Chapter 6

On Ethnic Matching: A review of the research and considerations for practice, training and policy

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Introduction

This chapter presents an overview of the research on the effects of ethnic matching between therapist and client (EM) on therapy process and outcome. Racial differences in therapy received some attention in the late 1940s but no systematic empirical study was carried out and by the 1950s interest in the area had faded (Atkinson, 1985). A review of the research carried out in the 1960s (Sattler, 1970, in Sattler 1977) found only three relevant studies but, since then, enough research has been carried out for a number of reviews and meta-analyses to also be published.

Their conclusions, however, appear contradictory. Early reviews of studies exploring process variables (e.g. preference for therapist ethnicity, client self-disclosure, perceived therapist credibility and facilitative conditions) and outcome variables (e.g. client satisfaction and willingness to return, dropout rates and length of treatment) found either no significant effect of EM (Sattler, 1977) or an even split between studies reporting an effect and those that did not (Harrison, 1975; Atkinson, 1983, 1985; Abramowitz & Murray, 1983). Later reviews, instead, suggest that EM can be beneficial for both process and outcome. Sue et al. (1994), for instance, conclude that conditions such as EM, culturally responsive treatment and pre-therapy interventions are associated with effectiveness for at least some ethnic groups. Atkinson and Lowe (1995) also found that most ethnic minority clients preferred an ethnically similar therapist, and that some considered such a therapist more credible and also benefited more from seeing them than an ethnically dissimilar therapist. In a third review Gray-Little and Kaplan (2000) suggest that, other things being equal, ethnic similarity may reduce the social distance and enhance the likelihood of shared beliefs and experiences between client and therapist, thus facilitating the therapeutic alliance and outcome. Nonetheless, in the latest review Karlsson
(2005) argues that "... the empirical support for ethnic matching is, at best, inconclusive and lacks a foundation of rigorous research designs" and that, as a result, "... the role of ethnic matching in therapy has been left essentially unexplored" (p. 124). Karlsson concludes indeed that:

Until such [valid] research findings have been generated, clinicians are left with making decisions regarding the need for ethnic matching based on unclear research findings and clinical lore, which hardly provides the information that is needed. (Karlsson, 2005, p. 125)

In our view, not only have studies using novel methodologies recently become available but the problems affecting the research on EM are also not different from those that affect much of the psychological research generally. In fact, we find Karlsson's conclusions curiously negative, for a careful analysis of the research actually suggests several *fundamental* practical considerations. Here we shall consider findings from: i) old studies using analogue designs, ii) large studies of archival data from actual clients, iii) recent studies of process and outcome as measured over time, iv) new in-depth qualitative studies of client experiences. Instead of reviewing individual studies, where possible we discuss reviews and meta-analyses, with a critical focus on Karlsson's paper. We will then consider their implications for therapy, training and policy in the conclusions.

**Analogue studies**

Like much of the social-psychological research from the 1960s to the 1980s, early studies on the effects of EM in therapy used primarily U.S. college students as participants in analogue designs, with brief sessions either simulated using participants as clients or presented to participants in audiotapes, videotapes, vignettes or transcripts. Lopez et al.
(1991) subdivided these studies into those that used a simple-choice method (preference paradigm) or a paired-comparison method (perception paradigm). In the simple-choice method participants are asked to express a preference for one of two or more simulations with ethnically matched/unmatched dyads. In the paired-comparison method participants are asked to rank their preference for therapist ethnicity but also other variables (e.g. therapist age, gender, levels of education, similarity of values/attitudes).

In a large meta-analysis Coleman et al. (1995) found that overall participants in analogue studies show a significant preference for - and more positive perceptions of - ethnically similar over dissimilar therapists, that paired-comparison studies tend to achieve a smaller effect size over simple-choice studies (d=.20 versus d=.73), and that the effect of ethnic differences is reduced when participants are affiliated to the therapist's culture. In his review Karlsson (2005) dismisses analogue studies arguing that: i) results from simple-choice studies are inconsistent, ii) those from paired comparison-studies show that when given choice participants rank other therapist characteristics higher than ethnicity, and iii) in their meta-analysis Coleman et al. (1995) found a smaller effect size achieved with paired-comparison over simple-choice studies. However, these criticisms are puzzling. First, the effect sizes reported by Coleman et al. run counter to Karlsson's first point, namely that results from simple-choice studies are inconsistent, as these are precisely the studies reporting a particularly strong effect. Second, that (in some studies) the effect of other background variables can be stronger than that of ethnicity is no ground to dismiss it. Third, a weakened effect of ethnicity in paired-comparison studies is precisely what to expect when considering it together with other significant variables.

Admittedly, because analogue studies only involve brief contacts between participants and hypothetical therapists and/or present participants with a snapshot record
of a therapy session, they cannot represent the intricacies of preferences and perceptions that emerge with time in real therapeutic relationships. Karlsson is right to argue that these studies "... might inform us more about a person's perceptions, attitudes about race, and interpersonal attractions across race than about actual psychotherapy" (2005, p. 119).

Nonetheless, it is reasonable to hypothesise that initial reduced preferences and negative perceptions in ethnically different dyads negatively affect process variables such as therapist credibility and the working alliance, and which strongly predict outcome. Additionally, since analogue studies typically recruited U.S. college students, who tend to be young, comparatively educated/acculturated, culturally conscious, liberal political and non-racist, their findings may actually under-estimate the strength of intra-ethnic preferences and inter-ethnic negative perceptions in other sections of the population, not to mention of populations outside the U.S.

**Archival studies**

Archival studies utilise existing records from the general client population and thus benefit from higher ecological validity than analogue ones. However, because few services routinely employ direct measures of process (e.g. working alliance, perceived therapist credibility, client self-disclosure, etc.) or actual outcome (i.e. difference between pre- and post-therapy functioning), by and large these studies use indirect measures such as premature termination, duration of treatment, post-therapy use of intensive services or overall post-therapy functioning.

Archival studies tend to show that, particularly when accompanied by linguistic matching, EM significantly increases therapy uptake and duration, and reduces early dropout. Flakerud (1986), for instance, examined the case records of 300 African-
American, Mexican, Asian-American and White clients treated in four community mental health centres and found that linguistic and ethnic match significantly reduced dropout and increased attendance (see also Flackerud & Liu, 1990). In another study, Flackerud and Liu (1991) examined files from 1,746 Asian-American clients and found that both linguistic and ethnic match significantly increased attendance and EM also significantly reduced dropout. In a study on 1,000 Asian-American women, Fujino et al. (1994) found that both ethnic and gender match were significantly associated with reduced dropout and increased treatment duration. In one of the few randomised control trials available, Mathews et al. (2002) examined the effect of EM amongst 5,983 inpatients by assigning African-Americans, Hispanics and Asian-Americans to three ethnically focused psychiatric inpatient units. They found that for Asian-Americans and Hispanics matching was associated with a significantly greater likelihood of accepting outpatient or residential treatment referrals and a significantly lower likelihood of referrals to locked facilities.

Archival data also suggest that EM may significantly improve outcome for some groups, again, especially when accompanied by linguistic matching. Analysing data from more than 13-thousand outpatient service clients, Sue et al. (1991) found that for all ethnic minority groups included (Asian-, Mexican-, African- and Caucasian-Americans) matching predicted notably longer treatment and, with the exception of African-Americans, substantially lower dropout. Ethnic match also predicted outcome (with pre-treatment functioning controlled for) for Asian-Americans and approached significance for Asian-Americans (p<.06), although effect sizes were small. In Asian- and Mexican-Americans who were non-native English speakers, instead, ethnic match predicted outcome to a clinically relevant degree. Archival psychotherapy studies outside the U.S. lag behind but in Australia, Ziguras et al. (2003) examined the effects of matching clients from a non-
English speaking background with bilingual, bicultural clinicians in 2,935 psychiatric clients. They found that ethnic minority clients (Vietnamese, Greek, Italians, Macedonians) who were matched with bilingual clinicians had longer and more frequent contacts with community care teams and fewer and shorter contacts with crisis teams. Clients matched with a bilingual clinician also benefitted from fewer and shorter hospital admissions than even Australian-born clients.

Similar effects of EM on outcome for some minorities are also reported in large U.S. studies of young people. Examining data from 4,616 young Caucasian-, Mexican-, African- and Asian-American, Yeh et al. (1994) found that while EM did not significantly predict dropout, treatment duration and post-therapy functioning in children, it predicted dropout to a clinically significant degree in adolescents from all three minorities considered and also duration in Mexican- and Asian-American adolescents. In a study of 4,695 African-, Asian- and Hispanic-American children and adolescents, instead, Jerrell (1998) found that when ethnically matched they tended to stay longer in outpatient treatment and used less intensive services irrespective of age group. And in a study of 912 Asian-American children, Yeh et al. (1994) found that those attending centres providing EM therapy (71% of cases) benefitted from reduced dropout, increased service use and post-therapy functioning than those attending mainstream centres (8% matching) also when social class and pre-therapy functioning were controlled for.

Maybe because they tend to belong to the same mainstream linguistic and cultural group, EM may affect African-Americans and Caucasian-Americans less than other U.S. ethnicities. In a recent meta-analysis of results for African-American and White clients drawn from 10 published and unpublished studies, Shin et al. (2005) found no significant effect of EM on: i) dropout, ii) total number of session attended, and iii) overall
functioning. However, the conclusion that EM is clinically irrelevant for African- and Caucasian-Americans would be incorrect. Shin et al. used random effects analysis, which yields a conservative measure of combined effects. A closer look at the studies from this very meta-analysis finds that the majority reported significant effects of EM on dropout and duration of treatment for both African-Americans and Caucasian-Americans, with effects ranging from weak to strong, i.e. suggesting that EM can affect dropout and treatment duration to a clinically significant degree. With regards to overall post-therapy functioning, the results from this meta-analysis lend themselves to many different interpretations. In addition, post-therapy functioning is not a good measure of outcome as it is most strongly predicted by pre-therapy functioning. The only study which used data on change in well-being over time (derived data from clients with severe diagnoses of psychotic or mood disorders) included Asian- and Latino-Americans and confirmed a clearer association between matching and positive outcome (as measured by therapist) for these groups over African- and Caucasian-Americans (Gamst et al., 2000). However, the authors argue that results for African-Americans were possibly affected by greater psychopathology over the other minorities and a paucity of African-American therapists, and conclude that:

For African Americans matching may be more important for clients who embrace their racial identity and disparage White American values... Without controlling for racial identity status (i.e. Afrocentrism) of African American clients during intake, preference and no preference clients are indiscriminantly lumped together to yield equivocal results (p.562).

Although very few archival studies find no effect of EM on therapy (e.g. Martin, 1994), Karlsson states that: "Unfortunately, archival studies have not produced consistent
findings regarding the benefits of ethnic matching in psychotherapy (Sue et al., 1994)\(^1\) (p. 116). Karlsson then refers to meta-analysis of 125 studies on psychotherapy dropout where Wierzbicki and Pekanik (1993) found that client ethnicity (white or non-white) was a weaker predictor of dropout than both Socio-Economic-Status (SES) and level of education. He fails, however, to mention that these were the only 3 significant factors from an original pool of as many as 32 variables covering study characteristics, client and therapist demographics, psychological factors and type of therapy. Furthermore, while SES had a notably stronger effect (d=.37) than both level of education and ethnic background, these had comparable and clinically significant effects (d=.28 and d=.23 respectively)\(^2\).

Moreover, not only Wierzbicki and Pekanik employed a gross measure of ethnicity (white/non-white) collapsing together the effects of different ethnic backgrounds but client ethnicity is also not a measure of EM. Because a proportion of therapists were non-white, their white clients were mismatched and their non-white clients matched (or mismatched with a therapist from a different ethnic minority), which could have reduced the dropout difference between whites and non-whites.

Admittedly, Karlsson also relies on the results of a meta-analysis by Maramba and Hall (2002) of 7 US archival studies on EM as a predictor of dropout, utilisation and client’s level of post-therapy functioning in either white or ethnic-minority clients. This meta-analysis shows that for ethnic minority clients matching was significantly associated with reduced dropout (p<.0001) and increased attendance (p<.0001) but, as stressed by Karlsson "the effect sizes were so small that the authors ruled out EM as a clinically

\(^1\) Interestingly, Sue at al. actually argue that archival studies overall suggest that EM in therapy can be beneficial.

\(^2\) The studies included were conducted between 1974 and 1990 and a meta-analysis including older studies by Garfield (1986) yielded very similar results.
significant predictor of outcome” (p. 116). In his conclusions on the validity of archival
data Karlsson (p. 120) also refers to Maramba and Hall's meta-analysis to state that:

Finally, the effect sizes of archival studies are minimal, which may indicate that
the significant results might be related to the enormous sample sizes in these
studies (Maramba & Hall, 2002).

However, this conclusion relies on a small meta-analysis, published as a brief report and
which, again, fails to consider the effects of: i) averaging results from many individuals
from the same group and, especially, ii) lumping together results from different ethnic
groups. Of the 7 studies included in Maramba and Hall's meta-analysis (some of which are
unpublished) 2 account for as much as 75% to 100% of clients in each analysis. Most
strikingly, overall these two studies (Sue et al., 1991; Yeh et al., 1994) report clinically and
statistically significant effect sizes for dropout and duration for all/most ethnic minority
and age groups considered. Because Maramba and Hall did not differentiate between these
groups, in their meta-analysis these effects are lost altogether.

Eventually, even Karlsson admits that: "Findings from archival studies do suggest
that ethnic matching is important” (p. 120). In line with other reviewers (e.g. Sue et al.,
1994), we conclude that archival studies show that EM tends to reduce dropout, increase
retention and also facilitate positive outcome, at least for some ethnic groups and especially
(but not only) when associated with language matching. Overall archival data also suggest
that EM can be a factor of clinical relevance for many individuals from all groups, even
when effect sizes for the group as a whole are not strong. Nonetheless, with some
exceptions archival studies fail to provide direct measures of outcome and, especially,
process, which means that they cannot be used to test the idea that EM affects outcome
because of its effects on process.
Studies using direct measures of process and outcome

To address these methodological shortcomings, some researchers have examined the effects of EM on direct measures of process and outcome over time. Ricker et al. (1999) examined ethnic similarity, working alliance and therapeutic outcome among 19 ethnically similar and 32 ethnically dissimilar therapeutic dyads engaged in brief therapy (maximum 6 sessions) at a university counselling centre. Outcome was significantly more positive in similar over dissimilar dyads but no relationship between ethnic similarity and working alliance was found nor, surprisingly, between the latter and therapeutic outcome. This runs counter to what we know on the strong relationship between working alliance and outcome (e.g. Horvath & Symonds, 1991; Horvath & Luborsky, 1993) and it is possible that the small sample, the beneficial characteristics of college students highlighted in relation to analogue studies, and the brevity of therapy all limited differences in working alliance ratings.

In a similar but much larger study, Erdur et al. (2000, 2003) considered data from 4,483 African-American, Asian-American, Hispanic, and White clients (students) and 376 therapists from 42 university/college counselling centres. Like other archival studies they found that ethnic mismatching was associated with fewer sessions attended. Surprisingly, they also found only a small relationship between outcome and working alliance (as rated by clients=.15) and no evidence that EM affected either the working alliance or outcome. These results are confusing but the final analysis was conducted on 2,154 dyads with only 70 ethnic minority matches (32 African-American, 1 Asian-American, 37 Hispanic) lumped together with 1,484 white matches, which may have over-run any positive effect of ethnic minority matching. Analyses of working alliance and outcome in individual
minorities as a function of therapist ethnicity were also conducted but the numbers were then small. In addition, the brevity of treatment (4-6 sessions) and beneficial characteristics of college students may have again weakened the relationship between working alliance and outcome and the effects of EM respectively.

Other studies employing direct measures of process and/or outcome conducted with young people from the general U.S. population report rather different results. For instance, Wintersteern et al. (2005) examined the effects of gender and racial differences between therapist and client on the therapeutic alliance and treatment retention in a randomised trial with 600 adolescent substance abusers. They found that gender-matched dyads reported better alliances and were more likely to complete treatment and that EM predicted greater retention and therapist-rated therapeutic alliance. In a study examining treatment outcomes of family therapy with 86 highly acculturated Hispanic and White substance-abusing adolescents, Flicker et al. (2008) found that whereas EM had no effects for White adolescents, ethnically matched Hispanic adolescents showed significantly greater reduction in their substance use than non-matched ones.

Some studies have also been carried out in western countries outside the U.S. In the Netherlands, Knipscheer and Kleber (2004a) examined the contribution of ethnicity to perceived therapist characteristics and treatment satisfaction in 82 Turkish and 58 Moroccan clients. Clients generally considered clinical competence and compassion more important than EM and those seen by a native Dutch therapist reported similar satisfaction as those who were ethnically matched. However, while more than half of clients did not prefer EM, a substantial number of ethnic minority clients (especially Turkish clients) rated it as very important. In addition, because only 18 clients were ethnically matched against 92 who were not (and of 14 therapists only 2 were Turkish and 2 Moroccan) individual
client/therapist factors may have overridden EM effects. In another study with 96
Surinamese migrants to the Netherlands, the same authors (2004b) found that while a
considerable minority of clients reported compassion and expertise to be more relevant
than ethnic background, the latter was a strong predictor for satisfaction in ethnic minority
clients. Overall these results are consistent with the hypothesis that when EM affects
outcome it is because of its effect on process.

To overcome some of the limitations in the available evidence, Farsimadan et al.
(2007) examined the effects of EM on the working alliance, perceived therapist credibility,
and therapy outcome over time (difference between pre- and post-therapy GSI) in 100
ethnic minority clients in London. All clients and therapists were South-Asian, Black-
African, Black-Caribbean or Middle-Eastern; clients in matched dyads had expressed a
preference for matching, and therapy was between 6 and 12 sessions. Outcome and process
variables were significantly better in matched than in non-matched dyads with notable
effect sizes (adj. R²=.194 for outcome, .782 for working alliance, .768 for therapist
credibility), whereas age, gender, and length of therapy did not predict outcome or process.
The two process variables were measured at different times in therapy but still almost
perfectly correlated to one another, suggesting that process quality was established early on
in therapy. Most importantly, however, the process variables were also found to fully
mediate the relationship between EM and outcome, providing the strongest evidence to
date that EM can affect therapy outcome because of its effect on process.

To test whether these results were not due to minority-minority mismatching, Khan
et al. (in preparation) examined the dynamics between working alliance and therapy
outcome in 236 dyads with white majority therapists and clients either from this majority
or a South-Asian minority. Again, outcome and working alliance were significantly better
in matched than in non-matched dyads, effect sizes were clinically as well as statistically significant (adj. R²=.115 for outcome, .56 for working alliance), and the working alliance fully mediated between matching and outcome. Age, gender and SES had no effect on process and outcome, and length of therapy (4 to 22 sessions) had a significant but weak effect on both. This study also considered 5 culture-sensitive characteristics that may negatively impact the process of therapy in mismatched dyads, namely pretence/secrecy with therapist, perceived stereotyping, self-concealment, social desirability, and client change from their original culture. All these culture-sensitive factors significantly differentiated between the two groups of clients, predicted the working alliance and, with the exception of cultural change, also therapy outcome. Most interestingly, however, whereas culture-sensitive factors related to therapist-client dyads (pretence/secrecy with therapist, perceived therapist stereotyping) also moderated the relationship between ethnicity and working alliance, those related to client background characteristics (self-concealment, social desirability, cultural change) did not. This suggests that emergent relational dynamics, rather than South-Asian relational tendencies per se, contributed to working alliance problems in mixed dyads, and provides the first evidence to date that the effect of specific cultural differences contributes to the negative effect of mismatching on process.

Most of these studies were not available to Karlsson's review and he notes that:
"There are few actual studies of psychotherapy that investigate ethnic matching per se... Of the few studies that are available, most suggest that ethnic matching does not affect the outcome of therapy" (2005, p.124). Here he refers to 4 studies, of which two are the studies limited to U.S. college students and reviewed above (Ricker et al., 1999; Erdur et al., 2003), one (Jones, 1982) excluded clients who attended less than eight sessions (and by
admission of its author might have thus selected out a proportion of its ethnic minority clients), and another was only published as a brief non-peer-reviewed letter and did not actually report any comparative results nor data on EM (Littlewood, Moorhouse, & Sourangshu, 1992).

We are not aware of any meta-analysis of studies involving direct measures of process and outcome. Karlsson duly notes that in their meta-analysis of therapy effectiveness Smith et al. (1980) conclude that therapist-client similarity was related to positive outcomes. He then immediately adds, however, that in a meta-analysis of 7 studies of the effect of EM on outcome Lamb and Jones (1998) found effect sizes ranging from -.09 to .68, with a very small overall effect size (d = .02), "which they concluded could not support the singular concept of ethnic matching" (Karlsson, 2005, p. 120). This is an unpublished manuscript and we cannot comment on its conclusions as reported by Karlsson. However, a range in effect size from -.09 to .68 is fully consistent with data from archival studies suggesting that matching can be unimportant for some groups/clients but very important for others.

In brief, like analogue and archival studies, published studies using direct measures of process and outcome tend to suggest that EM is a clinically as well as statistically significant factor, at least in brief or medium-term therapies, for most minorities considered thus far in large multi-ethnic Western cities. In our published contribution, we could also confirm the widespread hypothesis that EM affects outcome because of its effects on process. In addition, in another study we found that while a number of culture-sensitive background and therapy-related factors differentiated between white and South-Asian clients (working with white therapists) and predicted process and outcome, only those inherent to the relation with the therapist contributed to the effect of matching on process.
These findings are important and yet they only start to provide detail on the intricacies of the effects of EM/mismatching on the process and hence outcome of therapy.

**Qualitative studies**

Qualitative data are typically derived from small non-representative numbers of participants, however, when inserted within the broader picture sketched by quantitative data they afford a detailed understanding of how and why EM can affect therapy that is very useful for practitioners.

Chang and Berk (2009) used a consensual qualitative analysis of interviews to compare the experiences of 8 satisfied and 8 dissatisfied clients from various Asian, Latino and mixed-race ethnic minorities in New York who saw a Caucasian-American therapist. Differences revolved around expectations met/unmet, emotional connectedness/disconnectedness with the therapist, happiness around therapy ending, and interest/disinterest in continuing/resuming the relationship with the therapist. Discriminative therapist factors included: an active versus passive therapist role, self-disclosure, professionalism, attentiveness versus negligence and acceptance versus criticism. Interestingly, therapist cultural competence did not really feature in the narratives of satisfied clients but cultural incompetence was prominent for dissatisfied ones. All satisfied clients stressed the importance of therapeutic skills and tasks over ethnic differences that, instead, were often described as irrelevant to the presenting problems. Nonetheless, some satisfied clients experienced alienation from their own ethnic group and most reported compartmentalizing ethnic differences out of therapy, efforts from themselves and therapists to bridge differences, and some identification with their therapist. The authors conclude that despite the 'universality' of the core therapy processes
"...the dynamics of racial/ethnic mismatches introduce unique challenges to the therapy relationship that may require attention and flexible adaptation of basic therapy skills” (p. 532). They also warn against the possibility of therapist micro-aggressions due to cultural incompetence and note that:

...whereas affective disconnection and premature termination are obvious consequences of failed efforts to negotiate cross-racial therapy interactions, the costs and benefits of client bridging strategies such as compartmentalizing race remains unclear. (p. 534)

To explore how ethnically matched clients may experience process and outcome, and the ways in which demographic similarities influence these variables, Farsimadan (2002) used interpretative phenomenological analysis of interviews with 12 matched clients from various ethnic minorities in London (West Indians, Indians, Pakistani, Iranian, Nigerian, Iraqi, Lebanese). All participants reported fairly positive experiences of therapy and the facilitative themes emerging from the analysis included: sharing the same ethnic/cultural background, empathic understanding and acceptance, same-gender experiences and understanding, therapist experience and maturity. Six participants argued that their presenting problems were related to race/ethnicity and only someone ethnically similar could understand them. Most Black participants identified the White culture/society as the source of their problem and cultural mistrust as the key-determining factor in their choice of an ethnically matched therapist. For Asian participants, instead, family and relationship issues determined their choice in this sense. Three participants were matched by chance of which two reported that, because of their experience, in future they would express a preference for EM.
In a study with mismatched dyads, Khan (2005) used the same methodology to explore the experiences of 8 South-Asian clients in London who ended prematurely with a white psychodynamic therapist. Themes identified included: secrecy and trust, a tendency to present a socially desirable self, negotiating/wrestling with own culture of origin, therapist empathy and understanding, expectations met/unmet, emotions about leaving therapy, own insecurities/transference/projections. Participants explained that issues related to these themes lead them to withhold information for fear of being judged and stereotyped. All participants argued that their therapist ethnicity became particularly prominent for them when their problems were related to race/culture.

**Conclusions**

Conclusions from reviews and meta-analysis may appear contradictory but on close analysis the data actually paint a fairly clear picture. Analogue studies suggest that along with other characteristics people prefer an ethnically matched therapist. Archival data suggests that (other things being equal) this preference can have important clinical implications as ethnic dissimilarity is often associated with reduced therapy uptake, increased premature dropout, reduced duration and post-therapy functioning. Studies using direct measures of process and outcome confirm the hypothesis that mismatching can hinder outcome because of its negative effects on process. With some natural between-groups and within-group variation, this picture holds across most ethnicities and age groups considered.

Clearly, when working with a client from a different ethnic background we should seriously consider the potential for added difficulties. But what should we look out for? Some authors (e.g. Karlsson, 1995) argue that it is not ethnic mismatching *per se* that may
be problematic and point the finger at intervening factors such as language, levels of acculturation, affiliation to one's own culture of origin, client education, socio-economic status, the therapist's cultural competence, etc. These factors, however, are not independent of ethnicity but, rather, its constituents. Were we to strip ethnicity of all linguistic, cultural, religious, educational and socio-economic differences, there would be little left other than perhaps physical differences (in skin, hair, body and facial features) that in themselves really cannot affect therapy. In other words, differences in 'intervening variables' play a role because this is what ethnicity is about, not instead of it.

One may argue that when these differences are identified they may be also worked with, since process and outcome in many mismatched dyads are comparable to those in matched dyads. But what happens there? Next to quantitative results, qualitative ones suggest that when ethnic differences do not affect therapy it is because they do not interfere with basic conditions such as perceived acceptance, emotional connectedness, empathic understanding, genuineness, clarity of communication and, overall, a positive therapy process. Whether this follows the therapist's and/or in fact the client's skills and cultural competence, however, remains unclear. Quantitative data suggest that reduced differences in the constituents of ethnicity (e.g. language and culture) play an important role, and that often it is the client's acculturation, i.e. their competence into the host culture, that counter-balances therapist cultural incompetence. Qualitative data also indicate that clients who are struggling with aspects of their own culture (e.g. around sexuality or social/family roles) may particularly benefit from working with a white western therapist, and that to increase perceived similarity clients may also 'bracket out' issues related to ethnic differences and focus on other similarities within the dyad (e.g. of gender, sexuality, politics or worldview). However, the research also indicates that, especially when differences are
strong, clients in mismatched dyads often drop out prematurely, and when they stay they are less likely to benefit from positive process and hence outcome. This is striking since data are typically collected from therapists who work in multicultural cities, often for cross-cultural centres, and benefit from relevant training/experience, good intentions and open minds.

In our view there are at least three interrelated concurrent processes that can render therapy with ethnically different clients so difficult. First, clients may come to an ethnically similar/dissimilar therapist with a positive/negative assumption about being understood, which will self-fulfil inasmuch as they will be more/less open and trusting. Second, people naturally give prominence to aspects of reality that fit their assumptions, so that in therapy negative (and not necessarily conscious) stereotypes about the other's ethnic background would automatically obstacle the development of a positive process. Third, but most importantly, clients and therapists may simply fail to understand each other, and not just because of their different cultural values and experiences. For instance, much affective information is exchanged, especially in the initial sessions, that makes the client and the therapist feel whether they can connect or not. Affective communication also tends to be non-verbal, implicit and deeply affected by cultural ways of relating to others, especially as others of a given gender, age, social class, sexual identity, etc. Cultures can also differ in the ways they deal with the same affects, for instance in how and when they should be manifested, or the very meaning ascribed to their occurrence and manifestations. These differences develop in early interactions with significant others and continue to be affected by one's cultural milieu throughout development. As cultural idiosyncrasies they also operate automatically below one's immediate awareness and control and can thus generate misunderstandings in mismatched dyads that are difficult to avoid or sort out. A Caucasian
male therapist, for instance, may not be prevented against a South-Asian female client but may still perceive her, say, secretiveness, as manipulative. And she could then perceive his ensuing uneasiness as judgmental and stereotyping.

Clearly, practitioners should gather as much information as possible on the cultural background of their clients. Special attention to the individual’s culture, beliefs, values and needs (e.g. individuation versus collectivism, focus on family, respect for the elderly, how love and affect are expressed, etc.) is paramount. In addition, sensitivity and particular attention to the individual’s mode of acculturation to the host culture (assimilation, integration, separation, marginalisation (Berry, 1980), their acculturative stress and cultural commitments, is also important. However, how much knowledge of how many cultures and modes of acculturation is really possible? Knowing a culture well will require years of continued contact. Some comfort can be found in qualitative data suggesting that problems stem more from making assumptions than not knowing, as clients seem to note cultural incompetence more than cultural competence. Maybe, even when (we think) we do understand someone's cultural background, an open attitude of not knowing (enough) may be best.

In summary, when working with ethnically different clients we should pay extraordinary attention to the therapeutic relationship and alliance, and facilitative conditions such as empathic understanding, respect for difference, positive regard, a seriously open attitude of not knowing, etc. A consistent finding within this review is support for similar therapeutic factors. Interestingly, these are shared across most therapeutic approaches and yet both quantitative and qualitative data indicate that, all too often, ethnic differences can still undermine a positive therapy process and outcome. Ultimately, therefore, the obvious way forward must be to offer more ethnic matching than
is currently available. Universities and professional bodies in counselling and psychotherapy should make a concerted effort to recruit more ethnic minority trainees. Mental health services need to be more proactive and place a greater emphasis on recruitment and career promotion of ethnic minority professionals, to be able to offer optimal mental health services to people of all ages from this rapidly growing client group. Training therapists to work with clients from different ethnicities is an ethical duty and can only help but the data suggest that it may not suffice. Needless to say, EM should be offered not forced. Cultural categorisation would do a disservice to the client and the therapeutic relationship. Nevertheless, the research is clear. Even though from the outset it may seem that EM may foster segregation and avoidance, adopting a colour-blind approach that denies the difference, i.e. the real world in which we live, is not the solution.
References


