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Racial/Ethnic Matching of Clients and Therapists in Mental Health Services: A Meta-Analytic Review of Preferences, Perceptions, and Outcomes

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Abstract

The effects of matching clients with therapists of the same race/ethnicity have been explored using a variety of approaches across several decades. We conducted a meta-analysis of three variables frequently used in research on racial/ethnic matching: Clients' preferences for a therapist of their own race/ethnicity, clients' perceptions of therapists, and therapeutic outcomes. Across 52 studies of preferences, the average effect size was $d = .63$, indicating a moderately strong preference for a therapist of one's own race/ethnicity. Across 81 studies of individuals' perceptions of therapists, the average effect size was $d = .32$, indicating a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists. Across 53 studies of client outcomes in mental health treatment, the average effect size was $d = .09$, indicating almost no benefit to treatment outcomes from racial/ethnic matching of clients with therapists. These three averaged effect sizes were characterized by substantial heterogeneity; the effects of racial/ethnic matching are highly variable. Studies involving African American participants demonstrated the highest effect sizes across all three types of evaluations: preferences, perceptions, and outcomes.

Keywords: race, ethnicity, culture, psychotherapy, therapeutic alliance

Racial/Ethnic Matching of Clients and Therapists in Mental Health Services:

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Although there is evidence that mental illness is as prevalent among African

Americans, Asian Americans, Hispanic/Latino(a) Americans, Native Americans, and

Pacific Islander Americans as it is in the White/European American population (Regier et

al., 1993; Turner, Lloyd, & Taylor, 2006), these individuals are less likely than Whites to

seek mental health services (Alegría et al., 2008; Gallo, Marino, Ford, & Anthony, 1995).

The 1999 U.S. Surgeon General's Report called for further research to investigate the

reasons for the disparities in utilization of mental health services between Whites and

people of color. The 2001 U.S. Surgeon General's supplement report found that "racial

and ethnic minorities bear a greater burden from unmet mental health needs and thus

suffer a greater loss to their overall health and productivity" (p. 3). The concerns

expressed in these reports have paralleled a dramatic increase in the number of studies

investigating multicultural issues in mental health interventions and associated

indications of the importance of increasing multicultural competence among mental

health professionals (Ponterotto, Casas, Suzuki, & Alexander, 2009).

To improve mental health services for people of color, professionals have

emphasized the need for cultural congruence between therapists and clients (Pope-Davis,

Coleman, Liu, & Toporek, 2003; Smith, 2009). Matching therapists with clients of the

same ethnicity is one aspect of practice that has received sustained attention across

several decades (e.g., Møllersen, Sexton, & Holte, 2009; Sue, Fujino, Hu, Takeuchi, &

Zane, 1991). Much of the research described as ethnic matching consists of studies in

which client and therapist share the same racial rather than the same ethnic background.

Because the term *ethnic matching* does not accurately represent the type of similarity

evaluated most frequently in research, we will refer to the matching of client and

therapist based on either race or ethnicity as *racial/ethnic matching*

Theoretical Basis for Racial/Ethnic Matching

For several decades, the general presumption has been that matching clients with

therapists of the same race/ethnicity should result in stronger therapeutic alliances

(Harrison, 1975; Sue, 1977; Sue et al., 1991). This presumption has sound theoretical

underpinnings in social psychology. Worldview similarity fosters interpersonal attraction

(Byrne, 1971). People tend to be attracted to those who share similar perceived physical

attributes (e.g., Berscheid, Dion, Walster, & Walster, 1971). People typically associate

with those they perceive to be similar to themselves (Newcomb, 1961). The application

of these well-established tenets to therapy is obvious: clients should tend to prefer

therapists who are similar to themselves.

Interpersonal similarity not only influences individuals' preferences for social

interactions but also their perceptions of those interactions. Similarity is associated with

credibility (Simon, Berkowitz, & Moyer, 1970). People perceived to be similar to

oneself are more likely to be trusted initially than people perceived to be different. Thus

perceived similarity with others reduces negative stereotyping (Ames, 2004), but it also

increases the likelihood of projecting our own traits onto others (Critcher & Dunning,

2009). In particular, "people assume greater similarity of opinion between themselves

and in-group members than between themselves and out-group members" (Marks &

Miller, 1987, p. 80). In contrast to dyads of different races/ethnicities, clients and

therapists of the same race/ethnicity should be more likely to trust one another initially and also more likely to assume shared worldviews.

Explanations for how interpersonal preferences and perceptions differ as a function of similarity can be found in a variety of sources. Festinger's (1954) theory of social comparison suggests that we prefer to associate with others who are similar to ourselves for purposes of (self-serving) comparisons, but it is also plausible that we first project assumed similarity onto others who then become points of (self-serving) comparison (Miller & Marks, 1982). According to theories of consensus bias (i.e., Ross, Greene, & House, 1977; Marks & Miller, 1987), people tend to perceive their own judgments as being shared by others and alternative perspectives as being unusual or even unacceptable, such that perceptions of similarity with others are normative when contradictory information is unavailable. People typically presume similarity with others (Robbins & Kreuger, 2005) unless differences are brought to attention, such as by physical appearance differences across race/ethnicity. In the specific instance of racial/ethnic matching, this means that clients should be likely to assume alignment with therapists of their own race/ethnicity and unlikely to assume alignment with therapists of another race/ethnicity.

If the therapeutic alliance is likely strengthened under conditions of interpersonal similarity, then it stands to reason that client outcomes in therapy should also benefit. Indeed there is some research evidence that similarities in the values of client and therapist predict positive client outcome (Kelly & Strupp, 1992). Racial/ethnic matching may therefore improve client outcomes by enhancing mutual understanding between client and therapist and by reducing client concerns about being misunderstood or

mistreated (e.g., Kohatsu et al., 2000). At a more pragmatic level, it seems reasonable that shared social networks and shared community structures may also enhance therapist awareness of accessible resources and sources of support. Thus the client-therapist similarity fostered by racial/ethnic matching could possibly influence psychotherapy outcomes.

However, the reality is that clients and therapists of the same race/ethnicity may be very dissimilar. For instance, a female Korean American therapist raised in Houston may have very little in common with a young man who recently emigrated from Myanmar, although a researcher could technically consider this dyad "matched" on race. Even when therapist and client share ethnic backgrounds, interpersonal differences remain on other variables (socioeconomic status, religion, etc.). Thus a presumption of similarity (based on race alone) may result in disappointment, particularly when client and therapist have incongruous values.

This difference between expected vs. actual similarity could weaken the degree to which meeting clients' preferences for racial/ethnic matching translates into improved therapeutic outcomes. Studies of client preferences tap into projected imagination; potential clients asked by a researcher about their racial/ethnic preferences likely imagine a therapist who also shares their own gender, political opinions, etc. Thus studies of individuals' preferences may blur the issue of racial/ethnic similarity with overall interpersonal similarity.

In any case, the social psychological theories described earlier cannot be taken to the extreme. Perfect similarity of client and therapist is not only impossible but also undesirable; differences in perspectives promote insight, facilitate reframing, etc.

Although interpersonal similarity may facilitate effective therapy to some degree, racial/ethnic matching has primarily been promoted for reasons related to racism and multicultural competence (cite~). The specific issue requiring confirmation is whether differences based solely on therapist race/ethnicity are sufficient to justify intentional racial/ethnic matching with mental health clients.

Given the clear implications for practice and for training in multicultural competence (~), it is important to ascertain the exact magnitude of the effects of racial/ethnic matching. In recent decades the number of empirical studies of racial/ethnic matching in mental health services has increased substantially. These studies have investigated several types of variables, most notably clients' preferences, perceptions, and outcomes. Therefore the remainder of this systematic review specifically attends to (a) individuals' preferences for or against racial/ethnic matching, (b) individuals' perceptions of therapists (i.e., credibility, skill, therapeutic alliance) as a function of racial/ethnic matching, and (c) clients' outcomes in mental health services as a function of racial/ethnic matching.

Previous Literature Reviews

To date, three meta-analyses~ (Coleman et al., 1995; Maramba & Nagayama Hall, 2002; Shin et al., 2005) and several narrative literature reviews~ (Flaskerud, 1990; Karlsson, 2005; Sattler, 1977; Sue & Lam, 2002) have summarized the literature on racial/ethnic matching of client and therapist. The largest of these meta-analyses, conducted by Hardin Coleman and colleagues in 1995, included 21 studies conducted between 1971 and 1992. These authors found strong preferences for a therapist of one's own race/ethnicity ($d = .73$) and a small tendency to perceive therapists of one's own

race/ethnicity better than others ($d = .20$). A subsequent meta-analysis by Maramba and

Nagayama Hall (2002) involved seven studies conducted between 1977 and 1999. These

authors found virtually no effect of racial/ethnic matching on client dropout, number of

sessions attended, and level of functioning at termination (Pearson r's = -.03, -.04, and -

.01, respectively). Subsequently, Shin and colleagues (2005) summarized ten studies

between 1991 and 2001. Data specific to African American clients indicated minimal

effects of racial/ethnic matching on drop out, number of sessions attended, and post-

treatment functioning (d's = -.19, -.01, and -.28, respectively).

Thus previous reviews have generally concluded that although people of color

prefer therapists of their own race/ethnicity, racial/ethnic matching in therapy does not

improve client outcomes. Nevertheless, due to the small number of studies included in

previous reviews and the wide variability in the results observed across individual

studies, the field could benefit from greater certainty. Some authors doubt the usefulness

of ethnic matching (Alladin, 2002; Lambert et al., 2006), while the multicultural

psychology literature is open to racial/ethnic matching when practical and non-

discriminatory (e.g., Sue, 1998). Moreover, several questions about the salience of

racial/ethnic matching have not yet been addressed. To what degree do the effects of

racial/ethnic matching differ across studies of different racial/ethnic groups, including

Whites? Does participant age, gender, or level of education moderate the effects of

racial/ethnic matching? Have the results of studies changed over time? Fortunately,

dozens of research studies have appeared in the literature in recent years. These data

necessitate an updated synthesis of contemporary research with specific attention to

variables that might moderate the impact of racial/ethnic matching.

Previous Research on Potential Moderating Variables

       Client race/ethnicity. Given differences in cultural values and mores, it should

not be surprising that racial/ethnic matching may not impact all racial/ethnic groups in

the same manner. For instance, White/European American clients may implicitly expect

to see a therapist of their own race and may therefore initially mistrust a therapist of

color, but this possibility has not yet been confirmed. In contrast, research has

consistently shown that African American clients tend to mistrust mental health services

provided by White/European American therapists (O'Sullivan, Peterson, Cox, &

Kirkeby, 1989; Snowden, 1999; Sue, 1977; Sussman, Robins, & Earls, 1987).

Explanations for this finding include the possibility of a perceived racial bias in the

provision of mental health services and the implicit association of mental health services

with the values of White/European Americans (Maultsby, 1982; Ridley, 1984).

Moreover, racial mistrust among African Americans is moderately associated with their

psychosocial functioning (Whaley, 2001). Many studies conducted in previous decades

indicated that African American clients benefit from racial/ethnic matching in

psychotherapy (Atkinson, 1983, 1985; Griffith & Jones, 1979, Proctor & Rosen, 1981;

Sattler, 1977; Wolkon, Moriwaki, & Williams, 1973). However, some subsequent

studies have found that racial/ethnic matching was not as crucial for African American

clients as previously believed (e.g., Atkinson & Lowe, 1995). Although conclusions vary

somewhat, studies tend to support racial/ethnic matching as being particularly useful for

African American clients.

       The limited literature investigating the effects of racial/ethnic matching with other

racial/ethnic minority groups has yielded mixed results (Karlsson, 2005). For example,

some evidence indicates that Asian Americans may sometimes prefer White/European American therapists due to internalized racism by Asian Americans (Alvarez & Helms, 2001). Results of studies of the preference for racial/ethnic matching among Asian Americans have been inconsistent (Atkinson, Maruyama, & Matsui, 1978; Atkinson & Matsushita, 1991; Atkinson, Poston, Furlong, & Mercado, 1989). Similarly, some studies of Hispanic/Latinos(as) indicate a preference for racial/ethnic matching (Lopez, Lopez, & Fong, 1991; Sanchez & King, 1986), while others document no preference for matching (Acosta, 1979; Acosta & Sheehan, 1976; Atkinson, 1983; Sue, Zane, & Young, 1994). Studies with Native Americans have also generated conflicting results (Atkinson, 1983; Dauphinias, Dauphinias, & Rowe, 1981; Haviland, Horswill, O'Connell, & Dynneson, 1983; LaFromboise & Dixon, 1981). Inconsistency of findings has led some influential scholars to conclude that clients of different racial/ethnic groups should benefit equally from therapy, regardless of whether or not they are racially/ethnically matched with their therapist (i.e., Lambert et al., 2006). It is presently unclear if that conclusion is justified.

Client age, age cohort, gender, and level of education. Client characteristics such as age, gender, and level of education may influence the effects of racial/ethnic matching because these variables are associated with clients' worldviews and experiences. For example, older clients benefit more than younger clients from cultural adaptations in traditional mental health services, presumably because of the association between age and level of acculturation (Griner & Smith, 2006; Smith, Domenech Rodríguez, & Bernal, 2011). Exposure to more overt racial/ethnic prejudice over a longer period of time may also make older populations feel more comfortable working with members of their own racial/ethnic group. Nevertheless, several studies have

demonstrated that even young adult college students prefer therapists of their own

race/ethnicity (Atkinson, Furlong, & Poston, 1986; Atkinson et al., 1989; Haviland et al.,

1983; Ponterotto, Alexander, & Hinkston, 1988; Tharp, 1991). Although there is some

indication that adolescents may benefit from racial/ethnic matching (Wintersteen,

Mensinger, & Diamond, 2005), treatment outcomes for children do not appear related to

racial/ethnic matching (Gamst, Dana, Der-Karabetian, & Kramer, 2004).

It is also possible that research findings regarding racial/ethnic matching have

changed over time, such that any moderation by client age is confounded with age cohort.

Individuals raised in different periods of time have experienced different dynamics of

prejudice and discrimination based on race/ethnicity. The incidence of overt

discrimination has decreased in recent decades; nevertheless, inequities and micro-

aggressions persist (i.e., Morrison & Morrison, 2008). Because no longitudinal studies

on the topic of racial/ethnic matching have been conducted over a period of decades, only

meta-analysis can evaluate whether consistent changes in findings have occurred over

time.

Client gender also might moderate the effects of racial/ethnic matching. Previous

research findings indicate that men may experience stronger in-group bias than women

(Qualls, Cox, & Schehr, 1992; Ekehammar & Sidanius, 1982) and that men seek mental

health treatment less often than women (Takeuchi & Cheung, 1998). Indirectly related to

racial/ethnic matching, studies of gender matching across racial/ethnic groups have

observed benefits for Asian American male clients matched with male therapists, but

gender matching was not beneficial for Asian American female clients (Flaskerud & Liu,

1991) or for African American, Hispanic/Latino(a), or Native American clients (Wu &

Windle, 1980). Because so few studies of racial/ethnic matching have examined differences across client gender, we cannot yet ascertain whether males or females benefit more from racial/ethnic matching.

Because level of education is interrelated with level of acculturation to Western society and with attitudes about professional mental health interventions, it may influence the effects of racial/ethnic matching in therapy. Level of education influences not only attitudes about mental health but also the treatment outcomes observed across racial/ethnic groups (Alvidrez, Azocar, & Miranda, 1996; Atkinson, 1987; Betancourt & Lopez, 1995; Lorion & Parron, 1985; Wolkon et al., 1973). Specific evaluations of how level of education may impact racial/ethnic matching have not been conducted previously.

Purpose of Study

In order to address these complex issues and substantively extend the existing literature, the present study synthesized several times the number of research articles covered by previous literature reviews on racial/ethnic matching. Specifically, our analyses summarized findings relevant to (a) preferences for therapists of individuals' own race/ethnicity, (b) perceptions of therapists across racial/ethnic matching, and (c) outcomes in therapy as a function of racial/ethnic matching. This review also examined several potential moderating variables (e.g., participant age, age cohort, education, gender, race/ethnicity) in order to better understand the dynamics associated with racial/ethnic matching.

Method

Literature Search

  We reviewed studies included in previous meta-analyses that specifically measured preferences, perceptions, or outcomes. We used several techniques to obtain additional published and unpublished studies that have examined racial/ethnic matching of mental health clients and therapists. First, searches were conducted using the following electronic databases: PsychINFO, Academic Search Elite, Criminal Justice Abstracts, CQ Researcher, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Digital Dissertations, Education Resources Information Center (ERIC) databases, Family and Society Studies Worldwide, Medline, PsycArticles, Social Work Abstracts, Sociological Abstracts, Science Citation Index (SCI), Social Sciences Abstracts, and Social Sciences Citation Index (SSCI). We used four distinct sets of search terms across all databases. The first set included the following specific terms all separated by the Boolean "or" operator (with asterisks indicating inclusion of all terms sharing the word root): "ethnic* match*" or "racial* match*" or "cultural* match*" or "matched on/by ethnicity/race/culture." The second set of search terms consisted of the following: (therapist* or psychotherapist* or counselor* or therapy or treatment* or intervention*) and (client* or patient*) and ("same race" or "same ethnicity" or "same racial" or "own race" or "own ethnic*" or "own racial"). The third set of search terms included long lists of synonyms (connected with Boolean "or") for five concepts (connected with Boolean "and"): (ethnic* or multicultural* or cross-cultural or cultur* or racial or race* or trans-cultural or "Native American" or "American Indian" or Hispanic or Latino or Latina or Mexican or Cuban or "African American" or Blacks or Hatian or Asian or Korean or Vietnamese or Japanese or Chinese or "Pacific Islander" or Hawaiian) and (outcome or

data or subjects or experiment or results or empirical or quantitative or statistic* or study

or research or survey or finding* or analy* or method or participants or measure* or

assessment* or test* or hypothesis or questionnaire or collect or number* or quantif* or

random*) and (counsel* or treatment or guidance or therapy or psychotherapy or session

or intake or screening or clinic or service* or interven* or facilitate*) and (match* or

discrepancy or differ* or same or corresponding or parallel or equivalent or comparable

or similar or alike or like or identical or matrix or varied or combination or equal or

diverse) and (prefer* or perceiv* or "own race" or "own ethnic*" or "own racial" or

matched or matching). The fourth set of search terms was identical to the third, except

that the keyword symbol was applied to each synonym for the terms relevant to

ethnicity/race and for the terms relevant to therapy.

The hits resulting from these searches were reviewed initially on the title and then

abstract. Online searches were conducted by multiple individuals to reduce errors in how

the selection criteria (described below) were implemented. When the online hits appeared

to be relevant to racial/ethnic matching in mental health settings, the full manuscripts was

reviewed to confirm inclusion. In order to reduce the number of inadvertent omissions,

online databases were searched one to three additional times over several years (June,

2003 to March, 2007) for studies published through 2006. A subsequent final search

conducted November, 2009 of PsychINFO included studies published through 2008.

Data regarding the exact number of online hits and reasons for exclusion were not

systematically recorded because that practice was uncommon at the time the searches

were conducted; however, the repeated searches of multiple databases over several years

by multiple individuals provided ~methodological replication intended to decrease errors of omission.

Reference sections of located articles were examined to identify additional studies that met inclusion criteria. To solicit additional manuscripts, we emailed authors who had published two or more articles on the topic asking them to provide information regarding other (unpublished) studies that could possibly be included in the meta-analysis.

Inclusion Criteria

Studies that provide quantitative data evaluating individuals' preferences, perceptions, or outcomes relevant to racial/ethnic matching with mental health therapists were included in the meta-analysis. Case studies, single-subject designs, and qualitative research were excluded. We considered all other research designs for inclusion. Studies of individuals' preferences for and perceptions of racial/ethnic matching utilized several research designs, including surveys and analogue research (scenarios created by researchers, such as evaluations of videotaped mental health services provided in matched and unmatched conditions). We restricted studies of treatment outcomes as a function of racial/ethnic matching to clients receiving mental health services provided by therapists with some graduate training.

Our review was intended to broadly address the issue of racial/ethnic match, so we included all research in which the client-therapist combinations evaluated were exclusive to race/ethnicity, irrespective of the particular race/ethnicity involved. Thus pertinent data with White/European Americans were included, and our analytic strategy provided for the disaggregation of results by race/ethnicity.

Because at least two members of the research team were fluent in both English and Spanish (but not other languages), we initially considered all manuscripts written in those two languages (but not others). By the end of our review, however, we had failed to identify relevant manuscripts written in Spanish, so we used exclusively English during data coding.

Data Coding

Graduate and undergraduate research assistants, most with previous experience in meta-analytic coding, received training and supervision specific to this meta-analysis. Coding teams of two members each verified the accuracy of coding and data entry. Two teams reviewed every article. Coders extracted independent and identifiable characteristics from each study, including the publication year and manuscript type (journal article or dissertation/thesis), along with the number of participants and their age, gender, race/ethnicity, and years of education.

Adequate inter-rater agreement was obtained for categorical variables (average Cohen's Kappa value of .78) and for continuous variables (average intraclass correlation value of .96 using one-way random effects models for single measures). Discrepancies across coding teams were resolved through further scrutiny of the manuscript to the point of consensus among coders.

Computation of Effect Size Estimates

Among the studies included in this meta-analysis, several different statistics were reported: correlations, analyses of variance, *t*-tests, odds ratios, chi squares, means and standard deviations, and *p*-values. In order to compare these data across studies, the statistics reported were transformed to standardized mean differences (Cohen's *d*) using

the Meta-analysis Calculator software (Lyons, 1996). If an analysis was reported to be

"statistically significant" but no statistic was provided, the *d* value was determined by the

corresponding *alpha* level (assuming two-tailed *alpha* = .05 unless reported otherwise).

Analyses that reported results as "non-significant" but gave no additional information

were set to effect size *d* = .00. These procedures help yield conservative effect size

estimates. The directions of all effect sizes were coded uniformly on a continuous scale,

such that positive values indicated a comparatively greater preference for or benefit from

racial/ethnic matching and negative values indicated a disinclination for or reduced

benefit from racial/ethnic matching.

   Several studies contained data that were pertinent to more than one of the three

variables evaluated in this review (preference, perception, and outcome). These three

different types of data were handled separately. For instance, if a study contained data

pertinent to both client perceptions and client outcomes, those two types of data were

analyzed apart from one another.

   In some cases, studies contained multiple effect sizes pertinent to one type of

variable being analyzed. For example, some studies assessed several aspects of client

symptom reduction (i.e., anxiety and depression). According to the assumption of

statistically independent samples, there would be a greater likelihood of non-

independence in the data should every effect size be used within an omnibus analysis

(Cooper, 1998; Cooper & Hedges, 1994; Hedges & Olkin, 1985). Therefore, multiple

effect sizes within studies were averaged (weighted by the number of participants

included in the analysis) to compute an aggregate effect size (Mullen, 1989). For

instance, if a study contained two effect sizes pertinent to client perceptions and four

effect sizes pertinent to client outcomes, the two effect sizes were aggregated to obtain a single estimate of client preferences and the four effect sizes were aggregated to obtain a single estimate of client outcomes. Thus any given study contributed only one data point to the distinct analyses of preferences, perceptions, and outcomes.

Data Analyses

Because the results of this meta-analysis were intended to generalize beyond the studies located and because the effects of racial/ethnic matching were presumed to vary across different client and intervention characteristics, random effects models were used in all analyses (Field, 2005). Analyses were conducted using SPSS macros developed by Lipsey and Wilson (2001).

Data were analyzed separately to evaluate preferences for racial/ethnic matching, perceptions of therapists as a function of racial/ethnic matching, and outcomes in therapy as a function of racial/ethnic matching. The obvious differences in these three types of data clearly warranted distinct evaluation in the present review. When a study contained data across more than one of these three categories, effect sizes were disaggregated accordingly. For instance, an effect size pertaining to clients' perceptions of therapists was analyzed separately from effect sizes in the same study pertaining to client outcomes.

Effect sizes specific to individuals' preferences for or against racial/ethnic matching were typically derived from the differences between rated preferences for a therapist of participants' own race/ethnicity and rated preferences for a therapist of any other race/ethnicity. However, a few studies asked directly for participants' preferences for racial/ethnic matching in absolute rather than comparative terms. For these studies, the effect size was calculated from the difference between participants' preferences for a

therapist of their own race/ethnicity and the neutral rating that indicated no preference for therapist race/ethnicity.

Effect sizes specific to perceptions of therapists as a function of racial/ethnic matching were calculated based on the differences between the evaluations provided for therapists of the participants' own race/ethnicity and those provided for therapists of any other race/ethnicity. Effect sizes specific to clients' outcomes consisted of the statistical differences between the outcomes (i.e., symptom reductions) reported with clients matched with a therapist of their own race/ethnicity and clients who had a therapist of another race/ethnicity.

Results

Descriptive Information

A total of 154 studies were located that met inclusion criteria. Across these studies, 52 contained effect sizes specific to participant preferences for therapist racial/ethnic match, 81 contained effect sizes specific to participant perceptions of therapists as a function of racial/ethnic match, and 53 contained effect sizes specific to client outcomes as a function of therapist racial/ethnic match. Table 1 contains descriptive information broken down by these three categories of data. The type of data analyzed within each manuscript is identified in the reference section of this manuscript.

Studies evaluating preferences for therapist racial/ethnic match typically involved surveys administered to non-clinical populations, most often college students. We found a tendency for such studies to have been conducted more often in previous decades than in the recent past. Participants in these studies typically provided preference ratings for a

hypothetical future therapist based on race/ethnicity—or rated their levels of perceived self-disclosure or comfort across therapists of different races/ethnicities.

Many studies of perceptions of therapists as a function of racial/ethnic match presented hypothetical situations eliciting evaluations of therapists matched or not by race/ethnicity. About equally as often these studies compared the ratings of therapists by clients who had vs. did not have a therapist of the same race/ethnicity (which we termed a "group comparison" in Table 1). Across perception studies, ratings typically involved the Counselor Effectiveness Rating Scale (Atkinson & Carskaddon, 1975), the Counselor Rating Form (Barak & LaCrosse, 1975), and similar evaluations of therapist traits and skills.

Studies of clinical outcomes compared clients who had received treatment with a therapist of their own race/ethnicity vs. those who had received treatment from a therapist not of their own race/ethnicity. We found a tendency for those studies to have been conducted relatively recently, with half of them appearing during the previous decade. Some of these studies used archival data and others used prospective designs, but both involved essentially the same comparison of naturally occurring (non-randomized) racial/ethnic matching of client and therapist. Outcome studies commonly occurred in community clinics, college counseling centers, or inpatient mental health facilities. Client symptoms were measured by instruments such as the Outcome Questionnaire–45 (Lambert et al., 1996) and the Global Assessment of Functioning (American Psychiatric Association, 2000).

Omnibus Analyses

Across the 52 studies investigating participants' preferences for therapist race/ethnicity, the random effects weighted average effect size was $d = .63$ (SE = .08, p < .001, 95% CI = .48 to .78), indicating a moderately strong preference for a therapist of the same race/ethnicity. Across the 81 studies investigating client perceptions of therapists as a function of racial/ethnic matching, the random effects weighted average effect size was $d = .32$ (SE = .07, p < .001, 95% CI = .19 to .45), indicating a tendency for participants to evaluate matched therapists somewhat better than unmatched therapists. Across the 53 studies investigating client treatment outcomes under matched vs. unmatched conditions, the random effects weighted average effect size was $d = .09$ (SE = .02, p < .001, 95% CI = .05 to .13), indicating almost no difference in outcome when clients were matched with a therapist of their own race/ethnicity.

Effect size heterogeneity was substantial across all three categories of data. Among preference studies, effect sizes ranged from -.24 to 3.35, with 90% of the variability attributable to between-study differences ($I^2 = 90$; $Q_{(51)} = 509$, $p < .001$). Among perception studies, effect sizes ranged from -1.10 to 3.49, with 90% of the variability attributable to between-study differences ($I^2 = 90$; $Q_{(80)} = 776$, $p < .001$). Among outcome studies, effect sizes ranged from -.55 to 1.78, with 82% of the variability attributable to between-study differences ($I^2 = 82$; $Q_{(52)} = 295$, $p < .001$). Systematic effect size variability remained unaccounted for in all three analyses. Subsequent analyses were conducted to determine the extent to which the variability of the effect sizes was moderated by other variables.

Analyses to Evaluate Possible Publication Bias

We evaluated the possibility that the results were moderated by the publication

status of the research manuscript. In meta-analyses, publication bias is related to (a) the

likelihood for meta-analyses to include larger numbers of published than unpublished

studies and (b) the likelihood for published studies to have larger effect sizes than

unpublished studies. The combination of these two trends may result in a meta-analysis

reporting inflated effect size values unless publication bias is explicitly evaluated.

As a first step to rule out the possibility of publication bias, we calculated Orwin's

(1983) fail-safe *N*, the theoretical number of unpublished/missing studies with effect sizes

averaging zero (no effect) that would reduce the overall results obtained to a trivial

magnitude. These calculations indicated that 397 additional preference studies, 170

additional perception studies, and 48 additional outcome studies would need to be located

with average effect sizes of $d = 0$ to render negligible the results obtained.   These values

suggest that publication bias is unlikely for studies of client preferences and perceptions,

but publication bias could not be ruled out for the studies of client outcome because it is

conceivable that 48 additional outcome studies could have remained missing from our

analyses.

For the next step we plotted the effect sizes against the standard error of each

study, often referred to as a funnel graph (Begg, 1994). The data generally conformed to

the expected distribution, but several studies failed to fall within the typical range,

possibly indicating "missing" studies on the opposite side of the distribution. Therefore,

as a final step we conducted a "trim and fill" analysis (Duval & Tweedie, 2000) to

estimate the number of missing studies due to publication bias. In the current study, the

recalculated random effects weighted mean effect sizes remained the same across all

three data categories (preference, perception, and outcome) because no studies met the

statistical criteria to be "trimmed" from the analyses. Thus publication bias did not appear

likely to be a threat to the results obtained in this meta-analysis.

Moderation by Participant and Study Characteristics

Given the high degree of effect size heterogeneity observed, we examined

whether the omnibus values reported above were moderated by participant and study

characteristics relevant to racial/ethnic matching. Because differences across participant

race had been observed in previous research (Karlsson, 2005), we first analyzed the data

by client race/ethnicity. Effect sizes within studies that were specific to Asian

Americans, African Americans, Hispanic/Latino(a) Americans, and White/European

Americans were contrasted with one another. As shown in Table 2, statistically

significant differences were apparent across all three categories of data (preferences,

perceptions, and outcomes). The relevance of racial/ethnic matching was greatest among

African American participants, the only group with effect sizes statistically different from

zero for all three analyses. Their preferences for therapists of their own race/ethnicity

were very strong; their perceptions of therapists varied substantially as a function of

racial/ethnic matching; and their outcomes in therapy tended to be mildly better when

their therapist was African American. In contrast, racial/ethnic matching was apparently

least relevant to White/European Americans; none of the three effect sizes statistically

differed from zero. The results with Asian American and Hispanic/Latino(a) Americans

were mixed. Asian Americans showed only mild preferences for a therapist of their own

race/ethnicity but tended to provide more positive evaluations for therapists of their own

race/ethnicity. Conversely, Hispanic/Latino(a) American participants expressed

moderately strong preferences for a therapist of their own race/ethnicity but did not

evaluate therapists differently based on race/ethnicity.

We next evaluated the degree to which effect sizes were associated with the year

of study publication (to evaluate possible changes over time), average participant age,

average years of participant education, percentage of female participants in the sample,

and estimated average year of participant birth (year of study minus average age of client

as an estimate of cohort effects). Random effects weighted correlations were conducted

between the values obtained on those variables and the effect size for each study. As

displayed in Table 3, most correlations were of small magnitude, suggesting that none of

the participant variables moderated the data. The only correlation to reach statistical

significance was the year of publication of preference studies ($r = -.29$, $p = .04$). The

earlier the year of the study, the stronger the preference expressed for racial/ethnic

matching. To evaluate only relatively recent results, we re-calculated the average random

effects weighted effect size for the eight studies that have appeared since the year 2000.

The resulting value of $d = .49$ (95% CI = .07 to .90, $p = .02$) indicated that, on average,

preferences for a therapist of one's own race/ethnicity still existed in the most recent

decade but were of moderate magnitude.

Studies of individuals' perceptions of therapists included both analogue studies

and studies of actual clients receiving services, so it was important to distinguish whether

differences in the results would be found across those conditions. The average random

effects weighted effect size was $d = .46$ for analogue studies with hypothetical scenarios

but $d = .20$ for studies involving clients' evaluations of their own therapist, which

difference was statistically significant ($Q = 4.3$, $p = .04$). Thus the overall effect size

reported previously for perception studies was moderated by the research procedures used. Racial/ethnic matching was less relevant to the perceptions of therapists by actual clients than to individuals considering scenarios presented by researchers.

Studies of client outcomes in therapy included both prospective and retrospective (archival) designs. The results obtained across these two procedures were not statistically different ($Q =1.6$, $p > .05$).

Discussion

Enhancing client-therapist similarity should increase mutual understanding and strengthen the therapeutic alliance, with associated benefits to client outcomes in therapy. Nevertheless, the data indicate that mental health treatment outcomes do not substantively differ when clients do or do not have a therapist of their same race/ethnicity. "Match is neither a necessary nor a sufficient condition for positive treatment outcomes. In other words, match may be important for some, but not all, clients" (Sue, 1998, p. 444).

One explanation for the results of the outcome research could hypothetically involve differential experimental attrition if dissimilar client-therapist dyads are susceptible to premature termination (such that client outcomes erroneously appear unaffected by racial/ethnic matching). This possibility has not been verified in previous reviews (Maramba & Nagayama Hall, 2002; Shin et al., 2005) but could benefit from future confirmation. Another explanation involves the multiple influences of interpersonal similarity: Even though perceived similarity reduces negative stereotyping, it increases consensus bias (Ames, 2004), the assumption of greater similarity than actually exists. Perceived similarity is independent of actual self-other agreement (Kenny

& West, 2010); individuals make inaccurate assumptions about how similar they are to others. Specifically, people of the same race/ethnicity may not share the same worldview, and people of different races/ethnicities may have compatible worldviews. There is greater variability within racial/ethnic groups than individuals typically conjecture. Moreover, categorical conceptualizations of race/ethnicity do not account for related variables such as level of client inter-racial mistrust or therapist multicultural competence. Race/ethnicity is too imprecise and too complex to consistently impact averaged therapy outcomes.

One interpretation of the data from this meta-analysis is that racial/ethnic matching of client and therapist are more relevant to the cognitive heuristics of preferences for and perceptions of therapists than to the average effectiveness of therapy. In general, individuals tend to prefer having a therapist of their own race/ethnicity (who they likely imagine would share their own worldview), but once they enter a therapeutic relationship, the therapists' race/ethnicity makes only a little difference in how positively they evaluate the therapist and makes virtually no difference in how much they benefit from the treatment provided. These results, based on a substantial number of studies, are consistent with those of previous meta-analyses and reviews using far fewer studies (Coleman et al., 1995; Flaskerud, 1990; Karlsson, 2005; Maramba & Nagayama Hall, 2002; Shin et al., 2005; Sue & Lam, 2002). Nevertheless, the heterogeneity of the effect sizes in our review qualifies the degree to which the findings can be generalized.

The notable exception to the overall findings concerns African Americans. On average, African Americans very strongly preferred to be matched with African American therapists. They tended to evaluate African American therapists more

positively than other therapists. Their outcomes in therapy appeared to be mildly better

when they were matched with African American therapists. Factors responsible for these

findings likely include strong racial/ethnic identification and wariness about bias in the

mental health services provided by White therapists (e.g., Ridley, 1984; Snowden, 1999).

The finding that client race/ethnicity moderated preferences, perceptions, and

outcomes is not surprising (Griffith & Jones, 1979; Lopez, Lopez, & Fong, 1991; Proctor

& Rosen, 1981; Sattler, 1977; Wolkon, Moriwaki, & Williams, 1973). Our results

confirm that racial/ethnic matching is more salient for people of color than for

White/European Americans, as would be expected (Sue, 1998). Moreover, the results of

this meta-analysis clarify some mixed results noted in previous studies (i.e., Atkinson,

1983; Atkinson, Maruyama, & Matsui, 1978; Karlsson, 2005). Although Asian

Americans may not express strong initial preferences for a therapist based on race, they

appear to perceive Asian American therapists more positively than other therapists. The

opposite trend was noted for Hispanic/Latino(a) Americans, whose expressed preferences

for therapists of the same ethnic background were strong, but whose evaluations of

therapists differed only slightly as a function of racial/ethnic match.

Overall, the pattern of different findings across the three types of variables

(preference, perception, and outcome) can be explained in part by the nature of those

variables. Client preference for therapist race/ethnicity is the most straightforward

variable: It directly measures client attitudes about matched therapists (albeit likely

confounded by implicitly imagining someone of similar age, gender, etc.). By

comparison, perceptions of therapists are more complicated: Many factors other than

race/ethnicity enter into the equation, including variables more relevant to the

evaluations, such as therapist skills and dispositions. Client outcome is by far the most complicated variable, with dozens if not hundreds of factors impacting it, only some of which would relate to therapist characteristics. Thus the effect of racial/ethnic matching appears to be diminished as more variables become involved. Common factors are more predictive of client outcome than specific treatment variables (Messer & Wampold, 2002), including therapist race/ethnicity. This interpretation is consistent with Stanley Sue's (1988) observation that "ethnicity of therapist or client and ethnic match are distal variables; consequently, weak or conflicting results are likely to be found between ethnic match and outcome" (p. 306).

We therefore encourage inquiry into variables more directly relevant to therapist alignment with client worldviews (i.e., therapist multicultural competence, congruence of therapist and client racial identity status, interracial mistrust) that may further increase the amount of variance explained in client outcomes (APA, 2003; Arredondo & Perez, 2006). Racial/ethnic matching is a proxy variable for worldview matching (e.g., Zane et al., 2005). More than two decades after Sue and Zane's (1987) proposal to shift the focus from distal to proximal variables in research involving race/ethnicity, that advice still seems cogent. Future research can ascertain the specific mechanisms through which proximal variables (i.e., interpersonal trust, cognitive adaptability, shared linguistic parlance) help to improve treatment outcomes now that we understand the specific magnitude of the effect of racial/ethnic matching.

Limitations of the Meta-Analyses

Meta-analytic methods, like all other research methods, have limitations. Although the majority of the limitations of this particular meta-analysis are minor, several warrant further discussion.

First, substantial heterogeneity was found in the effect sizes obtained across all three categories of data (preference, perception, and outcome). Interpreting only the averaged findings masks the variability between studies. For instance, although most studies documented a preference for having a therapist of one's own race/ethnicity, several studies uncovered preferences for therapists of another race/ethnicity. Thus the omnibus results lack precision and should be considered as broad trends, rather than conclusive predictors of individuals' responses.

Second, the quality, methodology, and research design of each individual study included in the meta-analysis influence the overall results of any meta-analysis (Cooper, 1998; Cooper & Hedges, 1994; Matt & Navarro, 1997; Quintana & Minami, 2006). There are presently too few studies using experimental designs (see Table 1) for us to have complete confidence in the findings. Random assignment of participants to matched vs. unmatched conditions would be essential to control for possible systematic biases, including the differential selection of participants to those conditions (Campbell & Stanley, 1966). Future summaries of research using true experimental designs may yield more reliable results that those presented in this meta-analysis.

Third, most of the evaluations of individuals' preferences for therapist race/ethnicity involved hypothetical scenarios (*if* they were to seek mental health services). Most of those participants were not mental health clients, so the results of the

preference studies reflect preferences of the general public more than those of individuals actually seeking treatment. There is reason to suspect that the results would differ across those two populations; for instance, false consensus bias is stronger in laboratory settings than in actual interpersonal interactions (Robbins & Krueger, 2005). Our analyses with perception data indicated that clients in therapy evaluated their own therapists less as a function of racial/ethnic matching than did individuals not in therapy who evaluated hypothetical scenarios presented by researchers. Overall, it seems highly likely that studies involving hypothetical therapists share a major confound: people who imagine a therapist of their own race/ethnicity probably also imagine someone of their own age, gender, sexual orientation, etc. Thus hypothetical scenarios likely confuse the effects of shared race/ethnicity with overall interpersonal similarity.

Fourth, we did not re-calculate the effect size estimates within studies based on the procedures described by Gleser and Olkin (1994)~. Such procedures would have more accurately accounted for interdependence among the estimates, but they require estimates of the correlations among the measures used within studies, which information was unavailable in the vast majority of manuscripts. Although default values such as .50 are sometimes used, we preferred to maintain a straightforward procedure at the expense of some statistical precision.

Fifth, the studies located for the meta-analyses were all written in English, with only a few of the studies conducted outside North America. Even though the participants were from a variety of different racial/ethnic groups, they were almost all North American. Thus the results of our review do not represent research findings outside

North America or even populations in North America with low levels of acculturation, such as first generation immigrants.

Implications for Future Research

Despite evaluating therapists of one's own race/ethnicity more positively than those of dissimilar backgrounds, clients (and therapists) appear to be able to negotiate apparent differences such that the outcomes experienced in therapy are minimally impacted. Clients benefit from therapy despite their initial preferences being unmet and their evaluations of therapists' traits and skills being somewhat affected. By implication, the greatest relevance of racial/ethnic matching occurs prior to therapy and during the initial sessions of therapy when the therapeutic alliance is being formed. For instance, clients who enter therapy with a therapist of another race/ethnicity may presume worldview dissimilarity and thus be pleasantly surprised when it does not occur. Oppositely, clients who specifically request a therapist of their own race/ethnicity but then encounter divergent worldviews with a therapist of their same race/ethnicity may have unmet expectations detrimental to the therapeutic alliance. Future research can more specifically investigate the processes by which clients and therapists interact in similar vs. dissimilar dyads (e.g., Sue, 1988).

Given that individuals project their own worldview onto others (Critcher & Dunning, 2009), particularly on the values central to their own identity (Lee et al., 2009), a specific hypothesis in need of confirmation is that the more salient race/ethnicity is to the client and/or therapist, the more relevant racial/ethnic matching becomes in psychotherapy. Future research on the interaction between racial/ethnic matching and strength of client and therapist racial/ethnic identification and identity status appears

warranted. For instance, people whose social circles are restricted to their own group may have strong preferences for racial/ethnic matching (i.e., selective exposure; Marks & Miller, 1987), whereas those who regularly interact with out-groups may experience diminished projection (Robbins & Krueger, 2005) and lessened relevance of racial/ethnic matching in therapy.

The discrepant findings between clients' outcomes and their preferences for and perceptions of therapists that were observed in the meta-analytic data may be partially explained by service utilization and retention rates. Possible people of color who are willing to negotiate cross-cultural differences are those who actually come to services and those who persist in receiving services. Their preferences and perceptions may indirectly influence the likelihood of their utilizing mental health services and the likelihood of their remaining engaged in those services (Zane et al., 2005). In contrast, clients who experience discomfort across racial/ethnic differences may be less likely to attend and more likely to drop out of therapy. Hence the small magnitude of the effect sizes of client outcomes could partially reflect experimental selection bias and differential attrition (Campbell & Stanley, 1966). To control for these possible confounds, future research should randomly assign clients to matched vs. unmatched conditions and explicitly account for attrition.

An interesting finding suggested the possibility of a shift over time in client preferences, with recent studies demonstrating preferences of lower magnitude compared with studies conducted in previous decades. One possible explanation for this apparent trend relates to changes in the social and political climates in North America (Arredondo & Perez, 2006; Choma & Hodson, 2008). Although there is strong evidence that racism

persists in contemporary society, explicit racial tension with overt oppression was more

characteristic of the previous century (Dovidio, 2001; Dovidio, Gaertner, Kawakami, &

Hodson, 2002). Clients in earlier decades may have sought out therapists of their own

race/ethnicity to mitigate the possibility of discriminatory treatment (e.g., Whaley, 2001).

It is also possible that clients from historically disadvantaged backgrounds have become

more informed about mental health services over time, with reduced client anxiety and

negative expectations about treatment, or that therapists have become more competent in

working with clients of dissimilar race/ethnicity due to multicultural training required in

accredited graduate programs (Smith et al., 2006).

   Overall, the results of this meta-analysis confirm trends previously recognized in

the literature. However, they do not speak to the more pressing issues of causality and

utility. To what degree are differences in clients' evaluations of therapists across

matched vs. unmatched conditions attributable to therapists' biases or levels of

multicultural competence? Under what conditions do dissimilarities in

values/worldviews with therapists help clients? What specific variables influence the

differential perceptions of therapists observed across client race/ethnicity? Questions

such as these that go beyond a binary formulation of racial/ethnic matching would help to

promote more effective mental health services (Nagayama Hall, 2001).

   As suggested by Zane and colleagues (2005), future research would more

productively focus on the notion of worldview or cognitive matching rather than

matching by the more distal variable of race/ethnicity. This line of research is not new

(Mendelsohn & Geller, 1963), but it may have languished over the years because of the

additional effort required to measure both therapists' and clients' worldviews rather than

merely assume similarities (Nagayama Hall, 2001). Future research should attend to matching clients with therapists who accurately articulate and value the clients' conceptualization of well-being and dysfunction, mechanisms for coping, and desired goals for treatment (Smith, 2009). Attending to common factors (Messer & Wampold, 2002) and components of therapy that are amenable to intervention, like therapist communication skills, would seem to be constructive areas for exploration (see Sue, 1998). Optimally this work would be conducted in clinical settings, given the differences identified in this review between clinical and analogue research.

Implications for Practice

Even though we live in a multicultural society, with greater diversity than ever before, the practice of matching clients with therapists of the same race/ethnicity is not often feasible. Moreover, if agencies were to adopt rigid policies about matching clients with therapists of the same racial/ethnic background, unintended negative consequences might result (Alladin, 2002). Therapists and/or clients might feel segregated; therapists working primarily with a single population could fail to develop cross-cultural skills; treatment might minimize other meaningful differences such as gender orientation; and treatment might fail to acknowledge that within-group differences can be larger than between-group differences. And there are significantly fewer therapists of color than would be necessary to systematically implement racial/ethnic matching (APA, 2005). Concisely stated, "Psychotherapy for ethnic minorities is not simply an issue for ethnic minority persons" (Nagayama Hall, 2001, p. 508).

The results of this meta-analysis suggest that therapists who work with clients of another race/ethnicity can be optimistic rather than fearful; client outcomes are generally

unaffected by therapist race/ethnicity. Nevertheless, the results do suggest that therapists

need to apply multicultural competencies (Sue, Arredondo, & McDavis, 1992) to foster

positive client preferences and perceptions, particularly when working with African

American clients. The experiences and perceptions of African American clients

significantly differ when they have a therapist of their same race vs. another race. This

difference must be addressed. For instance, professional training programs may benefit

from an enhanced focus on the experiences and worldviews of African Americans to

enable therapists from other backgrounds to provide culturally congruent mental health

services.

The data from this meta-analysis also suggest that therapists should not naively

believe that all clients are alike (i.e., Neville, Spanierman, & Doan, 2006). The research

findings showed substantial variability. This does not suggest that race/ethnicity does not

matter for a client, but rather that racial/ethnic dynamics are so complex that prediction is

problematic. Individuals' experiences with race/ethnicity must be acknowledged more

than aggregate trends. Therapists who acquire multicultural awareness, knowledge, and

skills can work with both similarities and differences to enhance the therapeutic alliance.

The focus of cross-cultural mental health interventions needs to remain on issues

of effectiveness (Sue, 1998), attending to factors that directly influence clients'

utilization, retention, and outcome in mental health services. Rather than continue to

debate the utility of racial/ethnic matching, researchers and practitioners should place

primary emphasis on modifying treatments to match clients' worldviews (Benish,

Quintana, & Wampold, 2011; Smith, 2009; Smith et al., 2011), therapist multicultural

competence (Arredondo & Perez, 2006; D.W. Sue et al., 1992), and professional skills

development (Cates, Schaefle, Smaby, Maddux, & LeBeauf, 2007; Smith et al., 2006).

Conclusion

For decades, psychologists have rightly been concerned about reducing negative

stereotyping and increasing positive outcomes of clients whose race/ethnicity differs from

that of the therapist (e.g., Ridley, 1984). Matching clients with therapists of their own

race/ethnicity has been one strategy for doing so that has been increasingly been

overtaken by more practical alternatives, such as the provision of effective multicultural

training (Smith et al., 2006). The data summarized in the present meta-analysis indicate

that although people prefer to have a therapist of their own race/ethnicity and tend to

perceive therapists of their own race/ethnicity somewhat more positively than others,

their improvement in treatment is largely independent of therapist race/ethnicity.

Nevertheless, these averaged findings mask a high degree of variability in the

research data; racial/ethnic matching yields inconsistent results. In particular, African

Americans and individuals with strong racial/ethnic preferences or mistrust may benefit

from being matched with a therapist of their own race/ethnicity. So long as group biases

persist in society (e.g., Morrison & Morrison, 2008), racial/ethnic matching will remain

relevant to mental health services with discriminated and misunderstood populations.

Overall, we believe that it is past time to adopt refined conceptualizations of

racial/ethnic dynamics in therapy (e.g., Sue & Zane, 1987) that include proximal

variables such as perceived similarity vs. actual similarity. Social psychology has moved

past basic tenets about similarity in interpersonal settings (e.g., Berscheid et al., 1971;

Byrne, 1971; Newcomb, 1961; Ross et al., 1977; Simon et al., 1970) with theoretical

models and empirical research that have become increasingly complex (i.e., Ames, 2004;

Kenny & West, 2010). If the next generation of applied studies of racial/ethnic matching

better account for this complexity, we have reason to suspect that mental health services

can be improved by enhancing the alignment of those services with client racial/ethnic

worldview (Benish et al., 2011; Smith et al., 2011).

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Table 1

Study and Participant Characteristics by Study Type

Variable	Preferences $k = 52$	Perceptions $k = 81$	Outcomes $k = 53$
Study Characteristics			
Median number of participants	123	89	326
Median year of publication	1986	1991	1999
Unpublished/dissertations (%)	35	40	40
Research design			
Surveys/analogue studies (%)	88	39	0
Archival studies (%)	0	0	43
Experimental (%)	0	8	2
Group comparisons (%)	8	49	43
Other (%)	4	4	12
Participants' characteristics			
Average age	24	25	30
Average years of education	13	13	11
% Female	56	55	52
% Asian American	9	15	19
% African American	35	41	29
% Hispanic/Latino(a) American	17	15	20
% White/European American	27	24	28
% Other	12	5	4

Table 2

Weighted Average Effect Size Differences Across Participant Race by Study Type.

Study Type / Race	*Q*	*p*	*d*	95% CI	k
Preferences	9.1	.03			
Asian American			.28	[-.23, .80]	6
Black/African American			.88	[.60, 1.2]	22
Hispanic/Latino(a) American			.62	[.21, 1.0]	10
White/European American			.26	[-.09, .61]	13
Perceptions	11.8	.008			
Asian American			.56	[.10, 1.0]	11
Black/African American			.59	[.30, .88]	28
Hispanic/Latino(a) American			-.11	[-.53, .30]	13
White/European American			-.08	[-.50, .35]	13
Outcomes	9.9	.02			
Asian American			.11	[-.01, .23]	17
Black/African American			.19	[.08, .30]	23
Hispanic/Latino(a) American			-.04	[-.15, .08]	18
White/European American			.01	[-.10, .12]	17

Note. *Q* = an index of between-group differences. *d* = random effects weighted standardized
mean difference; the effect size. k = number of effect sizes included in the analysis.

Table 3

Random Effects Weighted Correlations of Effect Sizes with Study Year and Sample
Characteristics by Study Type

Variable	Client Preferences		Client Perceptions		Client Outcomes	
	r	k	*r*	k	*r*	k
Year of study publication	-.29[*]	52	-.08	81	-.21	53
Participant mean age	-.07	29	-.03	48	.05	33
Participant mean birth year[a]	-.24	29	-.01	48	-.16	33
Participant mean education	.01	51	-.03	79	.03	47
% Female participants	-.19	51	-.11	74	.09	47

Note: * p < .05; k = number of studies included in the analysis.

[a] Year of study minus average age of clients at time of study (to estimate cohort effects).