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CITATION

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Thomas E. Joiner[1], Morgan Robison[1], Lee Robertson[1], Pamela Keel[1], Allison M. Daurio[1],
Lushna M. Mehra[1], and Eugenia Millender[2]
[1] Department of Psychology, Florida State University
[2] Center of Population Sciences for Health Equity, College of Nursing, Florida State University

Objective: Psychotherapy access, utilization, retention, and effectiveness require continued improvement, especially for groups for whom availability and outcomes may be currently suboptimal, including ethnoracial minorities. Further, ethnoracial status' intersectionality with other identity variables (e.g., gender) may relate to structural barriers to care and effectiveness of care, an area in need of further research. *Method:* The Florida State University Psychology Clinic, a low-cost population-facing treatment center, has routinely collected clinically relevant information on all consenting clients, including severity of clinical presentation at intake and over time, number of therapy sessions attended and of no-shows, premature termination, demographics, etc. A large sample of clients ($N = 2,076$; 57% women; 67.9% non-Hispanic White) on whom we collected and entered at least some data, though missing data were common, has accrued. We conducted chi-square tests to examine treatment utilization gaps, analysis of variance to measure differences in intake severity, and analysis of covariance to measure differences in treatment effectiveness. *Results:* Based on the percentages of ethnoracial minority groups with mental disorders in the broader local community, we are falling short in outreach to Black clients, and when we do engage them, we retain them suboptimally. Once well engaged, however, results across groups suggest few differences in outcomes by ethnoracial status, gender, or their intersection. Ethnoracial match was associated with more sessions attended in Black people. *Conclusions:* Psychotherapy effectiveness has the potential to be optimized for everyone, and a promising direction in this regard is the case conceptualization of a cultural formulation interview and cultural humility mindset.

What is the public health significance of this article?
More than ever, in the wake of the COVID-19 pandemic, communities of color *need both* outreach and effective treatment. This study strongly suggests that once well engaged, psychotherapy effectiveness can be optimized for everyone, particularly in regard to ethnoracial and gender identity. This shows promise around the case conceptualization of a cultural formulation interview and cultural humility mindset. Through better understanding of how clients' various social and cultural identities impact treatment outcomes, these findings can continue to pave the way for more inclusive, culturally informed, and effective treatment for those who need it most.

Keywords: ethnoracial status, gender, psychotherapy, mental health outcomes

Most people with mental disorders do not receive treatment; however, significant disparities in mental health care exist among ethnoracial minorities with mental disorders. These disparities highlight the importance of developing a better understanding of access to and utilization of mental health care, its real-world effectiveness, and whether effectiveness parameters vary by demographic subgroup(s), alongside potential barriers to care. Two recent nationally representative, population-based epidemiological studies suggest either no differences in prevalence of mental disorders across ethnoracial groups or that some disorders may be more

Morgan Robison https://orcid.org/0000-0002-8685-9259
Lee Robertson https://orcid.org/0000-0002-6735-0908
Pamela Keel https://orcid.org/0000-0001-6542-5147
Lushna M. Mehra https://orcid.org/0000-0001-6839-346X
Eugenia Millender https://orcid.org/0000-0003-3042-9046

Correspondence concerning this article should be addressed to Morgan Robison, Department of Psychology, Florida State University, 1107 West Call Street, Tallahassee, FL 32304, United States. Email: mrobison@psy.fsu.edu

prevalent in non-Hispanic White individuals compared to Black or Hispanic individuals (Hasin & Grant, 2015; Hasin et al., 2018; Kessler et al., 2005; Thomas Tobin et al., 2022). Data from both confirm significant differences by gender.[1] The literature has historically reflected a higher prevalence of depression, eating disorders, anxiety disorders, and suicide attempts, and lower prevalence of substance use disorders in women than men (Eaton et al., 2012; Kessler et al., 2005; Seedat et al., 2009). Based on these epidemiological patterns, White women should be more likely to seek mental healthcare services in outpatient clinics compared to other demographic groups and less likely to seek treatment from rehabilitation centers. Nevertheless, the extent to which this is true far exceeds what can be accounted for by differences in prevalence.

Among those with any mental illness or serious mental illness, males are significantly less likely to receive treatment compared to females, and both Hispanic and non-Hispanic Black individuals are significantly less likely than White individuals to receive mental health care (Lê Cook et al., 2014; Walker et al., 2015). In addition to differences in the likelihood of receiving treatment, the 2019 National Healthcare Quality and Disparities Reports found lower quality of health care for Black, Hispanic, American Indian/Alaska Native, Asian, and Native Hawai'ian/Pacific Islander individuals compared to non-Hispanic Whites in several domains (U.S. Department of Health and Human Services, 2019). These patterns—reflective of general trends of individual, generational, and systemic racism as well as specific factors such as the impact of socioeconomic differences in insurance coverage—apply as well to college and graduate students (Lipson et al., 2018). In a sample of 43,375 students from 60 institutions, both females and non-Hispanic White students were significantly more likely to seek mental health treatment than males or students of color, respectively (Lipson et al., 2018). Knowledge and attitudes about treatment explained these differences more than students' financial background. Overall, the demographic composition of those in treatment reflects a combination of structural and attitudinal barriers (Walker et al., 2015).

Barriers to Accessing Mental Health Care

Attitudinal barriers to mental health care include fear of stigmatization, beliefs that treatment will not help, and fear of being forced into unwanted forms of treatment (i.e., inpatient treatment or medication; Walker et al., 2015; Lipson et al., 2018). A recent meta-analysis found that ethnoracial minorities showed greater stigma toward common mental disorders than ethnoracial majorities (Eylem et al., 2020). Greater stigma against mental illness contributed to ethnoracial differences in therapy utilization among undergraduate and graduate students (Lipson et al., 2018). Negative perceptions about mental illness and help-seeking coupled with discriminatory practices contribute to socioeconomic vulnerability which generates structural barriers to mental health care for ethnoracial minorities and, in particular, minority women (Hegewisch & Barsi, 2020).

Structural barriers to mental health care include the inability to afford the cost of treatment, lack of knowledge about where to access care, lack of time, and lack of insurance (Walker et al., 2015). Each of these barriers contributes, in that order, to unmet needs for mental health treatment (Walker et al., 2015). Such structural barriers, often referred to as social determinants of health, have

been implicated as drivers for ethnoracial mental health disparities (U.S. Department of Health and Human Services, 2019). Ethnoracial differences in employment in full-time salaried positions with benefits contribute to ethnoracial differences in income that can be spent on healthcare needs as well as insurance to reduce these out-of-pocket expenses. In one study, individual-level income explained why Black residents of low-income communities reported more mental stress than White residents (Barile et al., 2017), suggesting that those least able to afford treatment are those in greatest need. Although the Affordable Care Act was intended to overcome this barrier (Mechanic & Olfson, 2016), the lack of expansion of federal healthcare benefits on a state-by-state basis has limited the ability of this congressional act to reduce health care disparities (Lanford & Quadagno, 2016). Beyond the financial impact of ethnoracial differences in employment, hourly positions with work schedules that change biweekly are barriers to establishing a regular schedule for treatment (Henly & Lambert 2014; Lambert et al., 2012). This coupled with the lack of adequate childcare represent additional barriers to securing time for psychotherapy that is particularly relevant for women (Brunner et al., 2019; Henly & Lambert, 2014). Finally, lack of knowledge about where to receive care may explain the increased reliance on primary care physicians and emergency rooms for psychiatric needs by Black and Latinx clients (Lê Cook et al., 2014). Importantly, Lê Cook et al. (2014) reported that ethnoracial differences in initiation of treatment accounted for disparities in overall adequacy of care, intensity of care, and inclusion of specialists in care (Lê Cook et al., 2014), highlighting the importance of understanding differences in who seeks treatment before attempting to understand how well treatment works across ethnoracial groups.

Disparities in Retention and Effectiveness

The literature on disparities in treatment effectiveness by gender and ethnoracial status is inconclusive. Some studies on psychotherapy effectiveness as a function of ethnoracial status have found poorer outcomes among ethnoracial minority groups (e.g., Maura & Weisman de Mamani, 2017). Smith and Trimble (2016) reported lower attendance and higher premature termination for ethnoracial minority clients compared to White clients. Anderson et al. (2019) reported that premature termination of psychotherapy was more common among women, regardless of ethnoracial status, and those with therapists perceived as lacking in multicultural competence. Notably, other studies support no significant differences in treatment dropout (Owen et al., 2017) or psychotherapy outcomes (Hayes et al., 2015, 2016; Imel et al., 2011). For example, Holliday et al. (2017) compared treatment response to cognitive processing therapy for posttraumatic stress disorder (PTSD) among Black and White women and found good effectiveness overall, with no significant differences in effectiveness, number of sessions attended, or premature termination between Black and White women.

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[1] For most of the time of data collection, only data on binary sex assigned at birth were collected; the term from the assessment form was "gender" (a term of art when this effort was initiated 20 or so years ago). Gender identity data were not systematically collected for clients, a clear deficiency rectified too recently to yield statistically viable numbers. Throughout the current article, we have used the term "gender" as that was the term from the data collection form.

Limited Research on Intersectionality

Despite evidence of disparities in the presence and treatment of mental disorders based on gender and ethnoracial status, limited research has examined the intersection of these social identities (cf. the concept of "joint disparity"; Jackson et al., 2016). In reviewing conceptual and methodological considerations for Latinx mental health research, Torres et al. (2018) noted that Latina female adolescents made more suicide attempts than Latino male adolescents or non-Latina White girls. Discrimination faced by those with multiple marginalized identities (e.g., someone who is both a woman and Black) is not comprised of mutually exclusive experiences pertaining solely to gender and ethnoracial status respectively; intersectional discrimination is common (Scheim & Bauer, 2019; Takeda et al., 2021). Moreover, it negatively affects the mental health of women within ethnoracial minority populations (Barile et al., 2017; Vines et al., 2017). Moreover, studies have shown that African American women with higher levels of perceived unfair treatment demonstrated an increased likelihood of developing major depressive disorder compared to what would be predicted on the basis of ethnoracial status or gender alone (Assari et al., 2015; Schmitt et al., 2014).

Turning to psychotherapy outcomes, most studies examine the impact of client gender *or* ethnoracial status with little to no attention to intersectionality. This may reflect the methodological challenge of obtaining longitudinal data from sufficient numbers of women and men in diverse ethnoracial groups to permit tests of main effects and interactions. In one study, Kivlighan et al. (2019) found no main effects of clients' ethnoracial status or gender and no significant interaction for predicting changes in distress which decreased significantly across the course of psychotherapy. However, both ethnoracial status and the interaction of gender and ethnoracial status contributed to variability in client outcomes (Kivlighan et al., 2019). Crucially, the repeated calls to employ evidence-based treatment for mental health problems are necessarily undermined by the limited literature on how the intersection of ethnoracial identity with other identities (e.g., gender, sexual orientation) may impact needs, access, and efficacy.

Background for Present Study

For many years, the Florida State University (FSU) Psychology Clinic has routinely collected clinically relevant information on all psychotherapy clients who agree to provide it, including the severity of clinical presentation at intake and over time, number of therapy sessions attended and of no-shows, demographics, and much else. More specifically and relevant to the current effort, as treatment ends (average duration of treatment is approximately 3.5 months), clinicians rate progress (on the Clinical Global Impression—Clinician Version), and data are tracked on parameters like premature termination and psychotherapy outcomes. A large sample has accrued (overall $N > 2,000$), providing a potentially valuable opportunity to evaluate the associations between, on the one hand, ethnoracial status and the intersectionality between it and gender, and, on the other hand, clinical outcomes of interest.

Analyses in the present study included longitudinal evaluation of the relationship between the key demographic features of ethnoracial status and gender and the outcomes specified above. We also examine utilization and retention patterns as a function of ethnoracial status, gender, and their intersectionality. As an additional exploratory analysis, we evaluated ethnoracial and gender match/mismatch between clients and clinicians in relation to clinical outcomes. One meta-analysis found a large effect size for client preferences and moderate effect size for client perceptions of therapists that favor matching but a very small effect size (.09) for psychotherapy outcomes (Cabral & Smith 2011). Another recent study by Stice et al. (2021) did not find evidence that ethnoracial matching within a sample with body shape concerns ($N = 1,195$) was associated with larger intervention effects. As such, we did not form a priori hypotheses for an effect of client–therapist match on psychotherapy outcomes.

Notably, the FSU Psychology Clinic provides low-cost treatment to the wider community and region, as it is intended to facilitate access to care among underserved groups. Thus, our clinic's client population should reflect a reasonably wide range of features of diversity relevant to treatment access and outcomes as compared to many similar settings. Moreover, the clinic has only two exclusion criteria (i.e., individuals currently unmedicated while actively psychotic and/or manic; and risk for suicide death that necessitates immediate hospitalization). Thus, with regard to symptom severity, representation is also wide ranging.

The present study sought to provide critically needed information on how ethnoracial status, gender, and their intersectionality impact access to mental health care and treatment outcomes. For our first aim, we compared the demographic makeup of clients in the FSU Psychology Clinic to the estimated mental health needs of Leon County (the county encompassing Tallahassee, Florida), by weighting the demographic makeup of Leon County with prevalence estimates for mental disorders commonly treated in our clinic. Based on prior research, we predicted greater utilization in women, among individuals identifying as White, and for their intersection. That is, we predicted that the representation of White women among our clients would exceed their representation among those with mental health needs beyond the effects accounted for by ethnoracial status or gender alone. For our second aim, we compared parameters of retention and therapist-rated improvements across demographic groups in our clinic, examining both main effects of ethnoracial status and gender as well as their interaction. Given the mixed literature regarding main effects and extremely limited literature on intersectionality, we did not form an a priori hypothesis for this aim. Instead, we sought to add much-needed data on this issue.

Our clinic offers unique features that might facilitate access and contribute to fewer disparities in treatment outcomes. The FSU Psychology Clinic trains doctoral students in our clinical psychology program and functions as a community mental health center with, as noted, minimal exclusion criteria. We do not accept insurance and offer sliding fee scales for all services. We provide several evening groups and flexible scheduling of appointments. Our clinic uses informed consent prior to assessment and provides feedback from intake, treatment options, and rationales in a collaborative approach to establishing treatment goals and selecting evidence-based interventions to achieve those goals. Data collection at the clinic is reviewed and approved annually by the FSU Internal Review Board.

Method

Participants

The present study included 2,076 clients (M_{age} = 27.68, SD = 11.51) who engaged with the FSU Psychology Clinic. Of those, 53.2% were assigned female at birth, 40.1% were assigned male at birth and 6.7% of individuals had missing data on sex assigned at birth (see Footnote 1). The ethnoracial demography of the sample was as follows: 11.3% Hispanic, 0.8% American Indian/Alaska Native, 2.0% Asian/Pacific Islander, 10% Black, 67.9% non-Hispanic White, and 10% of individuals had missing data on ethnoracial status. The gender breakdown within each ethnoracial group was as follows: of the American Indian/Alaska Native clients (n = 17), 12 (71%) identified as women, and 5 (29%) identified as men; of the Asian/Pacific Islander clients (n = 45), 26 (58%) identified as women, and 19 (42%) identified as men; of the Black clients (n = 203), 99 (49%) identified as women, and 104 (51%) identified as men; of the Hispanic clients (n = 231), 124 (54%) identified as women, and 107 (46%) identified as men; and of the White clients, 900 (59%) identified as women, and 630 (41%) identified as men. For most of the time of data collection, there were limited response options for the race and ethnicity section of the demographic intake survey. Specifically, clients had to select the race *or* ethnicity option with which they most closely identified. This was a flawed approach for multiple reasons, including that it left no satisfactory response option for those who equally identified with two or more race and ethnicity categories. Therefore, we necessarily collapsed race and ethnicity into a single variable: ethnoracial status.

Among other emphases, we were interested in any effects of matching of ethnoracial status and gender of clients and therapists. Thus, we derived a "match" variable for ethnoracial status, as follows: if the code for the client's ethnoracial group (e.g., 3 = Black person) matched that of the therapist's (i.e., 3 = Black person), a new variable indexed that as a match (i.e., match = 1); else, that new variable indexed it as a nonmatch (i.e., match = 0). The same approach was taken regarding gender matches.

Diagnoses, not our emphasis here, were provided by graduate student therapists in consultation with clinical psychologist supervisors, based on the most current structured clinical interview for the Diagnositicand Statistical Manual of Mental Disorders [DSM] (SCID; First et al., 1995). The general diagnostic breakdown was as follows: 45% mood disorders; 30% anxiety disorders; 20% personality disorders; 5% substance use disorders; various other conditions, including 30% not otherwise specified/other specified variants (percentages total > 100% due to comorbidity).

We reiterate that the clinic is a community clinic serving the greater Tallahassee area; it is *not* a student counseling center (but *is* housed on a large state university campus, which is of potential relevance to mental healthcare access, utilization, and disparities therein). The clinic is embedded within a Department of Psychology's clinical psychology PhD program; the priority of the program and of the wider department is, by nature, science. Somewhat in contrast, our clinic's priorities are, in this order, client safety and well-being, the well-being and training of our clinical PhD students and other staff, and scientific and scholarly research. An upshot of this interplay of priorities is that the clinic's research data collection, while viable, valued, reasonably robust, and historically productive

(e.g., Anestis et al., 2011; Cukrowicz et al., 2011; Driscoll et al., 2003; Reardon et al., 2002; Rogers et al., 2017; Stanley et al., 2006; Venables et al., 2015), is imperfect and substantially affected by the real-world pressures and realities of running a busy community clinic providing low-cost, high-quality services to a client group of above-average clinical acuity.[2] Consequences include missing data, with varying Ns across variables and thus across analyses, and the fact that premature termination is the norm, as it regularly is in community mental health clinics (i.e., more than half of the clients in this report prematurely terminated services; in this context, it should be noted that premature termination covers a wide range of scenarios, from termination during or after the first session to deciding to leave treatment after several months when the client [but not the therapist] is satisfied with treatment response). Clients were included in the present study if they received psychotherapy services in the FSU Psychology Clinic from 2000 to 2021 and consented to participate in clinical research.

Therapists Delivering Treatment and Choice of Specific Treatment(s)

Clinical psychology doctoral-level student therapists comprised the pool of therapists in this study. All therapists were students in their second year or higher in the FSU clinical psychology PhD program. As such, all students completed coursework pertaining to the empirical support for various psychotherapy approaches prior to entering the clinic. With respect to gender, the composition of the student therapists has been stable over the years, with most identifying as women. Regarding ethnoracial status and whether there has been change over time, there has been considerable variability. For specific classes in a given year, the percentages range from 0% to 50%, with no clear trend over time, with the possible exception that since 2018 representation of ethnoracially diverse individuals has been somewhat better and more consistent.

During the time of the study, a 1- to 2-hr weekly didactic meeting[3] occurred in which the procedures and techniques involved in these treatments were discussed along with related topics. The specific treatment used was based on the available literature on empirically supported therapies for specific diagnoses with an emphasis on recommendations by Nathan and Gorman (1998), Chambless and Ollendick (2001), and updates since (e.g., Beck & Beck, 2011). Treatment selection was based on the primary or most pressing diagnosis at the time of initial intake and diagnosis. Treatment manuals or protocols were used when available and appropriate. In cases with comorbidity or multiple presenting diagnostic concerns, therapists used an indicated treatment for the most distressing or

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[2] The research program of this article's first author is on suicidal behavior, and though the clinic and that research program are mostly separate, the research does influence the clinic, for example, in signaling that we have familiarity and expertise with regard to the complex issue of suicide risk. Moreover, we see anyone who approaches us who has a mental disorder, including people whom many other providers will not see (e.g., due to clinical severity, lack of resources, students whose conditions require more intensive services than those provided by the campus' student counseling center, etc.). It is in these ways that we have an overall above-average level of clinical acuity in our client group.

[3] These meetings lasted 2 hr until 2006, at which point they were shortened to 1 hr.

impairing disorder, with a secondary focus on the comorbid condition(s) when primary symptoms have been reduced.

Approximately 80% of therapists deployed primarily behavioral or cognitive treatments with clients (i.e., cognitive therapy, behavior therapy, cognitive–behavior therapy, exposure and response prevention, exposure therapy, cognitive behavioral analysis system of psychotherapy, dialectical behavior therapy). The remaining approximately 20% of therapists used treatments such as interpersonal psychotherapy and motivational interviewing. Therapists in the FSU clinic use seven criteria for a recommendation of termination of therapy: symptom decrease, stable symptom decrease for 8 weeks, decrease in functional impairment, spontaneous remission ruled out and use of new skills tied to lower symptoms, use of new skills even at times or on themes of former vulnerability, sense of pride about new skills in contrast to initial doubt regarding techniques, and generalization of skills to other areas besides target areas (for more information, see Jakobsons et al., 2007).

Measures

Therapist-Rated Clinical Impression at Intake and Termination

The Clinical Global Impression scale (CGI; Guy, 1976) was used to assess clients' overall severity of illness and global functioning, accounting for symptoms, behavior, and psychosocial conditions. The CGI consists of two scales utilized in this effort: Clinical Global Impression severity at intake and Clinical Global Improvement at termination. The intake CGI was completed by therapists after the final intake session. Therapists rated clients' illness severity on a scale of 1–7 corresponding to the following values: 1 (*normal, not at all ill*), 2 (*borderline mentally ill*), 3 (*mildly ill*), 4 (*moderately ill*), 5 (*markedly ill*), 6 (*severely ill*), and 7 (*among the most extremely ill*). Higher values, therefore, indicate greater therapist-rated illness severity at intake.

When terminating services with a client, therapists used the CGI to rate the change (i.e., level of improvement or worsening) in client global functioning since intake on a scale of 1–7 corresponding to the following values: 1 (*very much improved*), 2 (*much improved*), 3 (*minimally improved*), 4 (*no change*), 5 (*minimally worse*), 6 (*much worse*), 7 (*very much worse*). Higher values of the CGI at termination indicate therapist-rated worsening psychological well-being, whereas low values at termination indicate improvement in psychological well-being (notably, a client-rated version of the CGI was utilized at termination, but missing data were rampant. Thus, we report therapist-rated CGI data; for those for whom client- and therapist-rated CGI scores were available, therapists' and clients' CGI ratings were correlated .73). Further support for the CGI's properties, important in that much in the current report depends on the CGI, is described in our previous efforts (e.g., Cukrowicz et al., 2005, 2011). Specifically, CGI improvement at termination was rated by the therapist seeing the case and two additional independent raters (doctoral students in clinical psychology) for a randomly selected subset of cases to determine the reliability of ratings. The therapist and additional raters evaluated all available client information, including progress notes, as well as objective assessment instruments (e.g., symptom scales associated with the specific client's presenting concern) administered routinely throughout the course of therapy, including at termination, to

determine client progress. The intraclass correlation coefficient for these ratings was .91 ($p < .001$), indicating strong interrater reliability. We also assessed bias in therapist ratings and found there was no significant difference between therapist-rated improvement at termination and independent rater-rated improvement at termination, consistent with a lack of compelling evidence of a positive bias in therapist ratings at termination. Other work on anxiety, depression, and other forms of psychopathology has indicated that the CGI has acceptable internal consistency and validity (Leon et al., 1993; Pérez et al., 2007; Stern et al., 1998). Still in other work, we have shown the reliability and concurrent validity of the CGI scale in this clinic (e.g., substantial agreement between CGI ratings, DSM-IV Axis V global assessment of functioning [GAF], and client improvement ratings by therapist and client; e.g., Reardon et al., 2002). Among other reasons (e.g., the GAF is not used in DSM-5), we have chosen to emphasize the CGI over the GAF because, as noted, we have ample support for both CGI reliability and validity in this specific setting whereas for the GAF, we have less.

Number of Sessions and No-Shows

After case closing, therapists tallied the total number of scheduled sessions and the number of no-shows. The total number of attended sessions represents the difference between the total number of sessions scheduled and the total number of missed sessions. The total number of sessions attended ranges from 0 (for those who disengage after screening but before being assigned to a therapist) to 210. The mean number of sessions attended was 14.01 ($SD = 18.87$; skewness was 3.85; kurtosis was 25.34). About half the sample attended 0–9 sessions; every number of sessions is represented from 0 to 66. We would characterize the variable as reasonably continuous, skewed, and clearly kurtotic. Regarding no-shows, we calculated a proportion of no-shows relative to total number of sessions.

Termination Type

After a client's case was closed, therapists then reported whether termination was premature (coded as 1) or not premature (coded as 0). Therapists reported a case was premature termination if the client stopped attending therapy before the end of the course against the recommendation of the therapist. Therapists reported a case as not prematurely terminated when a client attended therapy to the end of treatment (e.g., the therapist and client agree that the client no longer needs therapy; the therapist ends treatment because they believe therapy is no longer necessary; or external circumstance resulting treatment's end such as moving away from the Tallahassee area).

Data Analysis

First, we determined whether our clinic's demographics were significantly different from those for the general population of people with mental disorders in Leon County, Florida, where FSU and Tallahassee are located. In analyses on demographics, we conceptualized the hypothesis of between-group equivalence as a rather unlikely conceptual default, a useful starting point to

scrutinize the patterning of utilization between groups. We conducted chi-square tests to test this hypothesis.

We examined variables for outliers and violations of normality. We then performed analyses, including chi-square tests and correlational analyses, to determine if participants with complete data were different from those without, which was important in light of substantial (and expectable) missing data. Next, between-group differences in Clinical Global Improvement (CGI) ratings at intake were examined using analysis of variance (ANOVA); examination of clinical status at intake allowed determination of any between-group differences in those presenting for treatment and completing intake. Next, controlling for CGI at intake, between-group differences in whether termination was premature or not, number of sessions attended, number of no-shows, and, importantly, Clinical Global Improvement ratings at termination, were examined using analysis of covariance (ANCOVA)/logistic regression. In these latter analyses, we viewed the statistical interaction as an index

of intersectionality; our approach in this regard is multiplicative (see Jackson et al., 2016, for an in-depth discussion of quantifying intersectionality, including alternative, additive approaches).

Results

Frequencies, means, standard deviations, and intercorrelations for all variables are presented in Table 1, several features of which are of interest. For example, as would be expected, clinical parameters were somewhat intercorrelated and in interesting ways (e.g., number of sessions attended correlated with both intake and termination GGI [$|r|$'s $> = .23$, $p < .05$], but in opposite directions, such that those attending more sessions were worse than others at baseline and better than others at termination). Those whose clinical presentations at intake were more severe had more no-shows, were more prone to premature termination, and, as noted, tended to attend more sessions overall. There is an apparent tension in attending

Table 1

Sample Demographics, Means, Standard Deviations, and Correlations

Descriptive statistics and correlations			
Ethnicity/Race	Frequency	Percent	Valid percent
American Indian/Alaska Native	17	0.8	0.8
Asian Pacific Islander	45	2.0	2.2
Black	203	9.0	10.0
Hispanic	231	10.3	11.4
White (non-Hispanic)	1,530	67.9	75.5
Total	2026	90.0	100.0
Gender	Frequency	Percent	Valid percent
Female	1,198	53.2	57
Male	904	40.1	43
Total	2,102	93.3	100

Correlations								
Variable	1	2	3	4	5	6	7	8
1. Participant gender		−.082** .002 $N = 1,362$	−.102** .00 $N = 1,389$	−.050 .080 $N = 1,245$	−.017 .536 $N = 1,265$	.052 .091 $N = 1,065$	−.044 .298 $N = 555$	−.350** .00 $N = 2,120$
2. CGI severity (intake)			.236** .00 $N = 1,264$	.143** .00 $N = 1,201$	.232** .00 $N = 1,173$	.025 .404 $N = 1,115$	−.057 .162 $N = 607$	.038 .147 $N = 1,471$
3. Number of sessions attended				.152** .00 $N = 1,355$	−.266** .00 $N = 1,380$	−.326** .00 $N = 1,161$	−.183** .00 $N = 621$	.033 .194 $N = 1,520$
4. Number of no-shows					.131** .00 $N = 1,227$	.043 .155 $N = 1,113$	.048 .242 $N = 599$	.032 .232 $N = 1,356$
5. Termination type						.504** .00 $N = 1,096$	.384** .00 $N = 592$	−.048 .073 $N = 1,391$
6. CGI therapist improvement rating							.727** .00 $N = 622$	−.054 .065 $N = 1,167$
7. CGI client improvement rating								.032 .421 $N = 624$
8. Gen match								

Note. CGI = Clinical Global Impression scale. Gender is coded women = 1, men = 2; termination type was coded as premature = 1; not premature = 2; gender match was coded as match = 1; nonmatch = 0.
** Correlation is significant at the 0.01 level (two-tailed).

more sessions and being more prone to premature termination. This is at least partly resolved by the fact that many were coded as premature termination due to partial responses to an otherwise reasonably full course of treatment, which, if continued still longer, may have culminated in full treatment response. Clients improved on average under our care, though gains were moderate and variable, highly consistent with the experience of similar clinical settings.

We examined correlations of time/year with our main variables of interest. Notably, the variable that was most associated with the year was clinical severity at intake, such that over time we have attracted a somewhat more clinically severe client census ($r = .18, p < .001$). Encouragingly, the difference score in CGI severity rating at intake versus termination was also significantly associated with the year ($r = .14, p < .001$), such that over time we have increased clinical progress from intake to termination. We thus have recruited clients with a somewhat more severe clinical presentation over the years and at the same time have managed to increase their clinical improvement over time. There were no notable correlations of year to our two main variables of interest, ethnoracial status or gender.

The Demographic Makeup in Leon County, Florida, of People With Mental Disorders Compared to the Demographic Makeup of the FSU Psychology Clinic

Proportional access to and utilization of mental health care was tested by comparing our clinic's demographics to the demographics of those with mental disorders in the wider population in the county in which our clinic operates (approximately 97,000 people with mental disorders in Leon County, Florida at any given time during years of this study, from a total of approximately 280,000 people in general in Leon County, Florida). The chi-square test showed significant discrepancies, $\chi^2(4) = 408.93, p < .001$, indicating that ethnoracial status predicted treatment utilization in our clinic. However, not all comparisons yielded lower utilization by minorities. Specifically, whereas approximately 23% of those with mental disorders in Leon County, Florida were Black, approximately 10% of our clinic sample were Black, $\chi^2(1) = 182.44, p < .001$. Of those with a mental disorder in the local county, approximately 0.3% were American Indian/Alaska Native, whereas our clinic sample consisted of 0.8% American Indian/Alaska Native people, $\chi^2(1) = 21.00, p < .001$. Of those in the county with a mental disorder, approximately 1.8% were Asian American/Pacific Islander; our clinic sample consisted of 2.2% Asian American/Pacific Islander people, $\chi^2(1) = 2.12, p = .15$. Of those in the county with a mental disorder, approximately 4.1% were Hispanic; our clinic sample consisted of 11.4% Hispanic people, $\chi^2(1) = 249.68, p < .001$. Finally of those in the county with a mental disorder, approximately 71% were White, non-Hispanic, whereas almost 76% of our clinic sample identified as White, non-Hispanic, $\chi^2(1) = 18.68, p < .001$. In summary, then, these results indicate shortfalls in outreach to Black people, and roughly adequate or better outreach and connection to others, including American Indian/Alaska Native and Hispanic individuals.

Gender and Intersectionality

For any mental disorder, approximately 58% of affected individuals in Leon County would be female due to the slightly higher prevalence in women in the County and elevated prevalence of more common disorders. In our sample, 57% of clients were women, suggesting no clear gender bias in who sought treatment in our clinic, $\chi^2(1) = 1.28, p = .26$.

Importantly, we were unable to locate epidemiological data that reliably reported prevalence for any mental disorder by both ethnoracial status and gender for the United States. Thus, we were unable to establish estimates for the Leon County population. Table 1 provides descriptive statistics on the breakdown of our clinical population by the intersection of ethnoracial status and gender.

Missing Data

Chi-square tests and correlational analyses were used to determine if participants with complete data were different from those without. There are a number of possible ways to examine this question; one potentially interesting angle regarding missing data is to focus on those who engaged our services initially but who had neither an intake nor a termination GGI rating (reflecting that they disengaged prior to the completion of our sometimes lengthy intake process for any of an array of reasons; e.g., deciding not to pursue treatment; being advised that they were not a fit for our clinic due to having no mental health condition; moving away; emergent medical condition in self or loved ones; code = 1), as compared to those whom we retained, at a minimum, through intake completion (code = 0). Of the 2,026 clients who engaged our services and on whom we recorded and entered at least some data, 1,471 were followed through at least to intake completion (72.6%). Those who engaged our services but did not follow through to complete intake did not differ from those who engaged through intake with regard to gender ($r = -.01, p = ns$). However, those we retained through intake differed significantly from those we did not with regard to ethnoracial status ($\chi^2 = 16.05, df = 4, p < .001$). Proportions that significantly differed from others were among Black clients, whom we lost before intake completion at a rate of 43.3%, and among White clients, whom we lost before intake completion at a rate of 30.1%, both as compared to a rate of 32.1% for the entire sample. Gender and ethnoracial status did not interact to predict loss before intake.

Another perspective on missing data involves those for whom we have both an intake and termination GCI rating, as compared to those for whom we have an intake CGI rating only. Of the 1,471 clients on whom we have intake CGI ratings, 1,115 were followed through to termination (75%). These 1,115 (code = 0) did not significantly differ from the remaining 356 clients (code = 1) with regard to ethnicity ($\chi^2 = 8.05, df = 4, p = .09$). This nonsignificant effect was trending, indicating that only among Black participants were their differences in loss to follow-up (34.9% vs. 24.2% for the rest of the sample). Those who followed through to termination significantly differed from those not retained with regard to gender (women were more likely to have both an intake and termination CGI rating than men; $r = .07, p < .005$), and with regard to intake CGI (individuals with more severe clinical presentation at intake were more likely to have an intake and termination CGI; $r = -.30, p < .001$). This latter association allays concerns that our data are biased toward retention of the relatively well, and it may reflect in part that those most in need may, for that reason, persist through treatment in many instances. Gender and ethnoracial status did not interact to predict postintake attrition from therapy.

Ethnoracial Status, Gender, Their Intersectionality, and Associations With Clinical Status at Intake

To evaluate whether clients' ethnoracial status, gender, and their intersection were associated with the severity of clinical presentation at intake, we conducted a between-group ANOVA with Intake CGI as the dependent variable, and ethnoracial status, gender, and their statistical interaction as independent variables.[4] Note that the statistical interaction between ethnoracial status and gender included in our analytic approach represents a quantitative index of intersectionality.

The ethnoracial status by gender interaction effect on Intake GGI was significant, $F(3, 1307) = 4.84$, $p < .005$, partial eta-squared = .011. Examination of CGI means for this latter effect indicated that clinical presentation at intake varied little by ethnoracial status for women (all means were near the overall mean for women, i.e., $M =$ 3.80, $SD = 1.33$), but varied more based on ethnoracial status for men. The patterning of these means was such that Black men presented with the least severe clinical presentations ($M = 3.05$, $SD = 1.43$), Asian American/Pacific Islander men the most severe ($M = 4.31$, $SD = 1.03$), with Hispanic men ($M = 3.40$, $SD = 1.22$) and White men ($M = 3.61$, $SD = 1.34$) intermediate and near the overall mean for those identifying as men ($M = 3.54$, $SD = 1.35$).

Regarding main effects, the ANOVA indicated no significant difference in Intake CGI by ethnoracial status, $F(3, 1307[5]) = 1.37$, $p = .25$, and a significant difference in Intake GCI by gender, $F(1, 1307) = 4.69$, $p < .05$, partial eta-squared = .004. Examination of CGI means for this latter effect indicated that clinical presentation at intake was more severe for women ($M = 3.80$, $SD = 1.33$) than men ($M = 3.54$, $SD = 1.35$).

Ethnoracial Status, Gender, Their Intersectionality, and Associations With Clinical Status Over Time

To evaluate whether clients' ethnoracial status, gender, and their interaction were associated with clinical parameters over time, we conducted between-group ANCOVAs or binary logistic regressions as appropriate, with Intake CGI as a covariate and ethnoracial status and gender (and their statistical interaction) as independent variables. Here again, the statistical interaction between ethnoracial status and gender included in our analytic approach represents a quantitative index of intersectionality. Dependent variables were premature termination (premature vs. not, as rated by the therapist), number of sessions attended, number of no-shows, and Termination CGI as rated by therapists.[6] We conducted separate ANCOVAs/ logistic regression rather than one MANCOVA because, among other reasons, intercorrelation between dependent variables was not extensive (with the expected exception that therapist and client termination GGIs were correlated, $r = .73$, $p < .001$, further to the validity of each; see Footnote 7 below).

Regarding premature termination (a dichotomous outcome), we dummy-coded ethnoracial status and entered the dummy-coded variables and gender, along with the interactions between gender and the dummy-coded ethnoracial variables, into a binary logistic regression, controlling for CGI at Intake. With the exception of the effect for CGI at Intake ($B = .42$, $SE = .05$, $Wald = 60.95$, $p < .001$), no effects were significant (e.g., $Wald's < 2.49$, $p's > .11$). As expected, the direction of the effect for CGI at intake was such that

those whose initial clinical presentation was more severe were more likely to terminate prematurely.

For number of sessions attended, ANCOVA indicated no significant differences for ethnoracial status, $F(3, 1114) = 0.85$, $p = .47$, gender, $F(1, 1114) = 2.69$, $p = .10$, nor for their interaction, $F(3, 1114) = 0.45$, $p = .72$. Regarding number of no-shows relative to total number of sessions attended, ANCOVA indicated significant differences for ethnoracial status, $F(3, 1058) = 4.63$, $p < .005$, partial eta-squared = .013, but not for gender, $F(1, 1058) = 0.41$, $p = .84$, nor for the interaction between gender and ethnoracial status, $F(3, 1058) = 1.40$, $p = .24$.

The effect for ethnoracial status was driven by significant pairwise differences between Black ($M = .24$, $SE = .03$) and other participants ($M = .13$, $SE = .03$). Finally, for therapist-rated CGI at termination (again adjusted for intake CGI), ANCOVA indicated no significant differences for ethnoracial status, $F(3, 977) = 0.31$, $p = .82$, gender, $F(1, 977) = 0.33$, $p = .57$, nor for their interaction, $F(3, 977) = 0.70$, $p = .55$.

Therapist/Client Match

In an exploratory analysis, we evaluated ethnoracial and gender match/mismatch between client and clinician in relation to clinical outcomes. When we computed variables for ethnoracial match and gender match and ran ANCOVAs/logistic regressions with premature termination, number of sessions, number of no-shows, and termination CGI as dependent variables and while controlling for Intake CGI, results were null or nearly so, with one main exception. Specifically, within Black clients, ethnoracial match related to more sessions ($pr = .36$, $p < .05$). In all other permutations of ethnoracial match within ethnoracial status and gender, and gender match within ethnoracial status and gender, results were null and/or quite small ($pr's < .08$).

Discussion

With regards to availability, access, utilization, and effectiveness of mental health care, as well as retention therein, our results from the FSU Psychology Clinic indicate that improvement of care is possible at each stage of the process, especially for certain groups, but that this applies more to the front than to the back end of the process. That is, among people in Leon County with mental disorders, approximately 23% are Black, and yet among our clinic sample, approximately 10% are Black, suggesting, among other factors, shortcomings in the front-end efforts of outreach and

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[4] There were too few people of American Indian/Alaska Native backgrounds ($n = 17$, 12 women, 5 men, with several missing Intake GGI data) to enable an analysis of the Ethnoracial status × Gender interaction in the full sample; thus, this analysis involved clients whose ethnoracial status was either Asian American/Pacific Islander (26 women, 19 men), Black (99 women, 104 men), Hispanic (124 women, 107 men), or White (900 women, 630 men). Descriptive examination of data for people who identified as American Indian/Native Alaskan suggested intermediate intake CGI scores (i.e., $M = 3.40$, $SD = 1.43$).

[5] Degrees of freedom differ from expectation (e.g., we had 1,471 who completed intake) due to analytic procedures focusing only on those who had complete data for all variables entered across analyses.

[6] Missing data rendered some cell sizes small enough for client-reported CGI that, as alluded to already, we focus only on therapist-reported CGI, though the pattern of findings for client-rated CGI was similar to results for therapist-reported CGI (i.e., nonsignificant effects of ethnoracial status, gender, and their interaction).

awareness. Within those who do engage our services, retention of Black clients is again comparatively suboptimal, with above-average numbers of Black clients parting with us during the intake process and during therapy. Once clients are relatively well engaged with us (e.g., have completed the intake process and are in active treatment), the picture improves, in that, overall, there is little evidence of differential effectiveness of therapeutics by ethnoracial status, gender, or their intersectionality, though it should be noted that more no-shows were recorded for Black clients. Although tentative, intriguing exploratory results emerged regarding Black clients matched with Black therapists attending more sessions.

Recent meta-analyses found that racism experienced at a personal and group level (directed at the individual and directed at the group to which the individual belongs) was associated with delays in seeking/foregoing health services and with more negative experiences of health services received (Ben et al., 2017; Vines et al., 2017). Across studies, clients who reported greater experiences with racism endorsed lower levels of healthcare-related trust, satisfaction, and communication while also endorsing lower adherence in treatment. Both the history of mistreatment in medical and mental health care for people of color (Suite et al., 2007; Vines et al., 2017) and the overrepresentation of Black individuals in inpatient psychiatric treatment (Snowden et al., 2009) contribute to reluctance to seek treatment for mental illness and may account for patterns observed in our clinic.

One clue about shortfalls in outreach to Black clients can be derived from the fact that among the Black individuals we engaged, their clinical presentation based on intake CGI ratings was relatively nonsevere. Our clinic's outreach to Black individuals overall needs improvement, but improvement is especially needed in reaching those who are in the top half of the severity continuum. Previous research has indicated similar or higher levels of severity of clinical presentation at intake for Black populations compared to other ethnoracial groups (Brown et al., 1996; Chang et al., 2014; Minsky et al., 2003; Moitra et al., 2014), so the relatively low CGI ratings we found—especially considering the aforementioned findings on attrition and community prevalence of mental disorders—more likely reflect a shortcoming on our part than a uniquely less clinically severe Black population in Leon County. As our clinic does not accept insurance and operates on a financial sliding scale, we have taken steps to break down at least one structural barrier to care (Walker et al., 2015), and we have made strides on others (e.g., flexible use of telehealth services for group and individual therapy; expanding services further to include telephone therapy sessions for those with low access to the internet, computers, and smartphones is currently under consideration). However, we may be falling short on ensuring that Black populations in Leon County have the *knowledge* to access our services, not to mention on helping to address some of the attitudinal barriers common in Black communities (Eylem et al., 2020). Ways to remedy this issue include qualitative study of why and how we were able to retain Black clients, especially Black women, once they were well engaged with us, improved communication with local inpatient mental health facilities (which are discharging relatively severe clients to outpatient care), community outreach events, and consultation with leaders in the Black community (e.g., church pastors; colleagues at Florida A&M University, a Historically Black College and University [HBCU] in Tallahassee). We have

initiated such efforts over the years and have rededicated ourselves to them recently. Still, our clinic's failure to meet the needs of the local Black community remains a disparity in need of serious, ongoing attention.

As far as the positive side of our outreach efforts, we appear to be doing comparatively well with two groups: American Indian/Alaska Native and Hispanic people. Outreach to American Indian/Alaska Native people (among whom representation is approximately 0.80% when it should be approximately 0.16%) is perhaps in part related to our university's work put in over decades to build and sustain a trusting relationship with the Seminole Tribe of Florida. Outreach to Hispanic people (among whom representation is approximately 11.4% when it should be approximately 2.8%) may in part be due to FSU's attracting Hispanic students to the campus from large metropolitan areas in central (e.g., Tampa) and south Florida (e.g., Miami). FSU is one of Florida's major state universities, and thus draws students from the entire state, with the effect that Hispanic representation among FSU students tends to be higher than that in the greater Tallahassee area. Because our clinic sees a mixture of non-FSU community members and FSU students, staff, and faculty, drawing Hispanic students in general to FSU is of potential relevance to our clinic's census of Hispanic clients.

Despite the overall lack of an association between ethnoracial status and the effectiveness of psychotherapy delivered by our clinic, effectiveness can nonetheless be further optimized for everyone, and a promising direction in this regard is the addition of a cultural formulation interview (CFI) and cultural humility mindset to the case conceptualization. FSU graduate students now receive training in the CFI, which has been found to build trust among clients and increases clinicians' understanding of contextual factors that might impact clinical presentation (Ramírez Stege & Yarris, 2017; Lewis-Fernández et al., 2017). This means that providers in the clinic are grounded in relevant cultural context during their initial interview with a client, which bodes well for therapeutic alliance, cultural humility, and cultural competency.

Within Black clients, ethnoracial match related to more sessions ($pr = .36$, $p < .05$). These preliminary findings that ethnoracial match may benefit treatment progression suggest a need for more ethnoracially diverse providers, both to enable additional research in this area and to capitalize on the potential therapeutic benefits.

Given that these data were collected over a number of years, we explored associations between year and our main variables of interest. Intriguingly, the variable that was most associated with the year was clinical severity at intake, such that over time we have attracted a somewhat more clinically severe client census. This may be due to a general increased severity of mental health problems reported across the country (Mercado et al., 2017; Ruch et al., 2019; Twenge et al., 2019), as well as factors like reduced stigma around seeking mental health care and shifting sociopolitical contexts (e.g., Albright & Hurd, 2020). Additionally, there has been an overall increase in demands for university counseling services (Center for Collegiate Mental Health [CCMH], 2019). Perhaps encouragingly, the difference score in CGI severity rating at intake versus termination was also significantly associated with the year, such that over time we have increased clinical progress from intake to termination. We thus have recruited clients with a somewhat more severe clinical presentation over the years and at the same time have managed to increase their clinical improvement over time.

We offer a few interpretations of this pattern. First, it may be a mundane phenomenon involving a kind of regression-to-the-mean effect, in that, if clients present with more severity, they therefore have more room for improvement. Second, it may be that the quality of the services is improving over time, due to factors like the personnel's increasing expertise, especially personnel with long-lasting tenures (e.g., specific supervisors, Associate Directors, Director). Third, the finding could be due to personnel's growing cultural humility and competence. Some combination of these explanations is likely apt.

There were no notable correlations of year to our two main independent variables of interest, ethnoracial status and gender. This could be interpreted as dispiriting (e.g., lack of notable progress recruiting a diverse client group—plausible, especially regarding Black clients) or as encouraging (e.g., maintained diversity over time—plausible, given that, with the important exception of Black clients, we have above average or proportionate diversity overall). We present both interpretations and invite consideration of each.

We did not systematically collect data on therapists' years providing therapy, though in a previous report, we did track this over the course of a limited timeframe and found that there was an association between years of experience and clinical outcomes (Driscoll et al., 2003). Given that therapists spend their 2nd and 3rd years of their PhD experience in our clinic, and that there is therefore turnover of about half our therapists from year to year, this variable is likely relatively constant over the time in which the data were collected for the current article.

Limitations

Our study had several limitations. Due to deficiency in data collection, clients were forced to select only one race *or* ethnicity, preventing them from identifying as ethnically or racially mixed (e.g., Afro-Latinx clients were able to select Black *or* Hispanic but not both) and precluding us from exploring the experiences of mixed ethnoracial clients. Prior studies have shown individuals with mixed ethnoracial identities (24.9%) are more likely to report any mental illness within the past year than any other ethnoracial group, followed by American Indian/Alaska Natives (22.7%), White (19%), and Black (16.8%; American Psychiatric Association [APA], 2017). This flaw in our data collection at intake may have resulted in an underestimation of the degree to which ethnoracial match was associated with less premature termination. Similarly, initial data collection required clients to endorse one of two gender options (male or female), limiting our ability to determine outcomes for gender-diverse (i.e., transgender, gender non-conforming, and nonbinary) individuals. Prior research suggests that gender-diverse populations experience disproportionately high rates of mental illness and low rates of access to care (Downing & Przedworski, 2018; Institute of Medicine, Board on the Health of Select Populations, & Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011; Streed et al., 2017). Since the time of this data collection, significant improvements have been made to the clinic's demographic questionnaire, and reflecting the lived realities of our clients in the questions we ask at intake continues to be an area of ongoing improvement. These and similar adjustments will enable more inclusive and robust research in the future. Of the more than

2,000 clients in the database, follow-up information is available on more than half for most outcomes; missing data thus presented an issue (which has not unduly affected past work in this setting; e.g., Anestis et al., 2011), which we directly address empirically in this report. Data were missing at varying rates across variables and thus across analyses. Another issue involves relatively small numbers in intersectionally determined subgroups.[7] We were unable to locate epidemiological data that reliably reported prevalence for any mental disorder by both ethnoracial status and gender for the United States, which in turn limited our ability to establish estimates for the Leon County population. Also, as the number of people who decline to participate in our clinic's research has been consistently very low over the years, we have not systematically tracked this issue, and thus are not able to provide information about how the "decline" group may differ from those who do agree. Our estimate is that the percentage of those who decline is in the low-single digits, and anecdotally, the "decline" group seems to us very similar to those who agree to participate. Perhaps one difference is that a mild suspiciousness/mistrustfulness might characterize the "decline to participate" group; this could represent a substantive concern if the "decline" group differed from the "agree" group with regard to ethnoracial and/or gender status. By our observation over the years, however, this has not been the case, but future work would benefit from a more systematic treatment of this issue. Additionally, statistical power is low in some cases (e.g., with regard to American Indian/Alaska Native clients, who have historically suffered from notably elevated rates of mental disorders, the main driver of which is personal, historical, generational, and institutional forms of violence, cultural and land appropriation and dispossession, trauma, and overt and systemic racism). Also, due to the preponderance of White-identified providers in the clinic, resulting in pairings other than White–White being uncommon, our ability to study the effect of ethnoracial match on outcomes was fairly limited.

The validity of the CGI severity ratings by therapists deserves consideration. On the one hand, we referred to evidence that CGI ratings done by therapists converge reasonably well with those done by clients, and if there is an ethnoracial bias in the current ratings, it is if anything a tendency to rate for example Black men as having a less severe initial presentation. On the other hand, this same tendency may be accounted for by factors such as a lack of trust (e.g., certain clients not disclosing distress due to low trust in therapists), and if so, may represent a source of bias in the ratings. This was indeed the pattern observed in a recent clinical trial which one of the current authors coled: When asked about their level of trust and confidence in the treatment under study, Black participants reported lower trust and confidence than other clients (Schafer & Joiner, 2022).

Conclusions and Future Directions

Our findings illuminate crucial areas for future improvement within the FSU Psychology Clinic, such as deeper understanding

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[7] The state of the data set in early 2021 was such that, for example, approximately 60 people identified as both BIPOC and female. Recent efforts to pore through clinic files and retrieve missing information have mitigated but not fully undone these issues (e.g., in the current data, there were 261 people who identified as both BIPOC and female).

of our shortcomings in outreach to Black people. More in-depth mixed-methods data collection and analysis should be conducted to understand these deficiencies better. This knowledge may be helpful in addressing the structural and attitudinal barriers to care influencing high rates of early attrition for Black populations in general. Additionally, with the new changes to the demographic intake questionnaires, we will be able to better analyze how gender, race, and ethnicity impact CGI at intake and termination of treatment. Larger sample sizes for clients with multiple marginalized identities will enable more analysis of the impacts of intersectionality. Future analysis in this area should also consider the effect of other group identities and axes of oppression, such as sexual orientation, ability, weight, religion or religious background, native language, immigration status, and cultural beliefs, on clinical outcomes. Finally, considering the exploratory findings that ethnoracial matches were associated with less premature termination and gender matches with better CGI at termination, we should prioritize diversity of the clinic's treatment providers to increase clients' comfort levels and retention. This diversity would be enabled by the admittance of clinical psychology students from more diverse backgrounds. FSU's Psychology Department has already begun to take steps to remedy this; the Diversity in Psychology Organization of Graduate Students (DPOGS), the Committee on Diversity in Clinical Science, and the Diversity Committee within the broader Psychology Department all work together to both support and inform current graduate students and recruit and prepare future applicants to the FSU Clinical Psychology program.

In Leon County, Florida, nearly all of the minority ethnoracial populations have steadily increased in size over the past two decades. More to the point, in the wake of the COVID-19 pandemic, which was devastating for communities of color, and recent heightened publicity for issues such as anti-Asian American prejudice and police violence against Black and Latin American communities, ethnoracial minorities have faced increased stress, worry, and suicidality as of late (Bray et al., 2021; Department of Public Health, Illinois, 2021; McKnight-Eily et al., 2021; Mitchell & Li, 2021). Clearly, the need for outreach and effective treatment for ethnoracial minorities is greater than ever. A better understanding of how clients' various social and cultural identities impact treatment outcomes will only serve to pave the way for more inclusive, culturally informed, and effective treatment for those who need it most.

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