Received 04/20/16
Revised 01/03/18
Accepted 03/12/18
DOI: 10.1002/jmcd.12120

Counseling Canadian Indigenous Peoples: The Therapeutic Alliance and Outcome

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The aim of this study was to determine whether client therapeutic alliance ratings and client symptom severity were predictors of counseling outcomes among Canadian Indigenous clients. Participants included 179 Canadian Indigenous clients who completed an outcome measure at the 1st and last sessions and an alliance measure at both the 2nd and 3rd sessions. Results indicated that higher client alliance ratings at Sessions 2 and 3 and baseline client symptom severity were significant predictors of outcome.

Keywords: Canadian Indigenous peoples, counseling outcome, alliance, baseline severity, client–counselor relationship

El objetivo de este estudio fue determinar si las valoraciones del cliente de la alianza terapéutica y la severidad de los síntomas del cliente fueron indicadores de los resultados de la consejería entre clientes indígenas canadienses. Los participantes incluyeron 179 clientes indígenas canadienses que completaron una medida de resultados en la primera y última sesión, además de una medida de la alianza en la segunda y tercera sesión. Los resultados indicaron que unas valoraciones del cliente más altas de la alianza en las sesiones 2 y 3 y la severidad preliminar de los síntomas del cliente fueron indicadores significativos del resultado.

Palabras clave: pueblos indígenas canadienses, resultado de la consejería, alianza, severidad preliminar, relación cliente-consejero

Indigenous peoples compose about 4.9% of the national population in Canada, totaling approximately 1,673,780 Indigenous people in the country (Statistics Canada, 2016). When experiencing mental health problems, an estimated 17% of Indigenous peoples seek services compared to only 8% of the non-Indigenous population (Government of Canada, 2006). Although frequent consumers of mental health services, Canadian Indigenous peoples have rarely been the focus of quantitative counseling

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outcome research studies. In addition, outcome research with Native Americans in the United States typically includes a small percentage of Native clients embedded within a general population sample (Lambert et al., 2006). Quantitative outcome research with Indigenous populations is critically needed to better understand the relationship of the therapeutic alliance to counseling outcomes with this population.

Qualitative research and theoretical scholarship point to the therapeutic alliance as a key contributor to positive outcomes among Indigenous peoples (Duran, 2006; Hirini, 1997; Nuttgens & Campbell, 2010; Smith & Morrissette, 2001; Walker & Sonn, 2010). Indeed, there is a long-held consensus that the therapeutic alliance is essential for effective counseling (Norcross, 2010). Numerous empirical studies and meta-analyses with the general population support the therapeutic alliance as a factor contributing to treatment efficacy (Bordin, 1979; Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000; Norcross, 2010; Orlinsky, Rønnestad, & Willutzki, 2004; Wampold & Imel, 2015). Although there is evidence supporting the efficacy of the alliance in non-Indigenous populations, it is important to understand whether these findings generalize to Indigenous clients. To our knowledge, there has only been one study examining the relationship between alliance and outcome specifically with Canadian Indigenous peoples. DeSorcy, Olver, and Wormith (2016) examined the relationship between alliance and recidivism and treatment completion among sex offender participants in a correctional facility. In DeSorcy et al.'s study, the alliance was not significantly correlated with outcomes for Indigenous clients. Our study addresses the question of whether or not the therapeutic alliance and baseline client symptom severity predict counseling outcome, as measured by the Outcome Questionnaire–45 (OQ-45), among Canadian Indigenous clients in an outpatient mental health setting.

canadian indigenous peoples

Canadian Indigenous peoples comprise an estimated 618 Indigenous communities throughout Canada, with over 60 spoken languages across these communities (Statistics Canada, 2017). The term *Canadian Aboriginal peoples* has been used to describe the first inhabitants of Canada until recently, when the Canadian government adopted the term *Canadian Indigenous peoples* instead (Government of Canada, 2017). Dwight Dorey, National Chief of the Indigenous Peoples of Canada Assembly, reported that the term *Indigenous* is more inclusive, and it better captures the similar experiences of colonized Indigenous peoples globally (Steel, 2016). Currently, the Government of Canada (2017) identifies three broad groups of Canadian Indigenous peoples: First Nations (comprising 600 First Nations communities), Inuit (Indigenous peoples of the Canadian Arctic), and Métis. According to the Government of Canada (2006),

> The term Métis applied to the children of French traders and Cree women in the Prairies, and of British traders and Dene women in the north. Today, the term is broadly used to describe a group of people of mixed First Nations and European ancestry who see themselves as distinct from First Nations, Inuit and non-Indigenous people. (p. 160)

Approximately 56% of Canadian Indigenous peoples live in urban areas, and they were the fastest growing population in Canada between 2006 and 2016 (Government of Canada, 2017). Canadian Indigenous peoples are also the youngest population in Canada, with 44% of this population being under age 25 (Government of Canada, 2017).

According to archaeological records, Canadian Indigenous peoples inhabited what is now Canada from about 9,000 to 10,000 years ago (Boksa, Joober, & Kirmayer, 2015). Beginning in the 1600s, European colonizers, and later the Canadian government, implemented efforts to forcibly acculturate Indigenous peoples (Boksa et al., 2015). Due to infectious disease, forced displacement, and warfare, approximately 90% of the population died by the 1850s (Boksa et al., 2015). These historic events, oppressive residential boarding schools, and contemporary discrimination are important factors that contribute to intergenerational trauma and ongoing negative effects on well-being in Canadian Indigenous communities (Kirmayer, Gone, & Moses, 2014).

Conceptions of wellness and illness among Canadian Indigenous peoples differ in important ways from mainstream Western conceptions, which tend toward reductionism and individualism. First, Canadian Indigenous peoples generally view wellness as harmony among four dimensions: mental, physical, emotional, and spiritual (Nuttgens & Campbell, 2010). Second, the belief in collectivism and a community-oriented way of life are characteristic of Canadian Indigenous peoples (Nuttgens & Campbell, 2010). A third central concept is noninterference. Specifically, noninterference refers to a belief or way of being that is aimed at cultivating strong interpersonal relationships by avoiding coercion (Brant, 1990; Morrissette, 2008). The importance of noninterference in Canadian Indigenous culture is captured in the recommendation of respectful engagement and collaboration in the First Nations Mental Wellness Continuum Framework (Assembly of First Nations & Health Canada, 2015). Noninterference is an important cultural feature and value that influences the therapeutic alliance between counselors and Canadian Indigenous clients.

counseling outcomes

THE ROLE OF THE THERAPEUTIC ALLIANCE ON CLIENT OUTCOMES

Counseling outcome research has focused extensively on finding and illuminating specific therapeutic techniques for use with particular diagnoses or populations (Hubble, Duncan, & Miller, 1999). This focus on specific

techniques in counseling has become further systematized through the development of manualized treatments (Barlow, Allen, & Choate, 2004). Critics of manualized treatments have declared that research support for specific technical interventions in counseling is minimal. For example, numerous studies and meta-analyses have indicated that there is no significant difference in outcome across different treatment approaches (Benish, Imel, & Wampold, 2008; Imel, Wampold, Miller, & Fleming, 2008; Leichsenring & Leibing, 2003; Wampold & Imel, 2015) and that the common factors that different treatment approaches share are much larger contributors to outcome variance (Wampold & Imel, 2015). Central among these common factors is the therapeutic alliance between the counselor and the client.

The classic definition of the therapeutic alliance is three-dimensional: (a) mutual counselor and client goal setting, (b) collaboration on treatment tasks or methods, and (c) the counselor–client relational bond (Bordin, 1979). There is robust empirical support for the therapeutic alliance as a predictor of positive counseling outcomes. For instance, Orlinsky et al. (2004) reported over 1,000 research findings that show an association between therapeutic alliance and client outcomes. Also, research findings have demonstrated that the therapeutic alliance early in the treatment process is a stronger predictor of counseling outcomes than the alliance later in the treatment process (Hersoug, Monsen, Havik, & Høglend, 2002; Levin, Henderson, & Ehrenreich-May, 2012). Based on numerous studies and meta-analyses, researchers have reported that the client's view of the alliance is typically a better predictor of outcome than the counselor's view (Bachelor & Horvath, 1999; Castonguay, Constantino, & Holtforth, 2006; Horvath & Bedi, 2002; Horvath & Symonds, 1991). Indeed, meta-analytic research reveals that alliance factors are one of the strongest, most replicated predictors of outcome and that clients' alliance ratings are often a stronger predictor of outcome than counselors' ratings (Wampold & Imel, 2015). Additionally, alliance and outcome research has repeatedly demonstrated that initial symptom severity at intake is predictive of client outcome at the end of treatment (Burlingame et al., 2016; Callahan, Almstrom, Swift, Borja, & Heath, 2009; Elkin et al., 1995; McLellan, Luborsky, Woody, Druley, & O'Brien, 1983). For example, Falkenström, Granström, and Homqvist (2013) found that initial symptom severity at intake was predictive of outcome and that initial symptom severity did not significantly moderate the effect of the therapeutic alliance on outcome.

DEMOGRAPHIC VARIABLES AND OUTCOME: GENDER AND INCOME

Research findings about client gender differences in counseling outcomes are ambiguous: some studies found no difference (Owen, Wong, & Rodolfo, 2009; Zlotnick, Shea, Pilkonis, Elkin, & Ryan, 1996), whereas other studies indicated that there are gender differences in outcome (Cottone, Drucker, & Javier, 2002; Ogrodniczuk, 2006). There have not been studies conducted

with Canadian Indigenous peoples that examined the influence of gender on counseling outcomes. Additionally, several studies have found that client income does not predict counseling outcome (Hawley, Leibert, & Lane, 2014; Petry, Tennen, & Affleck, 2000); however, features of the broader concept of socioeconomic status, which includes income, have been shown to predict outcome (Hawley et al., 2014). Although our review of the literature indicates that client income has not been found to affect counseling outcomes, income inequality does increase risk for poor mental and physical health (Kahn, Wise, Kennedy, & Kawachi, 2000), making it an important variable to consider. Given that the relationship between income and counseling outcome has not been evaluated in previous research with Canadian Indigenous peoples, this variable was included in our analysis.

counseling with canadian indigenous peoples

Canadian Indigenous peoples experience disproportionately high rates of mental disorders in comparison with non-Indigenous Canadians (Government of Canada, 2006; Kirmayer, Brass, & Tait, 2000). Specifically, Canadian Indigenous peoples are reported as 2.5 times more likely to see a physician for anxiety and 1.4 times more likely to seek services for depression than non-Indigenous Canadians. Furthermore, they experience death by suicide at about twice the national average (Government of Canada, 2006). These mental health concerns among Canadian Indigenous peoples, and among Indigenous populations more broadly, are connected to the traumatizing and marginalizing effects of colonialism (Browne, 2007; Duran, 2006; Shepard, O'Neill, & Guenette, 2006). According to a large national survey (Environics Institute, 2010), 70% of Canadian Indigenous peoples reported being treated unfairly within the past year because of their Indigenous background. Effects of colonization (e.g., historical trauma, internalized oppression, loss of language, marginalization), ongoing experiences of racism, and socioeconomic disparities experienced by Canadian Indigenous peoples have been shown to increase feelings of loneliness and isolation and to decrease feelings of control over their own destiny (Reading, 2009). Thus, engaging Canadian Indigenous clients in strong, culturally sensitive therapeutic alliances may be helpful in reducing mental health disparities.

In a qualitative study conducted in the province of Alberta, Canada, researchers investigated the most salient themes for White male counselors working with Canadian Indigenous clients (Smith & Morrissette, 2001). The need to establish strong therapeutic relationships was a central theme identified. In reflecting on his work with First Nations clients, one counselor noted, "I think my most challenging work here is not intervention, more [it is] engagement" (Smith & Morrissette, 2001, p. 79). These findings are consistent with other qualitative and theoretical literature supporting the central role of the

therapeutic alliance in working with Canadian Indigenous peoples (Nuttgens & Campbell, 2010; Shepard et al., 2006). The importance of a strong therapeutic alliance has also been emphasized in counseling Indigenous peoples of nations other than Canada (Duran, 2006; Hirini, 1997; Walker & Sonn, 2010; Weinstein, 2006).

In our review of the literature, we found only one quantitative study that specifically examined the alliance–outcome relationship in counseling Canadian Indigenous peoples (DeSorcy et al., 2016). This study was conducted at a male sex offender treatment program in a maximum security correctional treatment facility and the program followed a specific cognitive-behavioral therapy model for sex offender treatment (DeSorcy et al., 2016). The treatment program, Clearwater Programme, included six modules, and completion of these modules was the criterion for treatment completion (Olver & Wong, 2013). The duration of the program was 6 to 9 months (Olver & Wong, 2013). The researchers examined the relationship between the working alliance and recidivism and treatment completion with both Indigenous and non-Indigenous clients. Findings indicated that there was a significant correlation ($r = -.19$) between alliance and treatment completion for non-Indigenous clients, but the relationship was not significant for the Indigenous clients ($r = -.10$). The correlation coefficients in this study were negative because the outcome variable (i.e., treatment completion) was a dichotomous variable with the lower score indicating a positive outcome (0 = *completer*; 1 = *noncompleter*) and the alliance measure, the Working Alliance Inventory, was rated on a scale in which higher scores reflect stronger alliances (DeSorcy et al., 2016). There was not a significant relationship between the alliance and recidivism for either group of participants in the study (DeSorcy et al., 2016). This study provided important information about recidivism with Indigenous clients in a correctional setting. Because Canadian Indigenous peoples commonly seek mental services in outpatient settings, it is imperative to conduct outpatient counseling research that evaluates client outcomes for Indigenous populations via validated client measures of therapeutic change.

the present study

The purpose of this study was to extend the counseling outcome literature in working with Canadian Indigenous peoples through quantitative outcome research. We examined one major research question: Do client alliance ratings early in treatment and baseline client symptom severity predict counseling outcome among Canadian Indigenous peoples?

method

PARTICIPANTS

The initial sample included 279 Canadian Indigenous clients who attended at least one session at the counseling center between October 2004 and

November 2011. Of these clients, 179 (64.2%; 66 male, 111 female, and two who did not indicate gender) participants between the ages of 18 and 61 years, with an average age of 32.94 (SD = 9.88), had baseline and follow-up outcome data and were included in the analysis. The average number of sessions attended was 6.93 (SD = 7.08). In terms of ethnicity, the sample included 93 First Nations participants and 86 Métis. As seen in Table 1, the mean income of participants was $18,221 ($SD$ = $27,896) and the mean age was 32.94 (SD = 9.88). Participants' first languages included English (n = 171; 95.5%), Aboriginal (n = 2; 1.1%), and other (n = 5; 2.8%); one participant (0.6%) did not specify first language. Because this study is focused on measuring client outcomes, we only examined data for participants with a baseline outcome score and an outcome score collected at the final session. In accordance with the Government of Canada (2006) guidelines at the time of data collection, participants were identified as belonging to one of two broad, distinct groups of Canadian Indigenous peoples: First Nations and Métis.

SAMPLING PROCEDURE

Archival data from a community-based charitable counseling center in an urban city in western Canada were used in this study. The institutional review board provided an exemption because the data utilized in the study were archival, and alliance and outcome data collection was part of standard practice at the counseling center. Clients complete a consent form upon initiation of services. This form includes consent to allow their data to be included or excluded from research that may be conducted. The counseling center offers a full range of counseling services to the community, including Indigenous and non-Indigenous clients. Clients are primarily self-referred, but referral sources also include physicians, school counselors, the provincial court, and child

TABLE 1

Bivariate Comparisons of Study Variables and Differences Between Men and Women

	Overall (N = 179)		Women (n = 111)		Men (n = 66)		
Characteristic	***M***	***SD***	***M***	***SD***	***M***	***SD***	***p***
Demographics							
Age (in years)	32.94	9.88	33.14	10.02	32.92	9.70	.891
Income (in dollars)	18,221	27,896	18,972	30,143	17,142	24,313	.678
Baseline severity							
OQ-45 Session 1	71.68	30.98	78.03	29.15	64.18	29.38	.003
Therapeutic alliance							
SRS Session 2	38.08	3.05	38.42	2.59	37.44	3.69	.137
SRS Session 3	38.36	3.33	38.71	3.45	37.83	3.11	.227
Therapeutic outcome							
Change in OQ-45	–13.02	24.88	–13.79	23.86	–11.94	26.96	.635

Note. Two participants did not identify gender. OQ-45 = Outcome Questionnaire–45; SRS = Session Rating Scale.

protective services (Babins-Wagner, 2011). The center provides counseling to a broad cross-section of clients within the city and surrounding area. The counseling center tracks outcomes of all clients on a session-by-session basis. The outcome and alliance measures completed by clients in this setting are part of standard, everyday practice with the aim of improving services.

MEASURES

Session Rating Scale. The Session Rating Scale (SRS; Version 3.2) was developed by Johnson (1995) as a tool to track clients' perspectives of the therapeutic alliance. Other alliance related measures influenced its development, including the Working Alliance Inventory (Horvath & Greenberg, 1986) and the Empathy Scale (Burns & Nolen-Hoeksema, 1992). The SRS is a 10-item client self-report scale; each item is ranked on a 5-point Likert scale (range = 0–4) with a maximum score of 40. Higher scores indicate a more positive view of the alliance and lower scores reflect a more negative appraisal. A score of 35 or less suggests that the alliance may be at risk, and the counselor is advised to ask the client for feedback at that time (Babins-Wagner, 2011).

The SRS was examined with 39 clients in a brief counseling clinic in the western United States (Stanford, 1999). Item analysis of the SRS showed a Cronbach's alpha reliability coefficient of .89 (Stanford, 1999). The first six items, measuring alliance, returned a high alpha of .86, whereas Items 7, 9, and 10, measuring session impact, provided an alpha of .75 (Stanford, 1999). The items measuring session impact include the domains of agreement on treatment (i.e., the degree to which the client agrees with the counselor's treatment approach), helpfulness/usefulness of the session, and hope (i.e., the degree of hope the client felt at the end of the session; Johnson, 2000). Interitem analysis of these items yielded moderate to strong correlations (Item 7: $r = 41$, Item 9: $r = .60$, Item 10: $r = .59$, $p < .01$) with other items in the SRS (Johnson, 2000). According to Johnson (2000), Item 8 assesses ideas about change, and this specifically addresses the degree to which the client's ideas about how therapeutic change might take place were incorporated into the session. Item 8 was moderately associated with session impact ($r = .36$, $p < .01$).

Concurrent validity of the SRS was not addressed (Duncan et al., 2003). Cronbach's alpha was recalculated in 2008 using 803 SRS scores, and the alpha was .87 (Babins-Wagner, 2011). The 10-item SRS used in the current study influenced the development of a brief four-item alliance measure also called the Session Rating Scale (Version 3.0; Duncan et al., 2003). The 10-item SRS (Version 3.2) was used in this study and is standard practice in this setting because this version of the SRS was deemed to provide more substantive content about process issues in the alliance than the shorter version of the SRS.

OQ-45. The OQ-45 is a 45-item self-report measure targeting symptoms of psychological disturbance (primarily anxiety and depression), interpersonal relationships, and social role functioning (Lambert & Shimokawa, 2011). The

OQ-45 consists of a total score (based on all 45 items) and three subscales: Symptom Distress, Interpersonal Relations, and Social Role (Lambert & Shimokawa, 2011). The total score for the OQ-45 ranges from 0 to 180, with higher numbers indicating higher symptom distress severity. It has demonstrated adequate test–retest reliability (r = .84; Lambert, Burlingame, et al., 1996) and validity across varied settings in both clinical and normative populations and excellent internal consistency (Cronbach's α = .93; Lambert, Hansen, et al., 1996). The OQ-45 also has strong concurrent validity (r = .55–.85) with the Symptom Checklist–90–Revised, Beck Depression Inventory, Zung Self-Rating Anxiety Scale, State–Trait Anxiety Inventory, Inventory of Interpersonal Problems, and Social Adjustment Scale (Beckstead et al., 2003). OQ-45 scores have been found to remain stable over time in untreated populations while also being sensitive to change in treated populations (Vermeersch, Lambert, & Burlingame, 2000).

PROCEDURE

Data collection took place between October 2004 and November 2011. The policy at the study setting was for all clients to complete the OQ-45 measure at the beginning of every session and the SRS alliance measure at the end of every session. We administered the OQ-45 and SRS in English in accord with the counseling center policy. Clients' first sessions are therapeutic counseling sessions, as contrasted with comprehensive intake sessions, and clients typically work with one counselor throughout their treatment unless the counselor leaves the agency or in cases of deliberate transfer. These data were collected and entered into a database for the purposes of tracking individual client outcome and for aggregate analysis to determine overall outcomes of the center. Inclusion criteria were that participants had an OQ-45 score at the first session and also at the last session. Additionally, because the alliance was assessed at the second and third sessions, inclusion criteria required an SRS score at these sessions.

In the current study, the OQ-45 total score was used as the outcome variable. The clinical cutoff for the OQ-45 represents cutoff between a score in the "dysfunctional" range, which is indicative of a clinical population, and a score typical of a "functional" nontreated population (Kendall, Marrs-Garcia, Nath, & Sheldrick, 1999). A score of 64 or higher falls within the dysfunctional (clinical) range, and a score of 63 or lower falls within the functional (nonclinical) range (Kendall et al., 1999).

The OQ-45 has a reliable change index of 14 points based on clinical and normative data. Consequently, clients who change by 14 points in a positive or negative direction are considered to have made "reliable change" (Lambert, Hansen, et al., 1996). This 14-point change in outcome is a high standard of change that reduces the likelihood that client changes occurred by chance (Babins-Wagner, 2011). The OQ-45 has been identified as the "gold standard of outcome assessment for outpatient practice" (Duncan, Miller, & Sparks,

2004, p. 87) and, given its rigorous study, is well suited for tracking treatment response. The current study analyzed OQ-45 total scores as continuous variables.

DATA ANALYSIS

We used descriptive statistics to analyze demographic variables. To determine the overall relationship between baseline symptom severity (i.e., first session OQ-45 score) and symptom severity at the end of treatment (i.e., last session OQ-45 score), we conducted a paired-samples *t* test. Independent-samples *t* tests were used to determine gender differences for variables of interest, including initial symptom severity, alliance, outcome, and income. Multivariate analyses included two multiple regression analyses with change in OQ-45 score from first session to last session as the outcome variable. The regression analyses included variables that were found significant at the bivariate level and variables of theoretical interest. The first multiple regression included the predictor variables of alliance at Session 2, and alliance at Session 3 was included in the second regression analysis. Other predictor variables included in both regression analyses were initial symptom severity, income, and gender.

results

Bivariate comparisons of demographic variables, baseline symptom severity, alliance, and outcome, with differences between men and women, are presented in Table 1. Baseline symptom severity based on gender was significant ($p = .003$), with women experiencing higher levels of symptom severity ($M = 78.03$) at baseline than men ($M = 64.18$). The results of the paired-samples *t* test indicated statistically significant participant improvement overall, based on an OQ-45 mean score of 72.87 ($SD = 29.92$) at the baseline session and a mean score of 59.84 ($SD = 31.53$) at the final session, $t(178) = 7.01$, $p < .0001$, $d = 1.05$. These findings indicate a statistically significant overall change from first session to last session of –13.03 points, with a large effect size. Average participant OQ-45 scores moved from the clinical range (64 or higher) to the nonclinical range (63 or lower). No significant correlation was found for the first-session alliance and OQ-45 change from first session to last session ($r = –.06$, $p = .524$).

The first multiple regression analysis model fit was statistically significant, $R^2 = .14$, $F(4, 106) = 4.21$, $p = .003$. Significant predictors in this analysis included baseline symptom severity ($\beta = –.30$, $p = .001$) and the therapeutic alliance at Session 2 ($\beta = –.20$, $p = .033$), and these two variables accounted for 14% of the variance in outcome. The second multiple regression analysis yielded a statistically significant model fit of $R^2 = .15$, $F(4, 81) = 3.619$, $p = .009$. Significant predictors in the analysis were baseline symptom severity ($\beta = –.32$, $p = .003$) and the alliance at Session 3 ($\beta = –.23$, $p = .028$), accounting for 15% of the variance in outcome.

discussion

The overall outcome of counseling with Canadian Indigenous peoples in this setting indicated statistically significant improvement that yielded a large overall effect size, $t(178) = 7.01$, $p < .0001$, $d = 1.05$. In addition, multiple regression analyses findings indicated that baseline symptom severity, the alliance at Session 2, and the alliance at Session 3 were significant predictors of counseling outcome. The negative correlation coefficients of each of the predictor variables, including baseline symptom severity ($r = –.31$), Session 2 alliance ($r = –.22$), and Session 3 alliance ($r = –.23$), indicate that as these variables increased there was generally a decrease in participant symptom severity by the end of treatment. For example, because lower scores on the OQ-45 are associated with lower symptom severity, the negative correlation coefficient of Session 3 alliance ($r = –.23$) indicates that stronger alliances at Session 3 predicted participant improvement. These results are similar to correlations found in meta-analytic research of alliance and outcome within the general population (Horvath & Bedi, 2002). For example, Horvath, Re, Flückiger, and Symonds (2011) conducted a meta-analysis on alliance and counseling outcome. Based on "190 independent alliance–outcome relations representing over 14,000 treatments" (p. 47), they reported a medium effect size ($r = .28$). The current results provide new empirical evidence that the therapeutic alliance is predictive of counseling outcome, specifically with an Indigenous population.

It is noteworthy that the Session 1 alliance yielded a nonsignificant finding ($r = –.06$, $p = .52$) in relation to overall outcome from first session to last session. Although early alliance has been examined in numerous studies, fewer studies have specifically investigated alliance at the first session. Kokotovic and Tracey (1990) and Plotnicov (1990) reported that first-session alliance scores were predictive of counseling dropouts. Other literature on early alliance has indicated that the alliance peaks at Session 3 (Horvath & Luborsky, 1993), with earlier sessions potentially reflecting a greater level of client transference (Gelso & Carter, 1985). Additionally, a study of couples counseling found that first-session alliance did not predict outcome, in contrast with later alliance scores (Anker, Duncan, & Sparks, 2009). Although the research literature on first-session alliance is mixed, it is clear that early alliance, but not necessarily first-session alliance, is a consistent predictor of overall client outcome (Arnow et al., 2013; Gullo, Lo Coco, & Gelso, 2012; Horvath et al., 2011; Horvath & Symonds, 1991). Based on results from the current study, it makes logical sense that first-session alliance may not be a useful predictor of outcomes, principally because establishing a strong working alliance may take longer with an Indigenous population. However, further research is needed to clarify the meaning of this finding.

Gender was not a significant predictor of client outcome in this study. Although some research studies have found that client gender does predict

counseling outcome (Cottone et al., 2002; Ogrodniczuk, 2006), other studies have found that client gender is not a predictor of counseling outcome (Owen et al., 2009; Zlotnick et al., 1996). Female participants did report significantly higher levels of symptom severity ($p = .003$) at baseline ($M = 78.03$) compared with male participants ($M = 64.18$). To our knowledge, there are no existing studies that examine gender differences in baseline symptom severity. Participant income was not a significant predictor of outcome in our study.

IMPLICATIONS FOR COUNSELING PRACTICE

This study has implications for counseling with Indigenous peoples. First, the findings in this study regarding decreased participant symptom severity from the beginning to the end of counseling are similar to those found in the general population. Although there are important multicultural considerations not discernible from this data set, it also seems that some common therapeutic factors are related to participant outcomes with Canadian Indigenous clients. For example, the finding that early alliance is predictive of outcome in the current study is consistent with theoretical literature on the importance of alliance in working with Indigenous peoples.

Second, this study demonstrates the use of alliance and outcome monitoring in real-world clinical settings with an Indigenous population. The data collected were an integral part of service delivery. Not only does this approach to collecting session-by-session alliance and outcome data have potential for improving outcomes in daily practice, it is also a reasonable methodology for collecting effectiveness data with minority populations (Lambert, 2010). Regarding Canadian Indigenous clients, ongoing alliance monitoring can be a way to engage clients with cultural sensitivity. The concept of noninterference in Indigenous culture may be particularly relevant here.

Noninterference generally refers to a common cultural value among North American Indigenous peoples that includes respecting autonomy and self-determination of others and discouraging coercion, interference, or imposition of values or ways of being onto others (Brant, 1990; Wark, Neckoway, & Brownlee, 2017). Noninterference is rooted in values of egalitarianism and maintaining relational harmony, and within these Indigenous values, even relatively small and subtle attempts to persuade or influence others can be seen as negative efforts toward dominance (Brant, 1993). A basic philosophy that underlies session-by-session monitoring of the alliance is collaboration with clients about the alliance and process of counseling (Duncan, 2010). This is inherently collaborative and noncoercive when enacted according to the basic principles and intent of alliance monitoring. Using session-by-session alliance monitoring is rooted in a stance of encouraging client feedback and of counselors taking steps to not impose their own goals or values onto the client or to dictate to clients how they may need to change. Examples of items from the SRS that promote this collaborative, noncoercive stance include the clients' perspective about the degree to which they felt accepted

and respected, client–counselor agreement on the goals, agreement between client and counselor on the treatment approach, and the degree to which the client's ideas about change were incorporated into the session (Johnson, 1995).

LaFromboise, Trimble, and Mohatt (1990) pointed out that Indigenous clients are aware of and experience anxiety regarding counselors communicating, even subtly, that they may be attempting to influence or change a client's Indigenous values or attempting to coerce the client, and this is akin to psychological colonization. Intentional session-by-session alliance monitoring has the potential to minimize the risk of counselors imposing non-Indigenous values or approaches on Indigenous clients and to help counselors embody noninterference. In addition, the collaborative principles underlying alliance monitoring are aligned with scholarly work that emphasizes the importance of counselor openness and collaboration in the therapeutic environment with Indigenous clients (Gray & Rose, 2012).

LIMITATIONS

Several limitations should be acknowledged. One limitation is the use of self-report measures of both outcome and alliance. The OQ-45 has been studied extensively and is considered the gold standard for outcome measures, but this measure also has its limitations. For example, self-report measures, such as the two used in this study, are susceptible to social desirability bias. Participants could realize over time that it is desirable to rate the SRS with increasingly high scores and the OQ with increasingly low scores if they suspect that this is the desired outcome. Additionally, the SRS Version 3.2 used in this study has been researched in only two previous studies.

There were also missing data in this study. For example, out of 279 clients total with an OQ-45 score for the baseline session, only 179 (64.2%) participants had a final session OQ-45 score. Additionally, although the sample includes Indigenous participants, it is not a representative sample of all Indigenous populations. All services were provided in one urban area in Canada, which limits generalizability to Indigenous client populations living in other Canadian cities and nonurban settings. Because there are over 600 Indigenous communities in Canada (Government of Canada, 2017), there is inherently a risk of "cultural glossing"—an assumption that broad cultural groups (e.g., Indigenous peoples) are the same culturally—that occurs in quantitative research (Duran, 2006). However, in considering the alliance in working with Canadian Indigenous peoples, we refer occasionally to research with other Indigenous peoples because of lack of previous research with Canadian Indigenous peoples. Despite important differences among Indigenous groups, there are some commonalities among colonized peoples (e.g., historical trauma). Duran (2006) wrote that "regardless of the colonial identity given in name, there is a unifying thread of identity for Original people all over the world and these different names have been used as a divisive tool of oppression" (p. 11). As the first empirical data attesting to the importance of

the therapeutic alliance in treatment outcomes with Canadian Indigenous peoples in an outpatient setting, these results may or may not generalize to other Indigenous peoples in other settings.

FUTURE RESEARCH

Future studies should focus on understanding and developing culturally valid alliance and outcome measures. As Chang, Hays, and Tatar (2005) reported, results from psychological measures can be misleading if the constructs measured are manifested differently in the culture being studied. One recommendation to address this concern is to use test adaptation methods. Advantages to adapting a test or measure to a particular cultural group include the potential for increased cultural validity and fairness in assessment (Chang, Hays, & Gray, 2010). A disadvantage is that adapting a measure may detract from its content validity (Chang et al., 2010). Increasing cultural validity of measures would require dialogue and collaboration with culturally based stakeholders.

Given that no previous quantitative outpatient outcome studies with Canadian Indigenous peoples were identified in the research literature, our aim was to develop further understanding of the relationship between alliance and outcome and provide an Indigenous perspective in the quantitative literature. Some valuable areas of future research include study of cultural applicability of outcome and alliance measures with Indigenous peoples, social desirability on self-report measures, and qualitative research to better understand counselor qualities that promote strong alliances with Indigenous peoples. Additionally, it is recommended that researchers work with Indigenous communities to generate alliance measures from within their cultural perspective. Although the current study was conducted in an urban setting, nearly half of all Indigenous peoples in Canada live outside urban settings (Government of Canada, 2006). Future research could include mixed-methods studies done in collaboration with Indigenous communities at every stage of the process, in both rural and urban settings.

Consistent with recommendations in the literature for research with minority cultural groups, we recommend pilot testing of protocols and instruments when conducting future quantitative research with Indigenous peoples (Heppner, Wampold, & Kivlighan, 2007). Pilot testing allows for early identification of flaws or limits with instruments or procedures, and it can empower the group being studied.

In conclusion, we found that early participant alliance ratings and baseline participant symptom severity were significant predictors of outcome among Canadian Indigenous peoples. The strength of the relationship between alliance and outcome is consistent with existing research (Horvath & Bedi, 2002; Horvath et al., 2011). Given the robustness of client ratings of alliance as a predictor of outcome in the research literature, combined with findings from this study with Canadian Indigenous peoples, it is recommended that future research focus not only on replication of these findings, but also on how

counselors can build strong therapeutic alliances with Indigenous clients. This would require cross-culturally sensitive qualitative and quantitative research designs to help understand the nuances of how effective therapeutic alliances may differ in Indigenous populations from alliances as typically conceptualized in the White population.

Although there are few studies on this topic, there are potentially some important distinctions from Bordin's (1979) conceptualization of the therapeutic alliance, which is prevalent in counseling research, and the conceptualization of the alliance among Indigenous populations. For instance, Weinstein (2006) found that appropriate self-disclosure and involvement in the Indigenous community were important elements of building strong therapeutic alliances with Indigenous clients. Indeed, a theme from qualitative research and theoretical scholarly work is that building effective alliances within Indigenous populations involves building alliances with the community in addition to the individual client (Gone, 2009; Smith & Morrissette, 2001; Weinstein, 2006). Thus, future research must focus on dimensions of the therapeutic alliance that are unique to Indigenous peoples. This will necessarily involve intercultural collaboration in developing culturally valid alliance measurement tools and research protocols that enhance understanding of the unique dimensions of the therapeutic alliance from Indigenous perspectives.

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