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BRIEF REPORT

Association Between Patient-Provider Racial and Ethnic
Concordance and Patient-Centered Communication in Outpatient
Mental Health Clinics

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Patient-centered communication (PCC) has been identified in the literature as central to providing quality care to patients. Some evidence suggests that racial/ethnic patient-provider concordance may be associated with increased PCC because of perceived similarity between the patient-provider match. This study examines whether there are differences in emotion focused PCC between racial/ethnic concordant ($n = 55$) and discordant ($n = 36$) dyads in a sample of behavioral health providers ($n = 34$) and their patients ($n = 91$) recruited from community mental health care settings as part of a larger study. PCC was measured using three items from a novel third-party coding system on whether providers “identified feelings,” “accepted feelings,” and “encouraged emotional expression” of the patient. Three separate mixed linear regression analyses were conducted to assess relationships between racially/ethnically concordant or discordant dyads and each of the communication items: (a) $\beta = .20, p = .12$; (b) $\beta = 0.12, p = .39$; and (c) $\beta = -0.05, p = .75$. No significant differences were found between groups in the three items, suggesting that racial/ethnic concordance may not be linked to PCC measures related to emotion. It is possible that racially/ethnically discordant providers may compensate for cultural barriers to communication through additional emotion-focused communication strategies, or that other aspects of patient-provider similarity are more salient to PCC. Continuing to identify the characteristics and circumstances that lead to improved PCC may be a way to bridge the gaps in the quality of behavioral health care received by underserved communities, particularly communities of color.

Keywords: patient-centered communication, race, ethnicity, psychotherapy, concordance

Editor's Note. This was an invited article, stemming from a poster presentation at the Diversifying Clinical Psychology event held in conjunction with the Midwinter Meeting of the Council of University Directors of Clinical Psychology. The invitation was issued with the intent to feature the work of an emerging scholar in our field. However, reviewers were unaware of that invitation and the entire blind review process was engaged, per usual, prior to acceptance of the paper for publication in this journal.—JLC

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Research has documented extensive evidence of mental health inequities across racial and ethnic groups in the United States (Centers for Disease Control and Prevention, 2014; National Alliance on Mental Illness, 2017). For example, multiple studies show that African American and Latinos receive less quality care for mental disorders than their White counterparts (Alegría et al., 2008; Dinwiddie, Gaskin, Chan, Norrington, & McCleary, 2013; Hirschfeld et al., 1997). While there are several reasons for the inadequate quality of mental health care received by people of color, some attribute it to the scarcity of clinicians, especially clinicians of color, available to adequately treat mental health issues. Others add that a lack of effective communication impedes the quality of care provided to patients of color (Alegría et al., 2008; Dinwiddie et al., 2013; Hirschfeld et al., 1997). Communication plays a central role in intercultural and interracial therapeutic relationships (Qureshi & Collazos, 2011). For example, Qureshi and Collazos (2011) describe how cultural differences in communication style regarding aspects of health and healing lead to difficulties for providers in connecting with patients in patients feeling comfortable disclosing their feelings.

Patient-Centered Communication (PCC)

The Agency for Health care Research and Quality (2011) suggested that to improve access to quality health care, people should be able to find a provider with whom they can communicate clearly, trust, and receive quality care. The Institute of Medicine (2001) indicated that a way to improve communication and trust is through the use of PCC. PCC has been operationally defined by Epstein et al. (2005) and includes understanding the patient's perspective which includes their feelings, concerns, and needs, among other characteristics. Other aspects which are not focused on in the present study include: understanding the patient within their own psychosocial context, working together to understand the patient's problems and what treatment would work best according to the patient's values, and sharing power and responsibility with the patient (Epstein et al., 2005).

Multiple studies have been conducted to examine the relationship between PCC, patient trust,

and health outcomes (Beck, Daughtridge, & Sloane, 2002; Hall, Roter, & Rand, 1981; Stewart, 1995; Street, Makoul, Arora, & Epstein, 2009; Swenson et al., 2004). The consensus in the literature seems to be that better-quality PCC results in greater trust, augmented patient empowerment, increased patient knowledge, and adherence to treatment—all of which are intermediary outcomes that lead to better health and general well-being (Street, O'Malley, Cooper, & Haidet, 2008). Other studies have found more direct relationships between PCC and health outcomes (Beck et al., 2002; Stewart, 1995). Stewart (1995) reviewed 21 studies and found that 16 studies reported positive health outcomes related to greater PCC (i.e., less headaches, lower pain levels, and improved hemoglobin status), while Jiang (2017) more recently found that there was a positive relationship between patient emotional well-being and PCC. Given the benefits of PCC on patient satisfaction and health outcomes, one way to improve health care quality may be to maximize PCC among mental health care providers.

Racial/Ethnic Concordance (REC) and Therapy Outcomes

According to Street et al. (2008), patients who perceive ethnic/racial similarity also perceive personal similarity in beliefs and values with their providers. Theoretically, health inequities can be improved via REC because it provides a foundation for mutual respect, trust, communication, and satisfaction, therefore strengthening the therapeutic alliance which is necessary for treatment to be beneficial (Cabral & Smith, 2011; Meghani et al., 2009). As such, REC could facilitate easier understanding of emotions and feelings than an intercultural therapeutic relationship as seen by improved communication of the patient-provider dyad.

The literature surrounding REC, while abundant, remains inconclusive. Various studies have found positive relationships between REC and psychotherapy outcomes such as increased attendance, improved level of functioning, and higher alliance ratings (Ricker, Nystul, & Waldo, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Thompson & Alexander, 2006; Wintersteen, Mensinger, & Diamond, 2005).

One meta-analytic study from Maramba and Nagayama Hall (2002) found that across various research studies, patients who were seeing a provider of the same ethnicity were less likely to drop out of care and were likely to attend more psychotherapy sessions.

In contrast, other studies find that racial/ethnic discordant dyads were equally as beneficial, and the discordance based on race/ethnicity does not lead to worse outcomes in psychotherapy (Erdur, Rude, & Baron, 2003; Jones, 1982; Ruglass et al., 2014). Additionally, two meta-analytic studies also concluded that REC between patient and providers does not lead to significant differences in treatment outcomes (Cabral & Smith, 2011; Shin et al., 2005). However, Shin et al. (2005) only addressed studies focused on White and Black samples and did not include Latinos. Cabral and Smith (2011) included multiple studies which addressed REC in various racial and ethnic groups (i.e., Latinos, Asian Americans, and Native Americans) and further examined patient preference and patient perceptions. When exploring these two topics, they found that there is a moderately strong preference for mental health providers of a similar racial and ethnic background ($k = 52$ studies, $d = 0.63$) and that there is a tendency for patients to perceive therapists of their own ethnicity more favorably ($k = 81$ studies, $d = 0.32$). However, none of these studies evaluated whether the communication and receptivity to emotions and feelings shared by concordant versus discordant dyads explained the positive outcomes linked to REC. Our study is one of the first to evaluate the role of REC on PCC tied to behavioral health providers' acceptance, understanding, and encouragement of their patient's emotions and feelings.

Racial-Ethnic Concordance and PCC

Although there is no conclusive answer as to the benefits of seeing a provider who is of the same racial/ethnic background, patients still seem to prefer and hold in higher regard providers of a similar background (Cabral & Smith, 2011). Some studies have provided evidence for the effectiveness of cross-cultural patient-provider dyads (Chang & Berk, 2009; Chang & Yoon, 2011). Differences in race and ethnicity between patients and providers have been considered important cultural barriers to providing

quality PCC because of possible differences in language and preferred methods of care (Cooper-Patrick et al., 1999). In particular, previous research indicates that the processing and interpretation of emotion varies by culture (Dewaele, 2014; Elfenbein & Ambady, 2003; Mesquita & Walker, 2003). For example, Qureshi and Collazos (2011) state that: "the therapist attends not only to the content of what the patient says, but also, to the manner in which he or she makes the communication" (p. 12). Therefore, there may be differences that exist in the way that providers work to address issues surrounding emotions when working with patients from similar or different backgrounds. Given this, it can be hypothesized that patients and providers of the same race or ethnicity will have less cultural barriers in communication, particularly regarding emotion. Therefore, it is important to understand whether REC is associated with PCC, as a potential pathway to improve outcomes in mental health settings.

Current research that explores the effect of REC on different aspects of PCC is inconclusive. The majority of this literature is focused on the medical field and particularly primary care, not behavioral health. Some studies have found that that REC is associated with higher levels of participatory decision making, mutual understanding, increased time with patient answering questions, and increased disclosure of important psychosocial topics (Cooper-Patrick et al., 1999; Oliver, Goodwin, Gotler, Gregory, & Stange, 2001; Van Wieringen, Harmsen, & Bruijnzeels, 2002; Wissow et al., 2003). Other studies have focused on the interactions between REC and PCC and mental health therapy outcomes such as patient satisfaction and improved trust. Cooper et al. (2003) suggests that REC is associated with more positive experiences in visits and consequently improved participation in health care treatment (i.e., improved trust). However, these results were not explained by levels of PCC among patient and provider. In contrast to the aforementioned studies, Schoenthaler, Allegrante, Chaplin, and Ogedegbe (2012) found that REC may not be as important as PCC levels for patient satisfaction or health outcomes.

To our knowledge there are two studies which explicitly examine PCC and REC in behavioral health care as variables (Adams et al., 2015; Alegría et al., 2013). However, these

studies yielded disparate results. Adams et al. (2015) found that higher levels of PCC impacted the willingness of Black patients (but not White patients) to accept a recommendation for therapy; however, REC did not result in higher ratings of the interaction with the provider. This study suggests a more important role for PCC than for REC but was focused on interactions with primary care providers rather than behavioral health specialists. In contrast, Alegría et al. (2013) more specifically explored the relationship between PCC and REC in behavioral health intake sessions and found that ethnically concordant Latino dyads had higher levels of PCC than White concordant or ethnically mixed dyads measured using the Roter interaction analysis system (Roter & Larson, 2002) and the Working Alliance Inventory Observer Bond scale (Horvath & Greenberg, 1989).

We aim to contribute to the literature focused on PCC and REC by further exploring a specific aspect of PCC—the provider’s identification, acceptance and encouragement of the patient’s feelings—and whether it is associated with the racial/ethnic makeup of the patient-provider dyad. We focus on this aspect of PCC because of the hypothesized link between REC, suggesting cultural similarity, and the reduction in cultural barriers to communication regarding emotions. This study compares clinical session ratings for racially/ethnically concordant versus racially/ethnically discordant patient-provider dyads and evaluates whether there were differences between the two groups in (a) providers identifying patient feelings, (b) providers accepting their patient’s feelings, and (c) providers encouraging their patient’s emotional expression. We hypothesize that there will be higher scores in PCC behaviors among the racially/ethnically concordant group versus the discordant group.

Method

Data Source

This study represents a secondary analysis of data collected from patients and providers participating in “Effectiveness of DECIDE in Patient-Provider Communication, Therapeutic Alliance, and Care Coordination” a Patient-Centered Outcomes Research Institute (PCORI) funded project (Grant CD-12–11-4187). The data set included previously independently

coded provider-patient interactions by a coder, blind to study group. The project was conducted in the Disparities Research Unit at Massachusetts General Hospital. Detailed information about the project including methods and outcomes can be found in another paper (Alegría et al., 2018).

Participants

Patients and behavioral health providers were recruited to test the effectiveness of the DECIDE intervention at community and hospital-based outpatient behavioral/mental health clinics in Massachusetts. Behavioral health providers needed to be practicing in the field and their caseload had to be a minimum of 4–6 patients to participate in the study. Patients were then recruited from the existing group of patients with whom the provider was already working. Patients were eligible to participate if they were between the ages of 18 and 80; spoke English, Spanish, or Mandarin; and were working with a provider recruited for the study. They were excluded from the study if they screened positive for mania, psychosis, or presented with current suicidal ideation. Patients over the age of 65 were given a cognitive function screen to test for cognitive impairment; if impairment was found they were excluded from study participation.

Measures

Racial/ethnic background. Racial and ethnic background information was collected via a screener provided to all interested patients and a baseline survey for providers. The information provided by both patient and provider was aggregated into four racial and ethnic categories: non-Latino White, Latino, non-Latino Black, and Asian. These four categories were chosen prior to receiving the data for analysis because of their general nature, which encompassed most of the racial and ethnicity options provided to participants. Using this information, the racial and ethnic background of both patient and provider were compared to establish whether a patient and provider dyad were racially/ethnically concordant or discordant.

Provider communication in behavioral health. Our main outcome variables consisted of three separate questions measuring specific aspects of PCC. These three questions were

taken from a larger, 20-item coding system, Provider Communication in Behavioral Health (PCBH), developed for the original PCORI-funded study (Johnson, Hall, & Alegría, 2019). The coding system was developed by Margarita Alegría, Judith Hall, and Kirsten Johnson to measure quality in the behavioral health care system and patient-centeredness behaviors exhibited by providers. Through a factor analysis, the team found three factors, which were labeled: (a) Establishes Interactive Partnership which consists of six items, (b) Creates Atmosphere of Acceptance which consists of 11 items, and (c) Encourages Expressive Communication (EEC) which consists of three items.

The coding system was scored using the 5–5–5 method which consists of coders separately coding three 5-min excerpts of a full tape of the patient provider session (Johnson et al., 2019). The first excerpt consists of the first 5min at the immediate start of the tape, the second excerpt consists of five minutes occurring during the middle of the session, and the final and third excerpt consists of the last 5 min of the tape. This 5–5–5 method was used for efficiency and prior evidence indicates that using slices of the tape can capture the behavioral pattern of health care visits effectively (Ambady & Rosenthal, 1992; Hagiwara, Dovidio, Eggle, & Penner, 2016). Using the 5–5–5 method, independent observers used the PCBH to rate interactions between patients and providers through the use of a recording collected early in the study during a clinical visit (patients and providers had been working together for varying periods—at least 3 months—of time before the beginning of the study). Coders were all trained to code interviews and had practice and supervision before beginning to code by using audio recordings from an earlier audio study (Alegría et al., 2008). More specific details on the development of the PCBH, including the factor analysis and scoring method, can be obtained from the authors.

To assess intercoder reliability, we calculated the intraclass correlation coefficient (ICC) using seven audio recordings that were independently scored by all five coders. ICC estimates and their 95% confidence intervals (95% CI) were calculated in STATA 15 (StataCorp, 2017) based on a mean-rating (5 coders), absolute-agreement, 2-way mixed effects model. We estimated the ICC for the overall EEC factor, as

well as for each of the three individual items included in this factor. Intercoder reliability for the ECC factor and for the items “accepts feelings” and “encourages emotional expression” were at or above .60 (ICC = 0.64, 95% CI [0.27–0.92]; ICC = 0.67, 95% CI [0.36–0.92]; and ICC = 0.60, 95% CI [0.28–0.89], respectively), while intercoder reliability for the item “identifies feelings” was lower (ICC = 0.40, 95% CI [0.09–0.81]). Cicchetti (1994) references several earlier guidelines stating that the level of clinical significance of an ICC between .60 and .74 is good and between .40 and .59 is fair. Koo & Li (2016) recommend a different rule of thumb in which values above .9 indicate excellent reliability, between 0.75 and 0.9 indicate good reliability, between 0.5 and 0.75 indicate moderate reliability, while values less than 0.5 indicate poor reliability. Koo & Li (2016) further state that these guidelines should be applied to ICCs calculated with at least 30 samples and three raters, and they recommend interpreting the range of possible values within the 95% CI.

For this study, we focused on one of the factors, the EEC. This factor includes the following three items: identifies feelings, accepts feelings, and encourages emotional expression.

The EEC factor was chosen because it captures a specific aspect of the operational definition of PCC proposed by Epstein et al. (2005) which suggests that PCC includes understanding a patient’s feelings and needs. We focused on this factor because, as mentioned, emotional expression and processing vary across cultures (Dewaele, 2014; Elfenbein & Ambady, 2003; Mesquita & Walker, 2003), and are important mechanisms of the therapeutic relationship in psychotherapy (Ehrenreich, Fairholme, Buzella, Ellard, & Barlow, 2007; Greenberg & Safran, 1989; Rottenberg & Gross, 2007). Given this, we aimed to explore how REC can influence levels of PCC related to emotions. Even though the factor addresses communication quality overall, each item was analyzed as a separate dependent variable to further examine how each behavior was rated individually between concordant and discordant groups. By examining these behaviors individually, we can further understand the factors that may be associated with PCC in both groups.

Within the same factor, scoring for one of the behaviors could be different from the other two.

The items accepts feelings and identifies feelings were rated on a 0–5 scale, where 0 meant the behavior did not occur and 5 meant the behavior was present, and the provider exhibited the behavior in a positive and encouraging manner. The item encourages emotional expression was also scored using a scale from 0 to 5; however, 0 meant no evidence of the behavior was present while 1 meant that the provider was not effective at encouraging emotional expression and may have even actively discouraged emotional expression. The study team concluded that no evidence of the behavior was better than a poor performance in the behavior, and recoded the data such that 0 became 2, resulting in a scale ranging from 1–5.

Data Analysis

We began by presenting descriptive data on the demographics of our sample, using the mean or frequency for age, gender, race/ethnicity, patient education level, provider specialty, and concordant versus discordant pairs. Our descriptive analysis also included statistics of the outcome measures (mean and standard deviation) by provider specialty and by concordant/discordant pairs. We then estimated the effect of REC on three primary outcomes: (a) providers identifying patient feelings, (b) providers accepting their patients' feelings, and (c) providers encouraging their patients' emotional expression. To account for the fact that each provider treats more than one patient (i.e., patients are nested within providers), we estimated multilevel linear mixed-effects models. Three separate models were estimated, each one using one of the three primary outcomes as the dependent variable and an indicator for discordant race/ethnicity as the independent variable. The hierarchical nature of these models accounted for nonindependence of multiple patients seeing the same clinician. Because multiple comparisons can increase the likelihood of Type I errors, we set alpha to .01 to take a more conservative approach.

To assess the robustness of our results, we graphically examined (see Figures A1 to A3 in Appendix) the association between the slope of our primary outcomes (PCC scores) and the provider-level variable REC to visualize the estimated effects from our multilevel models. This graphical analysis allowed us to determine

whether our results were influenced by a particular provider (e.g., there was one provider who really cared about encouraging emotional expression and most of her patients were not of the same race/ethnicity), as well as whether there was enough within-provider variation in PCC scores across concordant/discordant pairs to identify a potential significant effect. All analyses were conducted using STATA 15 (Stata-Corp, 2017).

Results

Demographics

A total of 79 behavioral health providers gave written consent to participate but five withdrew after randomization and before receiving an intervention. Eight other providers were excluded as they did not consent to the clinical session recording required for this study. We only used providers who were in the control group (i.e., did not receive the provider intervention) since measures used in this analysis were assessed at a follow-up visit rather than at baseline and the focus of the present study is not on evaluating the intervention. Therefore, the final provider sample consisted of 34 providers. While 312 patients were enrolled for the primary study, this study used data from 91 patients who either were not included in the randomized controlled trial and consented to have their clinical session recorded or were in the control group for the randomized controlled trial.

Most patients in this sample identified as Latino (41.76%) while most behavioral health providers identified as non-Latino White (58.52%). Both patients and behavioral health providers were predominantly male. Additional information gathered on the demographic characteristics of the patient and provider samples can be found in Table 1.

Fifty-five (60.44%) patient and behavioral health provider matches were labeled concordant—patients were of same race or ethnicity—based on reported racial/ethnic backgrounds. The majority of concordant patient and provider dyads reported being non-Latino White (54.55%) and Latino (32.73%). We also explored the mean score for each item by both provider specialty and by concordant and discordant group. This information can be found in Table 2 and Table 3, respectively.

Table 1
Demographic Characteristics of Patients (N = 91) and Behavioral Health Providers (N = 34)

Demographic characteristic	Patients, <i>n</i> (%)	Providers, <i>n</i> (%)
Age		
18–34	24 (26.37)	17 (50.00)
35–49	26 (28.57)	8 (23.53)
50–64	35 (38.46)	6 (17.65)
65+	6 (6.59)	2 (5.88)
Missing	0	1
Gender		
Female	33 (36.26)	10 (29.41)
Male	58 (63.74)	24 (70.59)
Missing	0	0
Race		
Non-Latino White	35 (38.46)	20 (58.52)
Latino	38 (41.76)	7 (20.59)
Non-Latino Black	9 (9.89)	2 (5.88)
Asian	9 (9.89)	5 (14.71)
Missing	0	0
Patient education		
<Sixth grade	7 (7.69)	
Seventh–11th grade	18 (19.78)	
12th grade	13 (19.29)	
≥12th grade	52 (57.14)	
Missing	1	
Behavioral health provider specialty		
Psychiatrist		12 (35.29)
Psychologist		6 (17.65)
Social worker		8 (23.53)
Other		8 (23.53)
Missing		0
Patient and provider racial/ethnic concordance		<i>n</i> (%)
Concordant		55 (60.44)
Non-Latino White		30 (54.55)
Latino		18 (32.73)
Non-Latino Black		1 (1.82)
Asian		6 (10.91)
Discordant		36 (39.56)

Association of Racial/Ethnic Discordance and PCC

Table 4 presents the results of our multilevel model. The effect of racial/ethnic discordance was not statistically significant for any of the outcomes, suggesting that racial/ethnic concordant dyads do not have higher or lower PCC scores than racial/ethnic discordant dyads. A potential concern is that the lack of a significant effect might be influenced by insufficient within-provider variation across racial/ethnic discor-

Table 2
Descriptive Statistics of Outcome Measures by Provider Specialty

Item and provider type	<i>M</i> (<i>SE</i>)	<i>N</i> (%)
Item: Identifies feelings		
All providers	4.17 (.08)	91 (100)
Psychiatrist	4.22 (.16)	31 (34.07)
Psychologist	4.32 (.12)	20 (21.98)
Social worker	4.04 (.17)	21 (23.08)
Other	4.07 (.13)	19 (20.88)
Item: Accepts feelings		
All providers	4.04 (.07)	91 (100)
Psychiatrist	3.94 (.15)	31 (34.07)
Psychologist	4.20 (.12)	20 (21.98)
Social worker	4.01 (.11)	21 (23.08)
Other	4.07 (.14)	19 (20.88)
Item: Encourages emotional expression		
All providers	3.74 (.08)	91 (100)
Psychiatrist	3.87 (.14)	31 (34.07)
Psychologist	3.90 (.12)	20 (21.98)
Social worker	3.52 (.18)	21 (23.08)
Other	3.57 (.14)	19 (20.88)

Note. *N* = 91.

dent dyads in the item scores. To address this concern, we compared the average item scores for each provider's patients (within-provider outcome variation) against the percentage of such patients that do not have the same race/ethnicity than the provider (within-provider discordant race/ethnicity variation). The results (see Figures A1 to A3 in Appendix) show that insufficient variation is not the cause of an insignificant effect: the average score within providers varies, but the variation is unrelated to whether patient and provider are of the same race/ethnicity. In Appendix Figure A1, for example, Provider 402 has the same average score for identifies feelings as Providers 206 and 1008, but these providers have different proportions of patients who do not share their race/ethnicity: 20%, 68%, and 100%, respectively.

Table 3
Descriptive Statistics of the Outcomes by Concordant/Discordant Race

Item	Concordant, <i>M</i> (<i>SD</i>)	Discordant, <i>M</i> (<i>SD</i>)
Identifies feelings	4.10 (.11)	4.29 (.10)
Accepts feelings	3.98 (.10)	4.13 (.09)
Encourages emotional expression	3.75 (.10)	3.72 (.11)

Table 4
Multilevel Linear Regression Models for the Association Between Discordant Race/Ethnicity and PCC^a

Item and discordant race/ethnicity	<i>b</i> (<i>SE</i>)	<i>z</i>	<i>P</i> > <i>z</i>	95% CI
Item: Identifies feelings				
Discordant race/ethnicity ^{a,b}	.20 (.13)	1.57	.12	[−.05, .45]
Item: Accepts feelings				
Discordant race/ethnicity ^{a,b}	.12 (.14)	.87	.39	[−.15, .39]
Item: Encourages emotional expression				
Discordant race/ethnicity ^{a,b}	−.05 (.17)	−.32	.75	[−.39, .28]

Note. PCC = patient-centered communication; CI = confidence interval.

^a Model includes 91 patients nested within 34 providers. ^b Discordant race/ethnicity is an indicator variable which equals 1 if the patient and provider do not share the same race/ethnicity.

Discussion

The results did not support our hypothesis that higher levels of PCC related to identifying, accepting, and encouraging the expression of emotions would be observed in racially/ethnically concordant dyads as compared with discordant dyads. In contrast to studies focused on physical health suggesting that REC results in higher levels of various aspects of PCC (Cooper-Patrick et al., 1999; Oliver et al., 2001; Van Wieringen et al., 2002; Wissow et al., 2003), our study found no relationship between REC and PCC. Our findings are also inconsistent with results from Alegria et al. (2013), who observed a relationship between ethnic concordance in Latino dyads and PCC as measured by self-reported working alliance and observer coding of patient-provider communication styles during mental health intake sessions.

There are several possible reasons for our null finding. First, PCC was defined in this study using a specific aspect of the operational definition created by Epstein et al. (2005): identification, understanding, and encouragement of a patient's feelings. As mentioned, we only used one aspect of the operational definition in order to address issues regarding differences by culture in emotion processing and expression (De-waele, 2014; Elfenbein & Ambady, 2003; Mesquita & Walker, 2003). It could be that racial/ethnic discordant providers are aware of the barriers for them to relate to patients of other racial/ethnic background and may compensate for that through additional emotion-focused communication. Other facets of PCC, like tone or body language, could be coded via video-

recorded interactions as they may provide further context for understanding emotions in racially/ethnically concordant versus discordant dyads.

Second, although many existing studies have measured REC and PCC among patients and their primary care providers, this study focused specifically on behavioral health in the context of actual practice in community mental health clinics. Strong therapeutic alliance, as evidenced in these practices and the overall high scores in PCC that we observed may explain the null results of this study (see Table 3; Castro, Van Regenmortel, Vanhaecht, Sermeus, & Van Hecke, 2016; Horvath, Del Re, Flückiger, & Symonds, 2011; Pinto et al., 2012; Rogers, 1951). Table 2 also shows that the majority of providers, regardless of specialty, scored relatively high on each of the items.

Additionally, because most of the patients in our study had been in treatment for more than 3 months, it could be that there was limited variation in PCC at this point in the therapeutic relationship, and only patients with strong therapeutic alliance remain in care. In fact, patients from racial and ethnic minority groups often drop out of therapy at a higher rate than White patients (Fortuna, Alegria, & Gao, 2010). Owen et al. (2017) found that cultural comfort could be a reason for this disparity, and we can theoretically link this to levels of PCC. If providers are not comfortable in working with patients from other cultures, it may lead to higher drop-out of those patients. It is possible that patients who did not experience high levels of PCC with their provider had already dropped out of treat-

ment and were therefore not recruited for the study. Observations of patients in their first session with a provider (similar to the Alegría et al., 2013 study) would be a way to further understand how levels of PCC related to emotional expression can change over time in therapy based on REC or can be linked to length of treatment with a certain provider.

Another possible reason for our null finding is that PCBH was assessed by trained coders measuring patient provider interactions. This coding system provides researchers with a less biased way than subjective ratings to measure PCC components and is consistent with other studies which have used more objective measures of PCC (Weiner et al., 2013). Using this coding system may have provided a more objective and accurate view of the nature of the relationship between patient and provider. At the same time, it is also possible that using a patient's subjective experience of PCC as an outcome would better account for the personal relationship of the patient to the provider. We know from the meta-analysis by Cabral and Smith (2011) that individuals tend to prefer providers of a similar racial/ethnic background and they often rate them more favorably. We also learn from Chang and Berk (2009) that when patients are unsatisfied with their provider, they find demographic differences to be at fault for miscommunication issues. Given this, results could have indicated a different relationship if we used a subjective measure that reflected the subjective experience of the patient. Additionally, the PCBH was a novel coding system that has not been tested by other studies, which limits comparability of our results to those found in other samples.

Furthermore, it is important to note that the ICC confidence intervals for our three outcome measures ranged from poor to good according to standards suggested by Koo and Li (2016), with a lower ICC for one of the three items. This could have been influenced by the low number of recordings used to calculate inter-coder reliability, given that we calculated ICCs based on seven recordings and Koo and Li (2016) recommend 30 samples. It is also possible that individual sessions might have been rated inconsistently, particularly with regard to the item identifies feelings. It would be important to improve levels of intercoder reliability in future studies by adding more recordings and

ensuring enough variability in the samples (Koo & Li, 2016), as well as ensuring that coder training addresses a consistent way to identify when clinicians identify patients' feelings.

Finally, the lack of differences in PCC between the groups may also be due to the inclusion of more racial and ethnic groups compared to other studies focused on PCC. Most similar studies compared only Black and White patient-provider discordant or concordant dyads, while this study also included people who identified as Latino and Asian (Adams et al., 2015; Cooper et al., 2003; Earl et al., 2013; Shin et al., 2005; Traylor, Schmittiel, Uratsu, Mangione, & Subramanian, 2010). Cabral and Smith (2011) did use studies in their meta-analysis that included participants from more diverse backgrounds but the majority of participants in the 53 studies used were Black (29%) and White (28%). Meanwhile, Alegría, et al. (2013) explored Latino dyads versus White dyads versus mixed dyads. By identifying Latino and Asian patients and providers, this study expanded previously used samples from other studies and encompassed two of the fastest growing minority populations in the United States (Pew Research Center, 2011). That said, our racial/ethnic concordant group consisted mostly of patient-provider dyads who identified as non-Latino White and Latino. Previous research suggests that Black patients (of which our concordant group only has one patient-provider dyad) have the most to benefit from a racially concordant provider-patient dyads (Cooper et al., 2003). Without a more diverse sample within the concordant group, or a larger sample that would allow for examination of between-groups differences, we may have missed important relationships between PCC and REC that may be unique to specific racial and ethnic identities or to cultural context. For example, cultural differences in how emotions are expressed might be identified by comparing levels of PCC between patient-provider dyads from distinct racial/ethnic groups (e.g., comparing Latino concordant dyads to Asian concordant dyads), and would not be seen in the present study.

Furthermore, race and ethnicity are complicated concepts which are challenging to capture. As mentioned, the four categories used were chosen for the larger study because of their general nature, which encompassed most of the race and ethnicity options that participants self-

selected. This approach allows for between-groups comparisons but does not capture the more fine-grained complexity of how people identify and how they are perceived by others. The overarching aggregation of race/ethnic categories rather than more granular categories based on country of origin might obscure important cultural and psychological differences between patients and providers assigned to the same broad category.

For example, racial/ethnic identity development varies among individuals within the same racial/ethnic group, such that a patient may not necessarily identify with the culture with which they are externally perceived to affiliate nor with a provider who is of the same race/ethnicity (Carter & Helms, 1992; Helms & Carter, 1991). Being matched with a provider based on one aspect of identity also does not mean you will have the same overall values. Chang and Berk (2009) found that many of the patients who chose a provider from a different racial/ethnic background did so because they thought that a provider from their own racial/ethnic background would either look down on or not understand other aspects of their identity (e.g., gender, sexuality, religion). As a result, matches labeled as racially/ethnically concordant in this study may or may not be experienced as such by individual patients and providers. Given this and the results of past meta-analyses suggesting that REC was not linked to mental health outcomes, research may need to look at other factors (i.e., gender identity and racial/ethnic identity development of both patient and provider), in addition to REC, that can potentially improve PCC and/or mental health outcomes (Cabral & Smith, 2011; Shin et al., 2005).

Although we noted no significant differences in PCC among racially/ethnically concordant and discordant patient-provider groups in this study, the lack of studies focusing on this topic in behavioral health care indicate a research gap that may be addressed with further consideration of how both PCC and REC are defined and measured. Future studies may use dependent variables that encompass all aspects of the PCC operational definition provided by Epstein et al. (2005) to develop a broader understanding of PCC as related to REC, may consider comparing results from observer-coded and self-reported PCC, and should address how PCC

varies over time in treatment. It is also critical for future research to look beyond concordance based on broad racial/ethnic categories to assess what other related constructs (i.e., salience of racial/ethnic identity, matching based on other identities, cultural differences in emotional processing, or differences in social position) may affect levels of PCC (Adams et al., 2015; Cooper et al., 2003). Incorporating greater nuance into the assessment of sociocultural similarities and differences between patients and providers will further efforts to understand the aspects of the patient-provider relationship that lead to improved PCC and greater quality in behavioral health care for communities of color.

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(Appendices follow)

Appendix

Figures: Percentage of Patients of Different Race by Item

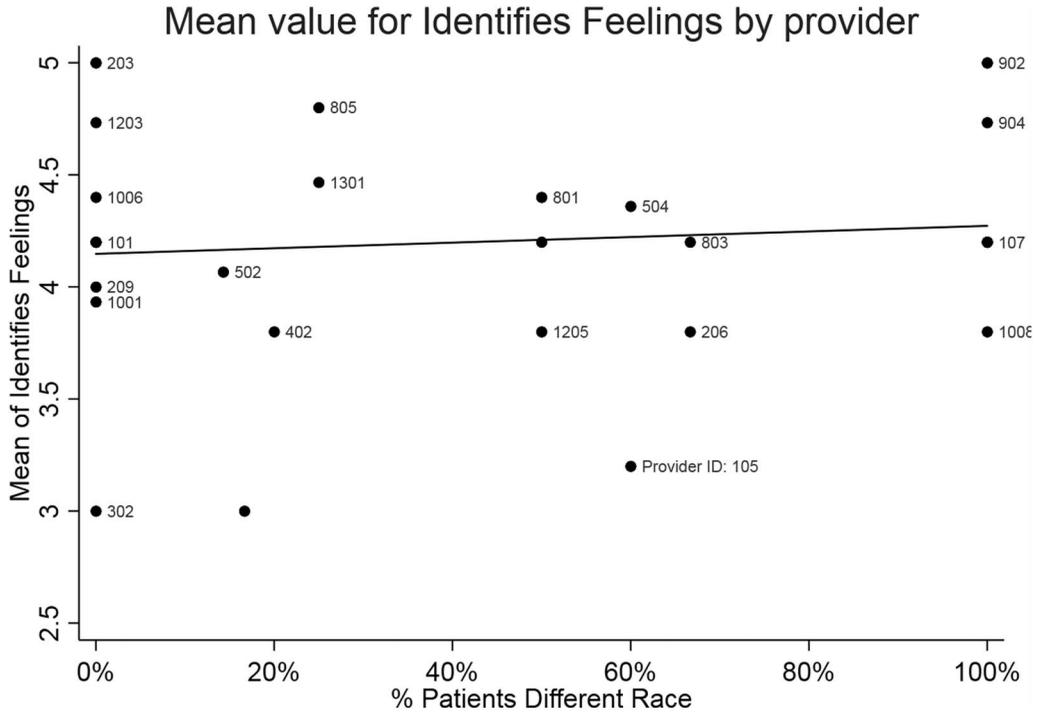


Figure A1. The data points are providers plotted by the percentage of patients they had that were of a different race and their mean score on the item "Identifies Feelings."

(Appendices continue)

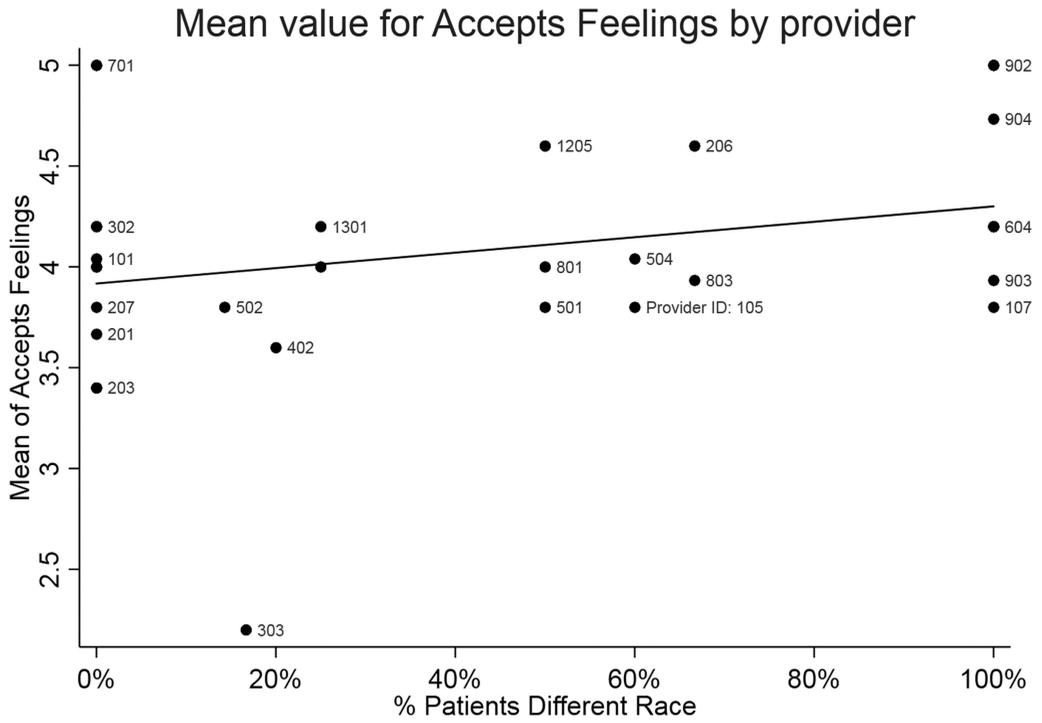


Figure A2. The data points are providers plotted by the percentage of patients they had that were of a different race and their mean score on the item “Accepts Feelings.”

(Appendices continue)

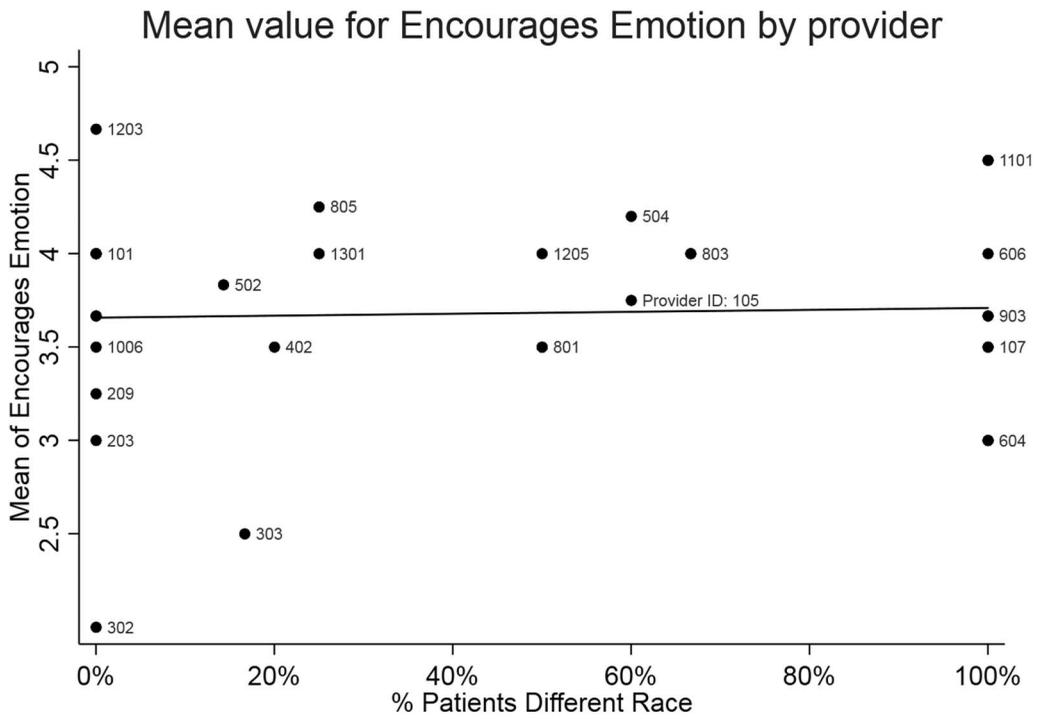


Figure A3. The data points are providers plotted by the percentage of patients they had that were of a different race and their mean score on the item “Encourages Emotion.”

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