

**ONE LESS BARRIER TO ALLIANCE: IMPROVING OUTCOMES OF
PSYCHOTHERAPY & OMBUDS PRACTICE IN VISIBLE MINORITY
COMMUNITIES**

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Abstract

As psychotherapy and ombuds services become more accessible in our societies, some groups are still marginalised. Research shows that visible minorities are much less likely to report a positive outcome or even continue seeking these services after one session. Research shows that one of the main reasons for this unfortunate reality is the lack of alliance that visible minorities feel, especially when their service providers are non-minorities. Finally, research shows that a strong alliance is key to retention and positive outcomes. The current research aims to study the EASE model in psychotherapy and ombuds services; a model that emphasises empathetic listening, acknowledgement of circumstances, solving (through sensible action) and evaluating (through exploration of thoughts) (EASE). Perceived use of EASE skills in services as usual was explored in relation to alliance, mental health, and other outcomes. In study 1, the psychotherapy sample consisted of 53 participants, 28 of whom were visible minorities and 25 non-minorities; nine participants had seen psychotherapists who were visible minorities while 33 participants had seen psychotherapists who were non-minorities. In study 2, the ombuds service sample consisted of 14 participants, six of whom were visible minorities and three who were not visible minorities: three participants had seen ombuds who were visible minorities, and six participants had seen ombuds who were non-minorities. These studies used a knowledge translation integrated (KTI) and mixed methods approach. These studies included measures of alliance, EASE, Meaning Mindset, mental health, and client-rated therapist multicultural competence. The hypothesis was that participants, clients or visitors, who had worked with service providers whom they perceived to have used EASE skills would score higher on these measures, and would be more likely to complete services, rather than terminate prematurely. This research used a KTI approach to collaborate with visible minorities to improve their experience in psychotherapy and ombuds services so that they are more likely to benefit from them.

This thesis is an article format thesis. The first chapter introduces psychotherapy and ombuds services with relation to the variables relevant to the current research. The second chapter is an article on study 1, concerning the psychotherapy client population. The third chapter is an article on study 2, concerning the ombuds visitor population. The fourth chapter is an overarching discussion.

Keywords: psychotherapy, ombuds, visible minority, alliance, retention rate, mental health

Chapter 1

Overarching Introduction

Despite increased accessibility to psychotherapy and ombuds services, visible minorities continue to face significant barriers in receiving equitable care (McGuire & Miranda, 2008; Khan et al., 2017; Lu et al., 2021). Studies reveal that these individuals are less likely to report positive outcomes or continue services beyond an initial session, mainly due to a lack of alliance with non-minority service providers (OHRC, 2004; Vaughan et al., 2009). Although psychotherapy is a health service and ombuds practice is not; both are aimed at enhancing well-being. For both types of services, visible minorities are less likely to report good mental health outcomes (Chow et al., 2003; Wong et al., 2016).

Racial disparities in health care are well-documented, stemming from socioeconomic inequities, underrepresentation in service providers, and culturally insensitive care, all of which contribute to poorer health outcomes for minority populations (Vaughan et al., 2009; OHRC, 2004). In psychotherapy, visible minorities experience additional challenges, including biased assessments, stigma surrounding mental health, and premature termination of services, which can further hinder effective treatment (Sue et al., 1991; Wong et al., 2016). Exploring the connection between psychotherapy and ombuds practice, research suggests that trust between an ombuds and a visitor—like the therapeutic alliance in psychotherapy—may play a crucial role in fostering well-being, cooperation, and compliance with collaborated recommendations (Creutzfeldt & Bradford, 2016; Tasca & Marmarosh, 2023). Research consistently highlights the critical role of alliance— trust, communication, and collaboration between provider and client—in improving retention and service outcomes (Horvath & Symonds, 1991; Kim et al., 2008). Strengthening alliance may, therefore, be a key factor in addressing racial disparities, potentially

enhancing the effectiveness of psychotherapy and ombuds services for visible minorities, regardless of the provider's background.

Racial Disparities in Health Services

Visible minorities have long been disadvantaged in the health care system and over decades, not much has changed (Todd et al., 1993; McGuire & Miranda, 2008; Macias-Konstantopoulos et al., 2023). For this research, the operational definition of visible minority is the one defined by the Employment Equity Act (Government of Canada, 2015). The Employment Equity Act defines visible minorities as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (Government of Canada, 2015). Harvard University has begun offering a course titled “Reducing Racial Disparities in Health Care.” (Harvard University, n.d.). In other words, there are still enough racial disparities in our health care systems that there are entire university courses offered on the subject. Differences in the experience of health services for visible minorities compared to their non-minority counterparts have been heavily documented, as have social, community, and systemic potential contributing factors (Vaughan et al., 2009; Hamed et al., 2022; Yearby et al., 2022). On the one hand, visible minorities have long experienced socioeconomic inequities, issues with cultural assimilation, housing discrimination and differences in neighbourhood preferences (Vaughan et al., 2009). According to Vaughan and their colleagues, these factors create both racial isolation within neighbourhoods and uneven racial distribution across neighbourhoods, resulting in racial differences in environments and the individuals residing in them (2009). Visible minorities also experience higher concentrations of poverty in their neighborhoods due to higher rates of unemployment and low-income, less proximity to health service providers, less access to information, education and resources, and poorer housing and neighbourhood

conditions (Vaughan et al., 2009; Chow et al., 2003). More specifically, according to the Ontario Human Rights Commission, racial disparities in health services are a result of socioeconomic factors, the under-representation of racialised groups in service providers and issues in communication, the delivery of culturally sensitive care, and the impact of clinical decisions on health outcomes (2004). Related to these risk factors, poorer nutrition and fewer exercise programs in lower socio-economic communities, as well as more stress and psychosocial issues, and lower social support also put visible minorities at greater health risks (Vaughan et al., 2009). Given these significant health risks for visible minorities, compared to non-minorities, culturally sensitive health care models must be put in place so that visible minorities receive appropriate care.

In addition to health risks that result in greater need for services, visible minorities have also long experienced disparities in health service referral patterns and admitting privileges, institutional discrimination, issues with third-party payer contracts, issues of cultural competence on the part of service providers and health organisations, and service provider preferences (Vaughan et al., 2009). These experiences lead to racial isolation within health care organisations as well as uneven racial distribution across organisations which result in racial differences in access to high-quality services, patient-provider cultural concordance, access to specialty services and general practice patterns (Hamed et al, 2022; Macias-Konstantopoulos et al., 2023). In the end, these differences result in disparities in the utilisation of health services as well as inequalities in the outcomes of health care (Hamed et al, 2022; Macias-Konstantopoulos et al., 2023).

Further socioeconomic factors that directly affect health include the ability to control stressful situations, good quality of life, job security, education, and the ability to access paid

health care services and medications, all of which visible minorities experience less than their non-minority counterparts (OHRC, 2004; Yearby, 2018). Less than half of low-income Canadians rated their health as very good or excellent compared to 73% of high-income Canadians, illustrating the disparity in health outcomes due to income differences (OHRC, 2004). The under-representation of racialised groups in health care providers means poorer perception of alliance between patient and provider, language barriers in services, and difficulties in conveying pertinent health information (OHRC, 2004; Cooper & Powe, 2004). Additionally, Health Canada has reported that visible minorities face health risks due to a lack of access to culturally appropriate health services (OHRC, 2004). This is, in part, due to the under-representation of racialised groups in providers and the heavily documented positive impact of an ethnic match between patient and health provider (Saha et al., 1999; OHRC, 2004; Cooper & Powe, 2004). Finally, many studies have shown differential health outcomes for visible minorities due to differential clinical decision-making (OHRC, 2004). Research has shown that visible minorities are less likely than their non-minority counterparts to receive larger procedures such as surgeries, as well as smaller treatments, and they are less likely to receive diagnoses for illnesses (OHRC, 2004). One key issue related to the above health difference, outcomes, and minority status is alliance with a practitioner (Kim et al., 2008).

Importance of Alliance in Health Services

The relationship between a client and a service provider in health care has not been robustly documented but the existing findings are significant. In 2008, Kim and their colleagues defined this relationship as one of effective communication, integration by both parties, collaboration and empowerment of the patient. They found that patient-practitioner relationships that prioritized these were perceived more positively by the patients and had higher patient

satisfaction scores (Kim et al., 2008). Fuertes and their colleagues found that when patients reported a stronger alliance with their physicians, they were more likely to believe their treatment to be useful and effective, more likely to believe that they can adhere to the treatment, more likely to follow through on treatment plans, and reported higher levels of patient satisfaction (2007). A strong alliance has also been consistently found to influence mental health outcomes regardless of interventions, type of therapy, duration, and type of outcome measure (Horvath & Symonds, 1991; Fluckiger et al., 2018). Therefore, not only does alliance predict client retention and general positive outcomes, but it also specifically predicts increased mental health outcomes (Tasca et al., 2023). Two types of practitioners who aim to enhance mental health are psychotherapy and ombuds practice. Ombuds practice was envisioned early on as a route for primary prevention and intervention approach for mental health (Wolkon & Moriwaki, 1977). Like ombuds practice, which promotes well-being through effective conflict resolution through the service provider and visitor relationship, psychotherapy seeks to improve mental health by fostering a strong relationship between the service provider and the client (Epperson & Armstrong, 2024). Thus, for both fields, racial disparities may play a role in service outcomes, including higher rates of service drop out for visible minorities (Sue et al., 1991; Swift & Greenberg, 2012; Owen et al., 2012).

Racial Disparities in Psychotherapy and Ombuds Practice

In the context of psychotherapy services, for decades, clients who have identified as visible minorities have had a difficult time accessing appropriate mental health care (Sue et al., 1991; Lu et al., 2021). Historically, psychological tests have typically been standardised and validated with non-minorities, which means that they do not fairly represent the experiences of visible minorities (Jones and Thorne, 1987; American Psychological Association, 2016).

Psychological examinations have often reduced or ignored variations in culture, language, and social position (Jones & Thorne, 1987; American Psychological Association, 2016). Second, there has been a reported consistent discriminatory treatment by therapists that is still ongoing: minority clients have frequently experienced worse quality care, higher rates of treatment discharge, shorter sessions, and a sense of bias from their therapist (Yamamoto et al., 1968; Office of the Surgeon General, 2001; Hamed et al., 2022). Furthermore, studies reveal that stigma around mental health is more prevalent among visible minorities than it is among non-minorities (Wong et al., 2016). Research also shows that minorities are less likely to seek treatment because they are more prone than non-minorities to hide mental health issues and feel inferior due to mental illness (Wong et al., 2016). Ultimately, it has been demonstrated that several conventional mental health interventions are unsuccessful for visible minorities (Sue et al., 1991; Alegria et al., 2010). Regrettably, White professionals have historically dominated institutional power positions in our health care institutions; as a result, the perspectives of visible minorities are frequently given little weight (Mensah et al., 2021). Additionally, according to a 2015 assessment by the American Psychological Association, 86% of psychologists in the US were White (Lin et al., 2018). This is problematic because, as stated earlier, research shows a significant positive impact of an ethnic match between patient and health provider (Cooper & Powe, 2004; OHRC, 2004; Sue et al., 1991).

In the context of ombuds services, though there is not much research on the racial disparities in the professional field, the existing research shows that ombuds are increasingly serving visible minority populations and working with issues of equity, diversity and inclusion (McGhee Peggs & Epperson, 2021). Although these issues are increasingly seen, visible minorities are significantly underrepresented among those seeking ombuds services (Department

of Justice Canada, 2024), despite that they are more likely to experience racism, stigma, or be minimised at work than their non-minority counterparts (Office of the Ombuds-Shared Services Canada, 2023). This lower service access to ombuds practice by visible minorities is comparable to lower service access for psychotherapy services by visible minorities (Grace et al., 2016). It is, therefore, important to understand what can lead to effective services for minorities to enhance fit, which could improve access in the first place. Finally, in addition to service access, another significant racial disparity in psychotherapy and ombuds services is service dropout.

Unfortunately, visible minorities are much more likely to terminate services prematurely, which can impact the overall outcome of the services (Sue et al., 1991; Owen et al., 2012).

Importance of Addressing Outcomes in Psychotherapy and Ombuds Practice for Visible Minorities

Although mental health services are more accessible now than ever, the Canadian Mental Health Association found that only about 16% of people who need mental health services access these services with a mental health professional (2021). In Canada, research shows that by age 40, about 50% of the population will have or have had a mental illness (Canadian Mental Health Association, 2021). And although mental illness affects people of all ages, genders, cultures, education and income levels, systemic inequalities like discrimination and racism, poverty and homelessness, and colonial and gender-based violence can make mental illness more prevalent in communities of visible minorities, especially if mental health resources are difficult to access (Canadian Mental Health Association, 2021). Therefore, accessible effective mental health support is critical. As immigration rates increase, with every one in four people in Canada being part of a racialized group as of 2022, this may be even more important (Hou et al., 2023).

Interestingly, ombuds practice, now associated primarily with conflict resolution, was originally designed as an intervention for psychological disorders (Wolkon & Moriwaki, 1977). Therefore, not only do ombuds work with people who have significant mental health needs, it is generally beneficial to have more professionals in our communities that effectively work with mental health to further access. As previously noted, a core ingredient for effective services for visible minorities may be the alliance between a service provider and recipient (Tasca & Marmarosh, 2023). However, little is known about how to practically enhance alliance: What are the “ingredients” to simmer alliance? A theory is needed to build a protocol that could promote alliance and improve mental health, in service provider relationships, particularly for those who are underserved or whose needs are not being met in existing approaches.

Theoretical Framework

Meaning Mindset Theory. Building on Frankl’s Logotherapy, Meaning Mindset Theory (MMT) posits that every challenge can produce something positive (Armstrong & Potter, 2022). Frankl’s Logotherapy emphasises the unique experience of a person’s everyday life, and how one can feel a sense of purpose by being grateful and connecting with meaningful moments each day (Frankl, 1986). Frankl believed that having a sense of meaning in life is critical to well-being and that a person can get through any difficulty in life by having a felt sense of meaning (Frankl, 1986). MMT asserts that challenges can be channelled positively and can even produce motivation and meaningful transformation, especially if the challenges offer opportunities for connectedness, creativity, or growth (Armstrong & Potter, 2022). Having a Meaning Mindset (MM) entails having agency over one’s thoughts and behaviours, a positive self-concept, openness to experience, and hope for the future (Armstrong & Potter, 2022). This means having the belief that one is capable of and responsible for their attitudes, actions and feelings; the belief

that one is worthy and capable of achieving their goals and finding meaning in their everyday life; the attitude of curiosity and a desire to learn new things, as well as appreciate the present moment; and the belief that the future can be promising, despite the present hardships (Armstrong & Potter, 2022). MM is the practice of recognising and appreciating valued experiences, connections, or moments of awe found in nature, art, music, and human relationships, often linked to self-transcendent states like mindfulness, flow, or spiritual experiences (Frankl, 1946/1986; Keltner, 2023; Shiota et al., 2014).

Adopting a Meaning Mindset can be done through the CHANGE protocol (Armstrong & Potter, 2022). Firstly, individuals who adopt this mindset **challenge** their unhelpful thoughts whenever they come up and transform them into healthier and more wholesome thoughts (Armstrong & Potter, 2022). Secondly, these individuals incorporate **healthy** actions into their daily lives to spend more time feeling good (Armstrong & Potter, 2022). They **acknowledge** their circumstances; focusing on what they can control and letting go of what they cannot (Armstrong & Potter, 2022). They also recognise the **need** for belonging and self-compassion and make efforts to develop strong connections with others and themselves (Armstrong & Potter, 2022). They also practice **gratitude** regularly and effectively use **emotional** language (Armstrong & Potter, 2022). Research shows that implementing these steps leads to positive coping with challenging circumstances and an increase in mental health (Armstrong & Potter, 2022).

Meaning mindset and mental health. Having a Meaning Mindset has been shown to set people up for success: a sense of meaning has long been a predictor of emotional, social and behavioural well-being (Ivtzan et al., 2015). Not only is the adoption of a Meaning Mindset helpful in positive coping and building resilience during difficult life events, but it is also important for building resilience for future challenges (Wong, 2017). Furthermore, the teaching

of MMT strategies has been found to increase meaning in daily life and mental health in various populations such as children, neurodiverse people, homeless people, blended families and families on mental health waitlists (Armstrong et al., 2025). In studying the effects of the COVID-19 pandemic, researchers found that people who used MMT strategies and tried to cope with challenges by focusing on positive aspects of the pandemic experience, such as spending valued family time, reported lower levels of mental illness and greater levels of well-being (Armstrong & Potter, 2022). Therefore, a Meaning Mindset can lead to positive mental health outcomes.

Stoic Dichotomy of Control. The Stoic dichotomy of control (SDC), an inspiration for Cognitive Behavioural Therapy, posits that we cannot control events, but we can control our evaluations of those events and our responses to them (LeBon, 2023). The Roman Stoic Epictetus states in his *Enchiridion* that “You will lament, you will be disturbed, and you will find fault both with gods and men” (2012). He also states that “some things are in our control and others not. Things in our control are opinion, pursuit, desire, aversion, and, in a word, whatever are our own actions. Things not in our control are body, property, reputation, command, and, in one word, whatever are not our own actions” (Epictetus, 2012). Stoicism, the philosophy upon which the Stoic dichotomy of control is based, asserts that most things in life are outside of our control (Smith, 2024). Stoics believe that our emotions are a direct result of our worldview and that we must accept that we will face difficulties occasionally, like everyone else (Smith, 2024). Stoicism also encourages us to see ourselves as a part of a collective human race and as part of nature, as opposed to individual beings (Smith, 2024). Finally, stoicism encourages us to think of everything we own as a loan that will be taken back one day; that everything we experience, and own, is temporary (Smith, 2024).

Epictetus warned that the only way to *ataraxia* (feeling of tranquillity regardless of circumstance) is to cease worrying about things that are beyond the power of our will (2012). He believed that much of a human being's unhappiness is a result of thinking that they have control over certain things when in fact, they do not (LeBon, 2023). Indeed, research has shown that balancing the dichotomy of "controlling the controllables" while "letting go of things outside of one's control" has a significantly high association with well-being (LeBon, 2023). Research has also shown that this dichotomy is significantly correlated with a balance of positive over negative emotions (LeBon, 2023). Furthermore, there is evidence that integrating the dichotomy of control in one's life can increase a person's resilience to difficulties, flourishing and overall levels of satisfaction with life (LeBon, 2023). On the contrary, ruminating over events, instead of letting them go, has been strongly associated with depression while overthinking about future events that are outside of our control has been strongly associated with general anxiety (LeBon, 2023). Additionally, social anxiety has been shown to be exacerbated by worrying too much about other people's judgment, and anger and frustration have been shown to increase when people assume that they can control others (LeBon, 2023). Therefore, integration of the stoic dichotomy of control can lead to positive mental health outcomes.

EAR. The EAR approach focuses on **e**mpathy, **a**ttention and **r**espect. This approach can be used with anyone, even outside of a therapeutic or ombuds setting, as it is simply a way to listen to someone effectively when they are upset so that they may calm down (Eddy, 2018). It is particularly helpful in de-escalating a dispute or collaborating for a peaceful resolution (Eddy, 2021). This approach suggests making an "EAR Statement" which emphasizes empathy, attention and respect. It begins with showing that you are connecting with the feeling that the person may be experiencing, e.g. through reflective listening, and that you want to help them

(Eddy, 2018). For example, a listener might say, “I can hear how frustrated you are by this situation. I’d like to help.” Then, it is important to show that you are willing to pay attention, through your words, tone of voice and body language (Eddy, 2018). For example, at this point, a listener might ask, “why don’t you talk to me about it so I can really understand?” Finally, it is important to show respect, through words, for the person and their problem so that they feel that they are valued and taken seriously (Eddy, 2018). For example, a listener might finally say, “I have a lot of respect for how you have tried to handle this problem so far.”

The EAR approach suggests that most people calm down within 30 seconds of hearing an EAR statement which then allows them to discuss their problem and collaborate on a resolution (Eddy, 2018). This demonstrates the power and benefit of making someone feel heard through empathy, attention and respect. Therefore, the EAR approach not only makes the upset person feel that their feelings are valid and important, but it also allows the listener to connect with the upset person, so that problem-solving is possible (Eddy, 2018). As stated previously, the use of empathetic listening has been consistently shown to be a critical condition for change (Kwon & Jo, 2012). Furthermore, the EAR approach works due to emotional contagion (Eddy, 2021). Brain research has shown that our mirror neurons can mirror the emotional expressions we see in front of us (Eddy, 2021). Thus, if a listener reacts to an upset person with an expression of empathy, attention and respect, the upset person will mirror their emotional expression and begin to calm down (Eddy, 2021). It is important to note that the EAR approach works best when there is already an established alliance between the upset person and their listener (Eddy, 2011). However, as stated previously, empathetic listening has been demonstrated to be critical in establishing alliance in the first place, which illustrates a two-way relationship between empathetic listening and strong alliance (Wynn & Wynn, 2006). In ombuds practice, an EAR

approach may be helpful in calming an agitated and highly emotional visitor and allowing space for a successful resolution. In a psychotherapy session, an EAR approach may be helpful in calming a dysregulated client and allowing space for successful therapy.

EASE

EASE is a new approach that can be used by psychotherapists and ombuds alike, which integrates the EAR approach, the Stoic dichotomy of control (SDC) and Meaning Mindset Theory (MMT), aimed at enhancing alliance (Epperson & Armstrong, 2024). The EASE model uses the skills of empathy, acknowledge, solve, and evaluate (Armstrong et al., 2025). Service providers who use EASE will naturally show empathy, attention and respect when listening to their clients or visitors (EAR). This approach involves the practice of reflecting and summarizing feelings and thoughts, as well as exploring content and feelings with an attitude of openness, genuineness and curiosity (Epperson & Armstrong, 2024; Armstrong et al., 2025), acknowledging their client or visitor's "uncontrollable" circumstances while working towards options of solving the problem involving sensible action that is within their control (SDC). Finally, they will evaluate and explore the client or visitor's difficult feelings as well as their sense of agency over their thoughts and behaviours, their self-concept, openness to experience, and hope for the future (MMT).

EASE aims at the following (Epperson & Armstrong, 2024):

- Attention: Giving a problem attention to understand what is going on for the person; responding with empathy.
- Biases: Checking in with one's own potential biases and setting them aside to listen non-judgementally.

- Caring: Noticing the person's feelings, showing respect, and validating their experience.
- Deepening understanding and defining the problem: Getting a true understanding of the issue from a client/visitor's perspective.
- Establish goals: Collaborating on realistic small attainable goals, based on what can be changed.
- Formulate a plan: Collaborating on tasks to solve the problem based on the reasonable and measurable goals.
- Generate agency: Exploring positive and challenging feelings and thoughts about the plan and steps to achieve the goals to reduce potential barriers for positive outcomes.

As mentioned previously, using the EAR approach in psychotherapy or ombuds services, employing empathy, attention and respect, has the potential to quickly regulate a visitor or client and allow for a successful resolution or therapeutic session (Eddy, 2021). Integrating the Stoic Dichotomy of Control can also have significant potential long-term positive impacts, as mentioned earlier. Learning to go through life with the understanding that everything we experience is temporary and that many things are outside of our control, and therefore not worthy of our worry, can empower clients and visitors (Smith, 2024). Collaborating with clients and visitors in learning and internalizing the Stoic Dichotomy of Control can increase positive emotions while decreasing negative emotions, increase resilience in the face of challenges, and generally higher levels of well-being and satisfaction with life (LeBon, 2023). Finally, as discussed previously, collaborating with clients and visitors to find meaning in their lives and experiences can have a significant impact as well. Clients and visitors who seek help are usually

experiencing a kind of difficulty or challenge in their lives and it is believed that having a felt sense of meaning can get one through any difficulty (Frankl, 1986). Meaning Mindset can build resilience in clients and visitors during challenging life events and can foster positive coping (Wong, 2017). It can also help clients and visitors foster resilience for future challenges and creates generally higher levels of well-being (Armstrong & Potter, 2022). Therefore, integrating EAR, Stoic Dichotomy of Control and Meaning Mindset, through the EASE model, in interactions with clients and visitors could have significant positive impacts.

The elements of EASE aim to foster alliance to enhance mental health and well-being for those seeking psychotherapy and ombuds services (Epperson & Armstrong, 2024). It is a structured, testable approach that integrates cognitive, emotional, and behavioural strategies grounded in MMT, Stoicism, and EAR, to support both practitioners and their clients or visitors. By emphasizing empathic listening, recognizing what can and cannot be changed, guiding individuals to focus on what is within their control, and fostering agency through thoughtful action, EASE aims to make services more accessible and effective, particularly for those who are underserved (Epperson & Armstrong, 2024), such as visible minorities.

Chapter 2

Article 1: EASE in Psychotherapy Services as Usual – Relationship with Alliance, Mental

Health, & Service Retention for Visible Minorities

Chapter 2

EASE in Psychotherapy Services as Usual – Relationship with Alliance, Mental Health, & Service Retention for Visible Minorities

Psychotherapy

The use of psychotherapy services around the world has increased rapidly in the past century. In clinical practice, there are now over 400 varieties of therapeutic approaches (Zarbo et al., 2016). In their work, psychotherapists draw these approaches from several major theoretical models. These models are composed of behavioural, cognitive, psychoanalytic, systemic, humanistic and constructionist theories (Neukrug, 2015). However, clinicians and researchers in the field have found that no single approach can be entirely effective or appropriate for all types of clients, contexts or presenting problems (Zarbo et al., 2016). In other words, a single approach cannot apply successfully to all. Therefore, to cater to each client's uniqueness and the totality of their experience in life and therapy, most psychotherapists rely on multiple theoretical modalities in their practice (Zarbo et al., 2016). According to the American Psychological Association guidelines on Evidence-Based Practice, clients are to be seen as active participants in therapy and therapists are to adjust their practices to their clients' individual characteristics and preferences for effective therapy (American Psychological Association, 2006). In 2015, a large survey of 1000 psychotherapists concluded that only 15% of them used a single theoretical approach in their work, with four being the median number of approaches used (Tasca et al., 2015). Some researchers even developed a system to choose therapeutic approaches based on “patient predisposing variables” (diagnosis, personal characteristics, environment and circumstances), “treatment context” (settings, format, frequency and duration), “relationship variables” (compatibility and alliance), and “strategies and techniques” (targets of change, how

treatment goals are mediated, and therapeutic methods) (Beutler & Clarkin, 1990). Despite these efforts, there is still a problem that impedes the delivery of otherwise effective therapeutic treatment: clients do not always stay in therapy as long as they should (Swift & Greenberg, 2012). Research shows that almost 50% of clients discontinue therapy prematurely (Swift & Greenberg, 2012). Furthermore, in visible-minority populations, the dropout rate is even higher (Arnow et al., 2007). This saddening reality invokes the need for change in this pattern for visible minority communities.

Premature Termination versus Client Retention

Ideally, clients should remain in treatment for the recommended course; this process is otherwise known as client retention (Anderson et al., 2019). When clients unilaterally terminate services before they complete the recommended course of treatment, this is considered premature termination (Anderson et al., 2019). Premature termination in outpatient psychotherapy rates range from 20% to 70% (Anderson et al., 2019). This means that at least one fifth of clients do not experience the full benefits of completed psychotherapy treatment (Anderson et al., 2019). As such, premature termination results in negative consequences for recipients of mental health services, such as lowered perceptions of therapy services, difficulty initiating treatment in the future, relapse of mental health or substance issues, and continued dysfunction (Anderson et al., 2019).

Additionally, premature termination rates affect therapists, the health care system and society as a whole (Anderson et al., 2009). For example, therapists who regularly experience premature termination not only face a loss of revenue and underutilisation of their time, but they may also experience feelings of rejection and demoralization (Swift & Greenberg, 2012). As they attempt to contact their clients and face delays in their work, new clients looking for

therapists may not find therapists who are available (Anderson et al., 2009). Mental health agencies may have similar experiences wherein they are keeping new clients at the door while their existing clients drop out unexpectedly (Swift & Greenberg, 2012). Finally, the larger society is affected when clients who drop out continue to face impairment and substance use (Swift & Greenberg, 2012). Interestingly, research shows that the greatest predictor of premature termination is, in fact, a poor therapeutic alliance (Anderson et al., 2009). To avoid such consequences, efforts to promote client retention are essential. Therefore, one way to increase client retention is effective use of therapeutic alliance (Martin et al., 2000; Tasca & Marmarosh, 2023), and understanding what factors are associated with alliance.

Therapeutic Alliance and Outcome

Over the past 20 years, psychotherapists and researchers have found that an essential part of the therapeutic process is the therapeutic alliance (Martin et al., 2000; Tasca & Marmarosh, 2023). While difficult to define, most theoretical definitions of the therapeutic alliance focus on three aspects: the affective bond between the therapist and the client, the collaborative nature of their working relationship, and their ability to agree on treatment goals and tasks (Martin et al., 2000; Tasca & Marmarosh, 2023). More generally, the therapeutic alliance is defined as the affective and collaborative bond between a therapist and their client (Martin et al., 2000; Tasca & Marmarosh, 2023).

A significant correlation has been consistently found between the quality of alliance and therapeutic outcome, including the outcome of client retention (Martin et al., 2000; Campbell et al., 2015). Some theorists have even referred to alliance as the “quintessential integrative variable” of therapy (Martin et al., 2000). In recent decades, researchers have sought to find a difference in the degree of effectiveness between therapeutic modalities but have been

unsuccessful (Martin et al., 2000). Instead, they have found a common denominator in effective psychotherapy, across modalities: a strong therapeutic alliance (Martin et al., 2000; Ardito & Rabellino, 2011; Tasca & Marmarosh, 2023). Studies have found that the strong association between alliance and therapeutic outcome suggests that the alliance itself may be therapeutic for the client, regardless of clinical interventions (Martin et al., 2000; Ardito & Rabellino, 2011).

A favourable therapeutic outcome is measured by client change. Client change is defined as improvement in the client's clinical symptoms and unhelpful characteristics, and ability to solve problems or respond to challenges outside of therapy, because of the skills learned in therapy (Sonderland et al., 2023). Client change has been found to be a result of client retention, effective use of clinical interventions and the practice of homework assignments (Sonderland et al., 2023). A model examining client change has organized the process into three primary parts: change processes, change mechanisms and ultimate outcomes (Sonderland et al., 2023). Change processes include therapy change processes (active ingredients in therapy such as therapist interventions and conditions) and client change processes (changes in client variables due to successful interventions or homework) (Sonderland et al., 2023). As a result, clients experience changes: changes in their characteristics or skills that expand to their lives outside of the therapeutic setting (Sonderland et al., 2023). Finally, ultimate outcomes, a result of these change mechanisms, are improvements in symptomology or a loss of diagnosis (Sonderland et al., 2023). Notably, a strong therapeutic alliance is key for client retention and willingness to collaborate in clinical interventions and homework (Martin et al., 2000; Ardito & Rabellino, 2011; Campbell et al., 2015; Tasca & Marmarosh, 2023). Since change processes are dependent on the success of interventions and homework, this means that a strong alliance is key for strong ultimate outcomes in psychotherapy.

Carl Rogers and his associates focused on the part of the therapeutic alliance that emphasizes the collaborative and affective bond between therapist and client (Rogers, 1957). According to their conceptualization, the therapeutic alliance is dependent on the therapist's ability to be constantly congruent, empathic and hold unconditional positive regard towards their client (Rogers, 1957). Rogers states that in a successful therapeutic relationship, while the client is in a state of incongruence (vulnerability or anxiety), the therapist should always be congruent and fully integrated in the relationship (1957). Additionally, the therapist should always be accepting of and caring towards the client and their experiences (Rogers, 1957). Finally, Rogers emphasizes empathy: that the therapist should always have an accurate understanding of the client's awareness of their own experience, in other words, the therapist should always sense the client's private world as if it were their own, but without ever losing the "as if" quality (1957). Indeed, many studies have shown that a therapist's empathetic listening is highly correlated with a strong therapeutic alliance (Myers, 2000; Kwon & Jo, 2012).

Empathetic Listening and Positive Outcomes

The benefits of empathetic listening have been extensively studied in various contexts. We now know that, for example, in a work environment, empathetic listening from supervisors is highly associated with work engagement, job satisfaction and performance (Jonsdottir & Kristinsson, 2020). In nursing research, patients consistently rank empathetic listening as the primary factor in positive experiences with their nurses (Myers et al., 2020). In the field of psychotherapy, studies conducted from 1961 to 2000 concluded that empathy is one of the most important variables to predict therapeutic outcome and that the skill of empathetic listening is significantly correlated with a strong therapeutic alliance and client retention (Kwon & Jo, 2012). The clinical use of empathy—listening empathetically to understand clients' experiences—

has also been consistently shown to be a critical condition for change (Kwon & Jo, 2012). A qualitative study has shown that clients feel heard when their psychotherapists create a safe space for exploration, do not seem negatively impacted when painful material is shared, and seem actively engaged by using techniques of questioning, paraphrasing, clarifying, and remembering details important to the clients (Myers, 2000). This research also shows that clients who report having a therapeutic alliance credit the alliance to their therapist's ability to make them feel heard and understood through these methods of empathetic listening (Myers, 2000). As such, empathetic listening has been developed as a critical skill in clinical practice (Kwon & Jo, 2012). Carl Rogers emphasized the use of this skill, arguing that therapists and counsellors should be able to understand their clients' moment-to-moment feelings and thoughts for positive therapeutic outcome (1957). Wynn and Wynn found that empathetic listening was especially important in the early stages of a therapeutic relationship, as it was critical in establishing an alliance (2006). As such, therapists who wish to have a strong alliance with their clients and retain them may wish to solidify their skill of empathetic listening.

An effective method of empathetic listening is the EAR model. Listeners who use the EAR model listen attentively and respectfully, and empathize by acknowledging the other person's feelings, experiences and circumstances, and actively connecting with them through those feelings and experiences (Eddy, 2021, p. 28-30). The result is a positive therapeutic outcome (Eddy, 2021, p. 30). The EAR approach will be discussed further.

Therapeutic Outcome in Visible-Minority Clients

Research shows that visible-minority clients tend to drop out of treatment at rates higher than non-minority clients (Swift & Greenberg, 2012). Studies have shown that about 50% of visible-minority clients terminate therapy after one session, whereas non-minority clients do not

exceed a 30% dropout rate (Sue et al., 1991; Swift & Greenberg, 2012; Lu et al., 2021). In fact, the ethnicity of clients is consistently a predictor of premature termination, even when other treatment and demographic variables are controlled (Sue et al., 1991; Swift & Greenberg, 2012).

The historical context is important here. Historically, visible minorities have been overrepresented in vulnerable subpopulations such as incarcerated or homeless populations (Office of the Surgeon General, 2001). These subpopulations have higher rates of mental disorders (Office of the Surgeon General, 2001). Furthermore, even minorities who do not fit into such subpopulations experienced and continue to experience daily struggles with systemic and interpersonal discrimination and racism, which affects their mental health (Office of the Surgeon General, 2001; Chow et al., 2003; Hackett et al., 2020). Minorities also experience higher rates of low economic status, which makes it difficult to afford certain mental health treatments (Office of the Surgeon General, 2001; Chow et al., 2003; Thomeer et al., 2023).

Beyond this, research over the past several decades has also shown that visible-minority clients have experienced many problems in attaining effective mental health services (Sue et al., 1991; Thomeer et al., 2023). Firstly, psychological assessments have generally been standardized and validated with non-minorities, and do not accurately capture the experiences of visible minorities (Jones & Thorne, 1987; American Psychological Association, 2016). Cultural, linguistic and social-status differences have typically been minimized or overlooked in the creation of psychological assessments (Jones & Thorne, 1987; American Psychological Association, 2016). Secondly, therapists have used discriminatory forms of treatment: minority clients have often felt that their therapist was prejudiced, have received poorer quality care, have been discharged from treatment more often, and have been seen for minimal durations (Yamamoto et al., 1968; Office of the Surgeon General, 2001; Hamed et al., 2022). Additionally,

research shows that visible minorities experience higher levels of stigma relating to mental health than non-minorities (Wong et al., 2016). Studies show that visible minorities are more likely than non-minorities to conceal mental health problems and feel inferior due to mental illness, therefore, they are less likely to seek treatment (Wong et al., 2016). Finally, many forms of traditional mental health treatment have been shown to be ineffective with visible minorities (Sue et al., 1991; Alegria et al., 2010). Unfortunately, there has always been overwhelming representation of White professionals in institutional positions of power within our health care systems, thus, the consideration of visible minorities' experiences is often minimal (Mensah et al., 2021).

It is also important to note that there are not many visible minorities working in the field of mental health in North America. The American Psychological Association reported in 2015 that 86% of psychologists in the United States were White (Lin et al., 2018). Therefore, when visible minority clients are searching for service providers that they feel can relate to them, based on their shared identity, they do not have much luck. This is especially problematic because research shows that clients prefer therapists whose ethnicity matches their own, especially if they are ethnic minorities (Steinfeldt, 2020). In fact, research shows a strong correlation between ethnic match of therapists and clients, and length of treatment across minority groups (Sue et al., 1991; Cooper & Powe, 2004; OHRC, 2004). Additionally, among clients whose primary language is not English, language match is a predictor of both length of treatment and outcome of treatment (Sue et al., 1991; Cooper & Powe, 2004). Research across time has also shown a direct correlation between increased numbers of visible-minority mental health professionals and utilisation of services from African American and Asian clients (Sue et al., 1991; Ziguras et al., 2003). Therefore, it would be greatly beneficial for visible minority communities to have access

to more mental health professionals who look and sound like them. However, as this is not always possible, it is critical for all mental health professionals to be multiculturally competent and culturally responsive to visible minorities, regardless of their own minority status. As immigration rates increase, with every one in four people in Canada being part of a racialized group as of 2022, this may be even more important (Hou et al., 2023).

Multicultural Competency in Psychotherapists

Multicultural competency in the field of psychotherapy has been largely defined as having the ability to work effectively with clients of diverse cultural backgrounds and the specific expertise to treat clients from minority and underrepresented groups (Sue et al., 2009; Tao et al., 2015). Since 1973, the American Psychological Association has deemed this competency an ethical imperative and has recommended its integration in all parts of the field, including practice, research, education and policy (American Psychological Association, 2008). The most used model of multicultural competence in practice is Sue et al.'s 1992 model that encourages psychotherapists to gain knowledge on their clients' cultural background and worldview and how it impacts their behaviour, develop and use culturally-relevant interventions appropriate for each client, and gain awareness of their own assumptions and beliefs and how they can impact their understanding of the client, the client's presenting problem and their interactions with the client in session (Sue et al., 2009; Tao et al., 2015).

Research shows a strong association between high ratings on therapist multicultural competency scales and therapeutic outcome, including psychological symptom reduction and positive change in behaviour (Owen et al., 2011; Tao et al., 2015). High ratings on these scales are also associated with higher ratings on scales measuring therapeutic alliance, impact of sessions (including post-session mood), and client satisfaction (including a willingness to

recommend their counsellor to loved ones) (Tao et al., 2015). Additionally, high ratings of multicultural competency are associated with higher ratings of empathy and genuineness, as well as successful repairs to ruptured alliances (Tao et al., 2015). Finally, there is a strong correlation between high ratings of multicultural competency and social and personal improvement of clients, as well as an increase in general well-being (Owen et al., 2011; Tao et al., 2015). Based on these needs—building empathy, therapeutic alliance, and multicultural competence—a theory is needed to build strong practice outcomes in these areas.

Theoretical Framework

Alliance and Mental Health

Even though mental health services are more readily available than ever, just 16% of those in need of them access the appropriate services, according to research from the Canadian Mental Health Association (2021). In fact, it has been reported that over 50% of Canadians will have had a mental illness by the age of 40 (Canadian Mental Health Association, 2021). Furthermore, structural injustices such as racism and discrimination, homelessness and poverty, colonial and gender-based violence, and difficulty accessing mental health resources can increase the prevalence of mental illness in communities of visible minorities, even while mental illness affects individuals of all ages, genders, cultures, educational levels, and economic levels (Canadian Mental Health Association, 2021). As such, accessible, high-quality mental health resources are so essential. Additionally, studies reveal a strong link between client-practitioner bonding and mental health (Horvath & Symonds, 1991; Tasca & Marmarosh, 2023). It's crucial to remember that alliance has consistently improved mental health outcomes despite a variety of factors, such as treatments, therapy type, length of treatment, and outcome measure type (Horvath & Symonds, 1991; Fluckiger et al., 2018). Alliance has been significantly correlated

with decreased psychological symptom intensity, enhanced quality of life, medication compliance, and increased global functioning in case management literature (Howgego, 2003). Higher degrees of alliance with therapists were associated with increased well-being, with 58% reporting clinical recovery and 57% reporting clinical improvement in their depressed symptoms, according to a more recent study done during the COVID-19 pandemic (Sagui-Henson, 2022). Thus, alliance particularly predicts improved mental health in addition to client retention and overall favourable outcomes. Therefore, it's critical that in their work, psychotherapists foster alliance. It is unclear, however, what factors specifically foster alliance in therapy. Building on the following theories may be helpful.

Meaning Mindset Theory. Meaning Mindset Theory (MMT), which is grounded in Viktor Frankl's Logotherapy, holds that any obstacle may lead to a beneficial outcome (Armstrong & Potter, 2022). Frankl's logotherapy places a strong emphasis on the individual experiences of daily life and how connecting with significant moments every day and practicing gratitude may help one feel purposeful in life (Frankl, 1986). According to Frankl, a person's sense of purpose in life is essential to their wellbeing and may help them overcome any challenge they face (Frankl, 1986). According to MMT, obstacles may be used constructively to foster motivation and significant change, particularly when they present chances for growth, creativity, or connection (Armstrong & Potter, 2022). Meaningful moments—or a sense of awe, gratitude, or value—arise when individuals feel a sense of agency over their thoughts and actions, remain open to new experiences and emotions, cultivate a positive social self-concept, set and achieve realistic goals, and maintain hope for a promising future (Armstrong et al., 2018). A positive self-concept, openness to new experiences, hope for the future, and control over one's ideas and behaviours are characteristics of a Meaning Mindset (Armstrong & Potter, 2022). Adopting a

Meaning Mindset involves cultivating a strong sense of self-worth, personal responsibility, and an appreciation for both growth and the present moment. It requires believing in one's ability to achieve goals, embracing learning with curiosity, and maintaining hope for a brighter future despite current challenges (Armstrong & Potter, 2022).

The Meaning Mindset can be developed through the **CHANGE** protocol, which includes the following steps (Armstrong & Potter, 2022):

- **Challenge** unhelpful thoughts and reframe them into healthier, more constructive perspectives.
- **Healthy actions** are incorporated into daily routines to foster well-being and positive emotions.
- **Acknowledge** one's circumstances by focusing on what can be in one's control and letting go of what cannot.
- **Nurture** a sense of belonging and self-compassion by building strong connections with others and oneself.
- **Gratitude** (realistic) is practiced regularly to enhance emotional resilience and perspective.
- **Express** emotions effectively using clear and constructive emotional language.

Research indicates that these skills promote positive coping with difficult situations and can improve mental health outcomes (Armstrong & Potter, 2022).

Meaning mindset and mental health. People with a Meaning Mindset (MM) are more likely to succeed because emotional, social, and behavioural well-being have long been linked to meaning (Ivtzan et al., 2015), constructive coping, and resilience development throughout trying life experiences (Wong, 2017). Additionally, it has been discovered that teaching MM

techniques improves mental health and purpose in life for a variety of populations, including children, homeless individuals, neurodiverse individuals, blended families, and families on mental health waitlists (Armstrong et al., 2025). Researchers who examined the potential impact of the COVID-19 pandemic discovered that those who employed MM techniques and attempted to deal with difficulties by concentrating on positives, such as spending valued family time, reported lower levels of mental illness and greater levels of well-being (Armstrong & Potter, 2022). Therefore, fostering a Meaning Mindset can lead to positive mental health outcomes.

Stoic Dichotomy of Control. Cognitive behavioural therapy was inspired by the Stoic dichotomy of control, which holds that although we cannot control events, we can influence how we interpret them and react to them (LeBon, 2023). The Roman Stoic Epictetus states in his *Enchiridion* that “You will lament, you will be disturbed, and you will find fault both with gods and men” (2012). He also states that “some things are in our control and others not. Things in our control are opinion, pursuit, desire, aversion, and, in a word, whatever are our own actions. Things not in our control are body, property, reputation, command, and, in one word, whatever are not our own actions” (Epictetus, 2012). The concept of stoicism, which forms the foundation of the stoic dichotomy of control, holds that the majority of things in life are beyond our control (Smith, 2024). Stoics hold that emotions are a direct product of our worldview and that we should accept that, like everyone else, we may periodically experience hardships (Smith, 2024). In addition, stoicism pushes us to view ourselves not as isolated entities but rather as members of the human race and the natural world (Smith, 2024). Last but not least, stoicism pushes us to consider everything we hold as a debt that will eventually be repaid; everything we own, and experience, is transient (Smith, 2024).

Epictetus warned that the only way to *ataraxia* (feeling of tranquillity regardless of circumstance) is to cease worrying about things that are beyond the power of our will (2012). According to him, a large portion of human misery stems from people believing they have control over things when, in reality, they don't (LeBon, 2023). In fact, studies have demonstrated a strong correlation between wellbeing and striking a balance between "letting go of things outside of one's control" and "managing the controllables" (LeBon, 2023). Additionally, studies have demonstrated a strong correlation between this dichotomy and an equilibrium of good and negative emotions (LeBon, 2023). Additionally, there is proof that incorporating the duality of control into one's life might improve one's ability to bounce back from setbacks, prosper, and generally feel content with life (LeBon, 2023). Contrarily, overthinking about uncontrollable future occurrences has been substantially linked to overall anxiety, whereas dwelling on past events rather than letting them go has been strongly linked to depression (LeBon, 2023). Furthermore, it has been demonstrated that caring excessively about other people's opinions may aggravate social anxiety, and that believing one can control others can make individuals more irate and frustrated (LeBon, 2023). Consequently, integrating the stoic dichotomy of control can have a favourable effect on mental health.

EAR. The EAR approach focuses on **e**mpathy, **a**ttention and **r**espect. This method is a simple way to effectively listen to someone who is upset so that they can calm down, and it can be applied to anyone, even outside of a therapeutic setting (Eddy, 2018). It is especially beneficial when working together to reach a peaceful resolution or defusing a conflict (Eddy, 2021). Using this strategy, you can create an "EAR Statement" that highlights respect, empathy, and attention. It starts by demonstrating your desire to assist them and your ability to relate to whatever emotion they might be feeling through effective reflective listening (Eddy, 2018). For

example, a listener might say, "I can hear how frustrated you are by this situation. I'd like to help." Next, it's critical to convey through your words, tone of voice, and body language that you are prepared to pay attention (Eddy, 2018). At this point, a listener could inquire, "Why don't you talk to me about it so I can really understand?" as an example. To make the person feel valued and taken seriously, it is crucial to express verbal respect for them as well as their issue (Eddy, 2018). "I have a lot of respect for how you have tried to handle this problem so far," the listener might finally say.

According to the EAR approach, most people can talk about their problems and work together to find a solution after they have calmed down for 30 seconds after hearing an EAR statement (Eddy, 2018). This shows the value and effectiveness of giving someone empathy, consideration, and respect to help them feel heard. Thus, the EAR approach enables the listener to establish a connection with the upset individual, enabling problem-solving in addition to giving the upset person a sense that their feelings are real and significant (Eddy, 2018). As previously mentioned, research has repeatedly demonstrated that the application of empathic listening is a prerequisite for change (Kwon & Jo, 2012). Furthermore, emotional contagion is one of the primary reasons that the EAR approach works (Eddy, 2021). Our mirror neurons can replicate the emotional expressions we see in front of us, according to research on the brain (Eddy, 2021). Therefore, the upset person will mirror the listener's emotional expression and start to calm down if they receive empathy, attention, and respect in return (Eddy, 2021). It's crucial to remember that the EAR method functions best when the distressed individual and their listener have already formed a strong alliance (Eddy, 2011). But, as previously mentioned, it has been demonstrated that empathetic listening is essential to forging an alliance in the first place, illuminating a cycle (Wynn & Wynn, 2006). An EAR approach may be useful in a

psychotherapy session to help calm a dysregulated client and create an environment conducive to effective therapy.

EASE

EASE is a new approach that can be used by psychotherapists and integrates the EAR approach, the Stoic dichotomy of control (SDC) and Meaning Mindset Theory (MMT). The EASE model uses the skills of empathetic listening, **acknowledgment** of circumstances, **solving** (through sensible action), and **evaluating** (through exploration of thoughts) (Armstrong et al., 2025). Psychotherapists who use EASE will naturally show empathy, attention and respect when listening to their clients (EAR). This approach will involve the practice of reflecting and summarizing feelings and thoughts, as well as exploring content and feelings with an attitude of openness, genuineness and curiosity (Epperson & Armstrong, 2024). They will also **acknowledge** their clients' "uncontrollable" circumstances while working towards options of sensible action that is within their control (SDC). Finally, they will explore the client's difficult feelings as well as their sense of agency over their thoughts and behaviours, their self-concept, openness to experience, and hope for the future (MMT). The sub elements of EASE are **attention**, **biases**, **caring**, **deepening** understanding and defining the problem, **establishing** goals, **formulating** a plan, and **generating** agency (Epperson & Armstrong, 2024). A psychotherapist naturally using EASE will give a client and their problem attention while responding empathetically; they will check in with their own biases and set them aside to listen non-judgementally; they will show care for the client's feelings and experiences through respect and validation; they will deepen their understanding of the client's problem to understand it from the client's perspective; they will establish realistic goals collaboratively with the client; they will formulate a plan based on the goals established with the client; and they will generate agency by

exploring the client's feelings and thoughts about the goals and plan to maximize positive outcomes (Epperson & Armstrong, 2024).

The psychotherapist using the EASE model may have an interaction like the one below with a client to showcase the model's skills and sub-elements (Epperson & Armstrong, 2024):

The psychotherapist: *"Would you like to share with me what's going on? I'm always here to support you."* (psychotherapist showing empathetic listening and giving attention to the client and their problem)

The client shares the problem they are experiencing.

The psychotherapist: *"I don't want to assume to know what it's like to be in your shoes exactly, but I sincerely want to understand. Can you tell me more about what this experience was like for you?"* (psychotherapist exploring difficult thoughts and feelings, and checking biases and deepening understanding of the problem)

The client shares their perspective.

The psychotherapist: *"I can hear how difficult this has been for you."* (psychotherapist acknowledging circumstances and caring for the client and their problem)

The client continues to share.

The psychotherapist: *"Thank you for sharing this with me today. What would you like us to work on first?"* (psychotherapist establishing goals)

The client shares short-term goal for session.

The psychotherapist proposes a plan and asks the client, *"how does that sound?"* (psychotherapist trying to find sensible action by formulating a plan)

After beginning the intervention, the psychotherapist checks in with the client by asking, “how is this going for you?” (psychotherapist generating agency to achieve a positive outcome that is appropriate for the client)

As previously stated, the EAR approach—which employs empathy, attention, and respect—has the potential to rapidly regulate a client and enable a successful therapeutic session (Eddy, 2021). Incorporating the Stoic Dichotomy of Control can also have major long-term benefits. Clients can be empowered by learning to live with the knowledge that everything we go through in life is fleeting and that many things are beyond our control, so they shouldn't be a source of concern (Smith, 2024). Working together with clients to understand and internalize the Stoic Dichotomy of Control can lead to a general increase in well-being and life satisfaction, a decrease in negative emotions, and an increase in resilience in the face of adversity (LeBon, 2023). Lastly, working with clients to discover meaning in their lives and experiences can also have a big impact. It is thought that having a felt sense of meaning can help one get through any challenge, and clients who seek help are typically going through some sort of hardship or challenge in their lives (Frankl, 1986). Meaning Mindset can promote positive coping and help clients become more resilient during trying times in life (Wong, 2017). Additionally, it can raise general well-being levels and assist clients in developing resilience for later difficulties (Armstrong & Potter, 2022). As a result, using the EASE model to incorporate the Stoic Dichotomy of Control and Meaning Mindset (EAR) into interactions with clients can have a big positive impact.

Knowledge Translation-Integrated Methodological Approach

The current research uses a Knowledge Translation-Integrated approach (KTI) (Armstrong et al., 2025). It is a participatory, third-wave positive psychology approach that ensures the

collaboration of the researcher with those directly affected by the research for recommendations regarding the research process and explores credibility, acceptability, sustainability, and feasibility of psychotherapy services that are perceived to use the EASE model. The aim is to work with knowledge users as they are the stakeholders in this research, while promoting equity, diversity, inclusivity, and belonging, and ensure that the use of the EASE model is useful and beneficial for them. The KTI approach has been increasingly used for co-creation with knowledge users and knowledge mobilization to incorporate diverse perspectives and ensure a culturally responsive fit (Armstrong et al., 2025).

We inquire about the credibility of the psychotherapy services, by asking visible minority clients if the services they received achieved what they thought they would. Credibility is also measured quantitatively through assessing EASE, alliance, mental health, and Meaning Mindset. We also inquire about the services' acceptability, by asking the visible minority clients if the services they received led to the outcomes they wanted. Additionally, we inquire about the services' sustainability, by asking if the outcomes were maintained after the services ended. Finally, we inquire whether the outcomes they were hoping for were feasible in the context of psychotherapy.

Current Study

Statement of Purpose

The literature on client retention is clear: while it is essential for a positive therapeutic outcome, visible-minority communities experience its lowest rates (Swift & Greenberg, 2012). It has also been shown that therapeutic alliance is a key factor in preventing premature termination and in the overall therapeutic outcome (Martin et al., 2000; Campbell et al., 2015; Tasca &

Marmarosh, 2023). An effective method of developing this therapeutic alliance is through empathetic listening (Kwon & Jo, 2012; Myers, 2000).

A newly emerging model expands on Meaning Mindset, the Stoic Dichotomy of Control, and the EAR model to foster a therapeutic alliance. As noted, the EASE model uses the skills of empathy, **acknowledge, solve, and evaluate** (Armstrong et al., 2025). Ultimately, if therapists in services as usual are perceived to be using EASE skills, it is hoped that these are the ingredients that support alliance, mental health, well-being (Meaning Mindset), and service retention outcomes for visible minority clients.**Hypotheses**

Credibility – Is EASE Correlated with Therapy Outcomes?

Our main quantitative hypothesis is that, given the theoretical frameworks in which the EASE model is grounded, the perceived use of EASE is expected to be associated with positive therapy outcomes: alliance, Meaning Mindset, mental health, multicultural competence, and service retention. This hypothesis is grounded in the literature which shows positive outcomes when a strong alliance is present between psychotherapist and client (Howgego, 2003; Ardito & Rabellino, 2011; Campbell et al., 2015; Fluckiger et al., 2018; Tasca & Marmarosh, 2023), when Meaning Mindset is fostered (Ivtzan et al., 2015; Wong, 2017; Armstrong & Potter, 2022), when psychotherapists are culturally competent (Owen et al., 2011; Tao et al., 2015), and when clients stay in services for the recommended duration (Anderson et al., 2019). This hypothesis is also grounded in the literature that shows a significant association between empathetic listening, cultural competence (which involves acknowledgment of circumstances and sensible action), *EASE elements*, and positive therapy outcomes (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012; Owen et al., 2011; Tao et al., 2015).

Several other findings are expected as well:

1. The perceived use of EASE is expected to moderate the relationship between visible minority status and retention rate. This hypothesis is grounded in the literature which shows that visible minorities experience lower retention rates in psychotherapy (Sue et al., 1991; Arnow et al., 2007; Swift & Greenberg, 2012). The EASE model emphasizes **empathetic listening**, as well as **acknowledgment of circumstances** and **solving** through the use of deepening understanding, establishing goals and formulating a plan (Epperson & Armstrong, 2024). The literature shows a strong association between empathetic listening, cultural competence (which involves acknowledgment of circumstances and sensible action) and positive therapy outcomes (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012; Owen et al., 2011; Tao et al., 2015).

2. The perceived use of EASE is expected to moderate the relationship between visible minority status and mental health. This is hypothesized as the literature shows that visible minorities experience lower levels of mental health (Office of the Surgeon General, 2001; Chow et al., 2003; Hackett et al., 2020). This hypothesis is also founded in the EASE model's emphasis on **empathetic listening**, **acknowledgment of circumstances** and **solving**, and the literature which shows an association between empathetic listening, cultural competence and positive therapy outcomes including increased mental health (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012; Owen et al., 2011; Tao et al., 2015).

3. The perceived use of EASE is expected to moderate the relationship between alliance and mental health. The literature shows the importance of alliance (Campbell et al., 2015) and its significance in improving mental health outcomes specifically (Howgego, 2003; Ardito & Rabellino, 2011; Fluckiger et al., 2018; Tasca & Marmarosh, 2023). This hypothesis is founded in the EASE model's emphasis on **empathetic listening**, and the association of empathetic

listening, alliance and positive outcomes in the broader research (Wynn & Wynn, 2006; Eddy, 2011).

4. The perceived use of EASE is expected to moderate the relationship between alliance and client retention. The literature also shows the importance of alliance for service retention (Cooper & Powe, 2004; Campbell et al., 2015) and is in line with the EASE model's emphasis on **empathetic listening** and **acknowledgment of circumstances** to foster an alliance (Armstrong & Epperson, 2024).

5. The perceived use of EASE is expected to moderate the relationship between client-perceived therapist cultural competence and client retention. This hypothesis is founded in the EASE model's culturally responsive emphasis on **acknowledgment of circumstances, solving** and **evaluating**, and the broader literature on the association of cultural competence and positive outcome, including service retention (Owen et al., 2011; Tao et al., 2015).

6. The perceived use of EASE is expected to moderate the relationship between client-perceived therapist cultural competence and mental health. Like the previous hypothesis, this hypothesis is founded in the EASE model's culturally responsive emphasis on **acknowledgment of circumstances, solving** and **evaluating**, and the broader literature on the association of cultural competence and positive outcome, including better mental health (Owen et al., 2011; Tao et al., 2015)

7. Meaning Mindset is expected to moderate the relationship between EASE and mental health. Since EASE aims to foster Meaning Mindset through **empathetic listening, acknowledgment of circumstances, solving** and **evaluating**, and the broader literature shows the impact of Meaning Mindset on mental health (Ivtzan et al., 2015; Wong, 2017; Armstrong &

Potter, 2022), this hypothesis expects that Meaning Mindset will be associated with mental health through the use of EASE.

Our qualitative hypothesis is that visible minority clients who perceive psychotherapists to be using EASE in their practice view services as more credible (e.g., see the value of services for them), acceptable (e.g., are satisfied with services), sustainable (e.g., more likely to maintain outcomes after services end), and feasible (e.g., have desired outcomes that are feasible in the context of psychotherapy).

Methods

Research Design

The current psychological research is conducted using survey methodology, with a mixed methods approach. Ethics approval from Saint Paul University has been granted and can be found in Appendix A.

Participants

The participant pool is composed of psychotherapy clients, visible minority and non-minority, who have had any experience in psychotherapy, terminating prematurely, or who have completed these services. Participants were recruited in Ottawa, Ontario, through the Centre of Counselling and Psychotherapy, as this is also informative for the Centre regarding retention of minority clients and alliance. A purposive sampling method of a convenient population was used. Originally, the target sample included 60 participants: 30 visible minority psychotherapy clients (group 1) and 30 non-visible minority clients (group 2). A sample of 30 per group was chosen, as 30 participants are recommended in the literature for initial pilot research (Beets et al., 2021). However, due to many duplicate responses that had to be removed from the data collection manually, the total number of participants was 53, 28 of them identified as visible

minorities while 25 identified as non-minorities. All participants were English-speaking and over the age of 18. For this research, the operational definition of visible minority is the one defined by the Employment Equity Act (Government of Canada, 2015). The Employment Equity Act defines visible minorities as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (Government of Canada, 2015).

In total, 53 participants responded to the survey via SurveyMonkey. Of those 53 participants, 28.3% were between the ages of 18 and 24 (n=15), with 17% of participants between the ages of 25 and 29 (n=9), 22.6% between the ages of 30 and 34 (n=12), 7.5% between the ages of 35 and 44 (n=4), 3.8% between the ages of 45 and 54 (n=2), 1.9% between the ages of 55 and 64 (n=1), and 18.9% declined to provide this demographic information (n=10).

Of the 53 participants, 58.5% identified as women (n=31), 13.2% identified as men (n=7), 3.8% identified as non-binary (n=2), 3.8% identified as transgender/2-spirit (n=2), and 11 participants declined to answer.

Of the 53 participants, 34% reported having graduate or professional training (n= 18), 18.9% reported having completed college or university training (n= 10), 17% reported having some college or university training (n= 9), 9.4% reported having a post-secondary certification (n=5), 3.8% reported having completed high school (n=2), and 9 participants declined to provide this demographic information.

Regarding annual household income, before taxes, 1.9% of participants reported making less than \$5,000 (n=1), 3.8% of participants reported making between \$5,000 and \$19,999 (n=2), 5.7% reported making between \$20,000 and \$34,999 (n=3), 13.2% reported making between \$35,000 and \$49,999 (n=7), 13.2% reported making between \$50,000 and \$74,999 (n=7), 15.1%

reported making between \$75,000 and \$99,999 (n=8), 18.9% reported making between \$100,000 and \$149,999 (n=10), 26.4% reported making between \$150,000 and \$199,999 (n=14), and 1.9% reported making \$200,000 or more (n=1).

Finally, as the current study aimed to investigate improving outcomes of psychotherapy for visible minority clients, inquiring about the minority status of participants was critical. 52.8% of participants identified as visible minorities (n= 28) while 47.2% identified as non-minorities (n= 25). Of the 53 participants, 47.2% reported being ethnically White (n=25), 13.2% reported being Black (n=7), 11.3% reported being Latin American (n=6), 3.8% reported being East Asian (n=2), 1.9% reported being Indigenous, Middle Eastern and South Asian, each respectively n=1. The remaining 10 participants who identified as visible minorities declined to specify their ethnicity. Interestingly, but not surprisingly, only 17% of participants reported having seen a therapist who was a visible minority (n= 9), 62.3% reported having seen a non-minority therapist (n=33), and 20.8% declined to answer (n=11).

Regarding their experience in psychotherapy, 28.3% of participants reported having seen a psychotherapist but had terminated prematurely (n=15), 17% reported still being in psychotherapy but likely terminating prematurely soon (n=9), 5.7% reported still being in psychotherapy and likely completing it until a natural end (n=3), and 20.8% reported having completed psychotherapy until a natural end (n=11). 15 participants declined to provide this demographic information. Interestingly, 64.2% of participants reported having followed all therapeutic recommendations and plans (n=34), 11.3% reported having followed some of their therapeutic recommendations and plans (n=6), 3.8% reported having not followed their therapeutic recommendations and plans (n=2), and 11 participants declined to answer.

Measures

EASE Inventory. The EASE Inventory is a 10-item self-report measure specifically intended for use by clients of psychotherapy. The scale measures perceived empathetic listening, acknowledgment of circumstances, solving through sensible action, and evaluation through exploration of thoughts and feelings. The inventory measures each item on a six-point scale from ‘Strongly Disagree’ to ‘Strongly Agree’ (Armstrong & Epperson, 2024). During the course of this research, the EASE Inventory was assessed to be highly reliable, with a Cronbach’s alpha of .94. Prior to the main study, an initial sample of 30 participants was recruited from a psychotherapist population, with lived experience of psychotherapy service use, at a university for pilot measure validation of the EASE measure to support reliability and validity of the measures for use in the main study. Psychotherapists, as measure users, were recruited as they were able to provide feedback on whether this measure would be useful in their own practices (sustainability, feasibility). They completed the EASE measure for assessment of internal consistency reliability, convergent validity, and a brief qualitative questionnaire. This questionnaire can be found in Appendix B.

Adult Identity and Meaning Scale (AIMS). The AIMS is a 12-item self-report measure. The scale measures “meaning mindset”, which is a mindset of hope for the future, self-concept and openness to feelings; engagement in pursuits, learning, creativity and social connection; and choice and responsibility over feelings, thoughts and behaviours. The inventory measures each item from 0 to 10 on a sliding scale (Watt, 2020). This measure was found to have a Cronbach’s alpha of .96 (Watt, 2020). This questionnaire can be found in Appendix C.

Interactive Symptom Assessment-Adult (ISA). The ISA is a 12-item self-report measure. The scale measures mental health and healthy functioning through mood symptoms, anxiety

symptoms, social connectedness, conduct concerns, compulsions and obsessions, attention deficit symptoms and self-esteem concerns. The inventory measures each item from 0 to 10 on a sliding scale (Armstrong et al., 2022). This scale has been found to be highly reliable, with a Cronbach's alpha of .83 (Armstrong et al., 2022). This questionnaire can be found in Appendix D.

Brief Revised Working Alliance Inventory (BR-WAI). The BR-WAI is a 16-item measure that assesses therapeutic alliance. The scale measures the bond between the therapist and the client, the therapist and client's collaboration on treatment goals and the therapist and client's collaboration on treatment tasks. The inventory measures each item on a five-point scale from 'Strongly Disagree' to 'Strongly Agree' (Mallinckrodt & Tekie, 2015). The original Working Alliance Inventory was found to have a reliability score of .87 (Horvath et al., 1989). This questionnaire can be found in Appendix E.

Multicultural Therapy Competency Inventory-Client Version (MTCI-CV). The MTCI-VC is a self-report scale that psychotherapy clients can use to assess their therapist's multicultural competence. The measure includes 32 items with each item being measured on a five-point scale from "does this well" to "does this poorly" (Cole et al., 2014). Its developers found a significant correlation between clients' perception of their therapists' multicultural competence and their satisfaction with and attainment of goals in therapy (Cole et al., 2014). This measure was found to have a reliability score of .98 (Cole et al., 2014). This questionnaire can be found in Appendix F.

Qualitative Questionnaire. The qualitative questionnaire is a series of open-ended questions that aim to encapsulate the participants' experiences in psychotherapy, exploring

credibility, acceptability, sustainability, and feasibility, as defined previously. This questionnaire can be found in Appendix G.

Demographic questionnaire. The questions capture the duration of psychotherapy, whether services were terminated prematurely, age, ethnicity, gender, and household income to accurately describe the sample. This questionnaire can be found in Appendix H.

Procedure

The current study consists of a mixed methods approach. Once informed consent was obtained, all participants completed the EASE, AIMS, ISA, BR-WAI and MTCI-CV questionnaires in the same order to control for order effects. Following the quantitative questionnaires, participants were given a brief qualitative questionnaire exploring credibility, acceptability, sustainability, and feasibility of the services they received. The purpose of this mixed methods approach was to gather comprehensive evidence, through a variety of perspectives, and allow the participants' experience to be shared authentically. This was conducted via SurveyMonkey.

The participants received a full disclosure of the research's purpose and its potential risks and benefits. This included a detailed explanation of the importance of disclosing their minority status, given the potentially sensitive nature of the subject. The consent form also included a complete confidentiality clause and an explanation of the data collection and storage process. Further, the consent form also detailed the participants' right to question, refuse or withdraw from the study at any time.

Statistical Analysis

Data Screening and Cleaning

Data screening and cleaning were conducted using SPSS 29.0 for Windows. Before analysis, data was examined for accuracy, outliers, distribution, missing values, and normality assumptions.

Univariate frequencies identified invalid scores, and missing data was verified and addressed using original questionnaires. A Missing Data Analysis was conducted, and data was missing at random. Linearity and homoscedasticity were assessed through bivariate scatterplots, and multivariate outliers were identified using Mahalanobis distance. There were no extreme outliers. Variables were not significantly skewed and followed a normal distribution.

To test the hypotheses, the current research employed correlational analyses and non-parametric Bayesian Moderation Regression analyses using SPSS's PROCESS macro, considered appropriate for small sample sizes (minimum of ten), as it automatically centres the variables (Surucu, Sesen, & Maslakci, 2023). In the first hypothesis, the researcher is testing EASE as a moderator between the independent variable of minority status and the dependent variable of mental health. In the second hypothesis, the researcher is testing EASE as a moderator between the independent variable of minority status and the dependent variable of retention rate. In the third hypothesis, the researcher is testing EASE as a moderator between the independent variable of client-perceived therapist cultural competence and the dependent variable of retention rate. In the fourth hypothesis, the researcher is testing EASE as a moderator between the independent variable of client-perceived therapist cultural competence and the dependent variable of mental health. In the fifth hypothesis, the researcher is testing EASE as a moderator between the independent variable of alliance and the dependent variable of mental health. In the sixth hypothesis, the researcher is testing EASE as a moderator between the independent variable of alliance and the dependent variable of retention rate. In the seventh

hypothesis, the researcher is testing EASE as a moderator between the independent variable of Meaning Mindset and the dependent variable of mental health. In the final hypothesis, the researcher is testing EASE as a moderator between the independent variable of alliance and the dependent retention rate. The variable of retention rate is measured through a demographic question in the qualitative questionnaire.

Qualitative Analysis

To minimize potential bias and ensure reliability in our qualitative analysis, the current study is conducted in accordance with the following guidelines (Cofie et al., 2022). There are a minimum of two coders; one coder who is removed from data collection; data collection is conducted by a coder with expertise and experience in coding qualitative data; a minimum of two coders code transcripts for each participant group using the same framework for analysis and a shared meaning of codes; a researcher with expertise is consulted if there are any conflicts; and there is consensus relating to the codebook for the transcripts (Cofie et al., 2022). Furthermore, according to Clarke and Braun's thematic analysis parameters, the researchers first look at the data and then read through the written survey responses several times, familiarizing themselves with the data and making note of any significant patterns (2013). Then, the researchers code any notable features of the data, reviewing it several times (Clarke & Braun, 2013). Next, the researchers examine the codes and patterns, and generate themes (Clarke & Braun, 2013). The researchers then review the themes they have generated, and how accurately they represent the data found (Clarke & Braun, 2013). Afterwards, the researchers name and define the themes, giving them significance in relevance to the data found (Clarke & Braun, 2013). Finally, they create a report using these themes and findings (Clarke & Braun, 2013). In the current study, qualitative data was organized into KTI themes of credibility, acceptability, sustainability, and

feasibility, while exploring subthemes that emerged. Clarke and Braun specifically encourage a Reflexive Thematic Analysis which uses the researcher's subjectivity as a tool in the research (2021). This kind of analysis assumes that the researcher's knowledge and understanding of the research is always context-dependent and can have a significant influence on the data (Braun & Clarke, 2021). As a result, the researcher's subjectivity in the research is deemed valuable and as something to be used, not avoided or minimized (Braun & Clarke, 2021). Due to the potential for bias with such an approach, Braun and Clarke encourage the use of two raters: Dr. Armstrong and Houda Ismaili in the current study.

Results

In the current study, a mixed methods design was used, including both quantitative and qualitative analyses. These analyses were used to assess credibility, acceptability, feasibility, and sustainability of the EASE model. Specifically, it was expected that the EASE model would be associated with positive therapy outcomes, such as alliance, higher service retention rates, higher Meaning Mindset, and better mental health. It was also expected that EASE would moderate outcomes for visible minorities specifically. Finally, it was expected that visible minorities who perceive their therapists to be using EASE would also qualitatively view psychotherapy services as more credible, acceptable, sustainable and feasible.

This study investigated the relationship between EASE, alliance and outcomes of psychotherapy for visible minority clients by looking at the variables in Table 1. The assessment of outcomes was measured through the EASE, AIMS, ISA and MTCI-CV questionnaires. The assessment of alliance was measured through BR-WAI.

Means and standard deviations of the measures are presented in Table 1, while correlations found between the variables can be found in Table 2.

Table 1*Means and Standard Deviations of Variables*

Variables	<i>Number of respondents</i>	<i>Means</i>	<i>Standard Deviations</i>
EASE	41	51.51	8.59
AIMS	47	94.95	21.81
ISA	46	51.15	32.53
MTCI-CV	35	87.88	9.10
BR-WAI	39	61.82	6.63

Note. EASE = Scores from the EASE Inventory measuring empathetic listening, acknowledgment of circumstances, solving through sensible action, and evaluation through exploration of thoughts and feelings in psychotherapy.

AIMS = Scores from the Adult Identity and Meaning Scale measuring Meaning Mindset.

ISA = Scores from the Interactive Symptom Assessment-Adult measuring mental health symptoms.

MTCI-CV = Scores from the Multicultural Therapy Competency Inventory-Client Version measuring client-perceived therapist multicultural competence.

BR-WAI = Scores from Brief Revised Working Alliance Inventory measuring therapeutic alliance.

Correlations: Credibility – Was EASE Correlated with Therapy Outcomes?

Correlations are presented in Table 2 below.

Table 2*Two-tailed bivariate correlations of variables at the .01 level.*

Variables	1	2	3	4	5	6	7
1. EASE	-						
2. AIMS	.81**	-					
3. ISA	-.73**	-.77**	-				
4. MTCI-CV	.77**	.77**	-.85**	-			
5. BR-WAI	.74**	.53**	-.57**	.61**	-		
6. Visible Minority Status	-.73**	-.75	.67**	-.57**	-.64**	-	
7. Retention Rate	.43**	.42**	-.46**	.52**	.17	-.22	-

** $p < .01$

Pearson bivariate correlations were conducted on the data, and significance was set at $p < .05$. As expected, EASE scores were significantly associated with all variables ($p < .01$). The following correlations were significant: A statistically significant inverse correlation was found between the participants' EASE scores and their mental illness symptom scores ($r = -.73$, $p < 0.001$). Secondly, there was a statistically significant inverse correlation between the participants' Meaning Mindset scores and their mental illness symptom scores ($r = -.77$, $p < 0.001$). Thirdly, there was also a statistically significant negative association between visible minority status of participants and Meaning Mindset scores ($r = -.75$, $p < 0.001$). Furthermore, alliance was significantly positively correlated with client-perceived therapist multicultural competence scores ($r = .61$, $p < .001$). Client-perceived therapist multicultural competence scores were also significantly correlated with mental illness symptoms ($r = -.85$, $p < 0.001$),

visible minority status $r = -.57^{**}$, $p < 0.001$), and retention rates ($r = .52^{**}$, $p < 0.001$).

Additionally, there was a statistically significant relationship between EASE scores and Meaning Mindset scores ($r = .81^{**}$, $p < 0.001$). As well, there was a statistically significant positive relationship between EASE scores and alliance scores ($r = .74^{**}$, $p < 0.001$). EASE scores were also significantly correlated with minority status ($r = -.73^{**}$, $p < 0.001$) and client-perceived therapist multicultural competence scores $r = .77^{**}$, $p < 0.001$). Additionally, there was a statistically significant correlation between Meaning Mindset scores and client-perceived therapist multicultural competence scores $r = .77$, $p < .001$). Furthermore, Meaning Mindset was significantly correlated with retention rates ($r = .42^{**}$, $p < 0.01$). Meaning Mindset was also significantly correlated with alliance scores ($r = .53^{*}$, $p < 0.001$). Alliance scores were also significantly correlated with mental illness symptom scores ($r = -.57^{**}$, $p < 0.001$). Mental illness symptom scores were also significantly correlated with retention rates ($r = -.46^{**}$, $p < 0.01$). Additionally, mental illness symptom scores were significantly correlated with visible minority status ($r = .67^{**}$, $p < 0.001$). Visible minority status was also significantly correlated with alliance scores ($r = -.64^{**}$, $p < 0.001$). EASE was significantly correlated with retention rates in psychotherapy. ($r = .43$ $p < 0.01$) However, the analysis showed no significant correlation between scores on alliance and retention rates ($r = .17$, $p = 0.31$) and a no correlation between visible minority status and retention rates ($r = -.22$, $p = 0.17$).

Credibility: How is EASE correlated with alliance?

As this is the first study of EASE, an exploratory analysis was carried out to see which elements of EASE might be correlated with alliance (i.e., be the “ingredients” of alliance). The following table shows that every element of EASE was found to be significantly correlated with alliance.

Item in EASE measure	Correlation with Alliance
My therapist or counsellor seemed to be genuinely interested in what was going on for me.	$r = .59^{**}$ ($p < .001$)
My therapist or counsellor didn't appear to let their own biases get in the way of our work together.	$r = .71^{**}$ ($p < .001$)
My therapist or counsellor noticed and showed care for my feelings.	$r = .68^{**}$ ($p < .001$)
My therapist or counsellor seemed to recognise and explore the problem(s) I was facing.	$r = .78^{**}$ ($p < .001$)
My therapist or counsellor helped me to establish goals.	$r = .57^{**}$ ($p < .001$)
My therapist or counsellor collaborated with me to explore steps to reach my goals.	$r = .35^*$ ($p = .02$)
My therapist or counsellor helped me develop a sense of "agency," or a belief that I am capable of choosing helpful actions and helpful thoughts.	$r = .55^{**}$ ($p < .001$)
My therapist or counsellor explored and validated the feelings I was having regarding my thoughts or potential actions to reach my goals.	$r = .59^{**}$ ($p < .001$)
I believe the work I've done with my therapist or counsellor is helpful for me.	$r = .68^{**}$ ($p < .001$)
My therapist or counsellor and I respect each other.	$r = .64^{**}$ ($p < .001$)

** $p < .001$, * $p < .05$

Moderation Analyses: Credibility – Was EASE Correlated with Therapy Outcomes?

Given the smaller sample size, non-parametric Bayesian Moderation Regression analyses were conducted using SPSS's PROCESS macro (Hayes, 2013) for the current study to assess whether EASE moderated the following relationships:

1) If therapists use EASE skills, does this moderate the relationship between visible minority status and mental illness symptoms? Specifically, does the effect of visible minority status on mental illness symptoms decrease with increased perceived therapist EASE skill usage?

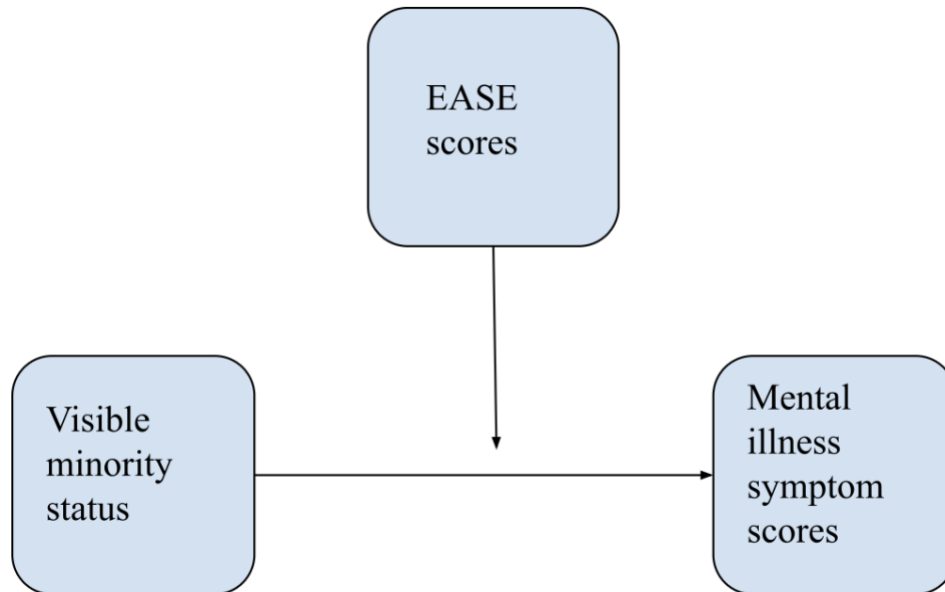


Figure 1.

Visible minority status was entered as the predictor variable (X), client self-reported mental illness symptoms scores were entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between visible minority status and EASE was significant (R^2 change = 0.34, $b = 7.54$, $SE = 0.79$, $t = 9.54$, $p < .001$), indicating that the relationship between visible minority status and mental illness symptoms was moderated by

EASE scores. The simple slope of X on Y was significant at low levels of M (Mean = 38.72, $b = -100.15$, $SE = 12.95$, $t = -7.73$, $p < .001$) and at high levels of M (Mean = 60.21, $b = 60.21$, $SE = 8.53$, $t = 7.96$, $p < .001$), but not at moderate levels of M (Mean = 53.00, $b = 7.46$, $SE = 6.45$, $t = 1.15$, $p = .26$). At low levels of EASE, visible minority status was associated with mental illness symptoms. At high levels of EASE, visible minority status was associated with mental health (low self-reported mental illness symptoms). Specifically, at low levels of EASE, with visible minority status, mental illness symptoms increased by 100.15 points. At high levels of EASE, with visible minority status, mental illness symptoms decreased by 60.21 points.

2) Does use of EASE skills moderate the relationship between visible minority status and client retention? Specifically, does the effect of visible minority status on dropping out of therapy prematurely decrease with increased perceived therapist EASE skill usage?

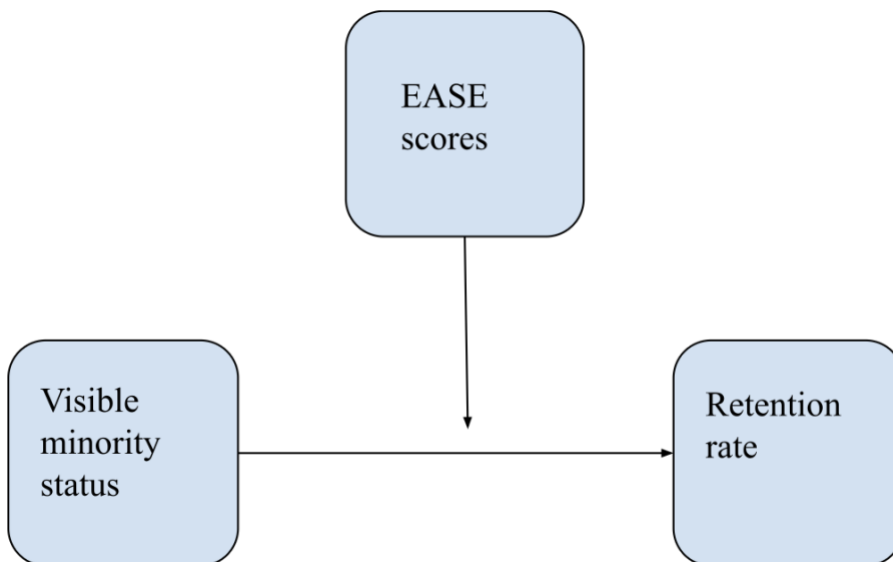


Figure 2.

Visible minority status was entered as the predictor variable (X), client retention (versus non-retention) was entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between visible minority status and EASE was not significant (Chi square

= 0.39, -.14, SE = 0.22, Z = -.62, p = .53), indicating that the relationship between visible minority status and client dropout was not moderated by EASE scores.

3) Does use of EASE skills moderate the relationship between therapeutic alliance and mental health? Specifically, does the inverse effect of perceived therapeutic alliance on mental illness symptoms increase with increased perceived therapist EASE skill usage?

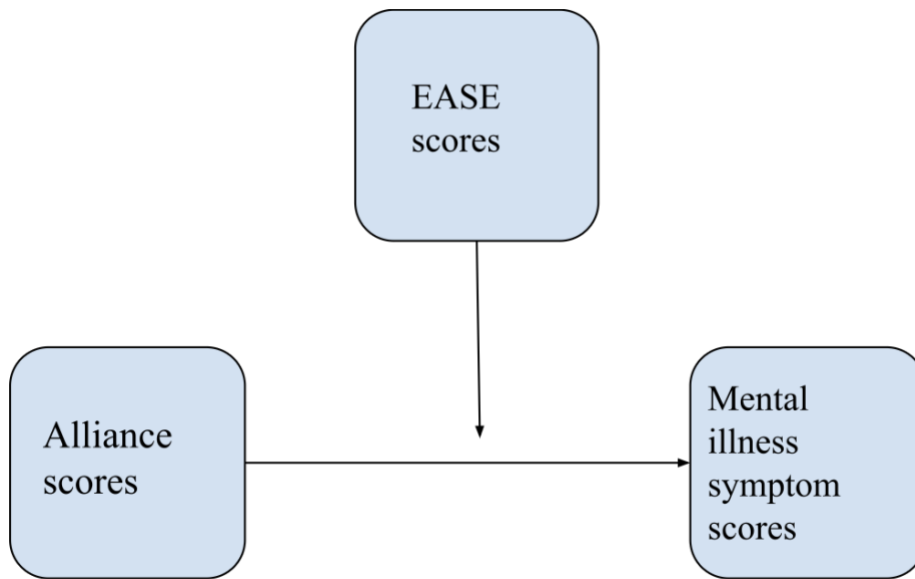


Figure 3.

Perceived alliance was entered as the predictor variable (X), client self-reported mental illness symptoms scores were entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between alliance and EASE was significant (R^2 change = 0.19, $b = -.29$, $SE = 0.07$, $t = -4.51$, $p < .001$), indicating that the relationship between alliance and mental health was moderated by EASE scores. The simple slope of X on Y was significant at low levels of M (Mean = 37.92, $b = 2.09$, $SE = .86$, $t = 2.42$, $p = .02$), at moderate (Mean = 53.00, $b = -2.33$, $SE = .86$, $t = -2.71$, $p = .01$) and at high levels of M (Mean = 60.00, $b = -4.39$, $SE = 1.18$, $t = -3.17$, $p < .001$). At low levels of EASE, a one-point increase in alliance predicted a one-point increase in mental illness symptoms. At moderate levels of EASE, a one-point increase in

alliance was associated with a 2.33-point decrease in mental illness scores. At high levels of EASE, a one-point increase in alliance was associated with a 4.39-point decrease in mental illness scores

4) Does use of EASE skills moderate the relationship between therapeutic alliance and client dropout? Specifically, does the effect of the therapeutic alliance on client retention increase with increased perceived therapist EASE skill usage?

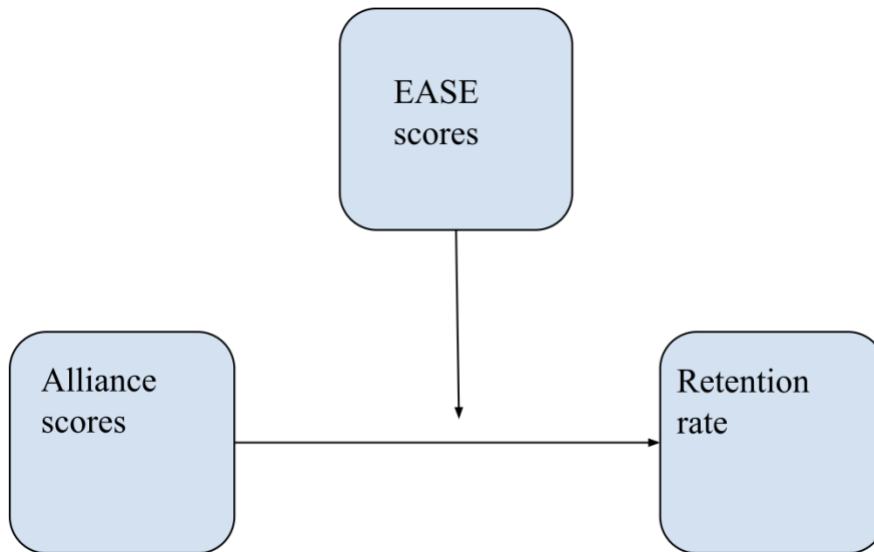


Figure 4.

Client-reported alliance with their therapist was entered as the predictor variable (X), the client reported binary of stay in therapy versus prematurely terminated was entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between alliance and EASE was significant (Chi square = 4.28, SE = 0.04, Z = -1.78, $p = .04$), indicating that the relationship between alliance and client retention was moderated by EASE scores. The simple slope of X on Y was not significant at low levels of M (Mean = 37.76, SE = .51, Z = 1.50, $p = .13$), but it was significant at moderate (Mean = 53.00, $b = -.30$, SE = .15, Z = -1.96, $p \leq .05$) and at high levels of M (Mean = 60.00, $b = -.79$, SE = .39, Z = -2.02, $p = .04$). Low levels of

EASE did not affect the relationship between alliance and client retention. However, at moderate levels of EASE, when alliance increases by one standard deviation, drop out decreases by .30 of a standard deviation. At high levels of EASE, when alliance increases by one standard deviation, drop out decreases by .79 of a standard deviation.

5) Does the use of EASE skills moderate the relationship between client-perceived therapist cultural competence and client retention? Specifically, does the effect of perceived cultural competence on staying in therapy increase with increased perceived therapist EASE skill usage?

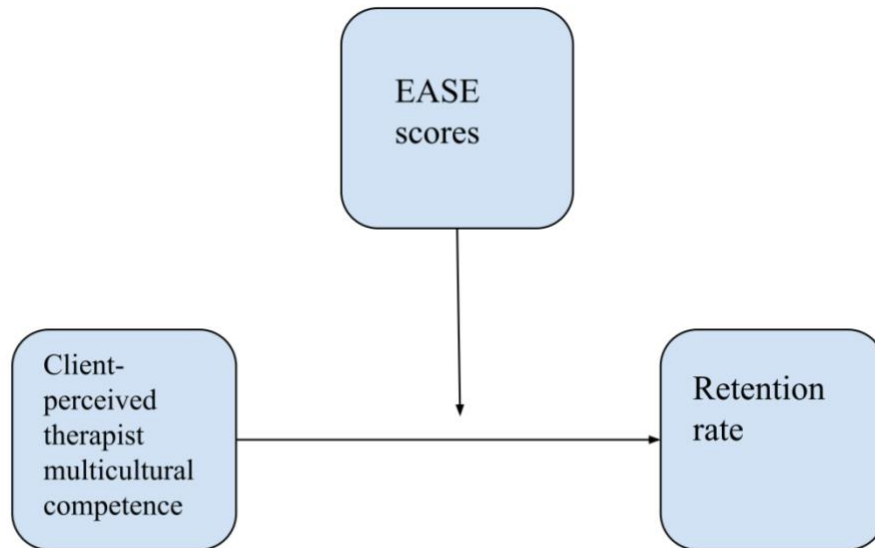


Figure 5.

Client-perceived therapist multicultural competence was entered as the predictor variable (X), client retention (versus non-retention) was entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between client-perceived therapist multicultural competence and EASE was not significant (Chi square = 0.39, -.14, SE = 0.22, Z = -.62, p = .53), indicating that the relationship between retention rate and client-perceived therapist multicultural competence was not moderated by EASE scores.

6) If therapists use EASE skills, does this moderate the relationship between client-perceived therapist cultural competence and mental illness symptoms? Specifically, does the effect of perceived therapist cultural competence on mental illness symptoms decrease with increased perceived therapist EASE skill usage?

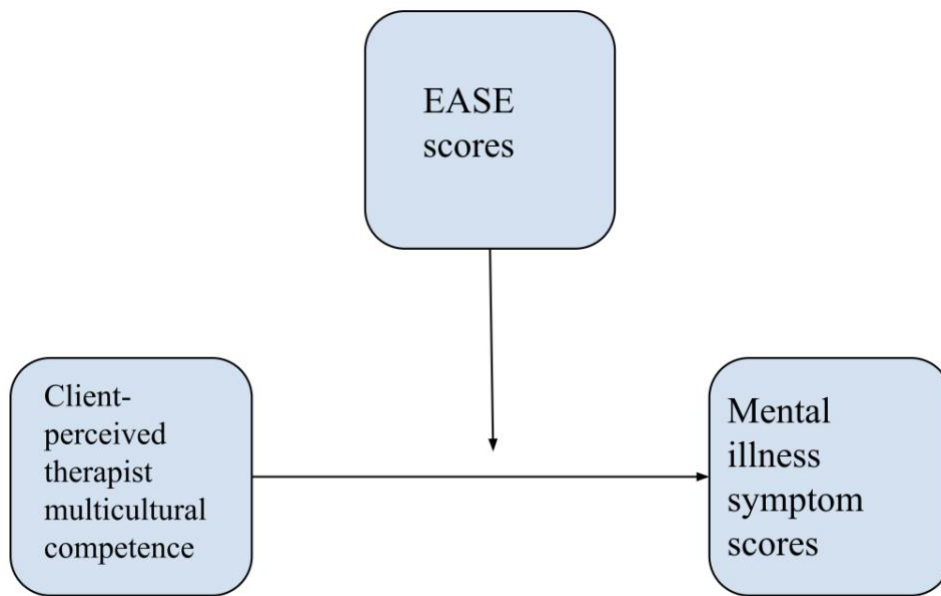


Figure 6.

Perceived therapist cultural competence was entered as the predictor variable (X), client self-reported mental illness symptom scores were entered as the outcome variable (Y), while EASE scores were the moderator (M). The interaction between client-perceived cultural competence, and EASE was significant (R^2 change = 0.16, $b = -.21$, $SE = 0.03$, $t = -6.61$, $p < .001$), indicating that the relationship between perceived cultural competence and mental illness symptoms was moderated by EASE scores. The simple slope of X on Y was not significant at low levels of M (Mean = 37.44, $b = .53$, $SE = .59$, $t = .92$, $p = .37$), but it was significant at moderate (Mean = 54.00, $b = -2.90$, $SE = .35$, $t = -8.34$, $p < .001$) and at high levels of M (Mean = 60.00, $b = -4.14$, $SE = .42$, $t = -9.96$, $p < .001$). At low levels of EASE, the relationship

between perceived cultural competence and mental illness symptoms was not affected. At moderate levels of EASE, a one-point decrease in perceived competence was associated with a 2.90-point increase in mental illness scores. At high levels of EASE, a one-point decrease in perceived competence was associated with a 4.14-point increase in mental illness scores.

7) Does Meaning Mindset moderate the relationship between EASE and mental health? Specifically, does the inverse effect of EASE on mental illness symptoms increase with increased Meaning Mindset?

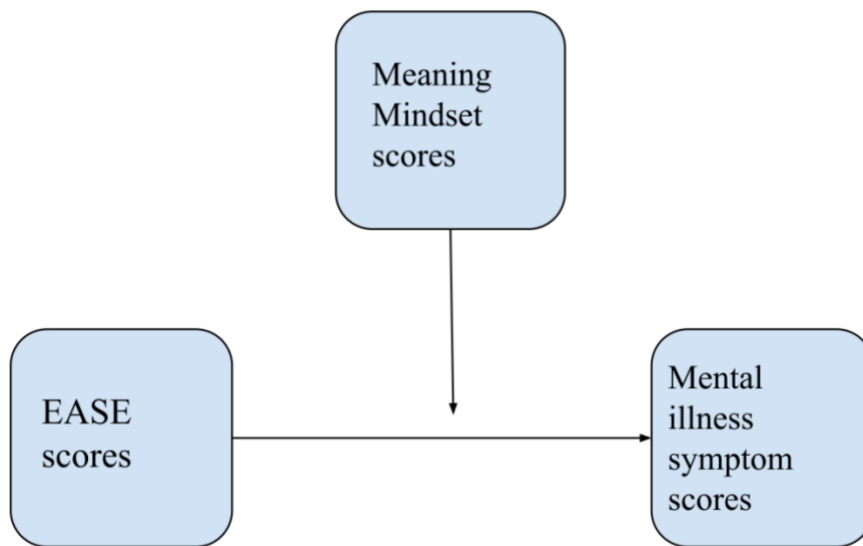


Figure 7.

EASE scores were entered as the predictor variable (X), client self-reported mental illness symptoms scores were entered as the outcome variable (Y), while Meaning Mindset scores were the moderator (M). The interaction between EASE and Meaning Mindset was significant (R^2 change = 0.25, $b = -.11$, $SE = 0.01$, $t = -8.86$, $p < .001$), indicating that the relationship between EASE and mental health was moderated by Meaning Mindset scores. The simple slope of X on Y was not significant at low levels of M (Mean = 68.24, $b = .40$, $SE = .38$, $t = 1.04$, $p = .31$), but it was significant at moderate (Mean = 89.50, $b = -1.91$, $SE = .37$, $t = -5.19$, p

< .001) and at high levels of M (Mean = 120.00, $b = -5.23$, $SE = .60$, $t = -8.76$, $p < .001$). At moderate levels of Meaning Mindset, a one-point increase in EASE was associated with a 1.91-point decrease in mental illness scores. At high levels of Meaning Mindset, a one-point increase in EASE was associated with a 4.39-point decrease in mental illness scores.

Qualitative Analysis

As previously noted, the current research used a Knowledge-Translation Integrated approach. To start, participants were given the opportunity to reflect and share whatever they wished about their experience in psychotherapy with an open-ended question. Secondly, to ensure that visible minority clients, the stakeholders in this research, can benefit from the research and the EASE model, standards of acceptability, credibility, sustainability and feasibility were examined. Additionally, participants were asked for feedback and recommendations relating to the research.

Out of the 53 participants, 11 participants responded to the first part of the qualitative survey. Theme 1A: “Positive experience in Psychotherapy.” Most participants expressed having a positive experience in psychotherapy.

Reflections:

- *“I was able to talk to a therapist about some of my problems.”*
- *“It increased my self-awareness and understanding.”*
- *“The therapist and I respect each other so communication is easier.”*
- *“My spouse and I are in a marital crisis due to chronic misunderstandings and miscommunication. My therapist taught us to listen, understand and tolerate each other through couples' therapy. Over time, we rebuilt trust, and our relationship became stronger and happier.”*

- *“I fell into deep anxiety because of creative pressure and doubts about my self-worth. Through a series of in-depth conversations and drawing therapy sessions, my psychotherapist helped me gradually regain my creative enthusiasm and confidence. In the end, I not only overcame the psychological barrier, but also gained recognition in the art world.”*

Theme 1B: “Negative Experience in Psychotherapy.” Two participants described a negative experience in psychotherapy.

Reflections:

- *“It is important to learn more about the experience of a therapist before choosing one.”*
- *“It’s better to go to a reputable therapist with more experience and patience.”*

Upon further analysis, the researcher made the following observation: both participants who described a negative experience had identified as visible minorities and had seen non-minority psychotherapists. Both participants had only followed some of their psychotherapist’s recommendations and one participant had terminated prematurely while the other had completed psychotherapy.

Qualitative Hypothesis 1: Credibility

The standard of credibility in this research is also twofold. Firstly, the research examined credibility quantitatively through the measures of EASE, alliance, Meaning Mindset, mental health, and multicultural competence.

Secondly, the research examined whether the experience of psychotherapy was credible for visible minority clients and see whether feedback, positive or negative, was relevant to the research questions. Out of the 53 participants, 12 participants responded to the part of the qualitative survey assessing credibility (e.g., therapy perceived as helpful). Theme 2A:

“Psychotherapy services were helpful.” Most participants expressed that their experience in psychotherapy achieved what they thought it would.

Reflections:

- *“Yes, because I am able to face my fear.”*
- *“I’m sleeping better.”*
- *“I achieved a lot.”*
- *“I’m still in therapy but I can feel that I’m a lot less stressed than before.”*

Theme 2B: “Psychotherapy services were not helpful.” Some participants expressed that their experience in psychotherapy did not achieve what they thought it would or only somewhat achieved what they thought it would.

Reflections:

- *“I thought it was going to be easy, but I guess I was wrong. It can sometimes be an ugly situation.”*
- *“It almost did.”*

The participants who responded negatively all had identified as visible minorities. Of the participants who had negative experiences, those who had seen a visible minority psychotherapist had either completed services or were planning to complete services, while those who had seen non-minority psychotherapists had either terminated services prematurely or were planning to do so. One participant had been seeing a non-minority psychotherapist, had been following all recommendations from their psychotherapist and was planning to prematurely terminate services. Another participant had been seeing a visible minority psychotherapist, had been following all recommendations from their psychotherapist and was planning to complete services. A third participant had been seeing a non-minority psychotherapist, had only followed

some of their recommendations and had terminated prematurely. A final participant had been seeing a visible minority psychotherapist and not followed any recommendations but had completed services.

Qualitative Hypothesis 2: Acceptability

The standard of acceptability in this research is twofold. Firstly, the research examined whether the items on the measures are easily understood by participants and that participants are satisfied with the measures. In the survey for the validation of EASE, four participants responded to the qualitative aspect of the survey regarding acceptability, while 15 participants declined to answer. Two participants noted that they did not have any issue understanding the items on the survey and that they were not dissatisfied. Two other participants noted that while they understood the items on the survey and were satisfied, they had difficulty choosing a single psychotherapist to reflect on because they had experiences with several different psychotherapists.

Secondly, the research examined whether the experience of psychotherapy was acceptable to visible minority clients and see whether feedback, positive or negative, was relevant to the research questions. Out of the 53 participants, 12 participants responded to the part of the qualitative survey assessing acceptability. Theme 3A: "Psychotherapy services were acceptable." Most participants expressed that their experience in psychotherapy achieved the outcome they wanted or was in the process of achieving the outcome they wanted.

Reflections:

- *"Yes, it led to the outcome I wanted."*
- *"I improved after talking to the psychotherapist."*
- *"All around!"*

- *“It led to my self-understanding.”*
- *“It’s going in a good direction.”*
- *“I believe it will achieve the effect I want - I am more confident now.”*

Theme 2B: “Psychotherapy services were not acceptable.” One participant expressed that their experience in psychotherapy did not achieve the outcome they wanted.

Reflection:

- *“It almost achieved the outcome I wanted.”*

The single participant who responded negatively had identified as a visible minority, had seen a non-minority psychotherapist, had only followed some of the psychotherapist’s recommendations and had prematurely terminated psychotherapy services.

Qualitative Hypothesis 3: Sustainability

The standard of sustainability in this research is twofold. Firstly, the researchers asked for feedback on the measures from participants and suggestions for changes to be made in the future. In the survey for the validation of EASE, three participants responded to the qualitative aspect of the survey regarding sustainability, while 16 participants declined to answer. Two participants recommended clarifications or elaborations, e.g. items in the survey beginning with “*My work with my psychotherapist helped me ...*” rather than “*My psychotherapist helped me...*” to denote the more collaborative nature of psychotherapy. Finally, one participant recommended adding an item to the survey regarding a *psychotherapist’s ability to explore feelings around barriers or limitations to reaching goals.*

The current research also examined whether the experience of psychotherapy was sustainable for visible minority clients and see whether feedback, positive or negative, was relevant to the research questions. Out of the 53 participants, 12 participants responded to the

part of the qualitative assessing sustainability (e.g., perceive outcomes they achieved were/could be sustained long-term). Theme 4A: “Psychotherapy services were sustainable.” Most participants expressed that they were able to maintain the outcomes they achieved in psychotherapy.

Reflections:

- *[The outcome] “will stay because it makes me feel happier.”*
- *“Yes, because I’ve learned a lot of new perspectives in therapy.”*
- *“My social fear improved.”*

Theme 4B: “Psychotherapy services were not sustainable.” Three participants expressed that they had difficulty maintaining outcomes they achieved in psychotherapy.

Reflections:

- *“I try but it’s not that easy.”*
- *“I only sometimes can [maintain the outcome].”*
- *“I kept a little.”*

These last three participants had all identified as visible minorities, with two of them having seen a visible minority psychotherapist and one having seen a non-minority psychotherapist. The two who had seen a visible minority psychotherapist had either completed services or were planning to do so, and the participant who had seen a non-minority psychotherapist had terminated services prematurely.

Qualitative Hypothesis 4: Feasibility

Finally, the current research examined whether the experience of psychotherapy was feasible for visible minority clients and see whether feedback, positive or negative, was relevant to the research questions. Out of the 53 participants, 12 participants responded to the part of the

qualitative survey assessing feasibility (e.g., outcomes they hoped for were feasible to attain).

Theme 5A: “Psychotherapy services were feasible.” Most participants expressed that the outcomes they were hoping to achieve were feasible in the context of psychotherapy.

Reflections:

- *“It’s attainable because I’m seeing the outcome now.”*
- *“It should be possible – we all work very hard.”*
- *“I believe it can change.”*
- *“Yes, because I have a very human therapist.”*

Theme 5B: “Psychotherapy services were not feasible.” Two participants expressed that the outcomes they were hoping to achieve were not feasible in the context of psychotherapy.

Reflection:

- *“Not at all.”*

Both participants who expressed that the outcomes they were hoping for were not feasible had identified as visible minorities and both had either terminated services prematurely or were planning to do so. One of the participants had seen a visible minority psychotherapist and the other had seen a non-minority psychotherapist.

Discussion

The current research has significant potential implications. The first potential significant implication of the current study is that it builds on ways to improve mental health outcomes in psychotherapy. As the literature shows, less than a fifth of individuals who need mental health services access these services appropriately (CMHA, 2021). This suggests a significant problem in the mental health care system. Therefore, improving well-being by exploring core elements of effective psychotherapy may be a key implication of the present research. More specifically, the

current research findings can have potentially significant implications for continued research on ways to improve mental health outcomes for visible minority populations, or marginalized communities in general. As presented previously, racial disparities in health services have been extensively studied; with visible minorities generally having worse experiences of health services than their non-minority counterparts (McGuire & Miranda, 2008; Vaughan et al., 2009; Lu et al., 2021). Further, the current research may have potentially important implications for the ongoing development of education for psychotherapists. Sue et al. has extensively studied the experience of visible minorities in mental health care and has shown that visible minorities have more difficulty accessing appropriate and satisfactory mental health care than their non-minority counterparts (1991; Lu et al., 2021). If the EASE model were to be further studied and later taught to psychotherapists, it may ultimately be beneficial to visible minority clients.

The current research used a mixed methods model, including quantitative and qualitative analyses. Further, as the current research studied the experiences of visible minority clients, a Knowledge Translation-Integrated approach was used, and the qualitative analyses assessed the credibility, acceptability, sustainability and feasibility of their experiences and the EASE model.

Although the sample size for the current study was fairly small, the general outcome of the research was significant and positive. The quantitative analyses showed that the perceived use of EASE was associated with Meaning Mindset, mental health, alliance, client-perceived therapist cultural competence, and retention rate. The qualitative analyses showed that the participants who did not report a positive experience in psychotherapy happened to be visible minorities.

Credibility

Credibility was assessed quantitatively, through the measures, and qualitatively by assessing perceived value of psychotherapy for participants.

Firstly, the research showed that a perception that psychotherapists were using EASE skills was associated with better mental health. This suggests that the more a client perceived EASE to be used in session by their psychotherapist, the less likely they were to report mental illness symptoms. Inversely, the less psychotherapists were perceived to use EASE, the greater the mental illness symptoms. Research shows that most people experience some improvement in their mental health with psychotherapy, showing the effectiveness of services (Howard et al., 1986; Gergov et al., 2021). If services can be made more effective, perhaps clients can see improvement in their mental health faster.

In addition to the relationship between EASE and mental health, there was also a relationship between EASE and alliance. Specifically, the more a client perceived their psychotherapist to be using EASE in their work, the stronger the alliance they reported. In fact, every component of EASE was associated with alliance. This finding has a potentially significant implication because of the importance of alliance. According to the literature, the common denominator in effective psychotherapy across approaches is a strong alliance (Martin et al., 2000; Ardito & Rabellino, 2011). On the other hand, the biggest predictor of premature termination is a poor alliance (Anderson et al., 2009). Understanding how to promote alliance is, therefore, of critical importance.

In addition to EASE and alliance, EASE was also associated with minority status. This suggests that visible minority clients were much less likely to perceive that their psychotherapists used EASE in their work. Since the research shows poorer psychotherapy outcomes for visible minorities (Sue et al., 1991; Swift & Greenberg, 2012; Steinfeldt, 2020), this finding has a

significant potential implication. Finally, EASE was significantly correlated with client-perceived therapist multicultural competence. This suggests that the more a client perceived their psychotherapist to be using EASE, the more likely they were to report that they perceived their psychotherapist to be culturally competent. Of course, the EASE model emphasizes acknowledgment of circumstances and sensible action, which are core aspects of multicultural competence (Owen et al., 2011).

Additionally, the research showed a statistically significant negative relationship between Meaning Mindset (MM) and mental illness symptoms. This suggests that the more Meaning Mindset a client had, the less mental illness symptoms they were likely to report. The potential implication of this finding is important as well: the more a person has Meaning Mindset, the better their mental health may be. In previous research on Meaning Mindset, researchers found that Meaning Mindset was associated with positive coping skills, mental health and general well-being (Armstrong & Potter, 2022). Specifically, Meaning Mindset characteristically cultivates positive self-concept, hope for the future and more control over one's thoughts and behaviours, which are all part of positive therapeutic outcome (Armstrong & Potter, 2022). Furthermore, the research showed a statistically significant relationship between EASE and Meaning Mindset. This suggests that clients who perceived their psychotherapist to be naturally using EASE in their work also had higher Meaning Mindset. Given that a high Meaning Mindset is consistently associated with good mental health in the literature, this potential implication is important. If EASE enhances MM, then this is likely to result in good mental health.

In addition to MM, there was a positive relationship between alliance and client-perceived therapist multicultural competence. This suggests that clients who perceive their psychotherapists to display multicultural competence also tend to report a strong alliance with

their psychotherapist. Given that the literature shows that visible minorities are less likely to experience a strong alliance in health care services, including mental health care (OHRC, 2004; Sue et al., 1991; Ardito & Rabellino, 2011), and that visible minorities search for psychotherapists who match their ethnicities for a stronger alliance and better outcome (Sue et al., 1991; Ziguras et al., 2003), the potential implication is that visible minorities may feel stronger alliances with multiculturally competent psychotherapists even if psychotherapists are non-minorities themselves. This suggests that visible minorities can have more positive experiences in psychotherapy, with better outcomes, if their psychotherapists are trained to be more multiculturally competent. Additionally, the research showed a statistically significant positive relationship between Meaning Mindset and client-perceived therapist multicultural competence. This suggests that clients who perceive their psychotherapists to display multicultural competence also tend to report more Meaning Mindset. The broader literature shows that multicultural competence is strongly associated with therapeutic outcomes (Owen et al., 2011; Tao et al., 2015).

The research also showed a significant correlation between client-perceived therapist multicultural competence and mental health. This suggests that the more a client perceived their psychotherapist to be culturally competent, the less mental illness symptoms they reported. This may have a significant implication due to the high rates of mental illness reported in Canada (CMHA, 2021). Client-perceived therapist multicultural competence was also significantly correlated with visible minority status. This suggests that visible minority clients were less likely to report that they perceived their psychotherapist to be culturally competent. Given the literature presented on the poor outcomes of psychotherapy for visible minorities, this finding makes sense. Finally, client-perceived therapist multicultural competence was significantly associated

with retention rates. This suggests that the more a client perceived their psychotherapist to be culturally competent, the more they were willing to stay in psychotherapy for the recommended time. This has a potentially significant implication for visible minority clients who terminate service prematurely at higher rates than their non-minority counterparts (Swift & Greenberg, 2012; Owen et al., 2012). Maybe if visible minorities perceived their psychotherapist to be culturally competent, they would stay in services longer than they would otherwise.

Unfortunately, minority status was also significantly correlated with mental illness symptoms. This suggests that visible minority clients were significantly more likely to report mental illness symptoms than their non-minority counterparts. This finding is in accordance with the broader literature on higher mental illness rates for visible minorities (Office of the Surgeon General, 2001; Chow et al., 2003; Hackett et al., 2020). Minority status was also significantly inversely correlated with alliance. This finding suggests that visible minorities were less likely to perceive a strong alliance with their psychotherapist than non-minority clients. This finding is also in accordance with the broader literature on lower alliance rates for visible minorities (OHRC, 2004; Steinfeldt, 2020). The research also showed a significant association between alliance and Meaning Mindset. This suggests that the more alliance a client perceived with their psychotherapist, the more Meaning Mindset they were likely to report. This is in accordance with the literature which shows that a strong alliance is the greatest predictor of positive outcomes in psychotherapy (Martin et al., 2000; Ardito & Rabellino, 2011; Tasca & Marmarosh, 2023). The finding in the current research has a potentially significant implication due to the powerful influence of Meaning Mindset on mental health and general well-being (Armstrong & Potter, 2022). Similarly, alliance was significantly correlated with mental health, suggesting that the more a client perceived a strong alliance with their psychotherapist, the less mental illness

symptoms they reported. This finding is in line with previously presented research on the impact of alliance and has a potentially significant implication due to high needs for mental illness treatment, as presented previously.

Finally, the data showed a significant correlation between retention rates and Meaning Mindset. This suggests that the longer a client stayed in psychotherapy services, the more Meaning Mindset they were likely to report. Similarly, there was a strong association between retention rates and mental health, suggesting that the longer a client stayed in psychotherapy services, the less mental illness symptoms they reported. The broader literature supports this finding as Anderson and colleagues found a significant correlation between retention and mental health in 2009. The research also showed a positive relationship between clients' perceived use of EASE by their psychotherapists and retention rate. This suggests that clients with psychotherapists who naturally use the EASE model in their work are more likely to stay in therapy. The potential implication of this finding is significant for visible minorities, for whom the literature shows significantly higher dropout rates (Sue et al., 1991; Swift & Greenberg, 2012; Owen et al., 2012). Half of visible minority-clients are shown to terminate therapy after just one session (Sue et al., 1991). In fact, client ethnicity has been repeatedly found to be a predictor of premature termination, even when other variables are controlled (Sue et al., 1991; Owen et al., 2012).

The current study suggests that if psychotherapists use the EASE model, their visible minority clients may be more likely to continue working with them than they would have otherwise. This would be quite a significant potential implication for visible minorities. Otherwise, the current research showed a weak relationship between alliance and retention rate, and visible minority status and retention rate. This suggests that a stronger alliance between

clients and psychotherapists only slightly impacts how willing the client is to stay in therapy. Similarly, the research showed that visible minority clients are only slightly more likely to drop out of therapy than their non-minority counterparts. Surprisingly, the findings were not in line with the literature which shows significant relationships. The literature shows that a strong therapeutic alliance is key for client retention (Martin et al., 2000; Campbell et al., 2015). The literature also shows that visible minorities are much more likely to drop out of services (Sue et al., 1991; Arnow et al., 2007; Swift & Greenberg, 2012).

Credibility was also assessed quantitatively through moderation analyses. The more a visible minority client perceived their psychotherapist to be naturally using EASE in their work, the less mental illness symptoms they were likely to report. The potential implication of this finding is very important. The marginally worse outcomes of psychotherapy experienced by visible minorities have been studied extensively, as presented previously (Swift & Greenberg, 2012; Sue et al., 1991; Jones & Thorne, 1987; Yamamoto et al., 1968; Office of the Surgeon General, 2001; Wong et al., 2016; Steinfeldt, 2020). Additionally, The Office of the Surgeon General reported in 2001 that visible minorities tend to experience mental illness at significantly higher rates than their non-minority counterparts due to several historical and socio-economic circumstances. This still seems to be the case (Hackett et al., 2020). Therefore, the integration of the EASE model in psychotherapy can be beneficial for the mental health of visible minorities. Secondly, the relationship between client-perceived therapist multicultural competence and mental illness symptoms was found to be moderated by EASE. This suggests that the more a psychotherapist is perceived to be naturally using EASE in their work, the better the client's mental health if the psychotherapist is perceived to be multiculturally competent. This finding may be, in part, due to the inherent nature of the EASE model. The model emphasizes

acknowledgment of circumstances and sensible action, which are at the core of therapist multicultural competence, as this competence requires acquiring knowledge of clients' cultural background and worldview and how they impact them and then using culturally responsive interventions (Owen et al., 2011; Tao et al., 2015). Notably, since multicultural competence has been found to be potentially effective in improving all aspects of therapeutic outcome, its use has become a required ethical competency as per the American Psychological Association (2008).

The relationship between alliance and mental illness symptoms was also found to be moderated by EASE. This suggests that the stronger the alliance between client and psychotherapist, the better the client's mental health if the psychotherapist is perceived to be using the EASE model in their work. In other words, if the psychotherapist is using EASE in their work, their client is more likely to report good mental health if their alliance is strong. The literature shows a strong link between alliance in psychotherapy and decreased psychological symptoms as well as increased well-being (Howgego, 2003; Ardito & Rabellino, 2011; Fluckiger et al., 2018; Tasca & Marmarosh, 2023). The literature also shows that a significant part of alliance is empathy. Rogers emphasized therapist empathy as the core ingredient of therapeutic alliance (1957), and many studies have since shown the effect of empathy on alliance (Myers, 2000). Therefore, the finding of the current study may be due, in part, to the emphasis on empathy in the EASE model. Additionally, the relationship between alliance and retention rate was found to be moderated by EASE as well. This suggests that the more a psychotherapist is perceived to be naturally using EASE in their work with clients, the less likely their clients are to drop out of therapy when they feel a strong alliance with their psychotherapist. As mentioned previously, the literature shows a strong correlation between alliance and client retention (Martin et al., 2000; Campbell et al., 2015). Therefore, the potential implication of this finding is

important. Specifically, psychotherapists who use EASE and put efforts towards having a significant alliance with their clients may have stronger retention rates. As the literature shows an exponentially larger dropout rate for visible minorities (Swift & Greenberg, 2012; Sue et al., 1991), combining the EASE model and efforts for strong alliances can benefit visible minority clients.

Finally, the relationship between EASE and mental illness symptoms was also moderated by Meaning Mindset. This suggests that the more Meaning Mindset a client has, the less mental illness symptoms they are likely to report if they perceive their psychotherapist to be naturally using EASE in their work with them. Previous research on Meaning Mindset has shown that a Meaning Mindset predicts mental illness symptom alleviation and increased resilience and well-being (Armstrong & Potter, 2022). The present finding suggests that a psychotherapist who uses EASE and works toward helping their clients cultivate a Meaning Mindset may help their clients have better mental health.

The current research showed that the relationship between visible minority status and retention rate was not moderated by EASE, nor was the relationship between client-perceived therapist multicultural competence and retention rate. However, the outcome variables were not continuous, and the moderation analyses used Chi-squares for these two models. Chi-squares reduce power more than analyses for continuous variables. Effects were not detected with a small sample size, and potentially lower power with these analyses. To increase power, further research should explore these variables with a larger sample size or continuous variables. If the findings are, however, genuine and not spurious false negatives, this would suggest that a psychotherapist who naturally uses EASE in their work may still have visible minority clients dropping out of services. It also indicates that a psychotherapist who naturally uses EASE in

their work may still have clients dropping out of treatment even if they are perceived to be multiculturally competent. These findings are surprising and are certainly worthy of being studied further. Although the research shows significantly higher dropout rates for visible minority clients, the current research shows that the EASE model is likely positively related to retention rate. The current study also indicates that client-perceived multicultural competence is likely associated positively with psychotherapy outcomes, such as mental health outcomes.

Credibility was also assessed qualitatively. Most participants found psychotherapy to be valuable and reported a positive experience. However, the participants who did not report a positive experience and did not find psychotherapy to be valuable happened to be visible minorities. Although the sample was too small to make a strong, generalisable inference, the literature over the past several decades does show that visible minorities experience significantly fewer positive outcomes in psychotherapy (Swift & Greenberg, 2012; Sue et al., 1991; Jones & Thorne, 1987; Yamamoto et al., 1968; Office of the Surgeon General, 2001; Wong et al., 2016; Steinfeldt, 2020).

Acceptability

Acceptability was assessed qualitatively in the current study. Specifically, participants in the current study reported on their experiences in psychotherapy. Most participants were satisfied with the quality of services they received in psychotherapy, and most were satisfied with the outcomes of the services. However, the participant who was unsatisfied with the services or their outcomes was also a visible minority. Again, although the dissatisfied sample was too small to make a significant inference, the literature does point to poor satisfaction with psychotherapy services by visible minorities (Swift & Greenberg, 2012; Sue et al., 1991; Jones & Thorne, 1987;

Yamamoto et al., 1968; Office of the Surgeon General, 2001; Wong et al., 2016; Steinfeldt, 2020).

Sustainability

Sustainability was assessed qualitatively in the current study. Participants in the current study reported on their experiences in psychotherapy. All participants reported maintaining the positive outcomes of their psychotherapy once services had ended. Those who were still seeing their psychotherapist could maintain outcomes since they began. However, some participants reported experiencing more difficulty keeping their outcomes. These participants were visible minorities. As mentioned previously, the sample in the current study of those with poor outcomes was too small to infer this finding. Still, the literature presented above shows worse outcomes for visible minorities, which may explain why visible minorities have more difficulty maintaining positive outcomes once services have ended. Otherwise, the literature indicates that many forms of traditional mental health assessments, interventions and treatments are not effective with visible minorities and, therefore, may be more challenging to maintain (Sue et al., 1991; Jones & Thorne, 1987; Alegria et al., 2010).

Feasibility

Finally, feasibility was also assessed qualitatively in the current research, with participants reporting on their experience in psychotherapy. Most participants shared that the outcomes they hoped to achieve in psychotherapy were feasible within the context of psychotherapy services. However, those who did not report feeling this way were visible minorities. As mentioned regarding the other findings, the dissatisfied sample size in the current study is too small to make an inference regarding this finding, but the literature shows that psychological assessments and interventions have been standardised and validated with non-

minorities (Jones & Thorne, 1987; American Psychological Association, 2016). As a result, many assessments and interventions may not fit the needs of visible minorities at all.

Additionally, as mentioned, many forms of traditional mental health treatments have already been found to be ineffective with visible minorities (Sue et al., 1991; Alegria et al., 2010).

Finally, the underrepresentation of visible minorities in positions of power in the mental health care system has shown that consideration of the needs and experiences of visible minorities has been limited (Mensah et al., 2021). These findings in the literature may explain why visible minorities did not feel that the outcomes they were hoping to achieve were feasible in the traditional context of psychotherapy.

Limitations

The current research has a few limitations. The current study's sample size was small but more than adequate for an initial pilot study (Totton et al., 2023). However, small and medium effects may be more challenging to detect with a small sample size. Therefore, relationships may exist, but data may present with false negatives. Secondly, for the qualitative portion of the survey, many participants only responded to yes/no questions and did not provide detailed responses to open-ended questions. Most responses were brief. Additionally, as the quantitative and qualitative data was collected through an online survey, the data included duplicate responses that later had to be removed manually, and some questions did not yield very fruitful responses.

Future Directions

To address these limitations, this kind of study would benefit from a larger sample size to allow for more inference, more generalisability and more real-world application, as the research questions have critical potential applications for visible minority clients. This kind of study

would also benefit from having its qualitative data collected through interviews. Furthermore, it would be beneficial to further investigate the findings that were surprising and/or contradicted other established findings.

Conclusion

The literature shows that visible minorities are much less likely to report positive outcomes or high retention rates in psychotherapy than their non-minority counterparts. The current research studied the use of a new model, EASE, in services as usual and showed that the perceived use of EASE in psychotherapy can result in a stronger alliance between psychotherapists and clients, more Meaning Mindset, better mental health, better client-perceived multicultural competence, and a higher retention rate. Further investigations based on larger samples could yield beneficial implications for visible minority psychotherapy clients.

Chapter Three

**Article 2: EASE in Ombuds Services as Usual – Relationship with Alliance, Mental Health,
& Service Retention for Visible Minorities**

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Chapter Three

Ombuds

Ombuds Services and Positive Outcomes

Ombuds work in organisations as facilitators and mediators in dispute resolutions (Harrison, 2004). They are mainly active in federal regulation, litigation and activism organisations, as well as institutions such as universities, healthcare, banks, prisons, and large corporations (Harrison, 2004). According to the International Ombuds Association, the job of an ombuds is to provide a safe space for *visitors*, the field's *client* equivalent, to discuss concerns, facilitate the exploration of options to resolve conflicts while remaining impartial, and bring systemic concerns to the attention of the organisation (International Ombuds Association, n.d.). Ombuds are “facilitators of an active change process” (Klockmo et al., 2012). Some strategies that ombuds use in their work include active listening, giving hearing to feelings, problem solving and facilitating options, defusing strong emotions, offering advice, conciliation and coaching (Harrison, 2004). Research shows that dispute resolution that incorporates the visitor's voice and collaboration receives higher ratings of outcome satisfaction (Harrison, 2004).

Furthermore, studies show that having a voice in the process is critical in the visitor's perception of fairness, and that visitors generally perceive fairness as more important than the outcome of the process itself (Harrison, 2004). Research also shows that visitors value ombuds who are unbiased throughout the process and are more likely to positively evaluate an impartial ombuds, even when they do not achieve their desired outcome (Harrison, 2004). Ombudsman Ontario posits that this process begins with building a relationship between the ombuds and visitor, and establishing trust (Dubé, 2017). An early theory about ombuds practice, grounded in procedural justice, hypothesises that the trust visitors have in their ombuds can help generate

cooperation, compliance and outcome acceptance (Creutzfeldt & Bradford, 2016). Additionally, visitors given the time and space to process their emotions evaluate their ombuds more positively (Harrison, 2004). Finally, like with alliance in psychotherapy, positive outcome is generally correlated with effective mediation, validation from the ombuds and the visitor feeling heard due to the ombuds' active and empathetic listening (Harrison, 2004). Also like in psychotherapy services, empathetic listening in ombuds practice includes empathy for the visitor's concerns, clarifying, re-stating, reflecting, summarising, and validating feelings and thoughts (International Ombudsman Association, n.d). The present research is, however, the first quantitative study exploring ombuds outcomes, so it is unknown if factors such as alliance led to positive outcomes in ombuds practice, as they do in psychotherapy.

Ombuds Work and Visible Minorities

According to the International Ombuds Association, part of the job of an ombuds is to communicate successfully with a diverse range of visitors (International Ombuds Association, n.d.); ombuds across the country regularly deal with issues of Equity, Diversity and Inclusion (EDI) in their work, which includes work with visible minorities (McGhee Peggs & Epperson, 2021). A 2021 survey showed that 44% of ombuds offices in Canada encounter EDI issues daily (McGhee Peggs & Epperson, 2021). EDI issues included complaints about microaggressions, stereotyping and bias, and racist, ableist or homophobic statements by other individuals in the visitor's institution (McGhee Peggs & Epperson, 2021). Additionally, ombuds reported dealing with issues of inequity and exclusion in institutional groups, as well as failures to incorporate EDI into policies and decision-making, and accommodate or provide services for minorities (McGhee Peggs & Epperson, 2021).

As a result, ombuds offices are increasingly making efforts to consider EDI in their practice. For example, 89% of ombuds offices approach EDI differently because of the Black Lives Matter movement (McGhee Peggs & Epperson, 2021). Ombuds seek to recognise key EDI concepts, such as unconscious bias, oppression, intersectionality, equality and equity, anti-Black and anti-Indigenous racism, and allyship (McGhee Peggs & Epperson, 2021). Additionally, ombuds are seeking to discuss EDI challenges like supporting Black, Indigenous and People of Colour (BIPOC) visitors (McGhee Peggs & Epperson, 2021). Specifically, ombuds are working towards being effective allies and collaborating with their BIPOC visitors with a sense of genuineness, humility and understanding (McGhee Peggs & Epperson, 2021). Ombuds are now striving to not only call their offices “safe spaces” but “brave spaces” for their visitors (McGhee Peggs & Epperson, 2021). Although these issues are becoming more recognised, visible minorities remain significantly underrepresented among those seeking ombuds services (Department of Justice Canada, 2024), despite facing higher rates of racism, workplace dismissal, and stigma compared to non-visible minorities (Office of the Ombuds-Shared Services Canada, 2023). This disparity in ombuds service access mirrors the lower utilisation of psychotherapy services among visible minorities (Grace et al., 2016). To improve access, it is crucial to identify factors that enhance service effectiveness and fit for minority populations. As immigration rates increase, with every one in four people in Canada being part of a racialized group as of 2022, this may be even more important (Hou et al., 2023).

Premature Termination in Ombuds Work

Unfortunately, ombuds work is not immune to the issue of premature termination. According to the Annual Report by the Government of Canada, 1554 new ombuds cases were handled last year (2024). Of those closed at intake, a little more than 1000 involved direct

information or assistance and on the contrary, 79 were withdrawn and 86 were abandoned (Government of Canada, 2024). Of those closed at complaint resolution, 24 involved informal resolution, 33 involved direct information and assistance and eight were withdrawn (Government of Canada, 2024). Finally, of those closed at investigation, 65 involved direct information or assistance, eight involved an informal resolution, four were abandoned and 11 were withdrawn (Government of Canada, 2024). Therefore, although rates of premature termination are much lower in ombuds work than psychotherapy, it is still beneficial for ombuds to develop strong alliances with their visitors to achieve the best outcomes.

Multicultural Competency in Ombuds

Although there has not been any research on the potential impact of multicultural competence in the work of ombuds, significant findings have been made on its impact in psychotherapy. Studies indicate a robust correlation between elevated scores on multicultural competence scales administered by therapists and favourable outcomes in treatment (Sue et al., 2009; Owen et al., 2011; Tao et al., 2015). According to Tao et al. (2015), high scores on these measures are also linked to higher scores on measures that gauge therapeutic relationship, the effectiveness of sessions (including mood after sessions), and client satisfaction (including readiness to suggest their counsellor to loved ones). Furthermore, Tao et al. (2015) found that successful mending of strained connections and more extraordinary judgments of empathy and authenticity are linked to high multicultural competence scores. Lastly, there is a substantial link between clients' improvements in their social and personal lives, their high assessments of multicultural competence, and a rise in their overall well-being (Owen et al., 2011; Tao et al., 2015).

As stated, ombuds consistently work with individuals who require help with their mental health. Thus, these findings may also apply to the context of ombuds practice. Additionally, ombuds practice can benefit from strong ombuds-visitor relationships, visitor satisfaction and overall positive outcomes, all of which psychotherapy research correlates with multicultural competence (Sue et al., 2009; Owen et al., 2011; Tao et al., 2015). As such, a theoretical framework is needed to build ombuds-visitor relationships.

Theoretical Framework

Alliance and Mental Health

While mental health services are now more accessible than ever, only 16% of individuals who need them seek the appropriate care, according to research from the Canadian Mental Health Association (2021). Additionally, more than half of Canadians will experience a mental illness by the age of 40 (Canadian Mental Health Association, 2021). Structural inequalities—such as racism, discrimination, homelessness, poverty, colonial and gender-based violence, and limited access to mental health services—can contribute to higher rates of mental illness among visible minority communities. However, mental health challenges can affect people from all walks of life, regardless of age, gender, cultural background, education, or socioeconomic status (Canadian Mental Health Association, 2021). This underscores the pressing need for accessible, high-quality mental health support.

Furthermore, studies highlight the significant impact of a strong client-practitioner bond on mental health outcomes (Horvath & Symonds, 1991; Tasca & Marmarosh, 2023). A positive therapeutic alliance has been consistently linked to improved mental health, regardless of treatment approach, therapy duration, or methods of measuring progress (Horvath & Symonds, 1991; Fluckiger et al., 2018). Case management research has also associated alliance with

reduced psychological symptoms, better quality of life, increased adherence to medication, and enhanced overall functioning (Howgego, 2003). A recent study conducted during the COVID-19 pandemic found that individuals with a stronger therapeutic alliance reported greater well-being, with 58% achieving clinical recovery and 57% experiencing an improvement in depressive symptoms (Sagui-Henson, 2022). This reinforces the role of alliance in improving mental health outcomes and enhancing service retention and overall success. For this reason, ombuds should prioritise building strong alliances in their practice. However, the exact factors contributing to fostering an effective alliance remain uncertain. Exploring existing theories may provide further insight.

Meaning Mindset Theory

Meaning Mindset Theory (MMT), which is based on Viktor Frankl's Logotherapy, proposes that challenges can ultimately lead to positive outcomes (Armstrong & Potter, 2022). Frankl's Logotherapy highlights the significance of everyday experiences and suggests that engaging with meaningful moments and practicing gratitude can enhance one's sense of purpose in life (Frankl, 1986). He emphasised that having a strong purpose is essential for overall well-being and can help individuals navigate difficulties (Frankl, 1986). According to MMT, obstacles can be used as opportunities to inspire motivation and meaningful change, particularly when they encourage growth, creativity, or deeper connections with others (Armstrong & Potter, 2022).

Moments of meaning—characterised by feelings of awe, gratitude, or a sense of value—emerge when individuals take control of their thoughts and actions, remain open to new experiences and emotions, cultivate a positive self-identity, establish and accomplish realistic goals, and maintain hope for a better future (Armstrong et al., 2018). A Meaning Mindset is defined by a strong sense of self-worth, openness to new opportunities, optimism for the future,

and the ability to manage thoughts and behaviours effectively (Armstrong & Potter, 2022).

Developing this mindset involves nurturing personal responsibility, embracing growth, and appreciating the present moment. It also requires confidence in one's ability to achieve goals, a willingness to learn with curiosity, and perseverance in facing challenges (Armstrong & Potter, 2022).

The Meaning Mindset can be cultivated using the CHANGE protocol, which includes the following steps (Armstrong & Potter, 2022):

- **Challenge** unhelpful thoughts by reframing them into more constructive perspectives.
- **Healthy actions** should be incorporated into daily life to support well-being and foster positive emotions.
- **Acknowledge** one's circumstances by recognising what is within one's control and letting go of what is not.
- **Nurture** a sense of belonging and self-compassion by strengthening relationships with oneself and others.
- **Gratitude** should be practiced consistently and realistically to build emotional resilience and enhance perspective.
- **Express** emotions clearly and constructively through effective communication.

Studies show that these skills can help individuals cope with challenges more effectively and lead to better mental health outcomes (Armstrong & Potter, 2022).

Meaning Mindset and mental health. People with a Meaning Mindset (MM) tend to achieve greater success, as emotional, social, and behavioural well-being are strongly linked to a sense of meaning in life (Ivtzan et al., 2015). Developing a Meaning Mindset is vital for building resilience to face future challenges, as well as for coping effectively and fostering resilience

throughout difficult life situations (Wong, 2017). Additionally, studies have shown that teaching MM strategies enhances mental health and a sense of purpose in diverse groups, such as children, homeless individuals, neurodiverse individuals, blended families, and those waiting for mental health services (Armstrong et al., 2025). Research on the effects of the COVID-19 pandemic found that individuals who used MM strategies, focusing on positive experiences like spending time with family, reported lower levels of mental illness and higher well-being (Armstrong & Potter, 2022). Therefore, adopting a Meaning Mindset can significantly improve mental health outcomes.

Stoic Dichotomy of Control

The widely used Cognitive behavioural therapy (CBT) takes inspiration from the Stoic concept of the dichotomy of control, which teaches that while we cannot control external events, we can influence how we interpret and respond to them (LeBon, 2023). In his *Enchiridion*, the Roman Stoic philosopher Epictetus writes, “You will lament, you will be disturbed, and you will find fault with both gods and men” (2012). He explains further that “some things are within our control and others are not. Our control extends to our opinions, actions, desires, and, in short, everything we do. What’s outside our control includes our bodies, possessions, reputation, authority, and everything that isn’t our actions” (Epictetus, 2012). The essence of Stoicism, which supports the dichotomy of control, suggests that most things in life are beyond our influence (Smith, 2024). Stoics believe that our emotions result from our mindset and encourage us to acknowledge that hardships are part of the human experience (Smith, 2024). Additionally, Stoicism encourages us to view ourselves as part of the broader human community and the natural world, rather than as isolated beings (Smith, 2024). Finally, Stoics advise that we should

treat everything we possess as temporary, reminding us that all things are ultimately transient (Smith, 2024).

Epictetus emphasises that achieving ataraxia—a state of tranquillity regardless of external circumstances—requires letting go of concerns about things we cannot control (2012). He argues that much of human suffering arises from the false belief that we can control things out of our hands (LeBon, 2023). Research has shown a clear connection between well-being and the balance of “relinquishing control over the uncontrollable” and “managing what we can control” (LeBon, 2023). Studies also show that this dichotomy leads to a more balanced experience of positive and negative emotions (LeBon, 2023). Moreover, evidence suggests that incorporating the dichotomy of control into daily life can improve resilience, increase well-being, and enhance overall life satisfaction (LeBon, 2023). In contrast, obsessing over uncontrollable future events has been linked to increased anxiety, while dwelling on past events instead of moving on is associated with depression (LeBon, 2023). Additionally, over-focusing on others' opinions can worsen anxiety, and believing that we can control others often leads to frustration and anger (LeBon, 2023). Therefore, applying the Stoic dichotomy of control can contribute positively to mental health.

EAR

The EAR approach centres on empathy, attention, and respect. It's a simple and effective way to listen to someone upset, helping them calm down, and can be applied to anyone, outside of ombuds settings (Eddy, 2018). It's beneficial for de-escalating conflicts and working towards peaceful resolutions (Eddy, 2021). This technique involves creating an "EAR Statement" that embodies empathy, respect, and attentiveness. The first step is to express a willingness to help and show understanding of the person's emotions through active listening (Eddy, 2018). For

example, a listener might say, “I can hear how frustrated you are, and I want to help.” Next, it’s essential to convey attentiveness through words and nonverbal cues, such as tone of voice and body language (Eddy, 2018). A listener might say, “Why don’t you tell me more about it so I can understand?” Finally, to make the person feel respected and taken seriously, it’s essential to verbally acknowledge them and their concerns (Eddy, 2018). For instance, the listener might add, “I respect how you’ve tried to handle this situation.”

According to the EAR approach, most people can discuss their issues and work towards solutions after calming down for 30 seconds following an EAR statement (Eddy, 2018). This highlights the power of offering empathy, attention, and respect in helping someone feel heard. Thus, the EAR approach enables the listener to connect with the upset person, which not only aids in problem-solving but also validates the person’s feelings (Eddy, 2018). Research has shown that empathic listening is a key factor in promoting positive change (Kwon & Jo, 2012). Emotional contagion is one reason the EAR approach is practical, as studies on the brain suggest that our mirror neurons can reflect the emotions we observe (Eddy, 2021). Therefore, when the listener responds with empathy, attention, and respect, the upset person will likely mirror the listener’s calmness and begin calming themselves (Eddy, 2021). It's important to remember that the EAR method is most effective when there is already a strong rapport between the listener and the distressed person (Eddy, 2011). However, as noted earlier, empathic listening plays a crucial role in building that rapport in the first place, creating a reinforcing cycle (Wynn & Wynn, 2006). The EAR approach can help calm a dysregulated visitor in an ombuds setting and foster an environment that supports effective conflict resolution.

EASE

EASE is an innovative approach for ombuds that integrates the EAR method, the Stoic dichotomy of control (SDC), and the Meaning Mindset Theory (MMT). This model emphasises empathetic listening, acknowledging circumstances, taking practical actions to solve problems, and evaluating thoughts through exploration (Armstrong et al., 2025). Ombuds utilising EASE will naturally demonstrate empathy, attention, and respect during visitor interactions (EAR). The approach includes reflecting on and summarising the visitor's emotions and thoughts, while exploring these with an open, genuine, and curious mindset (Epperson & Armstrong, 2024). Additionally, ombuds will recognise their visitors' uncontrollable circumstances while working with them to identify sensible actions within their control (SDC). Finally, ombuds will explore their visitors' emotional difficulties, sense of agency over their thoughts and behaviours, self-concept, openness to new experiences, and hope for the future (MMT).

The sub-elements of EASE are **a**ttention, **b**iases, **c**aring, **d**eepening understanding and **d**efining the problem, **e**stablishing goals, **f**ormulating a plan, and **g**enerating agency (Epperson & Armstrong, 2024). An ombuds naturally using EASE will give a visitor and their problem attention while responding empathetically; they will check in with their own biases and set them aside to listen non-judgementally; they will show care for the visitor's feelings and experiences through respect and validation; they will deepen their understanding of the visitor's problem to understand it from the visitor's perspective; they will establish realistic goals collaboratively with the visitor; they will formulate a plan based on the goals established with the visitor; and they will generate agency by exploring the visitor's feelings and thoughts about the goals and plan to maximise positive outcomes (Epperson & Armstrong, 2024).

An ombuds using the EASE model may have an interaction like the one below with a visitor to showcase the model's skills and sub-elements (Epperson & Armstrong, 2024):

The ombuds: *“Would you like to share what’s going on? I’m here to listen.”* (ombuds showing empathetic listening and giving attention to the visitor and their problem)

The visitor shares the problem they are experiencing.

The ombuds: *“I don’t want to assume to know what it’s like to be in your shoes exactly, but I sincerely want to understand. Can you tell me more about what this experience was like for you?”* (ombuds exploring complicated feelings and thoughts, and checking biases and deepening understanding of the problem)

The visitor shares their perspective.

The ombuds: *“I can hear how difficult this has been for you.”* (ombuds acknowledging circumstances, and caring for the visitor and their problem)

The visitor continues to share.

The ombuds: *“Thank you for sharing this with me today. What would you like us to work on first?”* (ombuds establishing goals)

The visitor shares a short-term goal for the session.

The ombuds proposes a plan and asks the visitor, *“How does that sound?”* (ombuds trying to find sensible action by formulating a plan)

After beginning the intervention, the ombuds checks in with the visitor by asking, *“How is this going for you?”* (ombuds generating agency to achieve a positive outcome that is appropriate for the visitor)

As previously mentioned, the EAR approach—which centres on empathy, attention, and respect—can quickly regulate visitors, fostering productive conflict resolution (Eddy, 2021). Integrating the Stoic dichotomy of control can offer substantial long-term advantages. By embracing the understanding that life’s events are temporary and that many factors are beyond

their control, visitors can be empowered to stop fixating on uncontrollable aspects of their lives (Smith, 2024). Collaborating with visitors to grasp and incorporate the Stoic dichotomy of control can improve well-being, reduce negative emotions, and enhance resilience when facing challenges (LeBon, 2023). Additionally, guiding visitors toward finding meaning in their lives and experiences can make a significant difference. A sense of meaning is thought to help individuals overcome obstacles, and visitors often seek ombuds services when experiencing hardship (Frankl, 1986). Cultivating a Meaning Mindset can foster better coping mechanisms and strengthen resilience during difficult times (Armstrong & Potter, 2022). It can also increase overall well-being and help visitors build resilience for future difficulties. Therefore, incorporating the Stoic dichotomy of control and Meaning Mindset into the EASE model (along with EAR) can profoundly benefit visitors and lead to positive outcomes.

Knowledge Translation-Integrated Methodological Approach

This study utilises a Knowledge Translation-Integrated (KTI) approach (Armstrong et al., 2025), a participatory, third-wave positive psychology model. It emphasises the collaboration between the researcher and those directly affected by the research to gather feedback on the research process. The approach also examines the credibility, acceptability, sustainability, and feasibility of ombuds services that are perceived to use the EASE model. The goal is to work alongside visible minorities, who are the stakeholders in this research, while fostering equity, diversity, inclusivity, and belonging, ensuring that the EASE model is both valuable and effective for them. The KTI approach is increasingly being applied to co-create with knowledge users and mobilise knowledge, integrating various perspectives to ensure the approach is culturally responsive (Armstrong et al., 2025).

To assess credibility, we ask visible minority visitors whether the psychotherapy services they received met their expectations. Credibility is also measured quantitatively through assessments of the EASE model, working alliance, mental health, and Meaning Mindset. To gauge acceptability, we ask visitors if the services provided the outcomes they were hoping for. For sustainability, we ask if these positive outcomes were maintained after the conclusion of the services. Finally, we explore the feasibility of achieving the expected outcomes within the context of ombuds services.

Current Study

Statement of Purpose

The literature on retention is clear: while it is essential for a positive outcome, visible-minority communities experience its lowest rates (Swift & Greenberg, 2012). It has also been shown that a strong alliance is a key factor in preventing premature termination and in the overall outcome (Martin et al., 2000; Campbell et al., 2015; Tasca & Marmarosh, 2023). A practical method of developing this alliance is through empathetic listening (Kwon & Jo, 2012; Myers, 2000).

A newly emerging model expands on Meaning Mindset, the Stoic dichotomy of control, and the EAR model to foster a strong alliance. As noted, the EASE model uses the skills of empathetic listening, acknowledgment of circumstances, solving (through sensible action), and evaluating (through exploration of thoughts) (Armstrong et al., 2025).

Hypotheses

Credibility – Is EASE Correlated with Ombuds Service Outcomes?

Our main quantitative hypothesis is that, given the theoretical frameworks in which the EASE model is grounded, the perceived use of EASE would be associated with positive ombuds

service outcomes: alliance, Meaning Mindset, mental health, and service retention. This hypothesis is grounded in the literature which shows positive outcomes when a strong alliance is present between practitioner and recipient (Howgego, 2003; Ardito & Rabellino, 2011; Campbell et al., 2015; Fluckiger et al., 2018; Tasca & Marmarosh, 2023), when Meaning Mindset is fostered (Ivtzan et al., 2015; Wong, 2017; Armstrong & Potter, 2022), and when recipients of services stay for the recommended duration (Anderson et al., 2019). This hypothesis is also grounded in the literature that shows a significant association between empathetic listening, cultural competence (which involves acknowledgment of circumstances and sensible action), *EASE elements*, and positive outcomes (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012; Owen et al., 2011; Tao et al., 2015). Though this research is based on the practice of psychotherapy, it may be applicable to ombuds services as well, especially given ombuds' emphasis on fostering relationships of trust in their practice (Creutzfeldt & Bradford, 2016; Elgoibar et al., 2021).

Several other findings are expected as well:

1. The perceived use of EASE is expected to moderate the relationship between visible minority status and retention rate. The literature shows that visible minorities experience lower retention rates in psychotherapy (Sue et al., 1991; Arnow et al., 2007; Swift & Greenberg, 2012). Though there is no literature specific to this for ombuds services, the existing literature shows that visible minority visitors experience worse outcomes (Huber et al., 2001; Lee et al., 2021), which may include lower retention rates. The EASE model emphasises **empathetic listening**, **acknowledgment of circumstances**, and **solving** problems through **deepening** understanding, **establishing goals**, and **formulating a plan** (Epperson & Armstrong,

- 2024). The literature shows an emphasis on effective listening and the fostering of trust in ombuds services (Harrison, 2004; Creutzfeldt & Bradford, 2016; Elgoibar et al., 2021), and a strong association in psychotherapy literature between empathetic listening, cultural competence (which involves acknowledgment of circumstances and sensible action) and positive outcomes (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012; Owen et al., 2011; Tao et al., 2015). Therefore, EASE is expected to moderate the relationship between minority status and retention rate.
2. The perceived use of EASE is expected to moderate the relationship between alliance and mental health for visitors. Given the EASE model's emphasis on **empathetic listening** through the use of **attention**, checking of **biases**, and **caring** (Epperson & Armstrong, 2024), and the literature on the strong association between empathetic listening and alliance (Myers, 2000; Wynn & Wynn, 2006; Kwon & Jo, 2012), as well as alliance and mental health outcomes (Howgego, 2003; Ardito & Rabellino, 2011; Fluckiger et al., 2018; Tasca & Marmarosh, 2023), EASE is expected to moderate the relationship between alliance and mental health. The emphasis on effective listening and fostering trust in ombuds services supports this hypothesis (Harrison, 2004; Creutzfeldt & Bradford, 2016; Elgoibar et al., 2021).
 3. The perceived use of EASE is expected to moderate the relationship between alliance and visitor drop out. The literature shows the importance of alliance for retention rates (Sue et al., 1991; Swift & Greenberg, 2012; Campbell et al., 2015). Given the EASE model's emphasis on **empathetic listening**, which fosters alliance as described above, EASE is expected to moderate the relationship between alliance and retention. Hence, visitors are more likely to stay in services for the recommended duration.

Our qualitative hypothesis is that visible minority visitors who perceive ombuds to be using EASE in their practice will view services as more credible (e.g., see the value of services for them), acceptable (e.g., are satisfied with services), sustainable (e.g., more likely to maintain outcomes after services end), and feasible (e.g., have desired outcomes that are feasible in the context of ombuds services).

Methods

Research Design

The current psychological research uses a survey, with a mixed methods approach. Ethics approval from Saint Paul University has been granted and can be found in Appendix A.

Participants

The participant pool comprises visitors of ombuds, visible minority and non-minority, who have had any experience as visitors, terminating prematurely, or completing these services. Participants were recruited through an international ombuds network. A purposive sampling method of a convenient population was used. Initially, the target sample included 60 participants: 30 visible minority visitors (group 1) and 30 non-visible minority visitors (group 2). A sample of 30 per group had been chosen as 30 participants are recommended in the literature for initial pilot research (Beets et al., 2021). However, recruiters experienced much resistance during the process as ombuds hesitated to be involved in such research. The current research is the first to assess ombuds conflict coaching outcomes worldwide quantitatively. The field of psychotherapy, now widely researched, faced a similar resistance in its early days, resulting in a vast knowledge gap, identical to the gap in research on ombuds service outcomes. This led to an increased recognition of the need for empirical research on psychotherapy outcomes (Docherty & Colbert,

2024). Similarly, the current research hopes for more research on the outcomes of ombuds services, especially for visible minority visitors, in the near future.

All participants in the current study were English-speaking and over 18. For this research, the operational definition of a visible minority is defined by the Employment Equity Act (Government of Canada, 2015). The Employment Equity Act defines visible minorities as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour” (Government of Canada, 2015).

The participants received a full disclosure of the research's purpose and potential risks and benefits. This included a detailed explanation of the importance of disclosing their minority status, given the potentially sensitive nature of the subject. The consent form also contained a complete confidentiality clause and an explanation of the data collection and storage process. The consent form also detailed the participants' right to question, refuse or withdraw from the study at any time.

In total, 14 participants responded to the survey via SurveyMonkey. Of those 14 participants, 14.3% were between the ages of 18 and 24 (n=2), with 14.3% of participants between the ages of 25 and 29 (n=2), 14.3% between the ages of 30 and 34 (n=2), 14.3% between the ages of 35 and 44 (n=2), 7.1% between the ages of 45 and 54 (n=1), and 35.7% declining to provide this demographic information (n=5).

Of the 14 participants, 35.7% identified as women (n=5), 28.6% identified as men (n=4), and five participants declined to answer.

Of the 14 participants, 28.6% reported having graduate or professional training (n= 4), 21.4% reported having completed college or university training (n= 3), 14.3% reported having

some college or university training (n= 2), 7.1% reported having a post-secondary certification (n=1), and four participants declined to provide this demographic information.

Regarding annual household income, before taxes, 21.4% reported making between \$20,000 and \$34,999 (n=3), 14.3% reported making between \$50,000 and \$74,999 (n=2), 14.3% reported making between \$75,000 and \$99,999 (n=2), 7.1% reported making between \$100,000 and \$149,999 (n=1), 7.1% reported making \$200,000 or more (n=1), and five participants declined to answer.

Finally, as the current study aimed to investigate improving outcomes of ombuds services for visible minority clients, inquiring about the minority status of participants was critical. 42.8% of participants identified as visible minorities (n= 6) while 21.4% identified as non-minorities (n= 3), with the remaining 5 participants declining to answer. Of the 14 participants, 21.4% reported being ethnically White (n=3), 21.4% reported being Black (n=3), 7.1% reported being East Asian (n=1), and 14.3% reported being Middle Eastern (n=2). Five participants declined to specify their ethnicity. Interestingly, but not surprisingly, only 21.4% of participants reported having seen an ombuds who was a visible minority (n= 3), 42.9% reported having seen a non-minority ombuds (n=6), and 35.7% declined to answer (n=5).

Regarding their experience in ombuds services, 21.4% of participants reported having completed services but had terminated prematurely (n=3), 14.3% reported still being in services and likely completing them until a natural end (n=2), and 28.6% reported having completed services until a natural end (n=4). Five participants declined to provide this demographic information. Additionally, 42.8% of participants reported having followed all of their ombuds' recommendations and plans (n=6), 7.1% reported having followed some of their ombuds'

recommendations and plans (n=1), 14.3% reported having not followed their ombuds' recommendations and plans (n=2), and five participants declined to answer.

Measures

EASE Inventory. The EASE Inventory is a 10-item self-report scale that measures perceived empathetic listening, acknowledgment of circumstances, solving through sensible action, and evaluation through exploration of thoughts and feelings. The inventory measures each item on a six-point scale from 'Strongly Disagree' to 'Strongly Agree' (Armstrong & Epperson, 2024). During this research, the EASE Inventory was assessed and found to be highly reliable, with a Cronbach's alpha of .94. Prior to the main study, an initial sample of 30 participants were recruited from a psychotherapist population, with lived experience of psychotherapy services, at a university for pilot measure validation of the EASE measure to support reliability and validity of the measures for use in the main study. Psychotherapists, as measure users, were recruited to provide feedback on whether this measure would be helpful in their own practices (sustainability, feasibility). They completed the EASE measure, to assess internal consistency reliability and a brief qualitative questionnaire. This questionnaire can be found in Appendix B.

Adult Identity and Meaning Scale (AIMS). The AIMS is a 12-item self-report measure. The scale measures "meaning mindset", which is a mindset of hope for the future, self-concept and openness to feelings; engagement in pursuits, learning, creativity and social connection; and choice and responsibility over feelings, thoughts and behaviours. The inventory measures each item from 0 to 10 on a sliding scale (Watt, 2020). This measure was found to have a Cronbach's alpha of .96 (Watt, 2020). This questionnaire can be found in Appendix C.

Interactive Symptom Assessment-Adult (ISA). The ISA is a 12-item self-report scale that measures mental health and healthy functioning through mood, anxiety symptoms, social connectedness, conduct concerns, compulsions and obsessions, attention deficit symptoms and self-esteem concerns. The inventory measures each item from 0 to 10 on a sliding scale (Armstrong et al., 2022). This highly reliable scale has a Cronbach's alpha of .83 (Armstrong et al., 2022). This questionnaire can be found in Appendix D.

Brief Revised Working Alliance Inventory (BR-WAI). The BR-WAI is a 16-item measure that assesses alliance. The scale measures the bond between the ombuds and the visitor, the ombuds and visitor's collaboration on treatment goals and their collaboration on treatment tasks. The inventory measures each item on a five-point scale from 'Strongly Disagree' to 'Strongly Agree' (Mallinckrodt & Tekie, 2015). The original Working Alliance Inventory was found to have a reliability score of .87 (Horvath et al., 1989). This questionnaire can be found in Appendix E.

Qualitative Questionnaire. The qualitative questionnaire is a series of open-ended questions that aim to encapsulate the participants' experiences with ombuds services, exploring credibility, acceptability, sustainability, and feasibility, as defined previously. This questionnaire can be found in Appendix I.

Demographic questionnaire. The questions capture the duration of ombuds services, whether services were terminated prematurely, age, ethnicity, gender, and household income to describe the sample accurately. This questionnaire can be found in Appendix J.

Procedure

The current study uses a mixed methods approach. Once informed consent is obtained, all participants complete the EASE, AIMS, ISA, and BR-WAI questionnaires in the same order to

control for order effects. Following the quantitative questionnaires, participants are given a brief qualitative questionnaire. The approach aims to gather comprehensive evidence, through a variety of perspectives, and allows the participants to share their experiences authentically. It is conducted via SurveyMonkey.

Statistical Analysis

Data Screening and Cleaning

Data screening and cleaning were conducted using SPSS 29.0 for Windows. Before analysis, data were examined for accuracy, outliers, distribution, missing values, and normality assumptions.

Univariate frequencies identified invalid scores, and missing data was verified and addressed using original questionnaires. A Missing Data Analysis was conducted, and data was missing at random. Linearity and homoscedasticity were assessed through bivariate scatterplots, and multivariate outliers were identified using Mahalanobis distance. There were no extreme outliers. Variables were not significantly skewed and followed a normal distribution.

The current research employed non-parametric Bayesian Moderation Regression analyses using SPSS's PROCESS macro. In the first hypothesis, the researcher tests the impact of EASE as the moderator on the relationship between the independent variable of minority status and the dependent variable of retention rate. In the second hypothesis, the researcher tests the impact of EASE as the moderator on the relationship between the independent variable of alliance and the dependent variable of mental health. In the third hypothesis, the researcher tests the impact of EASE as the moderator on the relationship between the independent variable of alliance and retention rate. The variable of retention rate is measured through a demographic question in the qualitative questionnaire. The variable of assessment of alliance is measured through the BR-

WAI. The variable of the assessment of outcome is measured through AIMS, ISA, and EASE. Non-parametric Spearman's rho correlations are also used, given the small sample size.

Qualitative Analysis

To minimise potential bias and ensure reliability in our qualitative analysis, the current study acts in accordance with the following guidelines (Cofie et al., 2022). There are a minimum of two coders; one coder who is removed from data collection; data collection is conducted by a coder with expertise and experience in coding qualitative data; a minimum of two coders code transcripts for each participant group using the same framework for analysis and a shared meaning of codes; a researcher with expertise is consulted if there are any conflicts; and there is consensus relating to the codebook for the transcripts (Cofie et al., 2022). Furthermore, according to Clarke and Braun's thematic analysis parameters, the researchers first look at the data and then read through the written survey responses several times, familiarising themselves with the data and noting any significant patterns (2013). Then, the researchers code any notable features of the data, reviewing it several times (Clarke & Braun, 2013). Next, the researchers examine the codes and patterns, and generate themes (Clarke & Braun, 2013). The researchers then review the themes they generated, and how accurately they represent the data (Clarke & Braun, 2013). Afterwards, the researchers name and define the themes, making them relevant to the data found (Clarke & Braun, 2013). Finally, they create a report using these themes and findings (Clarke & Braun, 2013). The KTI themes of credibility, acceptability, sustainability, and feasibility were used to organise the qualitative data in the current study, and subthemes that surfaced were also examined. Clarke and Braun emphasise using a Reflexive Thematic Analysis that employs the researcher's subjectivity as a research tool (2021). According to Braun and Clarke (2021), this type of analysis is predicated on the idea that the researcher's knowledge and

comprehension of the research is always context-dependent and can significantly impact the data. Consequently, the researcher's subjectivity is valued, and its use is encouraged rather than minimised or avoided (Braun & Clarke, 2021). Braun and Clarke recommend using two raters because of the possibility of bias with this method. In the current study, Dr. Armstrong and Houda Ismaili were the raters.

Results

The current study uses a mixed methods design, including quantitative and qualitative analyses. These analyses are used to assess the EASE model's credibility, acceptability, feasibility, and sustainability. Specifically, the EASE model is expected to lead to positive ombuds service outcomes, such as higher retention rates, Meaning Mindset, stronger alliance, and better mental health. EASE is also likely to positively impact these outcomes for visible minorities specifically. Finally, it is expected that visible minorities who perceive their ombuds to be using EASE would also view ombuds services as more credible, acceptable, sustainable and feasible.

This study investigated the relationship between EASE, alliance and outcomes of ombuds services for visible minority visitors by looking at the variables in Table 1. The assessment of outcomes was measured through the EASE, AIMS, and ISA questionnaires. The assessment of alliance was measured through BR-WAI.

Means and standard deviations of the measures are presented in Table 1, while correlations found between the variables can be found in Table 2.

Table 1*Means and Standard Deviations of Variables*

Variables	Number of respondents	Means	Standard Deviations
EASE	9	56.25	25.00
AIMS	9	81.89	42.12
ISA	9	63.89	43.33
BR-WAI	9	61.00	22.01

Note. EASE = Scores from the EASE Inventory measuring empathetic listening, acknowledgment of circumstances, solving through sensible action, and evaluation through exploration of thoughts and feelings in ombuds services.

AIMS = Scores from the Adult Identity and Meaning Scale measuring Meaning Mindset.

ISA = Scores from the Interactive Symptom Assessment-Adult measuring mental health symptoms.

BR-WAI = Scores from Brief Revised Working Alliance Inventory measuring alliance.

Correlations: Credibility – Was EASE Correlated with Ombuds Service Outcomes?

Correlations are presented in Table 2 below.

The following correlations were made using Spearman's rho correlation and were in accordance with Spearman's assumptions (Hauke & Kossowski, 2011). All variables analysed were measured on an ordinal, interval or ratio scale. All analyses included paired observations of two variables. A monotonic relationship was found between all variables for whom a relationship was assessed.

Table 2*Two-tailed bivariate correlations of variables.*

Variables	1	2	3	4	5	6
1. EASE	-					
2. AIMS	.99**	-				
3. ISA	-.58	-.59*	-			
4. BR-WAI	.86**	.86**	-.79**	-		
5. Visible Minority Status	-.60*	-.60*	.83**	-.60*	-	
6. Retention Rate	.91*	.90**	-.55	.83**	-.50	-

Scale. * $p < .05$, ** $p < .01$

Pearson bivariate correlations were conducted on the data. Significance was set at $p < .05$. Firstly, there was a statistically insignificant inverse correlation between the participants' EASE scores and their mental illness symptom scores ($r = -.58$, $p > .05$). Another insignificant negative correlation was that between visible minority status and retention rate ($r = -.50$, $p > .05$). Retention rate was also insignificantly correlated with mental illness symptom scores ($r = -.55$, $p > .05$). The rest of the correlations were statistically significant. Firstly, there was a statistically significant negative correlation between the participants' Meaning Mindset scores and their mental illness symptom scores ($r = -.59^*$, $p < .05$). Secondly, there was also a statistically significant association between Meaning Mindset scores and visible minority status of participants ($r = -.60^*$, $p < .05$). Visible minority status was also significantly correlated with EASE scores ($r = -.60^*$, $p < .05$). Additionally, visible minority status was significantly

correlated with mental illness symptom scores ($r = .83^{**}$, $p < .01$). Visible minority status was also significantly negatively correlated with alliance scores ($r = -.60^*$, $p < .05$). However, high scores on alliance were considerably correlated with high scores on Meaning Mindset ($r = .86^{**}$, $p < .01$) and low scores on mental illness symptoms ($r = -.79^{**}$, $p < .01$). EASE was also significantly correlated with alliance scores ($r = .86^{**}$, $p < .01$). Additionally, EASE was correlated considerably with Meaning Mindset scores ($r = .99^{**}$, $p < .01$). Finally, retention rate was significantly correlated with EASE in ombuds services ($r = .91^*$, $p < .05$). Retention rate was also highly positively correlated with Meaning Mindset and alliance with both correlations being significant at the $p < .01$ level with an r of $.90^{**}$ for Meaning Mindset and an r of $.83^{**}$ for alliance.

Credibility: How is EASE correlated with alliance?

As this is the first study of EASE, an exploratory analysis was carried out to see which elements of EASE might be correlated with alliance (i.e., be the “ingredients” of alliance). The following table shows that every element of EASE was found to be significantly correlated with alliance.

Item in EASE measure	Correlation with Alliance
My ombuds seemed to be genuinely interested in what was going on for me.	$r = .77^*$ ($p = .01$)
My ombuds didn't appear to let their own biases get in the way of our work together.	$r = .79^{**}$ ($p < .01$)
My ombuds noticed and showed care for my feelings.	$r = .77^*$ ($p = .01$)

My ombuds seemed to recognise and explore the problem(s) I was facing.	$r = .76^*$ ($p = .01$)
My ombuds helped me to establish goals.	$r = .77^*$ ($p = .01$)
My ombuds collaborated with me to explore steps to reach my goals.	$r = .77^*$ ($p = .01$)
My ombuds helped me develop a sense of “agency,” or a belief that I am capable of choosing helpful actions and helpful thoughts.	$r = .85^{**}$ ($p < .01$)
My ombuds explored and validated the feelings I was having regarding my thoughts or potential actions to reach my goals.	$r = .85^{**}$ ($p < .01$)
I believe the work I’ve done with my ombuds is helpful for me.	$r = .84^{**}$ ($p < .01$)
My ombuds and I respect each other.	$r = .73^{**}$ ($p = .01$)

** $p < .001$, * $p < .05$

Moderation Analyses: Credibility – Was EASE Correlated with Ombuds Service

Outcomes?

Given the very small sample size, the following analyses are preliminary. A minimum sample size of 10 is generally required for this type of analysis, with one predictor variable and one moderator (Smeden et al., 2016). Nonparametric Bayesian Moderation Regression analyses

were conducted using SPSS's PROCESS macro (Hayes, 2013) for the current study to assess whether EASE moderated the following relationships:

1) Does using EASE skills moderate the relationship between visible minority status and retention rates? Specifically, does the effect of visible minority status on dropping out of ombuds services prematurely decrease with increased perceived ombuds EASE skill usage?

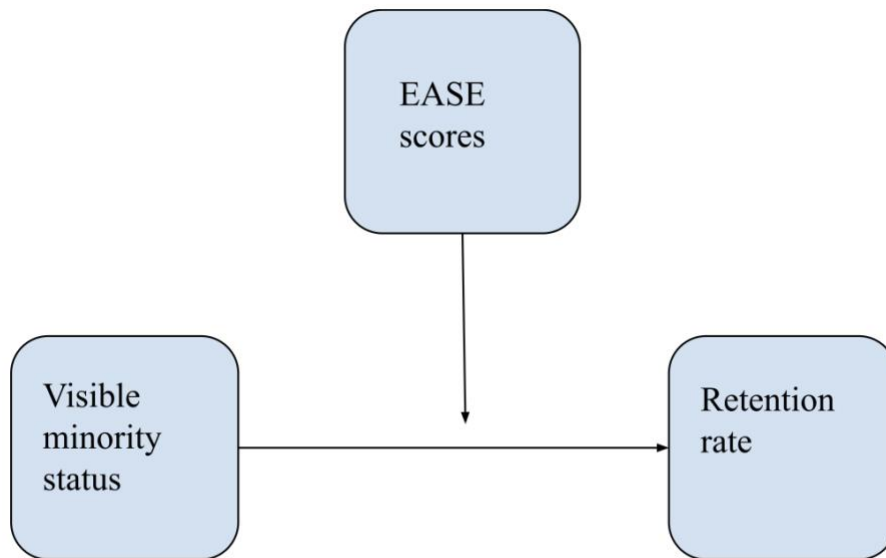


Figure 1.

Visible minority status was entered as the predictor variable (X), visitor retention (versus non-retention) was entered as the outcome variable (Y), and EASE scores were the moderator (M). The interaction between visible minority status and EASE was insignificant (Chi square = 0.00, $b = 0.11$, $SE = 65.40$, $Z = 0.00$, $p = 1.00$), indicating that EASE scores did not moderate the relationship between visible minority status and visitor dropout.

2) Does using EASE skills moderate the relationship between alliance and mental health? Specifically, does the inverse effect of perceived alliance on mental illness symptoms increase with increased perceived ombuds EASE skill usage?

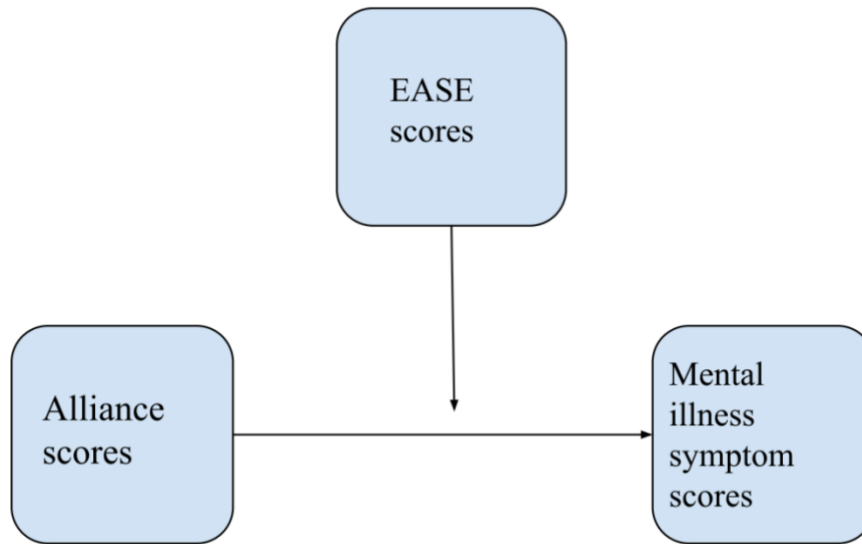


Figure 2.

Perceived alliance was entered as the predictor variable (X), visitor self-reported mental illness symptoms scores were entered as the outcome variable (Y), and EASE scores were the moderator (M). The interaction between alliance and EASE was not significant (R^2 change = 0.94, $b = 0.24$, $SE = 0.10$, $t = 2.38$, $p = .08$), indicating that EASE scores did not moderate the relationship between alliance and mental health, but the relationship approached significance. The simple slope of X on Y was significant at low levels of M (Mean = 15.40, $b = 19.46$, $SE = 6.01$, $t = -3.24$, $p = .03$), at moderate and high levels of M (Mean = 70.00, $b = -6.32$, $SE = 1.10$, $t = -5.80$, $p < .001$) respectively. At low levels of EASE, a one-point increase in alliance predicted a 19.46-point decrease in mental illness symptoms. At moderate and high levels of EASE, a one-point increase in alliance was associated with a 6.32-point decrease in mental illness scores.

3) Does using EASE skills moderate the relationship between alliance and visitor dropout? Specifically, does the effect of the alliance on retention rate increase with increased perceived ombuds EASE skill usage?

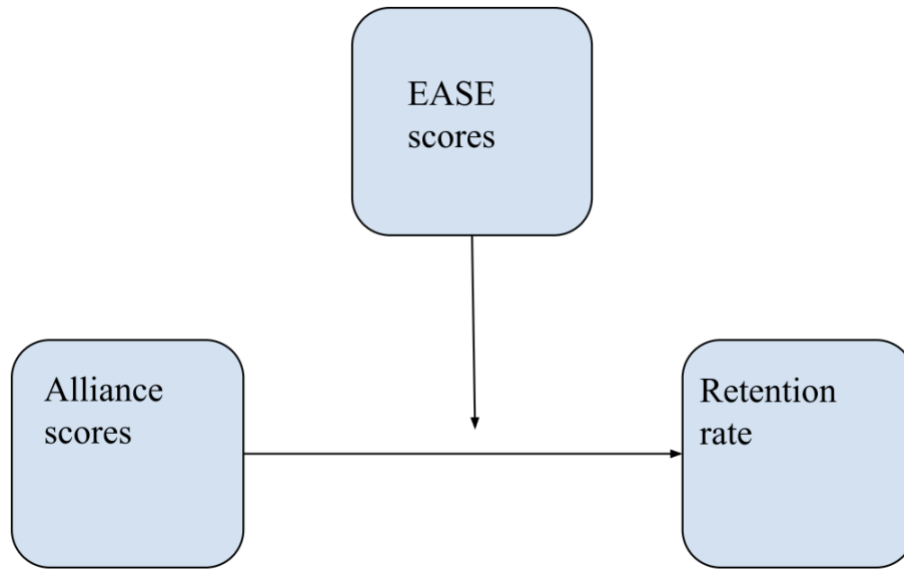


Figure 3.

Visitor-reported alliance was entered as the predictor variable (X), the visitor reported binary of stay in ombuds services versus prematurely terminated was entered as the outcome variable (Y), and EASE scores were the moderator (M). The interaction between alliance and EASE was insignificant (Chi square = 0.00, SE = 16.63, Z = 0.00, $p = .99$), indicating that EASE scores only slightly moderated the relationship between alliance and visitor retention. The simple slope of X on Y was not significant at low levels of M (Mean = 37.44, $b = -1.74$, SE = 1283.84, $Z = -0.00$, $p = .99$), at moderate (Mean = 54.00, $b = -1.74$, SE = 1283.84, $Z = -0.00$, $p = .99$) or high levels of M (Mean = 70.00, $b = -1.74$, SE = 1283.84, $Z = -0.00$, $p = .99$). This suggests that EASE does not significantly moderate the relationship between alliance and retention rate at any level of EASE skill usage.

Qualitative Analysis

As previously noted, the current research used a Knowledge-Translation Integrated approach. First, participants were given the opportunity to reflect on and share whatever they wished about their experience in ombuds services with an open-ended question. Second, to

ensure that visible minority visitors, the stakeholders in this research, could benefit from the research, and the EASE model, standards of acceptability, credibility, sustainability and feasibility were examined. Additionally, participants were asked for feedback and recommendations relating to the research.

Seven out of the 14 participants responded to the first part of the qualitative survey.

Theme 1A: “Positive experience in Ombuds Services.” Most participants expressed having a positive experience in ombuds services.

Reflections:

- *“My ombuds was supportive in managing a situation.”*
- *“The person I saw was compassionate and listened to all of the issues I had.”*
- *“It was good.”*
- *“My ombuds was supportive.”*

Theme 1B: “Negative Experience in Ombuds Services.” Two participants described a negative experience in ombuds services.

Reflections:

- *“My ombuds wasn’t helpful.”*
- *“My ombuds didn’t do what I asked.”*

Upon further analysis, another observation was made. One of the participants who responded negatively explained that they had visited an ombuds who was employed at their affiliate university and was told they could have only been able to help them had they been a student at the university at which the ombuds was employed. Otherwise, the other participant who responded negatively had identified as a visible minority, had seen a visible minority ombuds, had not followed any of their recommendations and had terminated services prematurely.

Qualitative Hypothesis 1: Credibility

The standard of credibility in this research is also twofold. Firstly, the research examined credibility quantitatively through the measures of EASE, alliance, Meaning Mindset, and mental health.

Secondly, the research examined whether the experience of ombuds services was credible for visible minority visitors and see whether feedback, positive or negative, was relevant to the research questions. Out of the 14 participants, eight participants responded to the part of the qualitative survey assessing credibility (e.g., services perceived as helpful). Theme 2A: “Ombuds services were credible.” Some participants expressed that their experience in ombuds services achieved what they thought it would.

Reflections:

- *“Yes, I reached my goals.”*
- *Yes, I clearly understood my options and the normative framework around my concern.”*

Theme 2B: “Ombuds services were not credible.” Most participants expressed that their experience in ombuds did not achieve what they thought it would. However, most of these participants still reported a satisfactory outcome, with three participant reporting that their experience did not achieve what they thought it would and did not report a satisfactory outcome.

Reflections:

- *“I had expected a different outcome but the outcome that happened worked for all parties.”*
- *“I thought my ombuds would just go fix the problem, but we collaborated on things I could do and that was helpful.”*
- *“No, I wanted my ombuds to fix the situation.”*

- *“No, I was hoping to have some, or all of my problem addressed, and it was not.”*
- *“No, I still have a problem.”*

As mentioned previously, one of the participants who responded negatively regarding the standard of credibility explained that they had visited an ombuds who was employed at their affiliate university and was told they could have only been able to help them had they been a student at the university at which the ombuds was employed. Otherwise, the two other participants who responded negatively had been minorities (one of them a visible minority, and the other an invisible minority due to their disability status). They had also both terminated services prematurely. The visible minority had seen a visible minority ombuds and had not followed their recommendations while the invisible minority had seen a non-minority ombuds and had followed all of their recommendations.

Qualitative Hypothesis 2: Acceptability

The standard of acceptability in this research is twofold. Firstly, the research examined whether the items on the measures are easily understood by participants and that participants are satisfied with the measures. In the survey for the validation of EASE by psychotherapy clients, four participants responded to the qualitative aspect of the survey regarding acceptability, while 15 participants declined to answer. Two participants noted that they did not have any issue understanding the items on the survey and that they were not dissatisfied. Two other participants noted that while they understood the items on the survey and were satisfied, they had difficulty choosing a single psychotherapist to reflect on because they had experiences with several different psychotherapists.

Secondly, the research examined whether the experience of ombuds services was acceptable to visible minority visitors and see whether feedback, positive or negative, was

relevant to the research questions. Out of the 14 participants, eight participants responded to the part of the qualitative survey assessing acceptability (goals met). Theme 3A: “Ombuds services were acceptable.” Most participants expressed that their experience in ombuds services achieved the outcome they wanted or was in the process of achieving the outcome they wanted.

Reflections:

- *“Yes, I got the outcome.”*
- *“The problem was solved.”*
- *“I was helped”*
- *“It broadened my perception of the issue.”*
- *“Initial outcomes [were not what I wanted], but the outcomes were good.”*

Theme 3B: “Ombuds services were not acceptable.” Some participants expressed that their experience in ombuds services did not achieve the outcome they wanted.

Reflection:

- *“The problem is still there.”*
- *“I wanted to have some, or all of my problem addressed, and it was not.”*

As mentioned previously, one of the participants who responded negatively regarding the standard of acceptability explained that they had visited an ombuds who was employed at their affiliate university and was told they could have only been able to help them had they been a student at the university at which the ombuds was employed. Otherwise, the two other participants who responded negatively had been minorities (one of them a visible minority, and the other an invisible minority due to their disability status). They had also both terminated services prematurely. The visible minority had seen a visible minority ombuds and had not

followed their recommendations while the invisible minority had seen a non-minority ombuds and had followed all of their recommendations.

Qualitative Hypothesis 3: Sustainability

The standard of sustainability in this research is twofold. Firstly, the research asked for feedback on the measures from participants and suggestions for changes to be made in the future. In the survey for the validation of EASE with a psychotherapy client population, three participants responded to the qualitative aspect of the survey regarding sustainability, while 16 participants declined to answer. Two participants recommended clarifications or elaborations, e.g. items in the survey beginning with “My *work* with my psychotherapist helped me ...” rather than “My psychotherapist helped me...” to denote the more collaborative nature of psychotherapy. Finally, one participant recommended adding an item to the survey regarding a psychotherapist’s ability to explore feelings around barriers or limitations to reaching goals.

The current research also examined whether the experience of ombuds services was sustainable for visible minority visitors and see whether feedback, positive or negative, was relevant to the research questions. Out of the 14 participants, eight participants responded to the part of the qualitative survey assessing sustainability (e.g., problem solved longer-term). Theme 4A: “Ombuds services were sustainable.” Some participants expressed that they were able to maintain the outcomes they achieved in ombuds services.

Reflections:

- “Yes, [I have] no issues currently.”
- “Yes, the problem was solved.”
- “Yes, I did the things we talked about.”
- “Yes, all parties are happy.”

Theme 4B: “Ombuds services were not sustainable.” Three participants expressed that they had difficulty maintaining outcomes they achieved in ombuds services.

Reflections:

- *“No, because nothing was achieved.”*
- *“No, I didn’t achieve outcomes intended.”*

As mentioned previously, one of the participants who responded negatively regarding the standard of sustainability explained that they had visited an ombuds who was employed at their affiliate university and was told they could have only been able to help them had they been a student at the university at which the ombuds was employed. Otherwise, the two other participants who responded negatively had been minorities (one of them a visible minority, and the other an invisible minority due to their disability status). They had also both terminated services prematurely. The visible minority had seen a visible minority ombuds and had not followed their recommendations while the invisible minority had seen a non-minority ombuds and had followed all of their recommendations.

Hypothesis 4: Feasibility

Finally, the current research examined whether the experience of ombuds services was feasible for visible minority visitors and see whether feedback, positive or negative, was relevant to the research questions. Out of the 14 participants, eight participants responded to the part of the qualitative survey assessing feasibility (e.g., goals were achievable). Theme 5A: “Ombuds services were feasible.” Most participants expressed that the outcomes they were hoping to achieve were feasible in the context of ombuds services.

Reflections:

- *“It was a conflict that needed mediation, and we got that.”*

- *“We set realistic goals.”*
- *“Yes, quite easily, if it were not so difficult, and physically and emotionally taxing to do the process [...] to help people with disabilities.”*
- *“Someone should be able to help me with this.”*
- *“Outcomes I had hoped for were not attainable, but we reached an attainable outcome.”*

Theme 5B: “Ombuds services were not feasible.” One participant expressed that the outcomes they were hoping to achieve were not feasible in the context of ombuds services.

Reflection:

- *“No, they couldn’t help because they can’t help at my university, just theirs.”*

Discussion

To date, there is little existing research on the outcomes of ombuds services. In fact, likely given that this was the first quantitative study of ombuds outcomes, there was great reluctance on the part of ombuds to participate, like the early days of initial psychotherapy research. As a result, the current research is quite preliminary with a very small sample size. However, its findings have potentially significant implications. This research contributes to the literature on ways to improve ombuds services, especially for visible minorities and marginalized communities. It also represents the first quantitative study of ombuds practice globally. As presented previously, racial disparities in health services have been extensively studied (McGuire et al., 2008; Vaughan et al., 2009; Khan et al., 2017; Lu et al., 2021). Visible minorities generally have worse experiences of health services than their non-minority counterparts (McGuire et al., 2008; Vaughan et al., 2009; Lu et al., 2021) and this may apply to ombuds services as well, as they also aim to enhance well-being. Though the research on racial disparities in ombuds services is limited, the existing research shows similar patterns (Huber et al., 2001; Lee et al.,

2021). Secondly, the current research may have potential significant implications for the ongoing development of education for ombuds and people who work in conflict resolution. Researchers have extensively studied the experience of visible minorities in mental health care and have shown that visible minorities have significantly more difficulties accessing appropriate and satisfactory mental health care (Sue et al., 1991; Lu et al., 2021). Similar difficulties were reported for visible minority visitors in ombuds services though the research is limited (Huber et al., 2001; Lee et al., 2021) Were the EASE model to be further studied and later taught to ombuds, it may be beneficial to visitors, including visible minorities.

The current research used a mixed methods model, including quantitative and qualitative analyses. The relationships were preliminarily explored between variables of EASE, mental health, Meaning Mindset, alliance, service retention rate and visible minority status. Additionally, the interaction between EASE on the relationships between variables was also explored. However, since the data was quite preliminary, as a minimum sample size of 10 is required for a Bayesian Regression to detect large effects (Surucu, Sesen, & Maslakci, 2023), only the correlations will be discussed here.

Finally, as the current research studied the experiences of visible minority visitors, a Knowledge Translation-Integrated approach was used, and the qualitative analyses assessed the credibility, acceptability, sustainability and feasibility of their experiences and the EASE model.

Although the sample size for the current study was very small, the general outcome of the research was significant and positive. The quantitative analyses showed that the perceived use of EASE is generally correlated with visible minority status, alliance, retention rate, and Meaning Mindset. The qualitative analyses showed that most participants had a positive experience in ombuds services.

Credibility

Credibility was assessed quantitatively, by assessing the measures, and qualitatively by assessing perceived value of ombuds services for participants.

Firstly, the research showed a statistically significant relationship between the EASE model and Meaning Mindset. This suggests that the more a visitor perceived EASE to be used by their ombuds, the more Meaning Mindset they were likely to have. This finding was statistically significant, and its potential implication is significant as well: the more ombuds use the EASE model in their work, the stronger the Meaning Mindset of their visitors may be. In previous research on Meaning Mindset, researchers found that Meaning Mindset has a significant effect on coping skills, mental health and general well-being (Armstrong & Potter, 2022). As such, the increased use of EASE by ombuds may be very beneficial for their visitors.

Secondly, the research showed a statistically significant relationship between the EASE model and retention rate. This suggests that visitors whose ombuds naturally use the EASE model in their work were less likely to terminate prematurely. The potential implication here is significant for visible minorities, whom the literature on psychotherapy services, which may apply to ombuds services as well, shows different dropout rates. Though there is no existing research on retention rates for ombuds services, psychotherapy research shows that half of visible minority-clients terminate therapy after just one session (Sue et al., 1991). In fact, ethnicity of clients has been repeatedly found to be a predictor of premature termination, even when other variables are controlled (Sue et al., 1991; Swift & Greenberg, 2012). Therefore, the finding in the current research would be quite a significant potential implication for visible minorities as they may be more likely to continue working with their ombuds, when they use EASE, than they would have otherwise.

Thirdly, EASE was statistically significantly correlated with alliance. This suggests that visitors who perceived their ombuds to be naturally using EASE in their work were also more likely to perceive a strong alliance with their ombuds. Given that the literature shows that visible minorities are less likely to experience a strong alliance in health care services, including mental health care (OHRC, 2004; Sue et al., 1991; Steinfeldt, 2020) and potentially ombuds services, the potential implication here is that visible minorities may feel stronger alliances with their ombuds if their ombuds are using EASE.

Interestingly, the EASE model was also significantly correlated with visible minority status, though the relationship was inverse. This suggests that visible minority participants were less likely to perceive their ombuds to be naturally using EASE in their work. This finding is in line with the broader literature on ombuds research which shows worse outcomes for visible minority visitors than their non-minority counterparts, though the research is limited (Huber et al., 2001; Lee et al., 2021). Visible minority status was also negatively correlated with Meaning Mindset. This correlation was significant and suggests that visible minority visitors were less likely to report having a Meaning Mindset. Given the significant correlation in the literature between Meaning Mindset and mental health (Armstrong & Potter, 2022), this has an important potential implication because it suggests that visible minorities may be less likely to report good mental health and that it may be in part due to their decreased levels of Meaning Mindset. Interestingly, the broader literature shows that visible minorities sometimes have higher levels of meaning making which leads to higher levels of eudaimonic well-being (Ryff et al., 2003).

Additionally, visible minority status was strongly associated with mental illness symptoms, suggesting that visible minority visitors were more likely to report worse mental

health than their non-minority counterparts. This finding is in accordance with the literature which shows that visible minorities tend to experience mental illness at significantly higher rates than their non-minority counterparts due to several historical and socio-economic circumstances (Office of the Surgeon General, 2001; Hackett et al., 2020). Visible minority status was also negatively correlated with alliance. This correlation was significant and suggests that visible minority visitors were less likely to report a strong alliance with their ombuds than their non-minority counterparts. This finding is also in accordance with the literature which shows that visible minorities are less likely to experience a strong alliance in health care services, including mental health care, (OHRC, 2004; Sue et al., 1991; Steinfeldt, 2020) and potentially ombuds services as they also aim to enhance well-being.

Furthermore, alliance was strongly associated with Meaning Mindset and mental health, suggesting that visitors who reported having a strong alliance with their ombuds were also more likely to report having a Meaning Mindset and better mental health. The potential implication of this finding is significant because it shows the importance of alliance for good outcomes, which is supported by the literature (Howgego, 2003; Martin et al., 2000; Fluckiger et al., 2018). Though this literature is on mental health care specifically, ombuds services emphasize the building of trust in their work for effective conflict resolution (Harrison, 2004; Creutzfeldt & Bradford, 2016; Elgoibar et al., 2021). However, if visible minorities visitors were less likely to report having an alliance with their ombuds, given the relationships between alliance, Meaning Mindset and mental health, the potential implication is very significant. The findings suggest that while non-minority visitors experience strong alliances with their ombuds and have stronger Meaning Mindsets and better mental health, their visible minority counterparts do not experience such positive outcomes. This is especially true since the research also showed a strong inverse

relationship between Meaning Mindset and mental illness symptoms. This suggests that visitors who reported more Meaning Mindset also reported less mental illness. This, of course, is in accordance with the literature which shows a significant correlation between Meaning Mindset and mental health (Armstrong & Potter, 2022).

Additionally, Meaning Mindset was significantly correlated with retention rate, suggesting that visitors who reported stronger Meaning Mindsets were also more likely to complete service until a natural end. This finding has a significant potential implication for the research question because the literature shows that visible minorities are more likely to terminate services prematurely, (Sue et al., 1991; Swift & Greenberg, 2012) and this may apply to ombuds visitors as well. Since the current research found that visible minority visitors were less likely to report having a Meaning Mindset, and Meaning Mindsets are highly correlated with retention rate, it makes sense that visible minority visitors would experience less retention rates than their non-minority counterparts. Retention rate was also highly correlated with alliance, suggesting that visitors who reported higher retention rates also reported having stronger alliances with their ombuds. Again, since the literature shows that visible minorities report lower retention rates (Sue et al., 1991; Arnow et al., 2007; Swift & Greenberg, 2012) and weaker alliances with their psychotherapists (OHRC, 2004; Sue et al., 1991; Steinfeldt, 2020), which may apply to ombuds visitors, this finding makes sense. The findings reported above on the relationships between EASE and retention rate, alliance and Meaning Mindset, which have significant potential implications for visible minority visitors.

Otherwise, the research also found statistically insignificant correlations between EASE and mental illness symptoms, visible minority status and retention rate, and retention rate and mental illness symptoms. These findings are surprising. Firstly, if EASE was found to have a

significant relationship with alliance and Meaning Mindset, and the literature shows that both alliance and Meaning Mindset are significantly correlated with mental health (Howgego, 2003; Armstrong & Potter, 2022), it would make more sense that EASE would also be significantly correlated with mental health.

Secondly, the finding of an insignificant relationship between visible minority status and retention rates contradicts the literature on psychotherapy services which shows that visible minorities tend to experience lower retention rates than their non-minority counterparts (Sue et al., 1991; Arnow et al., 2007; Swift & Greenberg, 2012). Lastly, there may be a justification for the insignificant correlation between retention rate and mental illness symptoms. The broader literature showing a correlation between the two variables is mainly about psychotherapy services, which focus on mental illness treatment, compared to ombuds services' focus on conflict resolution. Therefore, although visitors may have been more likely to stay in ombuds services until a natural end, since the focus may not have been their mental health, they may not have reported a difference in their mental illness symptoms. Interestingly, Global Affairs Canada reported that from 2023 to 2024, counselling for psychological concerns was the most sought ombuds service (Government of Canada, 2024).

Credibility was also assessed qualitatively. Most participants found ombuds services to have some value and reported a positive experience. However, most participants found that their experience with ombuds services did not achieve what they expected. Only a few participants found that their experience with ombuds services had matched their expectations. A few participants found that their experience did not achieve what they expected and reported a negative experience. Of these few participants, one participant had sought services with an ombuds at a university at which they were not a student. As a result, they were not able to access

services. The other two had both been minority visitors (visible minority and disability minority). Although the sample size was too small to make an inference, the literature does show that visible minorities visitors experience worse outcomes than their non-minority counterparts (Huber et al., 2001; Lee et al., 2021).

Acceptability

Acceptability was assessed qualitatively in the current study. Participants in the current study reported on their experience in ombuds services. Most participants were satisfied with the quality of services provided by their ombuds and most participants were satisfied with the outcomes of the services. Of the few participants who were not satisfied with their experience, one participant had sought services with an ombuds at a university at which they were not a student. As a result, they were not able to access services. The other two had both been minority visitors (visible minority and disability minority). As mentioned previously, although the sample was too small to make an inference, the literature does show that visible minorities visitors experience worse outcomes than their non-minority counterparts (Huber et al., 2001; Lee et al., 2021).

Sustainability

Sustainability was assessed qualitatively in the current study. When the EASE measure was validated, knowledge users were given the opportunity to offer feedback and recommendations. The psychotherapists who validated the measure recommended some clarifications and minor adjustments to items in the measure.

Participants in the current study reported on their experience in ombuds services. Half of participants reported being able to maintain the outcomes of the services once services had ended. The participant who was still seeing their ombuds was unable to answer. Finally, a few

participants reported not maintaining their outcomes at all since they felt that nothing had been achieved. Of these participants, one participant had sought services with an ombuds at a university at which they were not a student. As a result, they were not able to access services. The other two had both been minority visitors (visible minority and disability minority). Again, though the sample was too small to make an inference, the literature does show that visible minorities visitors experience worse outcomes than their non-minority counterparts (Huber et al., 2001; Lee et al., 2021).

Feasibility

Finally, feasibility was also assessed qualitatively in the current research, with participants reporting on their experience in ombuds services. All participants shared that the outcomes they were hoping to achieve in ombuds services were feasible within the context of such services or that they achieved a feasible outcome. The participant who did not respond in such a way was not able to access services.

Limitations

The current research has a few limitations. Firstly, very little research exists on the outcomes of ombuds services, including alliance and retention rates for visible minority groups. As a result, much of the literature gathered for the current study was about the psychotherapy client population. This is the first study to evaluate ombuds services quantitatively, and to study equity, diversity, inclusivity needs in relation to this issue. Secondly, the sample size for the current study was small. As a result, the researcher is unable to make inferences on the data analysed. Additionally, for the qualitative aspect of the survey, most responses were brief. Additionally, as the quantitative and qualitative data was collected through an online survey, some questions did not have very fruitful responses. Finally, the researcher hoped to use the

client-rated multicultural competence scale for the current study to test the relationships between multicultural competence of ombuds and outcomes for visible minority visitors. However, the items of the scale were too psychotherapy-focused and did not work effectively in the context of ombuds services. At present, there are no scales measuring cultural competence in ombuds practice specifically.

Future Directions

To address the above-mentioned limitations, this kind of study would benefit from a larger sample size to allow for more inference, more generalizability and more real-world application, as the research questions have important potential applications for visible minority visitors. Additionally, this kind of study would benefit from having its qualitative data collected through interviews. Furthermore, it would be beneficial to further investigate the findings that were surprising and/or contradicted other established findings. In general, more research needs to be conducted on the outcomes of ombuds services, including alliance and retention rates, for different groups of visitors. Finally, it would be beneficial to have a cultural competence measure for ombuds practices.

Conclusion

The literature shows that visible minorities are much less likely to report a positive outcome or high retention rates in ombuds services than their non-minority counterparts. The current research studied the implementation and potential impact of a new model, EASE and showed that the perceived use of EASE in ombuds services can result in a stronger alliance between ombuds and visitor, more Meaning Mindset, better mental health, and a higher retention rate. The EASE measure and the ombuds service experience of participants generally met the KTI criteria of credibility, acceptability, sustainability and feasibility. The promising, albeit quite

preliminary findings, warrant future investigations which may yield beneficial implications for visible minority visitors of ombuds.

Chapter 4
Overarching Discussion

Chapter 4

Overarching Discussion

The current research was born to help fill a gap for marginalized communities. For decades, research has shown that visible minorities experience higher rates of mental illness (Office of the Surgeon General, 2001; Chow et al., 2003; Hackett et al., 2020), due to higher rates of socioeconomic and systemic disparities (OHRC, 2004; Vaughan et al., 2009; Yearby, 2018). Visible minorities also experience higher rates of stigma around mental health and are more hesitant to seek help when needed (Sue et al., 1991; Wong et al., 2016). However, the research also shows that when visible minorities do seek help, it is often not the help they need (Jones & Thorne, 1987; McGuire & Miranda, 2008; Alegria et al., 2020; American Psychological Association, 2016; Lu et al., 2021). Research shows that visible minorities are much less likely to report an alliance with their service provider (Steinfeldt, 2020). They are also less likely to experience positive outcomes of health services or other services aimed to enhance well-being, including ombuds services, and a lot more likely to terminate services prematurely (Huber et al., 2001; Arnow et al., 2007; Swift & Greenberg, 2012; Lee et al., 2021). Contrary to these research findings, the broader literature shows that an alliance with one's service provider may be extremely important for positive outcomes in psychotherapy and ombuds services (Epperson & Armstrong, 2024; Howgego, 2003; Ardito & Rabellino, 2011; Fluckiger et al., 2018; Elgoibar et al., 2021; Tasca & Marmarosh, 2023). It is also extremely important for service retention (Campbell et al., 2015). Therefore, although visible minorities may need more help, the very ingredient to their success, alliance, seems to be potentially out of reach.

The current research proposed a model that can be used by psychotherapists and ombuds that may be beneficial to visible minority clients and visitors in increasing alliance and as a

result, aimed at positive outcomes. The current studies were a collaborative (KTI) endeavour in which the researcher gave visible minority clients and visitors a space to share recommendations regarding the research process and explore their thoughts and feelings on the credibility, acceptability, sustainability, and feasibility of services as usual that they either perceived or did not perceive to use the ingredients of the proposed model.

The EASE model emphasises **empathetic** listening (Step 1), **acknowledgment** of circumstances (Step 2), **solving** through sensible action (Step 3), and **evaluation** (Step 4) (Epperson & Armstrong, 2024; Armstrong et al., 2025). Empathetic listening is shown through giving empathetic **attention** to the problem to understand what it means to the unique client or visitor; checking one's own **biases** and assumptions to listen authentically and non-judgmentally; **caring** for the client or visitor's feelings and validating them with deep respect; and **deepening** one's own understanding of the problem from the client or visitor's perspective (Epperson & Armstrong, 2024; Armstrong et al., 2025). Next, **acknowledgment** of circumstances is done through the **establishment** of realistic and attainable goals collaboratively with the client or visitor based on what is within their control and has the potential for change (Epperson & Armstrong, 2024; Armstrong et al., 2025). Solving is done through the **formulation** of a sensible, and culturally responsive and contextually appropriate, plan collaboratively with the client or visitor based on the attainable goals established (Epperson & Armstrong, 2024; Armstrong et al., 2025). Finally, **evaluation** is done through the exploration of feelings and thoughts about the formulated plan to **generate** agency of the client or visitor and ensure that any potential barriers to the achievement of the goals and a positive outcome for the unique client or visitor are eliminated (Epperson & Armstrong, 2024; Armstrong et al., 2025).

The above-described steps to a successful therapeutic session or conflict resolution are grounded in theoretical frameworks around alliance building, EAR, Meaning Mindset, and the Stoic dichotomy of control. Beginning with alliance, Carl Rogers once said that in his early professional years, he would ask himself, “How can I treat, or cure, or change this person?” and later started asking himself instead, “How can I provide a relationship which this person may use for his own personal growth?” (Stubbe, 2018), showing that the relationship a psychotherapist or ombuds has with their client or visitor has a more powerful and longer-lasting impact than the work itself. As a result, researchers have called alliance the “quintessential” ingredient and decades later, researchers still agree with Carl Rogers that alliance itself may be therapeutic for individuals, regardless of the intervention (Martin et al., 2000; Ardito & Rabellino, 2011). The theoretical definition of alliance across scholars and conceptualisations comes down to the bond between the individual and their service provider, as well as their agreement and collaboration on goals and tasks (Stubbe, 2018). To ensure the development of a bond, Carl Rogers most emphasised the use of empathetic listening, and researchers since have supported its strong association with alliance and a general positive outcome (Wynn & Wynn, 2006; Tao et al., 2015; Stubbe, 2018). Empathetic listening is also emphasised by the theoretical framework of EAR (Eddy, 2011). When Eddy’s EAR approach is used by a psychotherapist or ombuds, they show their clients or visitors empathy, attention and respect (Eddy 2021). The literature on the EAR approach shows that it helps significantly with respectful and effective listening, regulating individuals who are dysregulated, and validating them (Eddy, 2018). The first step of EASE, empathetic listening, integrates empathy, attention, and respect as well as care, non-judgement and deepening of understanding (Epperson & Armstrong, 2024). Interestingly, the broader literature shows that the EAR method works best when there is an already formed strong alliance

(Eddy, 2011). Given the fundamental importance of alliance in such relationships for service retention and positive outcome, presented in the literature above, the EASE model uses empathetic listening (with the comprehensive A, B, C, D steps explained above) to develop a strong bond and uses acknowledgment of circumstances, solving and evaluation to ensure agreement and collaboration on goals and tasks (Epperson & Armstrong, 2024; Armstrong et al., 2025). In other words, the EASE model specifically considers every ingredient of the theoretical conceptualisation of working alliance, and EAR. During the current study, the perceived use by clients/visitors of the EASE model by psychotherapists and ombuds was assessed through a series of questions. Notably, every single question was significantly associated with a strong alliance.

The clients and visitors were asked how genuinely interested their service provider seemed in what was going on for them (Step 1, A); how their service provider's own biases didn't appear to get in the way of their work together (Step 1, B); how their service provider noticed and showed care for their feelings (Step 1, C); how their service provider seemed to recognise and explore the problems they were facing (Step 1, D). Next, the clients and visitors were asked how their service provider helped them establish goals (Step 2, E) and then how their service provider collaborated with them to explore steps to reach those goals (Step 3, F). Next, the clients and visitors were asked how their service provider helped them develop a sense of agency and belief that they are capable of choosing helpful actions and thoughts, how they validated the feelings they had regarding the actions and thoughts required to reach their goals, and how helpful they believed their work with their service provider to be (Step 4, G). Finally, the clients and visitors were asked if they felt they and their service provider respected each other (Step 1, C). Given the research presented above, it makes sense that the EASE model's

integration of the above steps was highly associated with alliance. Otherwise, alliance was also significantly associated in the findings with client-perceived therapist multicultural competence in the client population suggesting that a client who feels a strong alliance with their psychotherapist may also feel that their service provider is culturally competent. This is significant because the broader literature shows that cultural competence is key for positive outcomes, including better mental health (Owen et al., 2011; Tao et al., 2015). Alliance was also highly associated with Meaning Mindset, which will be discussed further below. Additionally, alliance was highly associated with mental health suggesting that clients or visitors who perceive a strong alliance with their service provider may also end up with better mental health, as supported by the broader literature presented. The relationship between alliance and mental health was also moderated by EASE suggesting that clients who perceived their psychotherapist to be using EASE were also more likely to have better mental health if there was a strong alliance. This is especially important given the literature presented above on mental health difficulties in visible minority populations. Notably, alliance was significantly associated with visible minority status, but the association was negative meaning that, as the literature above shows, visible minority clients and visitors were less likely to feel an alliance with their service providers.

The relationship between alliance and service retention was also moderated by EASE. This suggests that when clients or visitors feel that their service provider is using the elements of EASE, they are more likely to stay in services for the recommended duration as they feel an alliance: EASE creates that bond. This is significant since the greatest predictor of premature termination is a poor alliance (Sue et al., 1991; Swift & Greenberg, 2012). Finally, alliance was also significantly associated with mental health in all populations (client and visitor, minority

and non-minority), which is supported by the broader literature above that shows significant mental health improvement when there is an alliance. Therefore, not only was EASE significantly correlated with alliance between client or visitor and service provider, but alliance was also significantly correlated with positive outcomes, including service retention. This shows the significance of EASE in psychotherapy and ombuds services, especially for communities who are known to experience less alliance and as a result, less positive outcomes. EASE is, therefore, promising for building therapy services and ombuds practices that meet the needs of diverse populations. Another factor related to EASE was Meaning Mindset.

Meaning Mindset Theory teaches that, within any difficulty, the beautiful can also be seen. Inspired by Victor Frankl, it posits that when we find purpose, we can get through any hardship (Armstrong & Potter, 2022). Having a Meaning Mindset involves having a sense of agency over one's thoughts and actions, being hopeful for the future despite the present hardship, being open to new experiences including new and more helpful thoughts and feelings, having a strong sense of self-worth and belief that one can achieve the goals they set (Armstrong et al., 2018; Armstrong & Potter, 2022). The broader literature has shown that a Meaning Mindset leads to better emotional, social and behavioural well-being which of course includes stronger coping and resilience, and a better mental health (Ivtzan et al., 2015; Wong, 2017). To develop such a powerfully helpful mindset, one must challenge their unhelpful thoughts by reframing them; incorporate healthy actions into their lives; acknowledge the circumstances they can control and the circumstances outside of their control; nurture belonging with others and compassion towards oneself; practice gratitude realistically; and express one's emotions effectively (Armstrong & Potter, 2022). The EASE model integrates the Meaning Mindset with Steps 1 through 4. To have agency over thoughts and feelings, one has to be attuned to feelings

through empathy towards oneself and others. Further, Meaning Mindset encourages the acknowledgment of circumstances that are within and outside of one's control as well as self-compassion, agency over one's thoughts and behaviours, and the setting of realistic goals (Armstrong & Potter, 2022). The EASE model emphasises the acknowledgment of circumstances, solving and evaluating by establishing realistic goals collaboratively based on the individual client or visitor's context, as well as formulating a sensible plan tailored to them and generating agency by exploring their thoughts and feelings on the plan to ensure success (Epperson & Armstrong, 2024; Armstrong et al., 2025). The Stoic dichotomy of control also teaches the Meaning Mindset characteristics that are emphasized by EASE, notably the acknowledgment of circumstances within and outside one control, the practice of challenging and reframing unhelpful thoughts and actions for a healthier mind and lifestyle, the push for fostering belonging with others and more effective expression of emotions (Epictetus, 2012; LeBon, 2023; Smith, 2024).

Evidently, EASE, which is inspired by the theories of Meaning Mindset and the Stoic dichotomy of control, was found to be significantly associated with Meaning Mindset in both client and visitor populations. This suggests that clients and visitors who perceived their service provider to use EASE in their work also had more Meaning Mindset, as EASE aims at enhancing Meaning Mindset, which is significant due to the association of Meaning Mindset with mental health and well-being in broader literature presented. As mentioned previously, Meaning Mindset was significantly associated with alliance as well. This means that clients and visitors who perceived a strong alliance with their service provider were also more likely to have a Meaning Mindset. Additionally, the same way alliance was associated with service retention, Meaning Mindset was as well. This suggests that clients or visitors who had more of a Meaning Mindset

were also more likely to stay in services for the recommended duration. Meaning Mindset was also significantly associated with client-perceived therapist multicultural competence in the client population meaning the more clients perceived their therapist to be culturally competent, the more likely they were to have a Meaning Mindset. Finally, Meaning Mindset was negatively associated with visible minority status, as was mental illness. This suggests that the visible minority clients and visitors were less likely to have a Meaning Mindset but that the clients and visitors who did report having a Meaning Mindset also had better mental health. Interestingly, Meaning Mindset also moderated the relationship between EASE and mental illness symptoms in the client population suggesting that clients who had a Meaning Mindset and perceived their psychotherapist to be using EASE also had better mental health. Therefore, in the current research, it seems that one of the pathways from EASE to mental health may be through Meaning Mindset. Further research on this topic will be important to support this.

In addition to alliance and Meaning Mindset, EASE was negatively associated with mental illness suggesting that clients who perceived their psychotherapist to be using EASE also had better mental health. Additionally, the perceived use of EASE moderated the relationship between mental illness and visible minority status. This finding is beneficial because it suggests that visible minority clients may report better mental health if their psychotherapist is perceived to be using elements of EASE in their work. In both populations, EASE was positively associated with retention rates, suggesting that clients and visitors who perceived their service provider to be using EASE were more likely to stay for the recommended duration. EASE was also strongly associated with client-perceived therapist multicultural competence and moderated its relationship with mental illness. This means that participants who felt that their service provider was using EASE also likely felt that they were culturally competent and that this was

associated with better mental health. Unfortunately, visible minority clients and visitors were less likely to perceive their service providers to use elements of EASE in their work at all. However, if it was perceived, then this was associated with the positive outcomes noted above and negated the typical relationship seen between visible minority status and service dropout.

Therefore, the EASE model, inspired by the theoretical frameworks and concepts of alliance, EAR, Meaning Mindset and the Stoic Dichotomy of Control, may have significant implications for psychotherapy and ombuds services. The quantitative findings showed that, as the literature suggests, visible minorities experienced less EASE, more symptoms of mental illness, more service drop out, less alliance and less Meaning Mindset. However, the perceived use of the EASE model had a significant association with mental health, alliance and service retention. The qualitative findings showed that most participants found the experiences of psychotherapy and ombuds services to be positive and held up to standards of credibility, acceptability, sustainability and feasibility. However, the participants who had negative experiences, which did not hold up to these standards, were all minorities.

As a result of these potentially significant implications, the researcher makes several recommendations for the implementation of the EASE model, if warranted by future research with larger samples.

1. Community engagement
 - a. Working with visible minority communities to further ensure that the model meets the needs of the communities;
 - b. Promoting the EASE model to get buy-in and support from the communities.
2. Structured training and practice

- a. Designing curriculums that include courses or workshops focused on teaching the EASE model, beginning with the acknowledgment of racial disparities in the field that led to its creation;
 - b. Ensuring the understanding of its applications in psychotherapy and ombuds practice;
 - c. Designing interactive exercises that allow trainees to practice EASE skills;
 - d. Ensuring feedback from supervisors for trainees on the use of EASE skills.
3. Regular assessment and continuous improvement
 - a. Implementing tools to assess the effective use of the EASE model in practice;
 - b. Using assessment results to further refine training.
 4. Organisational culture
 - a. Integrating the EASE model into organisations' missions to foster cultures of empathy, acknowledgment of circumstances, and sensible actions.

In training, the following examples show suggestions of questions or statements that can be made in psychotherapy or ombuds sessions, according to the elements of EASE:

EASE – Step 1: Empathetic Listening

Attention: *“I’m here to listen. What’s going on?” “What brings you here today?” “You seem to be having a hard time today; do you want to talk to me about it?”*

Biases (to check within oneself): *“Am I making any assumptions about this person?” “Do I hold a judgement over part of their situation?” “Am I putting myself in their shoes and projecting my experience?”*

Caring: *“This is really hard.” “It must have been very difficult to share that; I don’t take it for granted.” “This has been weighing on you for a long time.”*

Deepening understanding of their perspective: *“Can you tell me more about ____ so I can understand better?” “What was that like for you?” “When something like that happens, some people feel ____, what about you?”*

EASE – Step 2: Acknowledge Circumstances

Establish attainable goals: *“What would you like for us to work on first?” “What are some things you would like to change that you think you can change at this point?” “What are some things that you think may be harder to change?”*

EASE – Step 3: Solve

Formulate sensible plan collaboratively: *“Now that we have some goals, do you have any ideas for how we can start to work on them together?” “What are some small steps that you could take to achieve these goals soon?” “What is most important to you about this plan?”*

EASE – Step 4: Evaluate

Generate agency by exploring thoughts and feelings about plan: *“What do you like about this plan?” “What is something you want to change about this plan?” “How confident are you about this plan working for you?”*

Limitations

The primary limitation of this research is its small sample size, though both studies had large enough samples for initial pilot studies (Totton et al., 2023). With a small sample size, however, small and medium effects may be more difficult to detect. Therefore, relationships may exist, but data may present with false negatives. Secondly, for the qualitative portion of the survey, many participants only responded to yes/no questions and did not provide detailed responses to open-ended questions. In fact, most responses were brief. Additionally, as the quantitative and qualitative data was collected through an online survey, collected data included

duplicate responses that later had to be removed manually, and some questions did not yield very fruitful responses.

Future Directions

To address these limitations, this kind of study would benefit from a larger sample size to allow for more effects to be detected, inference of the effects detected, generalizability of those effects, and real-world application. For example, future research with larger samples may be able to conduct structural equation modelling to find out how the EASE model could lead to the outcomes presented in the current study. This is especially relevant since the research questions have important potential applications for visible minority clients and visitors. Additionally, this kind of study would benefit from having its qualitative data collected through interviews. Furthermore, it would be beneficial to further investigate the findings that were surprising and/or contradicted other established findings. Most importantly, if larger samples are used in future investigations on the potential impact of EASE on therapy and ombuds outcomes, the findings of the research and the elements of EASE may be taught and implemented, as suggested above. Ultimately, it is the researcher's hope that EASE can be used for more culturally responsive services and provide a unique approach to strengthening alliances and reducing the global burden of mental illness, especially for marginalized communities.

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Appendix A – Ethics Certificate



**UNIVERSITÉ
SAINT-PAUL
UNIVERSITY**

21-06-2024
dd-mm-yyyy

Comité d'éthique de la recherche (CER) | Research Ethics Board (REB)
Bureau de la recherche et de la déontologie (BRD) | Office of Research and Ethics (ORE)

CERTIFICAT D'ÉTHIQUE | ETHICS CERTIFICATE

SPU-REB Number: 1360.5/24

Last name	Name	Affiliation	Role
Ismail	Houda	Faculty of Human Sciences	MA Candidate
Armstrong	Laura	Faculty of Human Sciences	Thesis Director
Epperson	Brent	Faculty of Human Sciences	Thesis Director


Type of project Master's Thesis
Title One Less Barrier to Alliance: Improving Outcomes of Psychotherapy & Ombud Practice in Visible Minority Communities.

Approval date	Expiry Date	Decision ^(*)
dd-mm-yyyy	dd-mm-yyyy	
21-06-2024	20-06-2025	1 (Approved)


(*) Approved:

The Saint Paul University Research Ethics Board (SPU-REB) approved the project. Recruitment and data collection may begin as outlined in the application. Please use **SPU-REB Protocol 1360.5/24**. The SPU ethics approval applies for one year. However, any [modification to Research Project](#) must be approved by the REB before the changes can be implemented. The SPU-REB must be notified of all changes or unanticipated circumstances ([Unanticipated issues / adverse events report](#)) that have a serious impact on the conduct of the research, that relate to the risk to participants and their safety. An [Annual Report](#) for ongoing projects must be submitted. The researcher must provide a [Final Report](#) for projects that have been approved by the Research Ethics Board (REB) in order to close all REB-approved files.

- ◊ In accordance with the [Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2](#) and other applicable laws and regulations, the Saint Paul University Research Ethics Board (REB) has examined and approved the application for an ethics certificate for this project for the period indicated and subject to the conditions listed above.
- ◊ Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completed four weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.
- ◊ Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).



Louis Perron, Ph.D.
Chair
Research Ethics Board (REB)



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Appendix B – EASE

EASE inventory

Instructions: You will find a list of statements and questions below about experiences people might have with their therapist or their ombuds. Think about your experience and decide which category might best relate to your own experience.

- 1) My therapist/ombuds seemed to be genuinely interested in what was going on for me.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 2) My therapist/ombuds didn't appear to let their own biases get in the way of our work together.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 3) My therapist/ombuds noticed and showed care for my feelings.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 4) My therapist/ombuds seemed to recognize and explore the problem(s) I am facing.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 5) My therapist/ombuds helped me to establish goals.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 6) My therapist/ombuds collaborated with me to explore steps to reach my goals.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree
 - e. Agree
 - f. Strongly Agree

- 7) My therapist/ombuds helped me develop a sense of “agency,” or a belief that I am capable of choosing helpful actions and helpful thoughts.
 - a. Strongly disagree
 - b. Disagree
 - c. Somewhat disagree
 - d. Somewhat agree

- e. Agree
- f. Strongly Agree

8) My therapist/ombuds explored and validated the feelings I was having in relation to thinking about my thoughts or potential actions to reach my goals.

- a. Strongly disagree
- b. Disagree
- c. Somewhat disagree
- d. Somewhat agree
- e. Agree
- f. Strongly Agree

9) I believe the work I've done with my therapist/ombuds is helpful for me.

- a. Strongly disagree
- b. Disagree
- c. Somewhat disagree
- d. Somewhat agree
- e. Agree
- f. Strongly Agree


10) My therapist/ombuds and I respect each other.

- a. Strongly disagree
- b. Disagree
- c. Somewhat disagree
- d. Somewhat agree
- e. Agree
- f. Strongly Agree


Appendix C – AIMS

On a scale of 1-10 please indicate how much you agree or disagree with the following statement.

* 1. Please move the slider to indicate your level of agreement:

When I experience difficult feelings like sadness, fear, or anger, I am NOT able to change my attitude toward the situation	When I experience difficult feelings like sadness, fear, or anger, I am able to change my attitude toward the situation so I feel a bit better	<input type="text"/>
		<input type="text"/>

* 2. Please move the slider:

When I have a difficult feeling like sadness, fear, or anger, I DON'T tend to talk to anyone	When I have a difficult feeling like sadness, fear, or anger, I have a meaningful person in my life who I like to talk to	<input type="text"/>
		<input type="text"/>

* 3. Please move the slider:

When I have a difficult feeling like sadness, fear, or anger, I often choose not to do much of anything	When I have a difficult feeling like sadness, fear, or anger, I often choose to relax, have fun, or create something to feel a bit better	<input type="checkbox"/>

* 4. Please move the slider:

I wish that I was a different person	I am happy to be me	<input type="checkbox"/>

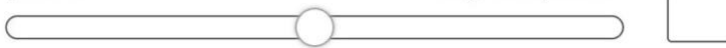
* 5. Please move the slider:

I DON'T think that I am valued by other people	I think that I am valued by other people	<input type="checkbox"/>

* 6. Please move the slider:

I DON'T think that I do many things to be proud of

I think that I do many things to be proud of



The slider bar is a horizontal line with rounded ends. A small circle is positioned in the center of the line. To the right of the line is a small, empty square box.

* 7. Please move the slider:

I do NOT expect good things to happen in my life

I know that good things will happen in my life



The slider bar is a horizontal line with rounded ends. A small circle is positioned in the center of the line. To the right of the line is a small, empty square box.

* 8. Please move the slider:

I believe my life is hopeless

I believe my life is meaningful

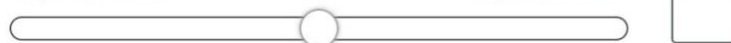


The slider bar is a horizontal line with rounded ends. A small circle is positioned in the center of the line. To the right of the line is a small, empty square box.

* 9. Please move the slider:

I DON'T know if I can find ways to get things that are important to me

I know that I can find ways to get something that is important to me




The slider bar is a horizontal line with rounded ends. A small circle is positioned in the center of the line. To the right of the line is a small, empty square box.

* 10. Please move the slider:

I am more interested in what I can see, feel, hear, taste, and touch, rather than noticing feelings

I am interested in noticing my own feelings as well as other people's feelings



* 11. Please move the slider:

I prefer to stick with things that I know

I like to try new things and learn new things



* 12. Please move the slider:

I DON'T participate in regular, meaningful leisure activities

I participate in regular, meaningful leisure activities



Appendix D – ISA

ISA-Adult Mental Health Scale

I.S.A. Parent Form
1) I felt cared about by the friends in my life this week / I didn't feel cared about by the friends in my life this week**
2) I felt I did many things well this week / I felt I didn't do anything well this week**
3) Over the past week, I've been feeling happy most of the time / Over the past week, I've been feeling sad most of the time**
4) This week, I wanted to do many things that I enjoy doing / I did not feel like doing much at all this week**
5) I was honest to everyone this week / I told lies or withheld important information this week**
6) I was cheerful this week / I was irritable this week**
7) I did not have arguments or fights with family or friends this week / I often had arguments with family or friends this week**
8) I was not worried or fearful this week / I was feeling worried or fearful a lot this week**
9) I didn't worry about dirt, germs or something bad happening to myself or someone I love this week / I worried about dirt, germs, or something bad happening to myself or someone I love this week**
10) I was nice to everyone this week / I said hurtful things to some people this week**
11) I found it easy to concentrate and focus this week / I found it hard to concentrate and focus this week**
12) I looked in the mirror this week and felt good about what I saw / I looked in the mirror and did not feel good about what I saw**

****10 point sliding scale**

Appendix E – BR-WAI (modified for Study 2 – use of “ ombuds” instead of “ therapist”)

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	My therapist and I understand each other.	1	2	3	4	5
2	We have established a good understanding of the kind of changes that would be good for me.	1	2	3	4	5
3	I feel that my therapist appreciates me.	1	2	3	4	5
4	I believe the time my therapist and I are spending together is not spent efficiently.	1	2	3	4	5
5	I believe my therapist likes me.	1	2	3	4	5
6	What I'm doing in therapy gives me new ways of looking at my problem.	1	2	3	4	5
7	I feel my therapist cares about me even when I do things that he/she does not approve of.	1	2	3	4	5
8	My therapist does not understand what I am trying to accomplish in therapy.	1	2	3	4	5
9	I am confident in my therapist's ability to help me.	1	2	3	4	5
10	I feel that the thing I do in therapy will help me to accomplish the changes that I want.	1	2	3	4	5
11	My therapist and I trust one another.	1	2	3	4	5
12	I disagree with my therapist about what I ought to get out of therapy.	1	2	3	4	5
13	I believe in my therapist is genuinely concerned for my welfare.	1	2	3	4	5
14	We agree on what is important for me to work on.	1	2	3	4	5
15	My therapist and I respect each other.	1	2	3	4	5
16	The things that my therapist is asking me to do don't make sense.	1	2	3	4	5

Appendix F – MTCI-CV

	Does this very well	Does this adequately	Does this poorly
1 My therapist uses relationship-building skills, such as listening and attending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 My therapist appropriately applies his/her own values in therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 My therapist has a positive and warm attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 My therapist values his/her own perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 My therapist knows about the customs of his/her culture, accepted behaviors, and general values	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 My therapist accepts my/my family's values and beliefs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 My therapist asks me/my family to tell him/her about my/our unique expectations for care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 My therapist encourages me/my family to share my/our point of view	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 My therapist cares about building relationships with people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 My therapist knows about several different ways of helping people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 My therapist cares about helping me/my family in appropriate ways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 My therapist appears to have some knowledge about my/my family's culture and background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 My therapist is able to explain things in a way that demonstrates familiarity with my/my family's ethnicity/culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 My therapist appears to understand that therapy needs to fit me/my family (i.e.: race, class, gender, culture, sexual orientation, religion, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 My therapist shows openness to my/my family's perspective	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16 My therapist desires to know me as an individual with unique experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17 My therapist is able to see things from my perspective without judgment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18 My therapist provides the opportunity to discuss his/her values related to family, culture, religion, etc. when they are relevant to therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19 My therapist displays a genuine interest to learn about me/my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 My therapist is open to my/my family's expertise on my/our life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21 My therapist acknowledges my/my family's values and beliefs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22 My therapist is open to my/my family's uniqueness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23 My therapist is open (through body language and communication) to the differences between us	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24 My therapist provides suggestions that fit my/my family's context (i.e.: race, class, gender, culture, sexual orientation, religion, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25 My therapist is knowledgeable about how my/my family's background may affect my/our availability of resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26 My therapist values my/my family's ideas, behaviors, and feelings in therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27 My therapist knows about how his/her biases can affect me/my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28 My therapist is familiar with how culture, religion, and gender can shape me/my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29 My therapist respects his/her cultural heritage as well as valuing differences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30 My therapist connects well with people in socially appropriate ways (e.g., eye contact, touch, greetings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31 My therapist knows basic principles that are helpful in relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32 My therapist believes it is important to look beyond stereotypes to uncover what fits for me/my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Did your experience in psychotherapy lead to the outcomes that you wanted? Explain.

4. Were you able to maintain the outcomes you achieved in psychotherapy after your sessions ended? Explain.

5. Do you feel that the outcomes you were hoping for in psychotherapy were attainable?
Explain.

Appendix H – Client Demographic Questionnaire

Demographic Questionnaire - Clients

Age:

How old are you?

- A. Under 18
- B. 18-24 years old
- C. 25-34 years old
- D. 35-44 years old
- E. 45-54 years old
- F. 55-64 years old
- G. 65+ years old

Gender:

How do you identify?

- A. Female
- B. Male
- C. Transgender
- D. Nonbinary
- E. Other (please specify)
- F. Prefer not to say

Education level:

What is your level of education (current or completed)?

- A. Less than High School
- B. High school (including GED)

- C. Some college (no degree)
- D. Technical certification
- E. Associate degree (2-year)
- F. Bachelor's degree (4-year)
- G. Master's degree
- H. Doctoral degree
- I. Professional degree (JD, MD)
- J. Prefer not to say

Ethnicity:

What is your ethnic background?

- A. White/Caucasian
- B. Asian
- C. Native Hawaiian or Pacific Islander
- D. Hispanic or Latino
- E. African-American
- F. Native American
- G. Two or more
- H. Other (please specify)
- I. Unknown
- J. Prefer not to say

Minority status:

Do you identify as part of a minority group? (yes/no)

If yes, check all that apply:

- A. I am part of a visible minority group

- B. I have an invisible or visible disability
- C. I'm part of the 2SLGBTQia+ community
- D. I am neurodiverse (e.g., gifted, ADHD, autism spectrum): Specify
- E. I am part of a linguistic minority group: Specify
- F. I identify as part of another minority group: Specify

Location:

Where do you live?

- A. Canada
- B. United States
- C. Mexico
- D. Central America
- E. South America
- F. Europe
- G. Asia
- H. Other (specify)
- I. Prefer not to say

Income:

What is your annual household income?

- A. \$0-\$29,999
- B. \$30,000-\$59,999
- C. \$60,000-\$89,999
- D. \$90,000-\$119,999
- E. \$120,000 - \$150,000

F. \$150000 +

G. Prefer not to say

Psychotherapist Minority Status:

Was your therapist a visible minority? (yes/no)

A. Yes

B. No

Sessions:

How many sessions did you have?

A. I completed services

B. I dropped out of services before we were finished working together

Recommendations:

Following your sessions, did you...

A. Follow all the recommendations/plans

B. Follow some of the recommendations/plans

C. Decide not to follow the recommendations/plans

3. Did your experience with ombud services lead to the outcomes that you wanted? Explain.

4. Were you able to maintain the outcomes you achieved with ombud services after the services ended? Explain.

5. Do you feel that the outcomes you were hoping for with ombud services were attainable?
Explain.

Appendix J – Visitor Demographic Questionnaire

Demographic Questionnaire - Visitors

Age:

How old are you?

- A. Under 18
- B. 18-24 years old
- C. 25-34 years old
- D. 35-44 years old
- E. 45-54 years old
- F. 55-64 years old
- G. 65+ years old

Gender:

How do you identify?

- A. Female
- B. Male
- C. Transgender
- D. Nonbinary
- E. Other (please specify)
- F. Prefer not to say

Education level:

What is your level of education (current or completed)?

- A. Less than High School
- B. High school (including GED)

- C. Some college (no degree)
- D. Technical certification
- E. Associate degree (2-year)
- F. Bachelor's degree (4-year)
- G. Master's degree
- H. Doctoral degree
- I. Professional degree (JD, MD)
- J. Prefer not to say

Ethnicity:

What is your ethnic background?

- A. White/Caucasian
- B. Asian
- C. Native Hawaiian or Pacific Islander
- D. Hispanic or Latino
- E. African-American
- F. Native American
- G. Two or more
- H. Other (please specify)
- I. Unknown
- J. Prefer not to say

Minority status:

Do you identify as part of a minority group? (yes/no)

If yes, check all that apply:

- A. I am part of a visible minority group

- B. I have an invisible or visible disability
- C. I'm part of the 2SLGBTQia+ community
- D. I am neurodiverse (e.g., gifted, ADHD, autism spectrum): Specify
- E. I am part of a linguistic minority group: Specify
- F. I identify as part of another minority group: Specify

Location:

Where do you live?

- A. Canada
- B. United States
- C. Mexico
- D. Central America
- E. South America
- F. Europe
- G. Asia
- H. Other (specify)
- I. Prefer not to say

Income:

What is your annual household income?

- A. \$0-\$29,999
- B. \$30,000-\$59,999
- C. \$60,000-\$89,999
- D. \$90,000-\$119,999
- E. \$120,000 - \$150,000

F. \$150000 +

G. Prefer not to say

Ombud Minority Status:

Was your ombud a visible minority? (yes/no)

A. Yes

B. No

Sessions:

How many sessions did you have?

A. I completed services

B. I dropped out of services before we were finished working together

Recommendations:

Following your sessions, did you...

A. Follow all the recommendations/plans

B. Follow some of the recommendations/plans

C. Decide not to follow the recommendations/plans