"It's Important to Work with People that Look Like Me": Black Patients' Preferences for Patient-Provider Race Concordance

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Abstract

A compelling body of research supports the race concordance hypothesis, which asserts that racially minoritized patients who share the same race and ethnicity with their provider have improved communication, better perceptions of care, and better health outcomes. Using a mixed methods approach, this study examined (1) the association between racial identity and patients' preference for race-concordant patient-provider dyads and (2) Black patients' subjective experiences of race concordance. Data were gathered from 47 Black caregivers who completed both a survey and participated in a focus group. Quantitative analyses revealed that the majority (83%) of caregivers reported that it is important to have a mental health provider of the same race and ethnicity. Greater racial centrality, but not private or public regard, was associated with a stronger race concordance preference. Thematic analysis of qualitative data revealed six themes related to race-concordant preferences: aspects related to the patient care experience, cultural humility, relatability, diversity in cultural experiences, role models for children, and intersecting identities. Patients with a race concordance preference felt more comfortable with their provider, perceived that it was easier to build a rapport with their provider, and emphasized the value of representation for themselves and their children. Patients who were neutral in their race concordance preference emphasized professionalism over race, valued diverse perspectives, and appreciated their providers' cultural awareness and willingness to self-educate. The integration of these findings will help to elucidate a more nuanced understanding of the factors that build the therapeutic relationship and cultivate a framework of comfort and understanding in the clinical setting.

Keywords Racial and ethnic health disparities · Race concordance · Black mental health · Racial identity

Evidence of racial and ethnic disparities in healthcare is consistent across a broad range of illnesses and healthcare services, especially those pertaining to mental health outcomes [1–3]. Due to an extensive history of medical racism, institutional mistrust, and racial and ethnic healthcare disparities, many individuals within marginalized groups are less likely to seek mental health treatment and are more likely to receive poor quality of care when treated [3]. Both of these findings have been consistently associated with impaired accessibility to quality healthcare, lack of insurance, and poor minority representation in the healthcare workforce.

Previous studies have shown that when given the choice, patients often prefer providers who share the same race and/or ethnicity as them [4–6]. This phenomenon is referred to as racial and ethnic concordance. However, the lack of underrepresented minority (URM) providers has made it difficult for URM patients to seek healthcare from URM providers of the same race and/or ethnicity. Research suggests that race concordance between patients and providers is associated with positive outcomes such as higher levels of perceived patient satisfaction of care, quality of healthcare, and more trust in their provider [5, 7]. Given the significance of race concordance to clinical outcomes, the current study will use mixed methods to elucidate the importance of race concordance among Black Americans as well as the cultural factors associated with higher levels of importance.

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Race Concordance and Mental Health Outcomes

Concordance, or congruence, occurs when patients and providers share one or more of several demographic characteristics: gender, social class, age, ethnicity, race, language, sexual orientation, beliefs, and values [8]. A compelling body of research supports the concordance hypothesis, which asserts that racially minoritized patients who match their mental health providers on the basis of their racial and ethnic demographics have better perceptions of care, and better health outcomes [9–13]. Previous research has found that minoritized patients were more likely to report higher perceived quality of care and greater levels of satisfaction of care when racially matched with a mental healthcare provider [10]. This is likely a result of the shared cultural experiences that promote mutual understanding and trust between the patient and provider and cultural competence acquired through the providers' clinical training and lived experiences [11].

A number of studies have also found that patient-provider concordance was positively associated with high ratings of patient experience [12, 13]. For example, a study examining the effect of patient-provider race concordance on several aspects of the therapeutic encounter—including, but not limited to, similarity, likeability, and rapport—revealed that Black patients in race-concordant dyads perceived greater similarity to their provider, more remarkable rapport, and greater satisfaction of care [13]. Taken together, race-concordant patient-provider dyads have been characterized by higher patient ratings of satisfaction, more patient positive affect, and patient-centered communication—where many patients reported enhanced feelings of trustworthiness and mutual respect [12, 13].

While the majority of studies have shown that there are benefits associated with racial concordance, other studies have found mixed results. For example, researchers sought to investigate the impact of race and gender concordance by examining therapeutic alliance and treatment retention [14]. Although racial concordance had no effect on patient satisfaction ratings or the therapeutic alliance, patients with racially discordant providers exhibited greater attrition, particularly among Black patients who were treated by White therapists [14]. The literature surrounding cultural mistrust and healthcare utilization suggests that this is likely due to the lack of trust in White therapists, as a reflection of historical and contemporary experiences [15]. Patients' preferences and beliefs are plausible reasoning behind the findings around the concordance hypothesis [13, 16–18]. Previous studies have shown that providers' self-disclosure (or willingness to share one's lived experiences) [13], interpersonal sensitivity [17], and perceived discrimination [18] are some of the factors that impact racially minoritized patients' perceptions of care when racially matched to their provider. On the topic of concordance, it is also essential to consider the implications of language and cultural concordance on the patient-provider relationship. Similar to race concordance, lingual and cultural matching of patients to their mental health provider has been shown to improve accessibility to mental healthcare resources, circumvent adverse effects on the quality of care, and improve provider communication [19, 20].

Racial Identity

For many Black people, race is a valued social group that informs their perceptions, attitudes, and behaviors. Thus, racial identity, the extent to which one feels belonging to and pride in their racial group, may be an important factor that may relate to an individual's preference for patient-provider racial concordance [24]. Previous research suggests that one's racial-ethnic identity can shape an individual's thoughts, beliefs, and perceptions, and racial identity serves as a protective factor against racism for many Black Americans [21–24]. Sellers and colleagues originally developed the Multidimensional Model of Racial Identity (MMRI) to assess multiple dimensions of racial identity including racial centrality, racial ideology, and racial regard. Racial centrality is the degree to which an individual's racial identity is central to their identity [24]. Racial ideology refers to one's attitudes, beliefs, and opinions about the ways that members of a given community should act. Racial regard is one's evaluative and affective assessment of their racial group which is subdivided into public regard (i.e., the extent to which an individual believes their race is viewed positively by others) and private regard (i.e., the extent to which an individual feels positively about their race; [24]). Research has found a positive relationship between centrality and therapeutic alliance with Black therapists [25]. Thus, in the current study, we examine various dimensions of racial identity as predictors of patients' preference for patient-provider racial concordance.

Current Study

The majority of the extant literature has found that racially minoritized patients with similar racial and ethnic backgrounds as their providers experience positive mental health outcomes and perceptions of care. However, other studies posit that racial and ethnic matching of patient-provider dyads does not guarantee higher levels of patient satisfaction or therapeutic alliance. Rather, research suggests that there may be additional contributing factors, including racial identity, that may liaise the therapeutic encounter. Therefore, further exploration of Black individuals' race concordance

preferences is warranted. To elucidate the psychological, social, and cultural factors that drive therapeutic effectiveness, there needs to be a deeper understanding of patients' subjective experiences within race-discordant and race-concordant therapeutic encounters.

Using a mixed methods approach, this study seeks to examine the subjective experiences, attitudes, and perceptions of Black patients in order to elucidate a more nuanced understanding of the factors that build the therapeutic relationship and cultivate a framework of comfort and understanding in the clinical setting. Specifically, this research aims to (1) examine patients' perspectives on race concordance and their experience with community-based therapists and instructors, (2) assess patients' perceptions of the importance of a racial concordant patient-provider relationship, and (3) examine racial identity and its association with patients' preference for racial concordant patient-provider dyads.

In order to do so, we will be utilizing three research questions to guide the framework of this exploratory study:

1. What percentage of Black patients prefer race concordance with mental health providers?

    We expect a majority of the sample will prefer race concordance.

2. What is the association between racial identity and patients' preference for racial and ethnic concordance?

    We expect those higher in racial centrality and private regard, and low in public regard, to prefer a race-concordant provider.

3. What are Black patients' perceptions of patient-provider racial and ethnic concordance by patient preference?

Methods

Participants and Procedures

This study represents a secondary analysis of a larger mixed methods study examining the impact of the Family Wellbeing Program on early childhood and family mental health amidst the dual pandemics of COVID-19 and racism. Participants for the current study were 47 Black caregivers (age range = 20 to 64; $Mean_{age} = 35.66$, $SD = 7.15$), all of whom were recruited from the Family Wellbeing Program between winter 2019 and summer 2021 (see Table 1 for a summary of sample characteristics). This multi-tiered, community-based mental health program is integrated into two early childhood education center networks located in the mid-Atlantic USA and offers a range of evidence-based and evidence-informed practices including mindful parenting, peer-led parenting classes, individual adult therapy, and parent–child dyadic therapy. Services were offered to caregivers alone or caregiver-child dyads; no services were available for children alone. The Family Wellbeing Program is an interdisciplinary team of mental health professionals including psychiatrists, therapists, mindfulness instructors, and parent advocates.

Patients that participated in the program received calls, text messages, and flyers inviting them to participate in a focus group and survey study as part of the larger study. Patients were compensated $100 for participating in the focus groups, which lasted approximately 2 h, and $50 for completing an online survey, which took participants approximately 45 min to complete, on average. Focus groups were specifically chosen in order to elicit group interaction and invite participants to reflect on their subjective experiences (i.e., phenomenology, attitudes, perceptions, and beliefs) of race concordance and their experiences with the program's therapists and instructors. This study was approved by the Georgetown University IRB. The secondary quantitative analyses and mixed methods analysis of the current study were restricted to Black/African American caregivers (6% of whom also identified as Hispanic/Latinx).

Quantitative Data

For the current study, only select measures and items (described below) from the survey were utilized to evaluate the association between the salience of racial identity and patients' preference for race concordance.

The Multidimensional Inventory of Black Identity

The Multidimensional Inventory of Black Identity (MIBI) is a 56-item inventory that is established in the literature and measures three stable dimensions of a multidimensional model of racial identity in African American adults [24]. For purposes of the present study, we used the following three subscales: centrality (e.g., *Being Black is an important reflection of who I am; 8 items*), private regard (e.g., *I am happy that I am Black; 6 items*), and public regard (e.g., *In general, others respect Black people; 6 items*). Each subscale includes statements that are measured on a 7-point Likert scale, ranging from 1 ("Strongly Disagree") to 7 ("Strongly Agree") with higher scores indicating greater agreement with each construct. In this study, internal consistency as estimated by Cronbach's alphas were adequate for centrality ($\alpha = 0.71$), private regard ($\alpha = 0.84$), and public regard ($\alpha = 0.66$).

Race Concordance Preference

Parents were also asked to assess the degree of importance that they assign to having a provider of the same race and ethnicity by responding to the following question, *"How important is it to*

you to have a therapist or mental health provider with a similar racial and ethnic background as you?" Responses were rated on a 5-point Likert response scale ranging from 1 ("Not at all important") to 5 ("Absolutely essential").

Qualitative Data

Forty-seven participants participated in six virtual focus groups, composed of up to 13 participants per group, in order to understand how participation in the well-being program affected parents' experiences during the COVID-19 pandemic and co-occurring racist events. Focus groups took place via Zoom over the course of a 4-week period in the summer of 2021 and occurred at various times throughout the week, each lasting approximately 90–120 min.
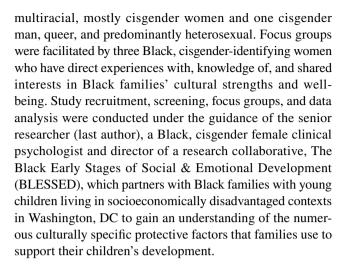
Prior to joining the focus group, participants completed a short "Entry Ticket" (i.e., Qualtrics survey) to review informed consent, record their attendance, and provide demographic information. The focus group facilitator reviewed the purpose and expectations of the focus group at the beginning of each session. Participants were encouraged to have their videos on to increase their engagement during the focus group. Because the questions contained sensitive topics, participants were advised to contact the facilitator via private message if they experienced any emotional distress. A contingency management plan was in place to connect participants with licensed mental health professionals who would provide emotional support and resources.

The following questions, included in the focus group guide, were posed to the virtual focus groups and analyzed for purposes of the present study:

1. *How important is it to you to have a therapist or class instructor with a similar racial and ethnic background as you?*
2. *Probe: Why is it important to you that your provider shares the same racial/ethnic identity as you?*
3. *Probe: In what ways did that shared racial/ethnic identity enhance your experience?*
4. *Probe: Were there any ways in which that shared racial/ethnic identity impaired your experience?*
5. How have the program therapists and instructors shown that they understand and accept your racial/ethnic background?
6. *Probe: In what ways have they demonstrated an understanding and appreciation for your culture?*
7. *Probe: In what ways have they demonstrated not understanding or appreciating your culture?*

Researcher Positionality

The authorship team is comprised of undergraduate, graduate, and professional scholars who identify as Black or

multiracial, mostly cisgender women and one cisgender man, queer, and predominantly heterosexual. Focus groups were facilitated by three Black, cisgender-identifying women who have direct experiences with, knowledge of, and shared interests in Black families' cultural strengths and well-being. Study recruitment, screening, focus groups, and data analysis were conducted under the guidance of the senior researcher (last author), a Black, cisgender female clinical psychologist and director of a research collaborative, The Black Early Stages of Social & Emotional Development (BLESSED), which partners with Black families with young children living in socioeconomically disadvantaged contexts in Washington, DC to gain an understanding of the numerous culturally specific protective factors that families use to support their children's development.

Data Analysis and Integration

Quantitative data analyses were carried out in a series of steps, all of which were conducted using the Statistical Package for Social Sciences (SPSS) software, version 28. First, data were screened for missing values at the variable level. Of the 47 participants, twenty-nine (62%) had complete data points for all variables. The degree of missingness at the variable level ranged from 10.6% (racial centrality, private regard, and public regard subscales) to 40.4% (racial concordance importance). Missing data were assessed and shown to be missing completely at random (MCAR), as evidenced by a non-statistically significant Little's (1988) MCAR test, $\chi^2 = 7.26$, $p = 0.51$ [26]. Therefore, missing values were addressed using the maximum likelihood expectation maximization imputation procedure (ML-EM), which uses an iterative technique for estimating and imputing missing values [27]. This method is appropriate when data are missing completely at random and is considered superior to traditional approaches such as listwise deletion or pairwise deletion, which tend to produce biased estimates and reduce statistical power [27, 28]. All analyses, excluding descriptive information, were conducted following the imputation of missing values.

Additionally, basic descriptive statistics were calculated to describe study variables and participant demographics, as well as to assess for normality and outliers. A Shapiro–Wilk test, along with an inspection of Q-Q plots and histograms, revealed slight departures from normality for the race concordance ($p = 0.004$) and the private regard subscale ($p < 0.001$). Given these deviations, and to examine study hypotheses, we conducted bootstrapped Pearson correlations with 1000 bootstrapped samples and 95% bias-corrected and accelerated confidence intervals (BCa 95%) [29]. Bootstrapping is a non-parametric statistical technique that involves repeatedly drawing random subsamples, with replacement, from the original sample to empirically derive a sampling distribution. This method, especially with bias-corrections,

is robust to normality deviations, provides high statistical power, yields reliable and unbiased parameter estimates, and is especially ideal for studies using small samples [30]. Lastly, given the rate of missing data, a sensitivity analysis was conducted to compare the bootstrapped correlation results estimated with the imputed data to those estimated with the original, unimputed data using case-wise deletion (i.e., data from participants without any missing values; $n = 26$). Results from the unimputed data were comparable and are shown as a footnote. Correlation coefficients with bootstrapped and bias-corrected 95% confidence intervals that do not include 0 and have a $p < 0.05$ are considered statistically significant.

Qualitative data were thematically analyzed using the thematic analysis framework outlined by Braun and Clarke [31]. Two Black female researchers (first author and fifth author) independently reviewed the focus group transcripts numerous times to familiarize themselves with the data, accompanied by reflective notes and creation of initial codes using an open coding process. The creation of initial codes was collated to facilitate the development of themes and subthemes. Both researchers came together to discuss their list of preliminary codes and resolve any discrepancies among related themes and subthemes that best reflected participants' experiences and perceptions. Once the themes/codes were finalized, each researcher independently coded the remaining transcripts. NVivo was used to conduct the qualitative analysis.

Finally, data integration occurred by synthesizing the perspectives shared in the focus groups with the quantitative data from the surveys. Specifically, using the dichotomized race-concordant variable described above, the focus group sample was divided into "race concordant preferred" and "race concordant neutral" groups. Themes and subthemes were analyzed both across and within each group. A visual depiction of the similarities and contrasts in themes across race concordance groups was created to facilitate generating meta-inferences from the data.

Results

Quantitative Results

Table 2 presents the descriptive statistics (means and standard deviations) and correlation coefficients among variables of interest. On average, caregivers felt that having a therapist or mental health provider with a similar racial and ethnic background was slightly to moderately important ($M = 2.79$, $SD = 1.47$). Regarding race concordance preference, irrespective of the degree of importance, 33 caregivers (83%) reported that it was important to have a mental health provider of the same race and ethnicity, which supports our hypothesis that a majority of the sample would endorse a race concordance preference. In terms of racial identity, caregivers reported relatively high levels of racial centrality and private regard, which suggests that being African American was central to their identity and they felt positively about being African American. Caregivers reported relatively lower levels of public regard, which suggests that they did not believe their race is viewed positively by outgroup members.

As shown in Table 2, caregivers' preference for race-concordant patient-provider relationships was positively associated with racial centrality ($r = 0.49$, [0.184, 0.771], $p < 0.01$), whereas private regard ($r = 0.20$, [-0.051, 0.437], $p = 0.18$) and public regard ($r = -0.06$, [-0.389, 0.284], $p = 0.69$) did not show significant relationships.

Mixed Methods: Qualitative Results by Race Concordance Preference

Using thematic analysis, researchers derived the following themes to represent the data from the focus groups: aspects related to the patient care experience, cultural humility, relatability, diversity in cultural experiences, role model for children, and intersecting identities. We describe the themes and subthemes below organized by patients' race concordance preference (see Table 3 for a summary of the mixed methods results).

Aspects Related to the Patient Care Experience

Comfort vs. Fear of Judgment

When discussing their preference for a racially and ethnically concordant mental health provider, both race-concordant preferred and race-concordant neutral participants (i.e., caregivers who deemed race concordance was not as important to them) distinguished between feelings of comfort and the fear of judgment as crucial facets of their experience in therapy. Participants with a race concordance preference reported feeling more comfortable sharing their hardships and experiences with providers of the same race and ethnicity, and, as a result, they found it easier to build rapport with their therapist. As stated by one patient,

> I feel like it is important [to have a provider of the same race and ethnicity]. You feel so comfortable, solid, and safe, and I feel like you'd build a relationship with that person…and a rapport with them.

On the contrary, central to the discussion among the race-concordant neutral participants was parents' appreciation for their therapists' lack of judgment and caring demeanor. These participants similarly valued traits of compassion and benevolence in their healthcare providers yet

saw them as traits unrelated to their therapists' race. One patient described being grateful to simply have a supportive provider despite not having the same racial or ethnic background,

> …I saw that she actually was a caring person…and I didn't think that she was gonna judge me.

Support

Patients who expressed a preference for race concordance and those who were race-concordant neutral highlighted support as a fundamental attribute to their therapeutic experience. Patients stated that due to the similarity in racial background and lived experiences, race-concordant mental health providers showed that they recognize the societal underpinnings of racism when expressing their support for patients through both verbal and nonverbal cues. Furthermore, participants with race-concordant preferences also appreciated their providers' attempt to work collaboratively to address issues mentioned during sessions, rather than focusing solely on the individual's responsibility to address and overcome the hardship. One participant elaborated on the reasoning behind her preference by detailing her positive experience with her provider,

> *What I appreciated was the idea of saying the word, "We", indicating that you and I are the same. You and I are in this together and not just from the perspective of people of color who are also African Americans, but the idea of wellness and mindfulness being something that is greater than just this country or wherever in the world you come from.*

Race-concordant neutral participants underscored the importance of providers' accessibility, open-mindedness, presence, and active listening skills when working with a racially and ethnically discordant patient. One parent described how race-discordant providers could show acceptance and understanding,

> I would say simply by being there and being available, having an open mind, listening to you, and encouraging us [to participate] in the conversation.

Celebration and Validation

Celebration and validation was a prevalent theme highlighted in discussions with both race concordance preference and neutral patients, specifically when both discussed providers' ability to show that they understood and accepted their patients' racial and ethnic background. Specifically, patients felt increasingly motivated to participate and engage in sessions when their provider affirmed their unique identities and validated their experiences when in group contexts.

Furthermore, participants reported feeling seen and heard when providers, regardless of their race, celebrated their accomplishments. A patient who participated in our peer-led parenting group stated,

> They celebrated everybody and everything we all go through…whether somebody's lost somebody or we're going through hardships, we were always celebrated or supported. Nothing was overlooked.

Cultural Humility

Participants who preferred to have providers of the same race and ethnicity expressed the importance of amplifying Black voices and perspectives in a group setting when under the care of a racially and ethnically discordant provider. One participant stated,

> *Sometimes just being quiet is better than trying to say something. I think a lot of times [White mental health providers] feel like they need to say something when they really don't need to say anything. Just let us go through what we're going through and stay out of the way.*

In contrast, when cultural humility was coded for race-concordant neutral participants, it was when providers demonstrated their awareness of, or willingness to educate themselves about systemic issues plaguing their patient's community and respected patient-established boundaries. Race-concordant neutral participants prioritized working with a provider who exhibited professionalism, empathy, compassion, and openness to self-education, regardless of their race or ethnicity. A patient who initially had a strong preference for race concordance provided the following quote,

> *As long as there's professionalism, empathy, compassion, and just the willingness to learn, I'm okay with working with whoever…I was having a moment of "No, I'm doing everything Black," and it didn't necessarily work out for me that way.*

Relatability

There was a wide range of views on the importance of relatability among the race concordance preference group. Specifically, participants emphasized mental health providers' ability to relate to patients based on their appearance, beliefs, and lived experiences. Many participants expressed that it was important that their support system consists of individuals who bear resemblance to them and their community. Participants also described that being able to relate to someone on the basis of appearance serves as a protective factor against harmful messages and stereotypes perpetuated by the media and other influences.

In addition to having a provider of the same race and ethnicity, participants emphasized the importance of having a provider who also holds the same beliefs as the patient. Participants explained that having a race-concordant provider establishes a common ground of understanding through similar lived experiences—which impacts the provider's ability to empathize with their patient. A patient shared the following sentiments:

> It's a difference between somebody being able to empathize with you and sympathize…like somebody who's not my race, all they can do is kind of sympathize with me, whereas somebody who's my skin color and my tone, they can empathize.

Diversity in Cultural Experiences

All respondents discussed a common theme related to providers' cultural experiences. However, the way in which participants discussed this theme was contingent on participants' preferences. For example, participants with a preference for race concordance stated that racially discordant providers tend to be out of touch with their patient's needs, lack understanding of their patient's circumstances, and appear to have a difficult time understanding the systemic issues plaguing their well-being due to their White providers' different cultural experiences. Additionally, patients alluded to concerns regarding white fragility during treatment. A patient stated the following:

> Certain things, culturally, may be hard for other races to understand, so it's nice to have that safe space where we can talk openly and not have to worry about potentially offending someone.

On the other hand, race concordance neutral participants highlighted the importance of having diverse perspectives and equal representation of races and cultures in therapeutic spaces. These parents saw having a racially discordant provider as an opportunity to learn and gain a different perspective on the issues and concerns brought up during sessions. One parent, in particular, spoke about her experience with a race-discordant therapist,

> My therapist is Caucasian, and she gives me a different perspective…and we learn from each other, and she's very much open.

Role Model for Children

Patients' preference for their children's providers' racial background (and gender) also emerged as a common theme among focus group participants regardless of race concordance preference. Parents highlighted the importance of their children having a provider who grew up with an experience similar to that of their child. Many parents viewed their child's provider as a crucial contributor to their child's sense of pride and confidence in their identity and valued their children witnessing someone who looks like them succeeding in a professional setting. One mother shared her considerations when she was in the process of selecting a therapist for her sons,

> For my sons, it was important that [their therapist] be a Black man. They're mentors, and they're all black men…I just wanted them to see themselves in someone that looks like them…and knows the same struggles and can sort of guide them along with me.

Intersecting Identities

Race concordance neutral parents also highlighted other identities that supersede the consideration of race or ethnity. Black female participants mentioned that they often feel more comfortable talking with female providers, of various racial/ethnic backgrounds, than with male providers, as it is easier to relate to them. Furthermore, one parent also highlighted that through their shared identities as parents in addition to being Black women, they were able to build a stronger connection with their provider. One mother highlighted the various shared identities between her and her provider in the following quote,

> My therapist, she's also a parent and has a child that actually goes to [same early learning center] … and we're all Black, so I feel like she understands and she's really, really nice.

Shared identities through religion and spirituality were additional factors brought up by parents in focus groups. One parent, comparing physical health treatment to mental health treatment, stated the following,

> I don't care about your background and how you were raised, as long as you're doing it professionally. But if you're going to give me some type of advice spiritually, make sure you come correct.

Discussion

In alignment with the majority of studies on the concordance hypothesis [4–6, 9, 10, 12–14, 16–18], the majority (83%) of the patients that participated in our study indicated a preference for racial concordance. Similar to previous findings, participants with a race concordance preference indicated enhanced feelings of comfort and safety, relatability, and cultural understanding. Given these factors, patients with a race concordance preference shared that it was much easier to build a close relationship with their mental health provider,

which was perceived to play a crucial role in patients' progress in treatment. These results align with previous studies that found that patients within racially concordant physician–patient dyads report enhanced feelings of trustworthiness and mutual respect, which is often accompanied by higher patient satisfaction ratings and positive affect [5, 7, 12, 13]. Based on focus group discussions, it is plausible that high patient satisfaction ratings and positive patient affect are a result of racially concordant providers' perceived ability to understand patients' needs and the systemic issues that are impacting patients' well-being. This is most likely due to the common ground of understanding established through similarities in racial background and lived experiences.

Many race concordance neutral participants expressed that racially discordant mental health providers were able to compensate for racial differences by exhibiting cultural humility and increasing their awareness of racial inequities. Cultural humility is an iterative process involving self-reflection, self-evaluation, and self-critique in order to dismantle power imbalances within the patient-provider relationship and facilitate mutually beneficial partnerships with patients and their communities [32]. Participants shared their appreciation for providers' willingness to actively listen and educate themselves in order to facilitate growth among both parties in the patient-provider relationship. This contrasts with participants' concerns about white fragility, or the reactions and behaviors of White providers in response to racial discomfort that arises when discussing systemic racism and White privilege [33]. This finding aligns with previous research that found educating providers who are working with diverse populations about the way systemic issues present themselves in mental health spaces can combat adverse experiences in therapy [5].

Racial identity was explored as a plausible contributing factor to mixed findings in the extant literature related to the concordance hypothesis. Racial centrality was found to have a significant association with race concordance preference indicating that patients with stronger salience of belonging to their racial group preferred race-concordant therapists. This finding supports previous research that has found a positive relationship between centrality and therapeutic alliance with Black therapists [25]. Additional studies have examined the relationship between racial identity development and cultural mistrust of race-discordant providers. William Cross outlined five stages of racial identity, which are referred to as pre-encounter, encounter, immersion-emersion, internalization, and internalization-commitment [34]. Similar to the racial identity ideologies examined in this study, each stage has implications for an individual's perceptions, feelings, and behaviors. Individuals in earlier stages of racial identity development do not see race as being central to their identity and oftentimes will idealize White culture and disparage Black culture [34], whereas those in later stages perceive race as a central tenet of their identity and experience feelings of Black pride and communalism [34]. Aligning

with the present study, previous research has found that those residing in earlier stages of racial identity tended to rate the alliance with race-discordant therapists higher than individuals in later stages [21], illustrating the influence of racial centrality. However, private regard and public regard were not associated with patients' race concordance preference indicating that patients' views of their racial group or perceptions of others' views of their racial group may not be significant factors to their race concordance preferences. The degree to which one's racial group is central to their identity (centrality) appears to be a foundational component contributing to patients' race-concordance preferences. Future research could further explore the association between regard and race concordance among a sample high in race centrality.

Our findings provide novel insight into patients' preference for the racial and ethnic background of their child's provider. Regardless of parents' preference for their own mental health provider, findings from the current study revealed that Black parents preferred their children to have a race-concordant therapist or instructor, preferably with gender concordance as well. Many parents highlighted the crucial role of mental health providers as role models for their children. Parents acknowledged providers' ability to not only promote their children's mental health and well-being, but they also recognized that therapists serve as crucial contributors to a child's sense of pride in their own identity. Black parents with Black sons specifically saw the role of Black, male mental health providers extend into that of a father figure in lieu of the presence of Black, male representation in their household. Based on previous investigations, the most important social effects Black fathers and father figures had on their children included influencing children's values, providing knowledge about relationships and manhood, and the importance of being personable and emotionally present [35]. Evidence from the present study reveals a novel concept, suggesting that Black parents perceive that the therapeutic alliance can potentially achieve similarly important social effects among young Black children. Future research examining parental race concordance preferences for their children's mental health treatment is needed to further unpack how best to treat Black children's mental health diagnoses.

Although race is a critical aspect of concordance investigated in this project, participants also discussed other aspects of identity as additional considerations that facilitate the patient-provider relationship. Specifically, when patients did not perceive race or ethnicity as a crucial factor of the therapeutic alliance, concordance on the basis of gender, parental status, religion, and spirituality tended to supersede or complement the racial and ethnic background of the patient's mental health provider. It is also important to consider the intersection of various identities, such as race and gender, and the ways in which they converge to create unique experiences of institutional oppression [36]. Intersectionality, as defined by Kimberlé Crenshaw, is a theoretical framework rooted

in Black feminism and critical race theory [37]. It was introduced to facilitate considerations of multiple identities, such as race and gender, in political discourse, academic dialogues, and new developments within fields of research [38, 39]. Although it was not a specific focus of the project, intersectionality emerged across multiple themes (i.e., child factors, and additional factors other than race and ethnicity). Future studies may wish to examine Black patient preferences using an intersectional lens to further understand provider characteristics that may decrease the racial treatment gap.

Limitations

While this study contributes a number of findings to the literature, there are notable limitations concerning sample size, sample homogeneity, socio-political racial climate, and retrospective reporting of participants' perceptions and experiences. Although our study included data from six focus groups meeting thematic analysis guideline recommendations for focus groups [31], the number of participants who provided their race concordance preference ($N = 39$) provided limited power for our quantitative analyses. A larger sample size may bolster statistical findings between racial identity ideologies and patients' preference for racial and ethnic concordance.

Concerning sample homogeneity, all participants in this study were Black parents associated with an early childhood center-based mental health and wellness program. Therefore, families who did not self-select into this program may have differing perceptions of racial and ethnic concordance. Furthermore, parents in the sample resided in the mid-Atlantic, urban region of the USA, and the majority of participants were low-income and female. Parents of a different geographic location, socioeconomic status, gender, and race/ethnicity may have varying opinions, experiences, and associations.

It is also important to note that these focus groups took place approximately 1 year following the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, and the onset of the COVID-19 pandemic. Therefore, the social justice movements and political climate during this time may contribute to patients' reflections on racial inequities within institutional systems and how these systems continue to oppress their communities. Although anti-Black racism is heightened in the current socio-political context, Black people in the USA have been aware of racial oppression and inequities for hundreds of years, and studies dating back to the 90 s highlight the majority preference for race concordance.

Patients participated in the well-being program at varying times from early 2020 to the summer of 2021, with some patients more recently participating and some having participated much earlier in the program. Although these findings relied on parents' retrospective reports, parental sentiments expressed were applicable at the time of the focus group interviews. However, future studies may wish to gather Black patients' preferences and experiences regarding race concordance/neutrality prospectively.

The present study was limited in its probing regarding race concordance and did not include questions probing concordance in gender, sexual orientation, socioeconomic status, etc. However, these additional characteristics did emerge as themes in our focus groups. Therefore, intersectionality will be a crucial lens through which we view the results of this research, as it may limit the generalizability of these findings to some extent given the multitude of social identities and their impact on one's subjective experiences. Future research on concordance preferences would benefit from increased intentionality in probing a wide array of social identities.

Practical Implications and Conclusion

Given that the majority of Black patients in this sample endorsed having a race-concordant provider as important, it is imperative to address the shortage of Black mental health professionals and mitigate the underutilization of mental health treatment by Black communities. A lack of representation of URM providers in medical professions and medical education has posed significant challenges for URM communities. Investigations from the past few decades have found that primary care physicians from URM, versus USA majority, backgrounds were more likely to serve medically underserved populations, including URM communities, those from disadvantaged socioeconomic backgrounds, and uninsured healthcare recipients [1, 2]. However, available data suggests that there is a disproportionate underrepresentation of URMs in psychiatry (e.g., 16.2% of residents, 8.7% of faculty, and 10.4% of physicians) when compared to their representation in the US population [40]. Not only do these statistics confirm the disproportionate representation of URM in the psychiatric workforce, specifically, but they also serve as an indicator of exacerbated physician shortages and the normality of cross-cultural therapy for minoritized individuals. This begs us to consider the implications of the URM physician shortage on mental health outcomes and racial and ethnic healthcare disparities within marginalized communities.

Given patients' emphasis on cultural humility among mental health professionals, findings from the current study suggest that anti-racism and cultural humility training for providers would benefit both parties of the therapeutic alliance. This education must be dynamic and culturally informed so as to acknowledge diversity within groups and the present social and cultural climate.

Furthermore, when working with minoritized populations, racial centrality should serve as a target in therapy interventions. If providers focus on promoting strong racial centrality, that would require providers to learn and expand their cultural knowledge while bolstering a well-established protective factor for Black adults.

Overall, findings from this research can be used to encourage cultural responsiveness to mental health interventions and improve the quality of care provided to clients from diverse backgrounds. In the realm of medical education, these results can be used to inform proper training for mental health professionals and educational materials to be disseminated to clients and members of their communities.

Appendix 1. Results

Table 1 Sample characteristics

Characteristics	Sample	
	Number	Percentage (%)
Race/ethnicity		
Black or African-American	47	100%
Hispanic/Latinx	3	6%
Gender identity		
Male	3	6.4
Female	44	93.6
Education		
9th, 10th, or 11th grade	4	8.5
High school diploma or GED	9	19.1
Some technical school or college	18	38.3
Associate's degree or technical certificate	8	17.0
Bachelor's of science or bachelors of arts	5	10.6
Master's degree	3	6.4
Relationship status		
Committed relationship	17	36.1
Never married and not in a relationship	15	31.9
Married	10	21.3
Divorced	1	2.1
Widowed	2	4.3
Other	2	4.3
Employment status		
Employed	27	57.5
Unemployed	20	42.5
Total family income		
Under $20,000	21	44.7
Between $20,000 and $50,000	14	29.8
Over $50,000	10	19.1
Unanswered	3	6.4

Table 2 Pearson's bootstrapped[a] correlations with bias-corrected and accelerated 95% confidence intervals (BCa), means, and standard deviations among study variables

Variable	1	2	3	M	SD	Range
1. Race concordance preference	–			2.79	1.47	1–5
2. Racial centrality regard	.49[cd]	–		4.98	0.97	1–7
3. Private regard	.20[b]	.49[cd]	–	6.28	0.95	1–7
4. Public regard	− .06[b]	− .32[be]	− .00[b]	3.31	0.91	1–7

BCa 95% confidence intervals were calculated and included in text but omitted from the table for parsimony; M, mean; SD, standard deviation; M and SD were calculated prior to estimating missing values via expectation maximization; [a] = bootstrap results are based on 1000 bootstrap samples; [b] = BCa 95% confidence interval contained 0; [c] = BCa 95% confidence interval did not contain 0; [d] = $p < 0.01$; [e] = $p < 0.05$

Table 3 Themes and subthemes expressed by parents with race concordance preference and those who deemed race concordance as not as important

Master theme	Subtheme	Sentiments expressed by parents with race concordance preference	Sentiments expressed by parents who deem race concordance is not as important
Aspects related to the patient care experience	Comfort vs. fear of judgment	Comfortable sharing experiences with providers of the same race and ethnicity Easier to build rapport and close relationship with race-concordant therapist	Appreciation for caring demeanor and lack of judgment from race-discordant therapist
	Support	Verbal and nonverbal cues from race-concordant providers show that they recognize societal underpinnings of racism	Underscored importance of race-discordant providers' accessibility, open-mindedness, presence, and active listening skills
	Celebration and validation*	Appreciate providers' ability to understand and accept patients' racial and ethnic background Motivated to participate and engage in therapy sessions when provider affirms patients' identities and validates their experiences	Important for race-discordant providers to demonstrate awareness, or willingness to self-educate themselves, about systemic issues plaguing the Black community
Cultural humility		Challenges associated with amplifying Black voices and perspectives with race-discordant providers	
Relatability**		Importance of having a support system with a common ground of understanding that resembles patient to serve as a protective factor against harmful messages from society	
Diversity in cultural experiences		Race-discordant providers tend to lack understanding of patients' needs and have difficult time understanding systemic issues regarding racism and implicit bias	Important to have equal representation of races and cultures in therapeutic spaces Opportunity to learn and gain an additional perspective
Role model for children*		Therapists have ability to promote child's mental health and well-being Crucial contributors to child's sense of pride and confidence in their identity	
Intersecting identities***			Patient-provider concordance in other identities, such as gender and parental status considered equally important

* indicates themes and sentiments commonly discussed among parents with race concordance preference and those who deem that race concordance is not as important

** indicates theme highlighted among only parents with race concordance preference

*** indicates theme highlighted among only parents who deem that race concordance is not as important

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