# MATCHING CLIENT AND THERAPIST ETHNICITY, LANGUAGE, AND GENDER: A REVIEW OF RESEARCH

*Jacquelyn H. Flaskerud, Ph.D., F.A.A.N.*
*University of California, Los Angeles*

*The purpose of this article is to examine whether therapy process and outcome are influenced by a client–therapist ethnicity, language, or gender match. A review of research in this area does not demonstrate support for a client–therapist match on any of these variables. The methodological problems and unresolved conceptual issues involved in this research may limit the findings. The ethical and political context of the research and the implications for mental health nursing are explored.*

## INTRODUCTION

The question of whether therapy is effective when there are cross-cultural differences between therapist and client has been raised frequently in the mental health literature (Atkinson, 1983; Helms, 1984; Leong, 1986; Sue, 1988; Sue & Sue, 1987; Tsui & Schultz, 1988; Tyler, Sussewell, & Williams-McCoy, 1985; Wu & Windle, 1980). The match between client and therapist race, ethnicity, language, and culture have all been considered important variables in clients' use of services, remaining in therapy, and satisfaction with their therapy and therapist (Jackson & Kirschner, 1973; Jones, 1978; Dolgin, Salazar, & Cruz, 1987; Leong, 1986; Marcos, 1988; McKinley, 1987; Sue, 1988). Client and therapist gender match has also been studied repeatedly in an attempt to understand its effects on the therapeutic relationship and therapy outcomes (Abramowitz, 1981; Felton, 1986; Fenton, Robinowitz, & Leaf, 1987; Gornick, 1986; Jones, Krupnick, & Kerig, 1987; Jones & Zoppel, 1982). Considerable controversy exists in the literature about

This work was supported by National Institute of Mental Health Grant MH 44331 and the National Research Center on Asian American Mental Health, University of California, Los Angeles.

Correspondence concerning this article should be addressed to Jacquelyn H. Flaskerud, School of Nursing 3-242, University of California, 10833 LeConte Avenue, Los Angeles, California 90024-6917.

*Issues in Mental Health Nursing, 11:321–336, 1990*

that may be important to future research attempts. The article concludes by placing this area of research in an ethical and political context. Finally, it raises questions about whether and how mental health nursing might get involved in this area of research.

## RESEARCH

### Ethnicity Match

The majority of practitioners and investigators do not distinguish between an ethnicity or racial match between client and therapist and a culture match. Instead the terms are used interchangeably. Recommendations are frequently couched in cultural terms: The therapist must understand the client's social values and experience, cultural orientation, level of acculturation, cultural expression of illness, and the stigma associated with mental illness in the client's culture (Dolgin et al., 1987; Leong, 1986; Marcos, 1988; McKinley, 1987; Sue & Sue, 1987; Tsui & Schultz, 1988; Vail, 1976). Yet questions for research are often asked in terms of race or ethnicity: Can a White therapist effectively treat a Black, Asian, or Hispanic client? (Dolgin et al., 1987; Griffith, 1977; Leong, 1986; Sue, 1988; Thornton & Carter, 1988; Vail, 1976). Studies of whether a Black, Asian, or Hispanic therapist can effectively treat a White client are rare (Griffith, 1977; Helms, 1984).

Much of the research literature regarding ethnic or racial similarity focuses on White–Black dyads, usually White therapists and Black clients. Relatively little of the research includes Asians, Hispanics, and American Indians. The research literature can be divided into studies dealing with preference for therapist, therapy process, and therapy outcomes. Studies of preference for therapist race or ethnicity have demonstrated a rather consistent preference of Black clients for Black therapists over the years (Atkinson, 1983, 1985). There is some evidence that preference is related to clients' level of racial consciousness and that similarity in socioeconomic background supersedes racial similarity in preference for therapist (Helms, 1984). Because of limited data, no definitive conclusions can be drawn for other ethnic groups.

The process of therapy and racial or ethnic similarity between therapist and client has been studied from the perspective of therapist credibility, therapist expressiveness, and client expressiveness. Again, the majority of studies have used Black subjects. Of 15 studies over 11 years, Atkinson (1983) found that in 60% there was no process effect from same-race pairings. A limited number of studies of American Indian, Asian, and White subjects were almost evenly divided among those that found an ethnic similarity effect and those that did not; among

these variables' effects on therapy process and outcomes. Some researchers and clinicians believe that similarity between client and therapist in ethnicity, language, or gender facilitates the process of therapy and produces beneficial outcomes for the client. Others believe that client–therapist matching on these variables is not related to the process of therapy or to client outcomes.

The theory of social influence proposed by Simons, Berkowitz, and Moyer (1970) provides the framework for proponents of both sides of the controversy. This theory proposes that source (therapist) credibility, attractiveness, and influence are a function of similarity between the source (therapist) and the receiver (client; Atkinson, 1983). Proponents of this side hypothesize that therapists who share ethnicity or gender with their clients are better able to understand their clients' problems, serve as role models for their clients, and resolve their clients' difficulties. However, Simons and colleagues further postulated that attitude similarity is a more powerful determinant of attraction toward and influence by the source than is membership or group similarity. Proponents of cross-cultural or cross-gender counseling have argued that sensitive counselors transcend cultural or gender differences just as they transcend other differences between themselves and their clients (e.g., economic, religious, or educational differences).

Available research findings have failed to demonstrate a consistent effect of ethnicity, culture, or gender on the process of therapy or client treatment outcomes (Atkinson, 1983, 1985; Sue, 1988). The persistence of controversy in the literature over these variables may be attributed in part to the lack of rigorous research on this issue. Much of the literature is of an anecdotal nature or involves uncontrolled observations and limited research findings. There is also an ethical and political context to the controversy that keeps it current (Atkinson, 1983; Helms, 1984; Sue, 1988).

This article's purpose is to review and summarize the research on the effects of client–therapist ethnicity, language, and gender match on therapy process and outcome. An extensive literature search of this topic revealed that, for more than 20 years, the disciplines of psychology and psychiatry have been exploring and studying these questions. Notably lacking in the literature are studies in this area by the other two disciplines that provide therapy, namely, mental health nursing and social work. These disciplines have instead focused on describing cultural beliefs and practices and differences of various ethnic and racial groups from the White majority group. They have not tested the effects of a client–therapist match on therapy process or outcome. After summarizing the research on this topic, this article explores the methodological problems that limit the research findings and discusses conceptual issues

Hispanic subjects no evidence of a similarity effect was found. Taken together, the research on the process of therapy offers little support for the assumption that ethnically similar therapist–client pairings are more effective than dissimilar ones.

The effects of race or ethnicity on client outcomes has focused on client satisfaction and client attitude and behavior change. Studies reviewed by Atkinson (1983, 1985) used willingness to return for counseling, satisfaction with counseling, and dropout rate as outcome measures. Eleven of these studies used Black subjects; one study involved White subjects and one study included Hispanic subjects. These studies had mixed results and offered very little support for the superiority of ethnically similar pairings.

Wu and Windle (1980) examined the utilization rates of Black, Hispanic, Asian, and American Indian clients relative to ethnic or racial specificity in staffing. They found that Black and Asian clients significantly increased their utilization if therapists were of the same ethnicity or race but that Hispanic and American Indian clients did not. Vail (1976) reported that client–therapist racial similarity was not significantly related to clients' remaining in therapy and that Black clients assigned to Black therapists rated their therapists' understanding and acceptance slightly lower than Black clients assigned to White therapists. Flaskerud and Liu (in press) studied the effects of Asian (Chinese, Japanese, Korean, and Filipino) client–therapist ethnicity match on three outcome measures: number of sessions with primary therapist, dropout from therapy, and admission–discharge change in the Global Assessment Scale (GAS) score. They found that a client–therapist ethnicity match significantly increased the number of sessions with the primary therapist and decreased the dropout rate but had no effect on the GAS score. However, in a similar study with Southeast Asian (Vietnamese and Cambodian) clients, Flaskerud and Liu (1990) found that an ethnicity match had a significant effect on number of sessions with the primary therapist but no significant effect on dropout rate or change in GAS score.

One explanation for the contradictory findings of the studies cited might be that cultural similarity, social class similarity, or therapist–therapy variables rather than ethnic or racial similarity variables are important influences on client treatment outcomes (Evans, Acosta, Yamamoto, & Skilbeck, 1984; Griffith, 1977; Helms, 1984; Jones, 1984; Sue, 1988). For example, a therapist of Chinese ethnicity born and raised in the United States might have little knowledge or understanding of the cultural beliefs and values of a Chinese client born and raised in China. Likewise, a Black, middle-class therapist might have little understanding of the world view and life experience of a

Black, lower-class client. Finally, therapist expressiveness, nurturance, or understanding might have more of an effect than racial similarity.

### Language Match

Several investigators and practitioners have suggested that clients have better therapeutic outcomes when they and their therapists share a common language. Lack of a common language is thought to result in a diagnosis of more severe psychopathology, decreased client self-disclosure, lower ratings of client–therapist rapport, and lower ratings of therapists' empathy and effectiveness (Belton, 1984; Dolgin et al., 1987; Leong, 1986; McKinley, 1987). The most difficult aspects of the lack of a shared language between clients and therapists are the risks that assessment will be inaccurate and clinical inferences will be inappropriate (Sue & Sue, 1987). Sharing a common language or language style is thought to be conducive to enhancing the treatment process. However, the majority of recommendations in the literature for a language match between client and therapist are not based on research findings. Intuitively it would seem correct that such a match is desirable, but few documented studies of language match exist. Most of those that do exist support a language match between client and therapist. Investigators working with clients whose primary language was Spanish have documented that when clients were interviewed in Spanish they were assessed by their interviewers as having less thought disorder and cognitive slippage than when they were interviewed in English (Marcos, 1988; Marcos, Urcayo, Kesselman, & Albert, 1973). Furthermore, clients were more often misdiagnosed and had inaccurate attitudes imputed to them when they were interviewed in English than when they were interviewed in Spanish. Flaskerud and Liu (in press) found than an Asian client–therapist language match significantly increased the number of client sessions with the primary therapist over non-language-match client–therapist pairings. However, language match did not have a significant effect on dropout rate or gain in the GAS admission–discharge score. Their study of Southeast Asian respondents also demonstrated that the effect of a therapist–client language match was to increase the number of therapy sessions for clients (1990). An unexpected result of this study, however, was that for Cambodian clients the effect of a language match on dropout rate was to increase the dropout rate. They offered both methodological and clinical explanations for this negative effect on dropout rate.

Given the limited number of therapists who share a common language with many minority clients, the use of interpreters has often been recommended as a solution to the lack of a language match between therapists

and clients. However, interpreters may bring additional problems to the interview situation. Several investigators have noted that three major forms of distortion were found when Spanish- and Chinese-speaking interpreters were used in clinical assessments (Leong, 1986; Marcos, 1979; Sue & Sue, 1987). First, interpreters omitted, substituted, condensed, and changed the focus of the therapist's questions in an attempt to make sense of disorganized statements, thus preventing the clinician from gaining a clear idea of the client's mental status. Second, interpreters normalized the patient's thought processes and descriptions because of a lack of psychiatric knowledge. Third, interpreters minimized psychopathology and answered the question for the client both because of their own attitudes and to prevent the stigma of mental illness being associated with their ethnic group.

There are other discussions in the literature that suggest that language differences might be responsible for stereotypes related to the personality and type and degree of pathology of a particular ethnic or racial group. Most diagnostic and personality tests are written in English and normed on White, middle-class subjects. Using untranslated measures of personality and psychopathology with clients whose English language facility is limited subjects them to misunderstanding, cultural response bias, and nonfamiliarity with test format (Flaskerud, 1988; Leong, 1986; Yamamoto et al., 1982). Even instruments that have been translated into client languages are subject to errors in interpretation of client personality and pathology. There may be cultural differences in what are perceived to be normal behaviors and in definitions of mental illness (Leong, 1986; Tyler et al., 1985).

Most studies of client–therapist language match that do exist document the detrimental effects when a common language is not shared. Few studies examine the beneficial effects on therapy outcomes. For the most part, the beneficial effects of common language on treatment outcomes have been assumed but not documented. Those few studies that do exist have reported equivocal results on the effect of a client–therapist language match on therapy outcomes.

## Gender Match

The gender match between therapist and client has been studied from the perspectives of client preference for therapist, assignment to therapist, and process and outcome of treatment (Abramowitz, 1981; Felton, 1986; Fenton et al., 1987; Gornick, 1986; Jones et al., 1987; Jones & Zoppel, 1982; Vail, 1976; Wu & Windle, 1980). The results are often contradictory. Fenton and colleagues (1987) reported that female clients prefer female therapists and physicians, especially in situations when a

woman is perceived as a more credible provider (e.g., psychotherapy, obstetrics, gynecology, and family planning). In examining the practices of therapists, investigators have found a predominance of female clients in the practices of female psychiatrists and of male clients in the practices of male therapists (Abramowitz, 1981; Fenton et al., 1987). Better educated clients of both genders tended to have same-gender therapists; clients experiencing marital disruption tended to be seen by opposite-gender therapists (Fenton et al., 1987).

The therapy process is thought to be affected by the therapist's gender in all four possible client–therapist pairings (Felton, 1986; Gornick, 1986). Issues such as gender identity, gender roles, intimacy, and sexual partner orientation are concerns that could create obstacles or advance progress in therapy. Therapists' perceptions of power, dominance, and the role of women, and therapists' own sexual orientation can affect their responses to clients and clients' responses to them. Gender components can affect transference and countertransference. These issues must be acknowledged if therapists are to provide the best treatment possible (Felton, 1986; Gornick, 1986).

Jones and colleagues (Jones & Zoppel, 1982; Jones et al., 1987) studied the impact of client and therapist gender on psychotherapy process and outcome. Female therapists rated themselves as more successful, particularly with female clients, and male therapists described clients in less socially desirable terms. Clients, regardless of gender, agreed that female therapists formed more effective therapeutic alliances than did male therapists (Fenton et al., 1987). Clients treated by female therapists experienced more symptomatic improvement and reported more satisfaction with treatment than those treated by male therapists. Female therapists were judged to arouse less negative affect and fewer interpersonal difficulties in female clients (Jones & Zoppel, 1982).

Most of the studies cited in this article used White, middle-class subjects (both clients and therapists). Findings of these studies might not be generalizable to other social and cultural groups. The role of women vis-à-vis power and dominance, the credibility of women as therapists or as health care providers, and the value placed on feminism all might differ in other cultural or social class groups. Studies that included racial or ethnic minority clients often reported contradictory findings. In a sample of Black clients, Vail (1976) found that when there was a gender match between client and therapist, clients dropped out of therapy more often than when there was not a match. Female clients dropped out of therapy more often when their therapist was female, and male clients dropped out more often when their therapist was male. To confound the gender match question even more, Wu and Windle (1980) reported that Asian male clients had greater utilization rates if their therapist were

male than if their therapist were female. This relationship was significant only for male and Asian clients and not for Black, Hispanic, or American Indian clients. Flaskerud and Liu (in press), in a sample of Asian clients, found no gender effect on the number of client sessions with the primary therapist in any of the four possible client–therapist pairings. The effect of gender on dropout was significant when there was a male client–therapist match. The odds of dropping out decreased significantly. A gender match for female clients and therapists of any of the other possible client–therapist pairings did not result in a significant effect. Gender match did not show a significant effect on GAS scores. From the studies cited, the influence of gender on the process and outcome of therapy is not at all clear.

## METHODOLOGICAL ISSUES

The research on the ethnicity or gender effects on the therapy situation has several limitations. Comparison of studies to one another is difficult because some studies use college students as subjects and others use patient populations; some studies use both nonpsychotic and psychotic patients and others use only psychotic or nonpsychotic subjects. Confounding variables that prohibit comparisons and have a major effect on study findings would be socioeconomic status, education of clients, presenting problem or diagnosis, and therapist discipline models. Whether therapist ethnicity or gender is as important to a student with an educational or vocational problem as it is to a patient with a diagnosis of schizophrenia is a question that has not been studied. Studies of gender pairing effects do not take into account the ethnicity or race of subjects. Findings of gender effect that are based on White, middle-class clients and therapists cannot be generalized to subjects of other cultural and social groups. Differences in these populations limit the generalizability of findings in one area to those in another.

Another limitation that makes comparison of research findings difficult is that many studies, especially those that focus on the process of therapy, are analogue studies. Conclusions from analogue research (i.e., laboratory research) that uses college students or volunteers to take part in an interview or other process or procedure cannot be compared with field studies in which actual clients are being treated or counseled. Furthermore, of those studies of process that are field studies, very few can be linked unequivocally with client outcome. In fact, the research reviewed suggests that for the client there is very little carryover from a positive therapy process experience to more direct evidence of therapy effectiveness. That is, clients might prefer or like a therapist who is ethnically similar, but there is little evidence that therapy outcomes from

such a pairing are better. Therapist race or ethnicity alone is not a predictor of therapeutic outcome.

One of the major shortcomings of most studies to date is that they fail to take within-groups differences into account in their designs. Gender groups or racial or ethnic groups may differ in their attitudes toward their group (level of racial or gender consciousness), their degree of assimilation, their previous experience with therapy, their attitudes toward therapy, and their expectations of therapy. The type of problem for which a client seeks help may also affect his or her preference for therapist gender, ethnicity, or both. Each of these characteristics needs to be considered as an independent variable in study designs. As noted earlier, social class, level of psychopathology, and sex may be confounded with race or ethnicity. Furthermore, the correlational nature of some of the studies has made it difficult to determine cause and effect (Atkinson, 1983; Sue, 1988).

Comparison of study results is made difficult by the differences in the outcome measures used. Measures used in the studies cited here included utilization rates, dropout from therapy, satisfaction with therapist, symptom improvement, client perception of therapists as warm and empathic, and preference for therapist. It is likely that none of these variables by itself can adequately measure the effectiveness of treatment. In addition, outcome measures may not have cross-cultural validity or may be insensitive to ethnic or gender differences.

## CONCEPTUAL ISSUES

The conflicting findings of studies of ethnic or racial and gender matches between therapist and client and these studies' critical limitations have led investigators to reconsider their conceptualizations of client–therapist pairings. Some of these theoretical explanations have focused on intergroup differences. The concept of levels of racial and gender consciousness has been used to provide a framework for the four possible White–Black racial pairings and the four possible gender pairings. Cross (1971, 1978) proposed a cognitive developmental model of Black self-actualization or racial consciousness that moved from self-abasement and denial of Blackness to self-esteem and acceptance of Blackness. According to this explanation, racial identity attitudes could affect whether a racial match between therapist and client would lead to positive treatment outcomes (Jackson & Kirschner, 1973). Differences in the stages of racial identity influence both therapist and client. There are advantages and disadvantages associated with all four dyads. For instance, a Black therapist–Black client therapy situation in which the therapist has developed racial self-actualization but the client is still in

the stage of self-abasement has the potential advantage of the therapist serving as a role model for the client in raising racial consciousness. On the other hand, this same situation could result in the client dropping out of therapy because he or she judges a Black therapist to be less desirable than a White therapist. Similarly, advantages and disadvantages occur with Black–White and White–White dyads depending on level of racial consciousness.

Helms (1984) developed this cognitive developmental model further by proposing a parallel explanation of the development of White racial consciousness. She discussed the possible affective issues, therapy strategies, and therapy outcomes of Black dyads, White dyads, and mixed dyads depending on client and therapist stage of racial consciousness. One implication of this model is that the therapist cannot move the client further than the therapist has come. Helms proposed that research be directed first at determining whether the racial consciousness process is a reality among Whites and Blacks and second at whether client and therapist level of racial consciousness can explain intergroup differences in determining the effectiveness of a racial client–therapist match.

This same theoretical explanation might be used as a framework for the various gender pairings in therapist relationships. The level of gender consciousness could be an issue for both male and female clients and therapists. The value attributed to gender equality could affect the attitudes and affective reactions of therapists and clients, the therapy strategies used, and treatment outcomes. Again, all of the four possible gender pairings offer advantages and disadvantages in the therapy situation. As an example, in a therapy situation in which both the therapist and client are female and have a strong feminist identity, this shared identity could facilitate the process of therapy, or it could create power struggles between therapist and client. Male–female and male–male therapy dyads are also affected by level of gender consciousness.

Another conceptual explanation of intergroup differences focuses on levels of acculturation (Sue & Zane, 1987). Although *groups* exhibit cultural differences, considerable *individual* differences may exist within groups. Ethnic pairings between client and therapist can result in cultural mismatches if therapists and clients from the same ethnic group show markedly different levels of acculturation (e.g., values, ideology, attitudes, beliefs about mental illness). Sue and Zane (1987) considered ethnic pairings a distal variable (distant and weak) in relation to client outcomes. Proximal variables (similar attitudes, values, life-styles, client's belief that the therapist is credible) are more likely to demonstrate a strong relation to outcome than are distal variables.

These conceptualizations focus on within-groups (or individual) differences and point out that the ethnic or racial match issue is a complex

one. The question of client–therapist match cannot be framed as if simple answers can be provided. Tyler and colleagues (1985) have proposed an ethnic validity model that emphasizes the variety in human interaction. The model addresses the convergence, divergence, and conflict between different ethnic world views and their consequent emergence in various patterns of human interaction. All of the patterns of interaction have potential gains and losses for client and therapist. Convergent patterns of interaction reflect similar attitudes and values and reaffirm culture, shared experience, and identity. Divergent patterns of interaction reflect differences in attitude and values but emphasize the richness of cultural diversity and provide an opportunity for growth. Conflicting patterns of interaction are not only different but clash. The tasks of therapy in this model are to enrich convergence (commonalities) and divergence (pluralism) and to reduce conflict.

This model could easily be applied to gender client–therapist pairings as well. The focus on shared experience and identity (convergence) or the richness of value diversity and the opportunity to transcend biases (divergence) or conflicting values and actions is applicable to the various gender pairings. This is especially true if gender consciousness and equality are considered influential in the therapy relationship.

The conceptual models proposed in the discussion of racial, ethnic, or gender pairings all emphasize the within-group or individual differences in racial, ethnic, and gender groups without discounting race, ethnicity, and gender as important group differences. By doing so, these models recognize the complexity of the client–therapist match issue. However, more important, they emphasize the salience and importance of racial, ethnic, and gender variables as such rather than as personal or individual factors.

These conceptual models acknowledge the unique strengths and limitations of various life-styles. The question of match between client and therapist might be better framed by a greater emphasis on therapists' and clients' belief systems, values, attitudes, and life-styles than on their ethnicity or gender. Such a theoretical explanation would focus on matching client and therapist on the basis of (a) conceptualization of the client's problem (is it defined as a somatic problem, a psychological problem, a socioeconomic problem, or a spiritual problem?); (b) conceptualization of the means for solving the problem (medical treatment, medication, psychotherapy, direction, reflection, counseling, meditation, hospitalization, social services, financial assistance, or legal services); or (c) goals of treatment (symptom relief, insight, individual growth, family stability, etc.). This conceptualization would be culture-specific (ideology, values, attitudes, and beliefs) rather than ethnic-, racial-, or gender-specific (Evans et al., 1984; Flaskerud, 1987a,

1987b; Sue, 1988). By matching on these variables it might be expected that therapy process and outcome would be evaluated as more effective by both clients and therapists.

## CONCLUSIONS

After reviewing the studies on the effect of ethnic, racial, and gender match on therapy outcomes and the studies' inconclusive findings, the reader might be tempted to ask how this area of research originated and why it continues. The ethical or political context of the research questions helps explain their origin and their continued interest. Studies such as those reviewed here were motivated originally by the racism, ethnocentrism, and sexism of American society as reflected in American psychiatry and psychology. These studies continue because racism and sexism continue. The paradigm of American psychiatry and psychology has traditionally and often still currently represents largely White, middle-class, male values and world view (Sue & Sue, 1987; Tyler et al., 1985). This paradigm ignores the importance of culture, race, ethnicity, and gender; denies the autonomy of clients to define their own worlds and shape their own destinies; and fails to acknowledge how the interaction between social systems and individuals influences how people function and organize their lives. The real life outcomes of this White, male paradigm were that psychotherapy with ethnic or racial minorities and women was frequently found to be ineffective and that diagnosis and treatment were found to be at best inaccurate and inappropriate and at worst prejudicial, discriminatory, and punitive. Furthermore, the effect of this paradigm was to discriminate against ethnic or racial minorities and women entering the mental health professions.

The original research questions on client–therapist ethnic and gender matches were undertaken to force American psychiatry to examine its racist, sexist, and ethnocentric paradigm and behavior. A scientific solution to a political and ethical or moral problem was sought. Despite the fact that the research fails to demonstrate that ethnic, racial, or gender pairings produce better outcomes, the research has succeeded in focusing attention on the sociopolitical inequalities and the unethical and immoral behavior occurring in the mental health professions and delivery system. Furthermore, to the extent that the research has produced more complex conceptualizations of the client–therapist match issue, the political and ethical convictions of the investigators involved has resulted in the development of knowledge in the field.

To date, the research has not demonstrated that client–therapist ethnic, racial, or gender matches are more effective than nonmatches to clinical outcomes. What are the issues of concern of this research for

mental health nursing and nurse psychotherapy? Should nurses also get involved in asking research questions about ethnic, racial, and gender matches of client and therapist? As noted in the introduction, nurses have involved themselves to date in studies that describe cultural beliefs, practices, and differences. Some nurses have been involved also in studies of women's roles as they influence mental health, mental illness, and health care. These studies have usually drawn implications for nurse psychotherapy and mental health nursing research. However, they have not suggested explicitly that therapists and clients should share race, ethnicity, or gender. Perhaps this is where nursing research should remain. As detailed throughout this review, there is little evidence that such matches produce better outcomes. Perhaps nursing's contribution to research involving culture, gender, and psychotherapy should continue in the areas in which nurses have expressed their preference through their research questions. These questions may reflect more of a nursing perspective.

Mental health nurses who do wish to pursue this line of research can be guided by previous studies in other disciplines. They can design their studies to avoid the methodological problems and limitations of earlier studies. They can make a major contribution to this area of research by using patient populations in field studies, by controlling for diagnosis or patient problem or behavior, and by controlling for other intervening variables, especially within-group differences. Mental health nurses could make their biggest contribution by designing valid and reliable outcome measures that are conducive to administration in a practice setting.

From a conceptual perspective, the research from other disciplines has demonstrated that the question of client–therapist match has been framed too simplistically. As alluded to earlier, there is a distinct character to nursing psychotherapy. This perspective includes a knowledge of and attention to physical illness problems and their treatment, as well as to mental health problems, a consideration of the client's social and economic situation, and a focus on the client's family and social network (Flaskerud, 1985). This comprehensive approach has the potential for allowing clients more autonomy in decisions about their therapy. Permitting self-determination and autonomy on the part of the client ought to lead nurse therapists who take a comprehensive perspective to adjust their approach to the client's needs for treatment and outcomes. For example, the client's conceptualization of the problem, the type of treatment desired, and the goals for treatment would all be taken into consideration by the therapist with a nursing perspective. And unless safety dictated otherwise, the course of therapy would be guided by these considerations. With this kind of conceptualization, the question of client–

therapist match could be studied from a unique and refreshing nursing perspective.

However, the sociopolitical and moral–ethical perspective of the original research questions remain. The strongest argument for increasing the number of female and ethnic and racial minority therapists is a moral–ethical and political (power) one (Atkinson, 1983; Sue, 1988). Although the number of women in the mental health professions has increased (they have always been the majority in mental health nursing), ethnic minorities are still sadly underrepresented in all the mental health disciplines, including nursing. The need to recruit more ethnic and racial minorities into nursing is not dictated by how effective therapy is with minority clients, but by the fact that it is unethical and immoral to exclude people from nursing based on race or ethnicity.

Finally, the paradigm used to teach and provide psychotherapy still reflects White, middle-class, male values and world view. This includes, in many cases, the way in which psychotherapy is taught and provided in mental health nursing. Given this orientation and lack of progress, the research question probably remains, "Is psychotherapy, as currently framed, effective?" and not "Which therapist is most effective for which client?"

## REFERENCES


1. Abramowitz, S. I. (1981). Sex and case assignment: Further evidence of a phenomenon in search of an explanation. *Psychological Reports, 48*(2), 644.
2. Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist, 11*, 79–92.
3. Atkinson, D. R. (1985). A meta-review of research on cross-cultural counseling and psychotherapy. *Journal of Multicultural Counseling and Development, 1*, 138–153.
4. Belton, M. A. (1984). The effect of therapist dialect upon the Black English-speaking patient's perception of therapist empathy, warmth, genuineness, and expertise. *Dissertation Abstracts International, 44*(8-B), 2547.
5. Cross, W. E. (1971, July). The Negro to Black conversion experience. *Black World*, pp. 13–27.
6. Cross, W. E. (1978). The Cross and Thomas models of psychological nigrescence. *Journal of Black Psychology, 5*, 13–19.
7. Dolgin, D. L., Salazar, A., & Cruz, A. (1987). The Hispanic treatment program: Principles of effective psychotherapy. *Journal of Contemporary Psychotherapy, 17*(4), 285–299.
8. Evans, L. A., Acosta, F. X., Yamamoto, J., & Skilbeck, W. M. (1984). Orienting psychotherapists to better serve low income and minority patients. *Journal of Clinical Psychology, 40*(1), 90–96.

9. Felton, J. R. (1986). Sex makes a difference: How gender affects the therapeutic relationship. *Clinical Social Work Journal, 14*(2), 127–138.
10. Fenton, W. S., Robinowitz, C. B., & Leaf, P. J. (1987). Male and female psychiatrists and their patients. *American Journal of Psychiatry, 144*(3), 358–361.
11. Flaskerud, J. H. (1985). Distinctive characteristics of nursing psychotherapy. *Issues in Mental Health Nursing, 6*(1), 1–19.
12. Flaskerud, J. H. (1987a). The effects of culture-compatible intervention on utilization of mental health services. *Community Mental Health Journal, 22,* 127–141.
13. Flaskerud, J. H. (1987b). A proposed protocol for culturally relevant nursing psychotherapy. *Clinical Nurse Specialist, 1,* 150–157.
14. Flaskerud, J. H. (1988). Is the Likert scale format culturally biased? *Nursing Research, 37,* 185–186.
15. Flaskerud, J. H., & Liu, P. Y. (in press). Effects of an Asian client–therapist language, ethnicity and gender match on utilization and outcome of therapy. *Community Mental Health Journal.*
16. Flaskerud, J. H., & Liu, P. Y. (1990). Influence of therapist ethnicity and language on therapy outcomes with Southeast Asian clients. *International Journal of Social Psychiatry, 36,* 18–29.
17. Gornick, L. K. (1986). Developing a new narrative: The woman therapist and the male patient. *Psychoanalytic Psychology, 3*(4), 299–235.
18. Griffith, M. S. (1977). The influence of race on the psychotherapeutic relationship. *Psychiatry, 40,* 27–40.
19. Helms, J. E. (1984). Toward a theoretical explanation of the effects of race on counseling: A black and white model. *Counseling Psychologist, 12*(3–4), 153–165.
20. Jackson, G. G., & Kirschner, S. A. (1973). Racial self-designation and preference for a counselor. *Journal of Consulting Psychology, 20,* 560–564.
21. Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research and Practice, 151,* 226–236.
22. Jones, E. E. (1984). Some reflections on the Black patient and psychotherapy. *Clinical Psychologist, 37*(2), 62–65.
23. Jones, E. E., Krupnick, J. L., & Kerig, P. K. (1987). Some gender effects in a brief psychotherapy. *Psychotherapy, 24*(3), 336–352.
24. Jones, E. E., & Zoppel, C. L. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology, 50*(2), 259–272.
25. Leong, F. T. (1986). Counseling and psychotherapy with Asian-Americans: Review of the literature. *Journal of Counseling Psychology, 33*(2), 196–206.
26. Marcos, L. R. (1979). Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. *American Journal of Psychiatry, 136,* 171–174.
27. Marcos, L. R. (1988). Understanding ethnicity in psychotherapy with Hispanic patients. *American Journal of Psychoanalysis, 48*(1), 35–42.
28. Marcos, L. R., Urcuyo, L., Kesselman, M., & Albert, M. (1973). The language barrier in evaluating Spanish-American patients. *Archives of General Psychiatry, 29,* 655–659.
29. McKinley, V. (1987). Group therapy as a treatment modality of special value for Hispanic patients. *International Journal of Group Psychotherapy, 37*(2), 255–268.

30. Simons, N. W., Berkowitz, N. M., & Moyer, R. J. (1970). Similarity, credibility, and attitude change: A review and a theory. *Psychological Bulletin, 73,* 1–16.
31. Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*(4), 301–308.
32. Sue, D., & Sue, S. (1987). Cultural factors in the clinical assessment of Asian Americans. *Journal of Consulting and Clinical Psychology, 55*(4), 479–487.
33. Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42,* 37–45.
34. Thornton, C. I., & Carter, J. H. (1988). Treating the Black female alcoholic: Clinical observations of Black therapists. *Journal of the National Medical Association, 80*(6), 644–647.
35. Tsui, P., & Schultz, G. L. (1988). Ethnic factors in group process: Cultural dynamics in multi-ethnic therapy groups. *American Journal of Orthopsychiatry, 58*(1), 136–142.
36. Tyler, F. B., Sussewell, D. R., & Williams-McCoy, J. (1985). Ethnic validity in psychotherapy. *Psychotherapy, 22,* 311–320.
37. Vail, A. (1976). Factors influencing lower class, black patients' remaining in treatment. *Clinical Psychologist, 29,* 12–14.
38. Wu, I. H., & Windle, C. (1980). Ethnic specificity in the relative minority use and staffing of community mental health centers. *Community Mental Health Journal, 16*(2), 156–168.
39. Yamamoto, J., Lam, J., Choi, W. I., et al. (1982). The psychiatric status schedule for Asian-Americans. *American Journal of Psychiatry, 139,* 1181–1184.