

## RACIAL/ETHNIC DISPARITIES IN PSYCHOTHERAPY: DOES THE OUTCOME MATTER?

JOANNA M. DRINANE  
JESSE OWEN  
UNIVERSITY OF DENVER

S. MARK KOPTA  
UNIVERSITY OF EVANSVILLE

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This study examined disparities in client psychotherapy outcomes within counselor' caseloads that occur on the basis of clients' racial/ethnic minority status. The sample was comprised of the caseloads of 324 therapists who treated a total of 23,168 clients across a number of clinical sites (mostly university counseling centers). Each of the therapists treated at least five White and five Racial or Ethnic Minority clients (REM). Client data were collected at the beginning of each therapy session utilizing the Behavioral Health Measure-20 (BHM-20; Kopta & Lowry, 2002). This measure is comprised of three subscales and each represents a distinct therapy outcome (well-being, symptoms, and life functioning). Disparities were assessed for each outcome domain. Results suggested that therapists did not differ in their abilities to facilitate change in well-being and life functioning across White and REM clients. However, there were significant disparities within therapists' caseloads between White and REM clients on the symptoms outcome. Some therapists produced reductions in symptoms of equal magnitude with their White and REM clients, while others had greater variability and exhibited greater amounts of symptom change with either White clients or REM clients.

Key words: Racial/ethnic disparities; Counselor effects; Multicultural orientation; Phase model; Mental health.

*Correspondence concerning this article should be addressed to Joanna M. Drinane, Department of Counseling Psychology, Morgridge College of Education, University of Denver, 1999 E. Evans Avenue, Denver, CO 80210, USA. Email: joanna.drinane@gmail.com*

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Cultural identities and the meaning drawn from them is a relevant part of the development of all relationships. Particularly salient in the therapy context, culture has long been conceptualized as being an influential force on the therapy environment and on the dynamics that play out between clients and therapists. The American Psychological Association (APA) outlined in the most recent code of ethics that psychologists must cultivate awareness around the impact of cultural identities and be respectful of clients related to their race, ethnicity, sexual orientation, socioeconomic status, and gender, among other things (APA, 2010). Even earlier still, in 2003, the APA presented a formal mandate that psychologists adhere to a model of multicultural competence, which highlights the importance of providing equitable care for all clients. The American Counseling Association, another one of the largest professional health organizations in the United States, also highlights the ethical importance of providing culturally sensitive care. Although training programs, governing bodies, agencies, and even individual therapists often endorse a willingness to adhere to such a model, mental health disparities are an ongoing issue amongst minority groups.

Central to the definition of mental health disparities is if certain populations differ with regard to the accessibility, quality, and outcomes of mental health care (Safran et al., 2009). Specifically, within the United States, cultural factors and historical antecedents of racism are inextricably linked to ongoing inequalities in mental health. Over time, there have been significant and documented accounts of unethical treatment of ethnic minorities in research and in practice as well (United States Department of Health and Human Services, 2001). While such overt injustice is less frequent now, there continue to be ongoing differences in the way ethnic minorities in the United States view the mental health system and how they engage with it as consumers.

In particular, research has examined racial and ethnic disparities that occur across various domains associated with mental health in the United States. More specifically, racial/ethnic disparities have been observed in regard to the prevalence of mental health problems and the rates with which services are utilized (e.g., Harris, Edlund, & Larson, 2005; Hayes, Chun-Kennedy, Edens, & Locke, 2011; Office of the Surgeon General (US), Center for Mental Health Services (US), National Institute of Mental Health (US), 2001; Whaley & Davis, 2007). For example, even when adjusting for mental health status, African Americans are provided less care by the mental health system than are Caucasian Americans (Cook, McGuire, & Miranda, 2007). Such broad and systemic disparities may be a function of minority stress experienced by racial/ethnic minority identified persons who encounter ongoing oppression, prejudice, and discrimination (Meyer, 2003; Whaley & Davis, 2007). The accumulation of such negative experiences as a result of stigma, via overt racism or more subtle microaggressions, can only exacerbate the presence of mental health symptomology and the need for access to services from a system that does not often provide them equitably.

Importantly, the outcome of psychotherapy has been evaluated as another potential area where racial/ethnic disparities might arise. As systemic injustice is vast and the contextual stressors for racial minority individuals impact daily living, such disparities would be important to locate and to work to mitigate. However, current research dedicated to understanding disparities in psychotherapy outcomes has demonstrated that, on average, therapy produces positive results for White clients and for racial/ethnic minority clients alike and that there are no significant differences between these two groups (e.g., Bohart & Wade, 2013; Imel et al., 2011; Owen, Drinane, Tao, Adelson, & Fookune, 2016). That is, when researchers compare White clients to REM clients (without considering who is providing the treatment), there are typically no differences in therapy outcomes based on clients' race/ethnicity. The investigation could have ended here with the assumption that, within the United States, and despite disparities occurring at broader levels, therapy works regardless of majority or minority racial identification.

#### THERAPIST EFFECTS AND WITHIN THERAPIST RACIAL/ETHNIC DISPARITIES

However, researchers initiated a process of inquiry to examine if therapists might have a role in producing differential outcomes amongst clients with varying racial/ethnic backgrounds. Indeed, therapists account for approximately 5% to 10% of the variance on treatment outcomes, variables including general distress, symptom distress, life-functioning, and client-dropout (e.g., Baldwin & Imel, 2013; Crits-Christoph et al., 1991; Kim, Wampold, & Bolt, 2006; Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011; Okiishi, Lambert, Nielsen, & Ogles, 2003; Ow-

en et al., 2011; Wampold & Brown, 2005). This represents a between therapist effect whereby therapists' caseloads are examined in comparison to one another. Accordingly, some therapists are more effective than others at facilitating positive change in their clients, and these differences have been found to be consistent over time (Wampold & Brown, 2005).

There is ample support in the literature to indicate that some therapists are more skilled than others. The next line of inquiry involved shifting from a comparison between therapists to better understanding what could be occurring within therapists' caseloads, and more specifically, if racial/ethnic disparities could exist that are not apparent via examination at the aggregate level. One of the first studies to address this issue was conducted by Imel et al. (2011). They utilized a sample of 13 therapists who treated 359 White and 223 REM adolescents who were engaging in care for cannabis abuse. Overall, they did not observe any significant differences in outcome related racial/ethnic identification. However, their results indicated that therapists varied significantly in their effectiveness. This variability was predicted by racial/ethnic status. Some therapists were better with White clients where as others were better with REM clients. In other words, when not considering who is providing the treatment, meaningful racial/ethnic disparities were obscured. A general disparity would have arisen if there were differences at the aggregate level (combing the data of all therapists and noting a difference in outcome based upon race/ethnicity). This was not the case. However, this study and those that have followed tapped into the richness of the data, and revealed racial/ethnic disparities that were occurring within therapists that had not been observed before.

A visual representation of the importance of this finding is depicted in Figure 1. The example we provide uses fabricated data viewing unilateral termination from treatment as the outcome. If the associated data were aggregated, there would be no observable differences in the treatment outcome between White clients and REM clients. However, this figure highlights that certain therapists achieve better results than others over all and also, that certain therapists are more effective with one group than they are with the other. In this example, Therapist 1 has high rates of unilateral termination among both White and REM clients (the "bad with everybody" therapist). Therapist 2 has low rates for both groups ("good with everybody" therapist). Therapist 3 has high rates of unilateral termination among REM clients and low rates among White clients ("better with White clients" therapist). For Therapist 4, the opposite was true ("better with REM clients" therapist). However, despite each of these profiles being different and two of the therapists producing differential outcomes according to group, the total column representing group means does not reflect a difference between group.

In fact, when more studies utilized this approach, therapists were found to significantly contribute to differences in treatment outcomes between White and REM clients (Hayes, McAleavey, Castonguay, & Locke, 2016; Hayes, Owen, & Bieschke, 2015; Imel et al., 2011; Larrison, Schoppelrey, Hack-Ritzo, & Korr, 2011; Owen et al., 2015; Owen, Imel, Adelson, & Rodolfa, 2012). For example, in 2011, Larrison and colleagues utilized a sample of 551 clients being treated by 62 counselors. The study found that approximately 20% of counselors had better outcomes with their White clients as compared to their Black clients and that clinicians moderated the relationship between race/ethnicity and therapy outcome. Further, in a sample of 31 counselors who treated 332 clients from a university counseling center, Owen and colleagues (2012), found that therapists varied in their dropout rates among White and REM clients. Which group had more dropout varied by counselor and some counselors had equal dropout rates regardless of race/ethnicity. In addition,

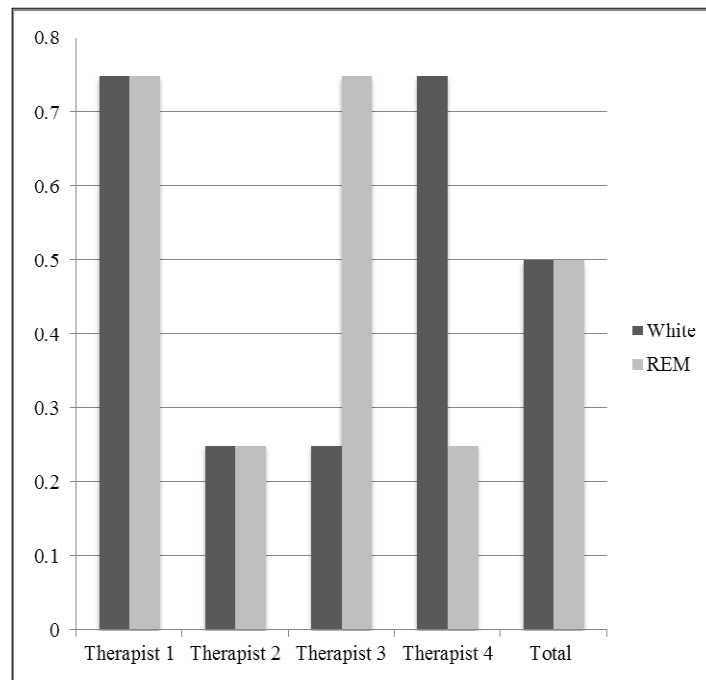


FIGURE 1  
Percentage of client unilateral termination (i.e., client dropout).

Hayes et al. (2015) utilized a different outcome and examined disparities in psychological distress. In a sample of 36 counselors and 228 clients at a university counseling center, they found that therapists produced differential results on the basis of race. Hayes et al. (2016) recently conducted a large, multi-site replication study. Their analyses included 3,825 clients who were treated by 251 therapists at 45 different counseling centers. This study also replicated the previous findings that racial/ethnic disparities were due to differences within counselors' caseloads. Similarly, in a study of group intervention, group membership was found to be a significant source of racial/ethnic disparities in the relationship quality (Kivlighan, Owen, & Antle, 2016).

Despite their large sample size and access to information about the treating therapists, Hayes and colleagues (2016) did not identify any therapist level variables that predicted these racial/ethnic disparities in general distress. Disparities were not influenced by therapist ethnicity, gender, age, type of professional position, highest degree completed, discipline of the degree, or number of years since licensure. However, one therapist level variable has been identified as predicting disparities in client unilateral termination from therapy. Owen and colleagues (2015) tested whether therapists' multicultural orientation might predict disparities. Multicultural orientation is considered a way of being with clients and their cultural identities that is humble, comfortable, and willing to connect on cultural topics (Owen, 2013). Cultural comfort, one of the three components formally defined in this framework, has to do with the ease with which therapists engage during cultural conversations. Cultural comfort is the only therapist level variable to date that has predicted racial/ethnic disparities, specifically in unilateral termination (Owen et al., 2015). Although it is a good first step to understand some potential predictors of racial/ethnic disparities,

there are many questions that remain open. In particular, one question that remains unanswered is whether these within therapist disparities are consistent across outcome variables within the same sample. Are there certain outcomes associated with particular phases of treatment where therapists are more or less variable in their ability to work with clients of different cultures? The present study sought to examine if the level of disparities might differ on the three variables associated with the phase model of psychotherapy.

### THE PHASE MODEL

This model, defined by Howard, Lueger, Maling, and Martinovich in 1993, asserts that therapy is characterized by progressive and sequential improvement. Formally, the three corresponding phases are named remoralization, remediation, and rehabilitation. Accordingly, specific change processes lead first to an improved sense of subjective well-being associated with feeling remoralized and hopeful that change is possible. Indeed, one of the first tasks for a therapist is to engage clients in a collaborative process whereby clients feel empowered and can gain clarity about what is going on in their life. As clients continue, the phase model delineates that they move progressively past this stage to one where they experience a reduction in symptomology or remediation facilitated by therapist interventions. In this phase, therapists engage other theoretically guided interventions (e.g., cognitive challenges, defense work, interpersonal skills, developing coping skills). Commonly, these interventions are aimed at symptom reduction, interpersonal and behavioral change, and/or intrapsychic transitions. After this occurs, clients enter the third phase, rehabilitation where they undergo more gradual and lasting changes related to enhancements in life functioning as a result of changes to longstanding life patterns (Howard et al., 1993). Observable changes in the rehabilitation phase may relate to enhanced ability to engage in role obligations such as parenting or participating in work responsibilities. The phases described are each unique in the change associated with them and they involve different sets of therapy interventions and processes.

The phase model of psychotherapy has been accumulating support in the literature (Howard et al., 1993; Lutz, Lowry, Kopta, Einstein, & Howard, 2001). Callahan, Swift, and Hyman (2006) tested the model in an outpatient training clinic utilizing the Outcome-Questionnaire (OQ-45.2; Lambert & Finch, 1999). Results from this study indicated that among clients who completed effective courses of treatment (i.e., achieving reliable improvement), generally speaking, well-being precedes improvements in symptoms and changes in life-functioning emerge last (Callahan, et al., 2006). More recently, Kopta and colleagues (2014) found related support for the phase model when examining outcome assessment systems in the university counseling center context. This study used the Behavioral Health Measure-20 (BHM-20) and the results indirectly support the phase model in that they highlight how scores of well-being and symptoms improved first and more quickly and life functioning took more time to change in a meaningful way (Kopta et al., 2014). Each of these studies looks broadly at changes that occur on average on each of the scales. They do not provide direct support for within client or within therapist effects.

As it has been observed in the literature that disparities exist across outcome variables (e.g., Hayes et al., 2016; Imel et al., 2011; Owen et al., 2015), the present study sought to test if the magnitude of the within therapist racial/ethnic disparities would vary across these different and sequential psychotherapy outcomes (assessed via the BHM-20 whose three subscales — well-

being, symptoms, and life functioning — correspond directly with the three phases of the model — remolarization, remediation, rehabilitation) (Kopta & Lowry, 2002). It may be that these disparities emerge early on in treatment and are present as early as phase one. On the contrary, they may occur as a function of therapists and clients forming a deeper bond during the working phase of treatment associated with the second phase. Therefore, the present study seeks to advance the literature on racial/ethnic disparities by first replicating the existence of disparities (using the Global Mental Health scale associated with the BHM-20) in a very large sample of clients and therapists and then by examining if the magnitude of differential outcomes between White and REM clients varies by specific domains associated with varying phases of treatment (based on the three corresponding subscales). We propose the following hypotheses:

Hypothesis 1: there will be no effect of racial/ethnic status at the client level for any of the four variables (global mental health, 1a; well-being, 1b; symptoms, 1c; and life functioning, 1d).

Hypothesis 2: disparities between White and REM clients will emerge within therapist caseloads on all four variables (global mental health, 2a; well-being, 2b; symptoms, 2c; and life functioning, 2d).

## METHOD

### Participants

The final sample included 23,168 clients from a sample that was originally comprised of 73,079 clients. Clients that attended fewer than three sessions or those that did not report their race/ethnicity were excluded from the analysis. In addition, the clients whose therapists did not treat at least five White and five REM clients were excluded from the analysis. As data were collected as part of an ongoing research participant pool, in order to conclude that treatment had ended, clients were only included in the analysis if it had been at least 90 days since their previous session. Although there is no further information regarding reasons for termination, this length of time was deemed sufficient to consider a client as having completed their therapy. The sample was comprised of 65% female identified clients, 34.6% male identified clients, and 0.4% of clients who did not indicate their gender. The majority of the sample endorsed identifying as White (67.7%) and about one-third identified as REM (32.3%). Within the sample of REM clients, the breakdown was as follows: Asian/Pacific Islander (26.5%), African American (18.8%), Latina/Latino/Hispanic (17.1%), Native American/American Indian (0.1%), multiracial/ethnic (35%), and 2.5% who identifies as a racial/ethnic minority but did not prescribe to these generalized demographic groups. The average number of sessions completed was 9.25 ( $SD = 9.26$ ). No diagnostic information was collected from the clients or therapists.

### Therapists

Three hundred twenty-four therapists treated the clients that were included in the final sample (mean number of clients per therapist was 71.51). Therapists varied in their average number of sessions with their clients (range 3 to 43 sessions). Detailed assessments of the therapists

were not conducted in a consistent manner across treatment settings. However, of those reporting, the majority of the therapists were female (68%) and identified as White (84%). Therapists included psychologists, counselors, psychiatrists, and social workers. There was no prescribed treatment approach at the various locations, and the majority of the locations were university-counseling centers in the United States.

### Measure

*Behavioral Health Measure-20* (BHM-20; Kopta & Lowry, 2002). The BHM-20 is a 21-item client-report clinical outcome measure with three subscales (well-being, symptoms, and life functioning). The well-being cluster includes three items that assess overall distress, life satisfaction, and motivation (e.g., “How satisfied have you been with your life?”). The psychological symptoms cluster contains 14 items that assess clinical symptoms such as depression, anxiety, and substance use (e.g., “Feeling sad most of the time”). The life functioning cluster contains four items that assess relationships, life enjoyment, and work/school functioning. All items were rated on a 4-point Likert-type scale ranging 0 to 4, with higher scores indicating better functioning. The psychometric properties of the BHM-20 have been supported in prior studies (e.g., strong correlations,  $r_s > .81$  with a variety of psychological functioning and therapy outcomes measures; see Kopta & Lowry, 2002). We calculated reliable change indices for the three subscales based on the two-week test-retest correlation from the norming sample (non-clinical sample; Kopta & Lowry, 2002), which were  $r = .71$  for well-being,  $r = .83$  for symptoms, and  $r = .80$  for life functioning. We also used the standard deviation at intake from the current sample. The reliable change indices were .80 for well-being, .51 for symptoms, and .68 for life functioning. In the current study, Cronbach’s alphas were .82, .88, and .79 for well-being, symptoms, and life functioning, respectively.

### Procedure

Analyses for this study were conducted using data from clients who were administered the BHM-20 by the computer-based CelestHealth System-Mental Health (CHS-MH; Bryan, Kopta, & Lowes, 2012; Kopta et al., 2014). These clients were treated with psychotherapy at university-counseling centers across the nation. The centers provided the data to CelestHealth Solutions LLC who manages the CHS-MH computer system. Prior to each session, clients completed the BHM-20 via the CHS-MH system that derives electronic input from the client and provides an electronic output that is available to the psychotherapist. Clients were informed that they were being administered the measure in order to help inform future research and provide helpful feedback to the therapist and client. They consented to have their data stored for this purpose and then all data were de-identified.

### Data Analysis

Because clients were nested within therapists (i.e., therapists treated multiple clients), we used multilevel modeling<sup>1</sup> (MLM; Raudenbush & Bryk, 2002) to account for the violated assump-

tion regarding independence of observations. We conducted four MLM models, for the four different outcome variables (i.e., GMH-total score, well-being, symptoms, and life functioning). In these models, the predictor variables were clients' racial/ethnic status ( $REM = 1$ ,  $White = 0$ ), number of sessions (i.e., control variable), and pre-therapy functioning (i.e., control variable). We also allowed clients' racial/ethnic status to vary across therapists. If the random slope for clients' racial/ethnic status were to be significant, it would provide support the therapist-specific racial/ethnic disparity hypothesis.

## RESULTS

To test our hypotheses, we ran the models described above for the whole sample and then again in the distressed sample. The results were the same regardless of if we restricted the sample, so we proceeded with the results from the larger group. Our first hypothesis, was that would be no significant association between client race/ethnicity and therapy outcomes; thus, we examined the fixed effects for the association between client race/ethnicity and therapy outcomes (i.e., GMH, well-being, symptoms, and life functioning) (see Table 1). For GMH, the association between clients' race/ethnicity and GMH-post therapy was statistically significant, but the effect size was very small (Cohen's  $d = 0.06$ ). A similar finding was also found for well-being ( $p < .001$ , Cohen's  $d = 0.09$ ), symptoms ( $p < .01$ , Cohen's  $d = 0.05$ ), and life functioning ( $p < .001$ , Cohen's  $d = 0.09$ ). In all cases, REM clients had worse therapy outcomes as compared to White clients, albeit slightly worse. As such, we did not find support for our first hypothesis because there were in fact significant differences between groups on the aggregate level. These significant effects may be a function of the extremely large sample size.

TABLE 1  
 Summary of multilevel models

	GMH Coefficient (SE)	WB Coefficient (SE)	SYM Coefficient (SE)	LF Coefficient (SE)
<i>Fixed effects</i>				
Intercept ( $b_0$ )	2.87 (.01)***	2.25 (.01)***	3.14 (.01)***	2.48 (.01)***
Client RE ( $b_1$ )	-0.04 (.01)***	-0.07 (.01)***	-0.03 (.01)**	-0.07 (.01)***
Pre-Tx functioning ( $b_2$ )	0.51 (.01)***	0.43 (.01)***	0.48 (.01)***	0.52 (.01)***
#Sessions ( $b_3$ )	0.002 (.01)***	0.002 (.01)*	0.003 (.01)***	-0.01 (.01)*
<i>Random effects</i>				
Intercept ( $U_0$ )	0.01***	0.01***	0.01***	0.01***
Client RE ( $U_1$ )	0.01*	0.003	0.01**	0.002
Pre-Tx functioning ( $U_2$ )	0.004**	0.01***	0.005***	0.001
#Sessions ( $U_3$ )	0.0002**	0.0002***	0.0002***	0.00001
Level-1 ( $r$ )	0.37	0.64	0.34	0.55

Note. GMH = global mental health; WB = well-being; SYM = symptoms; LF = life functioning; Client RE = client race/ethnicity (coded  $REM = 1$ ,  $White = 0$ ); REM = racial/ethnic minority clients; Pre-Tx functioning = pre-therapy functioning; #Sessions = number of sessions attended.

\*  $p < .05$ . \*\*  $p < .01$ . \*\*\*  $p < .001$ .



To address our second hypothesis, that some therapists would be more likely to have their REM clients report worse therapy outcomes as compared to their White clients (and vice versa), we examined the random effects. In other words, is the association between client race/ethnicity and therapy outcomes consistent across therapists? There was a significant random slope for client race/ethnicity for two outcomes: global mental health (2a) and symptoms (2c). There was not a significant random slope for client race/ethnicity for the other two outcomes: well-being (2b) and life functioning (2d). Our second hypothesis was partially thus supported. We hypothesized that disparities would exist across outcome domains as they have in other studies. However, the random slope was only significant for the Global Mental Health scale and for the symptoms subscale.

As the phase model is sequential in nature, we also ran an exploratory analysis to test whether the within therapist racial/ethnic disparities might be moderated by maximum number of sessions attended. The only outcome variable for which the random effect of the moderator was significant was well-being (variance component = .004,  $p < .05$ ). For symptoms, life functioning, and global mental, the random effect was not significant ( $ps > .05$ ). In addition, the fixed effects for the moderator were not significant for any of the outcome variables, suggesting that the association between the number of sessions and outcome did not vary for White and REM clients.

## DISCUSSION

The current study utilized a very large client sample to replicate and extend findings regarding within therapist racial/ethnic disparities in psychotherapy outcomes. Our results demonstrated that a) there is a very small sized, but statistically significant, effect of racial/ethnicity on the global mental health scale and on each of the three subscales (i.e., White clients had slightly better outcomes than did racial/ethnic minority clients), and that b) within therapists racial/ethnic disparities are domain specific (i.e., there are within therapist disparities on the Global Mental Health scale and on the symptoms subscale, but not on the well-being or the life functioning subscales). Whereas researchers have analyzed disparities looking at one therapy outcome variable that is intended to capture the changes that occur over the whole process, to our knowledge, this is the first study to examine if these disparities may be more phase specific. Accordingly, we replicated previous findings that therapists are a source of racial/ethnic disparities on overall therapy outcomes (Imel et al., 2011; Hayes et al., 2016; Owen et al., 2015), and also determined that therapists' differential influence is exerted most strongly during the rehabilitation phase of treatment, which is measured via symptoms.

It is interesting that we did find a significant main effect of client racial/ethnic status on therapy outcomes. This was not expected, as most previous research occurring at the client level has not supported this finding. However, there was only a small sized effect and it is likely that it was a function of our extremely large sample size of clients. The degree to which these findings are clinically relevant warrants further consideration. In some ways, these small sized effects could be capturing some general inequities in the way counseling services are offered in the United States. Additionally, we utilized clients' racial/ethnic status as a demographic variable, which oversimplifies the constellation of culturally related experiences associated with racial identity.

The inclusion of the moderator variable was exploratory in nature to determine if the association between number of sessions and outcome varied across therapists. It was only significant for the well-being outcome variable, which is associated with the first phase of treatment. This may connect to the timing of client dropout, which has been found to be an area of disparity in previous studies (Owen et al., 2015). If clients are dropping out differentially based on race/ethnicity, this may impact the effect of max number of sessions on this variable, which is thought to change early on in treatment.

The most relevant contribution to the field that arises from this study is that among the three outcome variables assessed, the within therapist racial/ethnic disparities were only significant for symptoms. First, we will consider the nonsignificant results for the outcomes associated with phase one (well-being) and phase three (life functioning). The fact that there were no significant within therapist disparities observed in well-being may suggest that therapists are skilled at instilling hope in the therapy process. This may be something they excel at with all their clients regardless of race, because when clients are distressed, seeking help can be empowering in itself. In addition, therapists receive extensive training on how to be skilled helpers and how to engage clients from the very beginning. Their ability to initiate care and connect with people as they get to know them may just be consistent and part of their routine regardless of client demographics. Additionally, racial/ethnic disparities were not observed for the phase three outcome: life functioning. Scores on the life functioning subscale have been found to be the slowest and the least likely to demonstrate improvement over the course of therapy (Kopta et al., 2014). As a result, the pre/post comparison may be minimal and therefore, there may be less variability to be explained, especially as it relates to short-term therapy.

However, the therapeutic processes associated with facilitating symptom reduction may be more variable. As therapy progresses and enters into the working phase, clients and therapists move toward behavior change and pathology reduction. This may be a time when therapists' preferences, biases, or multicultural orientation emerge and come to influence their clients more strongly. Therapists who over or under prioritize the role of culture with clients of certain demographics may then contribute to the existence of racial/ethnic disparities within their caseload. Therapists must attune to and assess the needs of each client and determine how much emphasis they place on connecting their cultural identities to the work they wish to do in treatment. In doing so, therapists can avoid culturally based assumptions, which are a potential source of differences in outcome between White and REM clients.

### Strengths and Limitations

The present study offers an important contribution to the field related to racial/ethnic disparities in therapy outcomes; however, the results must be interpreted within the context of the methodological strengths and weaknesses. The study was conducted across multiple sites and there is an extremely large participant pool. This gives us sufficient power to detect any effects that are truly present. There are at least five clients of each group (White and REM) assigned to each therapist, and the average number of clients per therapist was over 71. This allowed for sufficient representation of each therapist and for accurate measurement of the impact of racial minority status on client outcomes within their caseloads. Due to the procedure ensuring that thera-

pists had at least five of each group in their caseload, we were unable to break down the REM category to examine disparities across specific racial/ethnic groups (i.e., Asian American, African American). There were not enough therapists whose caseloads were diverse enough to model the data in this way.

In addition, the data were collected in naturalistic settings where there was limited control over clinical procedures. For example, clients were not randomized to therapists, there was limited information on diagnostic presentation or severity, and treatment was conducted as usual. Also, the majority of the sites were university-counseling centers, which limits our ability to generalize beyond this type of setting. It will be important to replicate these findings across settings (e.g., community mental health and integrated care settings). In addition, no therapist level variables were available, which limited our ability to incorporate second level predictors. As no demographic variables have been linked to disparities, identifying therapist facilitated processes that serve as predictors of these within provider disparities will be essential to future attempts to remedy them. As such, future studies with predictors such as therapists' multicultural orientation, working alliance, or perceptions of expertise, for example, should build upon this one to determine what causes these disparities now that there is more clarity about the domains where they are present.

### Implications

A number of practical implications can be drawn from the results of this study. First and foremost relates to the implementation of clinical practice. Therapists are having different amounts of success with their clients and it is occurring systematically. This is an important concern for those individual therapists, for the agencies in which they operate, and for the larger system. Accordingly, therapists and agencies should track client outcomes and periodically assess whether racial/ethnic disparities exist within the organization and within therapists' caseloads. It may feel daunting to consider the connotation of having such disparities within an organization or a caseload. However, fear to know the truth will ultimately lead to poorer services for minority clients.

The accumulating evidence in the field as well as in this study indicates that racial/ethnic disparities exist, and that they are particularly salient during what is considered the working phase of therapy when people undergo significant change in symptoms. What potential psychotherapy processes are associated with these disparities? For instance, could therapists or organizations be inadvertently microaggressing their REM clients? Microaggressions are subtle and ambiguous forms of racism and/or discrimination (Sue et al., 2007), and they commonly occur in treatment (50% to 80% of REM therapies; Hook et al., 2016; Owen et al., 2012, 2016). Alternatively, could there be other psychotherapy processes, such as attending to cultural opportunities in session, or engaging the client in conversations about their ethnic beliefs and doing so in a way that conveys cultural comfort (Owen et al., 2016; Owen et al., 2015). Some of the disparities could also be a function of how therapists engage with their clients. For instance, Hook and colleagues (2013, 2016) found that clients' ratings of their therapists' cultural humility was a positive predictor of therapy outcomes, and that association was facilitated by clients feeling more engaged and connected to their therapist. Additionally, they found that therapists' cultural humility was associated with committing fewer racial/ethnic microaggressions. Further research is re-

quired to uncover which processes and therapist characteristics matter, so that on a larger, systemic level, steps can be taken to train therapists in how to be effective across clients of varying demographics.

Lastly, this study has significant power to detect the small sized effect of racial/ethnic group identification on overall outcome. Although previous studies have not observed this same effect, no studies have had such a large number of clients and therapists. There may truly be a racial/ethnic treatment outcome disparity and it has taken a sample size this large to recognize it. Further research should attempt to model this again in a more diverse sample, so that attention can be called and a large scale intervention initiated if this is in fact another domain in which racial/ethnic minorities are being treated inequitably.

Ultimately, racial/ethnic mental health disparities do exist and they occur on the broader systemic level, on the level of individual therapists, and during specific phases of treatment. These disparities must be reduced because the tenets of the ethical practice of psychology call for the provision of equitable care regardless of identity. Such change can only occur if informed by further research to uncover why and when these disparities occur, and further understanding of the therapists who do contain disparities within their caseloads and those who are effective and do not have disparities within their caseloads.

#### NOTE

1. To run these models, we used HLM7.

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