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The Importance of Therapist-Client "Matching" on Client Experiences

by

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Undergraduate honors thesis under the direction of

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Introduction

Minority Stress Theory (MST) proposes compelling reasons for the elevated need for medical care required by multicultural, sexual orientation, and gender minorities: a constant onslaught of explicit, implicit, and institutional discrimination. This theory explains how constant oppression, microaggressions, and prejudices painstakingly chip away at the mental and physical health of black, indigenous, and people of color (BIPOC) and LGBTQ individuals. MST cites systemic oppression as fundamental causes for increased rates of depression, anxiety, and suicide amongst racial, gender, and sexual orientation minorities. Furthermore, these mental illnesses often trigger physical comorbidities that may explain the higher risk for heart failure, hypertension, and breast cancer. To combat the suffocating discrimination, many medical professionals suggest therapy as a mental reprieve to minority communities. However, when faced with the institutional flaws of Western therapy and unconscious biases of predominantly white therapists, BIPOC and LGBTQ communities struggle to find a truly welcoming and understanding space that can provide them with the mental reprieve they so desperately need.

In the summer of 2020, many minority communities experienced high rates of mental and physical stress. As sickening videos of police brutality and social injustice ran rampant on social media, the mental health needs of BIPOC continued to rise. The recent events of Asian hate crimes, including the murder of 6 Asian women in Atlanta, fueled by prejudiced statements from the media and politics continue to stoke the flames of discrimination and minority stress. These stressors, combined with recent attacks on LGBTQ equality, have led to a boiling point of stress and anxiety for the United States' minority groups. In response to these issues, many BIPOC and LGBTQ -focused outlets gained prominence. Forums such as the Therapy for Black Girls project arose on large platforms like iHeartRadio. Additionally, actress Taraji P. Henson's Boris

Lawrence Henson Foundation grew in public popularity, providing mental health resources and even free therapy to struggling Black men. The Trevor Project continued to provide a crisis line for LGBTQ youth, ensuring that all individuals had a compassionate and understanding source of support. These organizations demonstrate the need for minority-specific assistance while simultaneously uncovering its lack as an issue with modern mental health care. A major strength of the previously mentioned outlets is their focus on employing and matching mental health professionals and clients based on race and sexual orientation. These practices further revealed an issue plaguing the mental health field from its inception: a fundamental lack of understanding and care for minority clients.

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This thesis establishes the underlying biases of the creation of modern Western therapy and highlights the current discrimination faced by BIPOC and LGBTQ individuals in the mental health field. With the most dominant forces of therapy rooted in Western individualism and self-sufficiency, these techniques fall short for minority clients who require additional support and environmental solutions. From this analysis arises the proposed solution of therapist-client matching. By pairing mental health professionals and clients based on cultural, racial, or sexual orientation backgrounds, the barriers of systemic discrimination begin to dissolve, allowing for a stronger therapeutic relationship and increased quality of care.

Most if not all current therapeutic techniques employed in the United States are heavily biased towards upper-class, white audiences. While newer therapies attempt to incorporate values from so-called “Eastern societies,” the presentation of techniques is skewed by the white gaze. Hindu and Buddhist meditation practices have entered into the mainstream of self-help guides and budding therapeutic theories; however, descriptions of mindfulness barely scratch the

surface of these instrumental methods of mental care. By reducing multicultural approaches to catchy, Westernized trends, newer therapies lay an unstable foundation for minority clients searching for quality mental health care. While a modern therapist may display a warm and compassionate regard to their clients, their training ineffectively prepares them for the challenges BIPOC and LGBTQ clients face. Combining with cultural and economic barriers in receiving proper mental health care, this disconnect further impedes the minority individual from obtaining the necessary help. These systemic issues illustrate a need for broader change in the instruction and execution of therapy; however, many minority clients lack time to wait for the slow wheels of progress.

The inciting force of my work is a section Honors Introduction to Psychology textbook. The chapter discussing therapy delved into the many ways this process could help individuals, especially those struggling with lifelong trauma and pain. However, when considering demographic statistics, the author states that minority patients receive the same quality care from all therapists regardless of race, sexual orientation, or gender. This assertion astounded me as a bisexual woman of color. After reaching out to friends and family, I heard echoes of my response. My first mental health professional disregarded my cultural values, diminishing my domestic issues with flawed advice. However, through one meeting with a BIPOC female therapist, I felt more understood than ever before. Through this thesis, I hope to prove that a match in race, sexual orientation, and gender between a mental health professional and their client creates a positive effect on patient interactions. Furthermore, when mental health professionals and clients differ in race, sexual orientation, or gender, minority individuals feel a genuine disconnect from their therapists that takes time, money, and emotional energy to overcome.

Approach

To address this thesis, four distinct forms of research were conducted. First, a multicultural and LGBTQ lens was used to analyze the historical perspective of the development and creation of common therapeutic practices. Next, a literary review of current, reputable sources regarding the effect of race, sexual orientation, and gender on the quality of mental health care was conducted. With this baseline of credible sources, an online survey geared towards multicultural and LGBTQ individuals was created and disseminated. Forty-six responses were recorded, organized, and analyzed as a part of the Multicultural and LGBTQ Therapy Thesis Survey. Finally, interviews were administered with BIPOC and LGBTQ individuals who had previously received mental health care. Discussions were focused on a holistic view of the participant to gain insight into their experiences receiving mental health care. These three interwoven points of my research constitute the main intervention.

Soothing Practices Rooted in Oppression - A History of Therapy

Psychoanalysis

Most scholars credit Sigmund Freud with the development of talk therapy. While widely controversial, Freud's techniques emphasized the importance of sitting for lengthy conversations to gain information and form a relationship with patients and unlock the brain's inner motives. Though practices may have changed, the general arrangement of therapy remains the same. This establishing doctrine of therapy creates flawed foundational misunderstandings and insensitivities towards minority patients. With a main goal of insight, uncovering a patient's true desires, acclaimed multicultural researchers Sue and Sue emphasize that "insight is not highly

valued by many culturally different clients," repeating that these individuals "frequently do not perceive insight as appropriate to their life situations and circumstances" (Sue et al. 227). For a minority patient, the primary aim of psychotherapy may convolute an already stressful therapy experience by forcing European standards into personal care. This critique illustrates the central pitfall of psychoanalysis: techniques rigidly rooted in Western ideals. Without extreme modification, psychoanalysis' primary goals fail to match the needs of minority patients.

Additionally, the process of psychoanalysis often requires months of commitment with frequent sessions with a trained psychoanalyst. This drain of time and money is infeasible for many minority patients; with the added complication of disconnected goals, psychoanalysis is of little use to most BIPOC and LGBTQ patients. Freud's introduction to therapy reminds readers that many social institutions of mental health are founded on the teachings of archaic, rich, white men. These real historical characters inhabited a world explicitly controlled by white males who often misinterpreted and vilified the mental afflictions of surrounding minority groups, such as hysteria in women. A system created with a white, male audience in mind must frequently be altered and tweaked to barely fit BIPOC and LGBTQ patients' needs. In the end, these practices cannot fully accommodate minority differences without diligent reinforcement of these enormous changes.

Behavioral Therapy

Freud was followed by B. F. Skinner and other behavioral therapists who claimed that mental health issues stem from and can be controlled by behavioral modifications. With a new perspective, these following therapies contrast the relative pessimism of psychoanalysis by stressing the benefit of self-control. While Freud's teaching dwelled on the inevitability of

repression and psychological abnormalities, later therapeutic styles emphasized the patient's autonomy in rectifying their mental health. With a stark difference in viewpoints, behavioral therapy and following treatments diverge from the central tenets of psychoanalysis. Regardless, behavioral therapy's foundation of Western origins skews its orientation towards a privileged white male client. Kantrowitz and Ballou (1992) highlight that under this therapy, "individuals are expected to improve their adaptive capacities to meet the environmental conditions that serve to reinforce the dominant and male social standards" (Kantrowitz 79). Thus, the practice limits patients to the assumptions of normality in the dominant culture. With an overwhelming majority of white therapists, this "dominant culture" takes the form of white, heterosexual roles and beliefs, isolating multicultural and LGBTQ minorities.

Current behaviorists employ assertiveness training in the workplace. To curb office harassment and discrimination, therapists encourage minority clients, especially women, to alter their behavior, insisting that they must be more assertive to succeed in the American workplace. However, this recommendation does not consider that workplace culture may not fit a client's intentions and best path. New findings regarding the effects of assertiveness training on African-American individuals "clearly show that the focus of [an] intervention must often be on changing the environment, not just the individual" (Zalaquett et al. 285). With these practices, behaviorism forces minorities to assimilate into a dominant culture, removing all traces of individuality and uniqueness. By failing to consider the impact of an oppressive environment on a client, this therapy seeks conformity rather than diversity.

Another critique of behavioral therapy surfaces in the relationship between the therapist and the client. While most modern therapies view these two positions as equal, behavioral therapy emphasizes control. The first "ventures in behavioral psychology often gave the therapist

… almost complete power, and decisions sometimes focused on controlling the client rather than helping the client control [them]self" (Zalaquett et al. 262). In moderation, a guiding force can help clients; however, minority clients may feel pressured to submit and conform to the standards a therapist sets, which may enforce the dominant culture. This unequal dynamic compounded with the lower quality of care that minority patients receive creates a strained therapist-client relationship, leading to wrongly aligned goals, faulty diagnoses, and harmful solutions.

Cognitive Behavioral Therapy (CBT)

One of the most common therapies used today, CBT has proven to help many clients from multicultural and LGBTQ backgrounds. Improving on the foundations of behavioral therapy, theorists emphasized the individual's control over both behaviors as well as thoughts and mood. However, critiques of this field closely mirror the criticisms of behaviorism. With a central tenet of changing thoughts, emotions, and then behaviors, this therapy employs the same reasoning as Skinner's: an unfair amount of responsibility is placed on changing the individual. If a client approaches a CBT therapist with issues of depression or anxiety, the proposed treatment plan will often focus on challenging their central thoughts and beliefs. However, in a world where depression and anxiety result from mistreatment and abuse, BIPOC and LGBTQ wrongly find themselves to blame in CBT. These practitioners underscore the power of self-help and individualism in their advice and techniques, disregarding the environmental impacts highlighted in MST. In addition to this misattribution of responsibility, CBT fails to recognize that "challenging beliefs and thoughts may not fit well with many cultural and gender socialization patterns," especially "women's perspectives, views, and thoughts" which "have been minimized and misunderstood" (Kantrowitz 81). These repeated comments illustrate the

weaknesses of a mental health industry rooted in the practices and beliefs of white men. With a rigid understanding of mental health defined by the privileged few, how are therapists to accurately understand and empathize with minority clients without significant alterations to current techniques? These practices continue to perpetuate medical discrimination towards BIPOC and LGBTQ individuals seeking quality care.

Humanistic Therapy

The newest models of therapy delve into Existential and Humanistic theory. Most notably, Roger's Person-Centered therapy focuses on a highly individualistic approach, asserting the patient holds all necessary factors for self-growth and revelation. This self-emphasis mirrors American egocentrism, prioritizing the power of the individual over their social and environmental surroundings. However, from a female and multicultural perspective, "oppressed groups do not have the necessary conditions for growth," and "third force [therapies] incorrectly place the total responsibility and obligation on the individual for growth and development" (Zalaquett et al. 349). This analysis resonates with the criticisms from past therapies, reinforcing that there has been little to no deviation from the dominant norm of mental health care to incorporate the needs of minority clients.

Most Rogerian therapists possess a strongly individualistic view of their techniques and clients, which may place an unfair amount of stress on minority candidates struggling to survive in an oppressive world. With an "intense preoccupation with the individual and free choice," Existential-Humanistic theories are often "incompatible with a more environmentally oriented approach" (Zalaquett et al. 349). Many theorists argue that "Roger's emphasis on the self as a central construct goes back to his own roots in a … German family," reinforcing the ties of this

therapy to Westernized roles and constructs (Zalaquett et al. 365). These therapies expose the faults of a system developed by and for white males. While theorists such as Rogers may experience a privileged life filled with free choice, many minority clients do not. As stated before, these therapies require immense alteration before they can be usefully applied to minority clients.

History Discussion

Each of these therapies builds off of previous foundational layers, leading to an amalgamation of possible treatments and techniques. Psychoanalysis harped on the pitfalls of the human mind, focusing sessions on uncovering the childhood trauma which permeates into adult neuroses. With a distinct focus on repressions of true feelings and desires, this treatment asserted that patients had nearly no autonomy over their current and future thoughts; rather, past experiences basically defined the present and future mental state. Behavioral therapy departed from these beliefs, establishing hope for struggling patients. Instead of a morose view of present and future psychological strife, the behavioralists aimed to help clients control their mental state. This shift towards client empowerment continued into the tenets of Cognitive Behavioral Therapy. Expanding control even more, these therapists believed that the client could effectively employ therapeutic techniques to better manage negative thoughts and actions. With more autonomy, therapists imparted lasting care and positive progress. This continued to grow under Existential and Humanistic therapies. Through these theories the client holds all necessary factors for positive growth with the therapist functioning as a fellow traveler in life, providing helpful guidance and advice when needed. In summation, the historical progress through therapy indicates a progressive shift towards client autonomy and control, with each theory adding useful

insights and techniques to build upon the previous. However, this positive growth is still stunted by the lack of understanding and attention for minority clients, reinforcing the central claims of this thesis.

The story of therapy is a story of the privilege of white Western patriarchy. A history of therapy reveals a field rooted in the perspective of white men, creating a barren ground for minorities unless heavily fertilized by an extremely compassionate, educated, and dedicated practitioner. Even with new treatments, like Existentialist therapy, breaching the horizon, white Western thinkers still control these practices more often than not. Matching becomes crucial here. With the nuanced perspective of a similar race, sexual orientation, or gender, therapists can alter these (so-called universal but really narrow) techniques to apply to minority clients. The matching method can allow mental health practitioners to establish a stronger therapist-client relationship with shared experiences and knowledge of appropriate adaptations in current techniques. The increased understanding and empathy broadens the therapeutic lens, changing practices once suited for white male audiences, to assist a broader range of individuals. Until mental health professionals devote the time and energy to understanding a multicultural approach, the advantage of a therapist-client dynamic that matches in race, sexual orientation, or gender is necessary for minority mental health.

Literary Review

Racial Discrimination in Therapy

Modern American healthcare is infiltrated with racism and systemic oppression. Current medical textbooks still include racially charged statistics, claiming that African-Americans have a naturally higher pain tolerance or require less care for certain kidney conditions (Sabin 1 and

Levey 1). Other minority groups, such as Latinx and Asian communities, face overwhelming language barriers and immigration concerns when seeking quality care (NIHCM 1). These racial prejudices extend to the mental health field and medical resource distribution too. Alongside the flaws of major therapeutic techniques outlined previously, minority races struggle with equal access to necessary medical care, quality treatment from medical professionals, and overcoming cultural barriers. These issues exacerbate the difficulties in finding a well-trained and empathetic therapist and underscore the crucial need for therapist-client matching.

While geographic and economic inequalities contribute to the lack of access to medical facilities, minorities additionally face discrimination from health care professionals, which further restricts their ability to receive necessary care. For example, a 2002 study on therapeutic inequality for African-Americans and Latinx incorporated individuals from various neighborhoods, socioeconomic backgrounds, and home environments to measure the quality of therapy received. When researchers removed factors of economic inequality and housing, African Americans were still "less likely to receive specialty care than their white counterparts, even after adjustment for demographic characteristics and psychiatric morbidity" (Alegria 1). Despite the added benefit of suggested equality, Black clients received reduced specialty care, customized prescriptions, and referrals for additional testing. These findings highlight the racial discrimination which persists past economic situations and geographic strains. Unconsciously or explicitly biased therapists intensify the lack of medical accessibility for BIPOC, inhibiting racial minorities from receiving necessary care.

Furthermore, once BIPOC people acquire the coveted access to medical care, their experiences are subpar compared to white individuals. In this area, it is integral to understand that both real and perceived discrimination affect clients in therapy as they do not always receive

the environment of safety and comfort necessary to produce the desired results. When speaking with white mental health professionals, minorities express an underlying discomfort with relating personal experiences or explaining the effects of racism on their mental state. These difficulties result in either a shaky therapist-client relationship or the devotion of initial meetings to discussing racial discrimination. Either way, the disconnect between the white therapist and the BIPOC client introduces struggles that can only be overcome at the cost of the individual's time and money.

Recent research reflects D's experiences, highlighting the low quality of mental health care experienced by many African-Americans. When compared with white individuals, "demographic factors had little effect on whether [BIPOC] would see a provider but had a large effect on whether appropriate care would be received" for patients diagnosed with depression or anxiety (Young et al. 1). "Despite the fact that Blacks are as likely as whites to see a provider, they are significantly less likely to receive appropriate care," instilling a lack of trust in a racially-biased medical field and thus establishing an unstable therapist relationship (Young et al. 1). These reactions stem from racial and cultural misinterpretations as well as unconscious biases against clients. When finally addressing their mental needs, therapists treat minorities with an absence of understanding, open conversations, and hopeful views of future outcomes (Cai 1). With these prejudices, mental health professionals cannot approach BIPOC patients with full empathy and compassionate regard.

Additionally, racial minorities often feel a distinct cultural and linguistic barrier with their therapists. For example, schizophrenic individuals with African or Indian heritage are more likely to have benign visual and auditory hallucinations while white American's experience harsh and violent internal voices (Parker 1). These inherent differences create misunderstandings

between “intellectually rigid and culturally inattentive” Western professionals and diverse patients (Singh 1). In a field so focused on communicating issues, a lack of common language profoundly impacts therapist-client relationships. Most notably, this cultural disconnect leads to an increase in misdiagnoses for BIPOC patients, especially immigrants. “Stemming from Eurocentric diagnostic practices, Western psychologists are proposed to be more likely to misinterpret behavior and distress that is culturally alien to them as psychosis” even when “the patients neither have the illness nor the symptoms attributed to them” (Singh 1). While therapists search for Western-centric patterns of mental illness, they may overlook or misattribute the symptoms of BIPOC clients.

Without a dedicated and intentional understanding of the minority experience, white therapists cannot provide adequate care to their BIPOC patients. By matching minorities with professionals of their racial subgroup, an increased sense of knowledge, compassion, and awareness will expedite the therapist-client relationship, establishing a strong foundation of trust from the initial meeting. This foundation is integral to improving the quality and efficacy of mental health care for BIPOC clients.

LGBTQ Discrimination in Therapy

Recent studies have shown that LGBTQ individuals report elevated levels of depression, anxiety, and suicidal thoughts (Russel 1). These statistics highlight the need for compassionate, quality mental health care for same-sex-oriented or transgender communities. However, LGBTQ clients experience similar types of discrimination from therapists and psychiatrists. Whether individual or institutional, these issues invade the safe space of a therapeutic session, negatively

affecting the quality of treatment and undermining levels of trust between the client and therapist.

For decades, homosexuality has been considered a mental illness in the official Diagnostic and Statistical Manual of Mental Disorders (DSM) used by most Western mental health professionals. While revisions in 1973 removed this designation, the damage burned many members of the gay community, establishing a general wariness towards the field of mental health. Even with the removal of the categorization of sexual orientation as a psychological disorder, the previous designation's prejudice has already disseminated through the mental health field, distorting current research and techniques for LGBTQ patients. Recent research has found "mixed messages in well-regarded material (like the DSM…) mischaracterize and disregard the effect of sexual orientation on mental health," maintaining stereotypical beliefs and discriminatory attitudes (McAndrew 1). By failing to truly correct the wrongs of past iterations, these techniques perpetuate homophobic and transphobic practices that infiltrate the therapist-client relationship. A recent study found mental health providers frequently "discriminated against lesbian and gay [clients] by ignoring or questioning their sexual orientation; assuming that mental illnesses were in some way related to their sexual orientation; or not allowing mild displays of affection that were accepted for heterosexual patients" (Holley 1). These practices further strain the connection between therapists and LGBTQ clients. Rooted in misunderstandings or echoes of past discriminatory teachings, these techniques diminish the quality of care received by LGBTQ individuals, impeding a disadvantaged community from receiving appropriate care.

These outdated teachings transform into prejudicial treatment plans, as LGBTQ clients report some of the highest mental illness discrimination rates. Holley et al. (2016) detail the

experiences of LGBTQ individuals in various American mental health programs. Participants report feeling ignored, devalued, and disrespected after revealing their sexual orientation to therapists. Furthermore, some mental health professionals overstepped boundaries, "violating privacy and other rights" by sharing intimate details of their clients' sexuality (Holley et al. 1). As their studies and practices are rampant with underlying discrimination, mental health professionals fail to establish a safe and compassionate area for open communication. Through repeated disrespect and even explicit devaluation of patient rights, therapists invoke mistrust and fear rather than empathy and warm regard.

______These findings support previous research, revealing the importance of a strong connection between LGBTQ therapists and LGBTQ clients. While this bond may be achieved through multiple ways, such as dedicating sessions to discussing the intricacies of a client's sexual orientation, a deeper level of understanding is easily achieved through matching. Therapists who parallel the sexual orientation of their clients establish a foundation of trust and vocabulary of shared experiences. With matching, mental health professionals gain control of prejudicial biases and enter into sessions with a more profound comprehension of client issues. These alterations to therapy may be the key to effectively understanding, treating, and even preventing the elevated rates of mental illness within the LGBTQ population. Through these studies, a common trend of discrimination negatively impacting therapist-client relationships materializes. This issue illuminates the importance of matching as a circumvent for many flawed techniques and prejudices found in modern mental health care.

Survey and Interview Results

Findings from the Multicultural and LGBTQ Therapy survey paralleled the claims of discrimination and misunderstandings discussed in the literary review. Responses from minority individuals revealed their difficulties obtaining and receiving quality care from mental health professionals. Compared to cis, male, white clients, minority individuals highly emphasized the importance of matching in race and sexual orientation with their therapists. 100% of respondents who identified as a racial or sexual minority stated that a therapist-client match positively improved their therapeutic experience.

My analysis of interviews and written survey responses highlights two main areas of therapy that are strengthened with a therapeutic match: preliminary understanding and comfort levels. Beginning with understanding, many survey respondents discussed the manner in which white or heterosexual therapists failed to fully grasp their racial and LGBTQ-specific issues. One Black respondent stated that "because my therapist doesn't match on race, they struggle to understand the entirety of the society that I live in." This statement illustrates how white therapists lack a complex comprehension of the world racial minorities inhabit. Even with the intent of healing, these mental health professionals force arduous conversations onto their clients, forcing minorities to disclose potentially traumatizing details of racism and homophobia. As shown in the comment above, these discussions may not even create positive progress, as one African-American gay male expressed, "they don't understand what it means for me [to be gay and Black], no matter how I explain it to them." With a foundation of shared race or sexual orientation, the therapist-client relationship begins with commonalities, bonding over the formidable journey of explaining the minority experience.

During the interviews, an African-American, gay male named D repeatedly emphasized the importance of preliminary understandings with his therapist. When first meeting with a

mental health professional, he felt as though his struggles with internalized racism and trauma from discrimination "felt like fiction" to his white female therapist. Though dealing with concrete issues, D felt his therapist focused too much on the abstract, often "apologetic" and vague in her advice. This experience led to him pulling away from therapy for months, discouraged from the quality of care he received. However, after our interview, D reached out to Black therapists and has recently restarted therapy. Upon switching to a BIPOC mental health professional, D noticed the relative ease of their conversations, even from their first meeting. By making this instrumental change, D doesn't have to "waste [his] time convincing someone to take [him] seriously." Rather, his experiences are understood and validated by his therapist with an inherent level of empathy. Cases like this reinforce the positive effect of matching on improving preliminary understandings, perceptions of therapy, and mental health outcomes.

Secondly, a demographic match between the therapist and client results in an increased level of comfort and perceived compassion for minority individuals. Mental health professionals are equipped with the textbook tools to help clients, differences in race and sexual orientation create distrust. When discussing their past two "white male therapists," one East Asian and bisexual participant explained that their mental health professionals "didn't understand everything I wanted to talk about," saying "it would be too much work to bring up [racial and LGBTQ] issues with them because I felt less comfortable than with another therapist."]Due to the fear of misunderstanding and general discomfort, multiethnic and LGBTQ individuals feel hesitant to discuss important issues with disconnected therapists. Another East Asian and gay respondent echoed this statement, writing, "white therapists just don't know how to help me … I feel like it's just easier to open up to therapists that I have more in common with." By

establishing a baseline understanding of the minority experience, therapists who match with their clients improve the working relationship, creating a more relaxed and welcoming atmosphere.

Interviewee J emphasized these statements when discussing his experience with American therapy. As a native Spanish speaker, Hispanic, gay male, J struggled to find a therapist under his insurance who truly understood mental health needs. When he finally found a reasonable source for treatment, his options for providers were slim. Due to this, J selected a white, heterosexual woman as his first therapist, struggling to find commonalities and discuss his ultimate goals. J discussed the way his language barrier created misunderstandings between himself and his therapist. With unique cultural mannerisms and family values, J said that his therapist failed to understand the root of his issues, focusing on surface-level problems instead. From this experience, he realized his future goals of finding a Spanish-speaking therapist familiar with LGBTQ issues to truly receive help for his concerns. These options would help him feel understood and more comfortable with expressing his internal emotions with a therapist.

The current pandemic has both encouraged advancements and created limitations for BIPOC and LGBTQ individuals in search of mental health care. As more non-essential medical practices moved to the virtual sphere, so did therapy. Zoom and telehealth appointments became more common and widely accepted, expanding the range of accessibility for therapy. No longer confined by location and travel ability, minorities with stable internet access could connect with therapists around the nation. However, the strains of the pandemic have disproportionately affected minority communities. BIPOC and LGBTQ individuals were on average more likely to be hospitalized from COVID-19, put at risk as essential workers, and experience racial hate crimes and discrimination (Kantamneni). These factors further increased mental health needs and exacerbated the underlying effects mentioned in Minority Stress Theory. While accessibility is

on the rise, so is the minority need for quality mental health care. As the medical community progresses, it must reckon with the impacts of COVID-19 on the physical and psychological health of BIPOC and LGBTQ communities and continue to incorporate positive changes established during this period.

This thesis underscores the importance of matching for racial, gender, and sexual orientation minorities. Both survey and interview questions focused on the effect of matching in one of these categories (for example, the match between a Black therapist and a Black client or the match between a lesbian therapist and a lesbian client). This simplicity of research provided the evidence required to reveal the influence of demographic matching on therapy; however, many factors were not included, like social class, immigrant status, and age. Furthermore, the complexities of matching were not fully evaluated. There is an indication that racial minority matches, no matter which race, improve the therapist-client dynamic, but the extent of this connection is currently unknown. The level of influence of each type of match also requires further research. For example, a gay Korean male may have more in common with a straight Korean female than a gay white male therapist. The intricacies of matching and the effect of each demographic link require more research to thoroughly understand. With this said, the function of this work is to illustrate the issues multicultural and LGBTQ clients face, highlight the benefits of matching, and lay the foundation for future research that incorporates more demographic features and clarifies current complexities.

MST asserts that the health issues faced by minority individuals will continue to worsen unless we as a society move towards acceptance of diversity and increased equality. Written-responses and hour-long interviews can only document so many experiences. Throughout America, millions of minority individuals are in need of therapy and struggle with

finding a stable, trusting, and compassionate connection with mental health professionals. My Analysis of the history of therapy, a literary review of modern mental health discrimination, and responses from my original surveys illustrate the beneficial impact of therapist-client matching in the areas of race and sexual orientation. For communities who struggle with accessibility and experience stigma when seeking out care, these changes can make an immense difference in the perception of therapy. Receiving treatment from a minority mental health professional puts clients at ease and establishes a baseline of empathetic understanding. By seeking a therapist who matches in race or sexual orientation, multicultural and LGBTQ individuals can effectively enhance their quality of care and improve long-term mental health outcomes. While the road to improved mental health is long and tumultuous, the initial step of matching offers the much-needed opportunity for minority clients to heal.

Current helpful resources and organizations dedicated towards multicultural and LGBTQ mental health care include:

Asian Mental Health Collective - Organization focused on increasing Asian mental health awareness and establishing a database of Asian mental health professionals

Boris Lawrence Henson Foundation - A non-profit organization founded by actress Taraji P. Henson to address the need for quality mental health care in the African-American community

Inclusive Therapists - A mental health professional database that allows users to search for therapists under their insurance using demographic-specific tags

Pride Counseling - LGBTQ focused therapist database that enables clients to search for therapists based on gender and sexuality

South Asian Therapists - A website for South Asians to search and connect with South Asian therapists based on nationality and culture

Therapy for Black Girls - A website and podcast created by the Black female therapist Dr. Joy Harden Bradford started to encourage and support Black women in their search for therapy

The Trevor Project - A national organization providing mental health care and crisis services to LGBTQ youth

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Appendix A: Multicultural and LGBTQ Survey

Hello,

Thank you so much for helping me with my LSU Honors College undergraduate thesis. Through my work, I hope to elucidate the problems queer, poc, and minority individuals encounter in finding supportive and understanding therapists.

Please fill out this form to the best of your ability. Some responses may be tagged by email for the sole purpose of contacting individuals for future interviews. If you do not feel comfortable including your email address, you may skip this question. All information will remain anonymous if shared with research advisors or incorporated into my thesis writing.

Thank you again,

Alexandra Chetty

1. What is your race?

- Native American / Alaska Native
- East Asian
- South East Asian
- Middle Eastern
- African American
- African
- Pacific Islander

- Hispanic or Latinx
- White

2. What is your gender identity?

- Cis Female
- Cis Male
- Transgender Female
- Transgender Male
- Agender
- Non-binary
- Other:

3. What is your sexuality?

- Heterosexual
- Lesbian / Gay
- Bisexual
- Pansexual
- Asexual
- Other:

4. Have you ever sought mental health services from a licensed counselor, psychologist, or psychiatrist?

- Yes

- No
- Other:

5. Are you currently receiving mental health services from a licensed counselor, psychologist, or psychiatrist?

- Yes
- No
- Other:

6. Does your current (or previous) mental health provider "match" you in race, gender, or sexual orientation? (For example: A female therapist treating a female patient would match in the gender category.)

- Yes, in race
- Yes, in gender
- Yes, in sexual orientation
- Unsure / No

7. If yes to the previous question, do you believe this "match" affects your provider-client relationship and the level of care you receive? (Open Comments)

8. Do you believe your mental health provider understands the issues you face? (Rate 1 - 10 with 1 being Does Not Understand At All and 10 being Understands Fully)

9. Please explain your answer above. (Open Comments)

10. What was your experience finding a mental health provider? (Rate 1 - 10 with 1 being Extremely Easy and 10 being Extremely Difficult)

11. Please explain your answer above. (Open Comments)

12. Did you include race, gender, and sexual orientation of the mental health provider in your search?

- Yes, I searched for providers with a specific race.
- Yes, I searched for providers with a specifc gender.
- Yes, I searched for providers with a specific sexual orientation.
- Unsure / No

13. If yes to any of the checkboxes in the above question, please explain why. (Open Comments)

Interview Interest

Part of my thesis will involve excerpts and analysis of interviews with minority clients. If you would like to be interviewed about your experiences finding a mental health provider and the level of care you received, please complete this section.

14. I would like to share my experience searching for and/or receiving care from a mental health care provider in a virtual interview that will be used for research purposes.

- Yes
- No

15. Email Address for Interview Contact

16. Please enter relative weekly availability for a 30-minute interview in January 2021. (For example: Mondays from 1-4, Tuesdays from 8-12, etc.) (Open Comments)

17. I understand that all published responses from this form and possible interviews will be anonymous, and my name, demographic information, and email address will not be shared.

- Yes
- No

18. Do you have remaining questions, comments, or concerns you would like the researchers to address? (Open Comments)

Appendix B: Multicultural and LGBTQ Survey Responses

Page 1 (Questions 1 - 3)

Respondent ID	What is your race?	What is your gender identity?	What is your sexuality?
1	African American	Cis Male	Bisexual
2	African American	Cis Male	Lesbian / Gay
3	African American, White	Cis Female	Bisexual
4	African American, White	Cis Male	Heterosexual
5	East Asian	Cis Female	Lesbian / Gay
6	East Asian	Non-binary	Bisexual
7	Hispanic or Latinx, White	Cis Female	Bisexual
8	Hispanic or Latinx, White	Cis Female	Heterosexual
9	Hispanic or Latinx, White	Cis Male	Lesbian / Gay
10	Hispanic or Latinx, White	Non-binary	Lesbian / Gay
11	Hispanic or Latinx, White	Transgender Female	Bisexual
12	South Asian	unknown atm	Lesbian / Gay
13	South East Asian	Cis Female	Heterosexual
14	White	Cis Female	Bisexual
15	White	Cis Female	Heterosexual
16	White	Cis Female	Heterosexual
17	White	Cis Female	Heterosexual
18	White	Cis Female	Heterosexual
19	White	Cis Female	Heterosexual
20	White	Cis Female	Heterosexual
21	White	Cis Female	Heterosexual
22	White	Cis Female	Heterosexual
23	White	Cis Female	Heterosexual
24	White	Cis Female	Heterosexual
25	White	Cis Female	Heterosexual
26	White	Cis Female	Heterosexual
27	White	Cis Female	Heterosexual
28	White	Cis Female	Heterosexual

29	White	Cis Female	Heterosexual
30	White	Cis Female	Heterosexual
31	White	Cis Female	Heterosexual
32	White	Cis Female	Heterosexual
33	White	Cis Female	Heterosexual
34	White	Cis Female	Heterosexual
35	White	Cis Female	not a clue, just not straight
36	White	Cis Female	Pansexual
37	White	Cis Female	straight
38	White	Cis Male	Bisexual
39	White	Cis Male	Heterosexual
40	White	Cis Male	Heterosexual
41	White	Cis Male	Heterosexual
42	White	Cis Male	Lesbian / Gay
43	White	Cis Male	Lesbian / Gay
44	White	Non-binary	Lesbian / Gay
45	White	Non-binary	Pansexual

Page 2 (Questions 4-7)

Respondent ID	Have you ever sought mental health services from a licensed counselor, psychologist, or psychiatrist?	Are you currently receiving mental health services from a licensed counselor, psychologist, or psychiatrist?	Does your current (or previous) mental health provider "match" you in race, gender, or sexual orientation? (For example: A female therapist treating a female patient would match in the gender category.)	If yes to the previous question, do you believe this "match" affects your provider-client relationship and the level of care you receive?
1	Yes	Yes	Unsure / No	
2	No	No		
3	Yes	No	Yes, in gender	Yes. I feel it allowed me to be more comfortable with her because she related to a lot of

				my gender-specific problems.
4	Yes	No	Yes, in gender, Yes, in sexual orientation	Yes
5	Yes	Yes	Yes, in gender	Yes, the more matches, the better care in my experience
6	Yes	Yes	Unsure / No	
7	I've looked into it but have not received mental health treatment	No		
8	Yes	Yes	Yes, in race, Yes, in gender, Yes, in sexual orientation	No
9	Yes	No	Yes, in race	Yes
10	Yes	Yes	Unsure / No	
11	Yes	No	Yes, in gender	Absolutely
12	Yes	Yes	Unsure / No	
13	Yes	No	Yes, in gender	Yes, 100%
14	Yes	No		
15	No	No	Unsure / No	
16	Yes	Yes	Yes, in gender	Yes, I'm more comfortable talking to her about my issues
17	Yes	No	Yes, in race, Yes, in gender, Yes, in sexual orientation	yes i do! i feel like women are more comfortable with other women, which is why i chose a woman health care provider.
18	Yes	Yes	Yes, in race, Yes, in sexual orientation	no
19	No	No		
20	No	No		
21	Yes	Yes	Yes, in gender	Yes, I'm more comfortable talking to her about my issues

22	No	No		
23	No	No	Unsure / No	
24	Yes	No	Unsure / No	
25	Yes	Yes	Yes, in race, Yes, in sexual orientation	no
26	No	No	Unsure / No	
27	Yes	Yes	Yes, in race, Yes, in gender	I do not think this match affects my provider-client relationship and the level of care I receive. I do think that because my therapist and psychiatrist are women, we can maybe connect a little more and understand on a different level than if they were men. However, I don't think that if they were men I wouldn't get the adequate care and treatment that I need.
28	Yes	Yes	Yes, in race, Yes, in gender, Yes, in sexual orientation	Yes, matching my therapist in race, gender, and sexuality gives me a sort of comfort in knowing she may be able to relate to what I tell her.
29	Yes	Yes	Yes, in sexual orientation	no
30	Yes	No	Yes, in race, Yes, in gender, Yes, in sexual orientation	
31	Yes	No	Yes, in race, Yes, in gender, Yes, in sexual orientation	Yes

32	Yes	Yes	Yes, in race, Yes, in gender, Yes, in sexual orientation	Yes
33	Yes	Yes	Unsure / No	
34	No	No	Unsure / No	
35	Yes	Yes	Yes, in race, Yes, in gender	I have two (both women, one is my race one is not). I like them both equally
36	Yes	Yes	Yes, in race, Yes, in gender	yes, positively
37	Yes	No	Yes, in race, Yes, in gender, Yes, in sexual orientation	yes i do! i feel like women are more comfortable with other women, which is why i chose a woman health care provider.
38	Yes	Yes	Yes, in race, Yes, in gender	the lack of match in sexual orientation definitely affects the relationship
39	Yes	No	Yes, in race	Not really
40	Yes	Yes	Yes, in race	No
41	Yes	No	Unsure / No	
42	Yes	No	Yes, in race	No. I sought therapy from a straight woman, and I'm a gay man. She was a good therapist because she listened and gave good advice. Our shared race was inconsequential. We "matched" in one way, but differed in hundreds.
43	Yes	Yes	Unsure / No	
44	Yes	Yes	Yes, in race	

45	Yes	No	Yes, in race	No, as I actually prefer to see men psychologists generally with the exception of my most recent therapist.

Page 3 (Questions 8 - 11)

Respondent ID	Do you beleive your mental health provider understands the issues you face?	Please explain your answer above.	What was your experience finding a mental health provider?	Please explain your answer above.
1	5	They understand that it's hard but they don't understand what it means for me no matter how I explain it to them	7	I've had really good therapist in the past it's just hard finding one that has the same experiences as me
2				
3	7	Like i mentioned earlier, she understood a lot of my problems having to do with my gender, like sexual assault and harassment. But my family problems, not so much.	1	My most recent psychiatrist and counselor were at LSU. They make mental health services very accessible to students here on campus.
4	6	Because they don't match on race and age, they struggled to understand the entirety of the society that I live in.	5	My insurance company provided options and I had to select from that list.
5	6	they understand to some extent, and they at least try	10	I've gone through a lot of therapists trying to find a good one and I still haven't found one

6	7	My therapist is a white woman, and I'm assigned female at birth, so there are things that she understands in that sense. However, race and nuanced nonbinary topics are less understood on an immediate level.	5	I have been to other therapists, who I don't think understood all the issues that I wanted to discuss so it took a while to find one that I fit well with.
7			8	My university offers free treatment, however if you believe you have ADHD (which I believe I have and wanted to receive treatment or therapy for) you must receive a prior diagnosis from a nonaffiliated professional, the cheapest of which is $500 a session. My family is also very disapproving of any mental health treatments or diagnosis, so I knew that this would not be an option for me. After that I was too discouraged to go for more general therapy.
8	10	She really explains some of the thoughts and feeling I have in ways that I didn't view them before and provide a lot of clarity.	10	Because of Covid it was very difficult to find a mental health provider and find one that I established a good relationship with because it was all virtual

9	5	There were issues I was just not comfortable talking about and I think the provider could've introduced them or maybe understood they could've been central to my mental struggles.	5	LSU SHC. Hard to book an appointment and even harder if you want a specific provider.
10	5	She understands my trauma history but not my lgbt experiences or my experiences as a mixed person	9	I'm in the mental health field so it was easy to find a provider
11	8	She was a student psychologist working on her doctorate, and so I was one of her first patients. It took her a while to understand my deal but eventually she understood what I was dealing with by relating it to problems women face in general, and I think that moment was when she became much more sympathetic.	2	My university provides free treatment for students (because in exchange we 'train' the psych students), but I know that's not common.
12	6	well he's licensed in this stuff, so i feel like he's supposed to understand what i'm dealing with, which sort of invalidates the fact that sometimes i feel like he doesn't	2	we were recommended one so we didn't have to actively search

13	8	Although as a female, she is able to empathize with “female” issues better than a male would, but considering our different socioeconomic backgrounds (even from childhood), it is difficult for her to help me work through my grief growing up way beneath the poverty line without being textbook	8	Fairly easy considering I found my therapist through my friend (not same therapist, they both work in same office)
14			8	Especially in the area I live in, it's difficult to find a therapist that is accepting and understanding of LGBTQ folks.
15				
16	8	I believe she does because she listens to me and remembers what I say from pass sessions	5	She was recommended from a friend but I had to wait a month before actually seeing her
17	10	i’ve seen her for a while so she’s been in my life as certain events have happened. so she is very up to date.	6	it’s not easy finding a mental health care provider that you like
18	7		7	
19				
20				
21	8	I believe she does because she listens to me and remembers what I say from pass sessions	5	She was recommended from a friend but I had to wait a month before actually seeing her

22				
23	5		5	
24	5	I do not currently have a mental health provider.	9	In the past, I had difficulties finding a mental health provider that best suited my needs.
25	7		7	
26	5		5	
27	10	My mental health provider is very understanding and says that she has had similar struggles herself.	1	I have gotten recommendations from various people, and their website is very user friendly and easy to schedule and appointment.
28	9	There are a lot of things we share in common that help me believe that she understands what I am telling her and that her help is coming from an actual experience.	8	When looking for a mental health provider I originally called a clinic to see a therapist that I had found online, but was referred to my current therapist. I wanted someone who would focus on the issues I had at hand when starting, and she did that. I now see her for a routine therapist and she helps tremendously.
29	10		1	
30	3	She was not a good match for me, but I don't believe that had to do with her race, gender, or sexual orientation, but more about her more traditional background financially and in a traditional family	5	My mom chose which therapist I saw.

		structure, along with a different belief system.		
31	3	Some times, but I think there are large gaps where I feel misunderstood	8	Many times the counselors who I was drawn to, for whatever reason, were not covered by my insurance. I didn't want to go to someone who I didn't think would be a fit, and I felt like that about most people
32	8	She is older than me so it can be challenging to explain certain things that effect me	3	Only difficulty was with insurance
33	7	On a level, yes I think he does understand the issues I face. However, I think the way we experience things depends on the situation. For example; while we might both face heartbreak in our lives, they could be in different ways making the connection on only a certain and specific level.	2	I was fortunate enough to be able to get in at my university.
34	5		5	
35	9		1	Ive had one since I was little so my parents found one for me
36	9	as a woman she understands sexual violence issues personally	1	my friend recommended my therapist

37	10	i've seen her for a while so she's been in my life as certain events have happened. so she is very up to date.	6	it's not easy finding a mental health care provider that you like
38	3	does not seem to fully understand or empathize with the bisexual experience	8	difficult to call during business hours while working / taking classes. Many psychologists did not accept new patients. Most had wait time of ~1 month
39	6	I do not think they would ever fully understand, but it seemed like they tried to understand my issues as best they could	7	In between the hurdles of insurance and the rest of the U.S. medical system to find a counselor who would be covered, in a reasonable area to drive too, and that I felt I could connect with, it can be difficult to find mental health providers.
40	9	Have been seeing this therapist for 13 years	4	I was still young enough to not express emotions and present issues I was dealing with easily, and I went to a few doctors before the right one came along to guide me with conveying what i was feeling
41	7	I think it's hard for anyone to understand another person fully, I think the best providers are able to empathize even without full	6	It took me a few tries to find someone I trusted and felt comfortable talking to

		understanding		
42	8	There were of course many aspects of my life she couldn't relate to, but she listened, showed empathy, and gave advice. That's what matters. Superficial "matches" matter a lot less than the ability to empathize and care for a patient. In other words, empathy is more important than sympathy. Your therapist may not be able to relate to every aspect of your life, but their quality of care is determined by more substantive factors than superficial relations such as sexual orientation, race, or gender. My sexual orientation was a big cause of my mental anguish, but a straight woman was able to help me.	2	I talked to one of my friends who was also in therapy. She recommended her therapist. It was pure happenstance that her therapist was also a good fit for me.

43	8	I don't think "understanding" is very important. I getting therapy from a straight woman, but I'm a gay dude. The reason we have a good relationship is because what she "understands" is that the problems I face are problems. She doesn't have to understand the problem. Just that it's affecting me. All she needs to know is that's somethings bothering me and why it's bothering me.	3	It was easy to find someone once I knew how to go about looking for mental health services
44	8		3	
45	8	I put 8 because I find that I withhold certain relevant information in therapy as a means to "protect" my therapist, but otherwise they do an amazing job with listening to my perspective and needs.	6	It is fairly easy with the exception of health care provider restrictions, monetary cost, and the relationship with the psychologist.

Page 4 (Questions 12 - 14)

Respondent ID	Did you include race, gender, and sexual orientation of the mental health provider in your search?	If yes to any of the checkboxes in the above question, please explain why.

1	Yes, I searched for providers with a specific race., Yes, I searched for providers with a specific gender., Yes, I searched for providers with a specific sexual orientation.	Because it would make me more comfortable to see someone with the same struggles as me
2		
3	Unsure / No	
4	Unsure / No	N/A
5	Yes, I searched for providers with a specific race., Yes, I searched for providers with a specific gender., Yes, I searched for providers with a specific sexual orientation.	In my experience, white therapists just don't know how to help me with race based mental health issues and it's also just easier to open up to therapists that I have more in common with
6	Yes, I searched for providers with a specific gender.	My past two therapists were (white) men, and they didn't understand everything I wanted to talk about. I almost felt like it'd be too much work to bring up because then I'd have to explain more than with a female therapist.
7		
8	Unsure / No	
9	Unsure / No	
10	Unsure / No	
11	Unsure / No	
12	Unsure / No	
13	Yes, I searched for providers with a specific gender.	I feel more comfortable around women in vulnerable situations (seeking mental help)

14	Yes, I searched for providers with a specific gender.	I usually am more comfortable with a female therapist, because I feel they already have a base understanding of my life and are easier to talk to.
15		
16	Yes, I searched for providers with a specific gender.	I wanted someone I was comfortable sharing my story with
17	Yes, I searched for providers with a specific race., Yes, I searched for providers with a specific gender., Yes, I searched for providers with a specific sexual orientation.	i feel more comfortable with women and feel as thought they can relate to my problems more on a personal level.
18	Unsure / No	
19		
20		
21	Yes, I searched for providers with a specific gender.	I wanted someone I was comfortable sharing my story with
22		
23	Unsure / No	
24	Unsure / No	
25	Unsure / No	
26	Unsure / No	
27	Unsure / No	To me, sexual orientation, gender, or race don't really matter to me when choosing a mental health provider. All I really care about is making sure that the therapist/psychiatrist is friendly, easy to talk to, and helps me cope/healthily deal with my struggles!

28	Yes, I searched for providers with a specific gender.	I wanted a woman therapist so that I could feel comfortable talking about things regarding relationships and sex comfortably.
29	Unsure / No	
30	Unsure / No	
31	Yes, I searched for providers with a specific gender.	Personal preference, no specific reason
32	Yes, I searched for providers with a specific gender.	As a woman I could not see a male provider
33	Unsure / No	
34	Unsure / No	
35	Unsure / No	
36	Unsure / No	
37	Yes, I searched for providers with a specific race., Yes, I searched for providers with a specific gender., Yes, I searched for providers with a specific sexual orientation.	i feel more comfortable with women and feel as thought they can relate to my problems more on a personal level.
38	Unsure / No	
39	Yes, I searched for providers with a specific gender.	Part of what I was discussing involved trauma that was inflicted by a man and I did not feel comfortable talking to male counselors specifically because of it.
40	Unsure / No	
41	Unsure / No	
42	Unsure / No	
43	Unsure / No	
44	Unsure / No	
45	Unsure / No	N/A

Questions 15 - 18 are excluded as they include identifiable information about survey respondents.

Appendix C: Participant Demographic Breakdown

In total, there were 45 respondents to the Multicultural and LGBTQ Survey. Demographic breakdown is as follows:

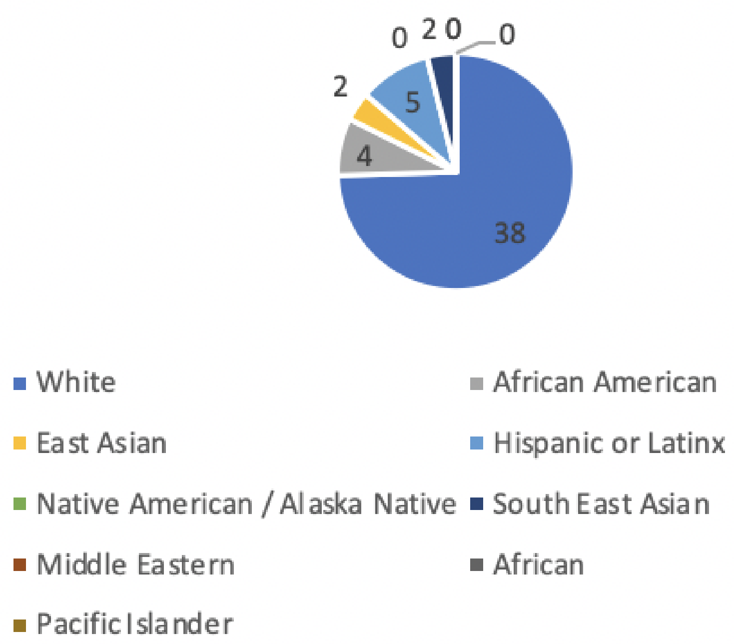

Figure 1. Survey Respondent Racial Groups

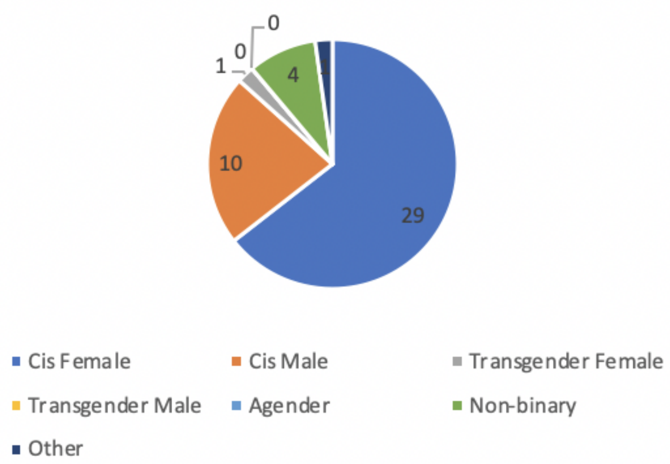

Figure 2. Survey Respondent Genders

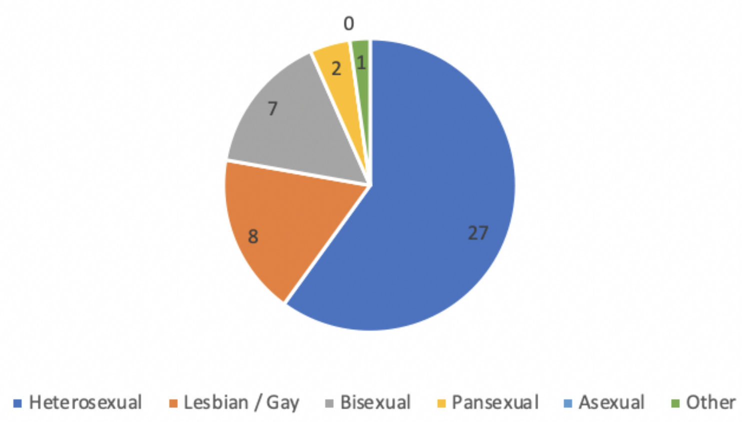

Figure 3. Survey Respondent Sexualities

Following the survey, ten individuals were selected for one-on-one interviews. These individuals were selected based on their short answer responses and racial, gender, and sexual orientation factors. Demographic breakdown is as follows:

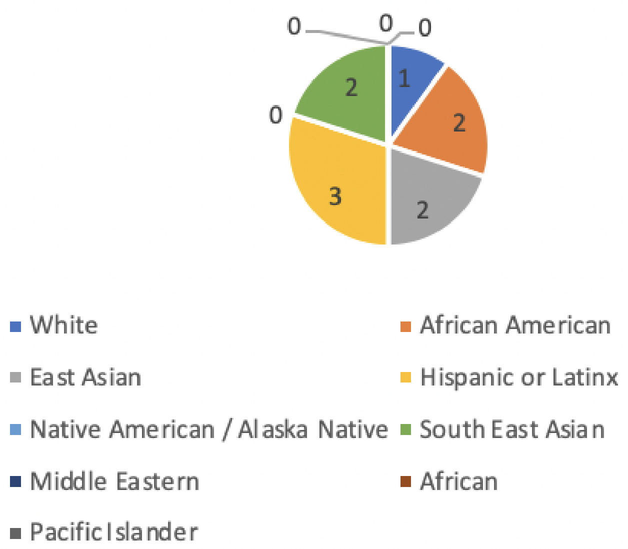

Figure 4. Interviewee Racial Groups

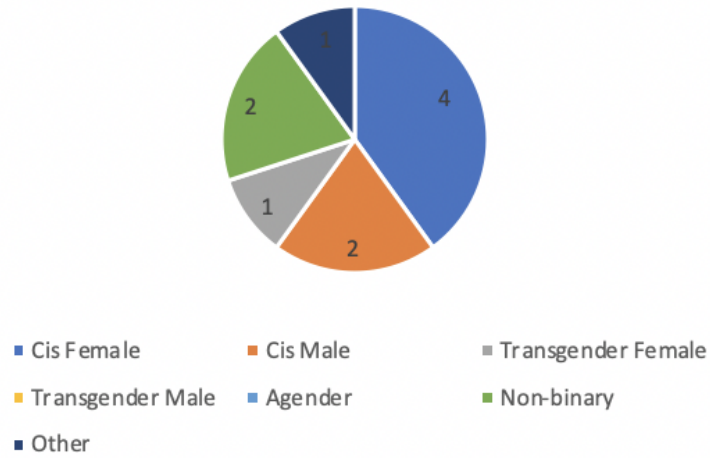

Figure 5. Interviewee Genders

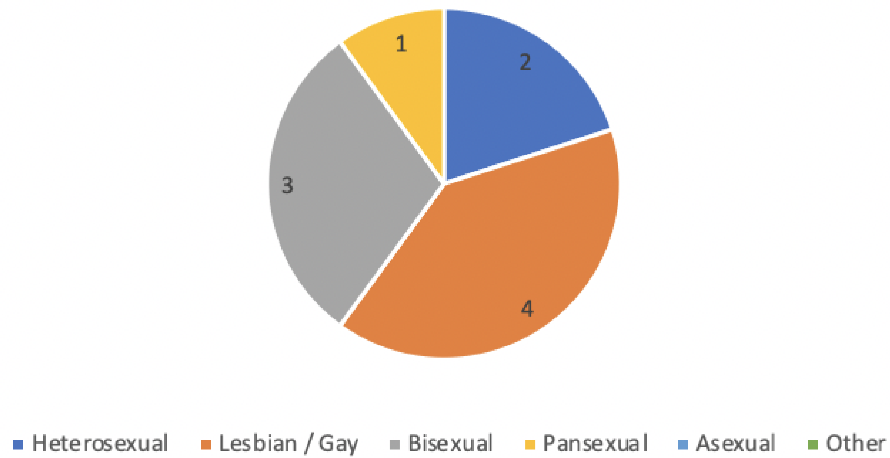

Figure 6. Interviewee Sexualities