A Need for Ethnic Similarity in the Therapist-Patient Interaction? Mediterranean Migrants in Dutch Mental-Health Care

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Evidence concerning a preference for ethnic matching in the therapist–patient dyad and the effects of ethnic matching on treatment satisfaction is equivocal. This study examined the importance of ethnic similarity in mental-health care in the Netherlands. A convenience sample of 82 Turkish and 58 Moroccan outpatients in the community mental-health care was interviewed. Quantified data were analyzed using multivariate techniques. The majority of the respondents did not value ethnic matching as important; clinical competence and compassion were considered to be more relevant than ethnic background. An ethnically dissimilar therapist treated the majority of the outpatients. Outpatients treated by a native Dutch therapist reported similar satisfaction with the services provided as those treated by an ethnically similar therapist. According to Turkish and Moroccan outpatients in Dutch mental-health care, ethnic matching is not considered to be preferential nor essential for treatment satisfaction. Other health-care characteristics such as empathy, expertise, and sharing of worldview are considered to be as important. © 2004 Wiley Periodicals, Inc. J Clin Psychol 60: 543–554, 2004.

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One of the most intriguing issues in mental-health-service delivery to ethnic minorities is the significance of an ethnically similar therapist. The ethnic-similarity hypothesis suggests that ethnic-minority patients will have a preference for a therapist of the same ethnicity. Presumably, patients perceived ethnically similar therapists as higher on credibility, attractiveness, and influence (Atkinson, 1983; Flaskerud, 1986; Gim, Atkinson, & Kim, 1991). Consequently, ethnic minorities probably will be more satisfied with the professional treatment.

However, the benefits of an ethnic therapist–patient match were not confirmed consistently by research into treatment characteristics and outcomes. In a cohort of 610 ethnically mixed opioid users, for instance, the evaluation of ethnically similar and dissimilar caseworker–patient dyads revealed no significant differences in treatment variables and treatment outcomes (Maddux & Desmond, 1996). Various studies also reported other characteristics than ethnic similarity to be more important for treatment satisfaction. Ethnic-minority students expressed the strongest preference for an older and more highly educated counselor, suggesting the counselor's expertise to be a more important criterion in selecting counselors than ethnic similarity (Atkinson, Furlong, & Poston, 1986; Atkinson, Poston, Furlong, & Mercado, 1989). Moreover, a relevant variable in ethnic-matching research seems to be the ethnic groups involved. Results of a review on psychotherapy and its outcomes with minority patients (Sue, Zane, & Young, 1994) demonstrated the importance of ethnic and language matches only with respect to Latin Americans. In a study among thousands of Asian-American, African-American, Mexican-American, and Caucasian-American patients, ethnic matching failed to be a significant predictor of treatment outcomes for most ethnic groups as well (Sue, Fujino, Hu, & Takeuchi, 1991).

Empirical evidence for the ethnic-similarity hypothesis is thus rather inconsistent and substantial variance between ethnic groups exists. Testing this hypothesis for different ethnic groups is relevant, especially in actual patient samples because many studies concerning this issue only were conducted with regard to college students and recurrently rather nonrealistic research procedures were used (e.g., exposing students to counseling vignettes). The majority of counselors and therapists in both the US and European countries do not share the language and culture of an ethnic-minority patient. Therefore, if ethnic similarity promotes better treatment outcomes, and ethnic dissimilarity results in premature termination and dissatisfaction, an ethnic matching approach to counseling and therapy would be beneficial.

Migrants and ethnic minorities in the Netherlands have been reported to underutilize mental-health services when compared to the majority group. However, this is not related to lower rates of mental illness in these groups (de Jong & van den Berg, 1996; Uniken Venema, Garretsen, & van der Maas, 1995). Apparently, some barriers prevent ethnic-minority patients from health-care utilization (Parkman, Davies, Leese, Phelan, & Thornicroft, 1997). In order to determine the contribution of cultural incompatibility as an obstacle in service utilization (and satisfaction), this study examines the preference for an ethnically similar therapist in relation to treatment satisfaction among Turkish and Moroccan people in the Netherlands.

Labor workers in Europe from the Mediterranean area (i.e., people from Turkey and Morocco) and their descents form relatively new major ethnic-minority groups in the Netherlands. About half a million Turks and Moroccans are living in the Dutch society. The majority of Turkish and Moroccan immigrants came from rural, under-developed areas where they had little contact with the western urbanized culture. They were poor and uneducated people who had a strong commitment to Islamic religious practices and the extended family. Most of the immigrants migrated in the 1960s and 1970s and settled

in poor quarters of the large Dutch cities of Amsterdam, Rotterdam, and Utrecht. They had to deal with an urban, secular, and individualistic society. By Dutch standards, most of the Turkish and Moroccan immigrants belong to the lower socioeconomic class (Al-Issa & Tousignant, 1997; Martens, 1999; Sterman, 1996). In our study, being a "Mediterranean immigrant" is operationalized by being born in Turkey or Morocco or by having at least one parent born there. Both Turkish and Moroccan immigrants were considered as "Mediterranean immigrants" in this study, as a result of their convergence in migration background.

The purpose of this study is to explore the contribution of ethnicity to therapist characteristics and treatment satisfaction among Turkish and Moroccan outpatients in mental-health care. To this aim, two research questions were examined: (1) How do Turkish and Moroccan outpatients value the availability of an ethnically similar mental-health professional? (2) Does ethnic similarity in the patient–therapist dyad predict service satisfaction? The main hypotheses state that (1) the majority of the respondents would prefer an ethnic match in the patient–therapist dyad and that (2) ethnic similarity would lead to significantly higher satisfaction rates.

Method

Sample

The outpatients were sampled in five Community Mental-health Care (CMHC) agencies in four large cities in the Netherlands.[1] The agencies are part of the national ambulant mental-health-care system in the Netherlands (with each of the approximately 50 centers serving a target population of roughly 250,000 inhabitants). The specific agencies included in the present study were chosen because of a relatively large proportion of ethnic groups in their patient populations. Regarding the demographic background of their clientele, the sample forms a representative reflection of the Mediterranean CMHC consumer population in the metropolitan areas of the Netherlands.

Procedure

The total population of Moroccan and Turkish outpatients in care within the participating agencies at the time of the study was invited to participate. In this way our sample was a convenience sample. Within this population, all people had an equal chance of participating. Only adult (18 years and older) persons who were born in Turkey or Morocco, or had at least one parent born there, were invited for the face-to-face interview. The outpatients were solicited both via the health-care professionals as well as via letters directed to them personally (written in Turkish, Arabic, and Dutch). This method of obtaining respondents has been proven to be a satisfactory technique for gathering information among groups that have a certain reluctance in participating in scientific research (Uniken Venema & Garretsen, 1995).

The potential participants were told that the study was being conducted in order to improve the quality of mental-health care for migrants in the Netherlands. Participants read and signed informed consent forms. It was emphasized that anonymity would be guaranteed. Evidently, participation was voluntary. The interviews took place at the

[1]The following agencies were included: the regional ambulatory mental-health-care centers "Amsterdam Oost," "Stad Utrecht," "Amersfoort," and "Arnhem" and the outpatient mental-health departments of De Meren in Amsterdam Oost.

mental-health agency or at the home of the outpatient, depending on the preference of the participant.

The interviews were conducted in Arabic, Berber, Turkish or Dutch, again depending on the preference of the respondent. In the case of a Dutch interviewer, an interpreter translated the conversation. The duration of the interviews was on average a little bit more than one hour (M = 70 min, SD = 10.0, range 40–90). The answers were noted on paper by the interviewer and later processed by the research coordinator. After the interview, participants got a token gift of 25 guilders (about 10 U.S. dollars).

Measures

The survey questionnaire administered in this study consisted of several parts. In the first part, respondents were asked demographic questions including sex, age, nation of birth, ethnicity, education, and source of income. The subsequent parts concerned scales focusing on mental-health status, help-seeking behavior, social support, and acculturation demands. Results of these data have been published elsewhere (Knipscheer, 2000; Knipscheer, de Jong, Kleber & Lamptey, 2000; Knipscheer & Kleber, 1999, 2001; Knipscheer, van Klaveren, Kleber, & Jessurun, 1999).

In the last part, the participants were asked about their experiences with counseling in regular mental-health care. The question concerning ethnic preference for a Turkish respondent was phrased: "How important is it for you to be treated by a service provider with a Turkish background?" (For a Moroccan respondent the question included a service provider with a Moroccan background.) The following answers could be given: 0 = Not at all important, 1 = Important, 2 = Very important. Service satisfaction was assessed with the question: "Were you satisfied with the help provided?" The answer format was: 1 = Completely dissatisfied, 2 = Moderately dissatisfied, 3 = Reasonably satisfied, 4 = Very satisfied. Additional argumentation with regard to all the answers was noted by the interviewer in an open-text format.

The questions were pilot tested with ethnic-minority participants and proven to be understood well. Since the questions on ethnic preference and service satisfaction concerned self-constructed one-item forms, it was not possible to provide reliability and validity data.

Interviewers

Six female interviewers (one with a Turkish background, one with a Moroccan background, and four with an indigenous Dutch background) and three male interviewers (one with a Turkish background, two with an indigenous Dutch background) administered the semi-structured interview to the participants. Seven of them had almost graduated for their masters' degree in cross-cultural clinical psychology and had ample experience (at least one year) in cross-cultural research. The other two interviewers had a secondary-school level of education and already had many years experience in this field.

Inter-rater reliability across the interviews was enhanced by means of a protocol and a practical training. The protocol guided the interview process and consisted of questions that derived from the themes mentioned earlier. All interviewers followed an intensive training provided by the research coordinator, with several follow-up sessions. The training concerned the way in which the interviews should be conducted, including aspects of culturally sensitive communication. All the interviewers came together on a regular basis to discuss extensively how questions were administered, how answers were noted, and

how special situations were dealt with (such as respondents who refused to answer certain questions or who did not understand certain questions). The guidelines were discussed in small groups as well as individually. Additionally, the interviewers could call the research coordinator for advice. Following this intensive training program, the level of agreement for the interviewers conceived to be satisfactory. The nine interviewers reached consensus in more than 90% of the interviews.

Response

A total of 82 Turkish and 58 Moroccan outpatients responded positively to our request to participate. This is approximately 45% of the solicited outpatients. Slightly more men ($N = 72$, 51.4%) than women ($N = 68$, 48.6%) took part. The median age of the total group was 36 years ($M = 37.1$, $SD = 9.1$, range 20–62). More than half of the respondents ($N = 87$, 62.1%) had completed a lower professional education, about one third ($N = 41$, 29.3%) had an education at the intermediate (vocational) level, and 11 persons (7.9%) had completed an education on an academic (university) level. Nineteen respondents (13.6%) had a paid job; the majority ($N = 119$, 85.0%) received a kind of social benefit. The majority of the participants was born in Turkey or Morocco. They were living in the Netherlands on average for 17 years ($M = 17.4$, $SD = 7.3$, range 3–36).

The therapists ($N = 14$) in our study all had a degree in psychology or psychiatry. The male–female ratio was 8 to 6. The median age of this group was 44 years ($M = 44.6$, $SD = 7.9$, range 29–59). Of these fourteen therapists, four had a non-indigenous Dutch cultural background (2 Turkish and 2 Moroccan). There were no significant differences in levels of training experience or degree earned between the different ethnic groups of therapists. In the Netherlands, all therapists need the same educational basis. The outpatients were distributed among the therapists by the team coordinators in the CMHC centers on the basis of therapist's feasibility and caseload. They were not assigned to therapists on the basis of the patients' own preference.

Analysis

The data were analyzed using the Statistical Package for Social Sciences (SPSS) for Windows, version 9.0. All variables were summarized using standard descriptive statistics such as means, standard deviations, and frequencies. Additionally, correlational analyses were conducted to examine relationships between all variables of interest. To distinguish independent predictors of importance of ethnic matching, logistic analyses were conducted (Tabachnick & Fidell, 2001). The continuous independent variables age and length of stay in the Netherlands, as well as the ordinal independent variable education were transformed first by dichotomization according to the medians before entering the regression analysis. A direct (standard) logistic regression analysis was performed with importance of ethnic matching as the dependent variable, and gender, ethnicity (Turkish or Moroccan), age (<36 or ≥ 36 years), length of stay in the Netherlands (<18 or ≥ 18 years), education (lower professional or vocational/university), and source of income (paid job or social benefit) as independent variables. Another direct logistic regression analysis was conducted with service satisfaction as the dependent variable and gender, ethnicity (Turkish or Moroccan), age (<36 or ≥ 36 years), length of stay in the Netherlands (<18 or ≥ 18 years), education (lower professional or vocational/university), source of income (paid job or social benefit), and ethnic matching (ethnically similar therapist–patient dyad or ethnically dissimilar therapist–patient dyad) as independent variables.

Significance of the individual indicators was assessed by Wald χ^2.The overall goodness of fit was determined using the likelihood ratio χ^2 test (Hosmer & Lemeshow, 1989). In order to assess the importance of the predictors, odds ratios were calculated.

Results

The Importance of Ethnic Matching

The frequency distribution of the ethnic-matching preference of the total Mediterranean outpatients sample is shown in Table 1. More than half of the participants ($N = 91$, 65.0%) did not value ethnic similarity in the patient–therapist relationship to be important. A third ($N = 44$, 31.4%) considered ethnic equivalence either important or very important, predominantly for "a better communication and comprehension in the treatment." Moroccan outpatients considered ethnic matching to be significantly less important than did Turkish outpatients, $\chi^2 = 12.68$, df = 1, $p < .001$. Logistic regression analysis yielded ethnicity as the only variable independently predictive of importance of ethnic matching (Table 2).

Ethnic Matching Between Therapists and Outpatients

Data on actual ethnic similarity in therapist–patient interactions were obtained for 114 respondents (51 Moroccans and 63 Turks; the remaining respondents participated in another part of the survey and were not specifically asked). Most outpatients ($N = 92$, 80.7%) had a native Dutch therapist, 18 outpatients (15.8%) were treated by an ethnically similar therapist (Table 3). In four cases, the ethnicity of the dyad was not known. Slightly more Moroccan outpatients were treated by an ethnically similar therapist than were Turkish outpatients, although this did not reach significance, $\chi^2 = 3.57$, df = 1, $p = .059$.

Service Satisfaction and Ethnic Matching

Two-thirds of the outpatients ($N = 75$, 65.8%) were reasonably to very satisfied with the services; one third ($N = 36$, 31.5%) was moderately to completely dissatisfied (Table 4). In the satisfaction reports, no significant differences between Turkish and Moroccan respondents were found, $\chi^2 = 4.64$, df = 3, $p = .200$. Outpatients with an ethnically similar therapist did not report more satisfaction with the service provided than those who had a dissimilar therapist, $\chi^2 = 3.596$, df = 3, $p = .309$ (Table 5). Logistic regression analysis yielded no variables independently predictive of service satisfaction (Table 6).

Table 1
*Frequency Distribution for Variable Importance of Ethnic Matching (*N = *140*)*

Variable	*N* (%)	*N* (%)	*N* (%)
	Moroccan	Turkish	Total
	58 (41.4)	82 (58.6)	140 (100.0)
(Very) Important	9 (15.8)	35 (44.9)	44 (31.4)
Not at all Important	48 (84.2)	43 (55.1)	91 (65.0)

**Note*: Of five persons the opinion was not known.

Table 2
*Summary of Direct Logistic Regression Analysis for Variables Predicting Importance of Ethnic Matching (*N = *140)*

Variable	B	SE	Wald	OR
Ethnicity	1.53	.47	10.45**	4.63
Gender	.01	.43	.00	1.02
Age	.53	.43	1.54	1.70
Stay in the Netherlands	.54	.44	1.54	1.71
Education	.16	.43	.14	1.18
Source of Income	−.17	.64	.07	.84

Note: R^2 = Cox & Snell R^2, R^2 =.13; −2 Log Likelihood = 147,88 (χ^2 = 17.95, df = 6, $p < .01$); *$p < .05$, **$p < .01$.

Discussion

In order to make the service-delivery system more compatible with cultural expectations of care, investigators, as well as ethnic-minority counselors, have recommended that therapists and counselors should share the culture and language of the patient (American Psychological Association Office of Ethnic Minority Affairs, 1993; Aponte, Rivers, & Wohl, 1995; Cheung & Snowden, 1990; Nevid, Rathus, & Greene, 1997). However, empirical evidence concerning the actual importance of ethnic matching to patients is equivocal. Results of the present study with Mediterranean community mental-health-center outpatients in the Netherlands suggest the following:

1. More than half of the Mediterranean CMHC consumers did not prefer ethnic matching, but a substantial minority (especially Turkish respondents) considered it important to very important.
2. Outpatients in an ethnically equivalent dyad did not report to be more satisfied with the service provided compared to those attended by a native Dutch professional.

We conclude that ethnic matching is preferred by some ethnic-minority outpatients, but certainly not by all. Many people reported experience and clinical competence as more important than ethnic background. Furthermore, some people ($N = 10$) explicitly preferred indigenous Dutch service providers, stating these to be more skilled professionals: "They are better educated, do not gossip and are far less focused on prescribing

Table 3
*Frequency Distribution for Variable Ethnic Similarity in the Patient-Therapist Dyad (*N = *114*)*

Variable	*N* (%)	*N* (%)	*N* (%)
	Moroccan	Turkish	Total
	51 (44.7)	63 (55.3)	114 (100.0)
Similar Therapist	12 (23.5)	6 (10.2)	18 (15.8)
Dissimilar Therapist	39 (76.5)	53 (89.8)	92 (80.7)

**Note*: Of four persons the ethnicity of their therapist was not known.

Table 4
Frequency Distribution for Variable Service Satisfaction (N = 114)*

Variable	*N* (%)	*N* (%)	*N* (%)
	Moroccan	Turkish	Total
	51 (44.7)	63 (55.3)	114 (100.0)
Completely Dissatisfied	6 (12.0)	10 (16.4)	16 (14.0)
Moderately Dissatisfied	12 (24.0)	8 (13.1)	20 (17.5)
Reasonably Satisfied	16 (32.0)	29 (47.5)	45 (39.5)
Very Satisfied	16 (32.0)	14 (23.0)	30 (26.3)

**Note*: Of three persons the opinion was not known.

medication ('pills') only." Confidentiality becomes a real concern if the minority population in the community is relatively small. Patients from a minority background may prefer to be treated by a therapist from outside their own group. Negative ethnic transference also may occur. The patient may not trust a therapist of his own kind, with a minority or disadvantaged background, and may prefer to be treated by a therapist from a majority group. Nevertheless, knowledge of the culture was considered important for an adequate treatment. Additionally, it is advisable to employ more bilingual and culturally different professionals able to treat patients from several cultural backgrounds. As a substantial number of Mediterranean patients do not have fluency in Dutch, they can profit from therapists who conduct therapy in their own mother tongue.

It is intriguing that Moroccan outpatients especially did not express an ethnic matching preference. Moroccans form a relatively problematic and supposedly less-integrated group in the Netherlands. Maybe the ethnic background of the therapist is of lesser concern in this group because of a more urgent help demand. Another possibility is that a fear for gossiping in the rather close-knit community accounted for the low preference. The risk of stigmatization because of mental illness is considerable as well. Since several Moroccans do have notable language difficulties in the Netherlands, it nevertheless remains a complicated result that is hard to explain satisfactorily. However, it could represent a difference in preference, as the vast majority of migrants originating from Surinam in the Dutch general population did not consider ethnic resemblance that important either (see Knipscheer, 2000).

Table 5
Frequency Distribution for Variable Service Satisfaction (N = 114)*

Variable	*N* (%)	*N* (%)	*N* (%)
	Ethnically Matched	Ethnically Non-matched	Total
	18 (15.8)	91 (80.7)	109 (100.0)
Dissatisfied	4 (22.3)	31 (34.1)	35 (32.1)
Satisfied	14 (77.7)	60 (65.9)	74 (67.9)

**Note*: Of five persons the opinion was not known.

Table 6
*Summary of Direct Logistic Regression Analysis for Variables Predicting Service Satisfaction (*N = *114)*

Variable	B	SE	Wald	OR
Ethnicity	.43	.45	.89	1.53
Gender	.02	.47	.00	1.02
Age	.30	.45	.45	1.35
Stay in the Netherlands	−.46	.46	.98	.63
Education	.04	.46	.01	1.04
Source of Income	−.01	.70	.00	.99
Ethnic Matching	−.56	.64	.77	.57

Note. R^2 = Cox & Snell R^2, R^2 =.03; −2 Log Likelihood = 131,02 ($\chi^2 = 2.77$, df = 7, $p = .91$); *$p < .05$, **$p < .01$.

Furthermore, an ethnically similar therapist–patient relationship did not create more satisfaction with the services than an ethnically dissimilar dyad. Since ethnic similarity often is pictured as providing a safe and trustful situation, this is a rather intriguing result as well. The finding is supported by a review by Tseng (1999), who stressed there is no doubt that congruence of cultural background between therapist and patient can benefit the therapy process; however, the usual assumption that every client is better treated by a therapist of the same cultural background does not hold validity. Besides, from a practical point of view, there always will be too few therapists of various cultural backgrounds to match that of the patient in every case. Therapists who are clinically well trained and sensitive to their patients' cultural background can provide successful treatment even though their ethnicity may differ from that of the patient (Tseng, 1999). In fact, ethnic matching of client and therapist is not the solution to improve intercultural therapy because it can imprison the professional and the client in their own racial and cultural identities and diminishes the human element (Kareem & Littlewood, 2000).

To conclude, ethnicity may be, as Sue (1998) put it, ". . . more of a demographic variable than a psychological variable. The psychological aspects (e.g., identity, attitudes, beliefs, and personality) may be of greater importance" (Sue, 1998, page 442). Furthermore, treatment satisfaction is not equivalent to treatment effectiveness. A condition that is related to favorable outcomes within an ethnic match is most particularly a *cognitive* match: matches between therapists and patients in how they conceptualize goals for treatment and means for resolving problems (Sue, 1998). It could be a matter of sharing the same worldview; this is how a person perceives his/her relationship to the world. Possibly, it is the fear of a clash of worldviews within ethnically dissimilar counseling dyads that underlies much of the preference for—and satisfaction with—ethnic similarity in counseling and therapy. Consequently, 'worldview sharing', not ethnic background, may be crucial in treatment (Leong, Wagner, & Tata, 1995). This would be consistent with our findings suggesting the significance of empathy and comprehension beyond ethnic matching, and the lack of "guaranteed satisfaction" in an ethnic-match situation.

In order to provide an adequate delivery of mental-health services, it is not advisable for counselors and therapists to make assumptions about their patients' attitudes toward treatment based on ethnicity alone (Ruelas, Atkinson, & Ramos-Sanchez, 1998). Considerable differences between ethnic groups within the Mediterranean population may exist. Therefore, generalizations concerning "the Mediterranean outpatient," let alone all

ethnic patients, should be avoided. Our results implicate a need to train therapists to create openness to the cultural background of the patient and to understand the worldviews of their patients. Ethnic matching *per se* is no must—sensitivity, clinical competence, and worldview sharing seem to be as important. Therefore, culturally sensitive indigenous therapists may treat ethnic minorities just as well as therapists with matching cultural backgrounds.

A limitation of the current study is its retrospective nature and reliance on self-reports. Retrospective reporting may result in aspects or nuances of particular experiences being forgotten or misremembered. Respondents' reports may be biased by response sets, pre-existing beliefs, and self-presentational style. Additionally, the responses of the participants could be biased by concerns or fear that the therapists may have access to their responses, and consequently his/her service could be affected. Concerning methodological issues, the single items in the present study may be psychometrically inadequate to accomplish the task for which they were intended. Furthermore, caution must be taken with some results considering the potential lack of "power" for detecting differences in the statistical analyses. In particular, with regard to the analysis of the satisfaction variable, poor power may explain the lack of effect of ethnic matching.

Future research into treatment should lead to clarification as to why specific ethnic groups and individuals within these groups have a greater preference for ethnic matching. Furthermore, more in-depth understanding of the reasons for (dis)satisfaction with ethnically similar therapists should be gained. Moreover, future studies containing larger sample sizes should provide more insight into the robustness of the findings presented here.

When a choice is possible, ethnic-minority patients should be asked for their preferences with regard to the ethnic background of a therapist. However, matching an ethnic-minority patient to an indigenous professional is certainly not by definition a mismatch—as long as the therapist displays "cultural sensitivity."

Appendix

*Correlations Among All Variables in Study (*N = *140)*

	1	2	3	4	5	6	7	8	9
1. Ethnicity	–	.21*	.14	.03	−.16	.10	.18	.31**	−.08
2. Gender		–	−.24**	−.17*	−.10	.18*	.18	.03	−.02
3. Age			–	.35**	−.28**	.07	.05	.19*	−.13
4. Stay in the Netherlands				–	−.24	.06	.16	.08	−.13
5. Education					–	−.05	−.07	−.01	.07
6. Source of Income						–	−.09	.02	−.04
7. Ethnic Matching							–	−.13	−.16
8. Importance of Ethnic Matching								–	−.15
9. Service Satisfaction									–

Note. *$p < .05$, **$p < .01$.

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