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The Influence of Therapist Race on Preferences in Racial/Ethnic Matching

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Abstract

Racial and ethnic minority groups may face barriers when pursuing psychotherapy, and racial/ethnic matching has been proposed as one solution to meet the needs of these clients. Some research suggests that African Americans hold the strongest preference for a same-race therapist, but this preference is not observed in other studies. This study investigated the potential role of therapist race on perceptions of therapists, including the likelihood of wanting to work with the therapist which served as the proxy for matching preferences. Analysis indicated that on all measures, Black therapists were rated more positively by both Black and White participants. However, for some perceptions of the therapist, this preference for Black therapists was stronger among Black participants than White participants. These findings suggest that, at least for a college-age sample, Black therapists appear to be preferred and viewed more positively among a wider population rather than being limited to African Americans.

Keywords: Racial/ethnic matching, Therapeutic Alliance, Preference

The Influence of Therapist Race on Preferences in Racial/Ethnic Matching

Racial and ethnic minorities (REM) can face disparities when pursuing health care (Smedley et al., 2003; Williams & Mohammed, 2009) and this extends to mental healthcare (Whaley & Davis, 2007). Among REM groups, African Americans are less likely to pursue psychiatric care (Snowden & Yamada, 2005; Sue & Sue, 1990) and those who do, attend fewer sessions (Crow et al., 1994) and are more likely to dropout prematurely (Fortuna et al., 2010). Research has pointed to several factors to explain this, including perceptions of discrimination, mistrust of medical providers, and stigma regarding mental health and psychological services (Freiman & Cunningham, 1997; Unützer et al., 2003). While these factors are not limited to African Americans, the present study narrowed its scope to focus solely on this group.

Discrimination

For REM groups, discrimination may take the form of microaggressions (Hook et al., 2016; Owen et al., 2017). These microaggressions may be explicit verbal and nonverbal degradation (i.e., microassault), demeaning statements (i.e., microinsults), and statements that undermine the experiences of People of Color (microinvalidations; Sue et al., 2007). A significant effect of microaggressions is psychological distress (Mercer et al., 2011). Microaggressions also occur in the therapeutic process (Constantine, 2007; Hook et al., 2016; Owen et al., 2017). Within therapy, microaggressions represent a rupture in the working alliance, particularly the bond (Eubanks-Carter et al., 2012). While investigating microaggressions, Owen et al. (2018) found that only 52% of therapists could identify at least one microaggression during simulated therapy sessions. Moreover, participants rated the therapists who used a microaggression as less sensitive and less

culturally comfortable than therapists who did not commit a microaggression. A majority of therapist participants in the study were White, which may signify that many White therapists are not able to identify when these ruptures occur among their peers and possibly in their own therapeutic work (D'Andrea, 2005; McMaster et al., 2021; Neville et al., 2001). The topic of race and race-related issues is often a source of discomfort for White therapists (Knox et al., 2003). In that discomfort, some therapists may rarely broach the topic with clients (Knox et al., 2003) attribute client issues to socioeconomic factors (e.g., class), or outright deny that race played a role in a client's presenting problems (McMaster et al., 2021). Among REM clients, racial microaggressions made by the therapist lower their perceptions of the therapist's overall and multicultural competence, as well as their perception of the working alliance (Constantine, 2007; Owen et al., 2011).

Mistrust of Medical Providers

African Americans tend to have mistrust for healthcare institutions and the White providers who deliver treatment (Duncan & Johnson, 2007; Gamble, 1993; Whaley, 2001). Within the psychotherapy field, similar sentiments have been noted as well. At one time among African American focus group members, psychologists were described as "older White males, who were unsympathetic, uncaring, and unavailable" as well as "impersonal" (Thompson et al., 2004, p. 23). Participants in the same study were also concerned with psychologists misdiagnosing their symptoms or simply labeling them as "crazy" (Thompson et al., 2004, p. 23). Concerns regarding diagnoses are not unfounded for many clients. Physicians are less likely to detect and diagnose psychiatric disorders, particularly depression, in African Americans, compared to Whites in primary care

settings (Borowsky et al., 2000). In emergency room settings, African Americans and other REM groups are also diagnosed less accurately compared to their White counterparts (Strakowski et al., 1997). For African Americans who do receive a depression diagnosis, they are less likely to receive an antidepressant prescription (Gonzalez et al., 2008; Melfi et al., 2000; Snowden & Pingitore, 2002). Though practices have changed, at one time, African Americans who did receive a prescription were more likely to be prescribed tricyclic antidepressants (TCAs) over selective serotonin reuptake inhibitors (SSRIs; Melfi et al., 2000). There is evidence demonstrating comparable efficacy between the two classes, but SSRIs were shown to have higher tolerability and lower rates of discontinuations (Anderson, 2000). Regarding medication, the opposite has been found. In one study, compared to 15% of White patients, 27.4% of African American patients were given excessive dosages of antipsychotic medication (Lehman et al., 1998). Excessive dosages may be related to overestimations of the risk of violence for these patients (Garb, 1998). Increased perceived risk of violence or dangerousness has been found to be related to dosage (Baldessarini et al., 1995; Rabinowitz et al., 2003).

Among the psychiatric disorders, schizophrenia has been of particular interest due to their diagnosis rate among REM groups. Barnes (2008) researched 2,404 people who were admitted to Midwestern state psychiatric hospitals. The researcher found that race was the strongest predictor of an admission diagnosis of schizophrenia. Compared to Whites, African Americans were upwards of three to four times as likely to be diagnosed with schizophrenia (Barnes, 2004; Eack et al., 2012; Minsky et al., 2003; Neighbors et al., 2003). Furthermore, African Americans, compared to Whites, were more likely to be diagnosed with schizophrenia paranoid-subtype and less likely to be diagnosed with

bipolar and major depressive disorders (Barnes, 2008; Snowden & Pingitore, 2002). Hypotheses that have attempted to explain this overrepresentation have included clinicians' misinterpretation of "healthy cultural paranoia" (Whaley, 2001), clinician differences in applying diagnostic criteria (Trierweiler et al., 2006), and a reliance on stereotypes (Schwartz & Feisthamel, 2009).

On explanatory example cited in understanding the origins of African Americans' feelings of mistrust is the Tuskegee Syphilis Study, which ran from 1932 to 1972. In 1932, the United States Public Health Service (USPHS) began their study aimed at recording the natural course of untreated syphilis. Six hundred African American men were recruited. Of those recruited, 399 had syphilis and 201 who did not were matched (Heintzelman, 2003). The men were told they were being treated for "bad blood" and in exchange for their participation, they would receive free medical exams and free meals. By 1943, penicillin was identified as the choice treatment for syphilis, but the men in the study were denied access. The disease was unintentionally passed on to many of the men's wives and newborn children. Over 100 people died as a result of advanced syphilis. Many African Americans continue to reference the Tuskegee study as an example of racist attitudes present in medical research (Freimuth et al., 2001).

Stigma

Stigma regarding treatment-seeking can be split into two types: public/social stigma (the belief that someone who seeks psychological care is perceived as flawed) and self-stigma (a person's negative beliefs about themselves for seeking psychological care; Corrigan, 2004; Vogel et al., 2006). For both types, perceptions of mental illness also play a role.

Varying opinions among REM groups exist regarding mental illness, but a frequent belief is that mental illness was both inappropriate in family settings to discuss (Alvidrez et al. 2008) but also something that should only be addressed within the family (Carpenter-Song et al., 2010; Wynaden et al., 2005). Cultural messages among African Americans regard mental illness as a source of shame and an issue that afflicts “crazy” people (Alvidrez et al., 2008). Some are taught that African Americans are built to handle life’s challenges and mental health concerns are things to be dealt with quietly (Venner & Welfare, 2019). Seeking help (i.e., psychotherapy) may be seen as a sign of weakness and reflect poorly on a family’s ability to manage internal problems (Alvidrez et al., 2008; Thompson et al., 2004). However, this association can lead to ostracization which may prompt some African Americans to dissolve friendships and move away from family (Alvidrez et al., 2008). Even among those who may not have been treated differently, many African Americans feel ashamed for needing treatment and worry that they are different from other community members (Alvidrez et al., 2008).

Racial/Ethnic Matching

Racial/ethnic matching, defined simplistically, is the process of matching a client and therapist based on shared race or ethnicity (Cabral & Smith, 2011). A significant assumption is that a client and therapist who share a racial or ethnic background will result in stronger therapeutic alliances (Sue, 1977; Sue et al., 1991). That similarity is believed to boost credibility (Simons et al., 1970) and decrease reliance on negative stereotypes because both parties are part of the same in-group (Ames, 2004). Another assumption of racial/ethnic matching is that the dyad will share values which will improve client outcomes (Kelly & Strupp, 1992; Kohatsu et al., 2000). These shared

values should translate into multicultural competence. However, previous research on the benefits of racial/ethnic matching has been mixed. Among REM clients, researchers have found a preference for therapists of the same race/ethnicity (Cabral & Smith, 2011; Coleman et al., 1995), with African Americans possessing the strongest preference (Cabral & Smith, 2011; Thompson et al., 2004). Research has suggested that African Americans experience greater minority status stress, which has been associated with negative mental health outcomes (Cokley et al., 2013). Furthermore, minority status stress may influence preferences for who may provide assistance (Smedley et al., 1993). Meaning, REM group members who have experienced minority status stress have a stronger preference for a racially/ethnically similar therapist (Nioplias et al., 2018).

A meta-analysis performed by Maramba & Hall (2002) found that among seven studies, racial/ethnic matching was not a significant predictor for decreasing dropout after the first session or subsequent sessions. Racial/ethnic matching has also been found to have little to no benefit on treatment outcomes (Cabral & Smith, 2011; Sterling et al., 2001). However, these results have not been universal as racial/ethnic matching was found to directly improve global assessment of function (GAF), as well as increase the number of therapy sessions attended (Kim & Kang, 2018).

Though previous research has pointed to racial/ethnic preferences among REM groups, results have been mixed. While African Americans have been shown to favor matching, having a racially/ethnically similar therapist is not a universal sentiment (Atkinson & Lowe, 1995). Furthermore, the value placed on racial/ethnic matching may be outweighed by the desire for a culturally competent therapist, even at the cost of treatment efficacy (Swift et al., 2015).

The purpose of the present study was to assess the potential role of therapist race on perceptions of a therapist. Specifically, the perceived importance of racial/ethnic matching. This study aimed to add to the literature regarding what factors clients may evaluate when considering whether to pursue psychotherapy services with a therapist. Additionally, this study aimed to add to the literature on racial/ethnic minority client preferences. Past research has identified African Americans as one group with strong preferences for racial/ethnic matching, and the present study sought to explore if those results would be found with the present sample. The study sought to answer the following questions: Is there a preference for racial/ethnic matching? Do racial/ethnic matching preferences vary based on therapist sex?

Method

Participants

Students enrolled in psychology courses from the University of Memphis were recruited through the SONA system software. A total of 198 participants completed the study. One participant was removed for failure to complete the study, and three were removed for incorrect responses to the attention check question. As the therapist vignettes (see below) featured Black and White therapists, only participants who identified as White or Black were included. As a result, 25 participants who identified their race as other than White or Black (i.e., Native American, Asian, Pacific Islander) were removed. Analyses were conducted with the remaining 169 participants. 18.3% identified as male and 81.7% identified as female. 60.4% of participants identified their race as White and 39.6% identified as Black. The average age was 20.9 years. 76.3% of participants

reported that they were not currently accessing psychotherapy or counseling services. Participants were compensated 0.5 course credits for their participation.

Measures

Likelihood of seeing the therapist

Participants' preference for racial/ethnic matching was posed as a likelihood of seeing a therapist using the question, "If you had a mental health concern, how interested would you be in having this person as your therapist?" The question was created for the purpose of the present study. The question was rated using a nine-point Likert scale ranging from 1 (Not at all) to 9 (Very much).

Perceptions of the Therapist Questionnaire

This four-item measure was created for the purpose of the present study (see Appendix A). The questionnaire was used to assess participants' perceptions of the therapist in four categories: similarity, interpersonal abilities, comfortability, and trust. The measure was rated using a nine-point Likert scale ranging from 1 (Not at all) to 9 (Very much).

Demographics

Participants reported their race, age, sex at birth, and psychotherapy/counseling experience.

Therapist vignettes

Vignettes of mock therapist biographies were created which featured a picture and biography. Eight images were used: two African American females, two African American males, two White females, and two White males (see Figure 1). Two therapist vignettes were adapted from online directories (see Figure 2). Each vignette featured one picture and one version of the biography. A total of eight vignettes were created.

Procedure

The study was administered through Qualtrics, a free survey platform. Participants were provided with a consent form prior to the survey, confirming their agreement to participate. Once informed consent was provided, participants were randomly assigned to one of 16 experimental combinations using the Qualtrics randomizer. Each combination contained two vignettes. Participants were either presented with a Black or White therapist first. Sex was held constant; participants viewed two male or female therapist vignettes. For example, a participant may have viewed the first picture of the White male and saw either the first or second picture of the Black male next. Alternatively, a participant may have viewed the second picture of the Black female first and had equal chances of being shown the first or second picture of the White female. Participants were asked to review the first vignette. Participants then responded to an attention check question related to the vignette. After completing the attention check, participants were instructed to complete the question regarding the likelihood of seeing the therapist as well as the Perceptions of a Therapist Questionnaire. These steps were repeated for the second vignette excluding the attention check. After responding to both vignettes, participants completed questions related to demographic information, and the study concluded. Upon completion, participants were granted course credit through the SONA system.

Results

A preliminary analysis was conducted to see intercorrelations between the primary dependent variable (i.e., likelihood of seeing the therapist) and additional variables (i.e., similarity, interpersonal abilities, comfortability, trust). For perceptions of White therapists, likelihood of seeing the therapist was moderately positively correlated with similarity ($r(167) = .66$, $p < .001$) and trust ($r(167) = .66$, $p < .001$). Likelihood of seeing

the therapist was strongly positively correlated with interpersonal abilities ($r(167) = .70$, $p < .001$) and comfortability ($r(167) = .75$, $p < .001$). See Table 1 for correlations among the secondary dependent variables. For perceptions of Black therapists, likelihood of seeing the therapist was moderately positively correlated with similarity ($r(167) = .50$, $p < .001$), interpersonal abilities ($r(167) = .64$, $p < .001$), and trust ($r(167) = .62$, $p < .001$). Likelihood of seeing the therapist and comfortability were found to be strongly positively correlated, $r(167) = .73$, $p < .001$. See Table 2 for correlations among the secondary dependent variables. The decision was made to keep all variables separate.

The main analysis was conducted using a therapist race (Black/White) × participant race (Black/non-Black) × therapist sex (male/female) × therapist race order (Black therapist presented first/White therapist presented first) analysis of variance with therapist race as the repeated measures factor.

Tables 3 through 7 present results for each of the five dependent variables. As can be seen in the tables, there is a significant main effect for all variables. On all variables, the Black therapists were rated higher than the White therapists. The results of the simple effects for all variables can be seen in Table 8.

Significant interactions were suggested between therapist race and participant race for the following variables: similarity, comfortability, and trust (see Tables 4, 6, and 7). The difference in ratings for Black and White therapists was significantly greater for Black participants compared to White participants (see Table 9). The analysis did not find a significant interaction for the likelihood of seeing the therapist variable (see Table 3).

Significant interactions were suggested between therapist race and therapist sex for the following variables: similarity, interpersonal abilities, comfortability, and trust (see Tables 4 through 7). The difference in ratings for Black and White therapists was

significantly greater for male therapists compared to female therapists. The results of the simple effects for all variables can be seen in Table 10.

The interaction between therapist race and therapist race order was significant for the following variables: likelihood of seeing the therapist, similarity, and trust (see Tables 3, 4, and 7). The difference in ratings was significantly greater when the White therapist was presented first compared to when the Black therapist was presented first. Results of the simple effects can be seen in Table 11.

No significant interactions were found between therapist race, participant race, and therapist sex. No significant interactions were found between therapist race, participant race, and therapist race order. No significant interactions were found between therapist race, therapist sex, and therapist race order. Lastly, no significant interactions were found between therapist race, participant race, therapist sex, and therapist race order.

Discussion

In the current study, the main findings were that: on all dependent variables (i.e., likelihood of seeing the therapist, similarity, interpersonal abilities, comfortability, trust), participants provided higher ratings for the Black therapists compared to the White therapists. In particular, participants rated a higher likelihood of seeing the Black therapist. These results depended on participant race and therapist sex for some variables. Additionally, the order in which therapists were presented influenced some ratings.

The primary question guiding this study concerned whether there was a preference for racial/ethnic matching. Results of the study did not suggest a preference, inconsistent with past research, especially those concerning African Americans (Cabral & Smith, 2011). However, there was evidence of a general preference for Black therapists. For African Americans in the sample, this result would be of little surprise as the literature has supported the claim of strong preferences among this group (Cabral & Smith, 2011). However, a preference among White participants requires further exploration.

Compared to non-White clients, White clients view race and cultural issues as being of lesser importance in the therapy process (Meyer & Zane, 2013). Racial/ethnic matching also seems to be of lesser importance for White clients (Cabral & Smith, 2011). In the current study, White participants contributed to scores indicating a preference for a Black therapist. Similar results were found in Bernstein et al. (1987) and social desirability was considered. White participants were being led by an African American experimenter which may have influenced their preference for a Black therapist. In the current study, participation was conducted online with no researcher presence and minimal identification. However, the possibility of White participants artificially inflating ratings. The possibility of these participants attempting to engage in colorblind racial ideology (CBRI) has also been discussed. CBRI, defined plainly, is a belief system based on the idea that race does not matter, as well as racism not being a factor in interpersonal

interactions or a structural issue within institutions (Neville et al., 2000; Neville et al., 2014). In the current study, participants were asked to rate how similar they believe themselves to be to both a Black and White therapist. One of the tenets of CBRI is an emphasis on similarity and minimization of racial differences. White participants may have relied on this way of thinking to assign ratings of similarity and desire to see a Black therapist. However, some research has pointed to greater endorsement of colorblind racial ideology as being associated with more negative perceptions of non-White groups (Howard, 2019). While it cannot be discounted, there is the possibility of CBRI not being of great influence on these participants.

Therapist race and participant race

This study attempted to provide an answer to the question of whether there were preferences for racial/ethnic matching. The results do not support the notion of racial/ethnic matching preferences, contradicting previous research (Cabral & Smith, 2011). However, evidence was found to support the idea of participants valuing other therapist characteristics which may serve as potential markers of racial/ethnic matching preferences (Stewart et al., 2013). This possibility is supported by the data, with all secondary variables (i.e., similarity, interpersonal abilities, comfortability, trust) showing moderate to strong associations with the likelihood of wanting to see the therapist, the variable used to assess racial/ethnic matching preferences. Considering past research on matching preferences involving African Americans, this idea deserves further exploration, especially considering the significant difference in scoring between Black and White participants on some secondary variables. The question asking participants to rate their similarity with the therapists was left intentionally vague. Meaning, participants' sense of similarity to the therapist could have been regarding attributes and beliefs (i.e., personal similarity) or their race (i.e., ethnic similarity; Street et al., 2008). Possibly for Black participants, these dimensions were intertwined.

For Black participants, their perceptions of a Black therapist and a hypothesized relationship with this therapist were consistent with previous studies: greater perceptions of similarity, comfort, and trust (Moore et al., 2022; Nazione et al., 2019). These participants may have felt more comfortable with a same-race therapist out of the assumption that the therapist would have some shared lived experiences, easing the process of building trust (Moore et al., 2022). On the opposite end, a lack of perceived similarity, comfort, and trust in White therapists may have been influential. Mistrust of (White) healthcare providers has been noted in the literature (Duncan & Johnson, 2007; Gamble, 1993; Whaley, 2001). Research has also noted how cultural mistrust among Black participants predicts a preference for a same-race therapist (Townes et al., 2009). In the current study, participants may have viewed the White therapists as being too dissimilar to understand their needs or may have felt too apprehensive to try (Moore et al., 2022). While racial similarity may be associated with feelings of personal similarity, comfort, and trust (Street et al., 2008), racial discordance or dissimilarity may be associated with the opposite. The ratings of trust by White participants should be noted as well. The concept of cultural mistrust has usually been studied using Black or African American participants, but results from the present study warrant further exploration among White racial group members.

Therapist race and therapist sex

Past studies have reported that there is a preference for a female therapist (Landes et al., 2013; Liddon et al., 2018), or a preference for a therapist not of a participant's sex (Anderson, 2005; Black & Gringart, 2019). In the current study, there was insufficient evidence to support the primary indicator of preference. However, the case has been made for the secondary variables to be considered markers of racial/ethnic matching preferences. To that end, the largest difference in scores given to Black and White participants was for males. Among perceptions of female therapists, scores were not as

significantly different between Black and White therapists. Comparing by sex, female therapists were rated more positively on all variables. Why the disparity in scores for males is not clear. Though not an exhaustive search, the literature comparing perceptions of Black and White male therapists is scarce. In their focus group interviews, Thompson et al. (2004) noted that the general characterization of psychologists was that of an uncaring and impersonal older White male (p. 23). While that study utilized an African American sample, this perception may be relevant to how the present sample perceived White male therapists. The idea that participants would view themselves in closer proximity to the Black male therapists is worthy of further consideration on its own. Similarity was not defined further, so there is no way to determine what characteristics participants found comparable to their own. The variable Interpersonal abilities, on the other hand, was narrowed to the degree to which participants believed the therapists would care about their mental health. It is possible that participants, similar to those in Thompson et al. (2004), found the White male therapists to be less caring, particularly regarding their mental well-being.

Another point of consideration lies in the actual pictures. Among the four images depicting male therapists, only the African American males are depicted with broad smiles. The images of White males feature subtler smiles. Additionally, the White males have low-cut hairstyles, which may be reminiscent of grooming standards employed by police officers. Previous research has noted African Americans holding less favorable views of police compared to their White counterparts (Lloyd et al., 2020; Peck, 2015). Assuming the images in the vignettes match participants' mental representation of police, it is likely those images would generate fewer positive ratings. However, this theory would mainly explain the rating patterns of African Americans. Discounting the possible resemblance to police, all participants regardless of race may have perceived the White male therapists as being less friendly, negatively impacting scores given to them.

The majority of participants were not currently involved in any psychotherapy or counseling services, but that does not consider whether participants previously used these services. Past experiences may have shaped perceptions. However, that would not fully account for perceptions of Black male therapists. Approximately 5.08% of active psychologists in the United States are African American and within that statistic, Black men make up 17% (American Psychological Association, 2022). It is reasonable to assume most participants have not worked with a Black male therapist. Additional research would have to be conducted to ascertain what would elicit these favorable ratings about a group that participants are statistically not likely to encounter.

Therapist race and therapist race order

Though not the focus of the study, the racial order in which therapists were presented was also explored. In part, this was done to identify potential order effects while also examining changes in perception. To address the first issue, the current study employed counterbalanced conditions and a relatively concise design to mitigate participant fatigue or disinterest. In spite of these efforts, the likelihood of seeing the therapists as well as two secondary variables (i.e., similarity, trust) were influenced by order. However, it was found that the order effect coincided with the direction of the main effect. This would suggest that the influence of order was minimal. Additionally, no evidence was found to suggest that any higher order interactions were impacted by therapist race order. The issue is still a worthwhile endeavor to theorize over, especially through the lens of how perceptions of therapists change from one biography to another.

Throughout these results, a pattern of attributing higher ratings to the Black therapists has been highlighted. Interestingly enough, the difference in scoring was most pronounced when the White therapist was shown first. In their study, Howard (2019) examined what factors contribute to White participants' selection of a Black therapist. Participants were asked to rank their choice on a four-point scale ranging from 1

(Strongly prefer a White therapist) to 4 (Strongly prefer a Black therapist). Though not an exact match to the current study's design, the 2019 study structured its question on preference in such a way that the option for a White therapist was presented first. In their study, as well as in the current study, Black therapists were rated higher on some variables even as the White therapist was shown first. Another possible explanation may be that the race order acted as a sort of prime. Not unrelated to social desirability, participants may have assumed to know the true purpose of the study after completing the first set of questions about the White therapist and adjusted their next set of ratings for the Black therapist. Those steps were taken to mitigate this possibility, attaching real names to the therapist biographies may have done a better job of concealing study intent Bertrand et al., 2013). The vast majority of psychologists in the United States are White (80.85%) with African Americans making up slightly more than 5% (American Psychological Association, 2022). Though most of the sample stated that they were not currently accessing psychological services, this does not mean that participants have not utilized them in the past. If that is true for some participants, the odds of their therapists being White are high. There is a possibility that their experiences negatively influence their perception of White therapists generally.

Strengths and limitations

Though some novel findings were found, the present study was not without limitations. While the study consisted of a racially diverse sample, participants were recruited from the same university. The attention check question used was created to filter out participants who did not pay close attention to the therapist vignettes. There is the possibility of some participants correctly responding to the question without having paid close attention. Another notable limitation was the use of a scale that has not been previously validated. The study's questionnaire intended to assess participants on four dimensions, but it is possible that the questions asked did not align with the intended aim.

Furthermore, other studies with similar goals employed the use of secondary variables to potentially account for confounding issues such as colorblind racial ideology. Lastly, no pilot testing was completed for the vignette images. It is possible that prior image testing would have revealed lower ratings of friendliness or warmth for the White male images, providing an opportunity for those to be replaced with images that scored higher.

Future Directions

Though the present study was not without its limitations, it does raise questions that are best explored through design modifications. Participant recruitment can be expanded to include college students as well as non-college samples, using online sources. Another improvement would be to expand the number of races and ethnicities presented in the therapist vignettes, as well as use names for each. This may increase the chances of a therapist vignette matching the race of the participant, to better assess racial/ethnic matching preferences. Lastly, future studies should employ previously validated measures. For instance, the Bonner Questionnaire for Therapy and Counseling assesses the client's perception of the therapist's level of empathy, genuineness, and positive regard, similar dimensions considered in the present study (Fuchs et al., 2003). A question asking participants to rate their personal and ethnic similarity to the therapist could be added as well. Modifications could be made to reflect participants' perceptions of a therapist they have not worked with.

Conclusion

The present study aimed to examine the influence of therapist race on racial/ethnic matching preferences and perceptions of a therapist. Results indicated a general preference for Black therapists. The findings in the current study provide relatively novel evidence that racial matching preferences may be more complicated. Furthermore, the study raises questions about the view of racial and ethnic minority therapists, particularly Black therapists, among same and different-race clients.

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Table 1

Correlations for Dependent Variables for White Therapists

	PRIM	SIM	INTER	COM	TRUST
PRIM	-				
SIM	.66	-			
INTER	.70	.45	-		
COM	.75	.72	.66	-	
TRUST	.66	.65	.70	.84	-

Note. PRIM = Likelihood of seeing the therapist. SIM = Perception of similarity to the therapist. INTER = Perception of interpersonal abilities of the therapist. COM = Perception of comfortability with the therapist. TRUST = Perception of trust with the therapist. *ps* < .001.

Table 2

Correlations for Dependent Variables for Black Therapists

	PRIM	SIM	INTER	COM	TRUST
PRIM	-				
SIM	.50	-			
INTER	.64	.39	-		
COM	.73	.54	.64	-	
TRUST	.62	.39	.69	.82	-

Note. PRIM = Likelihood of seeing the therapist. SIM = Perception of similarity to the therapist. INTER = Perception of interpersonal abilities of the therapist. COM = Perception of comfortability with the therapist. TRUST = Perception of trust with the therapist. $ps < .001$.

Table 3

Summary Table for the Repeated Measures ANOVA for Likelihood of Seeing the Therapist

	df	*MS*	*F*	*p*
Participant race (A)	1	1.81	0.35	.554
Therapist sex (B)	1	31.78	6.19	.014
Present order (C)	1	1.52	0.30	.588
A × B	1	16.62	3.24	.074
A × C	1	0.35	0.068	.794
B × C	1	0.33	0.064	.800
A × B × C	1	3.56	0.69	.406
Between Error	161	5.14	-	-
Therapist race (D)	1	52.99	35.58	.000
A × D	1	3.05	2.05	.154
B × D	1	2.81	1.89	.172
C × D	1	6.00	4.03	.046
A × B × D	1	0.42	0.28	.598
A × C × D	1	0.27	0.18	.669
B × C × D	1	1.01	0.68	.412
A × B × C × D	1	0.038	0.026	.873
Within Error	161	1.49	-	-

Note. Present order is defined as the order in which the races of the therapists in the vignettes were presented.

Table 4

Summary Table for the Repeated Measures ANOVA for Similarity

	df	*MS*	*F*	*p*
Participant race (A)	1	12.08	1.92	.168
Therapist sex (B)	1	29.39	4.67	.032
Present order (C)	1	2.23	0.35	.553
A × B	1	16.57	2.64	.106
A × C	1	5.08	0.81	.370
B × C	1	3.04	0.48	.488
A × B × C	1	10.17	1.62	.205
Between Error	161	6.29	-	-
Therapist race (D)	1	52.77	29.04	.000
A × D	1	56.88	31.30	.000
B × D	1	10.02	5.51	.020
C × D	1	16.96	9.34	.003
A × B × D	1	0.53	0.29	.589
A × C × D	1	0.14	0.077	.782
B × C × D	1	0.004	0.002	.961
A × B × C × D	1	1.69	0.93	.337
Within Error	161	1.82	-	-

Note. Present order is defined as the order in which the races of the therapists in the vignettes were presented.

Table 5

Summary Table for the Repeated Measures ANOVA for Interpersonal Abilities

	df	*MS*	*F*	*p*
Participant race (A)	1	2.24	0.52	.471
Therapist sex (B)	1	15.83	3.69	.056
Present order (C)	1	0.23	0.052	.819
A × B	1	7.39	1.72	.191
A × C	1	1.42	0.33	.565
B × C	1	2.18	0.51	.477
A × B × C	1	3.37	0.79	.377
Between Error	161	4.29	-	-
Therapist race (D)	1	22.01	23.52	.000
A × D	1	0.001	0.001	.981
B × D	1	6.11	6.53	.012
C × D	1	0.062	0.066	.797
A × B × D	1	2.05	2.19	.141
A × C × D	1	0.014	0.015	.904
B × C × D	1	0.62	0.66	.416
A × B × C × D	1	0.23	0.24	.624
Within Error	161	0.94	-	-

Note. Present order is defined as the order in which the races of the therapists in the vignettes were presented.

Table 6

Summary Table for the Repeated Measures ANOVA for Comfortability

	df	*MS*	*F*	*p*
Participant race (A)	1	5.00	0.876	.351
Therapist sex (B)	1	54.70	9.58	.002
Present order (C)	1	0.15	0.027	.871
A × B	1	7.04	1.23	.269
A × C	1	0.32	0.056	.814
B × C	1	0.96	0.17	.683
A × B × C	1	8.00	1.40	.238
Between Error	161	5.71	-	-
Therapist race (D)	1	80.83	54.86	.000
A × D	1	8.48	5.76	.018
B × D	1	10.45	7.09	.009
C × D	1	2.44	1.66	.200
A × B × D	1	0.72	0.49	.486
A × C × D	1	0.90	0.61	.435
B × C × D	1	1.42	0.96	.328
A × B × C × D	1	1.17	0.79	.374
Within Error	161	1.47	-	-

Note. Present order is defined as the order in which the races of the therapists in the vignettes were presented.

Table 7

Summary Table for the Repeated Measures ANOVA for Trust

	df	*MS*	*F*	*p*
Participant race (A)	1	32.47	6.64	.011
Therapist sex (B)	1	57.54	11.76	.001
Present order (C)	1	7.08	1.45	.231
A × B	1	1.47	0.30	.584
A × C	1	0.19	0.039	.843
B × C	1	11.28	2.31	.131
A × B × C	1	5.26	1.08	.301
Between Error	161	4.89	-	-
Therapist race (D)	1	80.99	59.82	.000
A × D	1	10.31	7.61	.006
B × D	1	9.73	7.19	.008
C × D	1	6.02	4.45	.036
A × B × D	1	1.96	1.45	.231
A × C × D	1	0.23	0.17	.682
B × C × D	1	1.03	0.76	.385
A × B × C × D	1	0.58	0.43	.514
Within Error	161	1.35	-	-

Note. Present order is defined as the order in which the races of the therapists in the vignettes were presented.

Table 8

Likelihood of Seeing the Therapist and Perceptions of the Therapist Questionnaire Scores for White and Black Therapists

	Therapist race			
	White		Black	
Measure	*M*	*SE*	*M*	*SE*
Likelihood	6.14	.15	6.96	.13
Similarity	4.58	.16	5.39	.16
Interpersonal abilities	6.84	.14	7.37	.12
Comfortability	5.79	.16	6.80	.14
Trust	5.89	.15	6.90	.13

Note. Likelihood = Likelihood of seeing the therapist. Ratings are 1 (Not at all) to 9 (Very much).

Table 9

Scores for White and Black Therapists by Therapist Race and Participant Race

	Therapist race					
	White		Black			
Participant race	*M*	*SE*	*M*	*SE*	*F*	*p*
			Likelihood of seeing the therapist			
White	6.16	.19	6.78	.17	13.05	.000
Black	6.12	.24	7.13	.21	22.55	.000
			Similarity			
White	4.81	.20	4.77	.20	0.027	.870
Black	4.35	.24	6.01	.25	49.75	.000
			Interpersonal abilities			
White	6.92	.17	7.45	.15	15.08	.000
Black	6.76	.21	7.28	.18	9.60	.002
			Comfortability			
White	6.08	.20	6.76	.18	15.92	.000
Black	5.51	.25	6.84	.22	39.66	.000
			Trust			
White	6.39	.18	7.04	.17	15.72	.000
Black	5.40	.23	6.76	.21	45.41	.000

Table 10

Scores for White and Black Therapists by Therapist Race and Therapist Sex

	Therapist race					
	White		Black			
Therapist sex	*M*	*SE*	*M*	*SE*	*F*	*p*
			Likelihood of seeing the therapist			
Male	5.73	.22	6.73	.20	25.38	.000
Female	6.55	.21	7.18	.18	11.22	.001
			Similarity			
Male	4.10	.23	5.26	.24	28.21	.000
Female	5.06	.21	5.52	.22	4.93	.028
			Interpersonal abilities			
Male	6.48	.20	7.28	.17	25.84	.000
Female	7.20	.19	7.45	.16	2.81	.096
			Comfortability			
Male	5.20	.23	6.57	.21	47.79	.000
Female	6.39	.22	7.03	.19	11.98	.001
			Trust			
Male	5.29	.21	6.65	.19	51.12	.000
Female	6.49	.20	7.15	.18	13.60	.000

Table 11

Scores for White and Black Therapists by Therapist Race and Therapist Race Order

	Therapist race					
	White		Black			
Therapist race order	*M*	*SE*	*M*	*SE*	*F*	*p*
			Likelihood of seeing the therapist			
White therapist first	6.07	.21	7.16	.19	32.72	.000
Black therapist first	6.21	.22	6.75	.19	7.61	.006
			Similarity			
White therapist first	4.26	.22	5.54	.23	36.71	.000
Black therapist first	4.89	.22	5.24	.23	2.65	.106
			Interpersonal abilities			
White therapist first	6.83	.19	7.33	.16	10.86	.001
Black therapist first	6.85	.20	7.41	.17	12.68	.000
			Comfortability			
White therapist first	5.69	.22	6.87	.20	38.91	.000
Black therapist first	5.90	.23	6.73	.20	18.20	.000
			Trust			
White therapist first	5.61	.20	6.89	.19	49.89	.000
Black therapist first	6.18	.21	6.91	.19	15.38	.000

Note. Therapist race order = the order in which the therapist race in the vignettes was presented. White therapist first = White therapist presented first. Black therapist first = Black therapist presented first.

Figure 1

Therapist Vignette Pictures

Note. Pictures obtained through online directories.

Figure 2

Therapist Vignette Biographies

Biography 1	Biography 2
My job as a therapist is to serve you in making sense of your world and the thoughts and feelings that color your worldview. In our work together we will establish a course of action and measure our progress. If we need to change the plan to fit your needs, that will happen. Whatever you hope to get out of therapy. I will ensure that our sessions meet that expectation. I am honored to do this work and support you on your journey.	My primary goal as a therapist is to empower my clients to improve their mental and physical well-being, as well as change their behavior for the better. I enjoy helping my clients set goals and providing the tools needed to reach them. Therapy is not a one size fits all process and part of my job is to make the process as personalized as possible to fit your daily life. I am of the belief that everyone is capable of change, and I look forward to the opportunity to work with you.

Note. Biographies adapted from online directories.

Appendix A

Perceptions of the Therapist Questionnaire

On a scale from 1 = Not at all to 9 = Very much, rate your opinions of the therapist:

1. How similar do you think you are to the therapist?
2. How much do you believe this therapist would care about your mental health?
3. How comfortable would you feel talking to this therapist?
4. How much do you think you can trust this therapist?

Note. 1 = Similarity, 2 = Interpersonal Abilities, 3 = Comfortability, 4 = Trust.