ethnic and social supports, working toward reducing stigma, supporting clients' in building skills to deal effectively with stigma, and offering new perspectives through which they can understand their decision to attend therapy are all ways in which these constructs can be central to therapy work.

These interventions also make sense in light of the findings that self- and systemic alliance are related to outcome (Horvath, Del Re, Flückinger, & Symonds, 2011; Slone & Owen, 2015; current study). Therapists should seek to build an alliance with clients. A strong alliance can provide a solid base upon which to engage in work, which may be

especially important with the interaction of cultural variables. Using formal measures of systemic client feedback might offer one empirically-supported way to gauge the alliance (Miller, Duncan, Brown, Sorrell, & Chalk, 2006), as a client's perspective is strongly related to therapy outcome (Wampold, 2001). However, any measure or intervention which generates feedback and elicits reflection is likely to provide therapists with a sense of the alliance. Consistent with the systemic alliance, it is also recommended that therapists seek to build and attend to their alliances with clients' support systems. Since a clients' support system is relevant to their therapy process (Mallinckrodt, 1996; Slone & Owen, 2015; Vogel, Wade, & Ascheman, 2009), incorporating it into therapy process, either literally by inviting significant others into the therapy room or metaphorically by discussing clients' social support systems and their impact, may be beneficial.

For organizations and businesses that are negatively affected by treatment dropout, it is recommended that more robust constructs (e.g. stigma and ethnic identity) be collected and tracked, in addition to racial/cultural demographic information. Other cultural variables might have similar effects on therapy dropout as ethnic identity. It is also recommended that staff be provided with support and training related to culturally-informed and culturally competent care, which may play a critical role in achieving positive therapeutic outcomes. Indeed, organizations may also support the work that therapists are doing by de-stigmatizing the larger organization and intentionally changing the organizational culture to reflect existing multiculturalism, specifically with respect to ethnicity.

Limitations and Recommendations for Future Research

There were a few notable limitations to these studies. Both studies employed a convenience sampling approach to data collection. While this approach was deemed as the most practical and least invasive for the clinical settings of interest, it also violated the statistical assumptions of logistic and multiple linear regression, making the findings susceptible to a self-selection bias. This was particularly challenging to tease out regarding the findings on dropout/outcome, since the impact of this bias could be a decreased rate of dropout and an increased outcome. No data was available to analyze for clients who declined to participate in the study. Study 2 was conducted used a cross-sectional design. Though this allowed the studies to support the specific hypotheses generated a priori, little information was obtained regarding the interaction of many of the variables (such as ethnic identity and stigma) across time. One recommendation for future research is to conduct pre- and post- tests exploring similar constructs that were included in this study. This would allow a more in-depth exploration of the ways in which the variables change over time and affect the outcome of therapy. One strength of both studies was their racial/ethnic diversity. However, statistical analyses in both studies were conducted with low power due to small sample sizes, preventing the full use of statistical tools available and reducing the ability to test certain effects. This includes being unable to test between-group ethnic differences in dropout and outcome or conduct regression analyses to test each hypothesis. Also, information about the therapists was not included in the studies, which meant that therapist effects could not be tested.

Future research may also look to replicate the findings with larger, similarly diverse sample sizes to assess for the generalizability of the results. Though conducting

two separate studies allowed for a richer interpretation of the data, differing definitions of therapy outcome (dropout vs session outcomes), different samples (families at a community mental health center vs. students at a college counseling center) and differences in who defined outcome (therapist-rated vs client-rated) prevented a true comparative analysis of the two studies. Relatedly, a measure of ethnic identity was not included in Study 2. While ethnic status was used instead, it may not have captured the same level of ethnic depth since it would be unable to convey clients' subjective sense of their ethnic identities. The data for Study 1 was completed by parents/guardians who presented for treatment with their children. Though this is useful data, as families, too, are consumers of mental health treatment, the data may not reflect the report of other family members or the effects of interactions among those other family members on treatment dropout. The findings from the current studies demonstrate the importance of client social location and context as it functions within the therapy process. It is recommended that future studies continue to explore this relationship as it holds potential to understanding the therapy process, especially for clients who self-identify as REMs. Lastly, although these studies found significant associations of stigma, ethnic identity, self-alliance, and systemic alliance related to therapy outcome, they are only a few of the many cultural variables that exist. Future research contributions could seek to explore the impact of other cultural variables that may underlie or be related to race/ethnicity (i.e. cultural mistrust), and be influential upon client decisions to drop out of therapy.

REFERENCES

Abe-Kim, J., Takeuchi, D., & Hwang, W. (2002). Predictors of help seeking for emotional distress among Chinese Americans: Family matters. *Journal of Consulting and Clinical Psychology, 70* (5), 1186-1190.

Armbruster, P., & Kazdin, A. E. (1994). Attrition in child therapy. In T. H. Ollendick & R. J. Prinz (Eds.), *Advances in clinical child psychology* (Vol. 16, pp. 81–109). New York: Plenum.

Ayalon, L., & Young, M. A. (2005). Racial group differences in help-seeking behaviors. *The Journal Of Social Psychology, 145*, 391-403.

Baldwin, S. A., Berkeljon, A., Atkins, D. C., Olsen, J. A., & Nielsen, S. L. (2009). Rates of change in naturalistic psychotherapy: Contrasting dose–effect and good-enough level models of change. *Journal Of Consulting And Clinical Psychology, 77*(2), 203-211.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: Conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology, 51*, 1173-1182.

Barr, V., Eells, G., Jones, D., Colbs, S., & Meyer, B. (2008). *Counseling centers today: A review of results from the AUCCCD directors survey*. Unpublished document.

Barrett, M.S., Chua, W.J., Crits-Christoph, P., Gibbons, M.B., & Thompson, D. (2008). Early withdrawal from mental health treatment: implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training, 45*, 247-267.

Björk, T., Björck, C., Clinton, D., Sohlberg, S., & Norring, C. (2009). What happened to the ones who dropped out? Outcome in eating disorder patients who complete or prematurely terminate treatment. *European Eating Disorders Review*, *17*(2), 109-119.

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

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath, L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 13-37). Oxford England: John Wiley & Sons.

Breaux, C. & Ryujin, D. (1999). Use of mental health services by ethnically diverse groups within the United States. *The Clinical Psychologist, 52*, 4-15.

Callahan, J.L., Aubuchon-Endsley, N., Borja, S.E., & Swift, J.K. (2009). Pretreatment expectancies and premature termination in a training clinic environment. *Training and Education in Professional Psychology, 3*, 111-120.

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist, 35*, 13-105.

Cheng, H., Kwan, K., & Sevig, T. (2013). Racial and ethnic minority college students' stigma associated with seeking psychological help: Examining psychocultural correlates. *Journal of Counseling Psychology, 60*, 98-111.

Clarkin, J. F. & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change*. (5th ed, pp. 194-226) New York: John Wiley and Sons.

Coker, E. M. (2005). Selfhood and social distance: Toward a cultural understanding of psychiatric stigma in Egypt. *Social Science and Medicine, 61*, 920–930.

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*, 1–16.

Cooper-Patrick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (1997). Identification of patient attitudes and preferences regarding treatment of depression *Journal of General Internal Medicine, 12,* 431–438.

Corrigan, P. W., & Phelan, S. M. (2004). Social support and recovery in people with serious mental illnesses. *Community Mental Health Journal, 40*(6), 513-523.

Erikson, E.H. (1968). *Identity: Youth and Crisis.* New York: Norton.

Farmer, E. Z., & Burns, B. J. (1997). Impact of children's mental health problems on families. *Journal of Emotional & Behavioral Disorders, 5*, 230–238.

Goldston, D. B., Molock, S. D., Whitbeck, L. B., Murakami, J. L., Zayas, L. H., & Hall, G. C. (2008). Cultural considerations in adolescent suicide prevention and psychosocial treatment. *American Psychologist, 63*, 14–31.

Greene, M. L., Way, N., & Pahl, K. (2006). Trajectories of perceived adult and peer discrimination among Black, Latino, and Asian American adolescents: Patterns of psychological correlates. *Developmental Psychology*, 42, 218–238.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. (2003). *American Psychologist, 58*, 377-402.

Hair, J. F. Jr., Anderson, R. E., Tatham, R. L. & Black, W. C. (1995). *Multivariate Data Analysis* (3rd ed). New York: Macmillan.

Hamilton, S., Moore, A. M., Crane, D., & Payne, S. H. (2011). Psychotherapy dropouts: Differences by modality, license, and DSM-IV diagnosis. *Journal of Marital And Family Therapy*, *37*, 333-343.

Hammer, J. H., & Vogel, D. L. (2010). Men's help seeking for depression: The efficacy of a male-sensitive brochure about counseling. *The Counseling Psychologist, 38*, 296-313.

Hatcher, R. L., & Barends, A. W. (2006). How a return to theory could help alliance research. *Psychotherapy: Theory, Research, Practice, Training, 43*, 292-299.

Hatcher, R. L., & Gillaspy, J. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, *16*,12–25.

Hatchett, G. T., & Park, H. L. (2003). Comparison of four operational definitions of

    premature termination. *Psychotherapy: Theory, Research, Practice,*

    Training, 40, 226-231.

Helms, J. E., & Talleyrand, R. M. (1997). Race is not ethnicity. *American*

    Psychologist, 52, 1246-1247.

Hickling-Hudson, A., Ahlquist, R. (2003). Contesting the curriculum in the schooling of

    Indigenous children in Australia and the USA: From Eurocentrism to culturally

    powerful pedagogies. *Comparative Education Review 47*, 64-89.

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in

    individual psychotherapy. *Psychotherapy: Theory, Research, & Practice 48*, 9-16.

Huber, E. & Stephens, J. D. (1993). Political parties and public pensions: A quantitative

    analysis, *Acta Sociologica, 36*, 309-325.

Hyppolite, J. (2012). The role of acculturation, racial identity and ethnic identity in

    understanding utilization rates, attitudes toward formal mental health services and

    preferences for help among Caribbean black college students. *Dissertation*

    Abstracts International, 72.

Kendra, M. S., Mohr, J. J., & Pollard, J. W. (2014). The stigma of having psychological

    problems: Relations with engagement, working alliance, and depression in

    psychotherapy. *Psychotherapy*, *51*(4), 563-573.

Kim, C., & Kwok, Y. S. (1998)Navajo use of native healers *Archives of Internal*

    Medicine, 158, 2245–2249.

Klein, E. B., Stone, W. N., Hicks, M. W., & Pritchard, I. L. (2003). Understanding

    dropouts. *Journal of Mental Health Counseling*, *25, 89-100.*

Komiya, N., Good, G. E., & Sherrod, N. (2000). Emotional openness as a predictor of

    attitudes toward seeking psychological assistance. *Journal of Counseling*

    Psychology, *47*, 138–143.

Lampropoulos, G. K. (2010). Type of counseling termination and trainee therapist-client

    agreement about change. *Counselling Psychology Quarterly, 23*, 89-100.

Leong, F.T.L. & Kalibatseva, Z. (2011). Cross-cultural barriers to mental health services

    in the United States. *Cerebrum,* 1-12. Retrieved from

    http://dana.org/news/cerebrum/detail.aspx?id=31364.

Leong, F.T.L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help

    seeking attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M.

    Alexander (Eds.), *Handbook of multicultural counseling* (pp. 415–438). Thousand

    Oaks, CA: SAGE.

Marcia, J. E., (1966), Development and validation of ego identity status, *Journal of*

    Personality and Social Psychology 3, 551-558.

Mallinckrodt, B. (1996). Change in working alliance, social support, and psychological

    symptoms in brief therapy. *Journal Of Counseling Psychology*, *43*(4), 448-455.

Marcia, J. E. (1980). Ego identity development. In J.Adelson (Ed.), *Handbook of*

    adolescent psychology (pp. 159-187). New York: Wiley.

McCabe, K. M. (2002). Factors that predict premature termination among Mexican-American children in outpatient psychotherapy. *Journal Of Child And Family Studies,11*, 347-359.

Menard, S. (1995). Applied Logistic Regression Analysis: Sage University Series on Quantitative Applications in the Social Sciences. Thousand Oaks, CA: Sage.

Miller, S. D., Duncan, B. L., Brown, J, Sorrell, R., & Chalk, M. (2006). Using formal client feedback to improve retention and outcome: Making ongoing real-time assessment feasible. *Journal of Brief Therapy, 5*(1).

Mills, M. L. (2012). Unconventional mental health treatment: Reexamining the racial-ethnic disparity in treatment-seeking behavior. *Psychiatric Services*, *63*, 142-146.

Mossakowski, K. N. (2003). Coping with perceived discrimination: Does ethnic identity protect mental health? *Journal of Health and Social Behavior, 44*, 318–331.

Neighbors, H. W., & Jackson, J. S. (1984) The use of informal and formal help: Four patterns of illness behavior in the black community *American Journal of Community Psychology , 12,* 629–644.

Owen, J., Imel, Z., Adelson, J., & Rodolfa, E. (2012). 'No-show': Therapist racial/ethnic disparities in client unilateral termination. *Journal Of Counseling Psychology,59*, 314-320.

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 & Psychotherapy Research*, *11*, 204-212.

Owen, J., Quirk, K., Hilsenroth, M. J., & Rodolfa, E. R. (2012). Working through: Insession processes that promote between session thoughts and activities. *Journal of Counseling Psychology*, *59*, 161–167.

Owen, J., Smith, A. A., & Rodolfa, E. (2009). Clients' expected number of sessions, treatment effectiveness, and termination status: Using empirical evidence to inform session limit policies. *Journal of College Student Psychotherapy, 23*, 118-134.

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*(4), 283-290.

Owen, J., Thomas, L., Rodolfa, E. (2013). Stigma for seeking therapy: Self-stigma, social stigma, and the therapeutic process. *The Counseling Psychologist, 41*, 857-880

Peifer, K. L., Hu, T. W., & Vega, W. (2000) Help seeking by persons of Mexican origin with functional impairments *Psychiatric Services , 51,* 1293–1298.

Pekarik, G. (1985). Coping with dropouts. *Professional Psychology: Research and Practice, 16*, 114-123.

Peng, C. J., Lee, K. L., & Ingersoll, G. M. (2002). An introduction to logistic regression analysis and reporting. *The Journal Of Educational Research*, *96*(1), 3-14.

Phinney, J. S. (1992). The multigroup ethnic identity measure: A new scale for use with

    diverse groups. *Journal of Adolescent Research, 7*, 156-176.

Phinney, J. (2003). Ethnic identity and acculturation. In K.Chun, P.Organista, & G.Marin

    (Eds*.), Acculturation: Advances in theory, measurement, and applied research.*

    (pp. 63-82). Washington, DC: American Psychological Association.

Phinney, J. S., Chavira, V., & Tate, J. D. (1993). The effect of ethnic threat on ethnic

    self-concept and own-group ratings. *The Journal of Social Psychology, 133*, 469-

    478.

Phinney, J. S., & Ong, A. D. (2007). Conceptualization and measurement of ethnic

    identity: Current status and future directions. *Journal of Counseling*

    Psychology, 54, 271-281.

Reece, M. D. (2001). Dropout from community-based, HIV-related psychotherapy: The

    influence of health beliefs and perceptions of stigma (immune deficiency).

    Dissertation Abstracts International, *61A*, 3075.

Reis, B. F., & Brown, L. G. (2006). Preventing therapy dropout in the real world: The

    clinical utility of videotape preparation and client estimate of treatment duration.

    Professional Psychology: Research and Practice, *37*, 311-316.

Richman, L., Kohn-Wood, L. P., & Williams, D. R. (2007). The role of discrimination

    and racial identity for mental health service utilization. *Journal of Social and*

    Clinical Psychology, 26, 960-981.

Schaumann, E. M. (1998). The effects of racial identity attitudes on the therapeutic

    alliance in cross-racial dyads (Doctoral dissertation, California Institute of

    Integral Studies, 1997). *Dissertation Abstracts International*, 58(12), 6826B.

    (AAT 9817689).

Schofield, W. (1964). *Psychotherapy: The purchase of friendship.* Englewood Cliffs, NJ:

    Prentice Hall.

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial

    discrimination. *Journal of Personality and Social Psychology, 84*, 1079–1092.

Sharf, J., Primavera, L. H., & Diener, M. J. (2010). Dropout and therapeutic alliance: A

    meta-analysis of adult individual psychotherapy. *Psychotherapy: Theory,*

    Research, Practice, Training, 47, 637-645.

Shea, M., & Yeh, C. J. (2008). Asian American students' cultural values, stigma, and

    relational self-construal: Correlates of attitudes toward professional help seeking.

    Journal of Mental Health Counseling, 30, 157–172.

Shelton, J. N., Yip, T., Eccles, J. S., Chatman, C. M., Fuligni, A. J., & Wong, C. (2005).

    Ethnic identity as a buffer of psychological adjustment to stress. In G. Downey, J.

    S. Eccles, & C. M. Chatman, *Navigating the future: Social identity, coping, and*

    life tasks (pp. 96–115). New York: Russell Sage Foundation.

Sirey, J., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B.

    S. (2001a). Stigma as a barrier to recovery: Perceived stigma and patient-rated

    severity of illness as predictors of antidepressant drug adherence. *Psychiatric*

    Services, 52, 1615-1620.

Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Raue, P., Friedman, S. J., & Meyers, B. S. (2001b). Perceived stigma as a predictor of treatment discontinuation in young and older outpatients with depression. *American Journal of Psychiatry*, *158*, 479–481.

Sledge, W. H., Moras, K., Hartley, D., & Levine, M. (1990). Effect of time-limited psychotherapy on patient dropout rates. *American Journal of Psychiatry*, *147*, 1341–1347.

Slone, N. C., & Owen, J. (2015). Therapist alliance activity, therapist comfort, and systemic alliance on individual psychotherapy outcome. *Journal of Psychotherapy Integration*, doi:10.1037/a0039562

Sparks, W. A., Daniels, J. A. & Johnson, E. (2003). Relationship of referral source, race, and wait time on preintake attrition. *Professional Psychology: Research and Practice, 34*, 514-518.

Sue, D., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice (4th ed.)*. Hoboken, NJ US: John Wiley & Sons Inc.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*, 477-486.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*, 616-624.

Sue, S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. S. (1991). Community mental

    health services for ethnic minority groups: A test of the cultural responsiveness

    hypothesis. *Journal of Consulting And Clinical Psychology*, *59*(4), 533-540.

Sue, S., McKinney, H. L., & Allen, D. B. (1976). Predictors of the duration of therapy for

    clients in the community mental health system. *Community Mental Health

    Journal,12*, 365-375.

Sun, W., & Starosta, W. J. (2006). Perceptions of minority invisibility among Asian

    American professionals. *Howard Journal of Communications, 17*(2), 119-142.

Swift, J. K., Callahan, J., & Levine, J. C. (2009). Using clinically significant change to

    identify premature termination. *Psychotherapy: Theory, Research, Practice,

    Training,46*, 328-335.

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult

    psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*,

    80(4), 547-559.

Tabachnick, B. G., & Fidell, L. S. (2001). *Using Multivariate Statistics (4th ed.)*. Boston,

    MA: Allyn and Bacon

Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among

    Blacks. *The Western Journal Of Black Studies, 5*, 180-184.

Terrell, F., & Terrell, S. L. (1984). Race of counselor, client, sex, cultural mistrust level

    and premature termination from counseling among Black clients. *Journal of

    Counseling Psychology, 31*, 371–375.

Torres, L., & Ong, A. D. (2010). A daily diary investigation of Latino ethnic identity, discrimination, and depression. *Cultural Diversity and Ethnic Minority Psychology*, *16*(4), 561-568.

Umaña-Taylor, A. J., Diversi, M., & Fine, M. A. (2002). Ethnic identity and self-esteem among Latino adolescents: Making distinctions among the Latino populations. *Journal of Adolescent Research, 17*, 303–327.

Vandereycken, W., & Vansteenkiste, M. (2009). Let eating disorder patients decide: Providing choice may reduce early drop-out from inpatient treatment. *European Eating Disorders Review, 17 (3)*, 177-183.

Vogel, D. L., Wade, N. G., & Ascheman, P. L. (2009). Measuring perceptions of stigmatization by others for seeking psychological help: Reliability and validity of a new stigma scale with college students. *Journal of Counseling Psychology*, *56*, 301–308.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325-337.

Wade, N. G., Post, B. C., Cornish, M. A., Vogel, D. L., & Tucker, J. R. (2011). Predictors of the change in self-stigma following a single session of group counseling. *Journal of Counseling Psychology*, *58*, 170–180.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods and findings.* Hillsdale, NJ: Erlbaum.

Warnick, E. M., Gonzalez, A., Weersing, V., Scahill, L., & Woolston, J. (2012). Defining

    dropout from youth psychotherapy: How definitions shape the prevalence and

    predictors of attrition. *Child And Adolescent Mental Health, 17*, 76-85.

Wester, S. R., Arndt, D., Sedivy, S. K., & Arndt, L. (2010). Male police officers and

    stigma associated with counseling: The role of anticipated risks, anticipated

    benefits and gender role conflict. *Psychology Of Men & Masculinity, 11*, 286-302.

Whaley, A. L., & Davis, K. E. (2007). Cultural competence and evidence-based practice

    in mental health services: A complementary perspective. *American*

    Psychologist,62, 563-574.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout.

    Professional Psychology: Research and Practice, 24, 190–195.

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in

    health: Evidence and needed research. *Journal of Behavioral Medicine, 32*, 20-

    47.

Wing, J. Y. (2007). Beyond Black and white: The model minority myth and the

    invisibility of Asian American students. *The Urban Review, 39*(4), 455-487.

CURRICULUM VITA

NAME: Le'Keldric Jawon Thomas

ADDRESS: 143 McGill Park Ave NE
Atlanta, GA 30312

DOB: Americus, Georgia—June 6, 1984

EDUCATION: B.A., Psychology and Spanish
Morehouse College, 2002-2006

M.Ed, Counseling Psychology
University of Louisville, 2009-2012

PROFESSIONAL
SOCIETIES: Phi Beta Kappa, Liberal Arts
National Society of Collegiate Scholars

PUBLICATIONS

PRESENTATIONS: *Stigma for Seeking Therapy: Self-Stigma, Social Stigma, and Therapeutic Processes*. Poster presented at the annual Great Lakes Conference, Purdue University, West Lafayette, IN, March 2012.

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JOURNALS: Owen, J, Thomas, L. & Rodolfa, E. Stigma for Seeking Therapy: Self-Stigma, Social Stigma, and Therapeutic Processes. *The Counseling Psychologist,* October 2012.

INVITED TALKS: *Influence of Racial Identity and Ethnocultural Empathy on Interpersonal Forgiveness* Presentation presented to Department of Education and Counseling Psychology, Louisville, KY, January 2011.