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Interpersonal Identity Cues: The Effect of Therapist Identity on Expectations for the Therapeutic Relationship

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ABSTRACT. Identity cues can impact levels of comfort for marginalized individuals in various contexts, including STEM fields and medical spaces. In this study, we examined whether a therapist's personality and race can serve as identity cues for racial/ethnic minority clients and affect the therapeutic relationship. We recruited Asian American and Hispanic/Latinx women ($N = 260$) for a 3 (trait: high agreeableness, low agreeableness, control) x 2 (race: Black, White) between-subjects experimental study to test the effects of a therapist's race and personality traits on women's expectations for a therapeutic relationship and anticipated prejudice from the therapist. We found that racial/ethnic minority women anticipated a more genuine relationship, $F(1, 252) = 10.36$, $p = .001$, $\eta_p^2 = .04$, with a Black female therapist and perceived her to be more culturally competent, $F(1, 252) = 20.04$, $p < .001$, $\eta_p^2 = .07$, and less likely to be racist, $F(1, 252) = 12.68$, $p < .001$, $\eta_p^2 = .05$, than a White female therapist. We found no significant differences in perceived prejudice based on the therapist's personality. Similarly, there were no significant differences in expectations for the therapeutic relationship based on therapist personality.

Keywords: identity cues, client-therapist relationship, social identity threat, prejudice, personality

Diversity badge earned for conducting research focusing on aspects of diversity. Open Data and Open Materials badges earned for transparent research practices. Data and materials are available at https://osf.io/sjecw/.

ABSTRACTO. Las señales de identidad pueden afectar la comodidad de los individuos marginados en varios contextos, incluyendo los campos de STEM y los espacios médicos. En este estudio, examinamos si la personalidad y la raza de una terapist pueden servir como señales de identidad para las clientes de minorías raciales/étnicas y pueden afectar la relación terapéutica. Reclutamos mujeres asiáticas e hispanas/latinas ($N = 260$) para un estudio experimental interindividual de 3 (la característica: alta amabilidad, baja amabilidad, condición de control) por 2 (la raza: raza negra, raza blanca) para probar los efectos de la raza y la personalidad de una terapista en las expectativas de las mujeres para una relación terapéutica y el prejuicio percibido de la terapeuta. Encontramos que las mujeres de minorías raciales/étnicas anticipaban una relación más genuina con una terapista negra, $F(1, 252) = 10.36$, $p = .001$, $\eta_p^2 = .04$, y la percibían como más competente culturalmente, $F(1, 252) = 20.04$, $p < .001$, $\eta_p^2 = .07$, y menos propensa a ser racista, $F(1, 252) = 12.68$, $p < .001$, $\eta_p^2 = .05$, que una terapista blanca. No encontramos diferencias significativas en

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el prejuicio percibido basado en la personalidad de la terapista. Del mismo modo, no hubo diferencias significativas en las expectativas de la relación terapéutica basada en la personalidad de la terapeuta.

Las palabras claves: las señales de identidad, la relación entre la terapeuta y la cliente, la amenaza a la identidad social, el prejuicio, la personalidad

Although mental illness is similarly prevalent among both racial/ethnic minority Americans and White Americans (Turner et al., 2006), individuals with racial/ethnic minority identities are less likely than White individuals to seek out and receive mental healthcare (Benuto et al., 2018). Racial/ethnic minorities who do seek out treatment are more likely to be misdiagnosed and tend to be unsatisfied with the treatment that they receive (Cook et al., 2017; Liang et al., 2015). Only 12% of practitioners in the health service psychology workforce have racial/ethnic minority identities (Lin et al., 2018), which may contribute to lower levels of mental healthcare-seeking behaviors among individuals with racial/ethnic minority identities. Research on identity cues suggests that a variety of environmental and interpersonal factors, including lack of representation of people with a shared identity, can impact levels of comfort and expectations of treatment in various settings, including healthcare facilities (Cipollina & Sanchez, 2019; Pietri et al., 2018). In the current study, we examined whether the race and personality of a therapist could serve as identity cues for racial/ethnic minority women. We assessed whether the identity and traits of a therapist impact racial/ethnic minority women's comfort with and desire to see the therapist among other therapeutic relationship outcomes that influence treatment effectiveness.

Identity Cues and Perceptions of Prejudice

Individuals with stigmatized identities rely on identity cues to determine how their identity will be valued in certain situations (e.g., Sanchez et al., 2017). There are two main types of identity cues. Identity threat cues indicate that marginalized group members may be treated poorly or are unsafe in the social environment, whereas identity safety cues indicate that marginalized group members will be treated well. Identity cues can exist within a social environment (e.g., gender-inclusive bathrooms; Chaney & Sanchez, 2018) or can come from other people (e.g., ingroup role models can alleviate identity threat; Chaney et al., 2018).

Identity cues can impact people with stigmatized identities in various contexts. For example, STEM fields tend to be unwelcoming for racial minorities and women who are underrepresented in the field due, in part, to stereotypes relating to intelligence and math and science abilities (Beede et al., 2011). However, numerous studies have suggested that same-race and same-gender role models can serve as identity safety cues to help buffer against identity threats in the environment (Pietri et al., 2018; Stout et al., 2011). For example, Black female STEM students reported higher expectations of trust and belonging in STEM when they were exposed to Black male and female professors (Johnson et al., 2019). Even role models who do not share the same identity but are similarly stereotyped have proven to be beneficial for women in STEM, as White women perceive Black men as being less likely to endorse negative stereotypes about women's intelligence than White men (Chaney et al., 2018).

Although the impact of same-race role models in the STEM fields has been studied by numerous scholars, minimal work has examined identities as identity safety cues in the therapeutic context. Research on medical contexts has demonstrated that the presence of identity safety cues can reduce expectations of encountering stereotypes and prejudice; improve expectations of medical visits and feelings of belonging; improve communication quality between the provider and the patient; and reduce vigilance to identity threat cues for patients with a stigmatized identity (Cipollina & Sanchez, 2019). Minority representation identity cues (i.e., diverse staff and clientele) signal to sexual minorities that the medical provider is more culturally competent and less likely to be biased against sexual minorities than medical providers lacking minority representation (Cipollina & Sanchez, 2021).

Maimon et al. (2021) suggested that personality traits can serve as interpersonal identity cues and influence perceptions of prejudice for individuals with a stigmatized identity, such that women expect a disagreeable White man to be more prejudicial and discriminatory than an agreeable White man. Although this work provided preliminary evidence that personality traits can serve as identity cues, it is unknown whether these findings would hold for women and racial minority targets. Both Black and White individuals perceive White men to be more prejudicial than White women on average (Babbitt et al., 2018), and people are more likely to perceive ambiguous behaviors as racist or sexist when perpetrated by White

men (Inman & Baron, 1996). Racial/ethnic minority individuals may rely on expectations of prejudice when interpreting other people's behaviors (Mills & Gaia, 2012). Therefore, it is important to extend past work and examine targets with different identities (e.g., racial/ethnic minority group members, women, LGBTQIA+ individuals) to learn more about traits and identities that can potentially serve as identity safety cues for marginalized groups. In the current study, we aimed to examine whether interpersonal cues from a therapist (i.e., personality and race) could serve as identity safety cues for racial/ethnic minority women in a therapeutic context.

Therapy Outcomes for Racial/Ethnic Minority Group Members

Although White individuals have historically had a higher reported rate of lifetime prevalence of mental disorders overall than do racial/ethnic minority individuals (Kessler et al., 2005), racial/ethnic minority individuals tend to have worse outcomes, such as a longer course of illness (Breslau et al., 2006). This might have changed during the COVID-19 pandemic, as racial/ethnic minority individuals reported higher rates of depression, substance use, and suicidal thoughts/ideation than did White individuals (McKnight-Eily et al., 2021). Additionally, racial/ethnic minorities might have higher prevalence rates of specific disorders than White individuals. For example, Black/African American and Hispanic/Latinx adults may develop PTSD at higher rates than White adults (Marshall et al., 2009) and may experience more severe PTSD symptoms than their White counterparts (Ortega & Rosenheck, 2000). Black/African American and Hispanic/Latinx adults are also less likely than White adults to achieve full recovery from PTSD during five years, even when receiving treatment (Sibrava et al., 2019).

Additionally, people with racial/ethnic minority identities are more likely than White individuals to be misdiagnosed by their clinicians and are less likely to be satisfied with treatment (Cook et al., 2017; Liang et al., 2015). For example, there is an overpathologizing bias with clients of color, with Black patients being overdiagnosed with psychotic disorders three to four times more than White patients and Latinx patients being overdiagnosed three times more than White patients (Schwartz & Blankenship, 2014). This race-based overpathologizing bias is also seen in the diagnoses of PTSD, eating disorders, and schizotypal personality disorder, among other disorders (Cicero, 2016; Garb, 2021). This overpathologizing bias is more common in therapist–client racial/ethnic mismatches than when clients share the same racial/ethnic identity with their therapist. Racially/ethnically matched therapists judged African American, Asian American, and Mexican American clients to have higher psychological functioning than mismatched therapists did (Russell et al., 1996). Racial/ethnic minority clients also report higher levels of satisfaction and rapport with therapists from a similar racial background than with White therapists (Chang & Yoon, 2011; Meyer & Zane, 2013). Additionally, racial/ethnic minority clients are more likely to stay in therapy with therapists with a similar racial/ethnic identity and experience better client outcomes than when there is a mismatch in racial/ethnic identity with the therapist (Farsimadan et al., 2007; Naser, 2019).

However, the research examining clients' preferences for therapist ascribed race has mixed findings. Some studies found that racial/ethnic minority clients prefer therapists with whom they share a racial/ethnic identity (Farsimadan et al., 2007; Ilagan & Heatherington, 2022), whereas other studies have found that most clients express no preference for a therapist with a particular ascribed race (Sue et al., 1994). Notably, this preference for racial/ethnic identity matching is strongest among Black individuals (Ilagan & Heatherington, 2022). Although there has not been as much recent work on preferences for racial/ethnic matching, a meta-analysis by Cabral and Smith (2011) found that preferences for racial/ethnic matching is more salient for racial/ethnic minorities than for White individuals. Additionally, they found that, although Asian Americans might not express strong initial preferences for a therapist with whom they share a racial/ethnic identity, they perceive Asian American therapists more favorably than therapists with a different racial/ethnic identity. On the other hand, Hispanic/Latinx Americans express a strong preference for Hispanic/Latinx therapists, but their perceptions of therapists do not differ significantly based on whether or not there is a racial/ethnic match (Cabral & Smith, 2011). Therefore, in the present study, we aimed to examine racial/ethnic minority women's preferences for therapist race, and the impact of therapist race on expected therapeutic relationship outcomes that are central for effective relationship dynamics and treatment outcomes.

Therapeutic Relationship Outcomes

In the therapeutic context, it is particularly important that people feel comfortable disclosing personal and sensitive information. Positive disclosure experiences are linked to better well-being for individuals with stigmatized identities, so positive disclosure experiences and disclosure comfort can have implications for therapeutic outcomes (Chaudoir & Quinn, 2010). Additionally, therapists use the information that clients disclose to make diagnoses, plan treatments, and create goals with the client (Carkhuff & Truax, 1965). Therefore,

discomfort with disclosing this information could lead to clients being misdiagnosed or being dissatisfied with the treatment that they are receiving. In fact, greater levels of client self-disclosure are related with better therapy outcomes (Drinane et al., 2018; Love & Farber, 2019). This includes a better therapeutic relationship, with both clients and therapists reporting a weaker working alliance when the client reported keeping a relevant secret (Kelly & Yuan, 2009). Additionally, clients report experiencing relief, pride, safety, and a sense of authenticity after disclosing personal and sensitive information, and most clients believe that withholding this information reduces the effectiveness of therapy (Farber et al., 2004).

In healthcare settings, cultural competence can have important implications for clients and patients. For example, when patients perceive their medical provider to be more culturally competent, they also anticipate a higher quality visit with their provider (Cipollina & Sanchez, 2020). In terms of mental healthcare, studies have shown that therapist effectiveness and treatment outcomes vary significantly between White and racial/ethnic minority clients in their caseload, which is likely influenced by the cultural competence of the therapist (Imel et al., 2011). Studies have also shown that there is a positive relationship between a therapist's level of cultural competence and therapy outcomes (Anderson et al., 2019; Rasheed, 2011). Therefore, we were interested in examining cultural competence as both an outcome and as a mediator between the race of the therapist and other anticipated therapeutic relationship outcomes.

Relationship genuineness is another contributing factor to therapy outcomes for diverse clients. Clients indicate that perceived genuineness and competence are important for the therapeutic relationship (Jung et al., 2015), which is consistently related to positive therapy outcomes (Flückiger et al., 2012; Horvath et al., 2011). Additionally, researchers have found a direct relationship between relationship genuineness and client change, such that genuineness generally predicts positive therapy outcomes, and can be a cause for client improvement (Orlinsky & Howard, 1987). Therefore, because research has shown the importance of these therapeutic relationship outcomes for therapy outcomes, in the current study, we aimed to examine whether the race and personality of a therapist would influence these therapeutic relationship outcomes (i.e., desire to see the therapist, disclosure comfort, perceived cultural competence, and relationship genuineness) for racial/ethnic minority women.

The Present Study

In the present study, we examined whether the personality traits and ascribed race of a therapist would influence Asian American and Hispanic/Latinx women's expectations about the therapeutic relationship and about the therapist's likelihood of engaging in discriminatory behavior. Given findings from past work that disagreeable men are perceived as more prejudicial and discriminatory than agreeable men, we hypothesized that participants would view a disagreeable therapist as being more prejudiced (i.e., higher in racism, sexism, and heterosexism) and higher in social dominance orientation (SDO) than an agreeable therapist. We predicted that this effect would be stronger when the therapist is a White woman than when she is a Black woman. We also hypothesized that perceived SDO would mediate the relationship between a therapist's personality and target outcomes and between a therapist's race and target outcomes. We hypothesized that participants would expect more cultural competence from, report greater disclosure comfort with, expect a more genuine therapeutic relationship with, and indicate more interest in seeing a Black female therapist than a White female therapist. Finally, we predicted that perceived cultural competence would mediate the relationship between a therapist's race and target outcomes.

Method

Data, syntax, and supplemental materials pertaining to the current study can be found on the Open Science Framework (OSF) at https://osf.io/sjecw/.

Participants

After approval was given by Rutgers Institutional Review Board (Pro2019000463), we recruited Asian American and Hispanic/Latinx women ($N = 275$) through Prolific Academic. Prolific Academic is an online survey recruitment platform that researchers use to recruit people to participate in online studies in exchange for compensation (~$8/hr). Only adult women who identified as Asian American or Hispanic/Latinx were able to participate in the study. We excluded participants from the data who did not meet the inclusion criteria ($n = 7$), had repeating IP addresses ($n = 4$), and failed both manipulation checks ($n = 4$). We had also planned to exclude any participants who viewed the experimental manipulation for less than ⅓ of the median viewing time, had recaptcha verification scores suggesting they were "bots," or completed the study in less than ⅓ the median completion time, but no participants met these exclusion criteria. The final sample included 260 participants ($M_{age} = 27.61$ years, $SD_{age} = 9.29$ years; 68.8% Asian American, 31.5% Latinx/Hispanic; 76.2% heterosexual, 15.4% bisexual, 3.1% queer, 2.7% lesbian, 2.7% another sexual orientation). We conducted an *a priori* power analysis for a small to medium effect size and 80% power using G*power to determine a minimum sample size of 244 participants for this study (Faul et al., 2009).

Procedure

Participants who consented to participate in the study were randomly assigned to one of six conditions. The present study employed a 3 (trait: high agreeableness, low agreeableness, control) x 2 (target race: White, Black) between-subjects design. Participants read a *Psychology Today* profile and reviews from previous clients that were manipulated to depict a target therapist as either a Black woman or a White woman. The *Psychology Today* profiles listed the race/ethnicity of the therapy as "Black" in the Black therapist condition, and as "White" in the White therapist condition. The profiles can be found in the supplemental files on OSF.

We also manipulated the personality traits of the therapist as described in the profile and reviews (i.e., agreeable, disagreeable, no information). Participants viewed a review from a previous client who described the therapist as "attentive and energetic" in all conditions. The review also described the therapist as "disagreeable" in the disagreeable condition, and "agreeable" in the agreeable condition. All client reviews included in the study can be found in the supplemental files on OSF.

Participants then completed a manipulation check to gauge understanding of the profile and reviews they read, followed by a series of open-ended questions about how they believe the described therapist would treat them in a hypothetical interaction. Participants then completed measures of likeability, perceived racism, perceived sexism (Sanchez et al., 2017), perceived heterosexism, perceived SDO (Ho et al., 2015), clientele demographics, and perceived identity of the therapist in a randomized order. Participants also completed measures of therapy interest, relationship genuineness, disclosure comfort, and perceived cultural competence for a hypothetical therapy session with the therapist (Kelley et al., 2010). Finally, participants completed an assessment of their own agreeableness and reported on their therapy experiences before completing demographic measures. At the end of the study, participants read a debrief form, and were compensated $1.50. Although there was no time limit imposed on the study, participants on average completed the survey in 9 mins 50 seconds.

Measures

We reverse-coded items when appropriate and averaged all scale items to create one average score for each measure with higher values indicating greater endorsement of the construct. To keep the study length short and avoid participant fatigue, we created three brief measures for the present work. These measures are similar to existing scales but were adapted for the design of this study.

First Impressions of the Therapist

Open Response Impressions. We asked participants two open-ended questions: "What is your first impression of the therapist?" and "How do you think a therapy session with the therapist would go?"

Perceived Identity. We measured perceived identity with two items. Participants indicated what they believed the therapist's political ideology and sexual orientation would be.

Likeability. On a scale from 1 (*strongly disagree*) to 7 (*strongly agree*), participants completed five items indicating how much they like or would enjoy meeting the therapist depicted in the profile (e.g., "I would get along well with the therapist;" Sanchez et al., 2017).

Anticipated Prejudice

Perceived Prejudice. Participants completed three items indicating the perceived likelihood that the therapist depicted in the profile would discriminate based on race (e.g., "How likely is this person to discriminate based on race/ethnicity?"), three items indicating how likely they believed the therapist would be to discriminate based on sex (e.g., "How likely is this person to discriminate based on sex?"), and three items indicating how likely they believed the therapist would be to discriminate based on sexual orientation (e.g., "How likely is this person to discriminate based on sexual orientation?") on a scale from 1 (*very unlikely*) to 7 (*very likely*; Sanchez et al., 2017).

Perceived SDO. We measured perceived SDO on a scale from 1 (*they would strongly oppose*) to 7 (*they would strongly favor*) with eight items (Ho et al., 2015). Participants reported their perceptions that the therapist would favor or oppose hierarchy-endorsing statements like, "an ideal society requires some groups to be on top and others to be on the bottom."

Therapy-Specific Measures

Therapy Interest. We measured therapy interest with three items on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Participants indicated their desire to participate in therapy with the described therapist, how much they believed they would benefit from a therapy session with the described therapist, and how likely they would be to recommend the therapist to a friend or family member (e.g., "I would choose to see the therapist over other therapists").

Relationship Genuineness. We measured relationship genuineness using a four-item modified version of the Real Relationship Inventory (RRI-C) measure (Kelley et al., 2010). On a scale from 1 (*strongly disagree*) to 7 (*strongly agree*), participants indicated whether they believed they would be able to be themselves and be open and honest with the therapist during a therapy session (e.g., "I would be able to be myself with the therapist").

Disclosure Comfort. We measured disclosure comfort on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Participants completed four items indicating how comfortable they would be sharing sensitive information with the therapist depicted in the profile (e.g., "I would feel comfortable disclosing personal information to the therapist;" adapted from Landes et al., 2013).

Perceived Cultural Competence. We measured perceived cultural competence with three items on a scale from 1 (*strongly disagree*) to 7 (*strongly agree*). Participants indicated how cognizant they believed the described therapist would be of the participant's culture and cultural differences (e.g., "The therapist would be aware of cultural differences when diagnosing and treating me;" modified from LaFromboise & Coleman, 1991).

Clientele Demographics. Participants indicated what percentage of the therapist's clientele they believed were White, Black/African American, Hispanic/Latinx, Asian American, or another race/ethnicity.

Participant Information

Participant Agreeableness. Participants completed a measure of their own level of agreeableness using six items (e.g., "I am compassionate, I have a soft heart;" 1 = *strongly disagree*, 7 = *strongly agree*; $\alpha = 0.76$) from the BFI-2-S (; Soto & John, 2017).

Participant Therapy. Participants indicated whether they had attended therapy before (dichotomous response) and when they had their last therapy session (< 6 months ago, 6 months – 1 year ago, 1 year – 2 years ago, > 2 years ago).

TABLE 1

Bivariate Correlations of Target Outcomes

	1	2	3	4	5	6	7	8	
1. Perceived Sexism	.82								
2. Perceived Racism	.71	.86							
3. Perceived Heterosexism	.66	.69	.84						
4. Perceived SDO	.52	.49	.46	.81					
5. Therapy Interest	−.39	−.43	−.48	−.40	.90				
6. Perceived Genuineness	−.49	−.57	−.56	−.43	.64	.87			
7. Cultural Competence	−.46	−.51	−.49	−.49	.53	.57	.86		
8. Disclosure Comfort	−.46	−.56	−.55	−.44	.62	.79	.53	.83	
9. Likeability	−.44	−.49	−.45	−.49	.76	.67	.55	.67	.92

Note. SDO = social dominance orientation. All bivariate correlations were significant at $p < .01$. Cronbach's alpha values for the measures are reported on the diagonal.

Demographics. Participants completed demographic measures of their gender identity, racial/ethnic background, age, and sexual orientation.

Additional Measures. There were a few additional measures included in the study that can be seen in the supplemental materials on OSF.

Results

Preliminary Analyses

Through bivariate correlations, we found that many of the target outcomes were related to one another (see Table 1). All the target outcomes measuring perceived prejudice (i.e., perceived racism, sexism, heterosexism) and perceived SDO were significantly positively correlated to one another, *p*s < .001. These target outcomes were also significantly negatively correlated with therapy interest, relationship genuineness, perceived cultural competence, and disclosure comfort, *p*s < .001. Therapy interest, relationship genuineness, perceived cultural competence, and disclosure comfort were all significantly positively correlated with one another, *p*s < .001. Finally, likeability was negatively correlated with the target outcomes measuring perceived prejudice and meta-SDO, *p*s < .001, and positively correlated with the anticipated therapeutic relationship variables, *p*s< .001.

We conducted a 3 (trait: high agree vs. low agree vs. control) x 2 (target race: Black woman vs. White woman) ANOVA to examine differences in likeability by condition. There were significant main effects of trait, $F(2, 254) = 18.41$, $p < .001$, $\eta_p^2 = .13$, and target race, $F(1, 254) = 13.01$, $p < .001$, $\eta_p^2 = .05$, on likeability. However, there was no significant interaction between trait and target race on likeability, $F(2, 254) = 0.86$, $p = .42$, $\eta_p^2 = .01$. Participants perceived both the control therapist ($M = 5.56$, $SD = 0.81$) and the highly agreeable therapist ($M = 5.39$, $SD = 0.90$) as significantly more likeable than the disagreeable therapist ($M = 4.77$, $SD = 01.06$), $p < .001$. Overall, participants viewed the Black therapist ($M = 5.44$, $SD = 0.93$) as being significantly more likeable than the White therapist ($M = 5.04$, $SD = 1.01$). Therefore, we controlled for likeability in subsequent analyses examining differences in the dependent variables by condition.

Similarly, we conducted a 3 x 2 ANOVA to examine differences in perceived target political ideology by condition. Although there was no significant main effect of trait, $F(2, 254) = 1.65$, $p = .19$, $\eta_p^2 = .01$, nor a significant interaction between trait and target race, $F(2, 254) = 2.05$, $p = .13$, $\eta_p^2 = .02$, on perceived political ideology, there was a significant main effect of target race on perceived political ideology, $F(1, 254) = 23.58$, $p < .001$, $\eta_p^2 = .09$, such that the White therapist ($M = 3.40$, $SD = 0.99$) was perceived as significantly

more conservative than the Black therapist (M = 2.81, SD = 1.02). Therefore, we also controlled for perceived political ideology in subsequent analyses examining differences in the dependent variables by condition.

Additionally, we conducted a 3 (trait: high agree vs. low agree vs. control) x 2 (target race: Black woman vs. White woman) x 2 (participant race: Asian American woman vs. Hispanic/Latinx woman) ANOVA to examine differences in the outcome variables by participant race (see supplemental file for analyses). We did not control for participant race in subsequent analyses.

Participants' level of agreeableness did not vary significantly across trait conditions, $F(2, 254) = 0.60$, $p = .55$, $\eta_p^2 = .01$, nor target race conditions, $F(1, 254) = 0.32$, $p = .58$, $\eta_p^2 = .00$. Additionally, participants' therapy experiences did not vary significantly across conditions, $X^2(5) = 4.25$, $p = .51$. Perceived sexual orientation of the therapist did not vary significantly across conditions either, $X^2(20) = 23.62$, $p = .26$. Thus, we did not control for participant agreeableness, participant therapy experiences, nor perceived sexual orientation in subsequent analyses.

Open Response Impressions

The first author first coded the open responses based on whether participants indicated a generally positive, neutral, or negative first impression of the therapist depicted in the profile (see Table 2). More than 85% of participants in the control condition reported positive first impressions of the therapist. Additionally, more than 65% of participants had a positive impression of the agreeable therapist, whereas 50–59% of participants reported a positive impression of the disagreeable therapist. Among participants exposed to the control or agreeable therapist, 89–96% of those who learned about a Black therapist reported a positive first impression, while 68–86% of those who learned about a White therapist reported a positive first impression.

The first author identified different themes in the open responses and coded for the presence of each theme in participants' responses. Table 3 depicts the breakdown of these themes by condition. Responses that stated something positive or negative about the specific trait of the condition (i.e., agreeable for the agreeable condition, attentive or energetic for the control condition, disagreeable for the disagreeable condition) were coded as either "trait positive" or "trait negative." Positive and negative statements about the race of the therapist were coded as "race positive" and "race negative," respectively. If participants indicated that the client reviews were what led the participants to view the therapist positively, the responses were coded as "reviews," whereas positive perceptions due to the gender of the therapist were coded as "female positive." Responses that indicated that a participant would be uncomfortable or comfortable talking to the therapist and at the first therapy session were coded as "disclosure discomfort" and "disclosure comfort," respectively. Responses where the participants indicated that they believed that the therapist would be warm and friendly were coded as "warm/friendly."

Less than 5% of participants in the agreeable and control conditions reported trait negative responses, whereas 25–31% of participants in the disagreeable condition had trait negative responses. Interestingly, approximately 11% of participants who viewed a disagreeable therapist gave a trait positive response. Participants only had race positive responses when the therapist was Black, although these responses were given infrequently.

Interestingly, even though we did not find significant differences in disclosure comfort between the different conditions through the quantitative analyses, the open-ended responses seem to suggest that clients have

TABLE 2

First General Impressions of the Therapist by Condition

	White Disagreeable	Black Disagreeable	White Control	Black Control	White Agreeable	Black Agreeable
Positive	58.70%	50.00%	86.05%	95.35%	68.09%	89.19%
Neutral	28.26%	38.63%	11.63%	2.33%	17.02%	8.11%
Negative	13.04%	11.36%	2.33%	2.33%	6.38%	0.00%

TABLE 3

Themes of First Impressions of the Therapist and Their Frequencies by Condition

	White Disagreeable	Black Disagreeable	White Control	Black Control	White Agreeable	Black Agreeable
Trait Positive	10.87%	11.36%	27.91%	23.26%	23.40%	21.62%
Trait Negative	30.43%	25.00%	0.00%	0.00%	4.26%	0.00%
Race Positive	0.00%	2.27%	0.00%	11.63%	0.00%	13.51%
Race Negative	2.17%	0.00%	6.98%	2.33%	21.28%	0.00%
Experience/ Specializations	58.69%	50.00%	44.19%	69.77%	48.94%	62.16%
Cost Negative	4.35%	4.55%	6.98%	2.33%	2.12%	0.00%
Reviews	39.13%	38.64%	41.86%	51.16%	25.53%	51.35%
Female Positive	4.35%	4.55%	4.65%	4.65%	4.25%	18.91%
Disclosure Discomfort	15.22%	18.18 %	0.00%	2.32%	0.00%	5.41%
Disclosure Comfort	6.52%	0.00%	13.95%	16.28%	10.64%	21.62%
Warm/Friendly	6.52%	6.82%	16.28%	6.98%	6.38%	13.51%

varying levels of disclosure comfort with the different therapists. More participants indicated being comfortable with disclosures in the control (13.95–16.28%) and agreeable conditions (10.64–21.62%) than in the disagreeable condition (0–6.52%). For the control and agreeable therapists, a greater percentage of participants indicated that they would be comfortable with disclosing personal and sensitive information to the Black therapist (16.28–21.62%) than to the White therapist (10.64–13.95%).

Perceived Prejudice and Discrimination

We conducted 2 x 3 ANCOVAs while controlling for likeability and perceived target political ideology to examine differences in perceived racism, perceived sexism, perceived heterosexism, and perceived SDO by condition (see Table 4). There were no significant main effects of trait nor significant interactions between trait and target race for any of these outcomes. There were also no significant main effects of target race on perceived sexism, perceived heterosexism, and perceived SDO. However, there was a significant main effect of target race on perceived racism, $F(1, 252) = 12.68$, $p < .001$, $\eta_p^2 = .05$, such that the White therapist ($M_{marg} = 2.81$, $SE = 0.09$) was perceived as more likely to be racist than the Black therapist ($M_{marg} = 2.36$, $SE = 0.09$).

We also conducted 2 x 3 ANCOVAs while controlling for likeability and perceived target political ideology to examine differences in perceived clientele demographics by condition (see Table 5). There were no significant main effects of trait, but there were significant main effects of target race, such that participants perceived the White therapist to have more clients with the same racial background as herself ($M_{marg} = 66.82\%$, $SE = 1.64$) than the Black therapist ($M_{marg} = 44.66\%$, $SE = 1.34$).

TABLE 4

ANCOVAs of Differences in Perceived Prejudice by Condition

	Trait			Target Identity			Trait x Target Identity		
	$F(2, 254)$	p	η_p^2	$F(1, 254)$	p	η_p^2	$F(2, 254)$	p	η_p^2
Perceived SDO	0.35	.70	.00	3.60	.06	.01	0.79	.45	.01
Perceived Sexism	0.84	.43	.01	1.45	.23	.01	0.25	.78	.00
Perceived Racism	0.15	.86	.00	12.68**	< .001	.05	0.09	.91	.00
Perceived Heterosexism	0.70	.50	.01	0.59	.44	.00	0.01	.99	.00

Note. SDO = social dominance orientation. ** F is significant at the .01 level (2-tailed).

TABLE 5

ANCOVAs of Differences in Perceived Clientele Demographics by Condition

	Trait			Target Identity			Trait x Target Identity		
	$F(2, 254)$	p	η_p^2	$F(1, 254)$	p	η_p^2	$F(2, 254)$	p	η_p^2
White Clients	0.01	.99	.00	293.99**	< .001	.54	0.25	.78	.00
Black Clients	0.20	.82	.00	324.56**	< .001	.56	0.16	.85	.00
Hispanic/ Latinx Clients	0.16	.85	.00	24.83**	< .001	.09	0.97	.38	.01
Asian Clients	0.77	.47	.01	0.01	.92	.00	1.21	.30	.01
Other Racial Identity	0.52	.60	.00	8.51**	.004	.03	0.55	.58	.00

Note. ** F is significant at the .01 level (2-tailed).

Meta-SDO and Perceived Cultural Competence as Mediators

Because we did not find any significant effects of trait or target race on meta-SDO and some of the perceived prejudice measures, we did not examine meta-SDO as a mediator between the therapist's level of agreeableness and target outcomes and between the therapist's ascribed race and target outcomes. We conducted mediation analyses using Hayes' (2013) PROCESS Macro for SPSS 26 Model 4 with bias-corrected confidence intervals (CIs) and 10,000 resamples to examine whether perceived cultural competence mediates the relationship between therapist race and the other anticipated therapeutic relationship outcomes. We controlled for likeability and perceived political ideology of the therapist and compared impressions of the White therapist (1) to impressions of the Black therapist (2). There were significant indirect effects of therapist race on therapy interest, $B = 0.10$, 95% CI = [0.04, 0.17], relationship genuineness, $B = 0.13$, 95% CI = [0.06, 0.22], and disclosure comfort, $B = 0.12$, 95% CI = [0.04, 0.20], through perceived cultural competence.

Therapeutic Relationship

We conducted 2 x 3 ANCOVAs while controlling for likeability and perceived target political ideology to examine differences in therapy interest, relationship genuineness, disclosure comfort, and perceived cultural competence by condition (see Table 6). There were no significant main effects of trait on any of the therapeutic relationship outcomes. Additionally, there were no significant main effects of target race on therapy interest and disclosure comfort. There was a significant main effect of target race on relationship genuineness, $F(1, 252) = 10.36$, $p = .001$, $\eta_p^2 = .04$, such that participants anticipated a more genuine relationship with the Black therapist ($M_{marg} = 5.08$, $SE = 0.07$) than the

White therapist (M_{marg} = 4.76, SE = 0.07). We also found a significant main effect of target race on perceived cultural competence, $F(1, 252) = 20.04$, $p < .001$, $\eta_p^2 = .07$, such that participants perceived the Black therapist (M_{marg} = 5.13, SE = 0.09) as more culturally competent than the White therapist (M_{marg} = 4.57, SE = 0.09).

Discussion

In the present study, we predicted that participants would perceive a disagreeable therapist as more likely to be racist, sexist, heterosexist, and high in SDO than an agreeable therapist. We predicted that this effect would be stronger when the therapist was a White woman than when she was a Black woman. We also hypothesized that participants would anticipate more positive therapy dynamics (i.e., cultural competence, disclosure comfort, relationship genuineness, and therapy interest) with a Black therapist than with a White therapist, and with an agreeable therapist than with a disagreeable therapist.

Importantly, we found significant differences in perceived racism, relationship genuineness, perceived clientele demographics, and perceived cultural competence between the Black therapist and White therapist conditions. Specifically, we found that Asian American and Latinx female clients anticipated a more genuine therapeutic relationship with the Black therapist and expected her to be more culturally competent and less likely to be racist than the White therapist. These findings provide preliminary support that the race of a therapist can serve as an identity safety cue for racial/ethnic minority clients, such that racial/ethnic minority clients anticipate better therapeutic relationship outcomes with a Black therapist than with a White therapist, even when they do not share the same ascribed race with either therapist. This is similar to what was found about identity safety cues in the medical field, as minority representation cues cause individuals with marginalized identities to anticipate better interactions with and treatment from medical providers (Cipollina & Sanchez, 2019, 2022).

Additionally, we found that the greater perceived cultural competence of the Black therapist compared to the White therapist related to greater therapy interest, disclosure comfort, and expectations of a genuine relationship with the therapist. Consistent with past research on cultural competence in healthcare settings (Cipollina & Sanchez, 2022), these findings demonstrate the importance of a therapist's cultural competence for racial/ethnic minority clients.

Diversifying the field of psychology is crucial to ensuring that people with diverse identities receive the support they need in a therapeutic context. White psychologists make up a staggering 88% of the health service psychology workforce, despite the United States population being only 62% White (Lin et al., 2018). The underrepresentation of psychologists with racial/ethnic minority identities could contribute to existing racial disparities in mental health and mental healthcare, as racial/ethnic minority individuals anticipate more racism, less cultural competence, and a less genuine relationship from White therapists than from Black therapists, and these therapeutic relationship factors impact treatment outcomes for clients (Anderson et al., 2019; Orlinsky & Howard, 1987). Therefore, increasing the presence of practitioners with racial/ethnic minority identities in the field could help to improve treatment outcomes and increase comfort in therapy for individuals with racial/ethnic minority identities.

Counter to our predictions, we found no significant differences in the outcomes of interest between the disagreeable therapist and the agreeable therapist. Because female clients tend to prefer to have a female therapist (Ilagan & Heatherington, 2022), and there are more female than male therapists (Lin et al., 2015), participants were asked to evaluate a female therapist in the present study. However, because common ingroup identities have been shown to reduce intergroup threat (Gaertner et al., 1993; Riek et al., 2010), it is possible that female participants' perceptions of prejudice of the female therapist were reduced in this study and that participants were less attuned to possible cues of threat (i.e., personality) than in previous studies where participants did not share a common identity with the target (i.e., Asian American and Latinx female participants formed impressions of White or Black men; Philip et al., 2022). Additionally, the manipulation of the therapist's personality was subtle. The therapist's personality was only mentioned and manipulated in one client review, so participants' opinions might not have been heavily

TABLE 6

ANCOVAs of Differences in Anticipated Therapeutic Relationship by Condition

	Trait			Target Identity			Trait x Target Identity		
	$F(2, 254)$	p	η_p^2	$F(1, 254)$	p	η_p^2	$F(2, 254)$	p	η_p^2
Therapy Interest	0.09	.91	.00	0.14	.70	.00	0.44	.64	.00
Disclosure Comfort	0.53	.60	.00	1.70	.19	.01	0.41	.66	.00
Relationship Genuineness	2.61	.08	.02	10.36**	.001	.04	1.02	.36	.01
Perceived Cultural Competence	0.27	.77	.00	20.04**	< .001	.07	1.44	.24	.01

Note. ** *F* is significant at the .01 level (2-tailed).

influenced by one client's perspective. Participants might have focused more on other aspects of the profile and reviews, such as the identity, experience, and specializations of the therapist, as these topics were frequently brought up in the open-ended responses.

Although it may be undesirable to interact with some people with a disagreeable personality (e.g., a boss, friend, family member), there could be some benefits to having a therapist who is not highly agreeable. In the open responses for the disagreeable therapist condition, some participants noted that they were glad that the therapist was disagreeable, as they believed this would encourage them to be the best version of themselves that they could be. Some participants indicated that having a therapist say what they think clients want to hear and agree with everything clients say would not help clients to improve and better themselves.

Strengths, Limitations, and Future Directions

The present work added to the literature on identity cues, perceptions of prejudice, and the effect of therapist race on anticipated therapeutic relationship outcomes with racial/ethnic minority clients. The current study expanded the literature of perceptions of prejudice to include female targets of different races and suggests that the race of a therapist can potentially serve as an identity safety cue for racial/ethnic minority clients, thus improving psychological health outcomes for these individuals.

One limitation of the current work is that we did not account for social desirability, so there is a possibility that participants responded to the questionnaires in such a way as to not be perceived as being racist, which could have impacted the results. Another possible limitation is that participants might have misunderstood the term "disagreeable" to mean "someone who does not agree with you" instead of the intended meaning of stubborn, demanding, and unsympathetic, as evidenced by their responses to the open-ended questions. This could potentially explain why the disagreeable therapist was rated so highly in the open-ended responses and why we did not find the expected differences from the personality manipulation. Therefore, future work should include terms such as "stubborn" or "unsympathetic" instead of "disagreeable" to reduce the risk of participants misunderstanding the trait.

Finally, we focused broadly on participants who self-identified as Asian American or Hispanic/Latinx. It is important to acknowledge that these racial/ethnic groups are not homogenous and that there are differences in the experiences, treatment of, and even social status of individuals within these racial/ethnic identity groups as well as between them (Teranishi, 2002; Weinick et al., 2004). Therefore, it is possible that perceptions of the therapist differ within the racial/ethnic groups included in the present study, and these differences may limit the generalizability of these findings to other populations.

Future studies should ask participants directly if they have preferences for the personality of their therapists to get a better sense of whether therapist personality influences the client's desire to see the therapist among other therapeutic relationship outcomes. Future work could also examine whether preferences for a therapist's personality differs from preferences for the personality of a friend, boss, coworker, or romantic partner. To extend the present work, future research could also examine whether manipulating other aspects of a therapist's identity (e.g., gender identity, sexual orientation, ethnicity) impacts prospective clients' perceptions of prejudice and anticipated therapeutic relationship outcomes, as individuals with dual stigmatized identities may benefit more from having therapists who are similarly stigmatized on multiple identity dimensions (Pietri et al., 2018). Subsequent research should also examine the perceptions of clients with different identities (i.e., Black, multiracial, men, LGBTQIA+), as this work may not generalize to these other identity groups. Additionally, future longitudinal research should examine the retention of racial/ethnic minority clients in therapy with therapists of different identities, as racial/ethnic minority individuals are more likely to drop out of treatment prematurely than White individuals (Cooper & Conklin, 2015).

Although we did not find expected differences in perceptions of prejudice and expectations for the therapeutic relationship based on personality, we did find that the race of a therapist impacted perceptions of racism, anticipated relationship genuineness, and perceived cultural competence among Asian American and Hispanic/Latinx women. This work provided support for diversifying the psychological workforce, which is currently predominantly White, as it demonstrated that representation of racial/ethnic minority group members within the mental healthcare field has important implications for improving therapeutic dynamics (e.g., relationship genuineness and cultural competence) and treatment outcomes for individuals with racial/ethnic minority identities. This could reduce racial disparities in mental healthcare by increasing satisfaction with treatment and treatment retention for racial/ethnic minorities. It is also important to consider how the identities of practitioners can impact the interactions they have with their clients, so future work should explore how likely people would be to seek therapy depending on the identity of the practitioners that are accessible to them.

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Positionality Statement: Jessica identifies as a heterosexual, cisgender Asian woman. Melanie identifies as a queer, cisgender White woman. Both authors acknowledge that their perspectives are influenced by their positions within all these dimensions of identity.

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