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THE INFLUENCE OF RACE AND ETHNICITY IN CLIENTS' EXPERIENCES OF MENTAL HEALTH TREATMENT

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Abstract

Clinicians and researchers have pointed to the need for culturally sensitive mental health interventions. Yet it has not been determined if the inclusion of cultural elements affects the way mental health clients experience services. This study examined 102 clients who had received mental health treatment from outpatient mental health clinics to investigate whether culturally related elements involving race and ethnicity were important to clients and whether they were related to client satisfaction and perceived treatment outcomes. Ethnic minority clients generally felt that issues regarding race and ethnicity were more important than did White clients. When these elements were considered important but were not included in their care, clients were less satisfied with treatment. Consistent with the notion of cultural responsiveness, these findings provide empirical evidence that culturally relevant aspects of the mental health service experience are salient to ethnic minority clients and can affect how they respond to services.

The U.S. Surgeon General's Report on Mental Health, Culture, Race, and Ethnicity (2001) acknowledged that racial and ethnic minority persons are underserved and ineffectively served by mental health professionals. Similarly, the Institute of Medicine (IOM, 2002) reported that African American and Hispanic patients were more likely to report dissatisfaction with their relationships with providers and to perceive poorer quality of care. Using a clinical sample of Asian American and White mental health outpatients, Zane, Enomoto, and Chun (1994) found that Asian Americans reported lower service satisfaction, less confidence in their provider, and greater levels of symptomatology that were attributed to a lack of culturally responsive therapy. In response to these problems, there has been an impetus to improve the cultural responsiveness of mental health providers through education and training (Sue & Sue, 1999).

Moreover, the American Psychological Association (APA, Committee on Accreditation, 2002) recognized the importance of integrating discussions of race and ethnicity into the field of psychology by highlighting these issues in clinical training programs. In 2003, the APA approved guidelines for multicultural counseling (APA, 2003). These guidelines

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underscore the importance of attending to racial and ethnic issues, in particular, as they affect the therapy relationship (Sue, Arredondo, & McDavis, 1992).

A variety of terms have been used to refer to the consideration of culture in mental health treatment, including “multicultural competence” “culturally sensitive,” “culturally competent,” or “culturally responsive.” Although the field continues to struggle toward operationalizing multicultural counseling competence and its component parts (Sue, Zane, Hall, & Berger, 2009), researchers have suggested that counselors’ multicultural counseling competence is critical for effectively working with clients of color, accounting for a significant proportion of the variance in clients’ satisfaction beyond ratings of general therapist competence (e.g., Constantine, 2002).

Client Experiences in Treatment

Mental health researchers have long recommended the use of a consumer perspective on care provider cultural competency (Pope-Davis et al., 2002). More recently, there has been an emphasis on patient-centered care in health and mental health systems (Clancy & Collins, 2010). Few investigations have examined the client’s subjective experience of race and cultural issues in treatment as well as what occurs during treatment (Ito & Maramba, 2002). Some studies (e.g., Ito & Maramba, 2002; Maxie, Arnold, & Stephenson, 2006) have investigated therapists’ perspectives regarding their practices, but there has been a lack of empirical research describing how clients actually experience therapy with regards to racial issues (Chang & Berk, 2009). This is troubling given that the client’s evaluation of the therapy relationship (as opposed to the counselor’s view) is most strongly associated with therapy outcome (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Horvath & Bedi, 2002; Quintana & Meara, 1990; Safran & Segal, 1990). Therefore, the assessment of client satisfaction is a necessary and critical element in the evaluation of mental health services (DiPalo, 1997).

Mental health consumer satisfaction refers to the extent that services gratify the consumer’s wants, wishes, or desires for treatment (Lebow, 1983). This definition also includes the perceived adequacy of treatment and the surrounding milieu (i.e., cost, continuity, availability, accessibility of care, and the reaction to supporting services). Given the continual emphasis on patient-centered care, it is important to understand what mental health clients expect regarding culturally responsive care.

The goal of this study is to examine how race and ethnicity affect the client’s experience of mental health treatment. Definitions of the terms race and ethnicity are varied and distinguishing between these two concepts is often challenging, as indicated by the fact that these terms are sometimes used interchangeably, despite their individual nuances (Bhugra & Bhui, 2002; Bhui, 2002; Helms & Cook, 1999; Helms & Talleyrand, 1997). “Ethnicity” often refers to the historical cultural patterns and collective identities shared by groups from specific geographic regions of the world (Betancourt & Lopez, 1993; Helms & Cook, 1999). Although race has been proposed as a social psychological construct and not a biological marker of difference (Smedley & Smedley, 2005), and there is no strong agreement regarding the construct in psychological research (Cokley, 2007; Helms, Jernigan, &

Mascher, 2005), race is an important topic to study because it is particularly salient for ethnic and racial minorities (Comas-Dıaz & Jacobsen, 1991; Helms, 2007; Wright and Littleford, 2002). Although we do acknowledge the importance of distinguishing between race and ethnicity, for the purposes of this article and its scope, issues of race and ethnicity are discussed collectively and inclusively, similar to other studies (e.g., Cardemil & Battle, 2003).

Racial Match

Racial match, or concordance, has been described as one element of culturally responsive care and a potential factor in reducing mental health disparities for ethnic minorities. Racial/ethnic match occurs when mental health clients and providers share the same race or ethnicity. In a counseling situation, therapist ethnicity may be one of the most important features to which clients first attend. Ward (2005) conducted a qualitative investigation of counseling processes and perceptions of counseling specific to African American clients within a community mental health agency. During the first counseling session, clients reported assessing the race and ethnicity of the counselor above everything else (Ward, 2005). Only after an assessment of racial match did clients assess other counselor variables (e.g., age, gender).

Some studies have shown racial match to be associated with increased utilization, favorable treatment outcomes (i.e., global assessment scores, substance use reduction), lower treatment dropout, and greater satisfaction (Blank, Tetrick, Brinkley, Smith, & Doheny, 1994; Flaskerud & Liu, 1991; Flicker, Waldron, Turner, Brody, & Hops, 2008; Gamst, Dana, Der-Karabetian, & Kramer, 2001; Gamst et al., 2003; LaVeist & Nuru-Jeter, 2002; O'Sullivan & Lasso, 1992; Sue, Fujino, Hu, Takeuchi, & Zane, 1991).[1] Maramba and Hall (2002) conducted a meta-analysis of seven studies and found that clients matched with therapists of the same ethnicity were less likely to drop out of therapy and more likely to attend more sessions; however, the effect was small, indicating that ethnic match alone was a weak predictor.

A more recent meta-analysis of 10 studies found no significant difference between racially matched dyads versus unmatched dyads with regard to staying in treatment and overall functioning for African American and White clients (Shin et al., 2005). Despite this, ethnic minority clients may view ethnically similar counselors as more credible sources of help than White counselors because they assume shared commonalities in culture or values, elements that may be important to minority mental health clients (Meyer, Zane, & Cho, 2011; Sue & Zane, 1987; Zane et al., 2005). It also may be that the counselor's and client's racial worldviews (or racial identity stages) have a much stronger impact on the counseling process than race (Atkinson & Thompson, 1992). Ward (2005) found that racial match might be more important for individuals with a stronger Black identity.

[1]Studies reviewed include both racial and ethnic match studies. For the purposes of this paper however, we are using race to encompass ethnicity (e.g., within the Asian race, Chinese are a specific ethnic group).

Addressing Race and Ethnicity in Treatment

Although a host of research studies has centered on the topic of racial differences (e.g., racial match) between client and therapist in treatment, little is known regarding the dialogues that take place between therapists and clients (Maxie et al., 2006). The discussion of race and racial differences early in treatment is an example of a cultural competency skill (Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002). Researchers have suggested that open dialogues about issues of race and ethnicity can promote an environment of trust that will ultimately benefit the treatment process (Cardemil & Battle, 2003).

The counseling literature is replete with examples of the importance of counselors acknowledging and addressing racial and ethnic differences between a counselor and client during treatment (Arredondo, 1999; Harley, Jolivette, McCormick, & Tice, 2002). Analogue studies (Thompson & Jenal, 1994; Thompson, Worthington, & Atkinson, 1994) have found that making sensitive responses to clients' concerns about racial issues is preferable to ignoring or avoiding clients' concerns. Other research has found that counselors who directly addressed racial issues in the first two sessions of a 12-session counseling experience reported creating an environment conductive to building a strong therapeutic relationship with their clients (Fuertes et al., 2002). In a qualitative study of African American views about counseling, some participants felt that discussions of race not initiated by the client were indicative of therapists' racism and discomfort. Overall, there are varied perspectives regarding individuals' beliefs about the discussion of race and ethnicity in treatment (Thompson, Bazile, & Akbar, 2004).

Provider Knowledge of Prejudice and Discrimination

Cultural issues like race and clients' history of discrimination certainly have influential roles in treatment because they are a part of the ethnic minority experience (Bernal & Saez-Santiago, 2006; Cardemil & Battle, 2003). Discrimination as a topic may be more salient because ethnic minorities typically report higher rates of perceived discrimination than Whites (Kessler, Mickelson, & Williams, 1999). Therefore, it is important to consider how these types of experiences might affect the therapeutic process. Chang and Berk (2009) found that culture-specific knowledge mentioned by participants as conspicuously absent from their therapists' knowledge base included issues such as racism and discrimination. Although they found that race was salient to a majority of their participants, they were unable to assess the relative *importance* of the various factors described by clients as salient (e.g., racism and discrimination) in their evaluation of the therapy experience.

PRESENT STUDY

The present study draws on process and outcome research as well as client satisfaction research that emphasizes the role of client perceptions and contributions to positive outcomes (Tallman & Bohart, 1999). We examined if specific elements associated with purportedly culturally sensitive or culturally competent mental health care were important to ethnic minority and White clients and whether or not their inclusion in treatment was actually related to the way clients experienced their treatment. Specifically, we examined provider-client racial match, provider knowledge of ethnic/racial group's history of

discriminations and prejudices, and provider discussions of race and ethnicity in treatment. Given that cultural issues may be of particular concern for ethnic minority clients (Owen, Leach, Wampold, & Rodolfa, 2010; Zane, Hall, Sue, Young, & Nunez, 2004), it was hypothesized that these three cultural elements would be more important for ethnic minority clients than White clients. Similar to other studies examining client satisfaction, we assessed client reports of events rather than ratings, allowing for the identification of specific provider behaviors that could be modified to increase client satisfaction and outcomes (Napoles, Gregorich, Santoyo-Olsson, O'Brien, & Stewart, 2009).

METHOD

Clients

A total of 102 mental health clients were drawn from two outpatient samples: (a) young adults seeking care from the private sector (e.g., health maintenance organizations) recruited from a local university and (b) adult clients from two public community-based mental health clinics.[2] The clinics were all located in Northern California. At the time of data collection, the university served a population of over 28,000 students, about half of whom were ethnic minorities. The majority of the clients (70.6%) were receiving services at the two community-based centers that provided outpatient mental health services to adults with serious mental health issues. Staff at these centers were comprised of clinicians, counselors, mental health workers, psychiatrists, and support staff.

The study was comprised of 75 (73.5%) females. In terms of ethnicity, there were 57 (55.9%) White Americans, nine (8.8%) Asian/Pacific Islanders, nine (8.8%) Latinos, 16 (15.7%) African Americans, eight (7.8%) Native Americans, and three (2.9%) biracial individuals (i.e., Black/White). The sample had slightly more Whites (55.9%) than ethnic minorities. Ages of participants ranged from 18–65 years (mean [*M*] = 37.07, standard deviation [*SD*] = 13.31). The majority of the clients were single (75.5%), not employed (63.7%), born in the United States (90.2%), and were being seen by a psychiatrist or psychologist (59.8%). Demographic differences by type of participant were analyzed. Private clients (70% White) did not differ significantly from community-based (CB) clients (50% White) in ethnicity, $p = .06$, gender (private = 80% female; CB = 70.8%), $p = .34$, or nativity status (private = 96.7% U.S. born; CB = 88.7% U.S. born), $p = .20$. No significant differences emerged for length of time seen by provider, with at about 50% of individuals in both groups having seen the provider for at least two years, $p = .77$. Significant differences emerged for marital status, education level, and employment. Private clients were more likely to be single or never married (66.7% vs. 37.1%), $p < .01$, to have some college (76.7% vs. 37.1%), $p < .01$, to be younger (mean age of 23.23 vs. mean age 43.00), $p < .001$, and less likely to be unemployed (36.7% vs. 79.4%), $p < .001$.

[2]Combining the samples from the two sites is warranted for several reasons: (a) both samples had received outpatient services for their mental health problems, (b) relatively modest differences were found between the two samples, with no significant differences in any of the outcome variables, and (c) the combined sample provided a broader cross-section of the outpatient mental health consumers in this area.

Procedure

Clients from the private sector were either currently receiving or had at some point received mental health services for their problems. These clients received course credit for their participation. Community-based clients who were waiting to see their care provider in the clinic were asked by a research staff member to participate in the study. Eligibility for the study was based on consent and sufficient mental capacity to complete all the measures. An Asian American research staff member thoroughly reviewed the consent form and procedures of the study with each client before he or she could participate. Participants completed the questionnaires individually while either waiting to see their provider or after meeting with their provider. The majority of clients spent approximately 20–30 minutes completing the measures. Respondents could also choose to enter a monetary raffle. This study received institutional review board approval.

Measures

Cultural elements—Cultural elements were items taken from the Cultural Acceptability of Treatments Survey (CATS). The CATS assesses how clients perceive and respond to specific service elements that address cultural issues (Leff et al., 2003). We examined clients' expectations regarding provider-client racial match, provider knowledge of discriminations and prejudices faced by one's ethnic/racial group, and provider discussions of race and ethnicity in treatment. These elements are reflected in the format of the survey, so that each element contains questions regarding its importance and inclusion in treatment. For example, the importance item asks, "How important is it to you that your provider include knowledge about the discriminations and prejudices faced by your racial/ethnic group?" Response choices ranged from *1* (*not important at all*) to *4* (*very important)*. The inclusion item asks, "In your treatment, has your provider included knowledge about the discriminations and prejudices faced by your racial/ethnic group?" Response choices ranged from *1* (*never)* to *5* (*always)*. Demographic questions also were included in this measure.

Client satisfaction and outcomes—Client satisfaction and outcomes were assessed by the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey. The MHSIP consumer survey was developed with input from a variety of stakeholders with support from the Center for Mental Health Services (CMHS, 1996). It is part of a broader mental health report card that also includes indicators obtained from medical records or administrative databases. The MHSIP consumer survey is a 28-item self-report instrument designed to be completed by the client without assistance. It consists of four scales that measure access (six items), quality/appropriateness of care (11 items), outcomes (eight items), and general satisfaction (three items). The items are rated on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Clients can also indicate that an item is not applicable to them. The MHSIP survey is widely used in public mental health systems and states (Teague, Ganju, Hornik, Johnson, & McKinney, 1997).

The Access subscale assesses the extent to which clients perceive that services are quickly and readily available to them ("Staff were willing to see me as often as I felt it was necessary"). Quality/appropriateness of care assesses the best possible match between a client and type of care and chosen treatment, as well as service utilization ("Staff told me

what side effects to watch out for"). Satisfaction assesses global satisfaction with the treatment ("I liked the services I received here"). Treatment Outcomes assesses the client's evaluation of improvements in psychological, social, and occupational functioning as a result of care ("My symptoms are not bothering me as much"). Cronbach alphas for the present sample were as follows: access, $\alpha = .87$; quality of care, $\alpha = .92$; satisfaction, $\alpha = .86$; and perceived treatment outcomes $\alpha = .94$.

Data Analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS), Version 20.0 (SPSS Inc., 2011). First, to test for ethnic differences in importance ratings of the three cultural elements, a multivariate analysis of variance (MANOVA) was conducted. If a significant overall ethnicity effect was found, *t* tests were performed. This multivariate adaptation of Fisher's protected *t* test guards against inflated setwise Type I error rates and also keeps both F and *t* tests relatively powerful (Cohen & Cohen, 1975). Second, bivariate analyses were conducted to assess the linear relationships among the key study variables. Given the somewhat small sample size of this study, we had these first two analyses inform which cultural elements should be entered as predictors in subsequent regression analyses.

Third, importance and inclusion scores were standardized, and then discrepancy scores were calculated reflecting the difference between the importance of an element and the extent to which it was included in service. Larger discrepancy scores indicated that clients tended to value the element, but it was not included in care. For example, if a client considered provider knowledge of history of discriminations/prejudices as very important, but it was perceived as not being included in treatment, this would result in a larger discrepancy score. A series of two-step hierarchical regression analyses were run to determine the relative contribution made by demographic and cultural factors on client satisfaction and perceived outcomes. In the first step, age, gender, and type of participant were entered as predictors. In the second step, cultural elements were added to the model. Regression analyses were run for each of type of client service evaluation: access, quality of care, satisfaction, and perceived treatment outcomes, using discrepancy scores as predictors in each analysis.

RESULTS

Characteristics of the Sample

Table 1 presents the mean or percentage distribution of demographic and outcome variables for all individuals by ethnicity. Crosstabs and *t* tests were employed for categorical and continuous variables, respectively. The ethnic minority and White sample differed significantly by age, nativity status, and employment status. Ethnic minorities were older ($M = 40.16$, $SD = 13.11$) than Whites ($M = 34.64$, $SD = 13.07$), $t = -2.09$, $p < .05$ (95% confidence interval [CI] = −10.75, −.28), and also more likely to be born outside the United States than Whites, $\chi^2 = 7.86$, $p < .01$. Ethnic minorities were also more likely to be unemployed (71.1%) compared with Whites (54.7%). No significant differences emerged on the four outcome variables.

Importance of Cultural Elements

A MANOVA tested for an overall ethnic difference in the importance of cultural elements. A significant effect of ethnicity was found, $F(3, 98) = 3.98$, $p < .05$. Univariate analyses were then performed to interpret this finding. Sample means of cultural elements for Whites ranged from 2.03 to 2.11, while means for ethnic minorities ranged from 2.44 to 2.96. These results indicate a generally higher level of importance of cultural elements for ethnic minority clients compared with White clients. There were significant differences between White and ethnic minority clients on two of the three cultural elements. Minorities felt that it was significantly more important for their provider to be racially matched ($M = 2.84$, $SD = 1.16$) than Whites ($M = 2.11$, $SD = 1.13$), $F = 10.19$, $p < .01$, *partial* $n^2 = .09$.

Minorities also felt that it was significantly more important that their provider be knowledgeable about their ethnic/racial group's history of prejudice and discriminations ($M = 2.96$, $SD = 1.07$) than Whites ($M = 2.29$, $SD = 1.19$), $F = 8.56$, $p < .01$, *partial* $n^2 = .08$. There was a marginally significant effect of ethnicity on provider discussions of race and ethnicity. Minorities tended to feel it was more important that their provider discuss issues regarding race and ethnicity during their treatment ($M = 2.44$, $SD = 1.09$) than Whites ($M = 2.03$, $SD = 1.07$), $F = 3.58$, $p < .10$, *partial* $n^2 = .04$. Thus, this element was not included in subsequent regression analyses.

Table 2 displays the intercorrelations for the cultural elements and outcome variables for the entire sample. First, correlations among the three cultural elements scores were low to moderate so that multicollinearity did not pose a problem. Second, correlations among the four types of service experiences were somewhat substantial. However, these moderately strong correlations typically have been found in other previous research (e.g., Howard, El-Mallakh, Rayens, & Clark, 2003). These subscales represent very distinct aspects of the service experience, and therefore, have been examined separately in these studies (e.g., Arneill-Py, 2004).

Relationship Between Cultural Element Discrepancy Scores and Client Experience

Table 3 summarizes the results from the regression analyses, using the cultural elements discrepancy scores as predictors and each of the four types of service evaluations (i.e., access, quality of care, satisfaction, and treatment outcomes) as the dependent variables.

In terms of *Access*, for Whites, neither Model 1 ($F = 1.83$, $p = .15$) nor Model 2 ($F = 1.29$, $p = .28$) was significant. For minorities, the first model with just age, gender, and participant type was not significant, $F = 0.69$, $p = .56$. However, there was a significant F change and the full model, with cultural elements was significant, $F = 3.01$, $p < .05$. Ethnic match was significantly related to clients perceptions of accessibility of treatment, $\beta = .37$, $p < .05$.

For *Quality of Care*, for Whites, again, neither Model 1 ($F = 1.08$, $p = .37$) nor Model 2 ($F = 1.08$, $p = .39$) was significant. For minorities, the first model with age, gender, and participant type was not significant, $F = .35$, $p = .79$. There was a significant F change and the full model, with cultural elements was significant, $F = 4.00$, $p < .01$. Both racial match and provider knowledge of discriminations and prejudices were significantly related to client perceptions of quality of care, $\beta = .38$, $p < .05$ and $\beta = .31$, $p < .05$, respectively.

For *Satisfaction*, for Whites, Model 1, with age, gender, and participant type was significant, $F = 2.94$, $p < .05$, although none of the predictors' regression coefficients were significant. The change in F to Model 2 was not significant and Model 2 was not significant, $F = 1.81$, $p = .13$. For minorities, the first model was not significant, $F = 1.60$, $p = .20$. There was a significant F change and the full model, with cultural elements was significant, $F = 2.67$, $p < .05$. Racial match was marginally associated with client satisfaction, $\beta = .31$, $p < .10$.

Finally, for *Treatment Outcomes*, for Whites, Model 1 was not significant, $F = 1.26$, $p = .30$. The change in F to Model 2 was marginally significant, but Model 2 itself was not, $F = 1.87$, $p = .12$. For minorities, the first model was not significant, $F = 0.01$, $p = .99$. There was a significant F change although the full model, with cultural elements was not significant, $F = 1.94$, $p = .11$.

DISCUSSION

Cultural competency on the part of mental health care providers has been mandated in county and federal systems, but it is unclear if cultural elements regarding race and ethnicity actually affect clients' experiences in treatment. This study demonstrated that issues surrounding race and ethnicity are important to ethnic minorities in the context of mental health treatment, and, in fact, clients are less satisfied when such elements are not included in their care. To our knowledge, this is one of the few empirical investigations of the effects of race and ethnicity elements on client satisfaction and perceived outcomes.

The three culture-specific elements assessed in this study (i.e., racial match, provider knowledge of prejudices/discrimination, and discussions of race and ethnicity) have been previously identified by cultural competence experts as important elements of care (Brach & Fraser, 2000; Leong & Lau, 2001). In the present study, ethnic minorities rated racial match and provider knowledge of discriminations/prejudices as significantly more important in their mental health care than Whites, consistent with research on the influence of culture on service issues and outcomes for ethnic and racial minorities (Zane et al., 2004). Provider discussion of race and ethnicity was marginally more important for minorities than Whites.

More noteworthy, when mental health clients felt like a cultural element was important in their care, but did not perceive it to be present, they were less satisfied with aspects of their treatment. However, this was the case *only* for ethnic minority clients, not for White clients. Across three of the four outcome variables (access, quality of care, and general satisfaction), racial match and provider history of discrimination/prejudices added significantly to the predictive power of the model, beyond that of demographic variables alone (i.e., age, gender, type of participant). Again, this was true only for ethnic minority clients, confirming the literature that highlights the value of including these elements in treatment for ethnic minority individuals (e.g., Flicker et al., 2008; Pope-Davis et al., 2002; Sue & Sue, 1999).

Additionally, various cultural elements were related to different types of client service evaluations for clients. For example, racial match appeared to be a strong predictor of the service experience across access, quality of care, and marginally for general satisfaction. Although a host of studies has debated the importance of racial match on ethnic minority

mental healthcare (Karlsson, 2005), studies continue to demonstrate the significance of racial match for minorities. A recent study examining clients with severe mental illness in community mental health centers found that racial match was associated with a stronger working alliance, even in a sample of highly acculturated individuals (Chao, Steffen, & Heiby, 2012).

In the present study, we did not assess racial identity of clients, but given the literature, racial match effects might have even been stronger for individuals who identify strongly with their race or ethnicity (Atkinson & Thompson, 1992). Minority clients who felt that it was important for their provider to understand their ethnic group's history of discrimination and prejudice and did not feel like this element was present in their care reported lower quality/appropriateness of care. Research has indicated that experiences with racism and discrimination affect the well-being of ethnic minorities (e.g., Hughes & Thomas, 1998; Jones, 2003), and other research on African Americans have found perceived discrimination to be associated with psychological distress, lower well-being, self-reported ill health, and number of days confined to bed (Ren, Skinner, Lee, & Kazis, 1999; Williams, Yu, Jackson, & Anderson, 1997).

In view of these findings, it is not surprising that those minority clients who were with care providers who did not acknowledge and process the reality of living in a racialized society (Jones, 2003) experienced poorer quality of care. Similarly, Thompson and Jenal (1994) found that African American clients paired with White providers who stressed the commonalities among individuals, while failing to address the ethnic issues related to being African American, perceived these providers as denying the influence that race has on their lives. Chang and Berk (2009) found that clients praised therapists who demonstrated culture-specific knowledge and an awareness of the importance of race and culture in shaping individual experience and identity and criticized those who displayed cultural ignorance or insensitivity.

Although racial match and provider knowledge of prejudices and discriminations was significantly related to aspects of the client service experience, neither was related to perceived treatment outcomes. These results seem to corroborate those of other studies that concluded that cultural elements (e.g., racial match) might aid in treatment engagement and/or retention but play only minor roles in treatment outcomes (Beutler, Machado, & Neufeldt, 1994; Cabral & Smith, 2011). It should be noted, however, that number of treatment sessions has been associated with treatment outcomes (Anderson & Lambert, 2001; Flaskerud & Hu, 1994; Howard, Kopta, Krause, & Orlinsky, 1986; Ritsher, Moos, & Finney, 2002), and, in some cases, racial match has itself been associated with treatment outcomes (Cabral & Smith, 2011; Gamst, Dana, Der-Karabetian, & Kramer, 2000; Sue et al., 1991).

The findings should be considered within the limitations of the study. First, the study did not obtain clinician perspectives or information. Another limitation of the study is the sampling of outpatients in only one urban community; thus, the results may not be generalizable to other community mental health agencies or consumers. For instance, findings from this

study may have been different if the sample had been drawn from an inpatient clinic where clients tend to be more clinically impaired.

A third limitation involved the aggregation of the various ethnic minority groups because the small sample sizes of each prevented separate ethnic group analyses. African Americans constituted the majority of the ethnic sample, and the findings of this study may be more specific to this ethnic minority group. However, inequitable treatment is a problem that most ethnic minority group members encounter (DHHS, 2001); therefore, we wanted to study the ethnic minority experience with treatment in general and not for any one particular group. There were no significant differences in terms of ethnicity or gender between the private and community-based clients and type of participant was controlled for in this study. However, future studies with larger sample sizes should disaggregate ethnic/racial minority group members as well as private and community-based mental health clients.

Another limitation of the study was its correlational design, thus, there was ambiguity with respect to causality or temporal sequence. It may be that clients formed their attitudes about importance of a cultural element based on previous questions. For example, the nature of the questions in the study (about race and ethnicity) may have led some clients to believe these elements should be important to them. Future studies utilizing a longitudinal design would help clarify any causal relationship between attitudes about importance and inclusion of cultural elements and satisfaction. We also did not have information regarding the nature of the problems that clients were seeking help for, and this may have been a factor in how salient issues of race and ethnicity were to clients. It may be that clients with more severe psychological problems were not as concerned about racial match as others with less severe issues.

A final limitation of the study involved the use of self-report measures and the fact that some clients reported on current experiences while others reported on previous experiences. As with all client surveys, the clients sampled were susceptible to biases in recall and this may have affected their satisfaction ratings. However, some patient satisfaction research showed that retrospective assessments were not significantly different from their prospective counterparts in means and variances (Kreulen, Stommel, Gutek, Burns, & Braden, 2002).

Despite these limitations, an implication of the study is that addressing issues related to race and ethnicity may be critical to the quality of care for many ethnic minority mental health clients. The exclusion of race and ethnicity elements was consistently related to lower client evaluations regarding accessibility, quality of care, and satisfaction for ethnic minority clients. Mental health practitioners working with minority clients may want to assess client perspectives and preferences regarding race and ethnicity issues in treatment. Failing to do so could result in lower client satisfaction.

Results of this study align with Constantine’s (2002) finding that perceptions of therapists’ multicultural competence was significantly associated with treatment satisfaction. Chang and Berk (2009) encouraged therapists working with clients high on race salience to actively demonstrate their comfort and willingness to broach topics involving race, ethnicity, and culture (REC). On the other hand, the same approach may alienate clients who view REC

issues as irrelevant to their presenting problem. Therapists may consider addressing the significance of REC differences with all clients, but they should be responsive to clients' feedback rather than assume that such differences necessarily be an issue in treatment (Cardemil & Battle, 2003). Although ethnic/racial match and discussions surrounding race and ethnicity may be salient for some ethnic minority clients, others (e.g., those with internalized racism) may not prefer this type of treatment (Trivedi, 2002). Racial/ethnic dynamics in treatment are complex, and, thus, it is important to note that the presence of ethnic/racial match or discussions of race and ethnicity are not the panacea to problems of race in therapy (Neville, Spanierman, & Doan, 2006).

At the same time, the findings strongly suggest that training programs in the allied mental health professions need to develop more empirically validated clinical strategies for addressing issues related to race and ethnic minority status when treating ethnic minority clients. Moreover, there should be a particular emphasis on how to manage and cope with life experiences involving prejudice and discrimination.

It is clear that certain elements may be more relevant for minorities, and these differences need to be considered in providing culturally competent mental health care (Sue & Sue, 1999; Zane et al., 2004). This study provides empirical evidence that addressing cultural, racial, and ethnic issues in treatment that align with the worldviews and life experiences of ethnic minority clients does enhance the quality of care for this clientele (Benish, Quintana, & Wampold, 2011).

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References

American Psychological Association. Guidelines on multicultural education, training, research, practice and organizational change for psychologists. American Psychologist. 2003; 58:377–402. [PubMed: 12971086]

American Psychological Association, Committee on Accreditation. Guidelines and principles for accreditation of programs in professional psychology. Washington, DC: Author; 2002.

Anderson EM, Lambert MJ. A survival analysis of clinically significant change in outpatient psychotherapy. Journal of Clinical Psychology. 2001; 57:875–888. [PubMed: 11406801]

Arneill-Py A. Measurement invariance of the Mental Health Statistics Improvement Program Consumer Survey. Dissertation Abstracts International: Section B: The Sciences and Engineering. 2004; 65(6-B):3215.

Atkinson, DR.; Thompson, CE. Racial, ethnic, and cultural variables in counseling. In: Woolfe, R.; Dryden, W.; Strawbridge, S., editors. Handbook of counseling psychology. 2. New York, NY: Wiley; 1992. p. 349-382.

Benish SG, Quintana S, Wampold BE. Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. Journal of Counseling Psychology. 2011; 58:279–289. [PubMed: 21604860]

Bernal B, Saez-Santiago E. Culturally centered psychosocial interventions. Journal of Community Psychology. 2006; 34:121–132.

Betancourt H, Lopez SR. The study of culture, ethnicity, and race in American psychology. American Psychologist. 1993; 48:629–637.

Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. Public Health Reports. 2003; 118:293–302. [PubMed: 12815076]

Beutler, L.; Machado, P.; Neufeldt, S. Therapist variables. In: Bergin, A.; Garfield, S., editors. Handbook of psychotherapy and behavior change. 4. New York, NY: Wiley; 1994. p. 229-269.

Bhugra, D.; Bhui, K. Racism in psychiatry. In: Bhui, K., editor. Racism and mental health. London, UK: Jessica Kingsley Publishers; 2002. p. 11-128.

Bhui, K. Race and racial discourse. In: Bhui, K., editor. Racism and mental health. London, UK: Jessica Kingsley Publishers; 2002. p. 15-25.

Blank MB, Tetrick FL III, Brinkley DF, Smith HO, Doheny V. Racial matching and service utilization among seriously mentally ill consumers in the rural south. Community Mental Health Journal. 1994; 30:271–281. [PubMed: 8045093]

Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Medical Care Research and Review. 2000; 57:181–217. [PubMed: 11092163]

Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. Journal of Counseling Psychology. 2011; 58:537–554. [PubMed: 21875181]

Cardemil EV, Battle CL. Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. Professional Psychology: Research & Practice. 2003; 34:278–286.

Center for Mental Health Services. The Final Report of the Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-Oriented Mental Health Report Card. Washington, DC: Center for Mental Health Services; 1996. The MHSIP Consumer-Oriented Mental Health Report Card.

Chang DF, Berk A. Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. Journal of Counseling Psychology. 2009; 56:521–536. [PubMed: 20414342]

Chao PJ, Steffen JJ, Heiby EM. The effects of working alliance and client-clinician ethnic match on recovery status. Community Mental Health Journal. 2012; 48:91–97. [PubMed: 21681459]

Clancy C, Collins FS. Patient-Centered Outcomes Research Institute: The intersection of science and health care. Science Translational Medicine. 2010; 2:1–3.

Cohen, J.; Cohen, P. Applied multiple regression/correlation analysis for the behavioral sciences. New York, NY: John Wiley & Sons; 1975.

Cokley K. Critical issues in the measurement of ethnic and racial identity: A referendum on the state of the field. Journal of Counseling Psychology Special Issue: Racial and ethnic identity theory, measurement, and research in counseling psychology: Present status and future directions. 2007; 54:224–234.

Comas-Dıaz L, Jacobsen FM. Ethnocultural transference and countertransference in the therapeutic dyad. American Journal of Orthopsychiatry. 1991; 61:392–402. [PubMed: 1951646]

Constantine MG. Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. Journal of Counseling Psychology. 2002; 49:255–263.

DiPalo MT. Rating satisfaction research: Is it poor, fair, good, very good, or excellent? Arthritis Care and Research. 1997; 10:422–430. [PubMed: 9481234]

Flaskerud JH, Hu L. Participation in and outcome of treatment for major depression among low income Asian Americans. Psychiatry Research. 1994; 53:289–300. [PubMed: 7870849]

Flaskerud JH, Liu PY. Effects of an Asian client-therapist language, ethnicity and gender match on utilization and outcome of therapy. Community Mental Health Journal. 1991; 27:31–42. [PubMed: 2019097]

Flicker SM, Waldron HB, Turner CW, Brody JL, Hops H. Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. Journal of Family Psychology. 2008; 22:439–447. [PubMed: 18540772]

Fuertes JN, Mueller LN, Chauhan RV, Walker JA, Ladany N. An investigation of European American therapists' approach to counseling African American clients. The Counseling Psychologist Special Issue: Counseling psychologists and schools. 2002; 30:763–788.

Gamst G, Aguilar-Kitibutr A, Herdina A, Hibbs S, Krishtal E, Lee R, Martenson L. Effects of racial match on Asian American mental health consumer satisfaction. Mental Health Services Research. 2003; 5:197–208. [PubMed: 14672499]

Gamst G, Dana RH, Der-Karabetian A, Kramer T. Asian American mental health clients: Effects of ethnic match and age on global assessment and visitation. Journal of Mental Health Counseling. 2001; 23:57–71.

Gurin P, Nagda BA, Lopez GE. The benefits of diversity in education for democratic citizenship. Journal of Social Issues. 2004; 60:17–34.

Harley DA, Jolivette K, McCormick K, Tice K. Race, class, and gender: A constellation of positionalities with implications. Journal of Multicultural Counseling and Development Special Issue: Race, ethnicity, gender, and social class in counseling. 2002; 30:216–238.

Helms JE. Some better practices for measuring racial and ethnic identity constructs. Journal of Counseling Psychology. 2007; 54:235–246.

Helms, JE.; Cook, DA. Using race and culture in counseling and psychotherapy: Theory and process. New York, NY: Allyn & Bacon; 1999.

Helms JE, Jernigan M, Mascher J. The meaning of race in psychology and how to change it: A methodological perspective. American Psychologist. 2005; 60:27–36. [PubMed: 15641919]

Helms JE, Talleyrand RM. Race is not ethnicity. American Psychologist. 1997; 52:1246–1247.

Horvath, AO.; Bedi, RP. The alliance. In: Norcross, JC., editor. Psychotherapy relationships that work: Therapist contributions and responsiveness to clients. New York, NY: Oxford University Press; 2002. p. 37-69.

Howard KI, Kopta SM, Krause MS, Orlinsky DE. The dose-effect relationship in psychotherapy. American Psychologist. 1986; 41:159–164. [PubMed: 3516036]

Howard PB, El-Mallakh P, Rayens MK, Clark JJ. Consumer perspectives on quality of inpatient mental health services. Archives of Psychiatric Nursing. 2003; 17:205–217. [PubMed: 14608550]

Hughes M, Thomas ME. The continuing significance of race revisited: A study of race, class, and quality of life in America, 1972 to 1996. American Sociological Review. 1998; 63:785–795.

Institute of Medicine. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academy Press; 2002.

Ito KL, Maramba GG. Therapeutic beliefs of Asian American therapists: Views from an ethnic specific clinic. Transcultural Psychiatry. 2002; 39:33–73.

Jones, J. Constructing race and deconstructing racism. In: Bernal, G.; Trimble, JE.; Burlew, AK.; Leong, F., editors. Handbook of racial and ethnic minority psychology. Thousand Oaks, CA: Sage; 2003. p. 276-306.

Karlsson R. Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. Cultural Diversity and Ethnic Minority Psychology. 2005; 11:113–129. [PubMed: 15884983]

Kessler RC, Mickelson KD, Williams DR. The prevalence, distribution, and mental health correlates of perceived discrimination in the United States. Journal of Health and Social Behavior. 1999; 40:208–230. [PubMed: 10513145]

Kreulen GJ, Stommel M, Gutek BA, Burns LR, Braden CJ. Utility of retrospective pretest ratings of patient satisfaction with health status. Research in Nursing & Health. 2002; 25:233–241. [PubMed: 12015785]

LaVeist TA, Nuru-Jeter A. Is doctor-patient race concordance associated with greater satisfaction with care? Journal of Health and Social Behavior. 2002; 43:296–306. [PubMed: 12467254]

Lebow JL. Client satisfaction with mental health treatment. Evaluation Review. 1983; 7:728–752.

Leff, HL.; Camacho-Gonsalves, T.; Shin, SM.; Cortés, D.; Altschul, D.; Levy, R.; Elmore, S. Cultural Acceptability of Treatment Survey (CATS). Cambridge, MA: Human Services Research Institute, the Evaluation Center at HSRI; 2003.

Leong FT, Lau A. Barriers to providing effective mental health services to Asian Americans. Mental Health Services Research. 2001; 3:201–214. [PubMed: 11859966]

Maramba GG, Hall GCN. Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. Cultural Diversity and Ethnic Minority Psychology. 2002; 8:290–297. [PubMed: 12143105]

Maxie AC, Arnold DH, Stephenson M. Do therapists address ethnic and racial differences in cross-cultural psychotherapy? Psychotherapy: Theory, Research, Practice, Training. 2006; 43:85–98.

Meyer O, Zane N, Cho YI. Understanding the psychological processes of the racial match effect in Asian Americans. Journal of Counseling Psychology. 2011; 58:335–345. [PubMed: 21574698]

Napoles AM, Gregorich SE, Santoyo-Olsson J, O'Brien H, Stewart AL. Patient characteristics that impact health and use. Health Services Research. 2009; 44:1326–1344. [PubMed: 19490162]

Neville H, Spanierman L, Doan B. Exploring the association between color-blind racial ideology and multicultural counseling competencies. Cultural Diversity and Ethnic Minority Psychology. 2006; 12:275–290. [PubMed: 16719577]

O'Sullivan MJ, Lasso B. Community mental health services for Hispanics: A test of the culture compatibility hypothesis. Hispanic Journal of Behavioral Sciences. 1992; 14:455–468.

Owen J, Leach MM, Wampold B, Rodolfa E. Client and therapist variability in clients' perceptions of their therapists' multicultural competencies. Journal of Counseling Psychology. 2010; 6:1–9.

Pope-Davis DB, Toporek RL, Ortega-Villalobos L, Ligiero DP, Brittan-Powell CS, Liu WM, Liang CTH. Client perspectives of multicultural counseling competence: A qualitative examination. The Counseling Psychologist. 2002; 30:355–393.

Quintana SM, Meara NM. Internalization of therapeutic relationships in short-term psychotherapy. Journal of Counseling Psychology. 1990; 37:123–130.

Ren XS, Skinner K, Lee A, Kazis L. Social support, social isolation, and self-assessed health status: Results from the Veterans Health Study in the United States. Social Science & Medicine. 1999; 48:1721–1734. [PubMed: 10405011]

Ritsher JB, Moos RH, Finney JW. Relationship of treatment orientation and continuing care to remission among substance abuse patients. Psychiatric Services. 2002; 53:595–601. [PubMed: 11986510]

Shin SM, Chow C, Camacho-Gonsalves T, Levy RJ, Allen IE, Leff HS. A meta-analytic review of racial-ethnic matching for African American and Caucasian American clients and clinicians. Journal of Counseling Psychology. 2005; 52:45–56.

Smedley A, Smedley BD. Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. American Psychologist. 2005; 60:16–26. [PubMed: 15641918]

SPSS Inc. SPSS Version 20.0 for Windows User's Guide. SPSS Inc; Chicago, IL: 2011.

Sue DW, Arredondo P, McDavis RJ. Multicultural counseling competencies and standards: A call to the profession. Journal of Multicultural Counseling and Development. 1992; 20:64–88.

Sue, DW.; Sue, D. Counseling the culturally different: Theory and practice. New York, NY: Wiley and Sons; 1999.

Sue S. In search of cultural competence in psychotherapy and counseling. American Psychologist. 1998; 53:440–448. [PubMed: 9572007]

Sue S, Fujino DC, Hu LT, Takeuchi DT, Zane NWS. Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. Journal of Consulting and Clinical Psychology. 1991; 59:533–540. [PubMed: 1918557]

Sue S, Zane N. The role of culture and cultural techniques in psychotherapy: A critique and reformulation. American Psychologist. 1987; 42:37–45. [PubMed: 3565913]

Sue S, Zane N, Hall GCN, Berger LK. The case for cultural competency in psychotherapeutic interventions. Annual Review of Psychology. 2009; 60:525–548.

Tallman, K.; Bohart, AC. The client as a common factor: Clients as self-healers. In: Hubble, MA.; Duncan, BL.; Miller, SD., editors. The heart and soul of change: What works in therapy. Washington, DC: American Psychological Association; 1999. p. 91-131.

Teague GB, Ganju V, Hornik JA, Johnson JR, McKinney J. The MHSIP mental health report card: A consumer oriented approach to monitoring the quality of mental health plans. Evaluation Review. 1997; 21:330–341. [PubMed: 10183285]

Thompson CE, Jenal ST. Interracial and intraracial quasi-counseling interactions when counselors avoid discussing race. Journal of Counseling Psychology. 1994; 41:484–491.

Thompson CE, Worthington R, Atkinson DR. Counselor content orientation, counselor race, and Black women's cultural mistrust and self-disclosures. Journal of Counseling Psychology. 1994; 41:155–161.

Thompson VLS, Bazile A, Akbar M. African Americans' perceptions of psychotherapy and psychotherapists. Professional Psychology: Research and Practice. 2004; 35:19–26.

Trivedi, P. Racism, social exclusion and mental health: A Black user's perspective. In: Bhui, K., editor. Racism and mental health. London, UK: Jessica Kingsley Publishers; 2002. p. 71-82.

U.S. Department of Health and Human Services. Mental Health: Culture, race, and ethnicity–A supplement to mental health: A report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.

Ward EC. Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. Journal of Counseling Psychology. 2005; 52:471–481.

Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: Socio-economic Status, stress and discrimination. Journal of Health Psychology Special Issue: Health and socio-economic position. 1997; 2:335–351.

Wright M, Littleford L. Experiences and beliefs as predictors of ethnic identity and intergroup relations. Journal of Multicultural Counseling and Development. 2002; 30:2–20.

Zane N, Enomoto K, Chun CA. Treatment outcomes of Asian- and White-American clients in outpatient therapy. Journal of Community Psychology. 1994; 22:177–191.

Zane, N.; Hall, GC.; Sue, S.; Young, K.; Nunez, J. Research on psychotherapy with culturally diverse populations. In: Lambert, MJ., editor. Handbook of Psychotherapy and Behavior Change. New York, NY: Wiley & Sons; 2004. p. 767-804.

Zane N, Sue S, Chang J, Huang L, Huang J, Lowe S, Lee E. Beyond ethnic match: Effects of client-therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. Journal of Community Psychology. 2005; 33:569–585.

Table 1

Demographic Characteristics of the Sample and Outcome Ratings by Ethnicity (N = 102)

Categorical variables	White (n = 57) Percentage	Ethnic minority (n = 45) Percentage	P-value
Female	73.7	73.3	.968
Nativity (born in U.S.)	98.2	82.2	.005
Marital status			.727
Single/never married	46.4	45.5	
Separated/divorced/widowed	23.2	29.5	
Separated/divorced/widowed			
Married/cohabitating	30.4	25.0	
Employed	44.2	23.8	.039
Education			.933
< High school degree	21.8	20.0	
High school degree or GED	20.0	24.4	
Some college	50.9	46.7	
≥College degree	7.3	8.9	
Participant type			.064
Public	50.0	50.0	
Private	70.0	30.0	

Continuous variables	Mean (SD)	Mean (SD)	P-value
Age	34.64 (13.07)	40.16 (13.11)	.039
Access	3.87 (.95)	3.99 (.85)	.511
Appropriateness/quality of care	3.80 (.91)	3.99 (.78)	.281
Satisfaction	3.90 (1.05)	4.16 (.98)	.200
Outcomes	3.55 (.90)	3.82 (1.06)	.193

Note. SD = standard deviation.

Table 2

Intercorrelations of Cultural Elements and Dependent Variables

	Mean	SD	1	2	3	4	5	6	7	8	9	10
1. Match IMP	2.43	1.20	–	.21*	.59**	.42**	43**	−.04	−.11	−.11	.05	−.07
2. Match INCLU	.56	.42		–	.08	.31**	.09	.11	.17	.16	.07	.01
3. Discriminations IMP	2.59	1.18			–	.48**	49**	−.06	.02	−.02	.14	.01
4. Discriminations INCLU	2.01	1.29				–	.28**	.13	.22*	.25*	.29**	.37**
5. Discussions of R&E IMP	2.21	1.09					–	.12	.14	.09	.28**	−.03
6. Discussions of R&E INCLU	3.33	.78						–	.27**	.15	.25*	.08
7. Access	3.92	.91							–	.72**	.66**	.50**
8. Appropriateness	3.88	.86								–	.61**	.61**
9. Satisfaction	4.01	1.02									–	.45**
10. Outcomes	3.67	.98										–

Note. SD = standard deviation; IMP = importance; INCLU = inclusion; “Discriminations” = provider knowledge of history of discrimination and prejudices; “Discussions of R&E” =provider discussions of race and ethnicity in treatment.

* $p < .05$.

** $p < .01$.

Table 3

Summary of Hierarchical Regression Analyses Predicting Client Service Experience

	White				*Ethnic minority*			
Outcome Variable	***B (SE)***	**β**	R^2	ΔR^2	***B (SE)***	**β**	R^2	ΔR^2
Access								
Model 1			.09	.09			.05	.05
Age	.03 (.02)	.39			.01 (.01)	.19		
Gender	−.52(.30)	−.24			−.17 (30)	−.09		
Participant type	−.78 (.44)	−.40			.09 (.37)	.04		
Model 2			.11	.02			.28	.23
Age	.03 (.02)	.41			.01 (.01)	.17		
Gender	−.46 (.31)	−.21			−.08 (.27)	−.04		
Participant type	−.74 (.45)	−.38			.50 (.36)	.24		
Ethnic match	.09 (.12)	.11			.31 (.14)	.37*		
Discriminations	.08 (.11)	.10			.14 (.10)	.22		
Quality of Care								
Model 1			.06	.06			.03	.03
Age	.02 (.02)	.31			−.99 (.01)	−.04		
Gender	−.23 (.29)	−.11			−.27 (.27)	−.16		
Participant type	−.27 (.43)	−.15			.05 (.34)	.03		
Model 2			.10	.04			.34	.31
Age	.02 (.02)	.33			−.00 (.01)	−.06		
Gender	−.17 (.30)	−.08			−.19 (.23)	−.11		
Participant type	−.23 (.44)	−.12			.47 (.31)	.24		
Ethnic match	.11 (.12)	.13			.29 (.13)	.38*		
Discriminations	.12 (.11)	.16			.17 (.09)	.31*		
Satisfaction								
Model 1			.14	.14			.11	.11
Age	.02 (.02)	.25			.02 (.01)	.27		
Gender	−.28 (.32)	−.12			.22 (.33)	.10		
Participant type	.22 (.48)	.10			.12 (.42)	.05		

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	White				*Ethnic minority*			
Outcome Variable	***B (SE)***	**β**	***R²***	**Δ*R²***	***B (SE)***	**β**	***R²***	**Δ*R²***
Model 2			.15	.01			.26	.15
Age	.02 (.02)	.25			.02 (.01)	.26		
Gender	−.28 (.32)	−.12			.30 (.31)	.14		
Participant type	.19 (.49)	.25			.51 (.42)	.21		
Ethnic match	−.03 (.13)	−.03			.29 (.17)	.31		
Discriminations	.08 (.12)	.09			.12 (.11)	.17		
Outcomes								
Model 1			.07	.07			.00	.00
Age	.02 (.02)	.34			.00 (.01)	.02		
Gender	.24 (.27)	.12			−.06 (.36)	−.03		
Participant type	−.29 (.40)	−.17			.01 (.45)	.00		
Model 2			.16	.09			.20	.20
Age	.02 (.01)	.37			.00 (.01)	−.01		
Gender	.30 (.27)	.16			−.02 (.33)	−.01		
Participant type	−.25 (.39)	−.15			.28 (.45)	.11		
Ethnic match	.11 (.10)	.15			.08 (.18)	.08		
Discriminations	.20 (.09)	.27*			.30 (.12)	.41*		

Note. SE is the standard error of B.

* $p < .05$.