Exploring the Role of Altruism on Counselor Implicit Bias and Adapting the National Institutes of Health Implicit Bias Training for Counselors in the United States

By

Crissa J. Allen

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Director of Dissertation: Dr. W. Leigh Atherton

Major Department: Department of Addictions and Rehabilitation Studies

ABSTRACT

Counselors continue to make biased decisions negatively impacting Black American clients. Research underscores implicit bias, defined as unconsciously held prejudiced beliefs, is a major source of bias effecting mental health treatment for diverse cultures. However, despite efforts to mitigate such bias, namely through the emergence of implicit bias trainings, counselors continue to make biased decisions negatively impacting Black American clients. The current study seeks to more comprehensively understand why. The reason posited in the current study is the counseling profession's altruistic nature. Altruism is defined as a prosocial helping behavior shaped by sociocultural context that is fundamentally ego driven because of its social rewards. As the counseling profession is altruistic, counselors may make decisions based from America's implicit prejudiced cultural values and their own egoic tendencies to promote their own social acceptance. Further, due to favorable perceptions of altruism and altruistic behaviors, counselors within the counseling professions have access to moral power. Counselors are therefore praised for their unconscious harmful behavior and use their authority in morality to perpetuate

damaging prejudicial beliefs unknowingly. As research on implicit bias indicates increased power increases bias effecting decisions, counselors given moral power through their association with altruism may be more likely to make biased decisions. Additionally, due to favorable perceptions of altruism, counselors are protected from ill beliefs about their decision making preserving biased tendencies. They may be less likely to see their own bias as their decisions are reinforced by the cultural beliefs of the surrounding society, increasing a counselor's implicit bias. As such, counselors may not be aware of the harm their altruistic tendencies can cause. Counselors' views of themselves as good intentioned and the perceptions of others reinforcing their goodness within a biased society warrant increased concern regarding treatment outcomes for clients of diverse cultures, especially Black American clients considering American historical context. Posited in the current study is implicit bias trainings may be ineffective for counselors because they lack analysis of this true helper culture, regarding American altruism, in attempts to mitigate bias. Further, research on implicit bias, as it has evolved, has lost its analysis of power. Incorporating altruism in this context serves as a surrogate for counselor culture and reintroduces power into implicit bias research while revealing elements of power not typically researched in the counseling relationship. The purpose of the study is to explore the role of altruism on implicit bias in counselors. In exploring such, the current study will utilize a mixed methods approach to a) explore relationships between counselor implicit bias and altruism and b) adapt the National Institutes of Health's (NIH) implicit bias training module to address counselors. While the current NIH implicit bias training is evidenced based, it is missing key characteristics for long term efficacy in mitigating implicit bias. Further, the NIH implicit bias training module is broad, addressing multiple healthcare disciplines. Given interventions are more effective when tailored

to a specific population, the current study will home in, adding altruism and other suggested additions adapting the module for counselors.

Keywords: implicit bias, altruism, counselor, power, supervisor- counselor- client triad, cultural competency, prosocial behavior

Exploring the Role of Altruism on Counselor Implicit Bias and Adapting the National Institutes of Health Implicit Bias Training for Counselors in the United States

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By

Crissa Allen

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Director of Dissertation: W. Leigh Atherton, PhD
Dissertation Committee Members:
Paul Toriello, RhD
Kyla M. Kurian, PhD
Levette Scott, PhD
Kevin O'Brien, PhD
Celeste Crawford, PhD

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DEDICATION

I have learned quite a bit about myself throughout this journey, as do most. Though, as a Black woman, I am often in spaces where my worth is overlooked, forgotten, and taken for granted. While there are many, I would like to dedicate this work to, first I would like to honor my space and my sacrifice to tell myself, 'I see you' and 'thank you'. 'As a tree still makes a sound even when others are not around to hear it, so do you Crissa.'

Throughout my research, a thread seems to clarify the immense amount of power we hold in shaping the narratives of each other. We have these highly intelligent spirit selves but within a flesh that cannot contain it. Reckoning, we make room for ourselves within other people grappling for their worth and a variety of their own territories. Those at peace seem to reckon with the conundrum by exploring the limitless spirit within instead.

My father, whom I also dedicate this work to, who is dwelling in the limitless of his spirit as he is no longer flesh, taught me this at a young age. He taught me how to explore my mind, ask questions, and research. I thank him immensely for these skills.

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TABLE OF CONTENTS

LIST OF TABLES xii

LIST OF FIGURES xv

CHAPTER I: INTRODUCTION..1

Problem With Counseling Black Americans 2

Problem With Multicultural Competency 5

Problems Within the Supervisor- Counselor- Client Triad Regarding Multicultural Competency 6

Social Justice Supervision 7

Implicit Bias 8

Altruism 13

Theoretical Framework 15

Social Cognition 15

Stereotypes and Stereotype Threat 16

Implicit Bias 18

Altruism 18

Statement of the Problem 19

Statement of Purpose 19

Current Study 20

Implications/ Significance 21

Implications for Counselors in Practice 21

Implications for Supervisors 22

Definition of Terms 23

CHAPTER II: LITERATURE REVIEW 26

Introduction 26

Background for Theoretical Underpinnings 30

Early Helper Culture 33

Philippus Aureolus Theophrastus Bombastus von Hohenheim (Paracelsus) 34

Benjamin Rush 35

Samuel Cartwright 38

Summary 40

Theoretical Framework 42

Social Cognition Research 42

Brief Discussion of Dominant Discourse..42

Stereotypes 44

Implicit Bias 47

Altruism 49

Altruism Definitions 50

Review of Literature 54

Influences of Social Cognition in Counseling 54

Stereotypes in Black Mental Healthcare 54

Critiques of the Research 56

Stereotype Threat 57

Stereotype Threat Regarding Black Americans 57

Critiques of the Research 58

Implicit Bias and the Current Study 58

Implicit Bias Interventions 60
Implicit Bias Interventions in Mental Health 62
Implicit Bias Intervention Efficacy 63
Critiques of the Research 64
Introspection as a Tool to Mitigate Bias 66
Altruism and Intersections of Social Cognition 67
Altruism in Healthcare 68
Altruism in Mental Healthcare 71
Altruism in the Current Study Regarding Counselors 71
Critiques of the Research 73
Multicultural Competence in Counseling 73
Defining Multicultural Competency 75
Studies in Multicultural Competency 76
Social Justice Counseling 77
Decolonized Paradigm 80
Changes in Supervision Regarding Multicultural Competence and Social Justice 81
The Current Study 83
Adaptation Studies in Mental Health 83
National Institutes of Health Implicit Bias Training 84
Missing Characteristics in The National Institutes of Health Implicit Bias Training 84
Specific Modifications for the Counseling Profession 85

Summary 85

The Case of Michelle 88

CHAPTER III: METHODOLOGY 97

Research Questions 97

Research Design 98

Instrumentation 99

Quantitative Instrumentation 100

Demographic data 100

Simplified Self Report Altruism Scale 100

A Note Regarding Social Desirability Scales 101

Implicit Association Test 102

Qualitative Instrumentation 103

SAMHSA guide for Adapting Evidence-based Practices for Under-resourced Populations 103

Sampling 104

Population 104

Procedures 106

Step 1- Recruitment 106

Qualtrics survey...107

Contacting Consenting Participants 108

Step 2- Virtual Quantitative Sessions 108

Step 3-Virtual Qualitative Sessions 110

Data Analysis Procedures 110

Quantitative 110

Qualitative 111

Ethical Considerations 111

Limitations 112

Summary 113

CHAPTER IV: RESULTS 114

Quantitative Results..... 114

Description of Data..... 114

Demographics Of Total Participants..... 115

Demographics Of Participants Who Took Implicit Bias Measure..... 133

Altruism Scores..... 138

IAT Scores..... 140

Analysis of Research Questions..... 144

Research question one..... 144

Research question two..... 147

Research question three..... 165

Additional Results..... 183

Qualitative Results..... 198

Demographics..... 199

Focus Group and Semi Structured Interview Responses..... 209

Questioning validity of IAT..... 210

Characteristics of altruism and counseling coincide..... 210

The counselor's struggle when trying to help altruistically (two

altruisms) 212

Counselor’s authority results in silenced clients....214

Importance of multicultural knowledge and humility....215

Counselor bias in helping is shaped by external influence 216

Additional adaptation suggestions 217

Notable Behaviors....219

Adaptations to the NIH Implicit Bias Training....220

CHAPTER V: DISCUSSION....241

Summary....241

Summary of Quantitative Findings....242

Implicit Bias....242

Altruism....243

Summary of Qualitative Findings....243

Interpretations....245

Implicit Bias....245

Altruism....260

References 268

Appendix A- IRB Approval 308

Appendix B- Altruism Scale Permission 311

Appendix C- Initial Recruitment Email 313

Appendix D- Recruitment Email Follow Up 315

Appendix E- Informed Consent 316

Appendix F- Qualtrics Survey 320

Appendix G– Directions for Survey 341

Appendix H- Focus Group Questions 344

Appendix I- Focus Group Follow Up for Intervention Feedback 346

Appendix J- Dr. Jaroslaw Kriukow CV... 347

Appendix K- Adaptation of the NIH Implicit Bias Training Module for Counselors................ 357

LIST OF TABLES

1. Table 1- Demographic Data: Survey Participant Age..116
2. Table 2- Demographic Data: Survey Participant Roles...117
3. Table 3- Demographic Data: Survey Participant Response to “I have the ability to work with clients of diverse backgrounds effectively.” 119
4. Table 4- Demographic Data: CACREP Status of Master’s Counseling Program...........121
5. Table 5- Demographic Data: Religious Affiliation of Participants................................124
6. Table 6- Demographic Data: Racial/ Ethnic Identity of Participants.............................125
7. Table 7- Demographic Data: Gender Identity of Participants..127
8. Table 8- Demographic Data: Sexual Identity/ Orientation of Participants......................129
9. Table 9- Altruism Scores of Participants..132
10. Table 10- Demographic Data: Age of Participants Who Took the IAT..........................133
11. Table 11- Demographic Data: Roles of Participants Who Took the IAT........................134
12. Table 12- Demographic Data: Response to “I have ability to work with clients of diverse backgrounds effectively.” of Participants Who Took the IAT.......................................134
13. Table 13- Demographic Data: CACREP Status of Master’s Counseling Program of Participants Who Took the IAT...135
14. Table 14- Demographic Data: Disability Status of Participants Who Took the IAT......135
15. Table 15- Demographic Data: Racial/ Ethnic Identity of Participants Who Took the IAT...136
16. Table 16- Demographic Data: Gender Identity of Participants Who Took the IAT.......137
17. Table 17- Demographic Data: Sexual Identity/ Orientation of Participants Who Took the IAT...138

18. Table 18- Altruism Scores of Participants Who Took the IAT......................................139

19. Table 19- Measure of Implicit Bias..141

20. Table 20- Central Tendency of Measure of Implicit Bias..142

21. Table 21- Participant Kind of Implicit Bias...143

22. Table 22- Implicit Bias Coding Key..145

23. Table 23- Relative Frequency: Measure of Implicit Bias and Role in Counseling Field...149

24. Table 24- Kind of Implicit Bias and Role in Counseling Field......................................151

25. Table 25- Relative Frequency: Measure of Implicit Bias and Racial/ Ethnic Background...154

26. Table 26- Relative Frequency: Kind of Implicit Bias and Racial/Ethnic Background....156

27. Table 27- Relative Frequency: Measure of Implicit Bias and Gender...........................158

28. Table 28- Relative Frequency: Kind of Implicit Bias and Gender.................................160

29. Table 29- Relative Frequency: Measure of Implicit Bias and Sexual Orientation..........162

30. Table 30- Relative Frequency: Kind of Implicit Bias and Sexual Orientation................164

31. Table 31- Key of Age Group Categories...167

32. Table 32- Relative Frequency: Altruism Scores and Role in Counseling Field.............169

33. Table 33- Relative Frequency: Altruism Scores and Racial/ Ethnic Background...........175

34. Table 34- Relative Frequency: Altruism Scores and Gender..178

35. Table 35- Relative Frequency: Altruism Scores and Sexual Orientation........................181

36. Table 36- Age of Participants Who Did Not Take the IAT..184

37. Table 37- Roles in the Counseling Field of Participants Who Did Not Take the IAT....185
38. Table 38- Participants Who Did Not Take the IAT Compared to IAT Takers: Working with Diverse Cultures....188
39. Table 39- Participants Who Did Not Take the IAT Compared to IAT Takers: Disability Status....189
40. Table 40- Participants Who Did Not Take the IAT Compared to IAT Takers: Religious Affiliation....190
41. Table 41- Participants Who Did Not Take the IAT Compared to IAT Takers: Racial/ Ethnic Background....193
42. Table 41- Participants Who Did Not Take the IAT Compared to IAT Takers: Gender..195
43. Table 43- Participants Who Did Not Take the IAT Compared to IAT Takers: Sexual Orientation....197
44. Table 44- Focus Group and Unstructured Interview Saturated Themes....210
45. Table 45- Qualitative Themes with Corresponding Adaptations....222
46. Table 46- Key of Order Changes in Implicit Bias for Comparison....248

LIST OF FIGURES

Figure 2.1- *Dominant Discourses in the United States* 43

Figure 2.2- *Multicultural and Social Justice Counseling Competencies (MSJCC)*.......................78

Figure 2.3- *Equation of* Helping...92

Figure 2.4- *Equation of Helping Decoded*..93

Figure 4.1- *Demographic Data: Age of Participants*...116

Figure 4.2- *Demographic Data: Roles Occupied in North Carolina Counseling Field*.............118

Figure 4.3- *Demographic Data: Survey Participant Response to "I have ability to work with clients of diverse backgrounds effectively."* 120

Figure 4.4- *Demographic Data: CACREP Status of Master's Counseling Program*.................121

Figure 4.5- *Demographic Data: Disability Status*..122

Figure 4.6- *Demographic Data: Religious Affiliation*..123

Figure 4.7- *Demographic Data: Racial/ Ethnic Identity of Participants*..................................125

Figure 4.8- *Demographic Data: Gender Identity of Participants*...126

Figure 4.9- *Demographic Data: Sexual Identity/ Orientation of Participants*..........................128

Figure 4.10- *Boxplot of Altruism Scores of Participants*..130

Figure 4.11- *Participant Altruism Scores*..131

Figure 4.12- *Altruism Scores of Participants Who Took the IAT*...140

Figure 4.13- *Measure of Implicit Bias*..141

Figure 4.14- *Kind of Implicit Bias*..144

Figure 4.15- *Kendall's Tau C Significance Test: Altruism Scores and Measure of Implicit Bias*..146

Figure 4.16- *Scatter Plot: Altruism Scores and Measure of Implicit Bias*................................146

Figure 4.17- *Relative Frequency: Measure of Implicit Bias and Role in Counseling Field*.......148

Figure 4.18- *Relative Frequency: Kind of Implicit Bias and Role in Counseling Field*.............150

Figure 4.19- *Relative Frequency: Measure of Implicit Bias and Racial/ Ethnic Background*....153

Figure 4.20- *Relative Frequency: Kind of Implicit Bias and Racial/ Ethnic Background*..........155

Figure 4.21- *Relative Frequency: Measure of Implicit Bias and Gender*...................................157

Figure 4.22- *Relative Frequency: Kind of Implicit Bias and Gender*...159

Figure 4.23- *Relative Frequency: Measure of Implicit Bias and Sexual Orientation*................161

Figure 4.24- *Relative Frequency: Kind of Implicit Bias and Sexual Orientation*.......................163

Figure 4.25- *Kendall's Tau C Significance Test: Altruism Scores and Age*...............................166

Figure 4.26- *Scatter Plot: Altruism Scores and Age*...166

Figure 4.27- *Relative Frequency: Altruism Scores and Role in Counseling Field*......................168

Figure 4.28- *Fisher's Exact Test: Altruism Scores and Disability*...171

Figure 4.29- *Kendall's Tau C Significance Test: Altruism Scores and Disability*......................171

Figure 4.30- *Scatter Plot: Altruism Scores and Disability*...172

Figure 4.31- *Relative Frequency: Altruism Scores and Racial/ Ethnic Background*.................174

Figure 4.32- *Relative Frequency: Altruism Scores and Gender*...177

Figure 4.33- *Relative Frequency: Altruism Scores and Sexual Orientation*..............................180

Figure 4.34- *Roles in the Counseling Field of Participants Who Did Not Take the IAT*............185

Figure 4.35- *Participants Who Did Not Take the IAT Compared to IAT Takers: Working with Diverse Cultures*...187

Figure 4.36- *Participants Who Did Not Take the IAT Compared to IAT Takers: Disability Status*...189

Figure 4.37- *Participants Who Did Not Take the IAT Compared to IAT Takers: Religious Affiliation*......191

Figure 4.38- *Participants Who Did Not Take the IAT Compared to IAT Takers: Racial/ Ethnic Background*......192

Figure 4.39- *Participants Who Did Not Take the IAT Compared to IAT Takers: Gender*......194

Figure 4.40- *Participants Who Did Not Take the IAT Compared to IAT Takers: Sexual Orientation*......196

Figure 4.41- *Demographic Data: Age of Qualitative Participants*......199

Figure 4.42- *Demographic Data: Roles Occupied in North Carolina Counseling Field of Qualitative Participants*......200

Figure 4.43- *Demographic Data: Survey Participant Response to "I have ability to work with clients of diverse backgrounds effectively" of Qualitative Participants*......201

Figure 4.44- *Demographic Data: CACREP Status of Master's Counseling Program of Qualitative Participants*......201

Figure 4.45- *Demographic Data: Disability Status of Qualitative Participants*......202

Figure 4.46- *Demographic Data: Religious Affiliation of Qualitative Participants*......203

Figure 4.47- *Demographic Data: Racial/ Ethnic Identity of Qualitative Participants*......204

Figure 4.48- *Demographic Data: Gender Identity of Qualitative Participants*......204

Figure 4.49- *Demographic Data: Sexual Identity/ Orientation of Qualitative Participants*......205

Figure 4.50- *Participant Altruism Scores of Qualitative Participants*......206

Figure 4.51- *Kind of Implicit Bias of Qualitative Participants*......207

Figure 4.52- *Adaptation of Implicit Bias Training (PowerPoint Slide 2)* 223

Figure 4.53- *Adaptation of Implicit Bias Training (PowerPoint Slide 3)* 224

Figure 4.54- *Adaptation of Implicit Bias Training (PowerPoint Slide 4)* 224

Figure 4.55- *Adaptation of Implicit Bias Training (PowerPoint Slide 5)* 225

Figure 4.56- *Adaptation of Implicit Bias Training (PowerPoint Slide 6)* 225

Figure 4.57- *Adaptation of Implicit Bias Training (PowerPoint Slide 7)* 226

Figure 4.58- *Adaptation of Implicit Bias Training (PowerPoint Slide 8)* 226

Figure 4.59- *Adaptation of Implicit Bias Training (PowerPoint Slide 9)* 227

Figure 4.60- *Adaptation of Implicit Bias Training (PowerPoint Slide 10)* 227

Figure 4.61- *Adaptation of Implicit Bias Training (PowerPoint Slide 11)* 228

Figure 4.62- *Adaptation of Implicit Bias Training (PowerPoint Slide 12)* 228

Figure 4.63- *Adaptation of Implicit Bias Training (PowerPoint Slide 14)* 229

Figure 4.64- *Adaptation of Implicit Bias Training (PowerPoint Slide 15)* 230

Figure 4.65- *Adaptation of Implicit Bias Training (PowerPoint Slide 16)* 231

Figure 4.66- *Adaptation of Implicit Bias Training (PowerPoint Slide 17)* 232

Figure 4.67- *Adaptation of Implicit Bias Training (PowerPoint Slide 18)* 233

Figure 4.68- *Adaptation of Implicit Bias Training (PowerPoint Slide 19)* 234

Figure 4.69- *Adaptation of Implicit Bias Training (PowerPoint Slide 20)* 234

Figure 4.70- *Adaptation of Implicit Bias Training (PowerPoint Slide 21)* 235

Figure 4.71- *Adaptation of Implicit Bias Training (PowerPoint Slide 22)* 236

Figure 4.72- *Adaptation of Implicit Bias Training (PowerPoint Slide 23)* 237

Figure 4.73- *Adaptation of Implicit Bias Training (PowerPoint Slide 24)* 238

Figure 4.74- *Adaptation of Implicit Bias Training (PowerPoint Slide 25)* 239

Figure 4.75- *Adaptation of Implicit Bias Training (PowerPoint Slide 26)* 239

Figure 4.76- *Adaptation of Implicit Bias Training (PowerPoint Slide 27)* 240

Figure 4.77- *Adaptation of Implicit Bias Training (PowerPoint Slide 28)* 240

Figure 5.1- Project Implicit Findings: Nationwide Implicit Bias...246

Figure 5.2- Project Implicit Findings: From 3.6 million People..247

Figure 5.3- Project implicit Findings: Implicit Bias by Age..250

Figure 5.4- Current Study: Relative Frequency of Implicit Bias by Age...................................251

Figure 5.5- Project Implicit Findings: Implicit Bias by Education Level...................................253

Figure 5.6- Current Study: Implicit Bias...254

Figure 5.7- Project Implicit Findings: Implicit Bias by Gender..255

Figure 5.8- Current Study: Relative Frequency of Implicit Bias by Gender..............................256

Figure 5.9- Project Implicit Findings: Implicit Bias by Race..258

Figure 5.10- Current Study: Relative Frequency of Implicit Bias by Race/ Ethnicity...............259

CHAPTER I: INTRODUCTION

Research on the process of unconscious thought driving biased decision-making reveals negative consequences in the counseling profession (Katz & Hoyt, 2014). Despite the implications of this research regarding the supervisor-counselor- client relationship (the supervisor- counselor- client triad), training and education standards have not changed (Boysen & Vogel, 2008; Nwosu. 2018). One potential barrier is that through the evolutions of unconscious bias research, the fundamental role of authority and control (i.e., power) has been lost. Power, as a key characteristic of this research, if reintroduced, may help counseling professionals account for their unconscious bias more effectively. However, reintroducing power alone may not be comprehensive enough due to complexity of the counseling context. Indeed, the overall contention guiding the current study is that a more comprehensive concept is needed for the counseling profession.

Altruism, defined as a prosocial helping behavior, is a key characteristic of the counseling profession. Encompassed in altruism theory are elements of power driven by assumptive beliefs, which are often unconscious (implicit). As implicit bias research is currently missing aspects of power, altruism could be used to fulfill both needs addressing issues regarding the efficacy of implicit bias training for counselors. In this way, given the counseling field's altruistic nature, altruism may serve as a surrogate for analyzing the helping relationship, while also accounting for cultural assumptions. As such, including altruism in implicit bias research, specifically for the counseling profession more comprehensively addresses implicit bias within the counseling profession. This chapter introduces and explores such, laying the foundation for the current study in the statement of the problem. Following is discussion regarding the underpinning theories of implicit bias and altruism. The statement of purpose introduces the

concept and means of the current study. Concluding are implications of the proposed study and significant terms defined.

Problem With Counseling Black Americans

The counseling profession evolved nebulously without well-defined ethical regulations (Capuzzi & Stauffer, 2008). Due to this and the field's culturally responsive nature, counselors must continuously correct to respond to current societal context and its needs. However, also due to the uniqueness of American context, given America's immense history of oppression, the counseling profession must also focus on correcting this aspect of its foundation. Current ethical codes according to the American Counseling Association underscore the importance of maleficence, beneficence, and cultural competence (American Counseling Association, 2014). Addressing concerns that greatly impact care regarding clients of color, specifically Black Americans, within the counseling profession are imperative.

For instance, one concern regarding Black American mental health is that despite disproportionately reporting higher rates of serious psychological distress than White Americans, Black Americans are less likely to use mental health services (Neighbors et al., 1983; Williams, 2018). Lack of cultural understanding on the part of practitioners and stigma are the top two cited reasons why Black people report not seeking clinical therapy services (Awosan et al., 2011). Considering historical context, Black people are justified. Acknowledged in research is Black people's distinct resulting physical and psychological experience in American context resulting from the unique abuse through chattel slavery (Gómez, 2015). From slavery forward, the lack of cultural understanding rooted in historical marginalization, systemic oppression, and overall prejudiced internalized beliefs about people of color has contributed to ineffective care.

Stereotypes about Black Americans' intelligence, class, and criminality (Watkins et al., 2010) persist decreasing access to competent unbiased care as Black people continue to be

misrepresented and misunderstood. In health professions, both now and historically, there has been a lack of cultural understanding resulting in practitioner lack of cultural awareness and respect of Black culture central to a Black client's identity. For example, a recent story in pop culture surfaced regarding a Black doctor who stopped a White doctor from administering a psychiatric evaluation on a Black female patient. The patient was regularly hitting her head and it was interpreted by the White doctor that there may be a psychological concern. Without asking initial questions, the White doctor assumed mental unwellness and called for a psychiatric evaluation. The Black doctor, because of cultural understanding knew that hitting one's head is typical when wearing braids as to not mess up the hairstyle. Public systems are often powered by stereotypes effecting the quality of care Black people can access. A combination of lack of cultural awareness and a bias toward psychological deficiency contributed to the White doctor's response.

Black patients are often subjected to incompetent care due to the combination of lack of cultural awareness and bias in White dominated healthcare spaces. With only 5% of doctors (Young et al., 2018) and between 2- 4% of therapists (O'Malley, 2021) being Black, implications are exhaustive. Another recent anecdote in pop culture notes possible implications for a Black patient who needed an emergency MRI. White doctors left a Black female patient without the MRI treatment because she had what they thought were unremovable black metal clips in her hair. A Black female doctor asked to access the notes only to determine that the patient was wearing a wig fastened on her head in a way common in Black culture. Based on her own experience with wearing wigs, she knew how to remove it, getting the patient the care she needed. Again, lack of cultural awareness and bias toward Black psychological inferiority stopped the doctors from asking for help, clarifying with the patient about the removability of the metal clips and ultimately created an obstacle for care.

Within the counseling field, this same lack of cultural understanding has translated to difficulties in accurately assessing clients of color resulting in overdiagnosis, underdiagnosis, misdiagnosis, and ultimately providing inappropriate treatment (Smedley et al., 2003; Snowden et al., 2009). For example, Black men are over diagnosed with schizophrenia, but underdiagnosed with posttraumatic stress disorder and mood disorders (Perzichilli, 2022). Despite scientific knowledge, cited in research, diagnoses for people of color are driven by mechanisms other than that of their white counterparts (US DHHS, 1985). The Covid-19 pandemic of 2020 revealed inequities persist regarding access to care and the competence of the field to address concerns. Resulting mental health concerns of the pandemic are disproportionately increased rates of depression and anxiety for people of color as their families were disproportionately affected by family loss and lack of resources (Snowden & Snowden, 2021).

In addition to lack of cultural awareness, American mental healthcare services are historically known to subject Black clients to mistreatment, experimentation, victimization and perpetuate abusive beliefs contributing to disparities (America Psychiatric Association, 2021). Early helpers pioneering mental health treatment historically argued Black people were biologically inferior. For instance, the father of psychiatry, Benjamin Rush, coined the diagnosis of Negritude only cured by turning the Black skin and other Black physical traits White (North, 2000; Szasz, 1971). He believed removing their physical Blackness would uncover humanity and unify Blacks with the Whites (Plummer, 1970). Pioneered by Samuel Cartwright, a physician in 1851, was the mental health diagnosis of Drapetomania categorizing enslaved Africans who had the tendency to run away, found in the Practical Medical Dictionary until 1914. Rush, Cartwright, and similar significant others are explored further in chapter two for their role in

violently employing bias and altruism in decision making. Violent means such as whipping or cutting off body parts was regular treatment for mental health diagnoses of enslaved Africans.

Early accounts of Black mental health treatment during slavery also note the use of Black people who were deemed mentally unwell (those who could not work or repeatedly ran away) as slaves in the mental institutions they were sent to (Jackson, 2017). As hospitals were segregated, conditions for Black patients were often poor or inhumane. According to Jackson, some were even made to live outside of the quarters as to keep the institution segregated (2017). Embedded historically are the resulting prejudiced beliefs that Black Americans lack insight, control of their actions, and self-awareness (Nayman, 1983; Primm et al., 2010). Counselors have a history of perpetuating these harmful beliefs through mental health diagnosis of Black clients ultimately decreasing efficacy and increasing incompetent care. Together, resulting is a contribution to the Black client's hesitancy to utilize mental healthcare.

Mental healthcare is an extension of Black American's overall historical distrust with healthcare systems stemming from continuous mistreatment. Awareness of the mental healthcare system's abuse is widespread in the Black community contributing to hesitancy to utilize services. Despite additions of multicultural competencies and social justice counseling to address these concerns, research continues to underscore the failure of the fields efficacy in meeting the needs of diverse cultures calling for continued progression (Ivers, Johnson, & Rogers, 2021; Mollen & Ridley, 2021; Ridley et al., 2021; Vandiver et al., 2021).

Problem With Multicultural Competency

Multicultural competence emerged beginning in the 1950s to address disparities regarding counseling diverse cultures (Sue et al., 1992). Initial approaches focused on awareness of the differing needs of diverse ethnic and racial groups. Differing religious, socioeconomic, and intersectional identity needs were later recognized contributing to a deeper understanding of

the responsibilities of a culturally competent counselor. While counselors in training were required to uphold standards, supervisors, professors, and various gatekeepers of the profession were not held to the rising standards until three decades later (Brown & Brown- Landrum, 1995; Constantine, 1997; D'Andrea & Daniels, 1997; Fukuyama, 1994; Leong and Wagner, 1994). The time gap resulted in 30 years, at minimum, of counselor's being released in the field ill equipped to handle the needs of counseling a diverse world. Some of these counselors who went on to become professors and supervisors were therefore ill equipped to teach students who were given differing mandates. Unlikely that gatekeepers who were not taught and are not mandated to learn cultural competency can teach and uphold standards mandated for incoming counselors. As such, multicultural competency mandates and therefore multicultural supervision do not comprehensively address the full influence of discrimination and oppression in the supervision triad effecting clinical outcomes with clients of diverse identities.

Problems Within the Supervisor- Counselor- Client Triad Regarding Multicultural Competency

Though there is evidence that supervisees who receive higher amounts of multicultural supervision feel more multiculturally competent, there are few amounts of confident culturally competent supervisors to meet the standards placed on counseling trainees (Multicultural counseling competence: History, themes, and issues, 2003) likely due to the gap in time for reform in supervision standards. Clinical students were given mandates that clinical supervisors were unsure how to teach. Currently, while efforts have been made to educate supervisors on how to broach difficult conversations (Day-Vines et al., 2021; Estrada et al., 2004; King, 2021), handle conflict within the classroom (Donald & Moro, 2014) and practice self-awareness to decrease effects of their own bias as clinicians (Constantine et al., 2007), the lack of comfort continues to prevail. Further, continued education requirements are variable across states and do

not uniformly mandate that any of the credits be in multicultural competency. As such, gatekeepers of the field are largely ill equipped to handle the growing needs of society and counseling trainees as it relates to multicultural competency.

Social Justice Supervision. Additionally, the wide angled view of multicultural competency may leave counseling supervisors susceptible to blind spots regarding their own biases and how they may influence the supervisor- counselor- client triad. Social justice has developed as the "fifth force" in counseling (Ratts, 2009) in response to limitations of the first awakening to cultural considerations. Its counterpart in supervision was developed to address the limitations of the initial approach in the supervision of multicultural efforts moving toward action and engagement (Dollarhide et al., 2021). Even still, little has been done to confront the unconscious bias of the supervisor and its implications, despite research underscoring the influence of unconscious bias within the supervisor- counselor- client triad (Correll et al., 2008; Czopp et al., 2006) before the adaptation of social justice into clinical standards. The current model of social justice supervision only includes self-awareness as it relates to explicit and known differences within the supervision relationship. The foci within this model are the differences in lived experiences between marginalized and majority group members, increasing self-awareness and examining power differentials (Pearrow & Fallon, 2019). Such a broad sweeping focus does not account for the appropriate depth and nuance of which bias exists in American society and therefore does not fully meet the needs.

A general failure to critically examine the nuanced influences in American historical context as it pertains to bias is evident throughout the counseling field's attempts to create a more culturally competent field. Negative beliefs about Black Americans have only increased (Valentino & Brader, 2011), further contributing to the lack of quality of care. It is imperative that we reexamine the foundations of the counseling field, analyzing our assumptions as

individual practitioners and a larger entity to increase efficacy with clients of color. One lens used to understand blind spots contributing to incompetent care, missing in the counseling field's current efforts, is implicit bias.

Implicit Bias

Implicit bias is defined as unconsciously held prejudiced beliefs that result in judgements or actions (Greenwald et al., 1998). Implicit biases are internalized stereotypes that a person uses to inform their behavior without realizing. Implicit bias can influence judgements of hostility against African Americans (Abreau, 1999) and the formation of impressions (Gawronski et al., 2003; Hugenberg & Bodenhausen, 2003) ultimately influencing prejudiced behavior. While self-examination is the main tool used for bias training, the covert nature of implicit bias means that those who hold the prejudiced beliefs are unaware of their bias. As such, implicit bias evades self-report (McConnell & Leibold, 2001). Given the person is unaware of the direct source of the belief or stereotype (Greenwald & Banaji, 1995), introspection is not an effective tool for mitigating its effect.

In the counseling field, implicit bias is known to negatively impact treatment outcomes (Boysen & Vogel, 2008; Katz & Hoyt, 2014). A study found significant levels of implicit bias among counselor trainees toward African Americans, gay men, and lesbian women despite reporting high levels of multicultural competence in congruence with their level in the program (Boysen & Vogel, 2008). Also noted in the study was that implicit bias does not correspond with level in the program. This indicates that those who do well at various stages in their counselor development under the previous standards of multicultural competence are not exempt from the influence of implicit bias. A similar study was conducted in 2014, which indicated similar findings. It was found that automatic prejudice (also known as implicit bias) was the strongest predictor of racial bias in the study (Katz & Hoyt). The study notes that because this

type of bias dictates behavior outside of conscious control, it impacts interpersonal interactions within the therapeutic dynamic (Katz & Hoyt, 2014). This means that counselors can hold prejudiced beliefs about their clients impacting the counselor's behavior and decision making. The result is the clinician administering incompetent care without ever knowing. Of ongoing concern is that, while explicit forms of counselor bias are acknowledged, education standards have not developed over time to mandatorily address implicit bias (Boysen, 2009). Further, to date few studies have examined implicit bias among counselors, despite negative implications regarding the supervisor-counselor- client relationship.

The most current research in implicit bias regarding counseling has been exploratory in nature, including working to determine relationships between implicit bias and mindfulness (Ivers, Johnson, & Rogers, 2021), as well as counselor-in-training attitudes regarding those with substance use disorders (Shiffler, 2020). While implicit bias research continues to evolve, a theoretical framework has not been established (Greenwald & Lai, 2020). Moreover, key concepts (e.g., power) have gone missing from implicit bias research even as the phenomenon of implicit bias has gained widespread awareness. This means, the effect of social authority and power integral to this research, most notably found in stereotype research, is missing in implicit bias. The inclusion of such is foundational to the current proposed study.

To gather a more comprehensive view of power within social cognition research, examination of how stereotypes work to influence behavior is critical. Stereotypes are defined as a collection of beliefs about the characteristics of a particular group (Dovidio, 2011; Fiske, 1993; Hilton & von Hippel, 1996). As such, stereotypes are a type of schema working to make processing information easier for the perceiver. Stereotypes are used to quickly gather important information about an individual occupying a particular scheme or set of characteristics. The stereotypes are ultimately used to inform the perceiver's decisions resulting in behavior.

Research notes that this process is both implicit and foundationally a mechanism of control (Fiske, 1993; Greenwald & Banaji, 1995). The thought process is simple: "In order to control me, I must be able to predict you."

While this thought process is helpful when deciding whether to bring a gift versus an arbitrary item to a birthday party, making assumptions about an individual's unique identity to inform behavior towards them is a flawed process. Rather than a harmless assumption to help us act appropriately, the development of schema becomes a process of overbearing control experienced by the stereotyped person, producing effects such as "stereotype threat" (Steele & Aronson, 1995). When stereotyping, the process of thought includes another person rather than a set of objects. The two thoughts become:

From the perceiver: "In order to control me, I must be able to predict you."

From the perceived, the response: "I am trying to control me, but my actions are not being perceived the way I intended."

In a counseling relationship, for example, this may look like the counselor unknowingly holding a belief that Black people are not self-aware and therefore consistently reflecting feelings differently than what the client wants to communicate. For example, a Black client comes in to discuss feelings after a loved one dies. Due to the complexity and suddenness of the event the client is having a difficult time expressing how they feel. The counselor unaware of their bias regarding the lack of emotional intelligence and self-awareness of people of color, adopts an affect of pity and reflects feelings they would feel in a similar situation thinking they are being helpful. The client after reflecting contrasting emotions than the clinician suggested each time may feel dissonance and like their being challenged. They may become confused and feel uncomfortable.

The dissonance in the interaction can lead to the perceived feeling insecure about what to do next, questioning their thoughts, beliefs, and intentions, etc. This stress resulting from the interaction with the stereotyped belief results in stereotype threat. Stereotype threat negatively impacts the perceived (client) physically, psychologically, and emotionally with disproportionally negative effects for people of color, especially Black women (Ashley, 2014; Harris- Perry, 2011; Jerald et al., 2017; West et al., 2016). Stereotype threat creates real differences in test scores, achievement, and anxiety (Aronson et al., 2013; Aronson et al., 2002; Steele & Aronson, 1995). The effect of stereotype threat is so strong, that simply the awareness that such a stereotype exists is enough to negatively impact individuals identified in the group (Aronson et al., 2002).

This negative impact is further compounded as the implicit stereotypes held by the perceiver (e.g., counselor) effects their decision making in a way to maintain intrinsic power over the perceived (e.g., client) (Fiske, 1993; Mangels et al., 2012). Indeed, implicit bias in social cognition research has revealed that increasing levels of power and authority lend itself to more stereotyping and bias (Fiske, 1993). That is, individuals who hold more power and authority in a social context are more likely to hold stereotypes and therefore behave biasedly more often. As such, those who historically occupy intersectional identities of power and privilege are more likely to stereotype and behave biasedly without being aware.

Regarding stereotypes in the counseling field, historically, Black Americans have been stereotyped in mental health treatment resulting from disparaging beliefs about capacity for insightfulness, self-control, and self-awareness (Nayman, 1983; Primm et al., 2009). Given implications for increasing levels of power, counselors, who can be said to hold moral authority (power) in a society and within the therapeutic relationship, are therefore more likely to be influenced by implicit prejudiced beliefs. Further, those who hold intersectional identities of

power and privilege (such as counselors who are white males), are increasingly more likely to operate from implicitly held prejudiced beliefs. The contention examined in the current study is that this is especially the case for those who operate from a sense of altruism.

In consideration of the role of power and privilege, altruism may provide a more comprehensive explanation for the persistent implicit bias in the counseling field. Fundamentally, altruistic theory analyzes power dynamics in a helping relationship imbedded in cultural context. Altruism exposes assumptions necessary for such a power differential between the helper and the helped. Given the established acknowledgement of the imbalanced power dynamic between clients and counselors (Palmer, 2018), altruism may serve as a surrogate for analyzing power differentials of the helping relationship within counseling while accounting for cultural assumptions relating to intersecting identities. The counseling field has analyzed power imbalances between cultural intersectional identities such as racial/ethnic, gender, sexual orientation, socioeconomic/class, and ability in how they effect therapeutic outcomes (Pearrow & Fallon, 2019; Ratts et al., 2015; Robinson, 1999). However, the field has not analyzed power imbalances as it relates to how we define help, who defines help, who gets to help, who should be helped, and further, how these are all impacted by the combination of intersectional identities between a counselor, client, and supervisee in a therapeutic context. The answers to these questions may be best explored through the context of altruism

Analyzing altruism in the context of assumptions necessary in a biased society may help outline additional power imbalances and their implications for intersectional identities within the helping relationship. Additionally, altruism is a socially desirable trait and social desirability contributes to counselor behavior causing counselors to overestimate their ability to behave in a culturally competent manner (Constantine & Landany, 2000; Pope-Davis et al., 2003). This means that cultural competence cannot be measured in counselors overtly. Another mechanism

must be used to covertly assess. Characteristics of altruism and the counselor's drive to be socially desirable make it an insightful addition to address implicit bias's persistence despite training among counselors.

Altruism

Altruism is defined as a prosocial and inherently ego driven helping behavior, of which the individual is aware of socially acceptable behaviors, their rewards, and their consequences (Robinson & Curry, 2007). Altruistic behaviors are fundamentally based on biased assumptions shaped from surrounding culture (Kraut, 2020). Who needs help and what type of help they need are labeled based on who holds the power in a given society. We help those in society who are different than the people who hold power. Therefore, the helper, in various roles within the supervisor- counselor- client triad, is influenced on a professional and individual level, perpetuating the beliefs of those who hold power in a society. The counselor's role consequently is to be hyperaware of the definitions of the surrounding society informed by those in authority and make decisions regarding those who do not adhere to those characteristics. For example, this is apparent in diagnoses. Diagnoses regarding mental illness are only apparent because of an established norm and an established "other". Historically this is most notably seen in the aforementioned diagnosis of "Negritude" by Benjamin Rush. Blackness was considered different from the normed Whiteness and therefore was diagnosable according to the surrounding culture. Coincidentally, given American context of oppression, bias, and discrimination, whether consciously or not, a counselor's acute orientation has to extend to stereotypes and bias within the culture they serve to make culturally reflective decisions. Stated simply, in this context, altruism is not necessarily a good quality. Considering the assumptive nature of altruistic tendencies, concerns regarding culturally competent care can be raised.

Due to counselors' proximity to power within a society, counselors both serve those in power and hold social power over those without power due to altruistic perceptions of the field. Since counselors are perceived and exalted as the do-gooders, based on their altruistic nature (Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982), they are not expected to behave in an unhelpful way. The unconscious thought process from surrounding culture may look something like "Counselors do good; therefore, they are good and can only do good things". In this way the terms counselor and altruism have become synonymous in practice. As such, made way for is the systematic perpetuation of implicitly held beliefs unchallenged and likely congratulated. Counselor behavior (e.g., decisions, diagnoses, recommendations), no matter how biased, is accepted due to perceptions about their role.

Additionally, counselors who overidentify with altruism may behave with increased bias. These counselors are blinded by the same thought process of the surrounding society protecting counselors from ill thoughts about their own behavior. The unconscious thought pattern from the counselor would sound something like "I think I am good, and others think I am good, so therefore I am good. Since I am good, I can only do good things". In this way, they also believe they cannot do harm because of their role and others' perceptions. Through this belief, counselors can engage in harmful behaviors by unknowingly perpetuating the biases within the society they operate while believing that they are doing good work. As they are reinforced by the perceptions of the public, they continue to do so being influenced by their own need to be socially acceptable contributing to inflated self-esteem. Established is a pattern of biased behavior linked to egoic (e.g., a decision that makes the counselor feel better about their self) decision making. Thus, the cycle becomes systematic: Counselors perpetuate stereotypes, working to change the client's behavior towards the beliefs of those in power and await the celebration of their flawed decision making from those in the surrounding culture. In this way

counselors are protected from ill beliefs about their behavior and reinforced as beacons of hope while simply carrying out the wishes of the majority, no matter how biased.

To summarize, the belief that counselors are altruistic from counselors and society, at various levels, exacerbates biased tendencies perpetuating barriers to authentic culturally competent care. In such a way, the power dynamic resulting from stereotypical beliefs about counselors is preserved through altruism. Altruistic tendencies of counselors, while on the surface seem good intentioned, may reduce multiculturally competent ethical decision making, particularly with clients of color. While a combination of practiced awareness and confrontation are typically used to combat implicit bias (Boysen, 2010), this combination has not been powerful enough to break this systemic cycle perpetuated by altruism. Thus, an addition of accounting for altruism may increase efficacy for counselors in decreasing biased decision making.

Theoretical Framework

Social Cognition

Fundamental to the current study are concepts found in social cognition research. Social cognition research, simply put, is the study of thought processes that influence social interactions (Devine, et al., 1994). Notably encompassed in social cognition research is how characteristics are attributed to individuals and groups (Bassilli, 1989), the mechanisms of prejudice (Olson & Zanna, 1993), and the formation of perceptions and personality (Nauts et al., 2014), among many others. Fundamental to the development of social cognition is past experiences work to inform thoughts, feelings, and behaviors regarding social interactions even when the precipitating event is not remembered. For example, seen in schema research, explored further in stereotypes below, is how our brain can create scripts from limited information. For instance, from past experiences, a set of balloons, a clown and a cake can trigger thoughts of a potential birthday party. However,

it is unlikely that the initial memory that scheme is derived from is conjured up for you. Even still, we follow suit with what the scheme suggests (bringing a birthday gift) even though we are unaware of where we learned the social script. In this way we play along with the narrative together as a collective group without questioning. Evidenced in each discipline of social cognition research is that our thoughts have the power to influence our behaviors and impact our interactions. In the current study, this is explored through research encompassed under the umbrella of prejudice social cognition by way of implicit bias, stereotypes, and stereotype threat, explored below.

Stereotypes and Stereotype Threat

Our brains create shortcuts (Fiske, 1993) called schema making assumptions about the surrounding environment to streamline everyday functioning. This natural process becomes problematic when the brain also makes these automatic assumptions about the people in an environment (Fiske, 1993; Greenwald & Banaji, 1995). Research notes interacting with people utilizing stereotypes, whether intentionally or unintentionally is harmful. Interacting with others utilizing stereotypes can negatively impact the stereotyped person or group of people psychologically (Adams- Bass et al., 2014; Fiske, 1993; Good et al., 2008; Jerald et al., 2017; McGlone & Aronson, 2006; Mitchell, 2018; Olion, 2016; Steele & Aronson, 1995). A negative historical impact results for Black Americans (Ashley, 2014; Harris- Perry, 2011; Donovan, 2011; West et al., 2016).

Stereotype threat research refers to automatic schema developed from past experiences that work to influence behavior covertly. Stereotype threat is defined as the resulting anxiety to act toward or against a known stereotype (Brown, 2017). Stereotype threat can contribute to psychological negative effects manifesting in real world consequences (Appel et al., 2011; Fiske, 1993; Good et al., 2008; McGlone & Aronson, 2006; Steele & Aronson, 1995). Psychologically,

it is known stereotype threat can negatively impact self-concept, motivation, determination, psychosocial development, intelligence, arousal, memory, and emotions to name a few (Aronson et al., 2002; Beilock et al., 2007; Bentley-Edwards et al., 2014; Ben-Zeev et al., 2005; Good et al., 2008; Mangels et al., 2012; McGlone & Aronson, 2006; Steele & Aronson, 1995). Accounting for increased effects regarding those perpetually and historically psychological abused within American society, there are likely increased negative effects for those of intersecting marginalized identities (Donovan, 2011; Jerald et al., 2017; West et al., 2016) within the supervisor- counselor- client triad (Ashley, 2014).

Put simply, the automatic assumptions created through our brain's natural thought processes do not stop when storing information about people. Past experiences from any context (media representation, entertainment, personal experiences, others' stories, and any other outlet) can impact our information stores for individual people and groups with shared characteristics. This process, just like schema developed for a birthday party, explained previously, occurs outside of conscious awareness. Stereotype threat explains what could happen when a stereotype becomes known to the person the stereotype is about.

Stereotype threat is the pressure to act toward or against a known widely held belief of which the person identifies with (Steele & Aronson, 1995). A person being stereotyped will change their behavior in response to the stereotype. In this way, a person's thoughts, feelings, and behaviors can be influenced by another's perception of them within an interaction caused by a mismatch between who a person thinks they are and how they are being perceived. It is due to the perceiver's influence over thoughts, feelings, and behaviors that make researchers recognize stereotyping as a form of intrinsic power and control over an individual (Fiske, 1993). It is the role of authority, power, and control present in this interaction in stereotype threat, also present in implicit bias, that is of particular interest in the current study. Of specific interest is how this

power dynamic, resulting from bias, plays out in the known power differential within a counseling relationship between the supervisor, counselor, and client.

Implicit Bias

Also foundational to the current study is the theoretical underpinning of implicit bias. Implicit bias is rooted in implicit social cognition research, studying unconscious thought process in social interactions (Greenwald & Lai, 2020). Implicit bias is the most recent form of covert bias research emerging over the last few decades (Greenwald & Lai, 2020). It is defined as unconsciously held prejudiced beliefs that result in judgements or actions (Greenwald et al., 1998). Individuals can hold prejudiced beliefs and be unaware, but still use them to inform interactions despite self-report (Allen, 2020). The utilization of implicitly held biased beliefs is important to the extent of its relationship to levels of altruism in the study. That is, explored in the current study is how implicitly biased a counselor may be depending on their levels of altruism.

Altruism

While there is historical debate regarding the definition of altruism, the current study utilizes definitions that describe altruism as a prosocial helping behavior (Robinson & Curry, 2007). While some argue that such behaviors are inherently ego driven (Andreoni, 1990; Kant, 1785), others argue that unintended positive side effects do not affect an otherwise truly altruistic motive (Batson, 2011). The current study adopts the argument that altruism is prosocial as altruism is a motivating factor for choosing to work in the helping professions (Byrne, 2008). Professional counseling is a service-oriented profession and almost exclusively focuses on altruistic acts (e.g., giving of oneself). As such, counselors are engaging in altruism with an awareness of socially acceptable behaviors, their rewards, and their consequences, noted in arguments describing altruism as a prosocial behavior (Bentham, 1789; Cialdini, 1991; Skinner,

1978). The current study theorizes that counselors choose the profession consciously aware of its favor, rewards, and social acceptance in surrounding culture.

Statement of the Problem

Overall, the capability to make appropriate decisions without bias is still a concern for counselor educators/supervisors, counselors, and counselors-in-training (Foster, 2022; Graham et al., 2022; Kugelmass, 2016). While implicit bias offers some insight to the cause, accrediting and licensing bodies have not mandated its inclusion (Boysen, 2009). Further, in research, implicit bias has deviated from its roots in analyzing the effect of power and authority in its effect on social interactions. As counseling is an altruistic profession, the inclusion of implications for dynamics involving power and authority present in bias research and altruism is imperative for approaching issues regarding cultural competence in the profession. This is explored further in the implications for the current study.

Statement of Purpose

The purpose of this study is to a conduct a mixed methods study to explore relationships between altruism and implicit bias with an added focus on improving implicit bias training in the counseling profession. Counselor's identification with altruism, reinforced by societal perceptions, serves as a system of reassurance solidifying biased decision making impacting those of diverse underrepresented cultures. Posited in the current study is that counselor's altruistic tendencies because they are a) assumption based b) informed by the definitions within the society and c) are reinforced throughout personal and professional identity, makes counselors resistant to correction regarding implicit bias. Additionally, altruism works to give counselors access to increased authority within the therapeutic relationship increasing implicit bias. Thus, two aims for the current study have emerged. Primarily, the current study will quantitatively explore correlations between counselors' implicit bias, altruism, and different facets of counselor

identity (race/ethnicity, gender, roles in the counseling field and other demographic information). Secondarily, the National Institutes of Health's (NIH's) Implicit Bias Training Module (2022) will be adapted to include altruism and other related key aspects for counselors.

Current Study

The overarching research question for this mixed methods study is: What additions to counselor training should be made in order to mitigate implicit bias increasing competent care for Black clients? Posited in the study is that altruism plays a significant role. Other additions may be found through consulting with professionals in the field. As such, the study utilizes a mixed methods approach exploring two aims.

Primary aims are covered in the quantitative research questions of the proposed study:

1. What is the relationship between counselor implicit bias scores and altruism scores?
2. What is the relationship between counselor demographic data and implicit bias scores?
3. What is the relationship between counselor demographic data and altruism scores?

In order to answer questions regarding the primary aims of the current study, participants will be asked to complete the Self Report Altruism Scale (Manzur & Olavarrieta, 2021) and Harvard University's Implicit Association Test for race (Nosek et al., 1998). Given the current study focuses on the American counseling profession, as race is an integral part of American context, the Implicit Association Test for race will be used. While previous research notes that in general those who self-report low bias score high altruism levels (Hale, 2016), it is unclear how unconscious bias will relate to altruism. As such, given the highly exploratory nature of the study, hypotheses were not derived.

The secondary aim of adapting the NIH Implicit Bias Training Module (2022) is explored qualitatively through focus groups comprised of counseling professionals. The Substance Use and Mental Health Services Administration (SAMHSA) guide for Adapting Evidence-based

Practices for Under-resourced Populations (2022) will be followed to conduct the current study. The research question guiding the secondary aim of the current study is as follows:

1. What else should be included in NIH's implicit bias training to adapt it for counselors?

Implications/ Significance

Generally, an adapted implicit bias training tool for counselors would be the first of its kind, spearheading opportunities for growth positively effecting treatment outcomes for clients of color. However, also significant is the restoration of power in implicit bias research necessary to accurately cultivate additional tools for mitigating negative implications of implicit bias. Finally, an analysis of power through the theoretical framework of altruism calls for more intimate questioning of the counselor's personal and professional identity laying the foundation for changes in the counseling field. Concerns raised regarding the power dynamics persistent within the therapeutic relationship considering the contexts of implicit bias, stereotypes and altruism suggest the need for more contexts where counselors hold less power. Research concerning such would be pivotal for the field.

Implications for Counselors in Practice

Implications of this study are that the field of counseling and counselor education will have added knowledge regarding decreasing the harmful effects of implicit bias. Gaining additional insight on the influence of implicit bias and altruism will support development in the ability to make unbiased decisions and increase client efficacy. Direct implications of the proposed study are that it furthers the understanding of the influence of implicit bias in decision making. Overtime, through continued research and application, counselors would be able to recognize implicit bias, identify harmful stereotypes negatively effecting client success, and decrease decision making unconsciously rooted in selfish desires. Continuing, related to their

own implicit bias, the overarching goal is that counselors regardless of experience, do not perpetuate harmful beliefs contributing to the identity development of historically marginalized/ minority groups causing additional harm within the unique power dynamic of the counseling relationship.

Implications for Supervisors

Implicit bias unaddressed can lead to the further perpetuation of engrained societal stereotypes. A supervisor armed with unconscious harmful biases within a power dynamic such as the supervisor- counselor- client triad lacking the tools to correct themselves charged with authority over an unequipped supervisee can absolutely negatively affect any involved, especially those in marginalized communities. With continued research on the negative implications of social cognition research and altruism, supervision standards can be revised to address competency standards more comprehensively for counseling trainees. It is essential that the field addresses thoroughly the gap in multicultural competency between supervisors and trainees by equipping supervisors with this knowledge. Clinicians need the tools to wholly respond to needs of diverse clients but cannot do so when supervisors are largely ill equipped. With an adapted NIH implicit Bias Training, supervisors can begin to address their own gap in competency passing it on to counseling trainees.

Definition of Terms

Altruism: Prosocial and inherently ego driven helping behavior of which the individual is aware of socially acceptable behaviors, their rewards, and their consequences (Kraut, 2020; Robinson & Curry, 2007).

Altruistic drive: A term established by the current study explaining a type of altruism focus group participants described in the counseling profession. Altruistic drive describes a counselor's need to help resulting in assumptive and biased based decision making rooted in preservation of ego to access social rewards of altruism. Altruistic drive results in the counselor believing they are helpful, unconsciously blinding themselves to the needs of clients. The client does not get their needs met. Altruistic drive, as a result, perpetuates implicit bias, increases counselor dominance, and silences clients. Altruistic drive is the need to help defined by the person helping.

Altruistic intention: A term established by the current study explaining a type of altruism focus group participants described in the counseling profession. Altruistic intention describes counselor behavior that is indicative of traditional definitions of altruism. It sacrifices ego, is collaborative and meets the needs of the client. Altruistic intention is the desire to be helpful defined by the person/group they are helping.

Authority: A person or organization having power or control in a particular, typically political, or administrative, sphere (Merriam-Webster).

Control: The power to influence or direct people's behavior or the course of events (Dovidio, 2011; Fiske, 1993; Hilton & von Hippel, 1996).

Counselor: For the purposes of the current study, only mental health professionals who belong to the counseling profession or counseling students and trainees will be included in the study. Social workers, psychiatrists, and psychologists are excluded.

Early helper: An early helper is a term established by the current study, referenced in background literature in chapter 2, and is defined as any professional who provided mental or physical clinical support to people prior to the official onset of the counseling profession.

Ego: A person's sense of self-esteem or self-importance (Oxford University Press, 2006).

Implicit bias: Unconscious held prejudiced beliefs that result in judgements or actions (Greenwald et al., 1998).

Intrinsic power*:* Ability to bend and influence others to your own will (Fiske, 1993).

Multicultural competency: The knowledge, skills and personal attributes needed to live and work in a diverse world. The current study focuses specifically on the following: a) The ability to question one's own beliefs, attitudes, and perceptions; identifying practices that are biased; and changing one's perceptions of self and others (Sharma et al., 2011) and b) A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al., 1989).

Power: The capacity or ability to direct or influence the behavior of others (specifically within the supervisor- counselor- client triad) or the course of events with special consideration regarding early stereotype threat research, that increased power encourages stereotyping and that those in power may be more at risk to developing unconscious bias (Fiske, 1993). Further, that there are intersecting identities that grant more access to varying degrees and types of power (social, economic, political, etc.) permeating throughout and within a societal context through dominant discourse based on said societal (Robinson, 1999). Mentioned in the current study are traditional power, moral power, intrinsic power, and social power.

Prosocial behavior: Acts or behavior of which is positive, helpful, and intended to promote social acceptance (Eisenberg et al., 2006).

Stereotype threat: The tendency to act toward or against a widely held belief after said belief is made known (Steele & Aronson, 1995).

Stereotype: A widely held but fixed and oversimplified image or idea of a particular social group of people (Hinton, 2019).

Supervisor- counselor- client triad: A term used in the current study referencing the interrelated helping system comprised of the counseling supervisor, counselor/supervisee, and client. Components are defined as follows: 1) Counseling supervisor- Any helping professional who regularly oversees the professional development of other helping professionals in clinical practice with or without added licensure, certification, or credentials. 2) Counselor/ Supervisee- Any helping professional or student who regularly holds appointments for individuals regarding mental health treatment or support with or without added licensure, certification, or credentials. 3) Client- a person who engages the professional mental health services of any helping professional or student with or without added licensure.

CHAPTER II: LITERATURE REVIEW

Introduction

The current study examines the role of altruism on the influence of implicitly biased decision making among counselors. Counselors are known to make biased decisions impacting clients of color, specifically Black American clients (Adebayo et al., 2022; Kemet et al., 2022). Implicit bias, characterized as unconsciously held prejudiced beliefs (Greenwald et al., 1998), in counselors has been traced to negative treatment outcomes (Boysen & Vogel, 2008; Katz & Hoyt, 2014). Though implicit bias trainings have been used to address this, they can be ineffective in mitigating bias long term (Brogaard, 2020). As diversity is vast, given America's extensive history of oppression, specifically of Black Americans, the study focuses on the mental health treatment of Black Americans for examinations of why, namely implicit bias, persists in the counseling field despite access to implicit bias trainings and other means to address biased decision making.

One reason may be linked to counselor's drive toward social desirability. For instance, despite research underscoring the potential negative impact of implicit bias, specifically in counseling clients of color, the field has not evolved to incorporate it in counseling education (Boysen & Vogel, 2008; Nwosu, 2018). Exploring altruism and its intersections with implicit bias in counselor behavior may help explain why. Altruism is defined as a prosocial helping behavior (Robinson & Curry, 2007). As a prosocial behavior, those engaging in altruism, according to the definition adopted for this study, do so with awareness of its sociocultural rewards and therefore are ego driven (Andreoni, 1990; Kant, 1785). Social desirability is cited as a reason why counselors overestimate their cultural competence (Constantine & Landany, 2000; Pope-Davis et al., 2001). As such, counselors have a drive to be socially acceptable, as do all humans. However, posited in the current study is that counselors who overidentify with altruism

may be resistant to implicit bias education due to its implications for their own behavior. For example, if implicit bias were to be added to education competency standards, responsibility would have to be taken for behaviors that are not desirable and therefore against counselor's identity threatening social rewards.

Altruism's prosociality may also account for concerns regarding implicit bias training efficacy. Implicit bias trainings continue to be ineffective (Brogaard, 2020) for a variety of reasons. When confronted with dissonant information counter to conscious report, individuals atone for the dissonance through rationalization. In this way, people explain away discrepancies unaware of their prejudiced source (Brogaard, 2020). It is likely that in order to maintain social desirability and manage ego, counselors dissociate with trainings for themselves but result to gathering the information for others. This would result in a response such as "I do not need this training, but I know someone who would greatly benefit". As such, conceptually, altruism contains elements of power and authority that may impact counselor's ability to receive correction.

Counselors are deemed as the helpers rather than the ones being helped in a counseling relationship; a fundamental hierarchy necessary for altruistic behavior. Altruism fundamentally requires a system of assumptions about the helper and the helped informing subsequent behavior driven by sociocultural context (Kraut, 2020). Counselors, therefore, may be resistant to receiving help unwilling to give up the moral power they hold in the context of a morally provoking topic especially in working to manage their ego as it pertains to social desirability. Therefore, inherent in counselor identity is the same power dynamic assumed in altruism informed by sociocultural context. Counselors are immovable in their role as the helper, recognizing its social benefits as they are praised for their proximity to altruism and therefore are resistant to giving up the power especially for a topic so morally driven as implicit bias. As such,

using altruism as a surrogate for counselor's power dynamic, the current study will explore tendencies that may not be revealed readily due to a counselor's tendency toward social desirability.

Proposed in the study is that altruism grants counselors with unique intrinsic and social power in a society simply due to their role as counselors mostly affecting those who have less societal power (such as people of color). The current study posits that perceptions of altruism within the cultural context effect the attitudes and beliefs of counselors and the surrounding society shielding counselors from being aware of their own biases. Counselors engage in behavior described as altruistic regularly (Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982) and therefore are perceived as altruistic. Through this association, they are granted the authority to enforce societal values and therefore perpetuate them in mental health treatment. Altruism, therefore, works within individuals in a society and in counselors granting moral dominance and authority. Due to favorable perceptions of altruism and altruistic behavior, counselor decisions are deemed as moral and good as long as they are consistent with the measure of morality in the society. Therefore, when a society has biased views of morality (explicitly or implicitly), counselors are praised for making decisions consistent with that bias. A counseling profession rooted in a biased America, given its history, should be reexamined for these patterns.

Additionally, as it is known that power can increase the likelihood of bias effecting decisions (Fiske, 1993), counselors with moral power over those of less power, who are known to make biased decisions (Adebayo et al., 2022; Boysen et al., 2006; Boysen & Vogel, 2008; Katz & Hoyt, 2014; Kemet et al., 2022; Liu, Coifman et al., 2022; McConnell & Leibold, 2001; Nayman, 1983; Primm et al., 2009) should be reevaluated through the lens of altruism. Altruism, because it is rooted in societal beliefs of morality and is associated with the counseling

profession, influences biased decision making in the American counseling profession and protects counselors from awareness increasing implicit bias. As it has been researched that most prejudiced beliefs are unconscious (Fiske & Taylor, 2013), the biases counselors hold are likely largely unconscious given the current orientation of American society. Given counselors role in perpetuating the beliefs in a society (Katz, 1985), unconscious bias likely plays a large role in decision making. Adding altruism in implicit bias research for its role in perpetuating bias and increasing bias blind spots may help in comprehensively understanding biased decision making in counselors.

Including altruism also helps address concerns in multicultural competency and implicit bias research. Elements of power and authority have been lost throughout the evolutions of implicit bias research and are not comprehensively explored accept in some social justice counseling research (Singh, Appling et al., 2020). Combining altruism and implicit bias for the context of this study will introduce analysis of power back into the research. Additionally, if these conceptualizations are correct, combining altruism with implicit bias training for counselors may make implicit bias interventions more effective.

The purpose of the current chapter is to expound on the theoretical underpinnings of the current study of altruism, social cognition research with an emphasis on implicit bias, and their intersections as it relates to the counseling profession. Explored are their historical roots in the profession outlining what is missing in current efforts to become a more culturally competent profession producing clinicians with the skill and insight to meet the growing needs of diverse clientele. In order to understand the intersections of implicit bias and altruism within the American counseling context, background exploration is provided. After such, the chapter will include a) development of social cognition theory relevant to the current study emphasizing implicit bias b) altruism theoretical underpinnings and development c) a review of literature

regarding multicultural competence d) review of literature regarding implicit bias training and e) discussion of adapting the NIH implicit bias training to include altruism to increase efficacy in outcomes for clients of color.

Background for Theoretical Underpinnings

The American counseling profession is said to have officially begun at the pioneering of vocational counseling during the rise of the industrial era before morphing into the talk therapy structure we know today. Current client centered approaches have foundations in Carl Rogers' (Marini & Stebnicki, 2016) practice while initial vocational work began under the auspices of Frank Parsons (Hartung & Blustein, 2002). Though this may be claimed as an official beginning to what we currently call the counseling profession, we miss characteristics of early helper culture by starting the conversation here. While the name "counselor" in the context of mental health was not seen in print until 1931 (Capuzzi &Stauffer, 2008), helping professionals, healers and those who guide had historical representation in different cultures for centuries and were essential to the society before the emergence of America as we know it today. Such examples of this are found in ancient Egypt, for instance, where ancient Egyptians were discovered to have codified and gathered knowledge of psychiatry in the Ebers Papyrus and Edwin Smith Papyrus in 1550 BC (Bou Khalil & Richa, 2014; Haas, 1999). It is difficult to believe the beginnings of the American mental health counseling field, with its prominence and importance in colonial settlers' origin lands, did not begin until the onset of school and vocational counseling.

Rather than beginning with a definite set of rules and ethical guidelines, early influences of the counseling profession were gathered at various times (Marini & Stebnicki, 2016) from leaders in diverse disciplines with global influence. Religion, opinions on race and culture differing from Whiteness, patriarchal structure, and many other global ideologies were at the foundation of the counseling profession. The structure of the counseling profession was derived

in context from major social, cultural, and political themes and beliefs permeating throughout its institutions (Herr, 1999). In American context, discrimination and bias are core to its foundation. As American counseling is culturally responsive to a now developed United States, the profession must continuously correct its roots to reflect the current unique American context.

In speaking of American context, characteristic of American culture, unfortunately still having pervasive effects on its citizens, is the history of chattel slavery and the immense oppressive systems it created in its wake. The physical and psychological toll left from chattel slavery on the collective psyche of American citizens, most palpably effecting Black Americans (Burrowes, 2019; DeGruy & Robinson, 2018; Gómez, 2015), also has its roots in the foundations of American counseling (Herr, 1999). Efforts to develop clinicians with the knowledge and skills to counsel clients of diverse cultures continue to be ineffective due to counselor bias (Adebayo et al., 2022; Boysen et al., 2006; Boysen & Vogel, 2008; Katz & Hoyt, 2014; Kemet et al., 2022; Liu, McRee et al., 2022; McConnell & Leibold, 2001; Nayman, 1983; Primm et al., 2009). Despite efforts to produce more culturally competent clinicians, without analyzing the real underpinnings of the profession, it is likely that efforts to mitigate bias within the therapeutic relationship will continue to be ineffective.

Early helpers influenced by global perceptions of who should hold power and why, despite their best intentions, were influenced by a surrounding culture that devalued Black bodies. Blackness was beaten, bullied, and terrorized under the belief that they were protecting the good of the people, which in context was arguably considered altruistic. Similar to a superhero praised for saving the day, early helpers were congratulated for torturing Blackness framed as protecting others from what they deemed "preserving the divine structure of humanity" (North, 2000). Their works were deemed morally good and likened to spiritual warfare defended biblically. Made evident were the roles of power and authority within the

helping relationship. Divine hierarchy was set and those who felt called to help were granted moral authority over most.

The real early pioneers of the counseling profession were gathered from various other disciplines of medicine, government, and religion. They combined their knowledge from their diverse disciplines and answered a call within themselves while aligning with the needs of their surrounding culture. Armed with the knowledge from their varied skillset and moral superiority, they made decisions based on societal assumptions of who was right (well) and wrong (unwell). Current ethical codes outline the importance of beneficence, or doing good (American Counseling Association, 2014). Questions raised through this exploration of research include "what is good" and "who really gets to define it". On the other hand, maleficence is underscored as foundational to counseling ethics (American Counseling Association, 2014), but "what is harmful" and "who defines that". These questions subsequently also lie at the definition of altruism. The ability to work with diverse clientele (cultural competence) seems to be more reliant on who is in authority and what type of world they want to live in rather than genuinely meeting the needs set by those seeking services within diverse cultures.

Rather than counselors removing their proverbial cape and putting on the client's lens to inform of their needs, some counselors may be too engulfed in an unconscious system of preserving their ego through the power that being a moral beacon provides through altruism. To meet the needs of people of color more accurately and live up to the aspirations of ethical mandates, it is imperative to revisit the profession's onset. Given the diversity of professions in early helpers, in exploring such a past, initially investigated is the historical prejudice found in general healthcare practices to get better insight on the actual foundations of the counseling profession. Though the history of abuse regarding Black mental healthcare is vast, included

throughout the following discussion is a framework of early helper culture and significant members founding our current helping professions.

Early Helper Culture

Though the field of counseling was not solidified as a profession, many early scientists were curious about the brain and its functioning even through the onset of American slavery (North, 2000). The field lacked unified structure making early practice regarding mental health more susceptible to individual ideologies (Herr, 1999). Therefore, the first mental health practitioners were individual scientists who exercised curiosity in many fields. They were prominent engrained members of society with international connections relying on a combination of their beliefs, the beliefs of others before them (often mentors) and the beliefs of society. As such they were granted unique power and authority within their societal structures.

As individuals with varied knowledge, they were often looked to as experts in many fields adding to the power and authority they were granted. Religion was a large part of the societal structure and helper identity and therefore was entangled into the understanding of mental illness. Helpers at the time were curious scientists with a variety of interests in other fields. Often, this resulted from working to integrate their own understanding of themselves and others with their own belief structure (this can be seen in Freud's development of psychosexual stages for instance). Combining their own beliefs influenced by those with scientific and political power, early helpers relied on religion and politics to make decisions about who was sick and how to treat them. From this combined context, decisions ultimately resulted in whether the sick were treated for societal reintegration or further isolation (both Benjamin Rush and Samuel Cartwright are examples of such explored further below). The culture of these helpers was that they intertwined their intensely self-informed knowledge from various contexts, creating combined theories to explain health from a holistic approach. While there were some perceived

as extreme within their various eras (such as Paracelsus explored further below) helping professionals had great authority in their societies with global impact.

Counseling was not a separate entity ahead of its time in morals and values, but instead a field comprised of the society's beliefs working to integrate those they can and pathologize those too far from the established norm. As such, the goals of the first helping professionals, as are today, were to combine their unique knowledge with the knowledge of the time to further the decisions of society. Decisions were made regarding who was normal (well) and who was not (unwell) in order to treat to protect the normality of society. Laws, culture, and religion dictated by those in power in society were all tools used by the first helpers to make decisions and treat clients (Herr, 1999). In order to explore this vast context in a simplified manner, focused on are three key prominent early helpers rooted in the mental healthcare professions with diverse perspectives within their contexts: Paracelsus, Benjamin Rush, and Samuel Cartwright. These respected leaders shed light on views of Black mental health, bias, and altruism that permeate throughout today's clinical practice.

Philippus Aureolus Theophrastus Bombastus von Hohenheim (Paracelsus)

Though America was said to be discovered in 1492 (1492: An ongoing voyage, 2008), exploration of early helper culture will begin during the 16th century with the Swiss philosopher, physician, alchemist, theologian and revered prophet, Philippus Aureolus Theophrastus Bombastus von Hohenheim (Hargrave, 2022) for his influence in American helper culture. He has since been known as the father of toxicology and was credited as providing the first clinical mention of the unconscious during the German Renaissance (Michaleas et al., 2021). Paracelsus was admired by Carl Jung (Hargrave, 2022), the founder of analytical psychology. Typical for early scientists to be deeply active in a society, he was not relegated to one discipline and often studied the entirety of the human body to explain disease (Grandjean, 2016; Michaleas, 2021).

It could be argued that all current fields of human health are derived from the thoughts and beliefs of early prominent scientists, such as Paracelsus. In the case of Philipus, he was ridiculed for his beliefs on the humane treatment of the mentally ill (Paracelsus, 1894) and seen as rebellious (Michaleas, 2021). In his era, the mentally ill were seen as spiritually possessed. However, despite his religious roots (Grandjean, 2016) he saw mental illness as a treatable medical illness rather than a spiritual possession (Paracelsus, 1894), contributing to his ideas being ignored for centuries becoming more relevant after his death (Edwards, 2012). This is reflective of societal beliefs about mental illness during the onset of African slavery- humane treatment was not a standard particularly for enslaved Africans. An exploration of Benjamin Rush's principles, below, helps shed light on these views in the context of altruism, helper culture, American slavery, and the views of mental illness.

Benjamin Rush

Benjamin Rush, born in 1745 and a prominent helper during American slavery, grappled with the decision of morally treating the mentally ill (Trent, 2021) similar to Paracelsus. Referred to as the father of psychiatry and mentored by William Cullen at the University of Edinburgh in Scotland, Rush was a well-known physician of his time who like Paracelsus was deeply active in his culture. He was an author, philosopher, evangelist, politician, and social reformist (North, 2000) indicative of the eclectic nature of many early helping professionals. Further illustrating his influence, power, and authority, he wrote the first American chemistry textbook, graduated from what is now Princeton University when he was 14 and signed the Declaration of Independence (North, 2000). Rush also was actively engaged in the education system serving as faculty at the University of Pennsylvania School of Medicine. Undoubtedly, he was a leader deeply rooted into the sociocultural structure of his time.

It is reflected that he had a paternalistic style and cared a great deal about his patients (North, 2000). He could undoubtedly be viewed as altruistic in his context as he sought to regularly help (Kraut, 2020). Integrating his professional philosophy with his religious, he believed that "God would reveal cures to all sickness so long as the doctor was chosen by God or sought it vigorously" (North, 2000). A type of altruism driven by moral authority and a religious calling to be of service (Kraut, 2020), Rush vigorously sought new cures for the treatment of patients during the Yellow Fever epidemic (Rush et al., 1799). Though, he was successful in his pursuits, Rush's unconscious bias gathered from his surrounding sociocultural context interfered with his treatment practices. Benjamin Rush's bias likely drove his belief that Africans were immune to the fever. He simply could not see the yellow in their skin and resolved they must not be like the others. During his era, the belief that Africans did not feel, think, or behave the same as others was pervasive, and continues today (Adebayo et al., 2022; DeGruy & Robinson, 2018; Nayman, 1983; Primm et al., 2009). These underlying beliefs still contribute to treatment disparities and manifest in a general empathy gap harming Black patients presently (Cleeland et al., 1994; Gatti et al, 2018; Tamayo-Sarver et al., 2003; Trawalter et al, 2012). Even still, working with Richard Allen, the founder of the African Methodist Episcopal church, Rush was able to extend his efforts within the Black communities. Often portrayed as a well-meaning moderate in literature, Rush stood for controversial beliefs of the time such as prison and education reform, women's rights, and the abolition of slavery (Fraser, 2019; Herschthal, 2017; King, 2017). Additional accounts reflect on his relationship with slavery at the time.

Rush believed that medicine should be practiced differently in America than in Europe due to its "upset of Nature" (North, 2000) and was particularly interested in the mental health of enslaved Africans as he sought to prove the necessity of abolitionism in his altruistic efforts. He believed that it was the Blackness of the Africans that caused them grief and contributed to their

ill state of mental health during slavery coining this mild form of leprosy as Negritude (Plummer, 1970). He believed that removing the Blackness would uncover their humanity and unify them with the Whites (Plummer, 1970). More specifically, becoming White physically (such as skin color) and adopting White ideologies (such as Christian and Republican views) was thought to be the cure (Herschthal, 2017). He also believed labor was good for the enslaved Africans helping them to develop White morality (Willoughby, 2018).

It appears Rush was able to stay congruent in his overall morals and beliefs about slavery and its negative effects to the mental health of Africans while still holding true to core values and beliefs in the society of the time. In this way, the type of altruism practiced is steeped in the values and beliefs in a social context (Kraut, 2020). Rush was informed by his surrounding society about who to help (enslaved Africans) and why (because they were different than the norm due to their Blackness and therefore deemed unwell). However, his "how" was influenced by his own principles dictated by his moral authority, ego. He felt a call toward moral authority and combined his understanding and his moral beliefs with those of people in power in science and politics to make treatment decisions. Here, it was profitable for slaves to be used for economic success and therefore it was greatly protected by those in power. Scientists were then used to justify their acts (Driggers, 2019). As scientists were often politicians, it was of direct interest. As such, Rush both embodied beliefs of his time and perpetuated them increasing his power and authority within his helping context.

Additionally, with scientists' involvement as theologians, prophets, and other religious leaders, these became platforms used extending their power and influence whether intentional or not. Rush, working within this system, wanted to treat the Africans in a way that was congruent with his values. As he was part of the society, while some may view his efforts as altruistic at the time, they were still drenched in implicit and explicit societal beliefs of the era. It is the nature of

the system, that counselors as professionals and individuals embody and enforce the overt and covert rules of the given society. Moreover, Benjamin Rush's example of the common othering of mental health pathology that occurs specifically with African Americans, outlines the role of both explicit and implicit bias within the culture of what is now the mental health counseling field.

Samuel Cartwright

Exploration of Samuel Cartwright offers further exploration of the social, cultural, and political views governing the mental health of Black people rooted in early American helper culture. Samuel Cartwright could be considered the opposite of Benjamin Rush in terms of his stance on slavery (Willoughby, 2018). Cartwright was a widely respected psychologist and surgeon, and his views of Black mental illness were indicative of the culture beyond Southern American ideology (Willoughby, 2018). These views can be explored through his notable diagnoses of Drapetomania and Dysaethesia Aethiopica.

Rules governing rightness and wrongness tied to the dichotomy of those who were deemed well and unwell in early American context regarding Black mental health can be seen in Samuel Cartwright's diagnoses of Drapetomania. Drapetomania is described as a constellation of symptoms that ultimately makes [enslaved Africans] predisposed to runaway (Cartwright, 1851). In essence, enslaved Africans who were cooperative and compliant with the demands and treatment of chattel slavery were viewed as mentally well and sane. On the other hand, enslaved Africans who were resistant to the systems, uncooperative and ran away as a result of their attitude towards the surrounding culture of abuse were considered unwell or "insane" (Cartwright, 1851).

Cartwright's arguments were grounded in science and religion noting that Black [people] were psychologically inferior due to their smaller brains. Combined with sensitive skin and

overdeveloped nervous systems, slavery was needed to keep them at peace. Therefore, Black [people] who rebelled against this truth must be clinically unwell. Samuel Cartwright's beliefs were monumental in justification for the enslavement of Africans paving the way for physicians and other prominent leaders to pathologize beliefs of Black inferiority for the common good (Willoughby, 2018). The mental health diagnosis was published in the Practical Medical Dictionary until 1914. Physical coercion and anatomical correction were common cures to this mental health diagnosis in order to extract as much work as possible from the enslaved African's anatomy (Cartwright, 1851). In the case of Drapetomania, it was prescribed that the right number of lashes would cure the disease among other changes in environment. Another measure of Cartwright's version of morality and helping, he did not believe in over punishment of enslaved Africans (Willoughby, 2018).

Too little or too much abuse was considered ripe environment for the disease to flourish (Cartwright, 1851). In his context, abuse consisted of too much punishment and not taking care of the enslaved African's basic physical needs, for instance. Within the context of slavery being a necessary role for Africans due to the inferiority of their body, Cartwright, and others of the time, believed they were acting out of kindness by being anti-abolitionists. Enslaved Africans would be lost and unable to fend for themselves outside of the context of being owned. Observed here is the prosociality within altruistic helping behavior (Kraut, 2020). Helping behavior must be considered helpful within a social context in order to be considered altruistic, therefore it must reflect the values of the time. Cartwright did not introduce these topics, he simply expanded upon them. The beliefs existed and were promoted in the surrounding sociocultural context prior, contributing to the celebration of Cartwright's efforts. Cartwright's efforts could be considered altruistic as he answered a call to moral authority by leading in helping with society's problems.

His celebrated helping behavior gave him more opportunity as he went on to present at medical conferences and chair initiatives for the research of Black mental health (Guillory, 1968).

Another disease to which Samuel Cartwright is well known is called Dysaethesia Aethiopica categorizing the “rascality” of free Black people during the era. Similar to the physical and mental attributes categorized in the previous diagnosis, Dysaethesia included Black skin, psychological inferiority, distinct “skin lesions” and overall lack of work ethic (such as disobedience and laziness) (Cartwright, 1851). Important to note that current stereotypes of Black Americans are often created and perpetuated by early helpers. Samuel Cartwright wrote that he would not treat the illness due to it mostly occurring among free Black [people]. As Black people not being enslaved was against his religious and scientific beliefs, it was morally and biblically wrong to treat the condition. Again, here explored is Cartwright’s moral authority working with the culture’s values dictating his helping behavior. His repeated helping behaviors qualify him as altruistic in his time, as repeated helping can be a characteristic of altruism (Kraut, 2020). Though many agreed with and praised Cartwrights beliefs, his practices did not become widespread standards as they lacked enough scientific evidence (Willoughby, 2018). Despite such, his views were indicative of his era embedded in the framework of the helping profession’s foundations.

Summary

Other indications of the views of Black mental health in early American context can be found in official government records. For instance, in early American census records in 1840, a category of “insane and idiotic” was added to account for slave status in the three-fifths compromise. A quote after reviewing the census by John Caldwell Calhoun, a political theorist from South Carolina who served as the 7th Vice President of the United States reads “Here is proof of the necessity of slavery. The African is incapable of self-care and sinks into lunacy

under the burden of freedom. It is a mercy to give him guardianship and protection from mental death" (Deutsch, 1944).

Throughout history, beliefs about groups, specifically Black people, were embedded into the practice. Again, counseling was not a separate entity ahead of its time in morals and values, instead a field comprised of the society's beliefs working to integrate those they can and pathologize those too far from the established norm (Whiteness). Bias and discrimination have always been the techniques used to measure success of those deemed unwell within the sociocultural context.

Early helpers had to hold the same beliefs of the time whether implicitly or explicitly to best help their clients. They performed their job correctly when they used the beliefs of the society to operate within a system and find their client treatment based on the context of a prejudiced society. Helpers, from the beginning, were trained to operate according to a prejudiced system and were incentivized to do such by public accolades, high moral perception, and general social desirability through their proximity to altruism. Through altruism, early helpers were granted moral authority to make decisions perpetuating the ideologies of the time and simultaneously tasked with preserving their own ego to sustain their moral power. As such, racism, a key belief that significantly impacted decision making among counselors during the time was incentivized by society and protected by helpers.

Those who may not have held fast to the belief explicitly still had to operate in a system that did (such as Benjamin Rush). Without opposition, this paved the way for the internalization of the beliefs implicitly while infusing them into the very structure of helping in a culture. Established therein is a unique helping mechanism commissioned to perpetuate beliefs sometimes without counselors and clients being aware. As the actual roots of the counseling profession are not taught, unaddressed is the pervasive implicit bias embedded in the counseling

profession. Any attempts to address bias over the years are trivial when compared to this colossal implicit machine driving decisions. The culture surrounding helping in America foundationally is a flawed structure that must be exhumed to reassess failed attempts to mitigate bias. Through this context, the overarching question driving the research for the current study is explored: “What additions to counselor training should be made in order to mitigate implicit bias increasing competent care for Black clients? This and the above concepts are explored throughout discussion of the theoretical underpinnings of the current study below.

Theoretical Framework

Social Cognition Research

Social cognition research formally emerged in the social context of the 1960s around the civil rights era. Research describes the conscious and unconscious thought patterns that facilitate social interactions. In brief discussion of power in social contexts relating to foundations of stereotype threat, stereotypes, and implicit bias (explored in this section), it is important to discuss dominant discourse.

Brief Discussion of Dominant Discourse

A brief discussion of dominant discourse helps lay the foundation of the current study’s focal points regarding social cognition research. Dominant discourse is defined by the social practice of ranking and ascribing value through language of which affect everyone within a social context (Winslade et al., 1997). Individuals in a society judge others and themselves according to these values (Monk et al., 1997). Relevant to the current study are dominant discourses surrounding intersecting identities through the use of stereotypes and bias.

Research indicates that through dominant discourse, intersecting identities are ranked and valued within a social context (Robinson, 1999). Rankings relevant to United States ideology (Robinson, 1999) have been depicted in Figure 2.1. Given at birth, the deemed value grants

power through the privilege that is ascribed to those separate and intersecting identities permeating throughout the social context imbedded in how a society functions. Dominant discourses shape the experiences of everyone within a social system (Monk et al, 1997) making apparent a set of behaviors, rules, privileges, and consequences for intersecting identities (Robinson, 1999).

Figure 2.1

Dominant Discourses in the United States

VISIBLE AND INVISIBLE IDENTITIES

Race | Sex | Sexual Orientation | Physical Ability | Class

DOMINANT U. S. DISCOURSES

Whites | Males | Heterosexuals | Able-bodied | Middle-Class

People of color | Females | Gay Men Lesbians Bisexuals | Persons with Disabilities | Poor People

CONSEQUENCES OF DOMINANT DISCOURSES

Racism ⟷ Sexism ⟷ Homo Prejudice ⟷ Able-Body-Ism ⟷ Class Elitism

Developed by Tracy L. Robinson

Note. The image is from The Intersections of Dominant Discourses Across Race, Gender, and Other Identities, by T.L. Robinson, 1999. Retrieved from *Journal of Counseling and Development, 77*(1), 73-79. https://doi.org/10.1002/j.1556-6676.1999.tb02423.x

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This social system permeates a social context through language. Those who are ascribed higher value are allowed the privilege to ignore the difficulties caused by the socially constructed system effecting those of lower rank. In the context of the United States, dominant discourse surrounding race has allowed White Americans the privilege to ignore the meaning of their race and others' (Robinson- Wood, 2015). As such, consequences of this social system of ranking result in the othering of those further away from the top of the rank (Robinson, 1999). These systems of othering are called racism (systematic prejudice toward those further from socially constructed Whiteness in United States), sexism (systematic prejudice toward those further from socially constructed maleness), and so on as it relates to additional identities related to sexual orientation, ability, class and many more. Stereotypes, explored in social cognition research, are driven through dominant discourse helping to perpetuate this ranked system.

Stereotypes

Research on stereotypes predate the labeling of social cognition but can be placed under the umbrella for its role in mediating social interactions. Research on stereotypes is extensive and broad, cited as early as the 1920s and 30s (Katz & Braly, 1933; Lippmann, 1922). However, literature increased heavily in the late 80s and into the early 90s (Bar-Tal, 1989; Bodenhausen et al., 1994; Smith 1993; Snyder & Miene 1994; Macrae et al., 1994). Stereotypes are defined as a fixed set of characteristics attributed to a social group of people (Hinton, 2019). Stereotypes are known to be harmful despite their anecdotal use (Allen, 2020) and are generally inaccurate and discriminatory (Hinton, 2019). For example, stereotypes regarding double minority Black women continue to negatively impact them physically, psychologically, and emotionally (Ashley, 2014; Harris- Perry, 2011; Jerald et al., 2017; West et al., 2016) despite their overwhelming use in media and entertainment.

Discussed in stereotype literature is the presence of overt and unconscious stereotypic thinking and its formation (Hilton & von Hippel, 1996). The purpose of stereotypes is explored as researchers analyzed the formation of stereotyping noting a variety of motivational factors are involved in the formation, maintenance, and alteration of stereotypes (Hilton & von Hippel, 1996). Identified also is the extensive role of emotion in the formation, maintenance, and usage of stereotypes both consciously and unconsciously (Dovidio & Gaertner, 1993). For example, strong negative emotions can make it easier to form a stereotype and make decisions using it. This can be seen with historical interactions between police officers predisposing Black men to criminality, for instance. Simply put, in a sociocultural context where bias and violence have fueled the policing of Blackness historically, the strong negative emotions gathered from the experiences are now engrained in our collective psyche, making it easier to activate and reinforce biased views regarding Black men and their potential criminal backgrounds. Found in stereotype literature also, the need for social identity could be what drives people toward embodying stereotypes (Hogg & Abrams, 1988). Notable research regarding stereotypes also involved analyzing how stereotypes are used in differing roles between people in an interaction (Eagly, 1995; Jost & Banaji, 1994; Sidanius, 1993), group conflict (Robinson et al., 1995) and power (Fiske, 1993). The latter, power, is the most relevant to the current study.

The focus in American stereotype research has been largely pertaining to minority and underserved groups with a concentrated emphasis on race and gender. Initial research focused on overt mechanisms of stereotyping referring to biased cognition where those occupying privileged identities (intersections of being White and male, for instance) simply did not have to pay attention to differences in order to survive in any capacity (socially or otherwise) (Fiske, 1993). In general, stereotypes are thought to make processing information faster and easier in social interactions serving as a shortcut for daily functioning. Stereotypes are mutually reinforcing (Lu

et al., 2020) meaning they are formed and enforced by preexisting social reality while also shaping reality simultaneously. As such, it is unclear how they emerge and travel through the collective social consciousness. Considering that they are widely used liberally in social interactions consciously and unconsciously, the impacts are pervasive. However, as only 10% of the population engages in overt stereotyping (Fiske & Taylor, 2013), key to the current research is the shift of stereotype research to unconscious mechanisms of thought (Hinton, 2017).

In continuing to research its characteristic shortcut nature, stereotype research extends to the inclusion of schema. Schema is the brain's automatic process of storing information about one's environment into schemes (Fiske, 1993). We engage with thoughts from this process regularly. Schema is created to give us a sense of ease and control over our daily lives. How to use utensils such as a knife, what to do during a birthday party or how to answer when someone asks 'How are you' are all controlled by schemes. Even in entertainment, the reason why we can watch movies seamlessly with very little information about the backstories of characters is because of the schemes that exist around specific triggers pulled from our collective social psyche. The transferal of this automatic process to our conceptualization of people becomes problematic for a variety of reasons.

Most relevant for the current research is the analysis of the role of power and control in stereotyping (Dovidio, 2011; Fiske, 1993; Hilton & von Hippel, 1996) particularly with schema. In a social interaction, the stereotyper (or perceiver) holds control over the person being stereotyped (or perceived). In social interactions where a stereotype is being used, the abstract presence of the stereotype can cause frustration to the perceived. In this way the perceived would respond internally. The stereotype implied by the perceiver then influences the thoughts and beliefs of the perceived ultimately influencing their actions in the present interaction and

extending to future interactions, either with the original person and/or others (Fiske, 1993). Implicit bias, described below, is one main facilitator of stereotypes.

Implicit Bias

Implicit bias is defined as unconscious held prejudiced beliefs that result in behaviors (Greenwald & Banaji, 1995; Greenwald et al., 1998) and is believed to be morally wrong (Holroyd et al., 2017). The term was first coined in 1995 involving a study where participants were to match dark faces (representing Black Americans) and light faces (representing White Americans) with positive and negative words (Greenwald & Banaji, 1995). The speed of which combination was easier to correlate helped determine the bias of the correspondent. For instance, quickly being able to match negative words to dark faces over repetitions indicated a bias against dark faces. This study (Greenwald & Banaji, 1995) was pivotal in implicit bias research leading the Harvard Implicit Association Test (IAT) used in the current study.

A key characteristic of implicit bias research is its use of mechanisms to measure thought process outside of self-report. Using self-report to measure implicit bias has been found to be ineffective as it only reflects attitudes respondents are willing to admit and therefore are subject to conscious manipulation (Dunton & Fazio, 1997; Plant & Devine,1998). As implicit bias occurs outside of the person's awareness, individuals may report thoughts that do not fully explain their behavior. As such, implicit bias evades self-report (McConnell & Leibold, 2001). Therefore, measures must be covert. The matching utilized in the initial study (Greenwald & Banaji, 1995) can be seen throughout implicit bias research. Project Implicit was founded as a result by three researchers, Tony Greenwald (University of Washington), Mahzarin Banaji (Harvard University), and Brian Nosek (University of Virginia) and incorporated in 2001 (Xu et al., 2022). Currently the IAT has 15 tests measuring bias against age, race, ethnicity, skin tone, disability,

religion, sexuality, presidents, weight, and weapons under Project Implicit. Many opt to use the Project Implicit website for its matching technology.

A significant study exploring clinician implicit bias below however, created their own implicit bias instrument from researched frameworks (Liu, Coifman et al., 2022). Other implicit bias measures make use of semantic priming (Banaji & Hardin 1996), for instance, where the target measure (gender in the case of the study for example) is matched to an unrelated and related prime noting the time difference between the two. Affect Misattribution Procedure (Payne et al., 2005) and a newer categorization style Go/No-go Association Task (Nosek & Banaji, 2001) have also been used to measure implicit bias in respondents.

The term implicit is broad throughout research (Brannon & Gawronski, 2017) referring to one of the following four explanations: a) a distinctive psychological construct or prejudice belief system, b) implicit measures referring to instruments used to measure unconscious thought without self-report, c) implicit processes referring to the variety of thought mechanisms responsible for affecting behavior, and d) thought process resulting from a categorization judgement resulting from the brain's natural assumptive decision making processes (Browstein, 2019). In general, implicit bias research analyzes attitudes, implicit thought processes, beliefs, traits, and situations involving unconscious processes influencing social interactions (Browstein, 2019).

Research regarding attitudes in implicit bias note the presence of dual attitudes. A person can hold attitudes that they are willing to admit and those that they are unwilling to or unable to admit simultaneously (Banaji & Greenwald, 2013; Greenwald & Banaji 1995; Krickel 2018; Wilson et al. 2000). In either case, they can be explicit (known) or implicit (unknown) to the individual. Both have been found to influence attitudes (defined as liking or disliking someone).

However, this study focuses on the impact of implicit bias on a person's attitudes and decision making.

Implicit bias research typically centers around exploring effects regarding historically stigmatized and minority groups. Negative attitudes regarding racial Black Americans are well noted in implicit bias research in schools (Chin et al., 2020) and effecting employment (Dovidio & Gaertner, 2000; Ziegert & Hanges, 2005), for instance. Another study on employment implicit bias explored its effect on gender outcomes (Steinpreis et al., 1999) finding that women were discriminated against despite being given the same resumé. Implicit bias is pervasive and most damaging when about stigmatized social groups, paving the way for patterns of prejudiced behavior through stereotyping (Holroyd et al., 2017). Implicit association tests have revealed that most participants identifying as racially White have an unfavorable bias against those who are racially Black, while about 50% of those who are racially Black have this bias (Nosek et al., 2002). Posited in the current study is that counselor's altruism may help explain this predominance of bias despite attempts for intervention.

Altruism

Altruism, referenced in the current study, speaks of the concept rather than a theoretical framework, as an established framework does not yet exist. While efforts are still being made to create an integrative model of altruism (Krebs & Hesteren, 1994), none are established enough for the foundations of the current study especially as it relates to counselor behavior. As such, the current study focuses on simply taking a stance between the two main schools of thought describing altruistic behavior in humans. One explanation of altruism describes behavior that is purely selfless and sacrificial (Batson, 2011). Another view of altruism describes it as a prosocial behavior that, while it may have components of selflessness, is ultimately practiced with an awareness of its positive perception from others and is therefore ego driven (Andreoni, 1990;

Kant, 1785; Kraut, 2020; Robinson & Curry, 2007). From this awareness then, the person engaging in altruism understands what they can gain from the behavior prior to engaging in the act. Where the two schools divide, is whether or not this awareness of the rewards of engaging in the behavior prior makes the act less selfless, and therefore not purely altruistic. The current study agrees with the latter definition of ego driven prosociality as it applies to the counseling profession. Throughout this discussion of altruism, foundation of the development of the concept of altruism in humans is explored between both stances on altruistic behavior. The purely self-sacrificial view is explored initially before detailing the second stance more comprehensively, laying the groundwork for the current study.

Altruism Definitions

Many definitions exist for describing altruism and altruistic behavior among humans. Altruism philosophically is wrapped in opinions of morality and judgement of which develops over time depending on societal norms and context. For example, a culture that values collectivism would define altruism differently than a culture that is individualistic. Early definitions of altruism described it broadly as engaging in an act that benefits others (Rushton, 1981). This definition does not account for cultural context, social norms, and the complications of intrinsic/extrinsic motivations for behaviors especially in varied environments. Questions such as the following are not accounted for through this lens:

1. If a person outside of a given culture engages in an act to help someone in a culture where people do not typically engage in such acts, is this still altruism?
2. Additionally, in this context, is this person more altruistic than the people of the culture who are already considered altruistic?

As such, the definition prompted many questions about how to define the concept.

Altruistic behavior in humans defined as truly selfless acts that are committed outside of the awareness of gains and rewards for engaging in the act is seen as idealistic (Krebs & Hesteren, 1994). Researchers have resolved that it is difficult to argue the semantics regarding altruism's definition (Krebs & Wispé, 1974). Therefore, what exists are idealistic arguments of aspirational morality in altruism often outlining our collective failure to meet the bar, and what is arguably a more realistic version given the history and social nature of the human experience. The many definitions throughout the development of conceptualizing altruism can be categorized under the two ideologies. That is, to what degree are the supposed altruistic behaviors engaged in for the sacrificial purpose of helping another and what are the rewards involved (considering the specific social/cultural context of the environment in which the act was engaged in). In such a case, a continuum of ego to altruistic behavior is introduced.

Efforts to define altruism also include understanding the individual's intention through purely analyzing motives separate from any costs or rewards of the behavior (Batson & Shaw, 1991; Reykowski, 1982; Rushton, 1982). For instance, some theorists argue Mother Theresa would be an example of an altruistic person because she engaged in consistent selfless acts in order to help others. Global perceptions of her goodwill, awards, favor, and any other rewards for her service would be considered irrelevant under this definition. Only her intention to help others is considered. Additionally, risking your life for the betterment of others is considered one of the most altruistic things you can do under this definition. Religious martyrs, evangelists, heroes, volunteers, and philanthropists for example, are all included under this classic definition. Models that propose altruistic behavior is developed similarly to morality in humans from early childhood (Dahl & Paulus, 2019) utilize this definition as well. However, as these arguments do not fully consider social norms or cultural context but only intention, those who believe that they

are doing right and behaving morally despite prevailing disagreement could be considered altruistic as well.

Other definitions proport that acts committed as a result of perceiving yourself in others are still considered altruistic because of empathetic intention (Hoffman, 1981). However, some researchers argue that this is still egoistic in nature (Hornstein, 1991) and is therefore not altruistic. For example, if one adopts another's distress as their own and behaves from the discomfort, it then becomes difficult to separate altruistic intention from an egoic drive to resolve one's own uncomfortability. Small examples of such could be the act of going to get a tissue for a person crying, for instance. While some may argue this is a small example of empathy and kindness (a person crying would, of course, want a tissue to wipe their face so getting one for them is putting yourself in their shoes), if the deeper intention was to relieve discomfort because people crying make you uncomfortable instead, this is not altruistic despite your level of awareness of your true intention. Unconscious motivations for behavior, in part, are what lead to definitions of altruism as a prosocial behavior.

Prosocial behavior in altruistic literature has varying semantic definitions between the fields of psychology, biology, and sociology (Simpson & Willer, 2015). The fields of biology and psychology for instance, typically define prosociality as being mediated by intrinsic mechanisms of motivation internal to the individual engaging in the altruistic act. Psychological egoism, from psychology for instance, argues that altruism may not exist. Since there are always rewards for the behavior whether socially (people perceive you as good, for example) or more tangibly (salary, for example) all behaviors therefore can be traced back to self interest in some capacity (Kraut, 2020).

Sociological perspectives, however, explore altruistic behavior in context with external factors. This study aligns with the sociological perspective analyzing counselor behavior in

American social context with its norms. The sociological approach considers the difficulty of separating altruism from the system of rewards it results in due to its prosocial nature. The approach incorporates how the system of rewards (accolades, perceptions, reputation regulation, etc.) can consciously or unconsciously drive decision making in future altruistic behavior. The stance regarding counselors involving the current study simply accepts that there is ambiguity in the mechanisms driving decision making effecting client outcomes by following the sociological approach. As such, when altruism is described moving forward, it refers to altruistic prosocial behavior being mediated by external sociological factors such as social norms, reputation systems, social networks, and various other contributing external factors (Simpson & Willer, 2015).

For example, social dilemmas wherein conflict is presented between differences in self-interests and the greater good occur frequently within the various ecological systems. Individuals, families, workplaces, and governments all engage in weighing the pros and cons of their behaviors which is essential to the overall wellbeing. At any level, cooperative relationships between people and groups are needed in order for systems to run smoothly and is at the center of prosocial behavior (Simpson & Willer, 2015). In an environment where relationships are not valued, necessary, or centered, as in a social vacuum, altruistic behavior decreases over time (Ostrom 2000; Sell & Wilson, 1991). As such, it can be argued that fundamentally, humans engage in altruistic acts because of their rewards in a social context, or relationship (Maner & Gailliot, 2007). If the behavior is not rewarded, it is practiced less.

These and the above theoretical underpinnings are explored regarding their influence in healthcare and Black mental healthcare in the review of literature. Significant to understanding the importance of the approach of the current study is exploration of the history of implicit bias, altruism, and multicultural competence in the counseling field. As such, to comprehensively

discuss areas relevant to the current study, a brief exploration of each and its critiques is necessary.

Review of Literature

Influences of Social Cognition in Counseling

Stereotypes in Black Mental Healthcare

Stereotypes in various ways can be described as a collection of stories moved throughout a society through collective discourse. The storyline encompassed in stereotypes works to anticipate behavior based off of widely held assumptions. Though stereotypes are used to project often inaccurate yet simplified meaning onto aspects of another, these stereotypes can accumulate into archetypes eventually becoming a larger projected story about the whole of a person. These are called archetypes. Both stereotypes and archetypes work to reduce the identities of the cultural group they are about, simplifying and nullifying their experiences (Lewis et al., 2016). As such, this is fundamentally a type of control through taking agency of the power to identify one's self and their cultural group.

The use of this type of narrative to control Black people, in particular, resulting in aspects of post-traumatic slave disorder, is rooted in the systemic structural oppression beginning in slavery (Burrowes, 2019). Post traumatic slave disorder refers to the multigenerational trauma characterized by a constellation of mental health concerns entrapping current generations of Black Americans as a result of the psychological abuse (psychological control) incurred during slavery (Burrowes, 2019; DeGruy, 2018). The established hierarchy of power rooted in stereotyping can be traced back to this system of control and abuse (Moore, 2022). As the person who holds the stereotype can influence the thoughts and behaviors of the person being stereotyped well after the interaction, stereotyping can be described as a form of personal

narrative hijacking for the stereotyped. Stereotypes, a form of narrative shaping, were one of the main tools used to control the actions of enslaved Africans (Moore, 2022).

General stereotypes attributed to Black Americans including laziness, violence, lack of intelligence, criminalization and many more contribute to disparities regarding socioeconomic status, education, employment, and familial outcomes (Taylor et al., 2019). In mental healthcare, stereotypes are extended to assumptions about the ability to be introspective, self-aware, insightful, and to exhibit self-control (Nayman, 1983; Primm et al., 2009). Early diagnosis of the mental health of enslaved Africans reveals that general psychological inferiority was assumed under the diagnosis of Negritude (Plummer, 1970). John M. Galt, the superintendent of the first mental health hospital in British North America, pioneering humane treatment for the mentally ill, believed that enslaved Africans were immune to mental illness (Davis, 2018). It was even thought that enslaved Africans did not perceive pain in the way humans do contributing to decisions about their overall treatment.

Stereotypes about Black women in particular are evidence of this historical viewpoint, for instance. The Strong Black Woman stereotype in particular, influences Black woman to resist care and is used to justify lack of treatment by healthcare professionals negatively effecting treatment outcomes (Adebayo et al., 2022; Kemet et al., 2022). Black women are thought to be physically, emotionally, and psychologically strong with higher physical and emotional pain tolerances effecting healthcare professionals' decision making.

Additional behavior resulting from prejudiced beliefs is known as a microaggression. Microaggressions are defined as verbal, behavioral, or environmental communication that suggests hostility, or generally derogatory negative attitudes. They also contribute to the efficacy of care intersecting with stereotype usage. A study found that there are stereotypes that solicit certain microaggressions simply based on an individual's race, gender, or class (Morales, 2014).

For example, in the study, the aggressiveness of Black men and women were perceived differently, with the Black individual's gender being the dictating factor (Morales, 2014). The study also notes unique intersections of multiple identities of the person being aggressed gives way to the use of a layering of multiple aggressions, or the creation of new microaggressions based on those intersecting identities (Morales, 2014). For example, a microaggression used on a Black woman can be layered and evolved when it becomes known that she is also a member of the LGBTQIA+ community. Counselor racial and ethnic bias is still noted serving as a barrier to effective and competent mental healthcare for minority groups (Liu, McRee et. al., 2022). Though overt stereotypes have not been recently noted in research for use against Black clients, there is evidence that unconscious stereotyping exists simply due to the presence of stereotype threat and its effect on Black client decision making.

Microaggressions and micro behaviors, can also result from implicitly held attitudes. Microaggressions impact Black American students and faculty effecting overall mental health (Davis, 1989; Kohli & Solórzano, 2012; Nadal et al., 2014; Solórzano et al., 2002; Sue et. al, 2007). On the other hand, micro behaviors are defined as small involuntary and unintentional non- verbal behaviors. Micro behaviors exhibited by White respondents, such as fidgeting, changed eye-blink rate, body positioning, and many others, have been revealed to negatively impact interracial interactions with Black people (Dovidio, Gaertner et al., 2002; Dovidio, Kawakami et al., 2002).

Critiques of the research. Critiques regarding stereotype literature have helped to evolve the concept. Initially critique regarding early definitions sought to account for what a stereotype could include noting that stereotypes can be positive or negative, and grounded in fact or unjustified (Mambrol, 2017). Research tends to concentrate on the unjustified (Schneider, 1996) rather than its other facets. Critiques also lead to the exploration of stereotypes held in a

collective society rather than on an individual level, among separate genders, racial/ethnic groups, etc. Few refute the historical role of stereotypes and their implications. Critiques, rather, lead to continued exploration in various fields continuing to analyze its effects.

Stereotype Threat

Stereotype threat is an extension of stereotypes describing the interaction between the stereotyper and the person being stereotyped. Stereotype threat is characterized by the drive to act toward or against a known stereotype of which one identifies with (Steele & Aronson, 1995). For example, in an environment where there is a known belief, the person being perceived will respond to the dissonant feelings of who they think they are compared to the belief and decide how to respond. Stereotype threat causes negative psychological effects and has real world consequences effecting intelligence, arousal, memory, emotions, and developmental transitions into adulthood (Aronson et al., 2002; Beilock et al., 2007; Ben-Zeev et al., 2005; Mangels et al., 2012).

Stereotype threat regarding Black Americans. The initial study on stereotype threat was conducted using stereotypes about Black Americans analyzing its effect on test scores (Steele & Aronson, 1995). Students, when confronted with stereotypes about not being intelligent before taking a test, scored lower overall than students who were not reminded of the stereotype. Research notes, the simple presence of a known stereotype is enough to cause negative implications (Aronson et al., 2002). The effect of stereotype threat is so strong, that regardless of agreement with the stereotype, the awareness of it in culture is enough to influence the thoughts, behavior and decision making of the perceived.

The effect on thoughts, behavior and decision making is compounded when considering the intrinsic power dynamic of narrative formation present in the mechanisms of stereotyping for the perceiver (Fiske, 1993; Mangels, 2012). Research notes increasing levels of power and

authority lend itself to more stereotyping and bias (Fiske, 1993). Compounded by the even more increased levels of power a healthcare professional holds, negative implications are concerning for Black clients.

Though research is lacking on stereotype threat's effect on behavior specifically regarding mental health, there are researched trends in general healthcare seeking behaviors. Literature on stereotype threat regarding Black patients in general health care note stereotype threat serves as a barrier to care impacting health related behaviors such as seeking treatment (Abdou & Fingerhut, 2014; Aronson et al., 2013; Burgess et al., 2010; Stangl et al., 2019). Due to stereotype threat, perceived trust is diminished contributing to diminished treatment satisfaction (Abdou & Fingerhut, 2014), increased treatment dropout (Owen et al., 2012) and lower use of services (Abdou et al., 2016; Jones et al., 2013).

Critiques of the research. Research critiquing stereotype threat is generally found in the field of psychology noting that it may be overrepresented and questions its role in real world achievement gaps suggesting publication bias (Flore & Wicherts, 2014; Wax, 2009). Critiques also question the validity of the original findings (Sackett et al., 2004). Generally, critics argue that stereotype threat is a weak interpretation of the larger concern of academic inequality and should not be generalized to other disciplines because of the lack of validity in statistical analysis in the original study (Jussim, 2015).

Implicit Bias and the Current Study

Implicit bias is the concept in social cognition that encompasses the impact of unconscious stereotyping and bias most relevant to the research questions of the current study. Key research on implicit bias relevant to the current study are findings noting implicit bias can influence judgements of hostility against African Americans (Abreu, 1999), the formation of impressions (Gawronski et al., 2003; Hugenberg & Bodenhausen, 2003), and prejudiced

behavior despite self-report (McConnell & Leibold, 2001). In the initially mentioned study (Abreu, 1999), unconscious stereotypes about Black Americans were studied in their impact on therapist decision making. A group of 60 therapists were primed on either stereotype typically concerning Black Americans or neutral language. The group primed using the stereotypes rated the client in the presented case scenario as showing more hostile attributes than the group who received neutral language. Results revealed that stereotypes can influence perceptions impacting therapist decision making ultimately resulting in ineffective care. This study highlights the purpose of the current study, to add to the body of literature regarding counselors and implicit bias in order to mitigate implicit biases' power on decision making regarding Black American clients.

Despite counselor training in multicultural competence and counselor's explicit negative views of prejudiced behavior, their implicit attitudes negatively impact Black American clients (Boysen et al., 2006; Katz & Hoyt, 2014; McConnell & Leibold, 2001). The current study seeks to understand this phenomenon more comprehensively through the second research question "What is the relationship between counselor demographic data and implicit bias scores?" Research regarding counselor implicit bias specifically is scarce, so the current study is designed to explore the concept. The most current research in implicit bias regarding counseling has been exploratory in nature including working to determine relationships between implicit bias and mindfulness (Ivers et al., 2021), as well as counselor in training attitudes regarding those with substance use disorder (Shiffler, 2020).

To date, few studies have examined implicit bias among counselors. However, one recent study conducted on school counselors found that school based mental health professionals show pro-White but anti- Black and anti- Latinx scores on their developed implicit association test (Liu, McRee et al., 2022). In other words, the study found that school counselors were biased

against Black and Latinx youth while being in favor of White youth. The current study seeks to add to this body of knowledge by collecting data on counselors and their implicit bias utilizing Harvard's Implicit Association Test (Xu et al., 2022). Another study found that counselors held significant levels of implicit bias towards African Americans, gay men, and lesbian women despite recorded high levels of multicultural competence (Boysen & Vogel, 2008) with implicit bias being the strongest indicator of racial bias in a similar study (Katz & Hoyt, 2014). Despite awareness that counselor's hold implicit bias that negatively impacts treatment outcomes for clients of historically oppressed identities, education standards do not address this form of bias (Boysen, 2009).

Implicit Bias Interventions

Implicit bias has been made evident across the health professions but has not improved due to inconsistent practices in implementing the topic into curriculum in healthcare professions (Tsai & Michelson, 2020). Currently, implicit bias training is not mandated, and there are barriers in accessing implicit bias training (Crawford, 2020). Those who seek to address bias are faced with little guidance and limited resources facing barriers to implement the interventions (Crawford, 2020). Recent articles provide a step by step guide to implicit bias training (Ogunyemi, 2021) with specific approaches catered to healthcare professions as well (Crawford, 2020). An implicit bias intervention or training speaks of varying tools used to help mitigate unconscious bias. Implicit bias trainings work to bring unknown bias to the forefront (or conscious mind) so that bias can be addressed. Clarifying definitions of implicit bias and the natural process of storing information in the brain are the first steps typically introduced in interventions through psychoeducation. Mindfulness and resilience training, exposure counter to the revealed bias including media and forming genuine relationships, mentorship, and stereotype replacement are all typical tools used for confronting implicit bias (Ogunyemi, 2021).

Increasing mindfulness skills has been proposed as a potential intervention to address implicit bias particularly with healthcare providers (Burgess et al., 2017). Given past research on how increased emotional states can increase implicit bias activation, practiced mindfulness meditation could reduce activation and increase self-awareness and compassion (Burgess et al., 2017). For instance, a study using mindfulness interventions had randomly assigned White students to participate in a lovingkindness mindfulness meditation toward a Black person via a photograph. After 7 minutes of meditation, White students reported lower levels of implicit bias toward the Black person (represented in the photograph) (Stell & Farsides, 2016). Mindfulness meditation is also reported to reduce cognitive load that makes implicit bias activation more likely (Burgess et al., 2017).

An article provided an example of how the tools gained in regular mindfulness meditation could mitigate biased decision making. The article described a busy lobby full of patients (Burgess et al., 2017). A burned-out clinician could stereotype people unknowingly in order to quickly problem solve, whereas a clinician who has practice in mindfulness can notice their feelings and thoughts confronting them before making a decision or avoids being overwhelmed altogether not activating the implicit beliefs. This method, however, does not require the clinician to comprehensively understand the history of biased decision making in healthcare professions. As such, the approach is perceived as nonjudgmental and less likely to prompt resistance (Burgess et al., 2017), especially due to social desirability as noted previously (Constantine & Landany, 2000; Pope-Davis et al., 2001). However, without education on systemic and historical inequities, the approach feels minimizing. Can you really correct hundreds of years of history in oppression resulting in abusive healthcare practices with a few minutes of regular meditation? Research on mindfulness interventions to address implicit bias is

still developing. More research should be done to measure its success more accurately in mitigating implicit bias.

Implicit Bias Interventions in Mental Health

Research on implicit bias specifically in the counseling field is lacking and therefore so is research on implicit bias interventions and counselors (Liu, Coiffman et al., 2022). Calls to action exist in literature outlining the need for research and including its concepts as part of competencies in curriculum (Abreu, 2001; Boysen, 2010). To date, competency standards have not changed explicitly stating its inclusion. As described previously in this chapter, counselors are known to be driven by social desirability when it comes to reporting multicultural competency and bias (Constantine & Landany, 2000; Pope-Davis et al., 2001). It is likely that including implicit bias highlights behavior counselors are unwilling to admit in attempts to preserve ego effecting its presence in research literature. There is some research on counselor implicit bias and mindfulness, a known nonjudgmental approach described above.

One study regarding such examined counselors' self-reported mindfulness practices with implicit racial bias and found that counselors had bias in favor of White people (Ivers et al., 2021) which is consistent throughout literature (Boysen & Vogel, 2008; Maina et al., 2018). Additionally, it was found that counselors who have a tendency towards mindfulness observation (the practice of being present and noticing internal and external sensory experiences) were less likely to have implicit bias in favor of White people (Ivers et al., 2021). Although, it was found that mindfulness was just as important to decrease implicit bias as was multicultural awareness in the study (Ivers et al., 2021). An online implicit bias intervention has been studied for school counselors as well (Liu, Coifman et al., 2022). The study revealed that scalable implicit bias interventions could be helpful in addressing counselor implicit bias.

Implicit Bias Intervention Efficacy

Implicit bias trainings are largely ineffective in the long term as they depend on a variety of factors for long-term success (Brogaard, 2020). Critiques of implicit bias interventions question its use of introspection and mindfulness especially for long-term mitigation (Brogaard, 2020). As stated above, individuals who are faced with results revealing bias on the IAT for instance, may become defensive, take the results personally and dismiss the findings. After initial awareness is facilitated, tools are needed to continue the intervention process (Brogaard, 2020). Acceptance of the information and willingness to continue a long term journey through intervention are necessary for implicit bias training to be effective.

Introspection is one of the main tools used in implicit bias intervention once the person becomes aware of their bias (Burgess et al., 2017; Crawford, 2020; Ogunyemi, 2021). This self-regulated attention to detail may prove challenging after an individual becomes aware that they can hold values unconsciously. Trusting their own abilities may be challenging and additional support through resources is paramount for long-term success. Additionally, it has been proposed that trainings that exclusively focus on implicit bias without addressing the full breadth of prejudice including explicit forms can work to protect biased behavior (Applebaum, 2019). Individuals can lean on the awareness of unconscious bias to evade accountability for their behavior.

Even still, interventions that are most effective over time have been found to have a few things in common (Liu, Coifman, et al., 2022):

1. The interventions are contextualized for a specific audience.
2. They increase the participants' awareness of their own implicit bias.
3. They increase empathy.
4. They provide psychoeducation and teach specific applicable tools that directly address

the cognitive processes of stereotyping.

Despite the exploration of implicit bias, counselors are still ineffective when counseling clients of color, namely Black American clients. Given the implications of implicit bias effecting the supervisor- counselor- client triad negatively impacting Black American clients throughout the counseling field's existence, implicit bias interventions are vital to mitigating negative effects. Proposed in the current study is an adaptation to the National Institutes of Health's (NIH) Implicit Bias Training. While the NIH implicit bias training is good in intention, there are concerns for its efficacy in addressing the implicit bias of counselors. Considering research underscoring the characteristics of interventions that are successful over time, the NIH Implicit Bias Training is missing key components. Additionally in cultivating an intervention specifically for counselors, the intervention must be tailored for the unique characteristics of the counseling profession.

Critiques of the research. Major critiques of implicit bias surround the validity of instruments. For instance, one critique of implicit bias regards the validity of implicit association tests and the images they use. Critics argue a type of circular form of bias can occur making it difficult to measure pure implicit association. In reference to a study (Payne, 2001), for instance, measuring attribution to violence via an object of a gun to racially White or Black faces may be subject to this circular bias. If respondents held a belief that Black people were more violent, critics argued, they may mistake any object for a gun in the study versus another tool being depicted (Siegel, 2012; Siegel & Oxford University Press, 2017).

The Harvard Implicit Association Test (Xu et al., 2022) in particular has received quite a bit of criticism in terms of its validity as researchers make claims regarding the statistical interpretations, the mechanics of the test (Schimmack, 2021) and whether the test is truly a measure of beliefs a person endorses (Karpinski & Hilton, 2001). Many critiques, such as the

latter mentioned, simply misunderstand the definition of implicitly held beliefs. As implicit bias is unconscious, a person may not actively endorse the belief as they do not know they have it. Critique also includes the individualistic approach of implicit bias (Albano, 2021). As research focuses on an individual's personal implicit bias, this may discount systemic pathways of oppression of which implicit bias drives (Payne & Hannay, 2021) analyzed in the context of this study for instance through altruism. In such a case, context may change implicit bias (Payne & Hannay, 2021).

Concerns of implicit bias regarding the current study relate to theory as implicit bias research does not explicitly explore the foundational perspective of power in social cognition literature found by its predecessor in stereotype literature. In the current study, explored are how increased power, through altruism, encourages stereotyping and that those in power (moral power and authority) may be more at risk to developing and maintaining unconscious bias (Fiske, 1993) by way of exploring counselors and intersectional identities of power (White male counselor vs. Black female counselor for instance) and their implicit bias. To address implicit bias more comprehensively in counselors, however, a few insights were considered.

For instance, counselors overestimate cultural competence and underreport bias due to social desirability (Boysen & Vogel, 2008; Constantine & Landany, 2000; Pope-Davis et al., 2001), contributing to counselor behavior. The counseling profession has been found to be chosen by counselors out of altruism (Byrne, 2008; Schmuldt, 2006). Given altruism's ties to social desirability (Bentham, 1789; Cialdini, 1991; Skinner, 1978), social desirability's influence on counselor decision making (Constantine & Landany, 2000), implications of the tendency to hold bias for those in authority (Fiske, 1993) and the recognized imbalanced power dynamic of the therapeutic relationship (Palmer, 2018), altruism is explored in the current study. Grouping implicit bias and altruism together for counselors may more comprehensively explain

deficiencies in counseling Black American clients despite training. The second research question for the current study "What is the relationship between counselor demographic data and implicit bias scores?" helps explore this dynamic. In further exploring counselor implicit bias, altruism and its characteristics related to power may clarify explanations for persistent counselor bias. The current study hopes to provide compelling evidence as to why education standards should be updated to include implicit forms of bias as current tools, such as introspection, are ineffective.

Introspection as a Tool to Mitigate Bias

Introspection is a common tool utilized in multicultural competency and supervision to help mitigate bias. Awareness through introspection is taught as a skill to guard against counselor bias (Ratts et al., 2015). This approach can be logically drawn from the connections in previous stereotype research where it was found that those in power make more biased decisions because they do not have to pay attention (Fiske, 1993). Mindfulness, defined as being fully present and aware, is often taught as a tool to combat this. In counseling research, mindfulness has been found to be correlated with high levels of multicultural competence (Campbell et al., 2018). That is, counselors who think of themselves as being more mindful, also think of themselves as being more culturally competent. Unfortunately, known is a type of bias, implicit bias, that escapes self-report (McConnell & Leibold, 2001). A counselor's perceptions of themselves and their own competence is not a reliable source of measurement.

Some counselors are deluded in their self-reports of competence and therefore continue to cause harm while thinking they are not. Many multicultural competency questionnaires (including the ones utilized in the previously mentioned mindfulness study) utilize counselor self-report to measure competency (Singh, Nassar, et al., 2020). Counselor self-report is not an effective measure as counselors shift their responses based on what they perceive to be socially acceptable (Boysen & Vogel, 2008; Constantine & Landany, 2000; Pope-Davis et al., 2001).

Exploration of counselor implicit bias and therefore the use of implicit bias training is utilized to address inaccurate self-report measures of counselor bias negatively impacting care of diverse clients. The role of unconscious bias effecting counselor decision making has been explored at the onset of the field's cultural awakening (Arredondo et al., 1996) in order to more comprehensively explain counselor's failure to help clients of diverse cultures. Despite the long history of research, counselor bias persists. Altruism's intersections with biased decision making may better explain the phenomenon.

Altruism and Intersections of Social Cognition

Characteristics of altruism relevant to the study are its intersections with power and authority found in social cognition research (namely stereotype literature). Altruistic behavior requires a system of assumptions. That is, in order to behave in a way that is consistent with prosocial helping tendencies, one must make assumptions about who needs help, why they need it and how to help that will be accepted in a particular sociocultural context (Kraut, 2020). In definitions that include this aspect of altruism, noted is how altruists in this domain have to engage in helping behavior that is intended to promote another's wellbeing. What counts as promoting depends on the definitions of who needs help and why within a sociocultural context (Robinson & Curry, 2007). How to give help is defined by the individual reckoning within this system and therefore promotes ambiguity regarding pure altruistic intentions.

It is this principle that is the driving factor for the current study. Those who hold power in a social context set the definitions and standards for helping behavior. As such, helping professionals are informed by those in power, and tasked with perpetuating societal norms imprisoned by their internal call to moral superiority. While they intend to do good, in a social context that thrives in prejudice, they must base their decisions within the context. In this case they do so implicitly. Being congratulated for their damaging behaviors, counselors therefore

extend harm throughout a society negatively affecting those deemed unwell (i.e., any identity not in the majority). What happens when the definitions you are handed are flawed? How do you know whether the definitions given are flawed or not? Since a subjective altruism exists, how do we practice an objective one? The ambiguity helps reveal the inherent power structure involved in altruism between who sets the societal standards, the altruist and the person/ people being helped. As a person's level of authority is also known to shape their behavior (Korstanje, 2013) including regarding biased interactions (Fiske, 1993), the presence of altruism may clarify shortcomings regarding efficacy in the counseling profession. In order to determine such, first explored is altruism in the American healthcare system.

Altruism in Healthcare

Altruism within healthcare has not been well studied over the years (Jones, 2002). However, some notable findings are relevant to the current study in exploring its development in American healthcare systems. Altruism has historical roots in Western healthcare practices (Burks & Kobus, 2012) as altruistic, empathic, and compassionate helping behaviors are foundational to many healthcare careers (Coulter et al., 2007) recorded in ethical mandates and educational standards. Some research, however, argues that despite other oriented tendencies in practice, in context the behaviors may not be altruistic at all. For instance, one argument is that engaging in altruism within a career that offers income is inherently egoic (Burks & Kobus, 2012). This ties into previous arguments regarding altruism and the difficulty between separating known rewards and altruistic behaviors. Does behavior count as self-sacrificial if you engage in it for your livelihood (i.e., salary and income)?

Arguments outlined above regarding the social relationships necessary for altruism are also researched in a healthcare setting. A study sought to analyze environments that promote or inhibit altruism in healthcare organizations (Peters, 2021). The study's findings reiterated that

altruism can be shaped based on the social context. The researcher performed an in depth case study analysis on a hospital that received unsavory feedback regarding its patient care. Revealed were several factors that can discourage altruistic practices: “emotional noise”, a threatening workplace culture, dissonant relationships, and a mismatch between the helper’s needs and their resources (Peters, 2021). Therefore, it can be argued that among many reasons, part of why altruism is lacking in this environment is due to interruptions in social rewards necessary (Maner & Gailliot, 2007). Humans benefit from a social structure where their behaviors are reinforced (Bhanji & Delgado, 2014). Accolades, praises, and positive reception aid in facilitating behaviors necessary for a cooperative society. These systems are biologically, psychologically, and sociologically driven based off of previous discussion on altruism. Healthcare workers, as people, are not immune to these intrinsic and extrinsic systems.

As such, research regarding altruism in healthcare is beginning to question its altruistic nature in the medical profession becoming skeptical of its moral superiority (Feldman, 2017). Some researchers posit a reevaluation of altruism in medical professions is necessary (Vearrier, 2020). The Lucifer Effect, coined by Philippe Zimbardo in his prison experiments is noted as having implications in the medical field (Hall, 2010). Researchers warn that authority in altruistic professions does not suggest morality (Hall, 2010). Reports also point to gender differences in altruism effecting ethical decision making in healthcare. A study found that women tend to engage in altruism and ethical decision making more often than men (Valentine et al., 2009). Research also indicates a decline in altruism in medical practice altogether (Jones, 2002). Decreased empathy due to increased workloads and burnout seem to be contributors (Burks & Kobus, 2012). Even still, as altruism is beginning to be questioned in other disciplines, the counseling profession should follow suit.

Altruism in early helper culture, described in this chapter's background introduction, helps outline why further questioning is imperative to the continuation of the healthcare fields. Benjamin Rush, for example mentioned in the introduction of this chapter, was arguably considered altruistic in his time. Benjamin Rush gave of himself in various helper related fields as a politician, physician, early mental health worker, humanitarian, and educator. His altruism was shaped by his social context. While he was pro abolition of slavery, which could be considered an altruistic intention of the time, the type of help he gave (his "how") was influenced by sociocultural context. To prove his moral decisiveness for the abolition of slavery he pathologized physical and mental attributes of enslaved Africans. Enslaved Africans' skin color for example, was categorized as an illness, as it was thought to contribute to the decreasing mental health of enslaved Africans during slavery rather than the abusive conditions they were subjected to. He posited that assimilation into Whiteness and removal of Black physical and cultural attributes would be the cure to their mental illness. Rush was respected in his era as many sought his opinions. Within the context, Rush's brand of altruism was suitable. Herein lies the dilemma established regarding definitions of altruism.

Rush's sociocultural context influenced his altruistic intentions and behaviors. In today's context, darker skin color is not overtly seen as a physical illness, but in Rush's era it was. The power structure of the time placed Whiteness as the standard and therefore those who needed to be helped were defined as those who were further away from Whiteness. Further established was the hierarchy needed for the assumptive nature of which altruism is based. Those in authority were determined based on race, gender, and socioeconomic status (affluent White males) and those who needed to be helped were set based on a continuum of their proximity to this standard. Given Rush's contextual altruistic decision making, the question guiding the review of literature regarding altruism in mental healthcare is "To what extent do these same assumptions

unconsciously guide altruism in counselor practice?" It could be argued that there are implicit rules pathologizing Blackness given the amount of bias present in healthcare. It seems altruism, most relevant here in the context of mental healthcare, facilitates the act.

Altruism in Mental Healthcare

It has been found that altruism plays an integral role in the therapeutic relationship between counselors and their clients (Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982), though to what extent is unclear (Sachse & Elliott, 2002). Research indicates that it may help drive client change (Bohart et al., 2002). Aspects of altruistic development such as empathy and relational depth relate to factors within the therapeutic relationship (Flasch et al., 2019). Some research underscores the tantamount nature of altruism and counseling. For instance, one researcher posited that altruism is simply the intersection of helping behaviors and empathy (Byrne, 2008). A study researched altruistic personality traits among counselors in training but struggled to find significant results (Schmuldt, 2006). Additional research linking altruism and counselors underscores the role burnout plays in altruistic behavior. For instance, a study on school counselors found that high levels of altruism are correlated on average with low levels of burnout (Limberg et al., 2017). In general, research connecting altruism and counselors, despite their relationship in cultural context is still exploratory in nature and evolving.

Altruism in the Current Study Regarding Counselors

Given the above explorations in research, the current study's approach is to gather more about the altruism practiced in the counseling profession, rather than taking a stance on subjective and objective altruism leading to moral and ethical decision making. Instead, the approach to the current study analyzes the unique lens of altruism practiced within the field facilitating increased implicit bias. Traditional arguments of altruism analyze it through a lens of morality, however proposed in the current study is a questioning of the nature of American

altruistic behavior. If bias can happen unconsciously and motivations for altruistic behaviors are ambiguous, how can altruism exist purely within United States counselor culture given America's history of oppression? Further, if power dynamics are known to influence moral decision making, how can counselors with moral power who are driven by prosocial behavior behave in a morally pure manner?

Proposed in the current study is that counselors exist within a sociocultural context that has engrained unconscious biases. As such unconsciously, counselors may use them effecting decision making rippling throughout the supervisor- counselor- client triad. A counselor's proximity to power and privilege through altruism makes them a) more likely to behave in a biased fashion, and b) further blinds them from the self-awareness needed to combat implicitly biased decision making. While altruism is historically a celebrated trait, particularly among counselors, given the historical underpinnings of the profession, altruism's impact should be re-evaluated in the context of providing multiculturally competent care. Altruistic tendencies of counselors may reduce multiculturally competent ethical decision making with clients of color. As research indicates true altruistic behavior often also benefits the person who performs it, some counselors may engage in altruism unknowingly to manage their own egoic priorities.

In summary, altruism works twofold in a society contributing to culturally incompetent care effecting Black clients. First, altruism's favorable reception in a society provides a system of rewards and access to moral authority and protection from awareness of bias given to counselors as the field has become closely associated with the concept. Second, counselors who identify with the altruistic nature, through this association due to the nature of altruism, engage in perpetuating problematic implicit prejudiced views engrained in the fabric of American social context, negatively impacting mental health treatment of Black clients. In this way, the same power dynamic that allows for stereotypes to influence the thoughts, feelings, and behaviors of

stereotyped groups in an interaction, is preserved through the power dynamic implied in altruistic helping behavior. As altruism has not been analyzed in counselor culture, counselors appear good intentioned while playing an integral role in the preservation of bias in American context.

Critiques of the research. Research regarding altruistic behavior in counselors is scarce, despite its acknowledged presence in the field (Elliot et al., 2018). Known in literature is that altruistic behaviors are fundamentally based on assumptions (Kraut, 2020). Who needs help, and what type of help are shaped from surrounding culture (Robinson & Curry, 2007). As counseling is a culturally informed practice (American Counseling Association, 2014), the answers to the above questions would likely influence culturally competent care. As previous research is limited regarding counselor implicit bias and altruism, the current study seeks to explore fundamental relationships between each to help further the field's understanding of counselor behavior effecting clients of color. To explore this more comprehensively, following is a review of literature exploring final concepts related to the current study. Through attempts to mitigate bias with multicultural competencies, social justice counseling and bias training, counselor bias continues to prevail because of counselors' roles in the larger American context.

Multicultural Competence in Counseling

Multicultural competence is the counseling field's response to an emerging cultural awareness of the unique needs of diverse cultures seeking mental health treatment in the counseling profession. Despite early critics of multicultural competence arguing that counseling is a separate entity not impacted by culture (Nassar & Singh, 2020), multicultural competence rose from the calls of social justice advocates to better meet cultural inequalities of diverse groups as early as the 1940s (Singh, Nassar, et al., 2020). Later, fueled by the Civil Rights Movement, research regarding inequalities in mental health care increased across the various

mental health disciplines (Singh, Nassar et al., 2020). Sociocultural context drove shifts in the counseling profession apparent in current practice.

Research analyzed the Eurocentric social, cultural, and political underpinnings of the profession and clinical practices negatively impacting clients of color. A pivotal study highlighted barriers to mental health care focusing on the traditional practices in the United States and how they impact clients from impoverished countries (Sue & Sue, 1977). Also underscored was counselors' use of stereotypes negatively impacting clients of color (Sue & Sue, 1977). Additional research regarding the lack of efficacy when treating clients of color revealed counselors' biased beliefs (Guthrie, 1976; Katz, 1985; Wrenn, 1962), counselor's need for social desirability in decision making when reporting their own multicultural competence (Constantine & Ladany, 2000) and clarified potential multicultural competencies (Arredondo et al., 1996; Holcomb-McCoy, 2000; Ponterotto & Casas, 1987).

By the 70s, it had been decided that in order to practice ethically, counselors must be taught the skills to counsel diverse clientele (Korman, 1974; Sue & Sue, 1977). Through continued advocacy and research, the counseling profession eventually shifted to incorporate multicultural competencies. The revelations from research regarding counselors and their lack of efficacy regarding culturally diverse clientele finally led to a call to include multicultural competencies in counselor preparation (Sue et al., 1992). Ten competencies were named (Sue et al., 1982) leading to 119 specific standards to better implement in training programs (Arredondo et al., 1996). Eventually the competencies were solidified and reflected in aspirations for the American Counseling Association's (ACA) Code of Ethics (American Counseling Association, 1995; 2014) and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) requirements, the national accrediting body for counseling programs (Council of the Accreditation of Counseling and Related Educational Programs, 2016). Currently CACREP

captures multicultural competencies under its standards for curriculum that teaches social and cultural diversity. Those standards include education regarding national and international characteristics of diverse groups, theories, techniques, and general knowledge pertaining to multicultural counseling, mechanisms of self-awareness particularly as it relates to one's own privilege, culture, attitudes and beliefs, social justice and advocacy, and power dynamics within the therapeutic relationship especially regarding intersectional marginalized identities. Of direct interest here is what is incorporated in multicultural competencies, explored below.

Defining Multicultural Competency

Since the initial exploration of multicultural competencies, multiculturalism has been named as the 'fourth force of counseling' (Pedersen, 1999) and is one of the most significant areas researched and discussed throughout health and education professions (Pope-Davis et al., 2003). While initial focus of multiculturalism in the health professions was ethnically focused (Singh et al.,2020; Nassar et al., 2020; Sue et al., 1992), continued research has led to a broader definition incorporating more aspects of identity, called intersectionality, such as disability and socioeconomic status for instance (Arredondo & Glauner, 1992), for a more comprehensive cultural view. Currently, multicultural competency in counseling is defined as the knowledge, skills and personal attributes needed to effectively work with clientele from diverse backgrounds inclusive of identities related to ability, gender, sexual orientation, socioeconomic status, racial/ethnic identity, religion, and any other important aspects of a client's identity. Multicultural competency consists of being able to adopt the client's comprehensive perspective in the helping process. Even still, initial efforts to address inequities in care through multicultural competency were not effective.

Studies in Multicultural Competency

Most studies regarding multicultural competency have historically discussed it conceptually but have not comprehensively explored it and its efficacy, especially for the first few decades of its emergence (Worthington et al., 2007). As such, most research takes on an unchallenging and agreeable approach contributing to a lack of criticism and slow change. A large portion of multicultural research is led by Madonna G. Constantine (Worthington et al., 2007) as she has worked to apply multicultural competencies to real world counseling practices effecting clients of color (Constantine, 1998; 2001a; 2001b; 2002a; 2002b; 2002c; Constantine et al., 2007), specifically for Black American clients (Constantine, 2007) and within counselor education programs (Constantine, Smith et al., 2008; Constantine, Warren et al., 2005). In multicultural competency literature, research seems to be produced by the same handful of researchers having implications for the lack of widespread expertise (Worthington et al., 2007).

A recent longitudinal study examined the development of multicultural competency in counselors in training to address concerns regarding the agreeable approach of multicultural competency research. The study found that multicultural competencies show increased development when students participate in multicultural practicum (Kuo et al., 2020). Meaning, students that are required to utilize their multicultural skills early on through supervised beginning experiences in the field have increased levels of multicultural competence. The research proports that early supervised experiences in multicultural counseling help “bridge the gap” between classroom instruction and real world professional practice (Kuo et al., 2020). The researchers also suggest that programs may be more effective if they tailor their students’ early multicultural practice experiences to the minority and underserved populations within their communities for increased relevance.

Another study with a sample of 40 counselors examined the efficacy of multicultural training by analyzing its relationship with multicultural competence, racial and ethnic identity, and gender role attitudes (Chao, 2012). The study found that multicultural training did not increase multicultural awareness as it relates to racial and ethnic identity but did impact multicultural awareness as it relates to gender but only with more advanced training. As outlined by the previously mentioned study, there seem to be some deficiencies in multicultural curriculum alone.

Another study tracked students' progress over the course of them taking a multicultural course (Zeleke et al., 2018). The study utilized self-regulated strategies where the students engage in a multilayered process of planning, monitoring, and regulating their own learning (Zimmerman, 2008). The study found that after just 12 class sessions with this self-directed approach, counselors in training increased their multicultural awareness, knowledge, and skills. The results of the study revealed that this approach was helpful in increasing the students' self-awareness, cultural sensitivity, motivation, and willingness to engage with social justice, ability to process material and facilitated a growth mindset in accepting themselves and others. Implications for the study helped establish empirical evidence for this pedagogical approach in multicultural competence. More research is needed to develop how multicultural competence is taught in order to promote long term development and increase efficacy. Continued research has led to the development of social justice counseling.

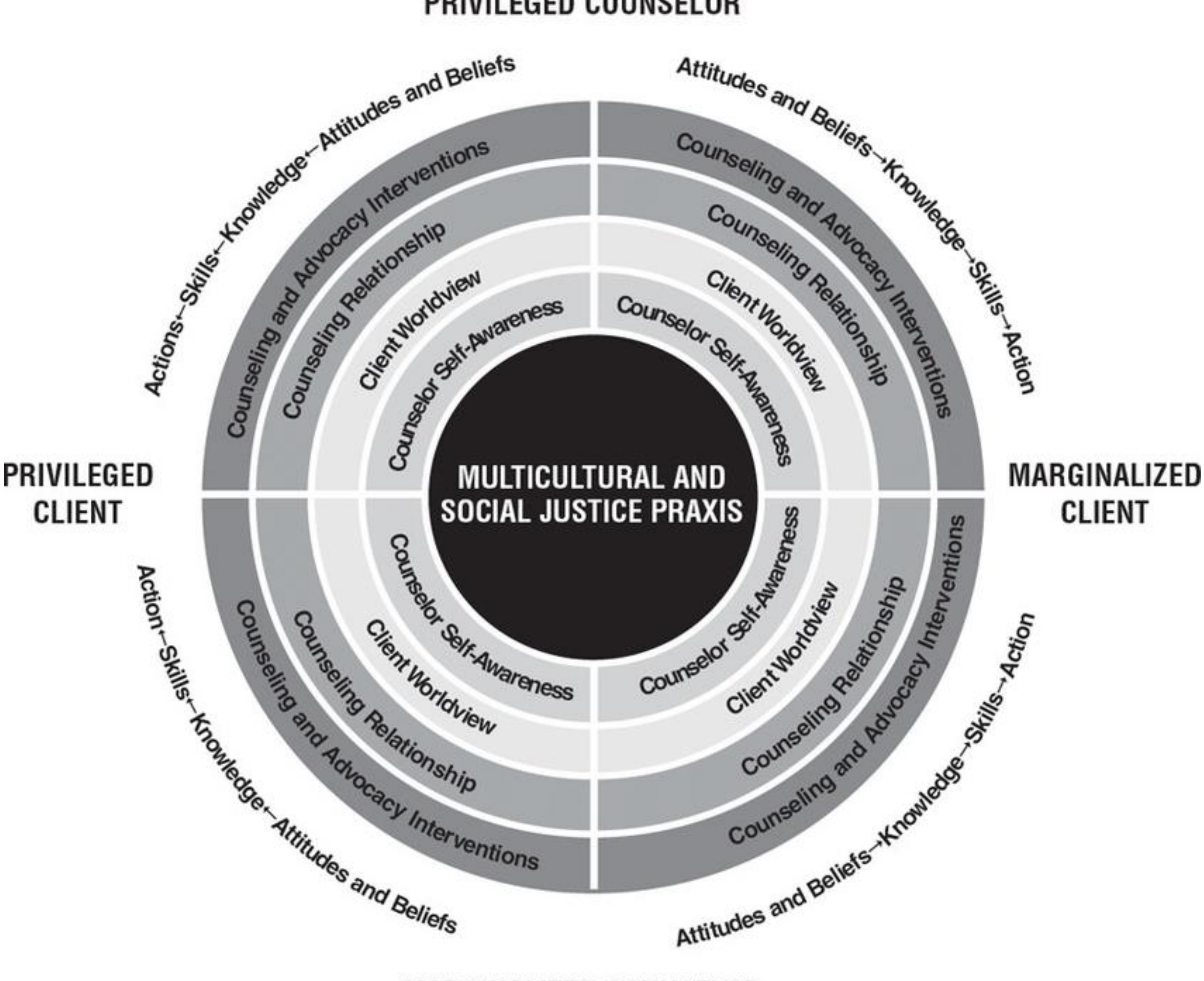
Social Justice Counseling

The inclusion of social justice competencies in multicultural competencies has emerged as the "fifth force" in counseling (Ratts, 2009) as a response to limitations of the first awakening to cultural considerations in multicultural competency. Multicultural and Social Justice Counseling Competencies (MSJCC) have emerged to practically address injustice utilizing

theory to better help counselors working on their cultural competence (Ratts et al., 2015). Figure 2.2 below is a visual map of the conceptual framework of the constructs underlying MSJCC.

Figure 2.2

Multicultural and Social Justice Counseling Competencies (MSJCC)



Note. The image is from Multicultural and Social Justice Counseling Competencies (p. 4), by M. J. Ratts, A. A. Singh, S. Nassar-McMillan, S. K. Butler, and J. R. McCullough, 2016. Retrieved from https://www.multiculturalcounselingdevelopment.org/competencies. Copyright 2015 by M. J. Ratts, A. A. Singh, S. Nassar-McMillan, S. K. Butler, and J. R. McCullough. Reprint for educational purposes only.

The MSJCC is a revised set of concepts and competencies derived from the original 10 noted in Sue, Arredondo, and McDavis (1992). The map, Figure 2.2, displays visual relationships between aspects of power and privilege between a counselor and their client with competencies in four quadrants. The map outlines the four sets of competencies with tiers of related skillsets. For instance, “actions, skills, attitudes, and beliefs”, the only aspirational competency in MSJCC, highlights the importance of a counselor’s awareness of themselves and their perspective, in relation to the counseling relationship and interventions especially pertaining to advocacy given intersections of power, oppression and privilege between the counselor’s and client’s identities.

Counselor awareness is the first step in this approach to counseling. Counselor self-awareness is characterized by developing a deep awareness and an understanding of one’s own attitudes and beliefs as it relates to the intersections of their own identities especially as it relates to power and privilege (Ratts et al., 2016). Further, counselors are charged to take steps to increase their skillset to understand other’s intersectional identities, worldview, values, culture, while working to advocate for their clients. In practicing self-awareness, counselors are also charged under these competencies to learn more about their biases and work to combat them so that they do not affect the therapeutic process. The MSJCC lists specific goals for each domain for application as it relates to theory and practice (Ratts et al., 2016).

The inclusion of power dynamics in MSJCC reflects social justice counseling as it called for a re-examination of cultural roots impacting client outcomes in response to the failure of multicultural counseling in addressing counselor bias. Reflected in its inclusion in the American Counseling Association’s (ACA) ethical codes (American Counseling Association, 2014) social justice’s inclusion adds the duty of counselors to analyze their own marginalized or privileged identities and how it can affect their own worldview. Also emphasized in social justice

counseling is action. Counselors are encouraged to advocate for their clients on intrapersonal, interpersonal, institutional, community, public policy, and international/global levels (Ratts et al., 2015). Despite MSJCC's acknowledgement of the power counselors hold in advocating for clients, the approach is not comprehensive. Current theory lacks the tools to conceptualize the depths at which power can exist in the therapeutic relationship when considering privilege, oppression, and advocacy (Brubaker et al., 2010; Duffey & Trepal, 2016; Haskins & Singh, 2015).

Decolonized paradigm. The awareness of power dynamics in socialization occurring in the therapeutic relationship due to the systemic oppressive North American Eurocentric values is present in social justice counseling. Social justice counseling works to reexamine these roots in attempts to address inequities in mental healthcare for diverse cultures. However, missing in MSJCC is analysis of power effecting counselor and client interactions (Singh, Nassar et al., 2020). There has been some recent exploration of power through social justice in counseling (Singh, Appling et al., 2020). A text highlighted the "re-socialization" that becomes a counselor's task when a client's unique worldview is not comprehensively examined and applied when providing treatment (Goodman & Gorski, 2015). The text describes, consistent with the current study, that within the social context of the era a counselor and client occupy, part of a counselor's job is to perpetuate social beliefs and indoctrinate a client with socially acceptable narrative reflective of the cultural context (Goodman & Gorski, 2015).

Despite intentions to meet diverse needs, the approach of multicultural counseling does not fully examine its own traditional North American Eurocentric views and bias toward a dominate culture core. It posits that by counseling clients with traditional approaches through the lens of accepting cultural inequities without working to dismantle them, we perpetuate harmful narratives making us, as counselors, complicit with the status quo. The work calls for an intimate

look at multicultural counseling to “decolonize” its counseling approaches and techniques in attempts to address disparities through utilizing the framework of social justice (Goodman & Gorski, 2015). Given America’s specific relationship with Black Americans resulting in unique mental health disparities (Burrowes, 2019; DeGruy & Robinson, 2018), efforts to address counselor bias more accurately would do well in including these aspects in counselor interventions.

Important to note, given America was first established on stolen land owned by indigenous Americans, full intervention of the counseling profession would require addressing this foremost cultural context (Duran et al., 2008; Ratts et al., 2015). Again, cultural frameworks embedded in the counselor field are vast and may likely require historical reevaluation for each of the specific diverse cultures. The focus of the current study is on addressing the relationship of the American counseling profession with Black American clients.

Changes in Supervision Regarding Multicultural Competence and Social Justice

Further outlining the purpose of the current study are the shortcomings in multicultural and social justice supervision in counseling. Like the above approaches of multicultural counseling and MSJCC, their counterparts in supervision have failed to address the needs of counseling trainees and therefore clients within the supervisor- counselor- client triad. Ensuring competency for supervisors in the profession was an afterthought beginning in the 1990s, decades after multicultural competence was explored for counselors (Brown & Landrum- Brown, 1995; Constantine, 1997; D’Andrea & Daniels, 1997; Fukuyama, 1994; Leong & Wagner, 1994). Due to concentrating on facilitating the growth of new clinicians without addressing the deficit in established clinicians, a gap was created in competency effecting both the supervisor and the supervisee. Though efforts have been made to educate established clinicians, continued education requirements do not mandate any of the credits be in multicultural competency. As

such, veterans in the field are given an option to pursue new knowledge in this area or not. As a result, gatekeepers of the field are largely ill equipped to handle the growing needs of society and counseling trainees.

Though there is evidence that supervisees who receive higher amounts of multicultural supervision feel more multiculturally competent, there are not enough supervisors who feel confident in their cultural competence to meet the standards placed on counseling trainees (Multicultural counseling competence: History, themes, and issues, 2003) likely due to the gap in time for reform in supervision standards. Clinical students are given mandates that clinical supervisors are unsure how to teach. Currently, while efforts have been made to educate supervisors on how to broach difficult conversations (Day-Vines et al., 2021; Estrada et al., 2004; King, 2021), handle conflict within the classroom (Donald & Moro, 2014) and practice self-awareness to decrease the effect of their own bias as clinicians (Constantine et al., 2007), the gap in comfort continues to prevail.

Social justice supervision was developed to address the limitations of the initial multicultural supervision approach moving toward action and engagement (Dollarhide et al., 2021). However, the current model of social justice supervision only includes self-awareness as it relates to explicit and known differences within the supervision relationship. The foci within this model are the differences in lived experiences between marginalized and majority group members, increasing self-awareness and examining power differentials (Pearrow & Fallon, 2019). Such a broad sweeping focus does not account for the appropriate depth and nuance of which bias exists in our society and therefore does not fully meet its needs.

Previously noted in research leading to the development of cultural competencies is the awareness that the counseling profession at its core holds cultural biases informed by sociocultural context negatively impacting clients of color (Katz, 1985). Despite an awareness of

Eurocentric cultural roots, the influence of systemic discrimination, and the importance of considering a client's intersectional identities through evolutions of multicultural competence and social justice counseling, counselors still make biased decisions (Adebayo et al., 2022; Boysen et al., 2006; Boysen & Vogel, 2008; Katz & Hoyt, 2014; Kemet et al., 2022; Liu, Coifman et al., 2022; McConnell & Leibold, 2001; Nayman, 1983; Primm et al., 2009). Neither supervision approach has been completely successful in addressing counselor bias effecting the mental health treatment of clients of color, specifically Black American clients for the context of this study. A more comprehensive approach is vital. Explored is the proposition of this related to the secondary aim of the current study.

The Current Study

Adaptation Studies in Mental Health

There is precedence for cultural adaptation in mental health interventions addressing ethnicity (Whitbeck, 2006), therapeutic process (Hwang, 2006), correcting for a specific community (Lau, 2006), and heuristic models (Barrera Jr. & Castro, 2006), to name a few. Unprecedented however is adapting an intervention for counselors rather than clients. Even still, similar procedures can be used to adapt the NIH implicit bias intervention for counselors. Cultural adaptation is utilized to modify an intervention for a specific cultural population (Castro et al., 2010; Faregh et al., 2019) and including the beliefs, values and norms of a specific group can improve the group's attitudes towards the intervention (Li et al., 2017). Proposed in the current study is an adaptation of the evidence based NIH implicit bias intervention utilizing the values and norms of the counseling profession based on its emergence from historical American sociocultural context in order to mitigate bias negatively impacting Black American clients.

National Institutes of Health Implicit Bias Training

In response to the Black Lives Matter Movement, the National Institutes of Health created an implicit bias training released in August of 2022 (National Institutes of Health, 2022). The course is an evidence based three module two hour interactive training covering concepts regarding affinity bias, confirmation bias and group think from evidence based information (McKinley, 2022). The training pulls on traditional introspective measures to encourage reflection and critical thinking regarding one's own thoughts and how they can lead to biased decision making. The training mainly addresses diversity, equity, and inclusion concerns regarding representation across the healthcare fields and in leadership. Psychoeducation is also a tool, typically used in implicit bias interventions, heavily utilized in NIH's intervention.

Missing characteristics in the National Institutes of Health implicit bias training. When utilizing the characteristics of a successful long term intervention from above and addressing critiques of implicit bias interventions, the NIH's training lacks a few key characteristics. The intervention is broad and therefore not fully contextualized for a specific audience. The training reflects some values of good intention and inclusivity but does not comprehensively explore these concepts in relation to the training. Additionally, the full breadth at which implicit bias exists within a particular context is missed- here historical context and underpinnings may have been helpful to explore in cultivating the intervention for its specific audience. Also, interventions in increasing empathy are not present in the NIH intervention. These shortcomings will be addressed in the adaptation of the intervention. Further, embraced in the intervention is the mindfulness approach to intervention. While it is beneficial to slow down the decision making process in circumstances where biased decision making is likely, it also encompasses the critiques of that approach. Though the nonjudgmental approach is helpful in evading resistance, this approach may protect counselor bias.

Specific Modifications for the Counseling Profession

As counselors sometimes work to maintain their ego through social desirability in cultural competence and bias interventions, an approach that does not directly challenge the tendency may stop counselors from recognizing their own bias and applying the intervention for themselves. It may be beneficial in adapting the intervention for American counselors to adopt nonjudgmental language throughout the intervention while simultaneously directly challenging counselor beliefs about their own bias. One way to do such would be to utilize psychoeducation. In shifting the broad health sciences approach of the original NIH implicit bias training, psychoeducation on the historical underpinnings of oppression in early mental healthcare practices even through slavery are important to include in adapting the training specifically for the counseling profession.

Further, the historical framework helps introduce the concepts of power and privilege found in the foundations of the counseling profession effecting interactions throughout the supervisor- counselor- client triad in cross-cultural interactions. Within the structure of power, altruism is a key characteristic of the counseling profession contributing to biased decision making. Revisiting the roots of prejudice within mental healthcare accounting for altruism’s role may help to address concerns more comprehensively for biased decision making among counselors effecting Black American clients. The current study is exploratory in nature and will follow the process of adapting interventions for specific cultures in order to more comprehensively create an intervention that considers American counselors’ unique sociocultural underpinnings and context.

Summary

Counselors, overall, still struggle with biased decision making effecting mental health outcomes of people of color (Foster, 2022; Graham et al., 2022; Kugelmass, 2016), specifically

Black clients (Adebayo et al., 2022; Kemet et al., 2022). While implicit bias offers some insight to the cause, accrediting and licensing bodies have not mandated its inclusion (Boysen, 2009). In multicultural competence, while explicit forms of bias are acknowledged, competency standards have not developed over time to include implicit bias (Boysen, 2009) despite research underscoring its negative influence in treatment outcomes and implications (Boysen & Vogel, 2008; Katz & Hoyt, 2014). This may, in part, be due to the lack of efficacy of implicit bias trainings in mitigating bias long term (Brogaard, 2020).

Another reason may be due to counselors' drive toward social desirability. Social desirability can lead counselors to overestimate their cultural competence (Constantine & Landany, 2000; Pope-Davis et al., 2001). As such, counselors may be blinded by their own ego, interrupting further growth in multicultural competence, and therefore effecting research in implicit bias for counselors. As a researcher found, multicultural competence is only furthered in the field by the same few handfuls of researchers (Worthington et al., 2007), counselors' need to preserve ego by avoiding applications of implicit bias may be a growing concern. As such, exploration of altruism, defined as a prosocial helping behavior (Robinson & Curry, 2007) in counselors may help clarify the root of biased decision making. Counselors engaging in altruism do so with awareness of its sociocultural rewards and therefore are ego driven (Andreoni, 1990; Kant, 1785). Counselors who overidentify with altruism may be resistant to implicit bias education due to its implications for their own behavior, opting to rationalize results of implicit bias association tests for instance as they go against counselors' altruistic identity threatening social rewards.

Further, analysis of altruism includes similar elements of implicit bias making it a helpful addition for counselor interventions. Counseling is arguably an altruistic profession (Dugatkin, 2006; Flasch et al., 2019; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982). Elements of

power and authority, present in both altruism and implicit bias, may impact a counselor's ability to receive correction. Fundamental to both bias and altruism is a system of assumptions based in hierarchy (Fiske, 1993; Kraut, 2020). Assumptions about the helper and the helped inform subsequent behavior driven by sociocultural context (Kraut, 2020). Counselors, therefore, are perpetuators of implicit beliefs in the American social context and are given moral power to do so. It is likely that they are resistant to giving up this moral power for such a morally provoking topic as prejudice, and therefore work to manage their ego to maintain their power instead. Through altruism, counselors maintain power and are immovable in their role as the helper recognizing its social benefits. Using altruism as a surrogate for counselors' power dynamic, the current study will explore tendencies facilitating implicit bias.

Further, merging implicit bias and altruism in this context helps address concerns in literature regarding the two concepts. Missing in current implicit bias research is the analysis of power present in predecessors of the concept in social cognition research. This has been lost throughout the evolutions of implicit bias research and are not comprehensively explored accept in some social justice counseling research (Singh, Appling et al., 2020). Missing in counselor research is the extent to which altruism facilitates decision making in the therapeutic relationship (Sachse & Elliott, 2002). Using altruism as a surrogate for counselor behavior helps reinfuse power back into the implicit bias branch of social cognition research while helping to further research regarding counselor behavior in the therapeutic relationship. Additionally, and that which is the overarching purpose of the study, is to more comprehensively explore counselor bias effecting Black clients to mitigate harm.

To summarize and better understand altruism's effect facilitating biased decision making, consider the following case scenario.

The Case of Michelle

Michelle is a white female graduate student in a CACREP accredited counseling program starting internship. From a rural area in North Carolina, throughout her life, Michelle has always struggled financially. Finally, being in a better position financially with graduation in sight, Michelle is extremely proud of her accomplishments. At her internship in a clinic that offers medically assisted treatment for substance abuse, she is assigned an 18 year old Black male client who suffers from depression and uses various substances to cope. Michelle believes she knows just how to help given her background of financial struggle. She feels she has had exposure to most difficult circumstances in life. She will finally be able to help people in the ways she needed throughout her life. In session, she allows the client to vent while she begins setting goals in her head. The client reveals he is a senior and is not sure if he wants to graduate and continue his education or drop out. He is exhausted emotionally and does not have any support. Michelle resolves that the one and only goal should be that they find a way to remove him from his unsupportive mother who is pushing him to drop out and get a job. She believes that if he could just get a college degree, all his problems would be solved. He would not be depressed, and he would have so much on his plate with school that he would not have time to think about anything else just like she did. She begins looking at college sites with him. Though he is apprehensive she continues telling him that it is the best thing for him. The client leaves the session without addressing his concerns.

Based on the above case scenario, Michelle, like many beginner counselors in training, feels an intense altruistic need and excitement to help her client. Altruistic characteristics are prosocial and shaped by perceptions of power and privilege driven by the surrounding culture (Fehr & Fischbacher, 2003). In Michelle’s case she has made implicit assumptions about her client’s position in the cultural context especially in relation to her role of power and authority.

She assumes a role of power to best help him and has access to additional moral authority, contributing to the client's hesitation of challenging her, allowing her to push her own agenda unchallenged. She feels called to this role of moral authority because of her plight and likely her race in relation to the client's. She then utilizes her power and authority within the counseling dynamic to perpetuate her sociocultural understandings. She has made assumptions about his role as the one being helped based off of his circumstances and identities differing from the rules of wellness within her context.

From Michelle's perspective, everyone should go to college because that is the societal standard. Therefore, the client's mother is not well because she does not want him to go to college and the client is unwell if he refuses her kind of help. She unconsciously assumes the client will listen because this is the right thing to do, and she is in a role of authority personally as a White woman and professionally and socially as a counselor. Michelle does not register her behavior as unhelpful because based on her lived experiences, she is doing what she would have wanted someone to do if she were in this situation. Michelle also may not be challenged because going to college is not considered the wrong thing to do in the surrounding social context. In this way, Michelle unconsciously utilizes the implicit rules of the society and her access to moral power to perpetuate the implicit standards and values of the culture. It does not occur to her to seek the client's perspective because he does not hold the authority over himself as a Black man with differing experiences than the established standard within that social context. Instead, Michelle does, as a counselor who is a White woman that worked hard to achieve the financial and educational standards deemed good, right, or well within her social context. Additionally, if the client becomes aware of these implicit biases, he will likely wrestle with stereotype threat impacting his behavior in the counseling session and whether or not he returns.

One study analyzed six counselors describing why they chose the profession (Bager-Charleson, 2010/2018). Found was that counselors are intrinsically driven to rewrite their own personal narratives vicariously through helping others (Bager-Charleson, 2010/2018). In this case, Michelle is doing the same. Michelle is using her lived experiences to inform her altruism, empathy, and treatment decisions regarding her client. Michelle, like may counselors, even through early helper culture, has an ingrained narrative of her own experiences complete with assumptions of who needs help, why they need help and what type of help they need informed by the larger social context. She has resolved to help her client exclusively through her lens thinking that she is being helpful. This is the harm altruistic behavior can cause when it is coupled with underlying unconscious bias and is the focus of the current study. Altruism equips counselors with the power to provoke change while further blinding them from awareness of bias ultimately resulting in ineffective care. Likewise, for Michelle, her altruistic behaviors coupled with unconscious bias led to assumptions ultimately reducing efficacy of treatment with her client.

Further, given Michelle's power as a therapist coupled with any intersectional identities of privilege from the surrounding sociocultural context in relation to the client's varying identities make it difficult for the client to confront Michelle's bias. Additionally, power structures enforcing Michelle's proximity to power and privilege contrastingly decrease the client's access to power. Attempts to level the power dynamic likely would not go in the client's favor. Michelle may become defensive or confused. Protecting Michelle and her biased decision making is the view that she is an expert not to be disagreed with coupled with any socialized responses to intersectional identities of power she may hold.

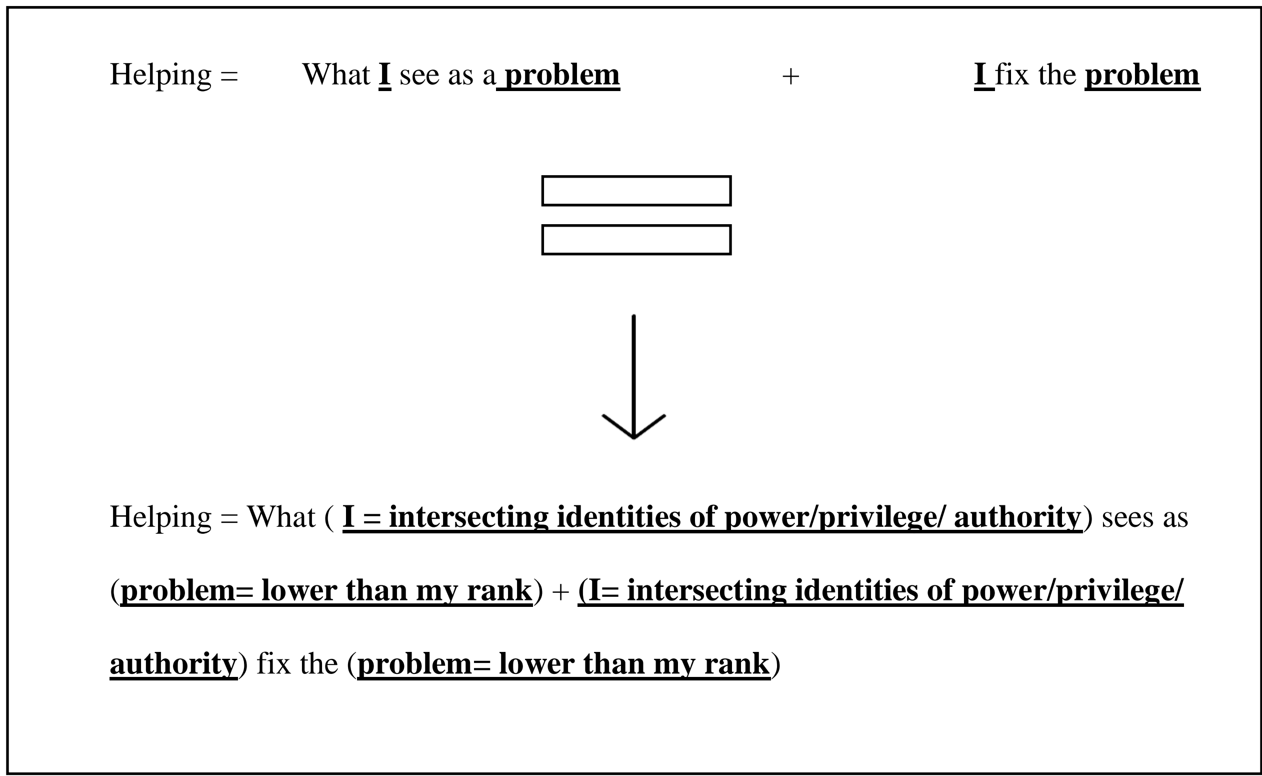
Based on the United States counseling profession's roots previously explored in the Preamble to this chapter, it could be stated that the way we define helping within the United States is a colonial construct. The first helpers established a precedence for helping in the context

of colonizing the United States with little information about those they were encroaching themselves upon. In this way, characteristic of United States altruistic helping is pursuing closer proximity to white heterosexual male able-bodied higher class. Those who help do so with this implicit goal in mind. Further, counselors already close in proximity to this standard do so with more implicit assumptions damaging to clients of color.

In Michelle's case, she is embodying this intrinsic understanding of the helping relationship through United States altruism. In Michele's mind due to her intersectional identities of privilege, the power that those have granted her in her social context and the moral power/ authority granted to her as a clinician within United States social context, she has implicit thoughts on how the helping process should look. As how we define help, who defines help, who gets to help, and who should be helped have been imbedded into social context and are impacted by the rank status of a person's intersectional identities, Michelle's implicit thought process would look similar to the figures below.

Figure 2.3

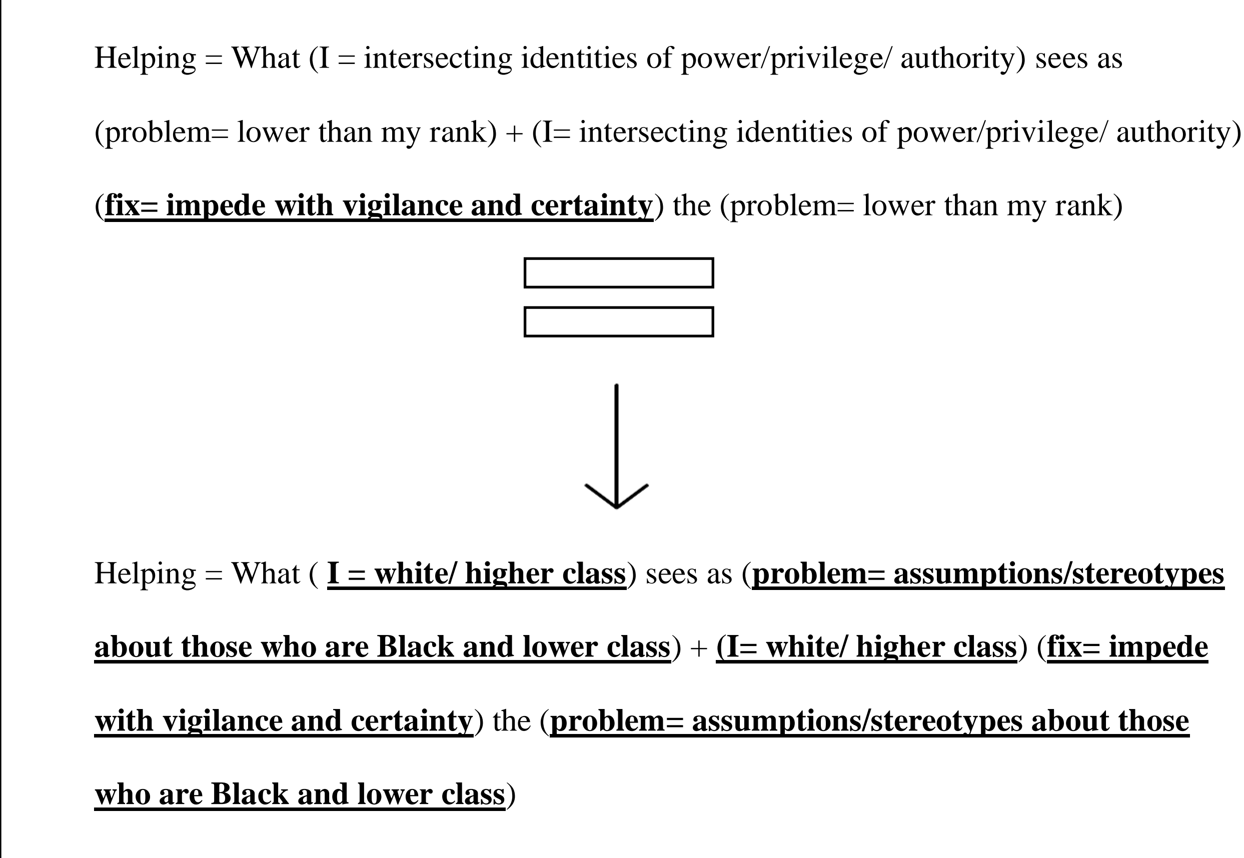
Equation of Helping



Michelle is being informed by several underlying implicit thought processes that while she has defined it as helping are actually ineffective for her client. In Figure 2.3, displayed is the meaning of parts of the helping relationship in Michelle's mind. Figure 2.4 displays what those decoded meanings become based on Michele's cultural identities.

Figure 2.4

Equation of Helping Decoded



For Michelle, she is a white female of higher class than her client based on her socioeconomic status and higher level of formal education. Despite her being a female, she has more ranked statuses of value over her client which grant her access to more power/authority in the relationship as an individual (Robinson, 1999). Based on her higher rank, she has paid less attention to the needs of her client making assumptions about who he is as a person and what he needs resorting to stereotypes (Fiske, 1993) such as the belief that Black people are not self-aware and incapable of making their own decisions (Nayman, 1983; Primm et al., 2009), so she must be vigilant about her helping by doing things for the client in order to be effective.

As counselors we may help out of self-interest, moral superiority, and pity rather than objective altruistic intentions due to the historical underpinnings of the field. The political, social, and cultural context of our surrounding society still embody prejudice, just implicitly and therefore so does the counseling profession. Counselors do not operate outside of this context but instead by nature work to perpetuate the insidious ranking rules of identity politics in America. In order to correct this, counselors must revisit our brand of helping and admit our true role in society. From that we must work to redefine our role.

Now, Michelle's behavior may be moderated by conscious awareness of counselor ethical mandates. As such, versions of this behavior may exist where instead of Michelle explicitly pushing her agenda, she tries to get the client to adopt her treatment ideas by guiding their thought process. The implicit bias for Michelle is at the root of the behavior. However, her need to help based in egoic drive (her need to give others what she did not have) through altruism blocks her from seeing her bias that in this case may be a) Black youth are underprivileged and therefore need overt guidance to stay out of trouble, b) those who lack resources need extra guidance and/or c) she knows best as a White woman in relation to a Black man because of social hierarchy and her access to power and privilege.

In this way, her overt access to power as a counselor is something that she is aware of and utilizes, likely attributed to multicultural courses as depicted in MSJC for instance. However, while she thinks she has acknowledged power dynamics to do what is best for the client, she only thinks so because of the system of implicit systems she operates from through her own bias perpetuated through altruism. Instead, what she actually does is push her implicit beliefs to further her agenda increasing her ego while preserving imbalance of power in social hierarchy. Further, she accomplishes the implicit goal of helping her client pursue higher social rank as

defined by proximity to white heterosexual maleness, able bodied-ness, and higher class. Due to this, while the client feels unheard Michelle feels great about her decisions.

Revisiting the equation in Figure 2.3, regardless of how you control for effects of intersectional identities (through multicultural competencies, social justice, etc.), if the definition of helping does not change, we will continue to be ineffective for clients of color. As a field, counseling has focused on the right side of the equation. The contention within the current study is that we should focus now on the left side of the equation by reexamining what it means to help in the American counseling profession. Based on the review of literature, a few analyses undergird the research questions:

1. The way helping is defined in America is influenced by colonialism and the implicit values assigned through dominant discourse around identities differing from white heterosexual able bodied and high class men in a hierarchical order. Helpers are implied to aid any differing from those identities of highest value by increasing their proximity.
2. As such, counselors who engage in helping, by nature are at risk of perpetuating colonial and implicit values regardless of education as seen in the lack of efficacy regarding multicultural competencies.
3. Due to the flawed definition of helping in American context, altruism practiced by Americans, because it is influenced by social context also reflects these flawed beliefs about the helping relationship.
4. As such, counselors who help with altruistic intentions implicitly perpetuate hierarchical structure within United States dominate discourse.
5. How these implicit beliefs surrounding helping and altruistic behavior are perpetuated can be influenced by the varying intersectional identities of the counselor, client, and supervisor in a therapeutic relationship.

The way Americans practice helping through altruism is influenced by our history of oppression against diverse cultural groups. Counseling, through its foundations of helping and altruism, in United States social context is implicitly defined by dominant discourse and the pursual of higher ranking status. As such, by the collective assumptions and nature of counseling and its proximity to altruism, counselors may be more at risk for biased decision making. Therefore, adding altruism to implicit bias training for counselors may work to help mitigate bias by educating counselors about the lesser known roots of ours and others profession highlighting responsibilities. These dynamics are what drive the research questions for the current study below.

Quantitative Research Questions:

1. What is the relationship between counselor implicit bias scores and altruism scores?
2. What is the relationship between counselor demographic data and implicit bias scores?
3. What is the relationship between counselor demographic data and altruism scores?

Qualitative Research Questions:

1. What else should be included in NIH’s implicit bias training to adapt it for counselors?

CHAPTER III: METHODOLOGY

This chapter outlines the process of approaching the overall purpose of the study: to explore additions to counselor multicultural competency training through analyzing the relationship between counselor altruism and implicit bias and adapting an evidence based implicit bias intervention for counselors. To explore such, the current study utilized a mixed methods approach to both quantitatively explore the relationship between counselor implicit bias, altruism and key demographic information and use qualitative data to adapt the National Institutes of Health's (NIH's) Implicit Bias Training Module for counselors. Included in the current chapter are a) research questions guiding the proposed study, b) research design, c) instrumentation, d) discussion of the population selected, e) procedures for implementing the proposed study, f) data analysis procedures for collected data, g) ethical considerations, h) limitations and i) a brief summary of the goal of the study.

Research Questions

Core to the purpose of the current study was exploration of what additions to counselor training should be made in order to mitigate implicit bias increasing competent care for Black clients. Posited in the current study was that altruism plays a significant role in the efficacy of implicit bias intervention. To quantitatively explore such further, primary research questions were:

1. For counselors, what is the relationship between implicit bias scores and altruism scores?
2. For counselors, what is the relationship between implicit bias scores and demographic data?
3. For counselors, what is the relationship between altruism scores and demographic data?

A secondary aim of the study used counselor feedback to adapt the NIH Implicit Bias Training Module. The research question that guided the qualitative portion of the proposed study was the following:

1. What else should be included in NIH's implicit bias training to adapt it for counselors?

Research Design

The current study used a non-experimental mixed methods approach. For the quantitative portion of the study, descriptive statistics by way of surveys were used to gather counselors' levels of altruism and demographic data. Altruism scores were gathered through the simplified Self Report Altruism Scale (Manzur & Olavarrieta, 2021), discussed further below in instrumentation. Additionally, participants took the Implicit Association Test (IAT) for race (Greenwald & Banaji, 1995) to gather a measure of implicit bias. The IAT is an experimental measure, discussed further below in instrumentation as well. As the current study was exploratory in nature, quantitative data was used to explore relationships between implicit bias and altruism among counselors while utilizing demographic data. For the qualitative portion of the study, focus groups and semi structured interviews were held to gather data relevant to the proposed study and to fulfill the secondary aim of adapting the NIH implicit bias training.

Overall, as the current study was exploratory, two qualitative techniques were used. First, a historical perspective (see chapter two) was used to gather aspects of altruism relevant in the counseling profession seen throughout the literature review. Second, for the qualitative portion of the research design guiding data gathering, the study used grounded theory. Coupling altruism with implicit bias to explain a unique process of biased decision making specifically found in the counseling field is new. Such a concept does not exist within literature as of yet. Utilizing

grounded theory aided in finetuning the concept within this context, as the aim of the approach is to generate a theory (Urquhart, 2013).

Additionally, grounded theory works from a position that there are plausible relationships between concepts and focuses on the participant's interactions with the proposed theoretical framework posited in the study (Urquhart, 2013). In the current study, the goal was to gather how counselors feel about the proposed relationship between their own and the field's implicitly biased behavior and altruism. Focus groups were used to gather counselors' understandings of altruism and implicit bias in the field and how they both contribute to biased decision making. To adapt the NIH implicit bias training, counselors discussed any other unique cultural norms of the counseling profession contributing to implicit bias based on their own perspective in the field. Studied was the phenomenon of altruistic behavior facilitating implicitly biased behavior effecting Black clients' mental health treatment in addition to counselors' ideas of other contributing factors unique to the counseling profession. Explored below are the instruments that facilitated both approaches for the quantitative and qualitative research designs.

Instrumentation

Information for the quantitative measures of the Simplified Self Report Altruism Scale (Manzur & Olavarrieta, 2021), Implicit Association Test (Greenwald & Banaji, 1995), and the qualitative approach, the Substance Use and Mental Health Services Administration (SAMHSA) guide for Adapting Evidence-based Practices for Under-resourced Populations (2022) are found below.

Quantitative Instrumentation

Demographic data. Demographic data of interest for the current study was based on variables of interest from the literature review. All demographic data is of interest in relation to counselors' scores on the altruism scale and IAT as well. As such, demographic data included:

- Counselor age
- Gender
- Race/ Ethnicity
- Status in the profession
- Multicultural competence
- CACREP status of school attended for master's degree at the time of incurred degree
- Ability
- Religious affiliation
- Sexual orientation

All of the above have precedence for relevance in research pertaining to counselor behavior and treatment outcomes (Constantine & Landany, 2000; Katz & Hoyt, 2014; Liu et al., 2022; Morales, 2014; Nayman, 1983; Pope-Davis et al., 2001; Primm et al., 2009; Robinson, 1999; Taylor et al., 2019).

Simplified Self Report Altruism Scale. The Self Report Altruism Scale, published in 1981, works to establish altruism as a broad-based trait (Rushton et al., 1981). Altruistic tendencies are measured by allowing respondents to self-report having done a series of traits researched as altruistic in nature. The scale being used in this study, published in 2021, is a simplified version of the original scale much research refers to and therefore is well noted in its

usage for the purposes of this study. Scores on the simplified scale have been found to be both reliable and valid (Manzur & Olavarrieta, 2021). The coefficient reliability of the revised scale was 0.77. Validity was assessed using chi squared tests (Chi-squared = 6.337, df = 1, p-value = 0.012) indicating validity of the revised nine item scale. Permission has been given by the originators of the simplified scale (see Appendix B for Altruism Scale Permission).

A note regarding social desirability scales. Social desirability has well researched effects on counselor decision making effecting self-report of multicultural competency (Boysen & Vogel, 2008; Constantine & Landany, 2000; Pope-Davis et al., 2001) and bias (Brogaard, 2020). Counselors may engage in other oriented perception management when presented with sensitive topics, such as multiculturalism and diversity. Aware of its implications if they fall on the wrong side of public perception, counselors are influenced by the views of others when reporting their own thoughts and behaviors sometimes resulting in inaccurate self-report (Boysen & Vogel, 2008). As such, assessing a counselor's degree of social desirability was ideal (how likely are they to not admit undesirable behavior due to other's perceptions, for instance) in comprehensively exploring relationships between altruism and bias.

However, there is some concern in whether or not social desirability scales are valid in their relationship to prosocial behavior. For instance, if social desirability scales measured socially desired traits, they should have a negative relationship with prosocial behaviors. According to a meta-analysis analyzing the validity of social desirability scales, unfortunately they are not valid in their relationship to prosocial behaviors (Lanz et al., 2022). As social desirability scales did not accurately measure the prosocial roots of interest here, altruism scores sufficed. Altruism has similar roots in prosocial functioning (Bentham, 1789; Cialdini, 1991; Skinner, 1978) and therefore was used in this study through the aforementioned altruism scale to

address the prosocial behaviors of counselors. Additionally, research notes specific procedures to decrease the risk of respondents engaging in prosocial behaviors disrupting the reliability and validity of the data. Suggestions include reordering instrumentation, using anonymity when possible for respondents, using self-administered surveys, forced choice items on surveys and indirect questioning (Wlömert et al., 2019). Those were implemented throughout the quantitative and qualitative portions of the study in order to decrease the influence of social desirability.

Implicit Association Test. Early definitions of attitude and stereotype were described as conscious behaviors, however the beginnings of the Implicit Association Test (IAT) sought to redefine implicit social cognition by finding correlates between it and implicit memory (Greenwald & Banaji, 1995). The Implicit Association Test was eventually created to measure the strength of associations between two subjects, relying heavily on stimulus response theory in order to quantitatively measure unconscious attitudes related to race, gender and other notable characteristics that have proven significance to social interactions in society (Greenwald & Banaji, 1995). In the case of this study, implicit association for race was used. According to the 1998 study, respondents participating in the test are asked to make associations between target concepts and attributes in order to measure differential association between them (Greeenwald et al., 1998). Quicker responses between target concepts and attributes suggest a stronger association.

Preliminary results of the study attest to its validity in measuring implicit associations (Greeenwald et al., 1998). The goal of an implicit association test is to reveal attitudes that may not be accurately measured through self-report and other qualitative methods (Greeenwald et al., 1998). The IAT has been established with usage in the helping professions since 2003 with associations of race since 2007 (Sukhera, et al., 2019). Average test-retest reliability was found

for the totality of IAT tests which is reported at .50 and is said to be suitable for analysis of group differences (Greenwald et al., 2022). The IAT has also been found to be a valid measure for measuring its various constructs. Use of the IAT for research has been widely addressed by the creators of Project Implicit noting to simply use proper citation when utilizing the measure (Xu et al., 2022).

Qualitative Instrumentation

SAMHSA guide for Adapting Evidence-based Practices for Under-resourced Populations. The SAMHSA resource guide for Adapting Evidence Based Practices for Under Resourced Populations (2022) was created to provide guidance on tailoring evidence based practices for differing cultural, social, gender, and various other socio-demographic contexts. Use of the guide has been widely addressed as well. Use of the guide has been widely approved as long as it is properly cited. The guide is meant to help practitioners adapt models for the cultural and moral values of a particular group. Different here was that the cultural group the evidence based practice was adapted for was counselors rather than a traditionally viewed under resourced clientele. However, the field's distinct culture made it helpful to use this approach. Additionally, adaptations of interventions typically follow similar protocol (Chen et al., 2013; Domenech-Rodríguez & Wieling, 2005; Lee et al., 2008; McKleroy et al., 2006; Sawyer-Kurian & Wechsberg, 2012; Sidani et al., 2018; Wingood & DiClemente, 2008), so arguments regarding the field's status of being under resourced are not pivotal to the selection of the type of adaptation protocol used here. Therefore, the SAMHSA guide was used for adapting the evidence based practice of the NIH implicit bias training. Seven steps are outlined in the guide in order to adapt interventions and are listed below.

1. Define the problem while engaging the stakeholders in the community

2. Assess the feasibility of implementing the change
3. Review the Evidence Based Practice
4. Select components that can be adapted while keeping the integrity of the original evidence based model
5. Train the staff and test the adaptation
6. Implement and review outcomes
7. Assess and make further changes if necessary

As the current study was exploratory, steps five through seven were not feasible at this time. As such, only steps one through four were carried out. Future research will be centered on the rest, but currently they are outside of the scope of the current study.

Sampling

Population

Participants for the current study were initially gathered by emailing counseling departments in colleges and mental health agencies for volunteers. Initially, the principal investigator emailed various mental health agencies and counseling departments in North Carolina requesting them to share the information about the study to their faculty, staff, and students. Additionally, request was granted to the North Carolina Board of Counselors listserv information. As such, emails from this source were randomized and sent information for the study as well. Those who wished to participate contacted the principal investigator.

Initially, a target of 85 participants was set for statistical power. To calculate such, a significance level of .05 and a power set at .80 were used. A medium effect size was chosen, .30 (Cohen,1992) after referencing various studies regarding effect sizes for the altruism scale (medium) and the Implicit Association Test (large). Calculating sample size with the

aforementioned parameters yielded an optimal sample size of 85 needed to draw meaningful correlations.

In total 170 counselors, counselor educators, counseling supervisors and counselors in training excluding other mental health disciplines (i.e., psychology, psychiatry, social work, etc.) accessed the survey, but only 157 were analyzed as others did not complete initial demographic information. Additionally, only 61 completed the full survey with the IAT.

Regarding the qualitative portion of the study, the priority was saturation. That is, in order for a subject to be of major significance mentioned in focus group discussion, about 5 or more participants must suggest the subject (Sawyer, 2004). As saturation, does not require a specific number of participants only for a subject to be mentioned, less participants were needed for the qualitative portion. As such, participants taking part in surveys were extended the opportunity to participate in focus group discussion on a volunteer basis. Though best practices, for groups suggest about 6-10 participants per group (Krueger & Casey, 2008), interest was low for this portion of the study. As such, five participants took part in the qualitative portion of the current study. There was one group of two and three separate semi structured interviews. There was no tangible compensation for either participation.

Participation in either or both of the portions of the study required the following:

- Participants should be a counselor, counselor educator, counseling supervisor or counselor in training in North Carolina.
- At least 18 years old
- Counselors in training are defined as being currently enrolled in a counseling program in North Carolina or having graduated from a counseling program in North Carolina and practicing under provisional licensure

- Supervisors must hold certification in North Carolina
- Practitioners must currently practice in North Carolina

The procedures for how participants were contacted and overall procedures for the current study are below.

Procedures

Below are step by step procedures that were used to conduct the study. The entire study was carried out in a virtual format using a combination of a virtual meeting platform (WebEx) and email. There is precedence for carrying out mixed methods studies in an online format (Salmons, 2015). Best practices were pulled from various approaches relating to such and are referenced where relevant below.

Step 1- Recruitment

After gaining IRB approval (Appendix A), the researcher contacted college counseling departments and mental health agencies in North Carolina via email for any interested in participating in the study (see Appendix C-D for Initial Recruitment Email and Recruitment Email Follow Up). Schools and agencies were asked to share the information regarding the study with students, counselor educators, counseling professors and counselor supervisors in the affiliated institution for participation. Additionally, listserv information from the North Carolina counseling board was randomized and emails were sent for initial recruitment. Initial emails contained consent information (see Appendix E), the survey link (see Appendix F for the Qualtrics survey) and the survey directions (see Appendix G). Those who wished to participate in focus group discussion contacted the researcher for additional instructions.

All participants were given the option to either complete quantitative portions on their own or in a scheduled virtual session, though all participants chose to complete the survey on their own. As such, procedures for how this may have gone are omitted for brevity.

Qualtrics Survey. The Qualtrics survey began with demographic information. Participants were initially presented with demographic information important for inclusion in the study. First, they consented to the research, then they selected a category that best described their age. A selection of "Below 18" forwarded them immediately to a screen thanking them for their consideration and informing them that they did not meet criteria. The same applied for the next question regarding their role in the counseling field. Marking "none of the above" removed them from the survey. Respondents who met criteria continued with demographics designating their comfort in working with diverse cultures, CACREP status of the counseling master's program they attended, disability status, degree of religious affiliation, and any racial/ethnic groups, genders, and sexual orientations they identified with. After, respondents were presented with questions from the simplified altruism scale. The final question in the Qualtrics survey asked for results of the IAT for race (Greenwald & Banaji, 1995) on the Project Implicit (Xu et al., 2022) webpage.

In order to provide the response, respondents were given directions (Appendix G) instructing them to leave the Qualtrics window open, open another tab and navigate to the IAT website to complete this separate measure before putting their result in the Qualtrics survey.

In consideration of order effects, altruism items were listed first, and all questions were forced choice stopping participants from continuing until the present question was answered. Additionally, respondents were not able to visit previous questions in the survey. The Qualtrics survey included 26 items and was about 5 minutes. The IAT typically takes approximately 10-15

minutes. Altogether the quantitative portion of the study took roughly 15-20 minutes. This concluded participation for participants only wanting to take the survey.

Contacting Qualitative Participants. After responding to initial recruitment, individuals who wanted to take part in focus group discussion reached out for more information. These participants were sent personal links for the survey to track demographics and scheduled a virtual WebEx meeting. They were also sent a list of the focus group questions and the NIH implicit bias training for review.

Step 2-Virtual Qualitative Sessions

For those who volunteered to participate in focus group discussion, after consenting, the participant and researcher set up a time to virtually meet. All virtual focus group meetings for the qualitative portion were recorded for thematic qualitative analysis and therefore, consent for recording was included in the informed consent. Participants were sent a DocuSign request to sign the informed consent prior to the virtual meeting.

Participants met once for a discussion covering the qualitative aims of the study. Upon clicking the WebEx link on the day and time of the meeting, participants were sent to a confidential locked virtual waiting room before being meticulously selected in after the researcher's review and confirmation of identity of each participant. Participants were reminded that the session was to be recorded and asked if they had questions concerning the study before starting. Participants were also reminded that they could withdraw consent at any time.

Focus group discussion consisted of discussion regarding the participants' IAT scores, altruism scores, implicit bias interventions, altruism's inclusion in the NIH implicit bias intervention and any other suggestions they may have for adapting the intervention for counselors.

Following SAMHSA's adaptation protocol, as stated above in instrumentation, initial steps included defining the problem while engaging the population of interest. Additionally, following step two, the feasibility of implementing changes in regard to the profession were discussed. For step three, the NIH implicit bias training module was reviewed with participants and suggestions for additions were gathered making the training more relevant to the counseling profession. After gathering suggestions, the researcher followed through with step four of the protocol, adding in the suggestions while keeping the integrity of the original training. For instance, the adaptions from the current study are meant to be used in conjunction with the NIH's module. In this way the original training acts as a foundation and the current research adds to the original work keeping its evidence based status in approach and content.

Discussions included questions regarding counselors' own decision making, their thoughts on their own implicit bias, altruism, and what should be incorporated in the training module that would best help them in mitigating bias. All group discussions were recorded for later analysis. After discussion, the researcher added the discussed components and sent the adaptations to the participants for approval and feedback. Participants approved the adaptations.

In alignment with both the model and suggestions regarding the number of questions asked, precedence is noted for a max of 12-13 focus group questions (Krueger, 1994). According to Krueger (1994), focus group questions should follow a format including an opening question to explore commonalities, two transition questions to the topic of discussion, five questions key to driving the research that are most closely related to the purpose, two follow up questions and ending questions. In alignment with such, 5 questions were asked following the aforementioned format (see Appendix H for Focus Group Questions).

In the case of the current study, the opening question involved discussion of the quantitative measures related specifically to the IAT and altruism scale. The following question transitioned into the problem addressed in the current study. The third question began discussion of adapting the implicit bias training driving discussion on altruism and its impact in counselor decision making. The fourth question clarified specific thoughts about what should be added through reviewing the training. Finally, the last two question gathered closing thoughts and summarized group findings.

Step 3- Gathering Feedback about the NIH after the Focus Group Session

After focus group discussion, only participants who were involved in the focus groups were given information on when to expect to hear back from the researcher regarding the additions to the training. The researcher emailed each participant involved in the focus groups the additions to the NIH training for feedback separately (see Appendix I for sample correspondence). Respondents were given eight days to respond with additional feedback and told that not emailing meant that they approved the adaptations.

Data Analysis Procedures

Quantitative

As the study was exploratory in nature, data was treated as nonnormal, therefore techniques for exploring the data used nonparametric methods. Initial visualizations of data included histograms, boxplots, and scatterplots. Kendall’s Tau, Fisher’s exact test, cross and relative frequency were all used to analyze data and relationships between variables. Quantitative data was analyzed using statistical software (SPSS 26).

Qualitative

The qualitative data gathered from the recorded focus group discussions was thematically analyzed using Microsoft Word. The method is outlined by Dr. Jaroslaw Kriukow (Kriukow, 2020). His CV can be found in Appendix J for review. Transcripts were gathered from WebEx recording and separated into two columns, on the left was the transcript and on the right is space for coding. Responses were thoroughly read separately line by line and summarized into initial codes. After, codes were then joined together for common themes. Following, themes were compared between participants to determine saturation. Codes repeated with five or more times in data have reached "saturation" and are therefore considered significant enough for thematic review (Sawyer, 2004). As the group was small, a majority of three of five was also used to determine saturation. From those themes, the researcher summarized and added to the implicit bias training.

Ethical Considerations

Of main concern in the current study was the confidentiality of participants in a virtual meeting where participants are in separate environments. Therefore, it was necessary to convey importance, to the participants to maintain confidentiality. Participants were instructed to participate in the research in a confidential space where they were by themselves and not distracted for the confidentiality of themselves and others participating in the study. Upon arrival in the virtual meeting, the Webex meeting was locked allowing for the main researcher to verify the identity of each participate before granting access to the meeting. At the end of focus group discussion concluding the meeting, participants were given instructions about the researcher's future contact and were reminded of confidentiality in order to help protect the identity of those in the discussion.

Limitations

Regarding limitations of the research design, given the subject matter, it was important to consider both how the order and subject matter could influence varied results in the study. While the study was not an experimental design, the John Henry Effect (Irving & Holden, 2013) highlights phenomenon relevant to the study. The effect explains that participants may view the study as a challenge resulting in participants exerting additional effort. This is particularly relevant for implicit bias measures. As multicultural competency has been increasingly researched in recent years, counselors engaging in social desirability through altruism who are participants in the study may be eager to show their skillset. Even still, the IAT is resistant to efforts to manipulate responses due to its limited time given for responses (Greenwald et al., 1998).

Response Shift Bias is another effect described as participants' behavior changing due to an awareness of the variable being measured. Though it is usually more relevant in pre and posttest measures, here, participants may have become aware that they are being assessed on their bias as measured in the IAT effecting self-report measures on the altruism scale. Considered here, was the order of presentation for each of the measures in the study. While participants may have become aware, ordering the altruism scale before the IAT aided in getting more accurate self-report data for the altruism scale. If positioned after the IAT, it may be likely that participants who scored high in implicit bias would have shifted answers for social desirability as seen in previous results discussed above. Though the IAT protects against order effects by requiring impulsive responses, the same advantage is not present for the reliance of self-report on the altruism scale. To protect against order effects, participants received the altruism scale before taking the IAT.

Other threats to the reliability and validity of the study relate to social interaction between participants, especially on social media, who have completed the study versus those who have not. Participants may discuss results with one another given the subject matter or share their experiences on social media platforms prior to the conclusion of data collection. To help protect the reliability and validity of the study, participants took the survey individually.

Summary

The current study used a mixed methods approach to understand the relationship between counselor altruism and implicit bias effecting treatment outcomes for Black clients. Quantitative methods of survey completion gathering demographic data, altruism scores and implicit bias scores were analyzed for their relationships with one another while focus groups were utilized to adapt the NIH Implicit Bias Training Module for the counseling profession using altruism. Explored in the next chapter are the results of the current study using these procedures.

CHAPTER IV: RESULTS

This chapter presents findings of both the quantitative and qualitative data analysis. First, the quantitative demographic findings will be discussed. Initially provided is a brief description of the data followed by a reminder of the research questions to be addressed. After, demographics of the participants are presented and analyzed for trends. Data were treated as non-normal, therefore, nonparametric tests were used throughout analysis. Following is a summary of data as it relates to the research questions. After quantitative findings are presented, the qualitative results from the focus groups will be discussed. Qualitative analysis presents a description of the focus group participants, thematic analysis of the findings and the resulting adaptation to the NIH implicit bias training. Below begins the analysis starting with quantitative results.

Quantitative Results

Description of Data

Participants were collected by gathering listserv information of counselors (full and provisional) and counselor supervisors in the North Carolina counseling field through the North Carolina Board of Counselors. Additional student and counselor educator participation was gathered by emailing counseling departments in North Carolina for recruitment. Mental health agencies in North Carolina were also contacted for recruitment. In total from the above methods, quantitative data for the study's survey responses garnered 170 participants who self-identified as being part of the North Carolina counseling profession. Three participant responses were initially discounted because they did not respond to any of the required measures including initial demographics. Survey data included demographic information, comfort with diverse cultures, the Simplified Self Report Altruism Scale (Manzur & Olavarrieta, 2021, and scores on the Implicit

Association Test (IAT) for race (Nosek et al., 1998) respectively. As such, an additional 10 responses were removed because they did not finish the altruism measure placed toward the end of the survey. While only 61 participants completed all the way to the end of the survey for the implicit bias measure, 157 respondents of the original 170 were still included for initial quantitative analysis of demographics. Implications for potential reasoning regarding the varying completion rates will be discussed in the discussion section further below. For now, in this section is the analysis of the 157 participants who answered at least through to the altruism measure to explore relationships and answer the research questions listed below.

Research Questions:

1. For counselors, what is the relationship between implicit bias scores and altruism scores?
2. For counselors, what is the relationship between implicit bias scores and demographic data?
3. For counselors, what is the relationship between altruism scores and demographic data?

Demographics of Total Participants

As the focus of the research is to understand trends related to key demographic information, the data was initially analyzed to better understand the population of counseling professionals surveyed. After consenting to research, respondents first answered questions regarding their age to abide by established inclusion criteria (respondents had to at least be 18 years of age to participate in the study). Respondents chose between five different age groups that best described their age. Seen in Table 1, the lowest age group reported was 18-30 years of age and the highest was 71-80+ years of age. About half of the respondents were in the age group of 31-45 years of age. The graph below (Figure 4.1) also displays the age groups showing them to be skewed to the right significantly. Important to note that in tables and graphs moving

forward, number of participants refers to data that was single response, frequency refers to multiple response data and total refers to the same where relevant indicated also in parenthesis.

Table 1

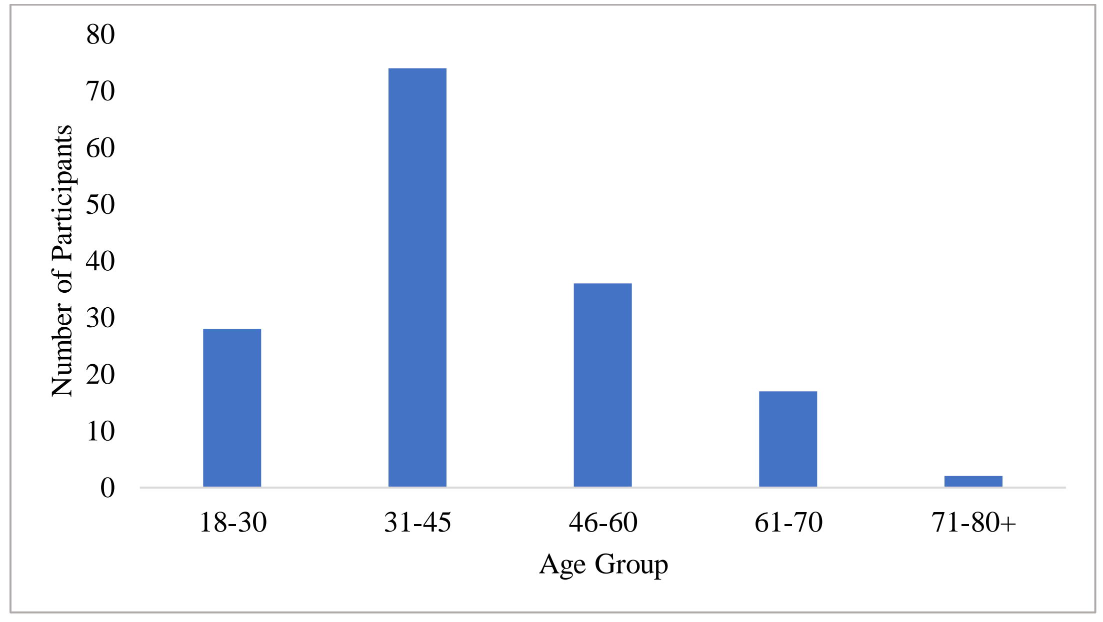
Demographic Data: Survey Participant Age

Age Group	Participants
18-30	17.83% (28)
31-45	47.13% (74)
46-60	22.93% (36)
61-70	10.83% (17)
71-80+	1.27% (2)
Total	100.00% (157)

Note. Table depicting age group of participants.

Figure 4.1

Demographic Data: Age of Participants



Note. Graph depicting the different age groups of survey participants.

Next respondents answered which roles they occupied in the profession. In this question, they could mark all that applied. Designations included the following:

- Being a counselor in training as defined as a master's or doctoral level student enrolled in a counseling program
- A North Carolina counselor who holds provisional licensure
- A North Carolina counselor who holds full licensure
- Counselor educator teaching at a college/university in North Carolina
- Counseling supervisor who holds licensure in North Carolina

Based on Table 2, most counselors who participated in the survey held a full North Carolina counseling license at 91 participants. Following behind, 48 participants held a provisional license. Based on the data, 32 participants were supervisors. The least number of participants were counseling students (10) and educators (five). From the table below, there are 186 different roles occupied by the 157 participants showing the breadth of engagement of the counselors.

Table 2

Demographic Data: Survey Participant Roles

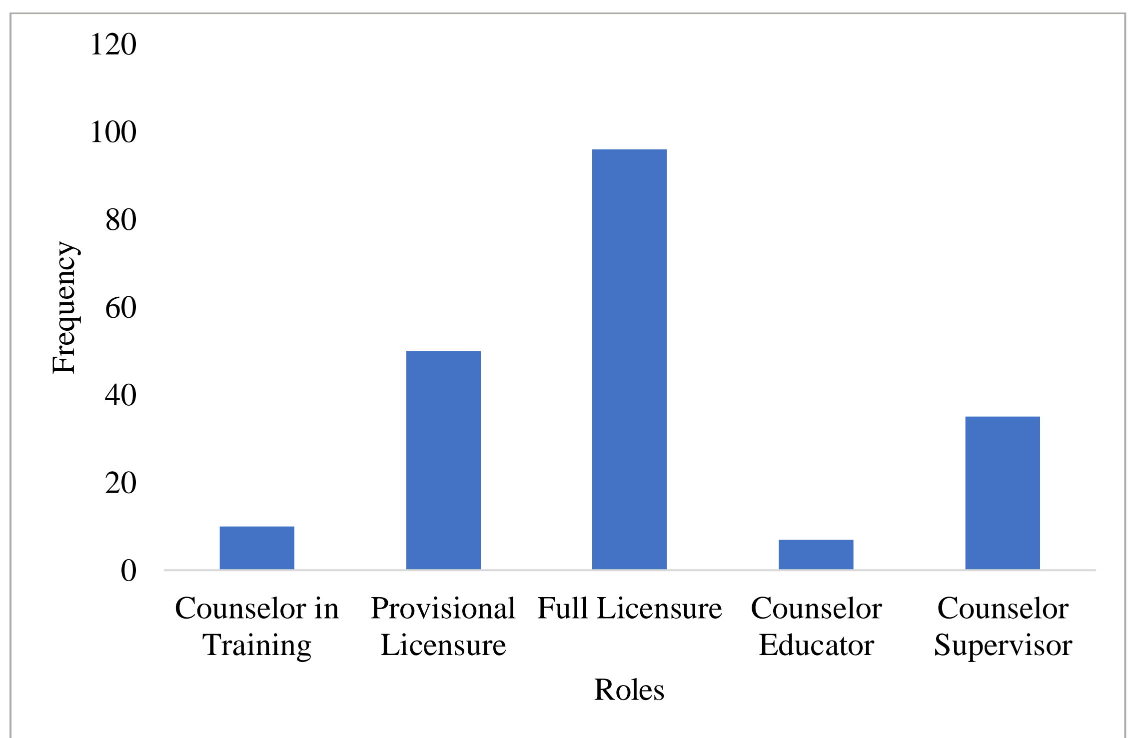
Roles	Frequency
Counselor in Training	5.38% (10)
Provisional Licensure	25.81% (48)
Full Licensure	48.93% (91)
Counselor Educator	2.69% (5)
Counselor Supervisor	17.20% (32)
Total	100.00% (186)

Note. Table depicting roles of participants.

The graph in Figure 4.2 below shows the distribution. Again, most counselors who took the survey are fully licensed with about as many being provisionally licensed and in graduate school as educators and supervisors.

Figure 4.2

Demographic Data: Roles Occupied in North Carolina Counseling Field



Note. Graph depicting the different roles in the North Carolina counseling field occupied by survey participants.

After respondents noted the roles they occupy in the field, they then noted how confident they are in their ability to treat diverse clientele. In answering the question "I have ability to work with clients of diverse backgrounds effectively" overwhelmingly most respondents, about 90%, reported "somewhat agree" or "strongly agree" as seen in Table 3 below.

Table 3

Demographic Data: Survey Participant Response to "I have the ability to work with clients of diverse backgrounds effectively."

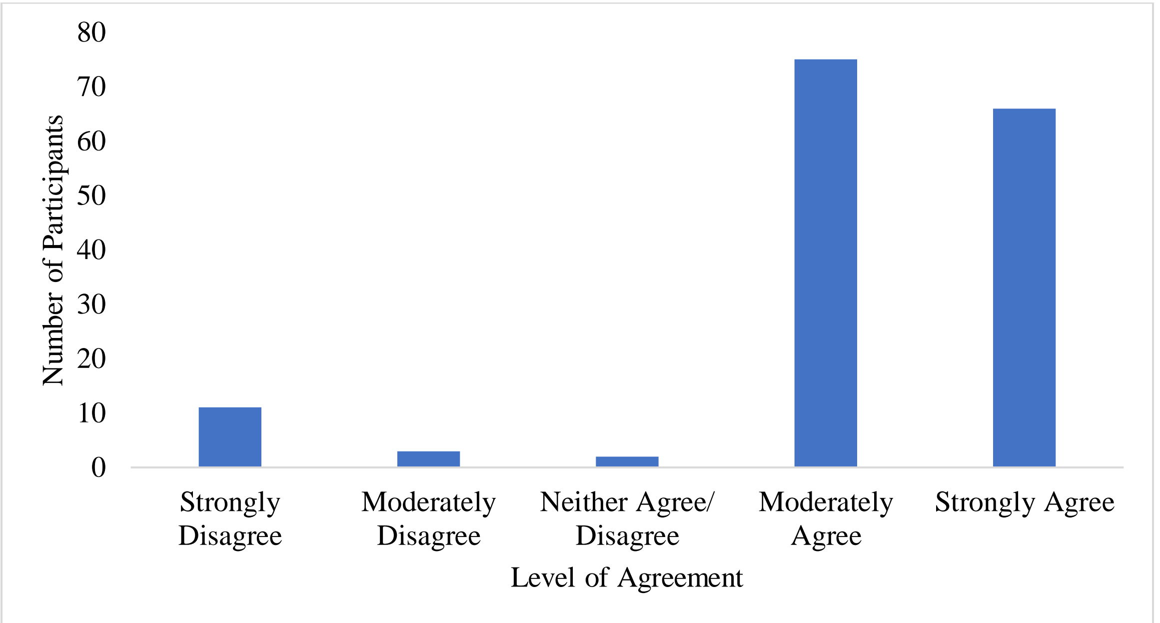
Agreement	Participants
1-Strongly disagree	7.00% (11)
2- Moderately disagree	1.91% (3)
3- Neither agree/ disagree	1.27% (2)
4- Moderately agree	47.78% (75)
5- Strongly agree	42.04% (66)
Total	100.00% (157)

Note. Table depicting participant comfortability with working with diverse cultures.

Figure 4.3 below shows the shape of the responses, a substantial left skew. Very few (14) respondents (or less than 10%) do not feel they can effectively work with clients of diverse backgrounds. Even fewer (two respondents) don't feel particularly strongly about their abilities.

Figure 4.3

Demographic Data: Survey Participant Response to "I have ability to work with clients of diverse backgrounds effectively."



Note. Graph depicting the level of agreement with statement to assess participant comfortability with working with diverse cultures.

Afterwards, respondents reported on whether or not the master's program they attended for their counseling degree was CACREP accredited. Most respondents (133 or 84.7%) reported that the program was CACREP accredited, as seen in Table 4, while 24 (15.3%) reported that it was not. A bar graph below (Figure 4.4) compares the two as well, showing the same.

Table 4

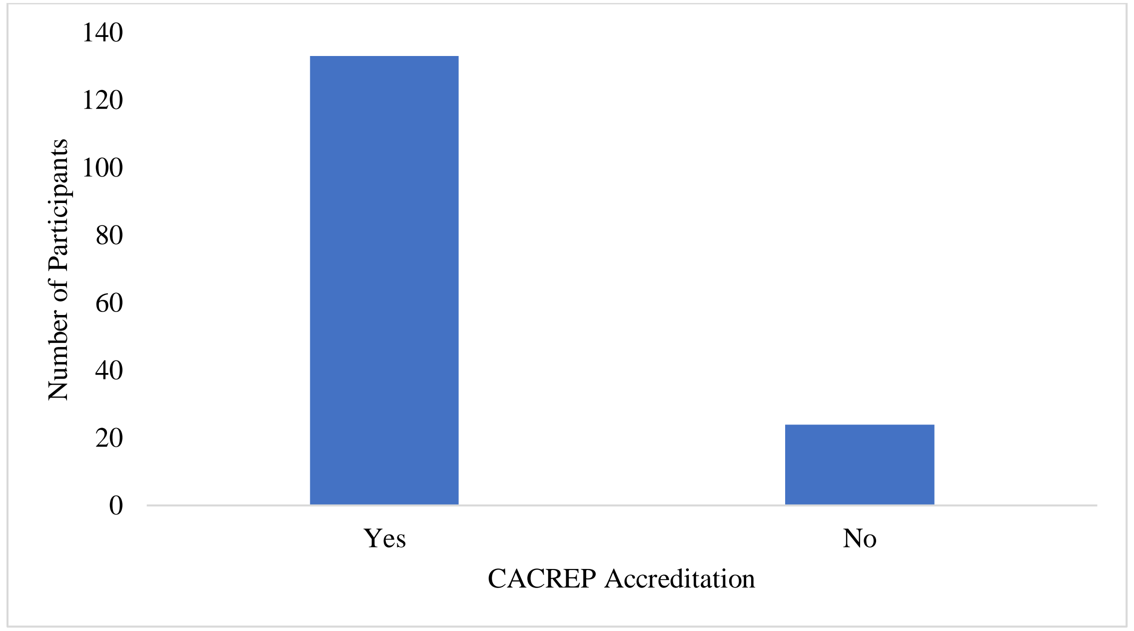
Demographic Data: CACREP Status of Master's Counseling Program

CACREP Accredited	Participants
Yes	84.71% (133)
No	15.29% (24)
Total	100.00% (157)

Note. Table depicting participant self-report of CACREP status of master's level counseling program.

Figure 4.4

Demographic Data: CACREP Status of Master's Counseling Program

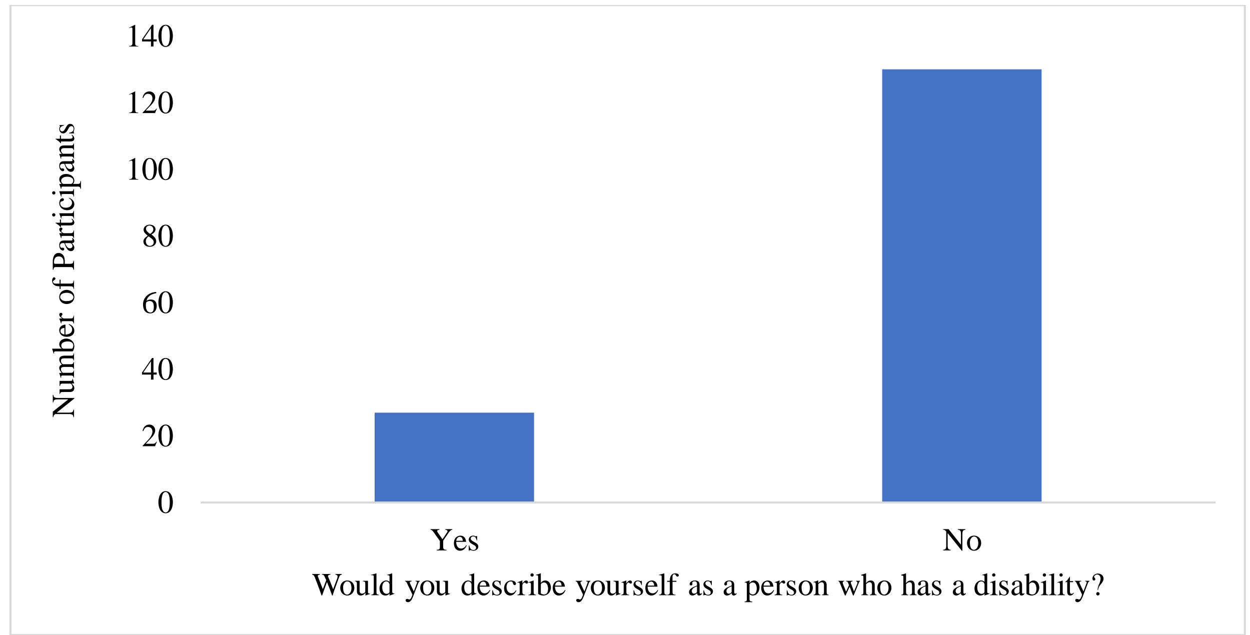


Note. Graph depicting participant self-report of CACREP status of master's level counseling program.

Continuing with demographics, 27 (about 17%) of the participants described themselves as a person with a disability, shown in Figure 4.5.

Figure 4.5

Demographic Data: Disability Status



Note. Graph depicting participant agreement with a statement regarding disability status.

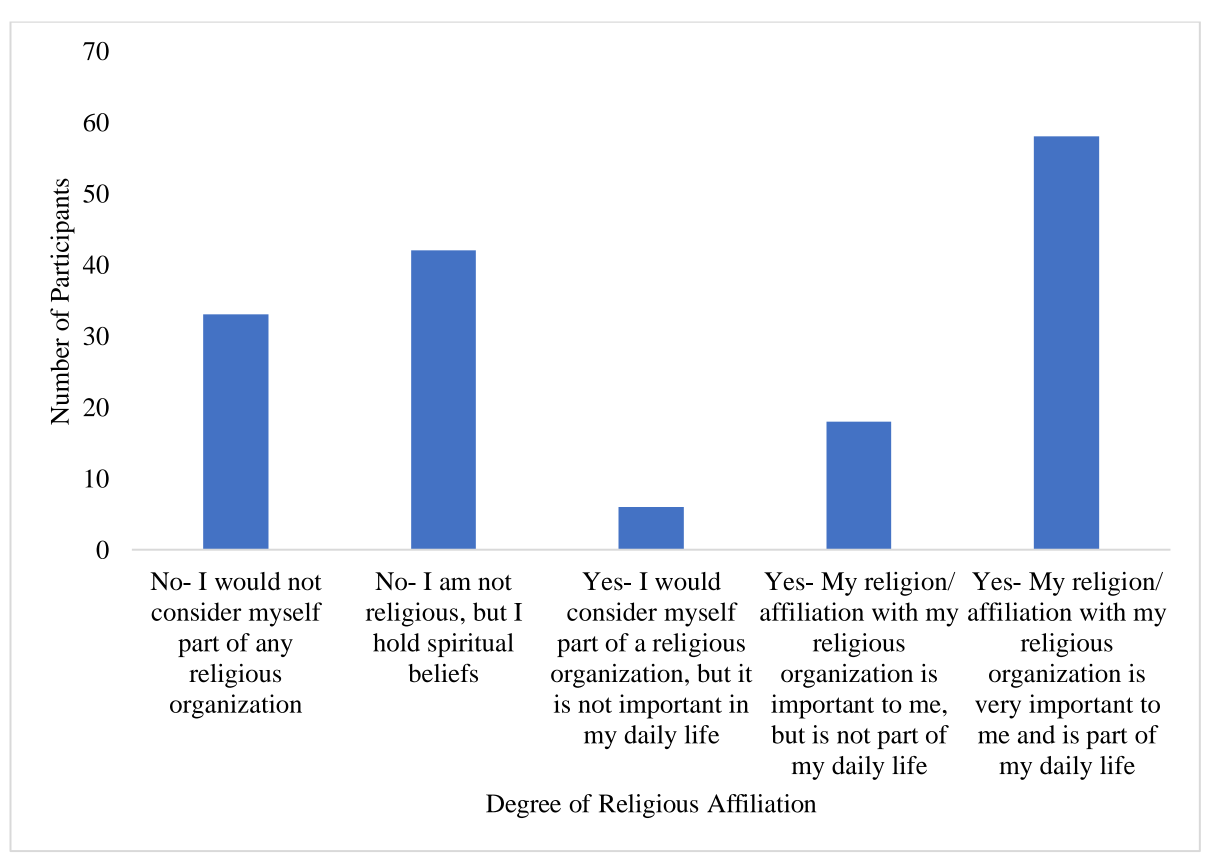
Then, respondents were asked if they strongly affiliated with any particular religion with five separate distinctions listed below respectively:

- No- I would not consider myself part of any religious organization.
- No- I am not religious, but I hold spiritual beliefs.
- Yes- I would consider myself part of a religious organization, but it is not important in my daily life.
- Yes- My religion/ affiliation with my religious organization is important to me but is not part of my daily life.
- Yes- My religion/ affiliation with my religious organization is very important to me and is part of my daily life.

More people self-identified as being affiliated with a religious organization that is very important to them and part of their daily life, displayed in Figure 4.6. Of the participants who responded, the least amount were a part of a religious organization but it was not part of their daily life. From Table 5, 21% of respondents indicated that they were not part of any religious organization. Overall, it appears that counselors who took the survey hold a wide variety of religious beliefs with the most responses on opposite sides of the scale.

Figure 4.6

Demographic Data: Religious Affiliation



Note. Graph depicting participant degree of religious affiliation.

Table 5

Demographic Data: Religious Affiliation

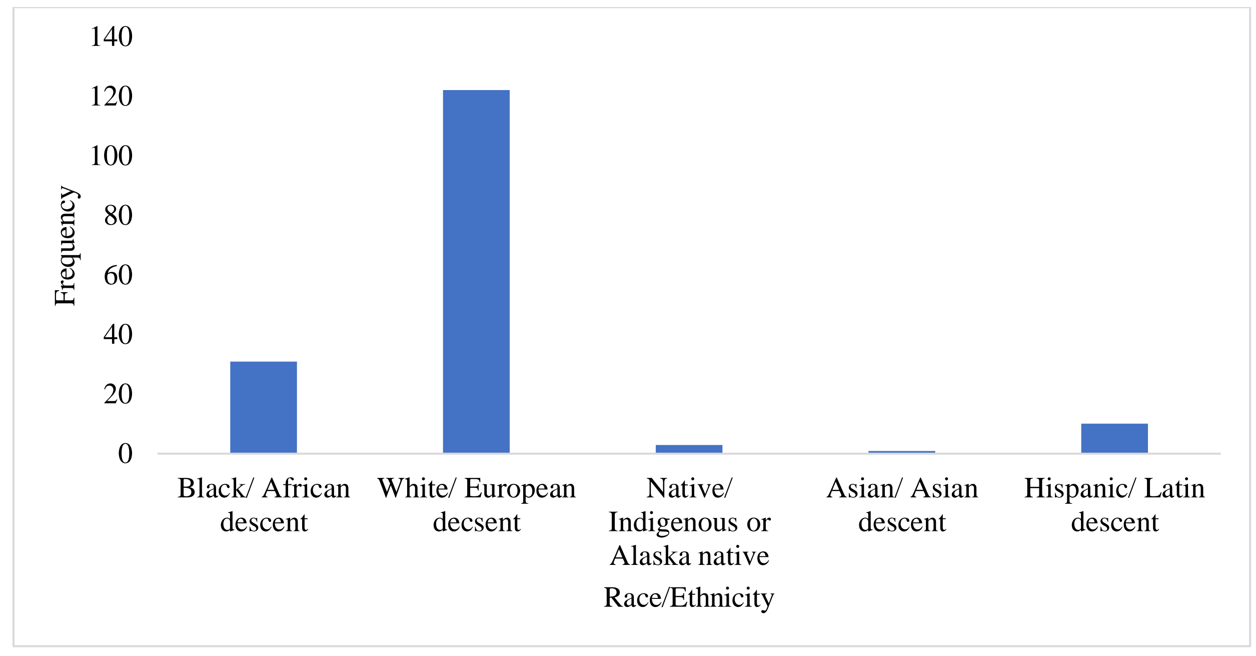
Religious Affiliation	Participants
No- I would not consider myself part of any religious organization	21.02% (33)
No- I am not religious, but I hold spiritual beliefs	26.75 % (42)
Yes- I would consider myself part of a religious organization, but it is not important in my daily life	3.82% (6)
Yes- My religion/ affiliation with my religious organization is important to me, but is not part of my daily life	11.46% (18)
Yes- My religion/ affiliation with my religious organization is very important to me and is part of my daily life	36.94% (58)
Total	100.00% (157)

Note. Table depicting participant degree of religious affiliation.

Next, respondents indicated any racial/ethnic groups they identified with. Below in Figure 4.7, shown is that the majority of respondents were White/European descent. The least number of respondents were Asian/Asian descent. A table below (Table 6) shows the exact numbers and percentages. While Black/African descent is the next largest number of respondents at 31 (18.6%), the overwhelming majority of respondents were White/European descent (73.1%) respondents. There were three Native/ Indigenous or Alaska native respondents and 10 Hispanic/ Latin descent respondents. As the question stated to "mark all that apply" respondents may be a combination of presented racial/ ethnic groups as well.

Figure 4.7

Demographic Data: Racial/ Ethnic Identity of Participants



Note. Graph depicting participant racial/ethnic background.

Table 6

Demographic Data: Racial/ Ethnic Identity of Participants

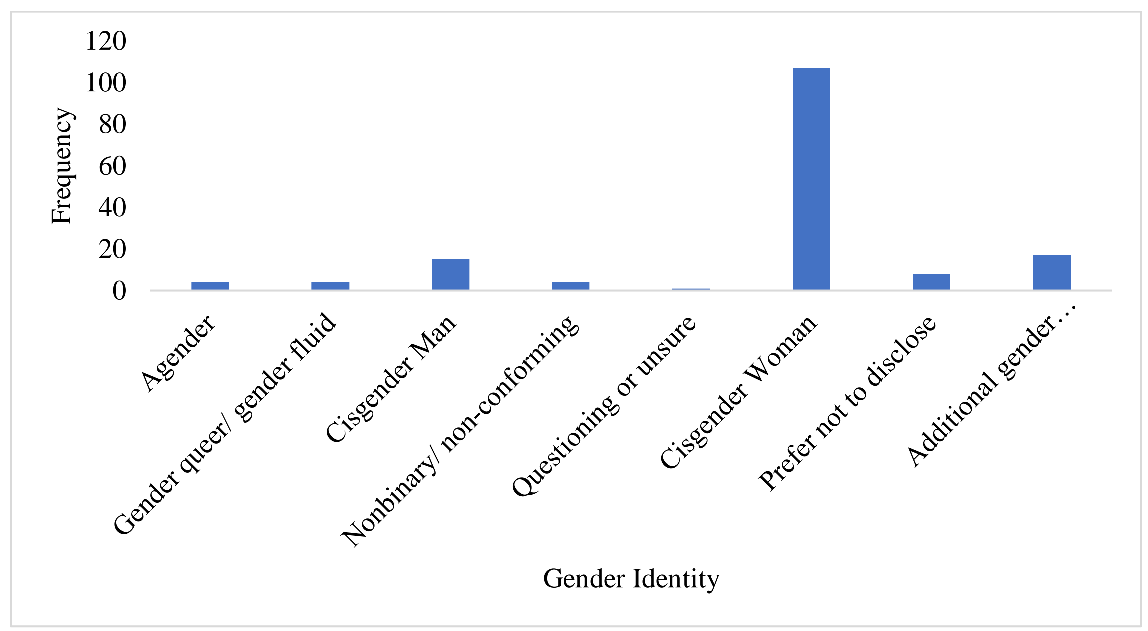
Race	Frequency
Black/ African descent	18.56% (31)
White/ European descent	73.05% (122)
Native/ Indigenous or Alaska native	1.80% (3)
Asian/ Asian descent	0.60% (1)
Hispanic/ Latin descent	5.99% (10)
Total	100.00% (167)

Note. Table depicting participant racial/ethnic background.

Next respondents indicated any gender identities they identified with. The majority of respondents were cisgender women as shown in Figure 4.8. Table 7 notes that it is 66.9% of respondents. Agender, gender queer/gender fluid and non-binary/non-conforming were 2.5% of responses each. While 10.6% of the responses marked a gender category not listed, it is important to note that all left notes that looked the same as cisgender woman ("woman" or "female") or cisgender man ("male") and one left a note showing unfamiliarity with the terms specifiying ("I don't know these categories. I'm an old lady."). For integrity purposes, such responses were left in case the respondents indeed felt that the gender was not covered and did not identify with the cisgender term. As such, it is important to note that 10.6% may be an overrepresented figure. Additionally, as the question stated to "mark all that apply", again respondents may have noted any combination of the genders listed as well as noted in the 160 responses even though there are only 157 respondents counted.

Figure 4.8

Demographic Data: Gender Identity of Participants



Note. Graph depicting participant gender.

Table 7

Demographic Data: Gender Identity of Participants

Gender Identity	Frequency
Agender	2.50% (4)
Gender queer/ gender fluid	2.50% (4)
Cisgender Man	9.38% (15)
Nonbinary/ non-conforming	2.50% (4)
Questioning or unsure	0.63% (1)
Cisgender Woman	66.88% (107)
Prefer not to disclose	5.00% (8)
Additional gender category/identity not listed (please specify below)	10.63% (17)
Total	100.00% (160)

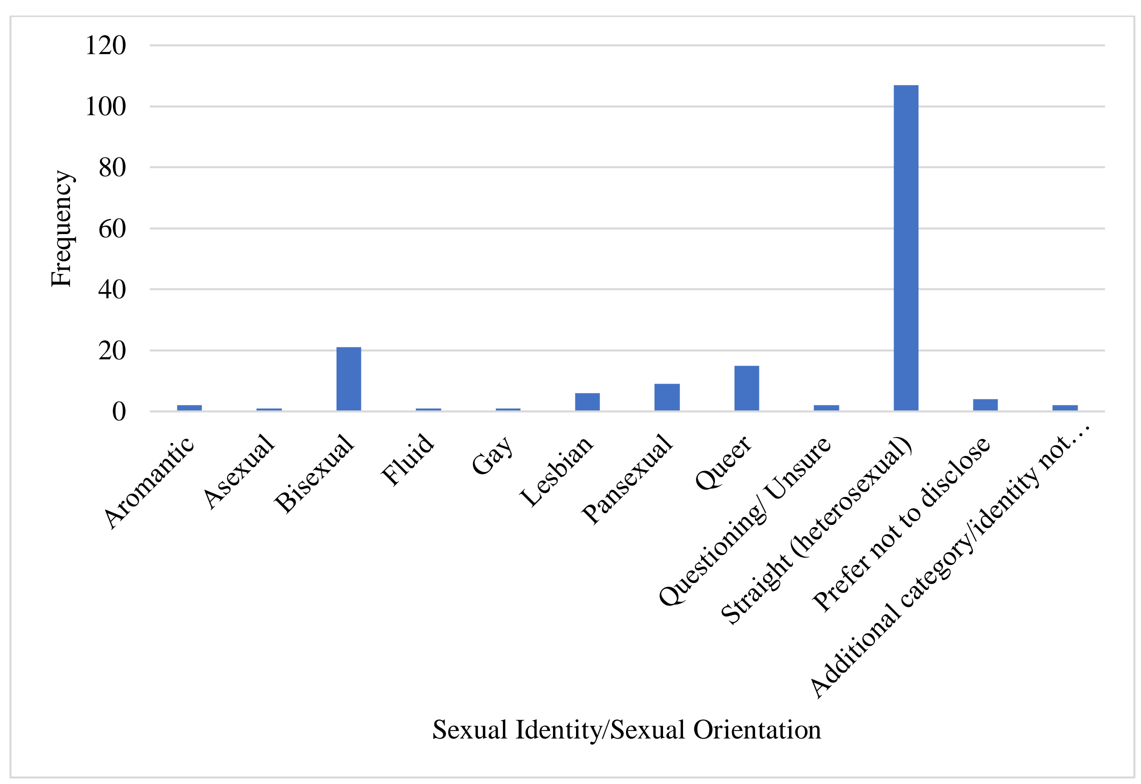
Note. Table depicting participant gender.

Regarding sexual orientation, most respondents reported that they were heterosexual, as seen in Figure 4.9. Table 8 clarifies that it is roughly 63% of respondents. Bisexual is the next highest, though only about 12%, compared to the previous. Queer was the next highest sexual orientation noted by respondents at about 9% or 15 respondents. Lesbian and pansexual were similar at six and nine respondents respectively accounting for about 9% of responses. Two respondents each marked aromantic or questioning/unsure. About 2% of respondents chose not to disclose. Respondents who identified as asexual, fluid or gay were one respondent each counting for almost 2% of the data in total. Additional categories not specified include "sapiosexual".

Important to note that one response of the two for additional categories looked similar to heterosexual, but for the sake of integrity with the respondent's selection it was left in the "additional" category. As such, there may be some overrepresentation for that category as well. Also, important to note that again, here, respondents were able to mark all or any that applied which resulted in potential combinations of sexual orientation raising the total amount of responses to 171 for the 157 participants. Even still, overall, so far, respondents seem to be mostly heterosexual White/European descent cisgendered women who either hold strong religious values that are part of their daily lives or who hold some variation of no religious values at all.

Figure 4.9

Demographic Data: Sexual Identity/ Orientation of Participants



Note. Graph depicting sexual identity/ orientation of participants.

Table 8

Demographic Data: Sexual Identity/ Orientation of Participants

Sexual Identity/ Sexual Orientation	Frequency
Aromantic	1.17% (2)
Asexual	0.58% (1)
Bisexual	12.28% (21)
Fluid	0.58% (1)
Gay	0.58% (1)
Lesbian	3.51% (6)
Pansexual	5.26% (9)
Queer	8.77% (15)
Questioning/ Unsure	1.17% (2)
Straight (heterosexual)	62.57% (107)
Prefer not to disclose	2.34% (4)
Additional category/identity not listed (please specify below)	1.17% (2)
Total	100.00% (171)

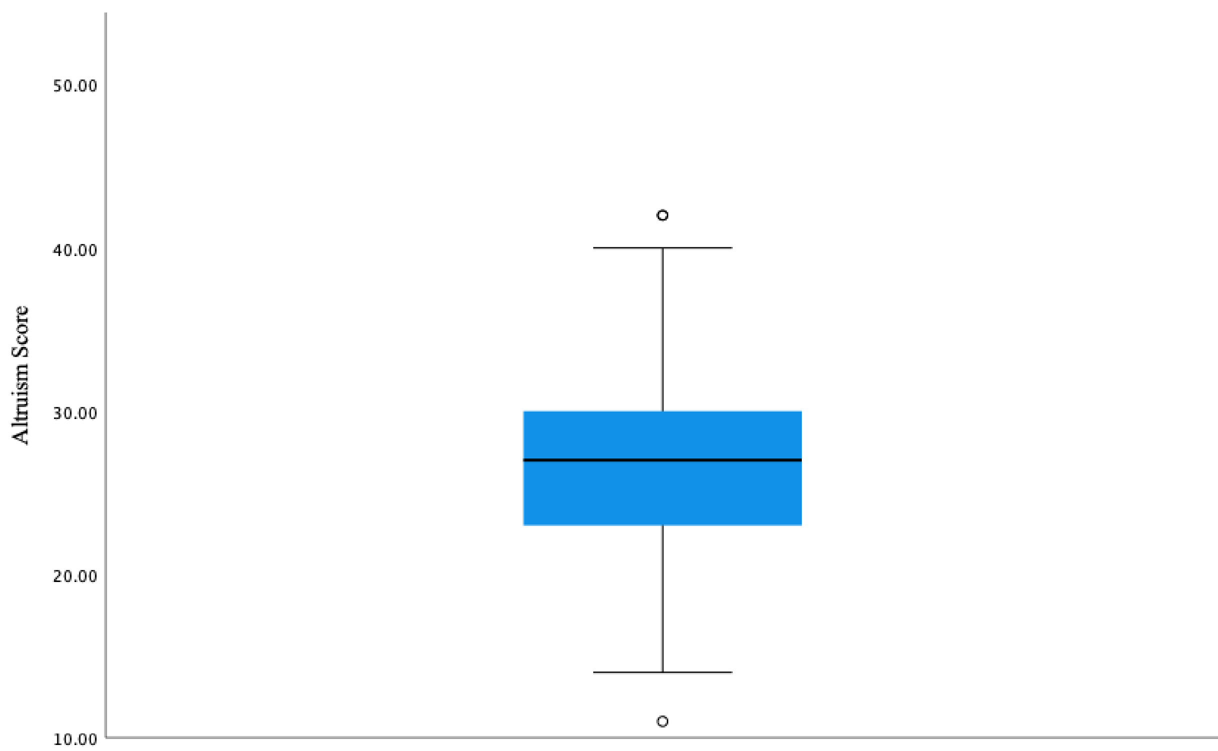
Note. Table depicting sexual identity/ orientation of participants.

Following demographic data, the participants took the Self Report Altruism Scale (Manzur & Olavarrieta, 2021), a brief altruism scale consisting of nine items and five Likert scale response options per item. The lowest response scale is one and the highest is five, meaning that the lowest possible score is 9 and the highest is 45. Below is Figure 4.10 depicting the range of scores gathered from respondents. As previously mentioned, all demographic information

above is true of altruism score results as those who did not at least complete the altruism score were removed from analysis.

Figure 4.10

Boxplot of Altruism Scores of Participants

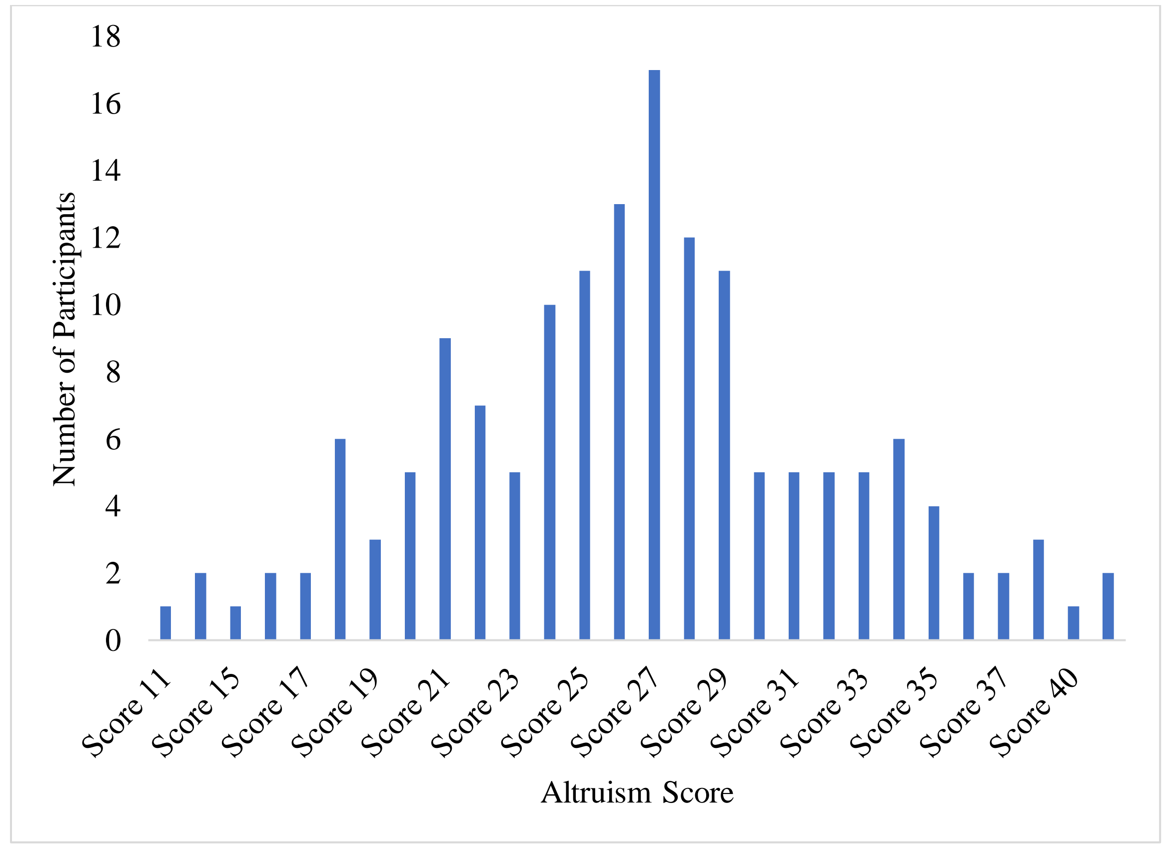


Note. Boxplot depicting participant scores on altruism scale.

From Figure 4.11 the lowest score is 14 with an outlier at 11. The highest score is 40 with an outlier just above at 42. Using Figure 4.10 and Table 9 below, the median altruism score is 27 with an average just below of roughly 26.5 out of a possible 45. A score of roughly 18 would indicate a 50% altruism score. As counselors who took the survey score at an average of 26.5, they are well above average when it comes to altruism. The data is roughly symmetric, however when keeping in mind that mid-levels of altruism is an 18 on the scale, most participants (143 out of 157) scored above average in altruism.

Figure 4.11

Participant Altruism Scores



Note. Graph depicting participant altruism scores.

Table 9

Altruism Scores of Participants

Central Tendency, Variation and Shape	
Mean	26.55
Median	27.00
Mode	27.00
Std. Deviation	5.76
Variance	33.19
Skewness	0.13
Std. Error of Skewness	0.129
Kurtosis	0.11
Std. Error of Kurtosis	0.39
Range	31.00
Minimum	11.00
Maximum	42.00
Percentiles	
25	23.00
50	27.00
75	30.00

Note. Table depicting central tendency, variation, and shape of participant scores on altruism scale.

Demographics of Participants Who Took Implicit Bias Measure

Initial plans to analyze data from the proposal of the current study were to have all participants complete all portions of the survey. However, only 61 of the 157 participants completed the full study including the IAT. Demographics of those who completed the IAT are discussed below.

Most participants who completed the IAT were between ages 18-60. Table 10 below displays how many participants were in each age group. Most participants who completed the IAT were also fully licensed on provisionally licensed. Table 11 shows that almost half (45.71%) of those who took the IAT were fully licensed. For the roles with the least number of participants who took the IAT, Table 11 shows that 1.43% of the those who took the IAT were counselor educators.

Table 10

Demographic Data: Age of Participants Who Took the IAT

Age	Participants
18-30	27.87% (17)
31-45	96.72% (29)
46-60	18.03% (11)
61-70	6.56% (4)
Total	100.00% (61)

Note. Table depicting the ages of only the participants who took the implicit bias measure.

Table 11

Demographic Data: Roles of Participants Who Took the IAT

Role	Frequency
Counselor in training	12.86% (9)
Fully licensed	27.14% (19)
Provisionally licensed	45.71% (32)
Counselor educator	1.43% (1)
Counseling supervisor	12.86% (9)
Total	100.00% (70)

Note. Table depicting the roles of only the participants who took the implicit bias measure.

When answering "I have the ability to work with clients of diverse backgrounds effectively", respondents who took the IAT mostly moderately agreed with the statement on a 1-5 Likert scale, while just two strongly disagreed. Specific amounts for each category are below in Table 12. In this group, there were no participants that "somewhat disagreed" or "neither agreed or disagreed".

Table 12

Demographic Data: Response to "I have ability to work with clients of diverse backgrounds effectively." of Participants Who Took the IAT

Level of Agreement	Participants
1- Strongly disagree	3.28% (2)
4- Moderately agree	57.38% (35)
5- Strongly agree	39.34% (24)
Total	100.00% (61)

Note. Table depicting the ability to work with diverse cultures of only the participants who took the implicit bias measure.

In the group of participants who took the IAT, most participants reported that their master's program was CACREP accredited at 54 of the 61. This can be seen in Table 13 below.

Table 13

Demographic Data: CACREP Status of Master's Counseling Program of Participants Who Took the IAT

CACREP Status	Number of Participants
CACREP accredited	88.52% (54)
Not CACREP accredited	11.48% (7)
Total	100.00% (61)

Note. Table depicting the ability to work with diverse cultures of only the participants who took the implicit bias measure.

Participants who took the IAT also reported that largely they did not have a disability (81.97%) when responding to the question "Would you describe yourself as a person who has a disability?". A full calculation can be found below in Table 14.

Table 14

Demographic Data: Disability Status of Participants Who Took the IAT

Disability Status	Participants
Yes	18.03% (11)
No	81.97% (50)
Total	100.00% (61)

Note. Table depicting the disability status of only the participants who took the implicit bias measure.

Regarding race, most participants were White/ European descent (48 participants) while very few (1 for each) were Native/ Indigenous or Alaska native and Asian/ Asian descent. Respondents were instructed to check all that apply. A full table of each race selected, Table 15, is found below.

Table 15

Demographic Data: Racial/ Ethnic Identity of Participants Who Took the IAT

Race/Ethnicity	Frequency
Black/ African descent	18.18% (12)
White/ European descent	72.73% (48)
Native/ Indigenous or Alaska native	1.52% (1)
Asian/ Asian descent	1.52% (1)
Hispanic/ Latin descent	6.06% (4)
Total	100.00% (66)

Note. Table depicting the racial/ethnic background of only the participants who took the implicit bias measure.

For gender, respondents were directed to select all that apply. Participants who took the IAT were largely cisgender women (43 selections). The lowest number of respondents regarding gender were the agender category (2 selections) and the non-binary/ nonconforming (2 selections). A Table of the gender selections by those who took the IAT are below in Table 16 As above, additional genders looked similar to the one provided but in the interest of keeping the integrity of respondent information, original respondent data was kept. Additional genders

respondents felt were not covered included “woman” (2 selections) and “female” (2 selections). Sexual orientation demographic data can also be found in Table 17 below. Here as well, respondents were able to select all that applied. Most respondents reported that they were heterosexual. Asexual, lesbian, questioning/ unsure, prefer not to disclose and additional category not listed were selected the least, at one selection for each.

Table 16

Demographic Data: Gender Identity of Participants Who Took the IAT

Gender Identity	Frequency
Agender	3.22% (2)
Gender queer/ fluid	4.84% (3)
Cisgender man	12.90% (8)
Nonbinary/ non-conforming	3.22% (2)
Cisgender woman	69.34% (43)
Additional gender not listed	6.45% (4)
Total	100.00% (62)

Note. Table depicting the gender identities of only the participants who took the implicit bias measure.

Table 17

Demographic Data: Sexual Identity/ Orientation of Participants Who Took the IAT

Sexual Identity/ Orientation	Frequency
Asexual	1.56% (1)
Bisexual	18.75% (12)
Lesbian	1.56% (1)
Pansexual	4.69% (3)
Queer	12.50% (8)
Questioning/ Unsure	1.56% (1)
Straight (heterosexual)	56.25% (36)
Prefer not to disclose	1.56% (1)
Additional category/ identity not listed	1.56% (1)
Total	100.00% (64)

Note. Table depicting the sexual identities of only the participants who took the implicit bias measure.

Altruism Scores

Respondents then took the brief altruism measure. The altruism measure is scored on a scale of 9 to 45. The test consists of nine items. Respondents answer on a Likert type scale how often they engage in a certain altruistic activity (1= “never” to 5= “always”). If a respondent answered “never” to all nine items, they would receive a score of nine and if a respondent answered “always” to all of the items they would receive a score of 45. A score of 18 would indicate that a person engages in altruism 50% of the time. Participants who took the IAT however, on average scored approximately 26.28 on the altruism score indicating that they

engage in altruistic acts about 73% of the time. Median scores were roughly similar at 26. The mode was 25. Below in Table 17, displayed is the central tendency and spread of altruism scores for participants who took the implicit bias measure. Of those who took the implicit bias test, average altruism scores were roughly 26.28. Figure 4.12 also displays the spread of scores. There is quite a bit of range with the lowest score being 14 and the highest being 42.

Table 18

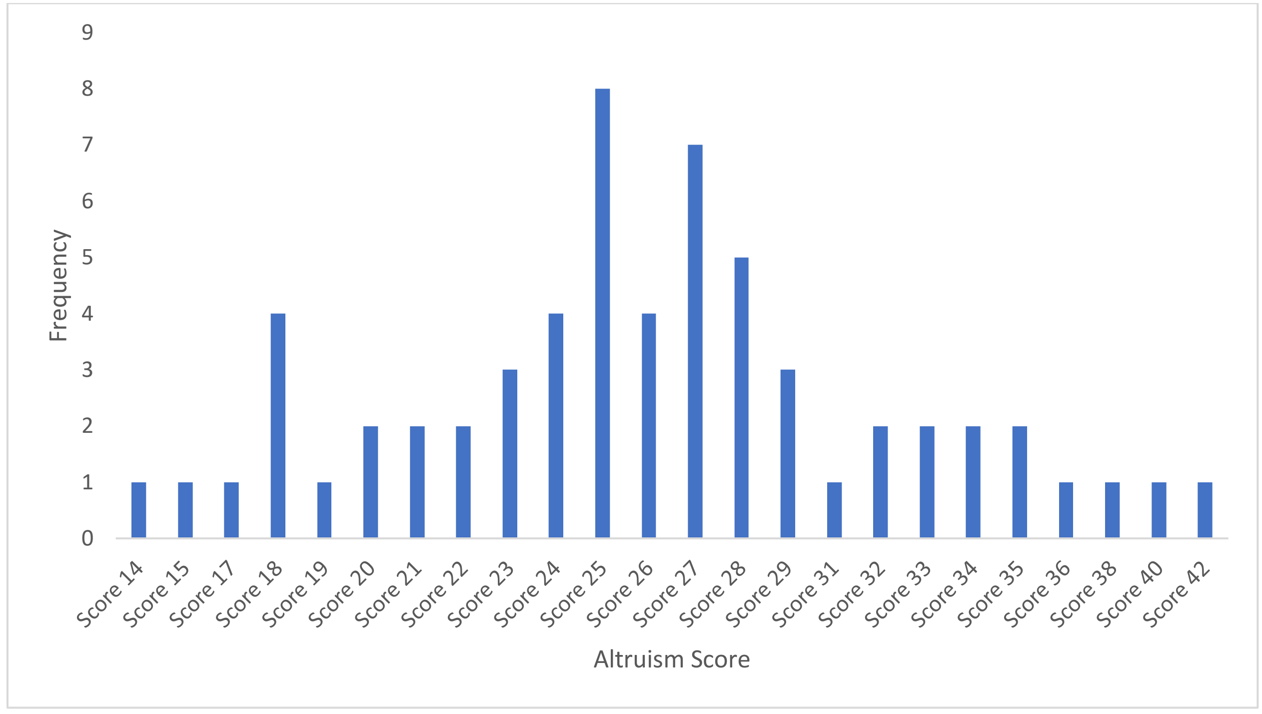
Altruism Scores of Participants Who Took the IAT

Central Tendency, Variation and Range	
Mean	26.28
Median	26.00
Mode	25.00
Std. Deviation	5.89
Variance	34.77
Range	28.00
Minimum	14.00
Maximum	42.00

Note. Table depicting the altruism scores of only the participants who took the implicit bias measure.

Figure 4.12

Altruism Scores of Participants Who Took the IAT



Note. Graph depicting the altruism scores of only the participants who took the implicit bias measure.

IAT Scores

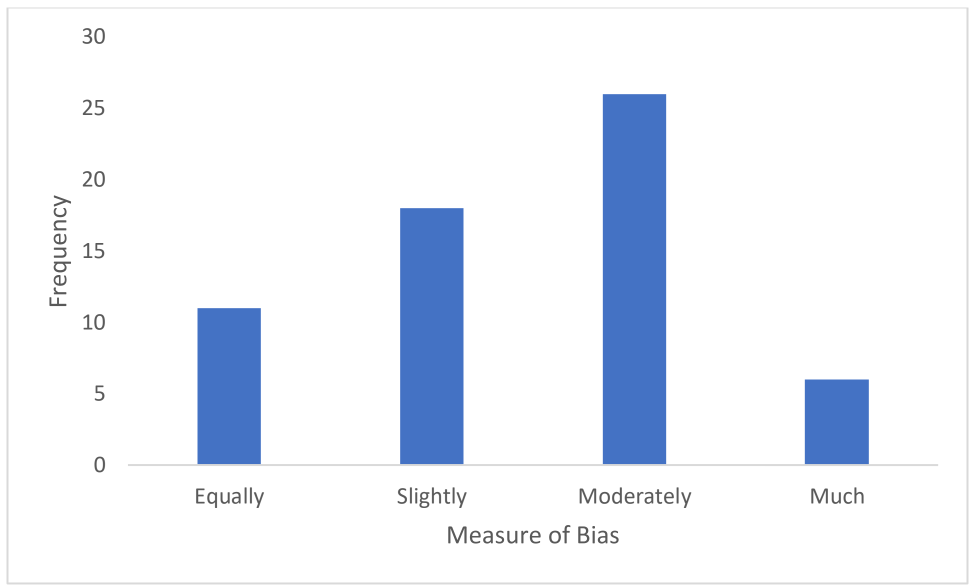
Finally, participants took the IAT. Initially, responses were coded for the measure of bias. IAT results give a measure of "slightly" "moderately", "much" or equally" in describing sorting of Black or White faces with "good" or "bad". Participants data was first analyzed by the "slightly", "moderately", "much" or equally" categories. That is, regardless of racial presence, analyzed was the level of preference or measure of bias. Additionally, the term unconscious preference is used interchangeably with implicit bias throughout analysis.

Below in Figure 4.13, shown is that most respondents had results indicating a moderate unconscious preference toward a particular racial group. From Table 19, eleven (7%) of the 61

respondents held equal preference. In the "slightly" preference, 18 (11.5%) of the participants scored. Very few held the highest implicit preference "much". From Table 18, seen is that out of the 61 responses only six (3.8%) scored "much" on the scale.

Figure 4.13

Measure of Implicit Bias



Note. Graph depicting participant measure of implicit bias.

Table 19

Measure of Implicit Bias

Measure	Participants
Equally	18.03% (11)
Slightly	29.51% (18)
Moderately	42.62% (26)
Much	9.84% (6)
Total	100.00% (61)

Note. Table depicting participant measure of implicit bias.

Preference categories were given a numerical score for statistical purposes. ("Equally" =0, "Slightly" =1, "Moderately" =2, "Much" =3). From the table below (Table 20) a mean score of approximately 1.44 indicates that on average respondents were in between slight and moderate implicit preference for implicit bias scores. Again, most respondents scored "moderately" on the implicit bias measure.

Table 20

Central Tendency of Measure of Implicit Bias

Central Tendency	
Mean	1.44
Median	2.00
Mode	2.00

Note. Table depicting central tendency of measure of implicit bias scores.

After gathering measure of preference, self-report data from the implicit bias measure was then coded for the full result adding the race of preference (called "kind of bias" in the current study). Gathered were seven different types of preference noted by the respondents. The IAT gives seven different combinations of the measures above with the race and the designation of matching them with "Good" resulting in a statement like the following "Slightly faster at sorting "Black" with "Good"". Corresponding numerical codes for statistical purposes were given noted below:

- 0 = Equally fast at sorting "White" and "Black" with "Good"
- 1= Slightly faster at sorting "Black" with "Good"
- 2= Moderately faster at sorting "Black" with "Good"
- 3= Much faster at sorting "Black" with "Good"

- 4= Slightly faster at sorting "White" with "Good"
- 5= Moderately faster at sorting "White" with "Good"
- 6= Much faster at sorting "White" with "Good"

Table 21 below shows that most respondents (20) were moderately faster at sorting “White” with “Good”. The same number of participants (11) were slightly faster at sorting "White" with "Good" as were equally fast at sorting "White" and "Black" with "Good". Figure 4.14 below helps show the relationships between kinds of implicit preferences among the respondents. More respondents (about twice as much) had an implicit preference toward White (33) than an implicit preference toward Black (17).

Table 21

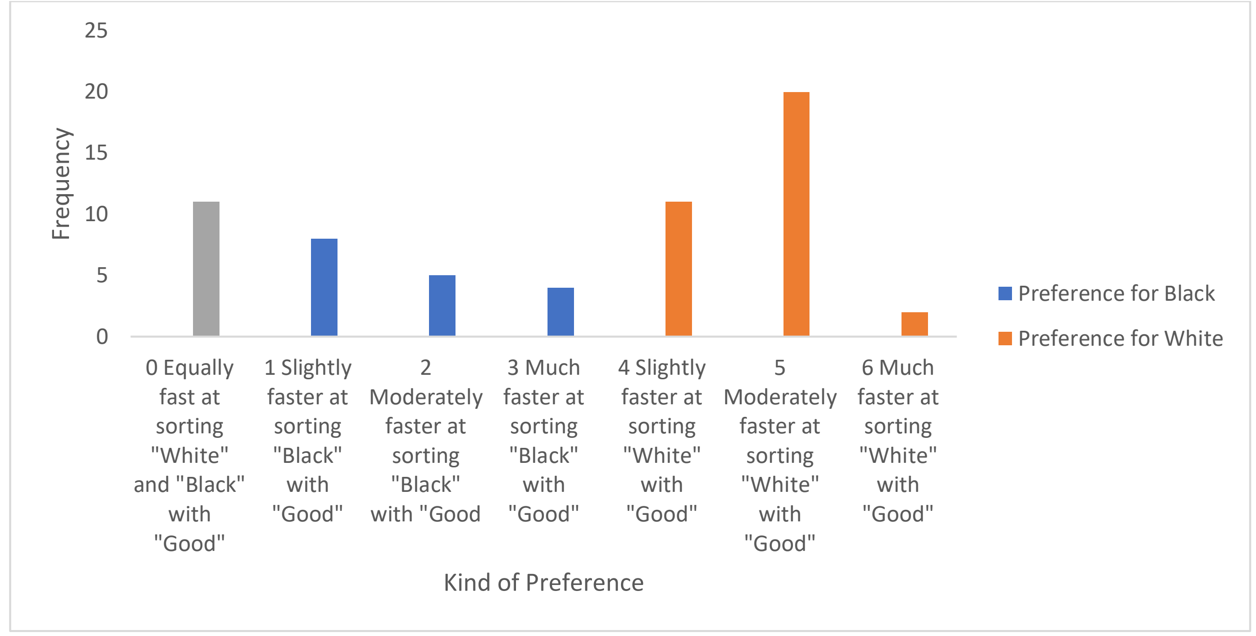
Participant Kind of Implicit Bias

Kind of Bias	Participants
.00	18.03% (11)
1.00	13.11% (8)
2.00	8.20% (5)
3.00	6.56% (4)
4.00	18.03% (11)
5.00	32.79% (20)
6.00	3.28% (2)
Total	100.00% (61)

Note. Table depicting participant kind of implicit bias coding the full score measure and preference.

Figure 4.14

Kind of Implicit Bias



Note. Graph depicting participant kind of implicit bias coding the full score measure and preference.

Analysis of Research Questions

Research question one. The first research question relates to determining if a relationship exists between implicit bias scores and altruism scores. As data was treated as nonnormal, nonparametric tests were used. For all tests, an alpha level of .05 was used for significance. Additionally, as previously stated, implicit bias results were coded for measure of bias ("equally", "slightly", "moderately" or much") from zero to three respectively and kind of bias that included the previous measure with an addition toward White or Black category from zero to six found in Table 22 below.

Table 22

Implicit Bias Coding Key

Measure of Bias	0= Equally fast at sorting "White" and "Black" with "Good" 1= Slightly 2= Moderately faster 3= Much faster
Kind of Bias	0= Equally fast at sorting "White" and "Black" with "Good" 1= Slightly faster at sorting "Black" with "Good" 2= Moderately faster at sorting "Black" with "Good" 3= Much faster at sorting "Black" with "Good" 4= Slightly faster at sorting "White" with "Good" 5= Moderately faster at sorting "White" with "Good" 6= Much faster at sorting "White" with "Good"

Note. Table includes statistical codes used to analyze implicit bias results.

First, Kendall's Tau C was run to assess correlation between the measure of bias ("equally", "slightly", "moderately", or "much") with altruism scores. The results indicated that there is a slight positive correlation between the measure of bias and altruism scores (r (61) =0.23, p=0.04). The output table from SPSS can be found in Figure 4.15 below. Additionally, a scatterplot below in Figure 4.16 displays this relationship. The y-axis begins and ends at the lowest and highest possible altruism score. The same is true for the measure of bias. Below, the graph depicts a slight increase in altruism scores as the measure of bias also increases. As participants move from an equal preference to a "much" preference, altruism scores also increase.

Figure 4.15

Kendall's Tau C Significance Test: Altruism Scores and Measure of Implicit Bias

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Ordinal by Ordinal	Kendall's tau-c	.234	.111	2.107	.035
N of Valid Cases		61			

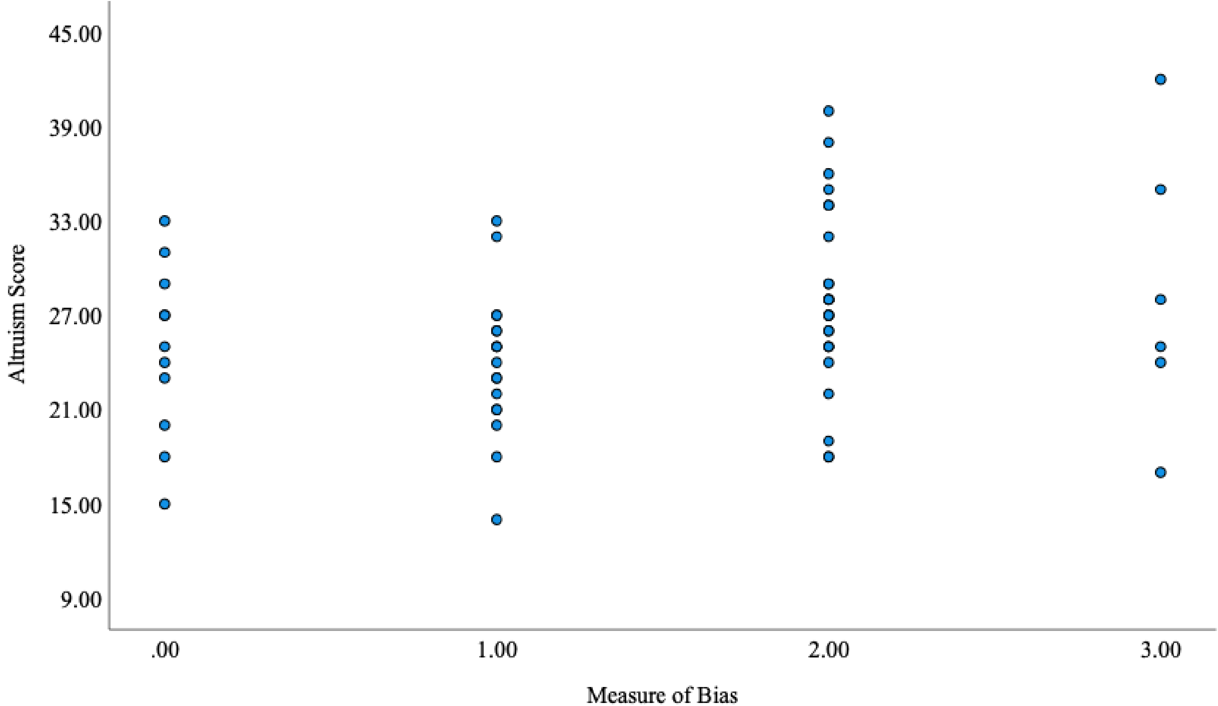
a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Note. SPSS output for significance between altruism scores and measure of implicit bias.

Figure 4.16

Scatter Plot: Altruism Scores and Measure of Implicit Bias



Note. Scatterplot of altruism scores and measure of implicit bias.

Next, Fisher's exact test was run to assess correlation between the kind of bias ("equally", "slightly", "moderately", or "much" with race the preference was toward) with

altruism scores. The results indicated that there is not a statistically significant relationship between kind of bias and altruism scores (two-tailed p=0.31).

Research question two. The second research question was to determine relationships between implicit bias scores and demographic information. Analysis will be in the order it was presented to respondents in the survey beginning with age. Again, all data was treated as non-normal, so nonparametric tests will be used to explore correlation. An alpha level of .05 for statistical significance was used for all tests as well.

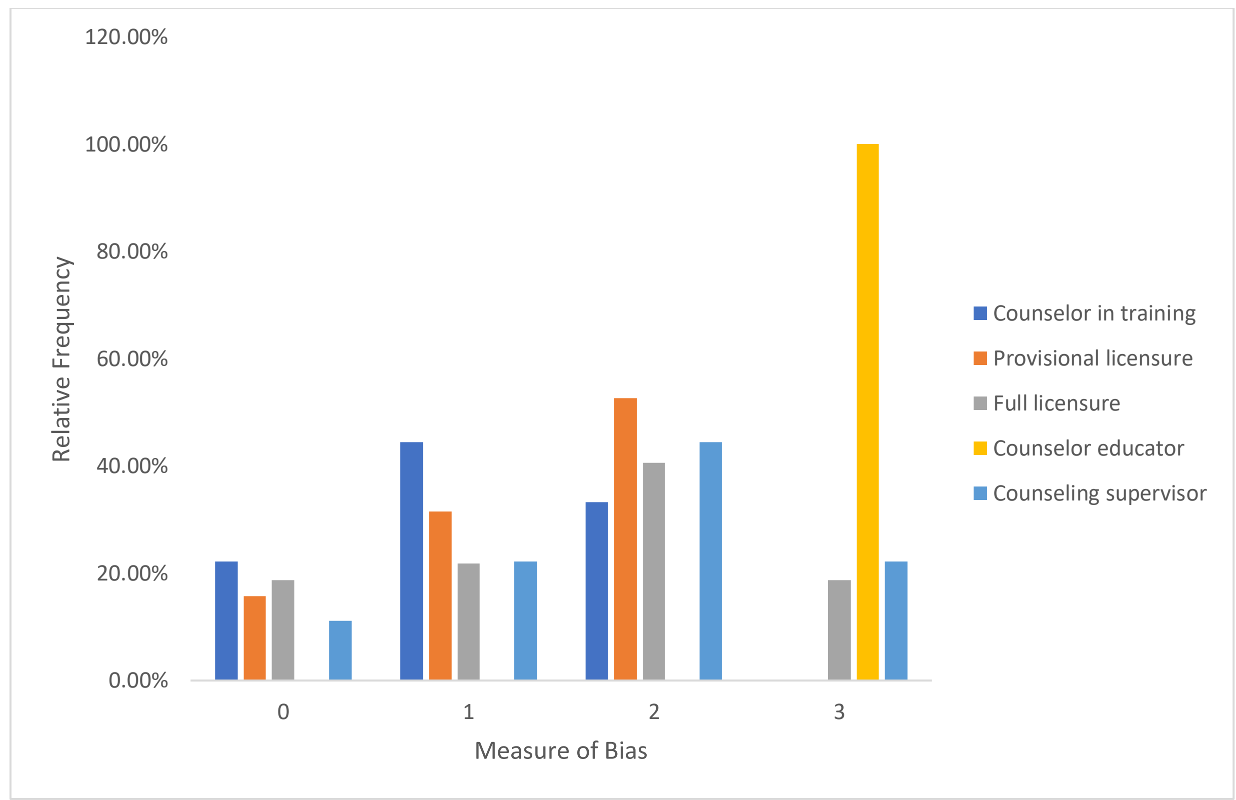
Age in the study is ordinal and measure of bias is ordinal as well making Kendall's Tau C most appropriate. Kendall's Tau C indicates that there is not a statistically significant relationship between measure of bias and age (r (61) =0.12, p= 0.22). Regarding kind of bias and age, Fischer's exact test was used. The Fisher's test indicated that there is not a statistically significant relationship between kind of bias and age (two-tailed p= 0.31).

Roles in the counseling profession were multiple response on the survey. As such, relative frequencies between and within the groups were analyzed for trends (displayed below in Figure 4.17 and Table 23). Regarding relationship between participant roles in the counseling field and measure of implicit bias, Table 23 shows that the greatest number of participants were fully licensed and had a moderate implicit bias (13 of the 61 participants). Fully licensed counselors were also the role that had the highest level of implicit bias at level three (for "much"). As seen in Figure 4.17, the graph shows that most participants who were counselors in training held an implicit bias level of one, indicating a slight implicit bias with none in the last category that indicates the strongest level of implicit bias. Provisionally licensed counselors mostly have a moderate implicit preference with none having a strong implicit preference either. Of the small portion of counselor educators who took the measure, all had a strong implicit bias.

Counselor supervisors have a similar range of unconscious/implicit preferences as provisionally licensed counselors except some counselor supervisors do have a strong implicit bias.

Figure 4.17

Relative Frequency: Measure of Implicit Bias and Role in Counseling Field



Note. Histogram of the relative frequency of measure of implicit bias and roles in the counseling field.

Table 23

Relative Frequency: Measure of Implicit Bias and Role in Counseling Field

Role	Measure of Bias 0	1	2	3	Total
Counselor in training	22.22% (2)	44.44% (4)	33.33%	0.00% (0)	100.00% (9)
Provisional licensure	15.79% (3)	31.58% (6)	52.63%	0.00% (0)	100% (19)
Full licensure	18.75% (6)	21.88% (7)	40.63%	18.75%	100% (32)
Counselor educator	0.00% (0)	0.00% (0)	0.00% (0)	100.00% (1)	100.00% (1)
Counseling supervisor	11.11% (1)	22.22% (2)	44.44% (4)	22.22% (2)	100.00% (9)
Total	18.03% (11)	29.51% (18)	42.62% (26)	9.84% (6)	100.00% (61)

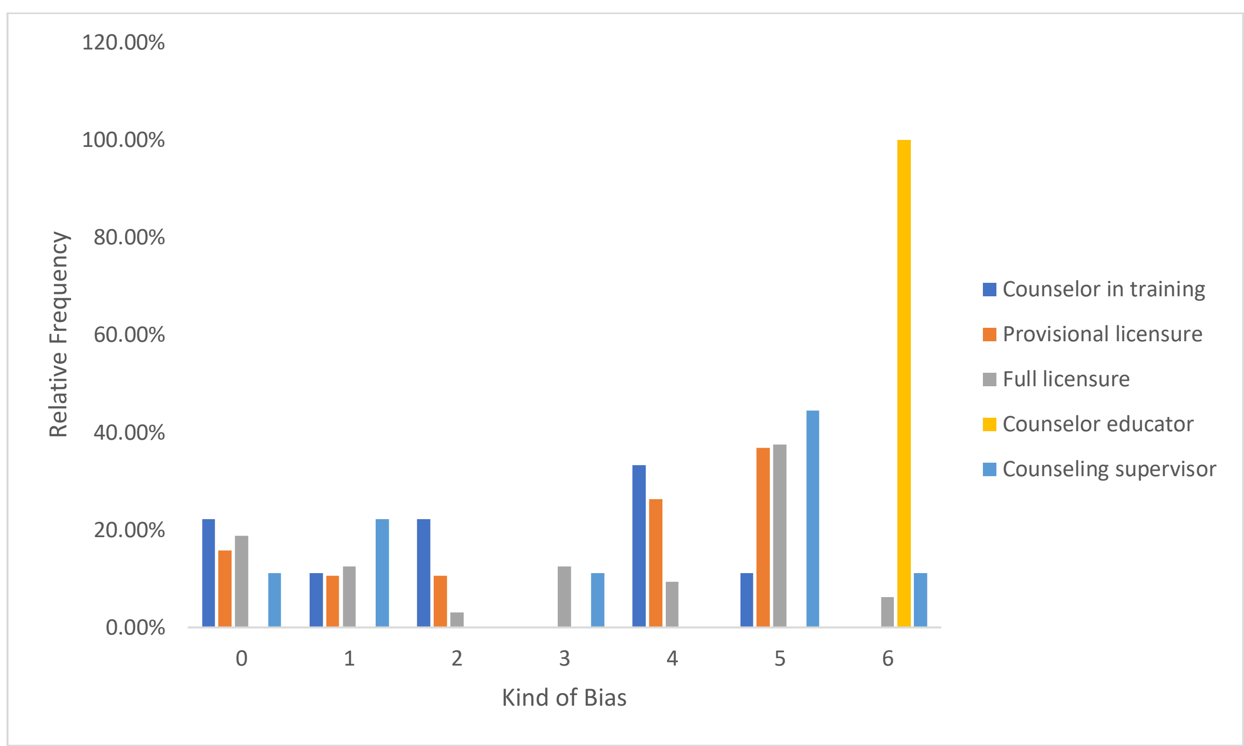
Note. Table of the relative frequencies of measure of implicit bias and roles in the counseling field.

In regard to kind of bias and counselor roles, both Figure 4.18 and Table 24 below display the results. Again, the key in Table 22 displays the meanings of each of the six categories of kind of bias. The graph shows that as counselors move through the counseling profession there is higher implicit preference toward White, with the sixth kind of bias (strong preference toward White) only appearing with fully licensed counselors, counselor educators and counseling supervisors. Of the counselor educators who took the implicit bias measure all have a strong automatic preference toward White. For counselors in training, there is a wide range of implicit bias and preference toward either White or Black. Counselors in training do not have a strong

automatic preference toward either White or Black. Similar is true for provisionally licensed clinicians, though they do have more implicit preference for White than Black. Counseling supervisors are the least neutral (zero kind of bias) but still have more of an automatic preference toward White.

Figure 4.18

Relative Frequency: Kind of Implicit Bias and Role in Counseling Field



Note. Histogram of the relative frequencies of kind of implicit bias and roles in the counseling field.

Table 24

Relative Frequency: Kind of Implicit Bias and Role in Counseling Field

Role	Kind of Bias							Total
	0	1	2	3	4	5	6	
Counselor in training	22.22% (2)	11.11 % (1)	22.22 % (2)	0.00% (0)	33.33% (3)	11.11% (1)	0.00% (0)	100.00 % (9)
Provisional licensure	15.79% (3)	10.53 % (2)	10.53 % (2)	0% (0)	26.32% (5)	36.84% (7)	0.00% (0)	100.00 % (19)
Full licensure	18.75% (6)	12.50 % (4)	3.13% (1)	12.50 % (4)	9.38% (3)	37.50% (12)	6.25% (2)	100.00 % (32)
Counselor educator	0.00% (0)	0%	0.00% (0)	0.00% (0)	0% (0)	0.00% (0)	100.00 % (1)	100.00 % (1)
Counseling supervisor	11.11% (1)	22.22 % (2)	0.00% (0)	11.11 % (1)	0.00% (0)	44.44% (4)	11.11% (1)	100.00 % (9)
Total	18.03% (11)	13.11 % (8)	8.20% (5)	6.56% (4)	18.03% (11)	32.79% (20)	3.28% (2)	100.00 % (61)

Note. Table of the relative frequencies of kind of implicit bias and roles in the counseling field.

For confidence with working with diverse cultures and its relationship with measure of implicit bias, Fisher's test was used. Fisher's test indicated that there is not a statistically significant relationship between confidence with working with diverse cultures and measure of implicit bias scores (two-tailed $p=0.36$). The relationship between working with diverse cultures and its relationship with kind of implicit bias was also not statistically significant using Fisher's exact test (two-tailed $p= 0.47$).

Regarding CACREP status of master's counseling program attended and implicit bias results, there was also not a statistically significant relationship between CACREP status and measure of bias (two tailed $p= 0.2$) or kind of bias (two tailed $p=0.32$).

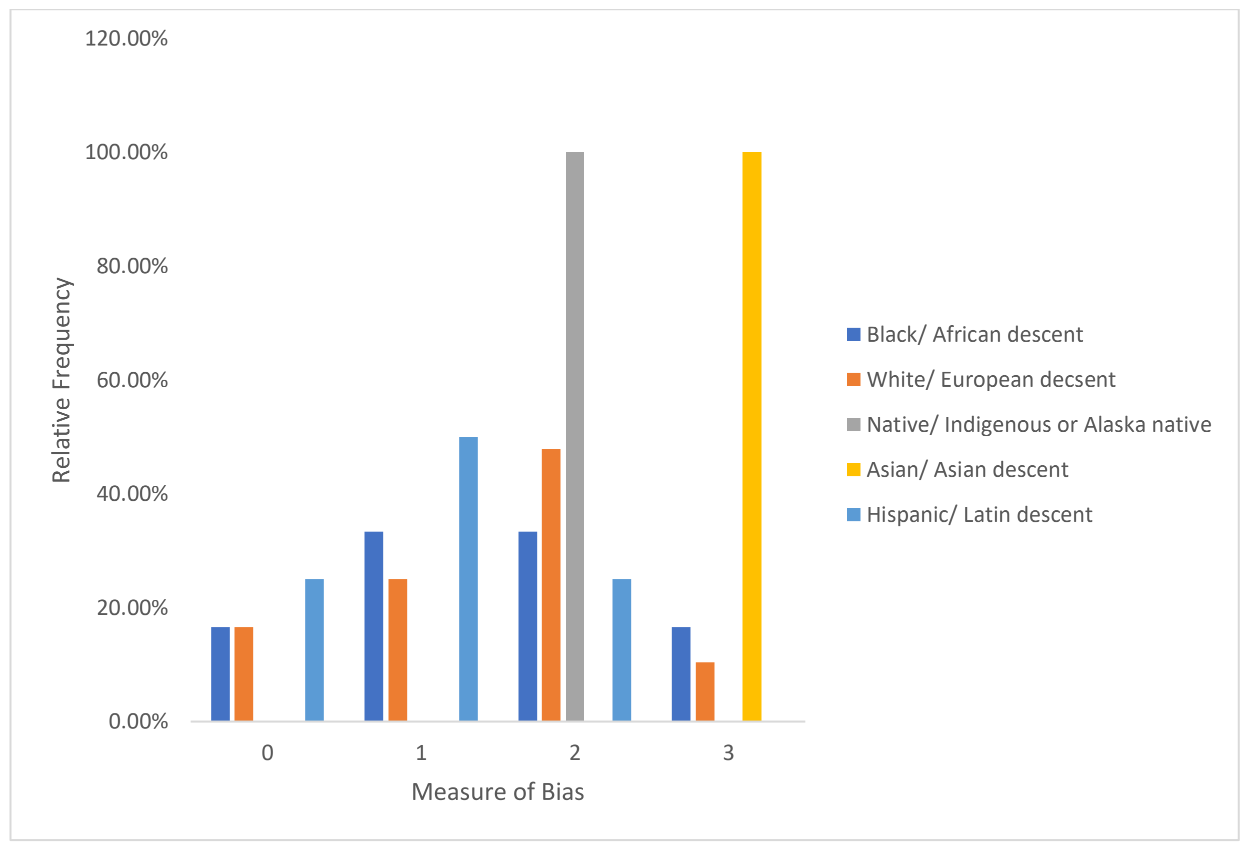
Using Fisher's test, there is also not a statistically significant relationship between disability status and measure of implicit bias (two-tailed $p= 0.13$) or kind of implicit bias (two-tailed $p= 0.15$)

In analyzing potential relationship between religious affiliation and measure of implicit bias, Fisher's test indicated that there is not a statistically significant relationship between measure of bias and religious affiliation (two tailed $p= 0.20$) or kind of bias (two tailed $p= 0.28$)

As race was a multiple response item in the survey, relative frequency was used to compare between groups. Figure 4.19 displays a graph of relative frequencies based on the percentages in Table 25 below. Based on the table and graph, there are some differences between racial/ethnic groups. For participants who are of Black/ African descent, implicit preference increases from neutral to slight in measure of bias and then decreases from moderate to strong. Similar is true for participants of White/ European descent, though there is a sharper decrease between moderate and strong unconscious preference. Generally, regarding measure of bias, most racial/ethnic groups follow a bell shaped curve. With exception, Native/ Indigenous or Alaska native participants only have moderate implicit bias and Asian/ Asian decent participants only have strong implicit bias. Analysis of kind of bias may give more insight.

Figure 4.19

Relative Frequency: Measure of Implicit Bias and Racial/ Ethnic Background



Note. Histogram of the relative frequencies of measure of implicit bias and race/ethnicity.

Table 25

Relative Frequency: Measure of Implicit Bias and Racial/ Ethnic Background

Race/Ethnicity	Measure of Bias 0	1	2	3	Total
Black/ African descent	16.67% (2)	33.33% (4)	33.33% (4)	16.67% (2)	100.00% (12)
White/ European descent	16.67% (8)	2.005% (12)	47.92% (23)	10.42% (5)	100.00% (48)
Native/ Indigenous or Alaska native	0.00% (0)	0.00% (0)	100.00% (1)	0.00% (0)	100.00% (1)
Asian/ Asian descent	0.00% (0)	0.00%(0)	0.00% (0)	100.00% (1)	100.00% (1)
Hispanic/ Latin descent	25.00% (1)	50.00% (2)	25.00% (1)	0.00% (0)	100.00% (4)
Total	16.67% (11)	27.27% (18)	43.94% (29)	12.12% (8)	100.00% (66)

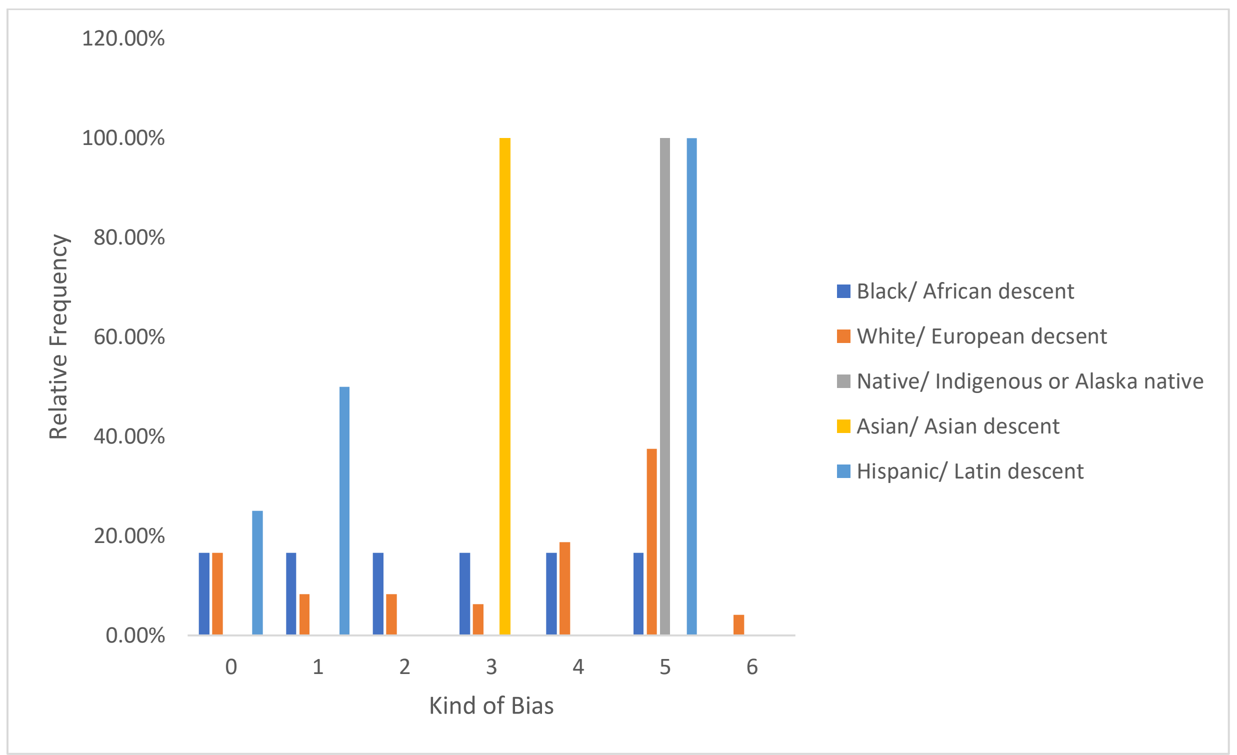
Note. Table of the relative frequencies of measure of implicit bias and race/ethnicity.

Figure 4.20 and Table 26 display kind of bias between the racial/ethnic groups for more insight. Black/ African descent participants have even numbers of participants across each kind of implicit bias with none having a strong implicit preference for White. Participants of Hispanic/ Latin descent have a larger number of participants who have a moderate implicit preference for White than those of the same racial/ethnic group who have a slight or moderate preference for Black. All Asian/ Asian descent participants have a strong unconscious preference

for Black and all Native/ Indigenous or Alaska native participants have a moderate unconscious preference for White. White/ European descent participants follow an upside down bell shape with slightly more having higher implicit preferences for White. Only those of White/ European descent have the strongest preference for White.

Figure 4.20

Relative Frequency: Kind of Implicit Bias and Racial/ Ethnic Background



Note. Histogram of the relative frequencies of kind of implicit bias and race/ethnicity.

Table 26

Relative Frequency: Kind of Implicit Bias and Racial/ Ethnic Background

Race/ Ethnicity	Kind of Bias 0	1	2	3	4	5	6	Total
Black/ African descent	16.67% (2)	16.67 % (2)	16.67 % (2)	16.67% (2)	16.67% (2)	16.67% (2)	0% (0)	100.00% (12)
White/ European descent	16.67% (8)	8.33% (4)	8.33% (4)	6.25% (3)	18.75% (9)	37.50% (18)	4.17 % (2)	100.00% (48)
Native/ Indigenous or Alaska native	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00 % (0)	100.00% (1)
Asian/ Asian descent	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00% (0)	0.00% (0)	0.00 % (0)	100.00% (1)
Hispanic/ Latin descent	25.00% (1)	50.00 % (2)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00 % (0)	100.00% (4)
Total	16.67% (11)	12.12 % (8)	9.09% (6)	9.09% (6)	16.67% (11)	33.33% (22)	3.03 % (2)	100.00 % (66)

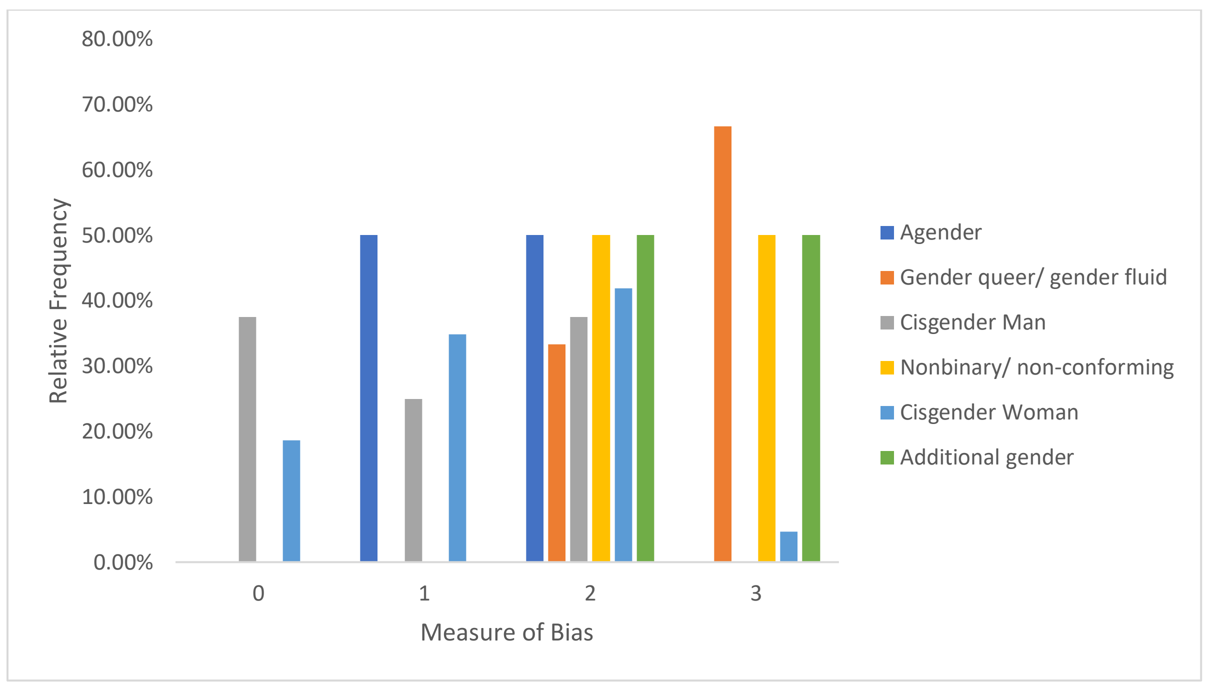
Note. Table of the relative frequencies of kind of implicit bias and race/ethnicity.

Relationship between gender and implicit bias was also analyzed through relative frequency displayed in Figure 4.21 and Table 27 below. From Figure 4.21, there are increasing amounts of Cisgender women from equal preference (zero measure of bias) through moderate

preference (measure of bias two). Implicit bias immediately drops to the lowest of all genders for cisgender women in the strong preference category (measure of bias three). Most gender queer/ gender fluid, nonbinary/ non-conforming, and additional ender participants have stronger preferences (moderate and strong in categories two and three). Agender participants occupy the lower preferences of slight and moderate (measures of bias one and two). Cisgender men in the study range from equal preference to moderate preference.

Figure 4.21

Relative Frequency: Measure of Implicit Bias and Gender



Note. Histogram of the relative frequencies of measure of implicit bias and gender.

Table 27

Relative Frequency: Measure of Implicit Bias and Gender

Gender	Measure of Bias				Total
	0	1	2	3	
Agender	0.00% (0)	50.00% (1)	50.00% (1)	0.00% (0)	100.00% (2)
Gender queer/ gender fluid	0.00% (0)	0.00% (0)	33.33% (1)	66.67% (2)	100.00% (3)
Cisgender Man	37.50% (3)	25.00% (2)	37.50% (3)	0.00% (0)	100.00% (8)
Nonbinary/ non-conforming	0.00% (0)	0.00% (0)	50.00% (1)	50.00% (1)	100.00% (2)
Cisgender Woman	18.60% (8)	34.88% (15)	41.86% (18)	4.65% (2)	100.00% (43)
Additional gender	0.00% (0)	0.00% (0)	50.00% (2)	50.00% (2)	100.00% (4)
Total	17.74% (11)	29.03% (18)	41.94% (26)	11..29% (7)	100.00% (62)

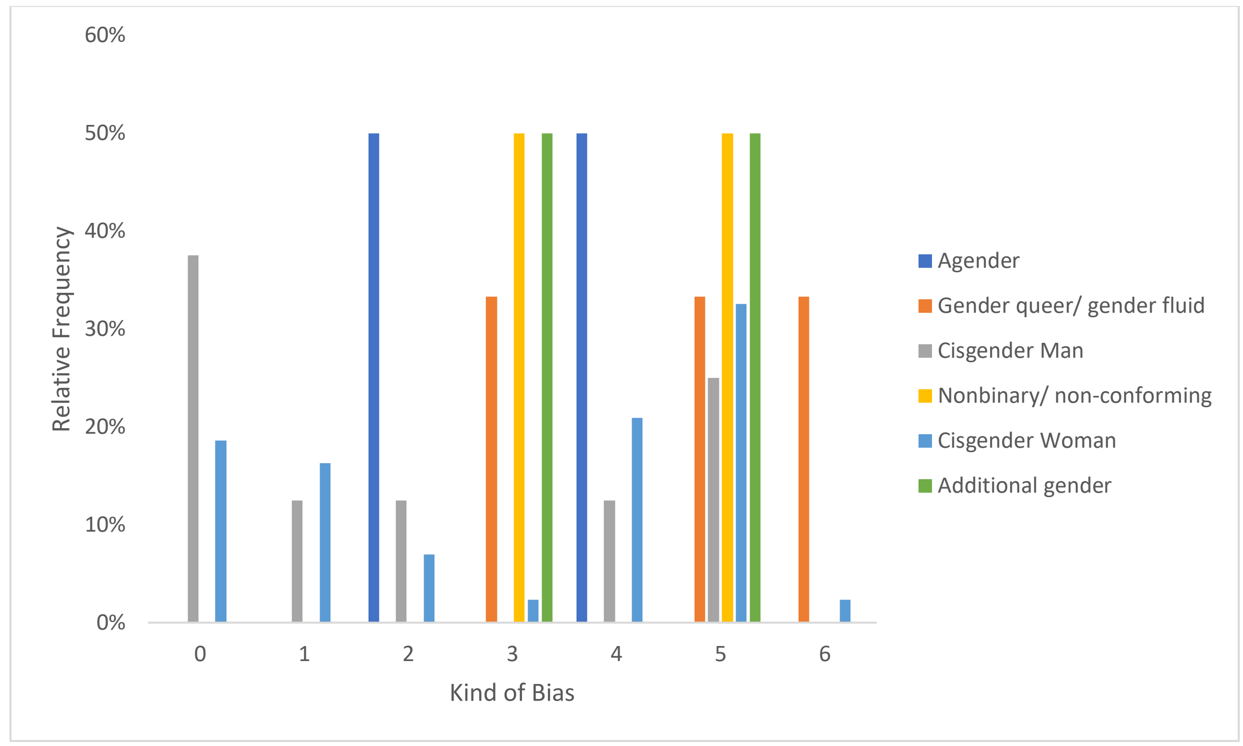
Note. Table of the relative frequencies of measure of implicit bias and gender.

Regarding relationships between gender and kind of bias displayed in Figure 4.22 and Table 28, cisgender men have an increased neutral preference that decreases through preferences toward Black and increases through preferences toward White. Similar is true for cisgender women. Agender participants have either a moderate preference toward White or moderate toward Black. Most gender queer/ gender fluid participants have a moderate or strong preference

toward White. Nonbinary/ non-conforming participants either have a strong preference toward Black or a moderate toward White.

Figure 4.22

Relative Frequency: Kind of Implicit Bias and Gender



Note. Histogram of the relative frequencies of kind of implicit bias and gender.

Table 28

Relative Frequency: Kind of Implicit Bias and Gender

Gender	Kind of Bias 0	1	2	3	4	5	6	Total
Agender	0.00% (0)	0.00% (0)	50.00 % (1)	0.00% (0)	50.00% (1)	0.00% (0)	0.00%	100.00 % (2)
Gender queer/ gender fluid	0.00% (0)	0.00% (0)	0.00% (0)	33.33 % (1)	0.00% (0)	33.33% (1)	33.33 % (1)	100.00 % (3)
Cisgender Man	37.50% (3)	12.50 % (1)	12.50 % (1)	0.00% (0)	12.50% (1)	25.00% (2)	0.00% (0)	100% (8)
Nonbinary/ non-conforming	0.00% (0)	0.00% (0)	0.00% (0)	50.00 % (1)	0.00% (0)	50.00% (1)	0.00%	100.00 % (2)
Cisgender Woman	18.60% (8)	16.28 % (7)	6.98% (3)	2.33% (1)	20.93% (9)	32.56% (14)	2.33% (1)	100.00 % (43)
Additional gender	0.00% (0)	0.00% (0)	0.00% (0)	50.00 % (2)	0.00% (0)	50.00% (2)	0.00% (0)	100.00 % (4)
Total	17.74% (11)	12.90 % (8)	8.06% (5)	8.06% (5)	17.74% (11)	32.26% (20)	3.23% (2)	100%.0 0 (62)

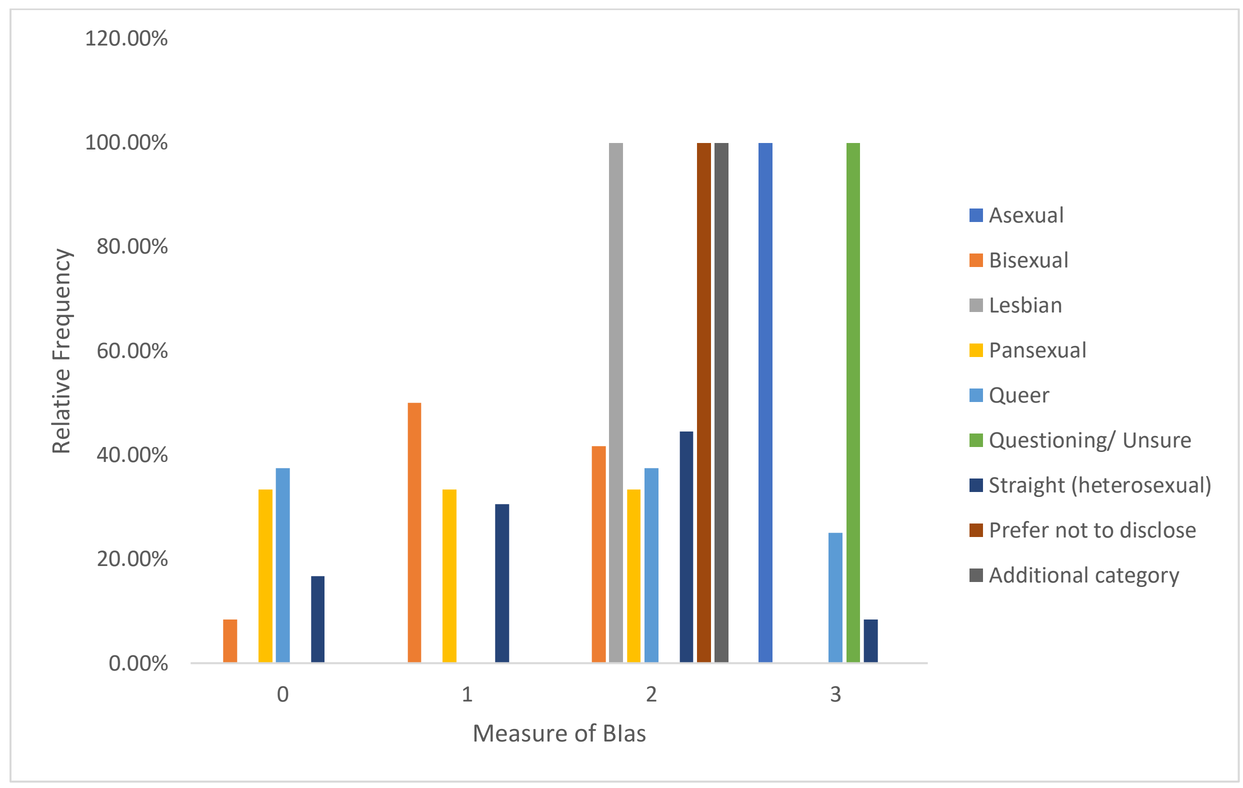
Note. Table of the relative frequencies of kind of implicit bias and gender.

Figure 4.23 and Table 29 below depict relative frequency data for sexual orientation and measure of bias. Bisexual participants mostly had a slight to moderate unconscious preference. Pansexual participants have an equal number of participants that have a neutral implicit preference, slight preference, and moderate preference with none that have a strong implicit

preference. All lesbian participants have a moderate preference as do those of an additional category and those who wished not to disclose. All participants who are questioning/unsure have a strong preference. Heterosexual participants have increasing numbers of participants between neutral preference through moderate and then drastically decrease at the strong preference.

Figure 4.23

Relative Frequency: Measure of Implicit Bias and Sexual Orientation



Note. Histogram of the relative frequencies of measure of implicit bias and sexual orientation.

Table 29

Relative Frequency: Measure of Implicit Bias and Sexual Orientation

Sexual Orientation	Measure of Bias				Total
	0	1	2	3	
Asexual	0.00% (0)	0.00% (0)	0.00% (0)	100.00% (1)	100% (1)
Bisexual	8.33% (1)	50.00% (6)	41.67% (5)	0.00% (0)	100% (12)
Lesbian	0.00% (0)	0.00% (0)	100.00% (1)	0.00% (0)	100% (1)
Pansexual	33.33% (1)	33.33% (1)	33.33% (1)	0.00% (0)	100% (3)
Queer	37.50% (3)	0.00% (0)	37.50% (3)	25.00% (2)	100% (8)
Questioning/ Unsure	0.00% (0)	0.00% (0)	0.00%	100.00% (1)	100% (1)
Straight (heterosexual)	16.67% (6)	30.56% (11)	44.44% (16)	8.33% (3)	100% (36)
Prefer not to disclose	0.00% (0)	0.00% (0)	100.00% (1)	0.00% (0)	100% (1)
Additional category	0.00% (0)	0.00% (0)	100.00% (1)	0.00% (0)	100% (1)
Total	17.19% (11)	28.13% (18)	43.75% (28)	10.94% (7)	100% (64)

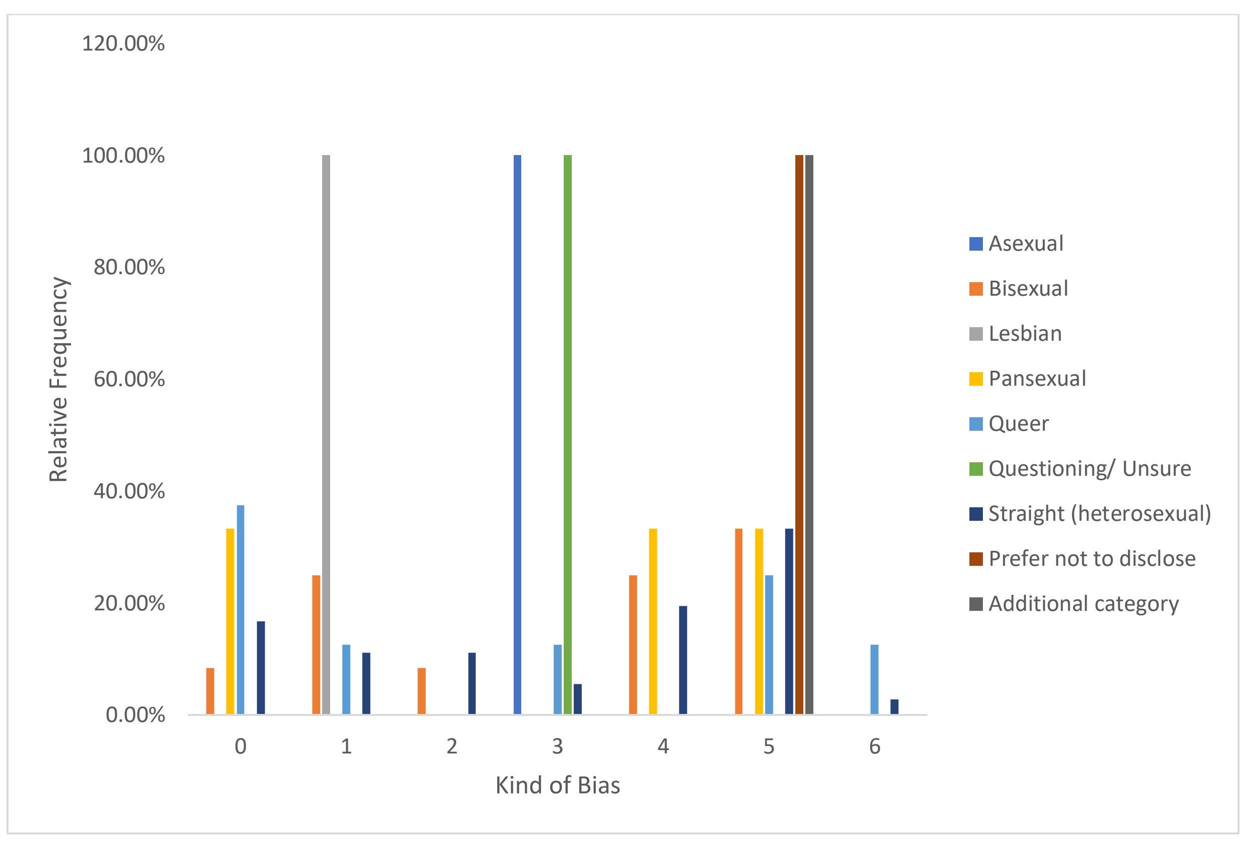
Note. Table of the relative frequencies of measure of implicit bias and sexual orientation.

Regarding kind of bias and sexual orientation, straight and bisexual participants follow a similar increasing and decreasing pattern across the kinds of bias, seen in Figure 4.24. Though, for bisexual participants, they increase from neutral preference to slight preference toward Black and decrease for moderate preference toward Black, following the then increase to slight and moderate preference toward White. With heterosexual participants, they decrease from neutral preference to slight preference toward Black, remain stable at moderate preference toward Black and then decrease again at slight preference toward White. Heterosexual participants continue to increase in moderate preference toward white until drastically decreasing at the strong preference

toward White. Pansexual participants are either neutral or have a preference toward White. Lesbian participants have a slight preference toward Black while questioning/unsure participants have a strong preference toward Black. Those who prefer not to disclose and of additional categories have a moderate preference toward White. Relative frequencies are also displayed in Table 30.

Figure 4.24

Relative Frequency: Kind of Implicit Bias and Sexual Orientation



Note. Histogram of the relative frequencies of kind of implicit bias and sexual orientation.

Table 30

Relative Frequency: Kind of Implicit Bias and Sexual Orientation

Sexual Orientation	Kind of Bias							Total
	0	1	2	3	4	5	6	
Asexual	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)
Bisexual	8.33% (1)	25.00% (3)	8.33% (1)	0.00% (0)	25.00% (3)	33.33% (4)	0.00% (0)	100.00 % (12)
Lesbian	0.00% (0)	100.00 % (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)
Pansexual	33.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	33.33% (1)	33.33% (1)	0.00% (0)	100.00 % (3)
Queer	37.50% (3)	12.50% (1)	0.00% (0)	12.50% (1)	0.00% (0)	25.00% (2)	12.50 % (1)	100.00 % (8)
Questioning/ Unsure	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)
Straight (heterosexual)	16.67% (6)	11.11% (4)	11.11 % (4)	5.56% (2)	19.44% (7)	33.33% (12)	2.78% (1)	100.00 % (36)
Prefer not to disclose	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00% (0)	100.00 % (1)
Additional category	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	100.00 % (1)	0.00% (0)	100.00 % (1)
Total	17.19% (11)	14.06% (9)	7.81% (5)	7.81% (5)	17.19% (11)	32.81% (21)	3.13% (2)	100.00 % (64)

Note. Table of the relative frequencies of kind of implicit bias and sexual orientation.

In summary, based on nonparametric tests measure of bias and altruism have a slight positive correlation. Based on analysis of relative frequencies, there are some notable interactions between implicit bias scores and counselor role, race, gender, and sexual orientation.

Measure of implicit bias was shown to increase through increased status and leadership in the field with increasing preference toward White as well. Regrading gender, participants of White European descent had polarized implicit bias scores, still with the most preference toward White while Black/ African descent participants were equal across the different kinds of bias. Visualizations showed interactions between Cisgender women, cisgender men and implicit bias scores as well. Both groups behaved similarly where implicit preference decreased through preferences toward Black and increased through preferences toward White. Additionally, heterosexual participants had a linear relationship through increased measures of bias before considerably decreasing at the strongest preference.

Research question three. The third research question requires an analysis of the altruism scores and demographic information of participants who took the implicit bias measure. Again, demographic data will be analyzed in order of the survey. Additionally, as before, data will be treated as non-normal and a statistical significance level of 0.05 will be used for all nonparametric tests.

Beginning with participant age, Kendall's Tau C was used to determine if there is a relationship between participant age and their altruism score. The test indicated that there is a statistically significant positive moderate correlation between participant age and altruism score ((r (61) =0.50, p< 0.001). The SPSS output (Figure 4.25) can be found below. Below in Figure 4.26, the graph depicts this relationship; moderately as altruism scores increase, participant ages also increase. The key (Table 31) displays corresponding categories in the graph to the age groups. Participants between ages 18-30 had the lowest altruism scores, while participants ages 61-70 had the highest altruism scores.

Figure 4.25

Kendall's Tau C Significance Test: Altruism Scores and Age

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Ordinal by Ordinal	Kendall's tau-c	.506	.088	5.761	<.001
N of Valid Cases		61			

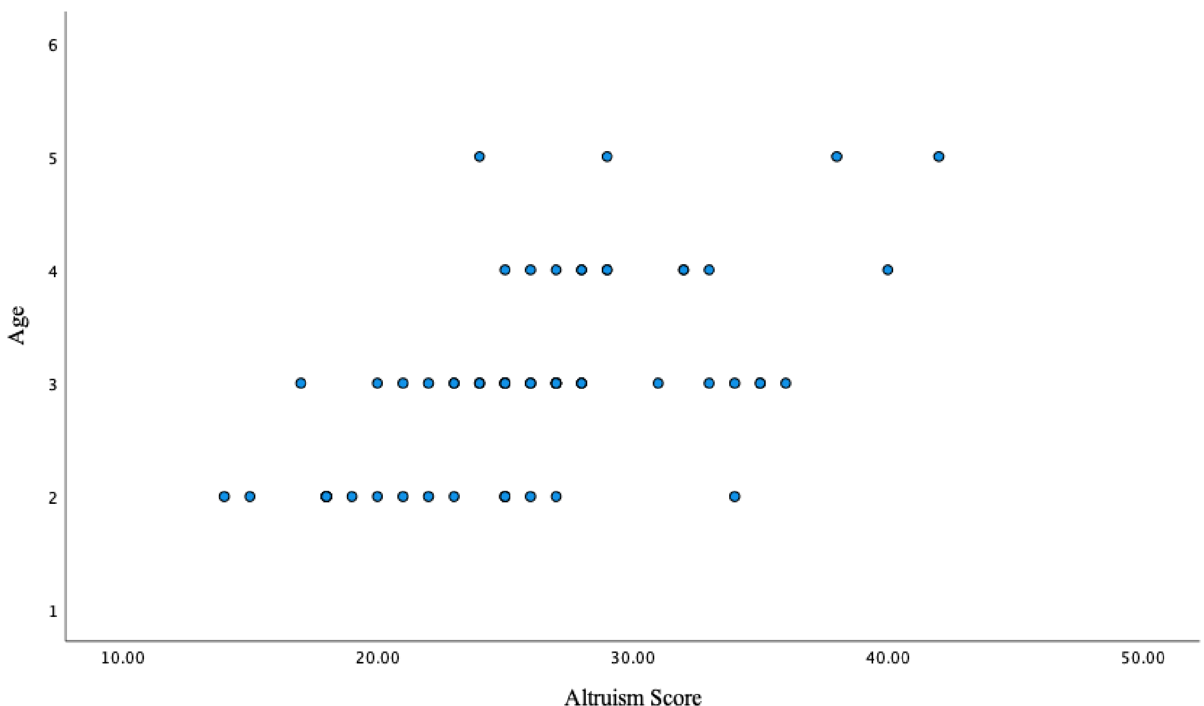
a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Note. SPSS output for significance of relationship between altruism scores and age.

Figure 4.26

Scatter Plot: Altruism Scores and Age



Note. Scatter plot of altruism scores and age.

Table 31

Key of Age Group Categories

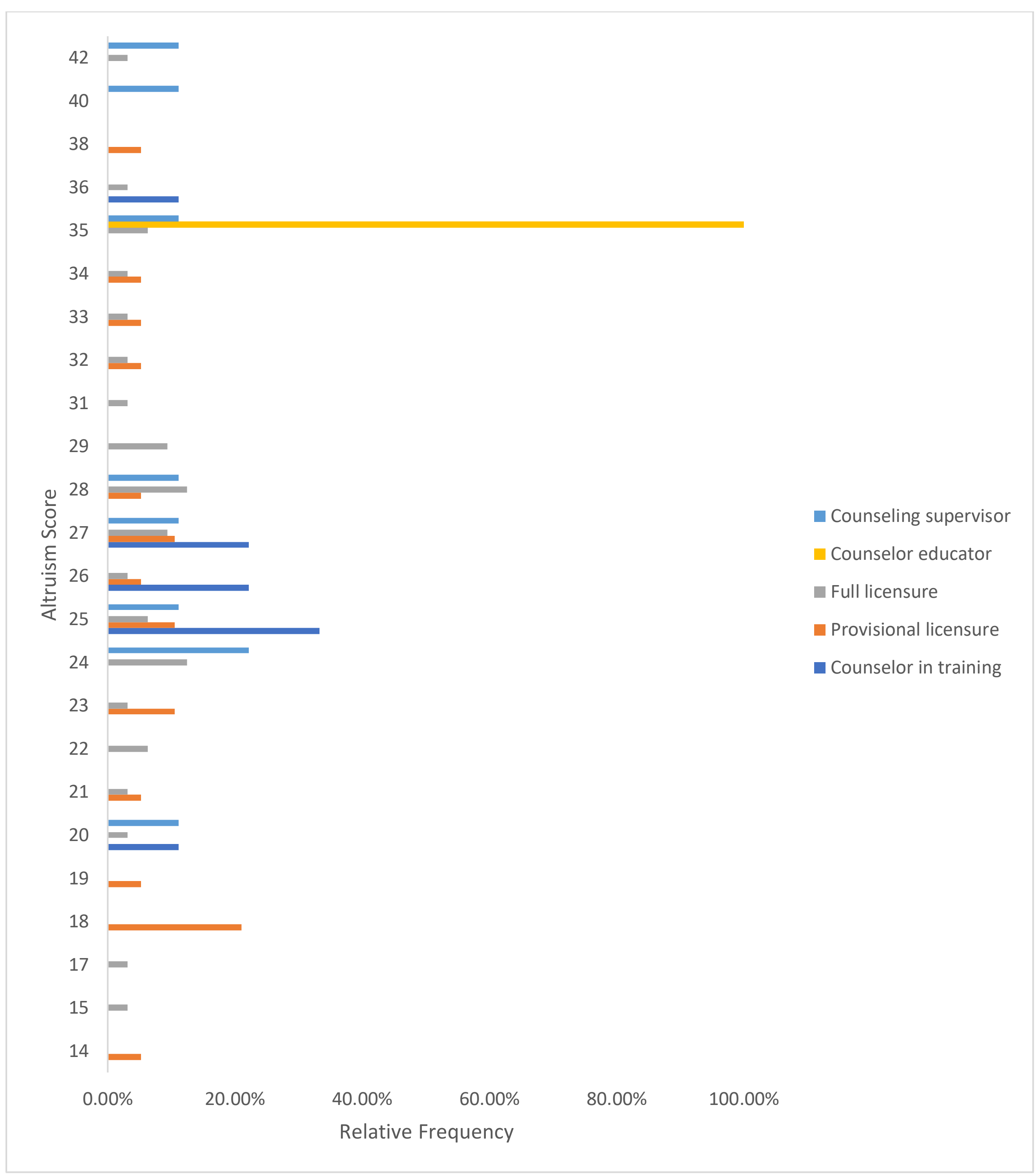
Category	Age
1	Below 18
2	18-30
3	31-45
4	46-60
5	61-70
6	71-80+

Note. Table of the corresponding age groups for categories used in graphs.

Given participant roles were multiple response data, relative frequencies were analyzed to assess relationship between altruism scores and the various roles occupied. Based on the graph in Figure 4.27, counselors with full licensure and provisional licensure make up the lower altruism scores. Counselors in training mostly occupy middle altruism scores while provisionally licensed counselors appear generally constant throughout the whole range of altruism scores. Counseling supervisors and counseling educators have generally higher altruism scores than the other roles. A table of relative frequencies can be found below as well (Table 32).

Figure 4.27

Relative Frequency: Altruism Scores and Role in Counseling Field



Note. Histogram of the relative frequencies of altruism scores and roles in the counseling field.

Table 32

Relative Frequency: Altruism Scores and Role in Counseling Field

Altruism Score	Role					Total
	Counselor in training	Provisional licensure	Full licensure	Counselor educator	Counseling supervisor	
14	0.00% (0)	5.26% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
15	0.00% (0)	0.00% (0)	3.13% (1)	0.00% (0)	0.00% (0)	1.64% (1)
17	0.00% (0)	0.00% (0)	3.13% (1)	0.00% (0)	0.00% (0)	1.64% (1)
18	0.00% (0)	21.05% (4)	0.00% (0)	0.00% (0)	0.00% (0)	6.56% (4)
19	0.00% (0)	5.26% (1)	0.00%	0.00% (0)	0.00% (0)	1.64% (1)
20	11.11% (1)	0.00% (0)	3.13% (1)	0.00% (0)	11.11% (1)	3.28% (2)
21	0.00% (0)	5.26% (1)	3.13% (1)	0.00% (0)	0.00% (0)	3.28% (2)
22	0.00% (0)	0.00% (0)	6.25% (2)	0.00% (0)	0.00% (0)	3.28% (2)
23	0.00% (0)	10.53% (2)	3.13% (1)	0.00% (0)	0.00% (0)	4.92% (3)
24	0.00% (0)	0.00% (0)	12.50% (4)	0.00% (0)	22.22% (2)	6.56% (4)
25	33.33% (3)	10.53% (2)	6.25% (2)	0.00% (0)	11.11% (1)	13.11 % (8)
26	22.22% (2)	5.26% (1)	3.13% (1)	0.00% (0)	0.00% (0)	6.56% (4)
27	22.22% (2)	10.53% (2)	9.38% (3)	0.00% (0)	11.11% (1)	11.48 % (7)
28	0.00% (0)	5.26% (1)	12.50% (4)	0.00% (0)	11.11% (1)	8.20% (5)
29	0.00% (0)	0.00% (0)	9.38% (3)	0.00% (0)	0.00% (0)	4.92% (3)
31	0.00% (0)	0.00% (0)	3.13% (1)	0.00% (0)	0.00% (0)	1.64% (1)
32	0.00% (0)	5.26% (1)	3.13% (1)	0.00% (0)	0.00% (0)	3.28% (2)
33	0.00% (0)	5.26% (1)	3.13% (1)	0.00% (0)	0.00% (0)	3.28% (2)
34	0.00% (0)	5.26% (1)	3.13% (1)	0.00% (0)	0.00% (0)	3.28% (2)

Table 32 (continued.)

35	0.00% (0)	0.00% (0)	6.25% (2)	100.00% (1)	11.11% (1)	3.28% (2)
36	11.11% (1)	0.00% (0)	3.13% (1)	0.00% (0)	0.00% (0)	1.64% (1)
38	0.00% (0)	5.26% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
40	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (1)	1.64% (1)
42	0.00% (0)	0.00% (0)	3.13% (1)	0.00% (0)	11.11% (1)	1.64% (1)
Total	100.00% (9)	100.00% (19)	100.00% (32)	100.00% (1)	100.00% (9)	100.00% (61)

Note. Table of the relative frequencies of altruism scores and roles in the counseling field.

Fisher's exact test was used to assess a relationship between altruism scores and confidence in treating diverse cultures. Fisher's test indicated that there is not a statistically significant relationship between confidence treating diverse cultures and altruism scores (two tailed p= 0.52).

Next, Fisher's exact test was used to determine a relationship between CACREP accreditation and altruism scores. The test indicated that there is not a statistically significant relationship (two tailed p = 0.43).

Fisher's exact test was also used to determine the relationship between disability status and altruism scores. There was a statistically significant relationship between disability status and altruism scores (two tailed p= 0.02). SPSS output results can be found in Figure 4.28 below. Kendall's Tau C was also run to gather more information about the type of relationship (SPSS output is below in Figure 4.29). Kendall's Tau C indicated a moderate negative correlation between disability status and altruism scores ((r (61) = -0.45, p= 0.74). That is, people who did not have a disability overall were less altruistic than those who had a disability. The graph in

Figure 4.30 displays this relationship (1 indicates the participant does have a disability while 2 indicates participants who do not have a disability).

Figure 4.28

Fisher's Exact Test: Altruism Scores and Disability

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	31.683[a]	23	.107	.083		
Likelihood Ratio	33.297	23	.076	.054		
Fisher-Freeman-Halton Exact Test	28.964			.022		
Linear-by-Linear Association	.255[b]	1	.614	.635	.315	.019
N of Valid Cases	61					

a. 46 cells (95.8%) have expected count less than 5. The minimum expected count is .18.

b. The standardized statistic is -.505.

Note. SPSS output for significance of relationship between altruism scores and disability status.

Figure 4.29

Kendall's Tau C Significance Test: Altruism Scores and Disability

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance	Exact Significance
Ordinal by Ordinal	Kendall's tau-c	-.045	.136	-.333	.739	.700
N of Valid Cases		61				

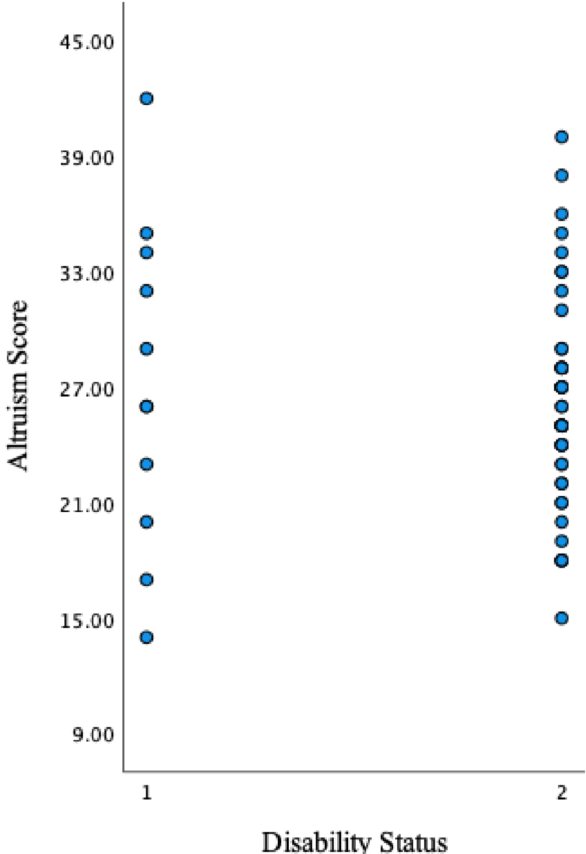
a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Note. SPSS output for significance of relationship between altruism scores and disability status.

Figure 4.30

Scatter Plot: Altruism Scores and Disability



Note. Scatter plot of altruism scores and disability status.

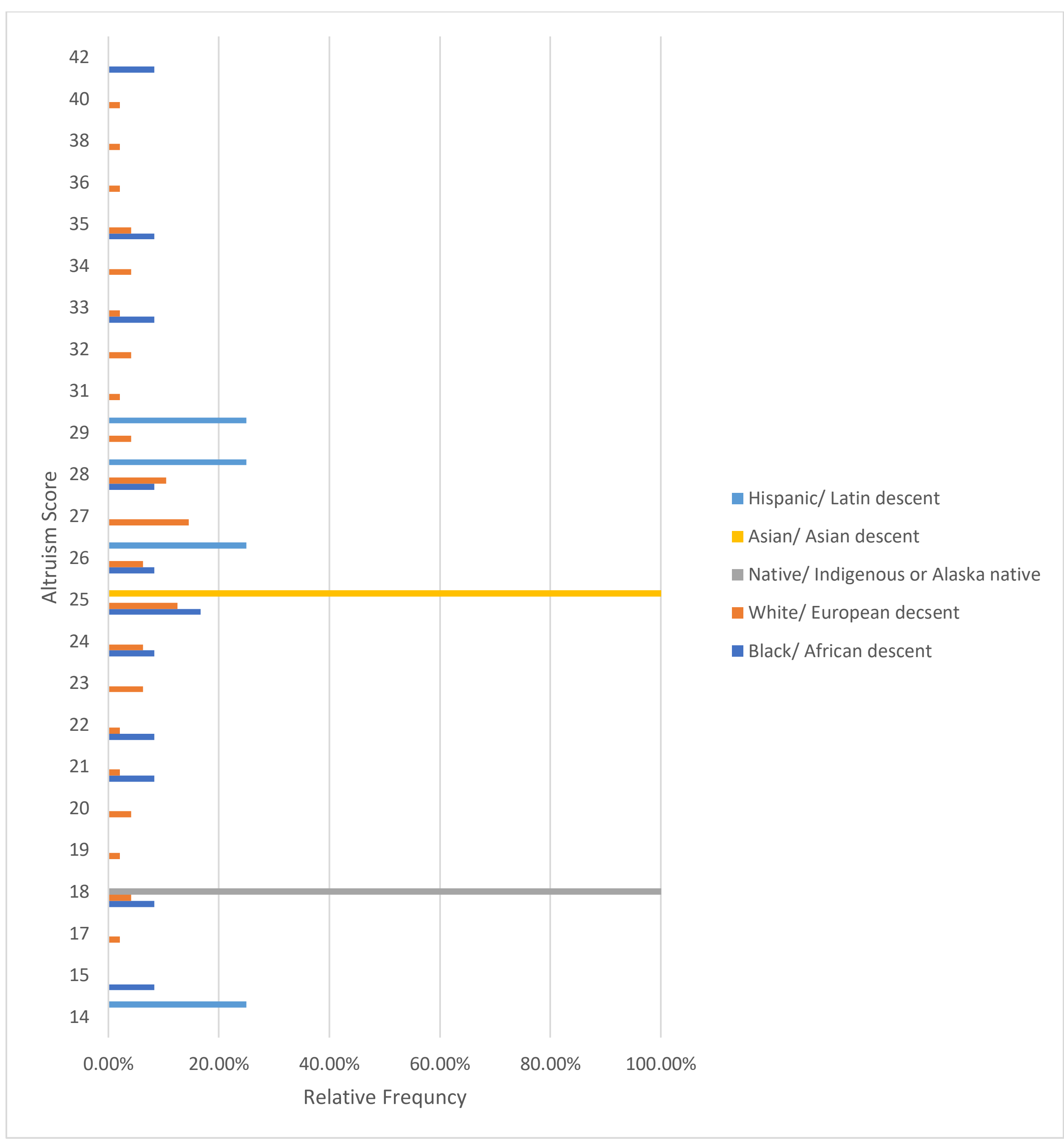
Religious affiliation and altruism scores were also analyzed for a potential relationship. Kendall's Tau C indicated that there is not a statistically significant relationship between them ((r (61) = -0.11, p= 0.26).

Relative frequency analysis was used to assess the relationship between race and altruism scores. Figure 4.31 and Table 33 below display the relative frequencies. From figure 4.31, White/European descent participants and Black/ African descent participants performed similarly both occupying a wide range of altruism scores. Though, generally there are slightly more White/ European descent participants represented in the high range of altruism than Black/African

descent participants. Most Black/African descent participants scored towards the middle of the altruism scale. Hispanic/ Latin descent participants tended to have a lower range of altruism scores compared to most of the other racial/ethnic groups. Native/ Indigenous or Alaska native participants were all significantly below the mean in altruism scores. Asian/ Asian descent participants scored similar, in the mid-range of scores, as other racial/ethnic groups. Overall, differences look to be negligible except regarding White and Black participants with White participants scoring slightly higher than Black participants.

Figure 4.31

Relative Frequency: Altruism Scores and Racial/ Ethnic Background



Note. Histogram of the relative frequencies of altruism scores and race/ethnicity.

Table 33

Relative Frequency: Altruism Scores and Racial/ Ethnic Background

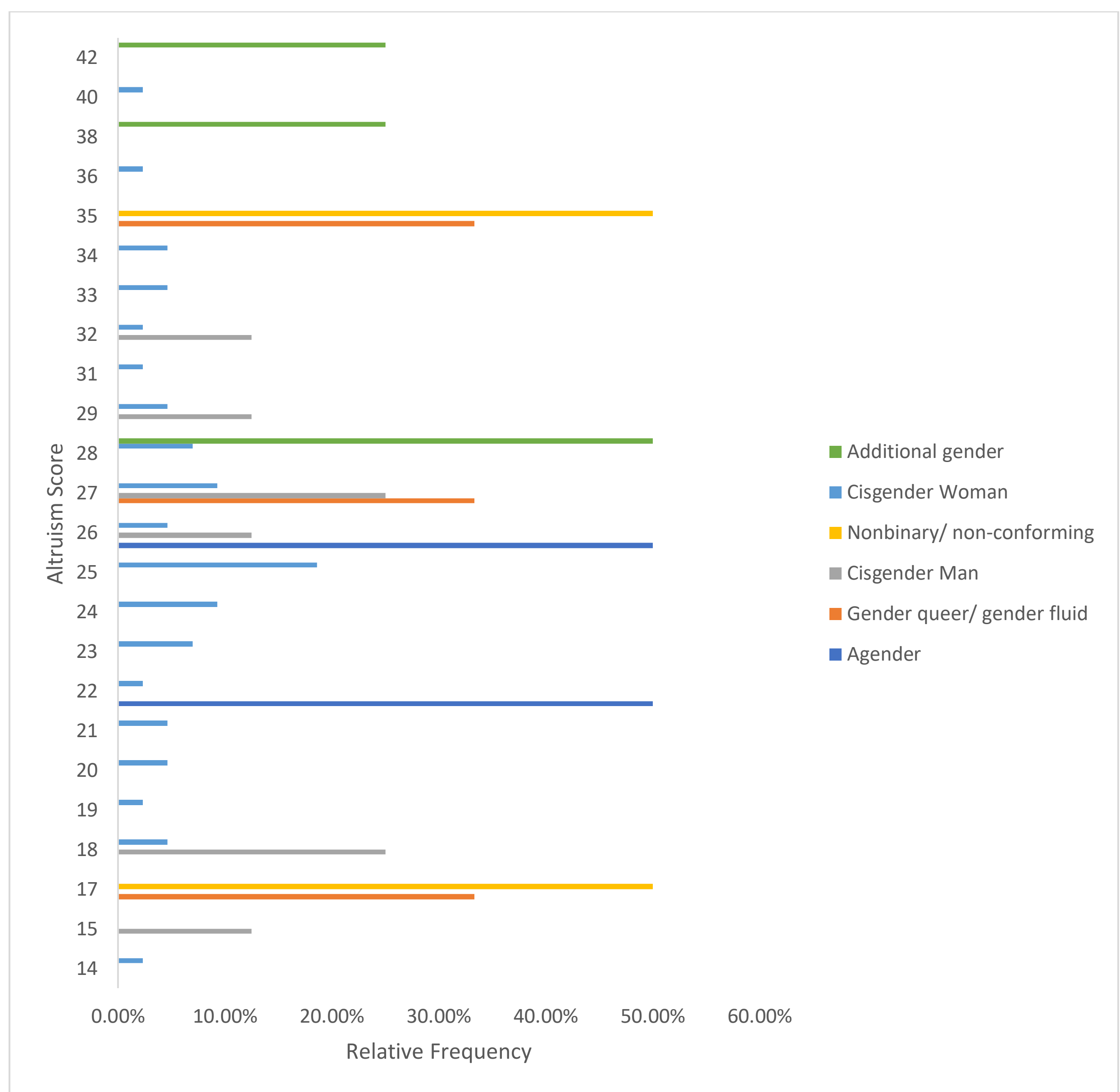
Altruism Score	Race/Ethnicity					Total
	Black/ African descent	White/ European descent	Native/ Indigenous or Alaska native	Asian/ Asian descent	Hispanic/ Latin descent	
14	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	25.00% (1)	1.64% (1)
15	8.33% (1)	0.00% (0)	0.00% (0)	0.00%	0.00% (0)	1.64% (1)
17	0.00% (0)	2.08% (1)	0.00% (0)	0.00%	0.00% (0)	1.64% (1)
18	8.33% (1)	4.17% (2)	100.00% (1)	0.00%	0.00% (0)	6.56% (4)
19	0.00% (0)	2.08% (1)	0.00% (0)	0.00%	0.00% (0)	1.64% (1)
20	0.00% (0)	4.17% (2)	0.00% (0)	0.00%	0.00% (0)	3.28% (2)
21	8.33% (1)	2.08% (1)	0.00% (0)	0.00%	0.00% (0)	3.28% (2)
22	8.33% (1)	2.08% (1)	0.00% (0)	0.00%	0.00% (0)	3.28% (2)
23	0.00% (0)	6.25% (3)	0.00% (0)	0.00%	0.00% (0)	4.92% (3)
24	8.33% (1)	6.25% (3)	0.00% (0)	0.00%	0.00% (0)	6.56% (4)
25	16.67% (2)	12.50% (6)	0.00% (0)	100.00% (1)	0.00% (0)	13.11% (8)
26	8.33% (1)	6.25% (3)	0.00% (0)	0.00% (0)	25.00% (1)	6.56% (4)
27	0.00% (0)	14.58% (7)	0.00% (0)	0.00% (0)	0.00% (0)	11.48% (7)
28	8.33% (1)	10.42% (5)	0.00% (0)	0.00% (0)	25.00% (1)	8.20% (5)
29	0.00% (0)	4.17% (2)	0.00% (0)	0.00% (0)	25.00% (1)	4.92% (3)
31	0.00% (0)	2.08% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
32	0.00% (0)	4.17% (2)	0.00% (0)	0.00% (0)	0.00% (0)	3.28% (2)
33	8.33% (1)	2.08% (1)	0.00% (0)	0.00% (0)	0.00% (0)	3.28% (2)
34	0.00% (0)	4.17% (2)	0.00% (0)	0.00% (0)	0.00% (0)	3.28% (2)
35	8.33% (1)	4.17% (2)	0.00% (0)	0.00% (0)	0.00% (0)	3.28% (2)
36	0.00% (0)	2.08% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
38	0.00% (0)	2.08% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
40	0.00% (0)	2.08% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
42	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
Total	100.00% (12)	100.00% (48)	100.00% (1)	100.00% (1)	100.00% (4)	100.00% (61)

Note. Table of the relative frequencies of altruism scores and race/ethnicity.

Relative frequency analysis was also used to analyze potential relationship between altruism scores and gender. From Figure 4.32 below, those of additional genders generally have higher altruism scores than the other genders. Cisgender women have the widest range of scores. Seen in Table 34 below, the lowest score for cisgender women is 14 and the highest is 40. Nonbinary/ nonconforming participants have the most polarizing scores with gender fluid/gender queer following similarly, though the latter does have some representation closer to the middle of the range. Cisgender men have a lower range than most other genders with scores between 15 and 32. Agender participants have the smallest range of scores between 22 and 26. While there are differences, they appear negligible.

Figure 4.32

Relative Frequency: Altruism Scores and Gender



Note. Histogram of the relative frequencies of altruism scores and gender.

Table 34

Relative Frequency: Altruism Scores and Gender

Altruism Score	Gender						Total
	Agender	Gender queer/ gender fluid	Cisgender Man	Nonbinary/ non-conforming	Cisgender Woman	Additional gender	
14	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.33% (1)	0.00% (0)	1.64% (1)
15	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
17	0.00% (0)	33.33% (1)	0.00% (0)	50.00% (1)	0.00% (0)	0.00% (0)	1.64% (1)
18	0.00% (0)	0.00% (0)	25.00% (2)	0.00% (0)	4.65% (2)	0.00% (0)	6.56% (4)
19	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.33% (1)	0.00% (0)	1.64% (1)
20	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	4.65% (2)	0.00% (0)	3.28% (2)
21	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	4.65% (2)	0.00% (0)	3.28% (2)
22	50.00% (1)	0.00% (0)	0.00% (0)	0.00% (0)	2.33% (1)	0.00% (0)	3.28% (2)
23	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	6.98% (3)	0.00% (0)	4.92% (3)
24	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	9.30% (4)	0.00% (0)	6.56% (4)
25	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	18.60% (8)	0.00% (0)	13.11 % (8)
26	50.00% (1)	0.00% (0)	12.50% (1)	0.00% (0)	4.65% (2)	0.00% (0)	6.56% (4)
27	0.00% (0)	33.33% (1)	25.00% (2)	0.00% (0)	9.30% (4)	0.00% (0)	11.48 % (7)
28	0.00% (0)	0.00% (0)	0.00%	0.00% (0)	6.98% (3)	50.00% (2)	8.20% (5)
29	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	4.65% (2)	0.00% (0)	4.92% (3)
31	0.00% (0)	0.00% (0)	0.00%	0.00% (0)	2.33% (1)	0.00% (0)	1.64% (1)
32	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	2.33% (1)	0.00% (0)	3.28% (2)
33	0.00% (0)	0.00% (0)	0.00%	0.00% (0)	4.65% (2)	0.00% (0)	3.28% (2)

Table 34 (continued.)

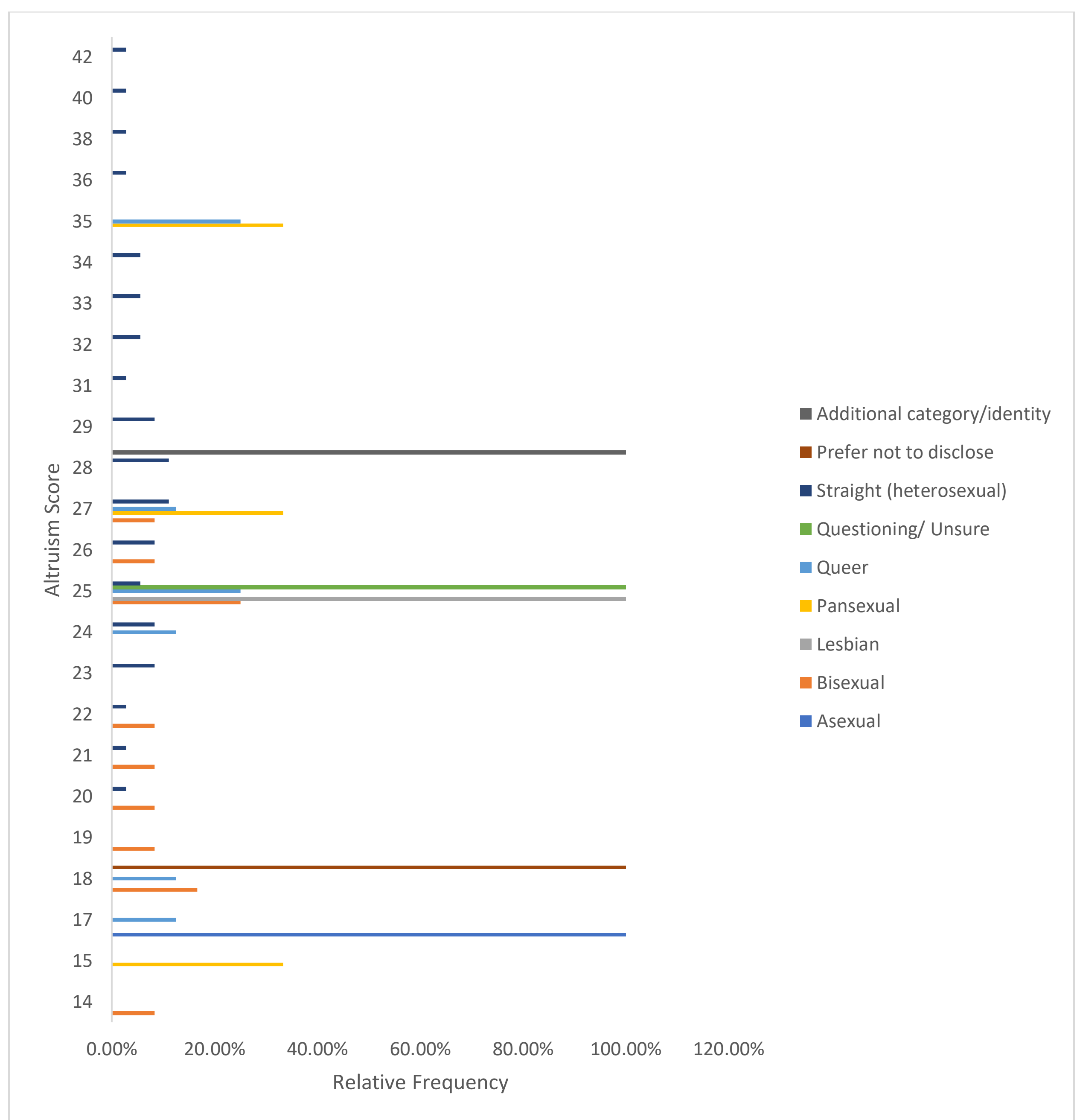
34	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	4.65% (2)	0.00% (0)	3.28% (2)
35	0.00% (0)	33.33% (1)	0.00% (0)	33.33% (1)	0.00% (0)	0.00% (0)	3.28% (2)
36	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.33% (1)	0.00% (0)	1.64% (1)
38	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	25.00% (1)	1.64% (1)
40	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.33% (1)	0.00% (0)	1.64% (1)
42	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	25.00% (1)	1.64% (1)
Total	100.00% (2)	100.00% (3)	100.00% (8)	100.00% (2)	100.00% (43)	100.00% (4)	100.00% (61)

Note. Table of the relative frequencies of altruism scores and gender.

Relationship between altruism scores and sexual orientation/sexual identity was also analyzed with relative frequency due to the multiple response nature of data. From Figure 4.33 and Table 35 below there are some noticeable differences between sexual orientation and altruism scores. For instance, straight/heterosexual participants generally have higher altruism scores overall with a range between 20 and 42 (the highest altruism score of the participants). Bisexual participants have lower scores with a range between 14 and 27 as do participants who are queer, though a little higher, with a range between 17 and 35. Additionally, the lowest altruism score of the participants is that of a bisexual participant. Questioning/unsure participants have scores closer to the middle of the range of scores.

Figure 4.33

Relative Frequency: Altruism Scores and Sexual Orientation



Note. Histogram of the relative frequencies of altruism scores and sexual orientation.

Table 35

Relative Frequency: Altruism Scores and Sexual Orientation

Altruism Score	Gender									Total
	Asexual	Bisexual	Lesbian	Pansexual	Queer	Questioning/ Unsure	Straight (heterosexual)	Prefer not to disclose	Additional category/ide ntity	
14	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
15	0.00% (0)	0.00% (0)	0.00% (0)	33.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
17	100.00% (1)	0.00% (0)	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
18	0.00% (0)	16.67% (2)	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	0.00% (0)	100.00% (1)	0.00% (0)	6.56% (4)
19	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	1.64% (1)
20	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	3.28% (2)
21	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	3.28% (2)
22	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	3.28% (2)
23	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	8.33% (3)	0.00% (0)	0.00% (0)	4.92% (3)
24	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	12.50% (1)	0.00% (0)	8.33% (3)	0.00% (0)	0.00% (0)	6.56% (4)
25	0.00% (0)	25.00% (3)	100.00% (1)	0.00% (0)	25.00% (2)	100.00% (1)	5.56% (2)	0.00% (0)	0.00% (0)	13.11% (8)
26	0.00% (0)	8.33% (1)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	8.33% (3)	0.00% (0)	0.00% (0)	6.56% (4)
27	0.00% (0)	8.33% (1)	0.00% (0)	33.33% (1)	12.50% (1)	0.00% (0)	11.11% (4)	0.00% (0)	0.00% (0)	11.48% (7)
28	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	11.11% (4)	0.00% (0)	100.00% (1)	8.20% (5)

Table 35 (continued.)

29	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	8.33% (3)	0.00% (0)	0.00% (0)	4.92% (3)
31	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	1.64% (1)
32	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	5.56% (2)	0.00% (0)	0.00% (0)	3.28% (2)
33	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	5.56% (2)	0.00% (0)	0.00% (0)	3.28% (2)
34	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	5.56% (2)	0.00% (0)	0.00% (0)	3.28% (2)
35	0.00% (0)	0.00% (0)	0.00% (0)	33.33% (1)	25.00% (2)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	3.28% (2)
36	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	1.64% (1)
38	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	1.64% (1)
40	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	1.64% (1)
42	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	0.00% (0)	2.78% (1)	0.00% (0)	0.00% (0)	1.64% (1)
Total	100.00% (1)	100.00% (12)	100.00% (1)	100.00% (3)	100.00% (8)	100.00% (1)	100.00% (36)	100.00% (1)	100.00% (1)	100.00 % (61)

Note. Table of the relative frequencies of altruism scores and sexual orientation.

Overall, significant relationships between altruism and demographic data are relationships between altruism scores and age, roles, disability, race, and sexual orientation. There was a positive correlation between altruism scores and age. There was also a positive correlation between altruism scores and roles, with counseling supervisors and counseling educators having generally higher altruism scores than the other roles. There was also a negative correlation between altruism scores and disability as people who did not have a disability overall were less altruistic than those who had a disability. There were also some slight differences between racial/ethnic groups where White participants had generally higher scores overall but slightly higher than Black participants. Finally, regarding sexual orientation, heterosexual participants had higher altruism scores overall.

Additional Results

Though not originally part of the current research, two distinct groups formed during analysis, those who completed the implicit bias measure and those who did not. As this is an exploratory study, data from those who did not complete the implicit bias measure are analyzed in the interest of thoroughly investigating potential relationships regarding altruism scores. As such, following is a comparison of the two groups demographic data and altruism scores.

In analyzing the data, 96 participants out of the 157 did not complete the implicit bias measure but did complete the altruism score. Average age is displayed in Table 35. Age groups were coded into categories also noted in Table 36. Most respondents who did not complete the implicit bias measure were in the second category, between 31-45 years old. All of the 71-80+ year old participants who took the survey in general can be found here as well. Further, the percentage of people who did not take the survey relative to the total in each age group increases by each age group.

Table 36

Age of Participants Who Did Not Take the IAT

	Category and Age Group					
	1	2	3	4	5	
Participant	18-30	31-45	46-60	61-70	71-80+	Total
No IAT	39.29% (11)	60.81% (45)	69.44% (25)	76.47% (13)	100.00% (2)	100.00% (96)
Total in age group	100.00% (28)	100.00% (74)	100.00% (36)	100.00% (17)	100.00% (2)	100.00% (157)

Note. Table of the ages of participants who did not take the implicit bias measure.

Continuing with demographics, in roles occupied, participants who did not take the implicit bias measure account for 116 of the original 186 roles selected shown in Table 37 below. From the graph (Figure 4.34), most participants who did not take the IAT were fully licensed while only one counselor in training did not.

Table 37

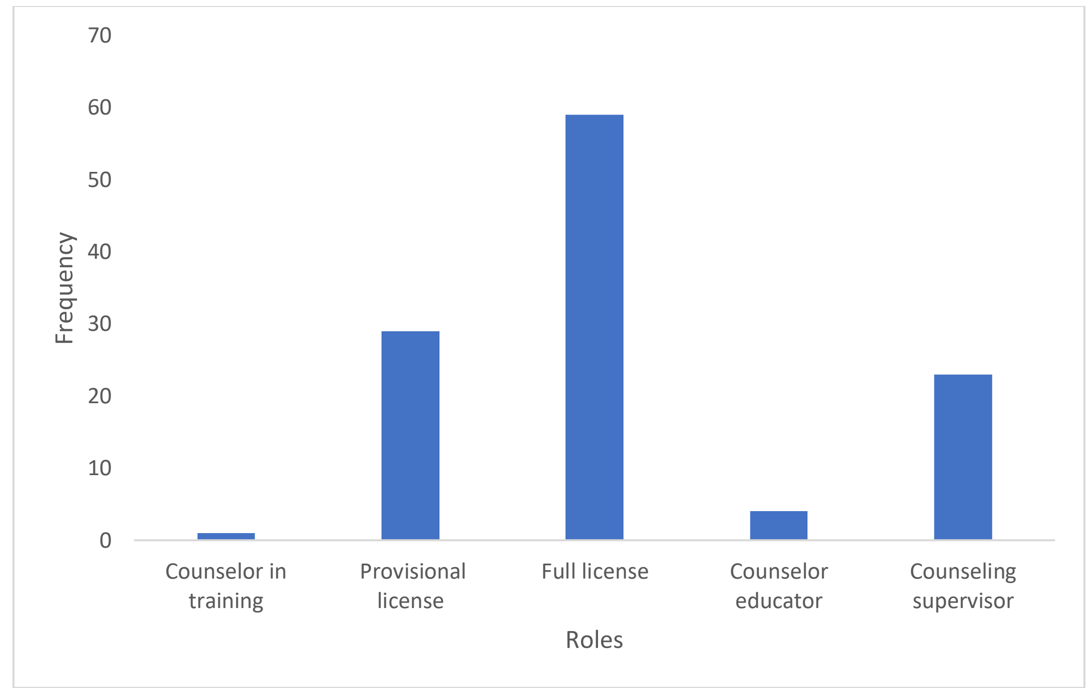
Roles in the Counseling Field of Participants Who Did Not Take the IAT

Role	Frequency
Counselor in training	0.86% (1)
Provisional license	25.00% (29)
Full license	50.86% (59)
Counselor educator	3.45% (4)
Counseling supervisor	19.83% (23)
Total	100.00% (116)

Note. Table of the roles of participants who did not take the implicit bias measure.

Figure 4.34

Roles in the Counseling Field of Participants Who Did Not Take the IAT

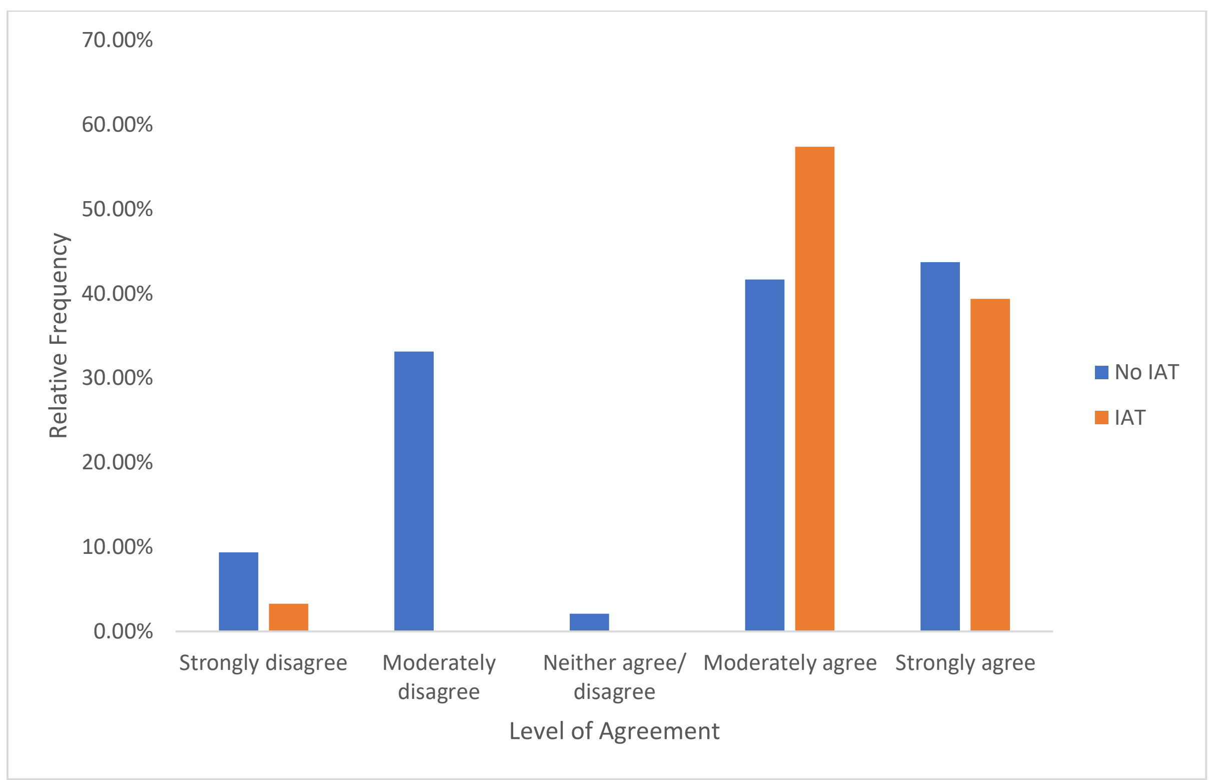


Note. Histogram of the roles of participants who did not take the implicit bias measure.

Figure 4.35 and Table 38 below display results regarding the ability to work with diverse cultures within participants who did not take the IAT compared to those who did. Participants who did not take the implicit bias test account for about 61% of the participants (96/157 participants). The majority of people who strongly disagreed, all who moderately disagreed, and all of the people who either disagreed or neither agreed with the statement “I have the ability to effectively work with diverse cultures” did not complete the implicit bias test (shown in Figure 4.35). Roughly about the same number of participants who took the test (35 participants) and did not take the test (40 participants) moderately agreed with the statement. Finally, those who did not take the implicit association test, who account for more than half of the data, report to be comparatively less confident in their ability to work with diverse cultures than those who took the implicit bias measure.

Figure 4.35

Participants Who Did Not Take the IAT Compared to IAT Takers: Working with Diverse Cultures



Note. Histogram of the response to "I have ability to work with clients of diverse backgrounds effectively" of participants who did not take the implicit bias measure compared to those who did.

Table 38

Participants Who Did Not Take the IAT Compared to IAT Takers: Working with Diverse Cultures

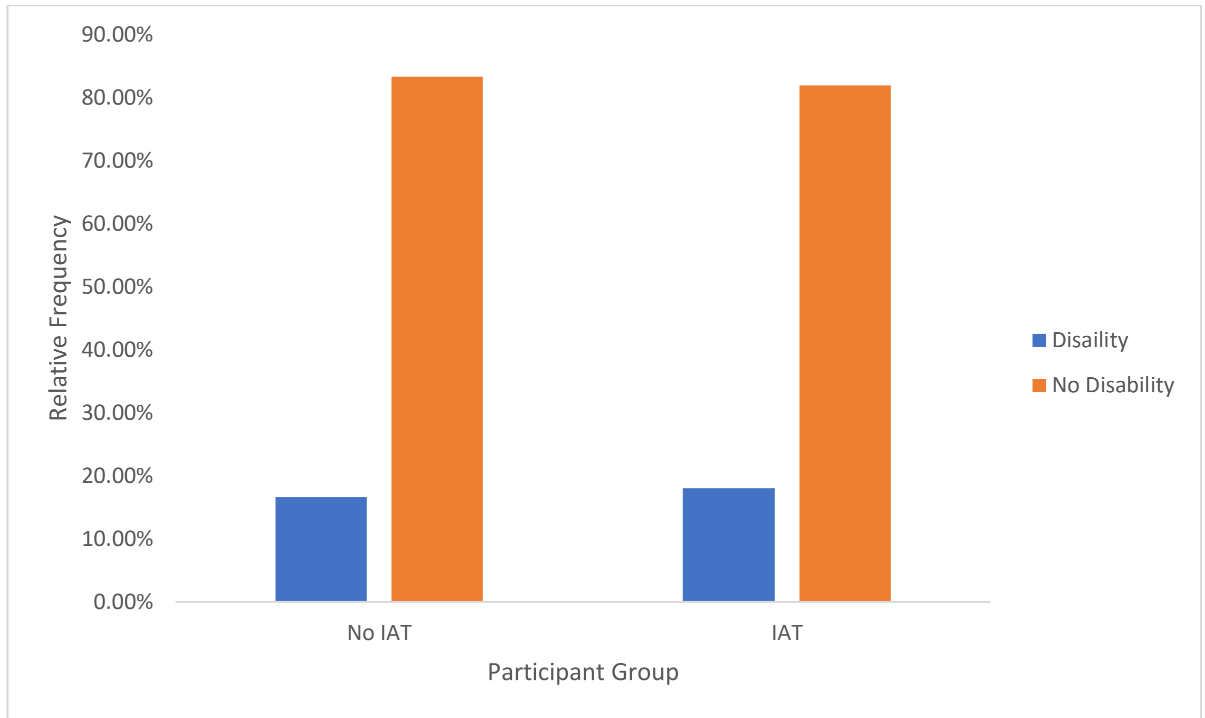
	Level of Agreement					
Participant Group	Strongly disagree	Moderately disagree	Neither agree/ disagree	Moderately agree	Strongly agree	Total
No IAT	9.38% (9)	33.13% (3)	2.08% (2)	41.67% (40)	43.75% (42)	100.00% (96)
IAT	3.28% (2)	0.00% (0)	0.00% (0)	57.38% (35)	39.34% (24)	100.00% (61)
Total	100.00% (11)	100.00% (3)	100.00% (2)	100.00% (75)	100.00% (66)	100.00% (157)

Note. Table of the response to "I have ability to work with clients of diverse backgrounds effectively" of participants who did not take the implicit bias measure compared those who did.

Figure 4.36 and Table 39 below display relationships between the next demographic, disability. Comparatively equal amounts of participants who said that they do have a disability did not take the implicit association test (about 16.67%) as those that do have a disability and did take the implicit association test (18.03%).

Figure 4.36

Participants Who Did Not Take the IAT Compared to IAT Takers: Disability Status



Note. Histogram of disability status of participants who did not take the implicit bias measure compared to those who did.

Table 39

Participants Who Did Not Take the IAT Compared to IAT Takers: Disability Status

	Disability Status		
Participant Group	Disability	No Disability	Total
No IAT	16.67% (16)	83.33% (80)	100.00% (96)
IAT	18.03% (11)	81.96% (50)	100.00% (61)
Total	100.00% (27)	100.00% (130)	100.00% (157)

Note. Table of disability status of participants who did not take the implicit bias measure compared to those who did.

Below is also Table 40 and Figure 4.37 comparing religious affiliation between participants who took the IAT and those that did not. When responding for religious affiliation, participants selected one of five choices. Those choices were separated into 5 categories for the purpose of graphing and are labeled in Table 39 below as well. In Figure 4.37, shown is that those that did not take the IAT are moderately more religious (in categories four and five) than IAT takers in the same categories. These categories both correspond to being part of a religious organization and it being important to them. However, in categories one, two, and three (categories that correspond to not being religiously affiliated or them not being important and part of daily life) there are comparatively more IAT takers than non IAT takers. This suggests that of the survey participants, non IAT test takers are modestly more religious than IAT takers. Even more so, the largest amount of people who did not take the IAT were part of a religious organization that is very important to them, and it is part of their daily life.

Table 40

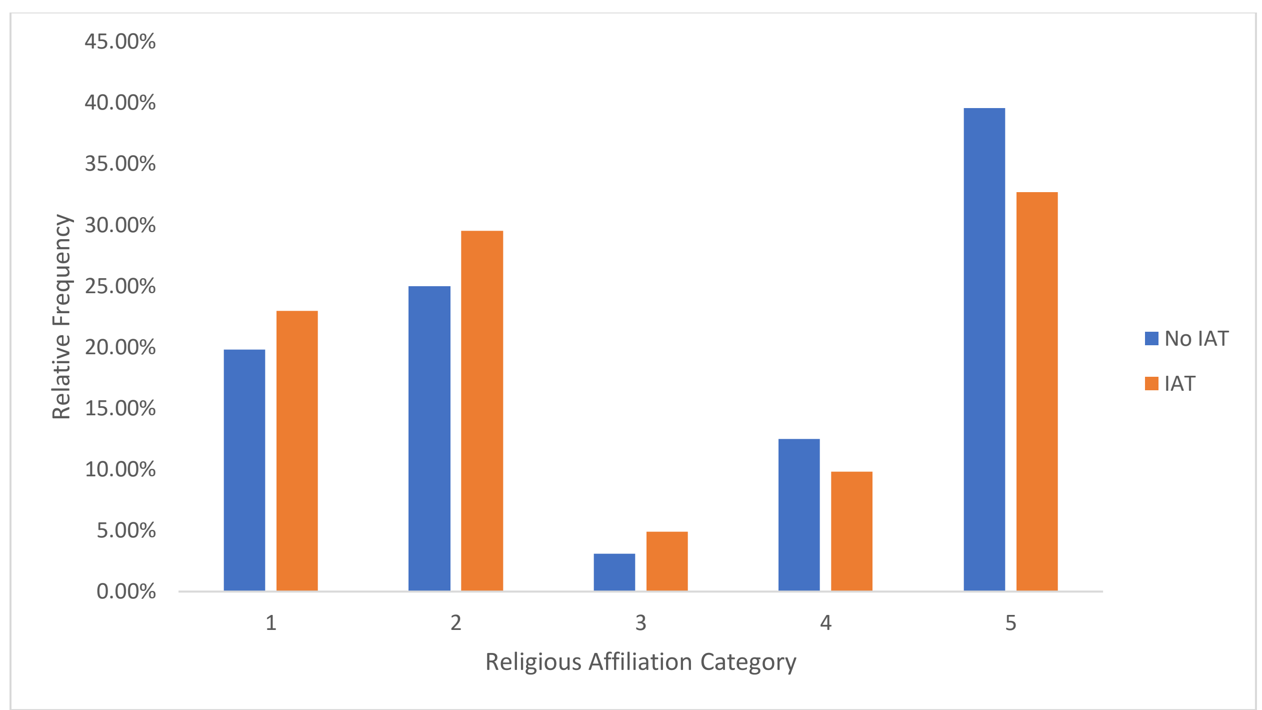
Participants Who Did Not Take the IAT Compared to IAT Takers: Religious Affiliation

	Religious Affiliation					
	Category 1	Category 2	Category 3	Category 4	Category5	
Participant Group	No- I would not consider myself part of any religious organization.	No- I am not religious, but I hold spiritual beliefs.	Yes- I would consider myself part of a religious organization, but it is not important in my daily life.	Yes- My religion/ affiliation with my religious organization is important to me but is not part of my daily life.	Yes- My religion/ affiliation with my religious organization is very important to me and is part of my daily life.	Total
No IAT	19.80% (19)	25% (24)	3.12% (3)	12.50% (12)	39.58% (38)	100.00% (96)
IAT	22.95% (14)	29.50% (18)	4.90% (3)	9.83% (6)	32.70% (20)	100.00% (61)
Total	100.00% (33)	100.00% (42)	100.00% (6)	100.00% (18)	100.00% (58)	100.00% (157)

Note. Table of religious affiliation of participants who did not take the implicit bias measure compared to those who did.

Figure 4.37

Participants Who Did Not Take the IAT Compared to IAT Takers: Religious Affiliation



Note. Histogram of religious affiliation of participants who did not take the implicit bias measure compared to those who did.

As such, so far, most respondents who did not take the IAT have the following in common:

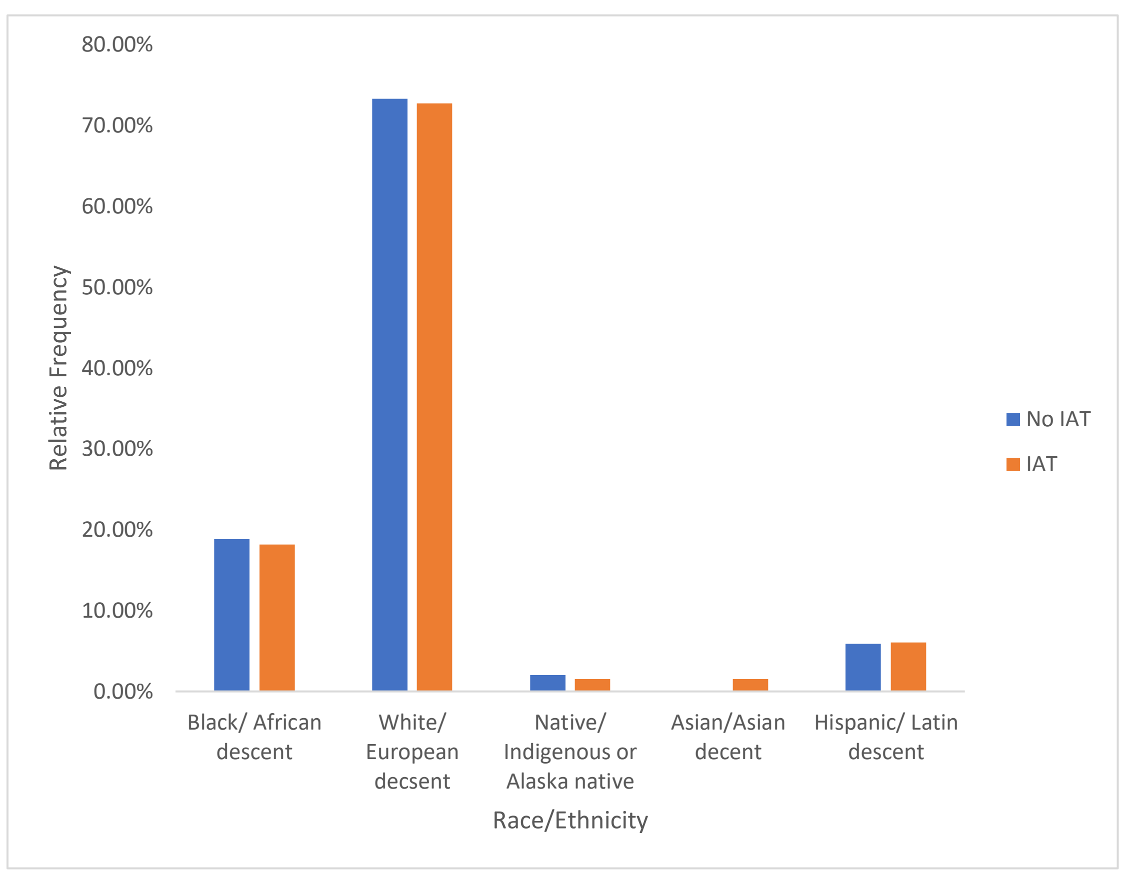
- Between 46-70
- Nonstudents who hold provisional licensure, full licensure, counseling supervisors or counseling educators
- Less confident in their ability to work with diverse cultures than participants who took the IAT
- Mostly do not have disabilities

- More religious than IAT takers

Regarding race, the graph below in Figure 4.38 reveals that consistently across each race/ethnicity except Asian/Asian descent, comparatively the same amount did not take the IAT as those that did. Table 41 provides specific percentages across race/ethnicity.

Figure 4.38

Participants Who Did Not Take the IAT Compared to IAT Takers: Racial/ Ethnic Background



Note. Histogram of race/ethnicity of participants who did not take the implicit bias measure compared to those who did.

Table 41

Participants Who Did Not Take the IAT Compared to IAT Takers: Racial/ Ethnic Background

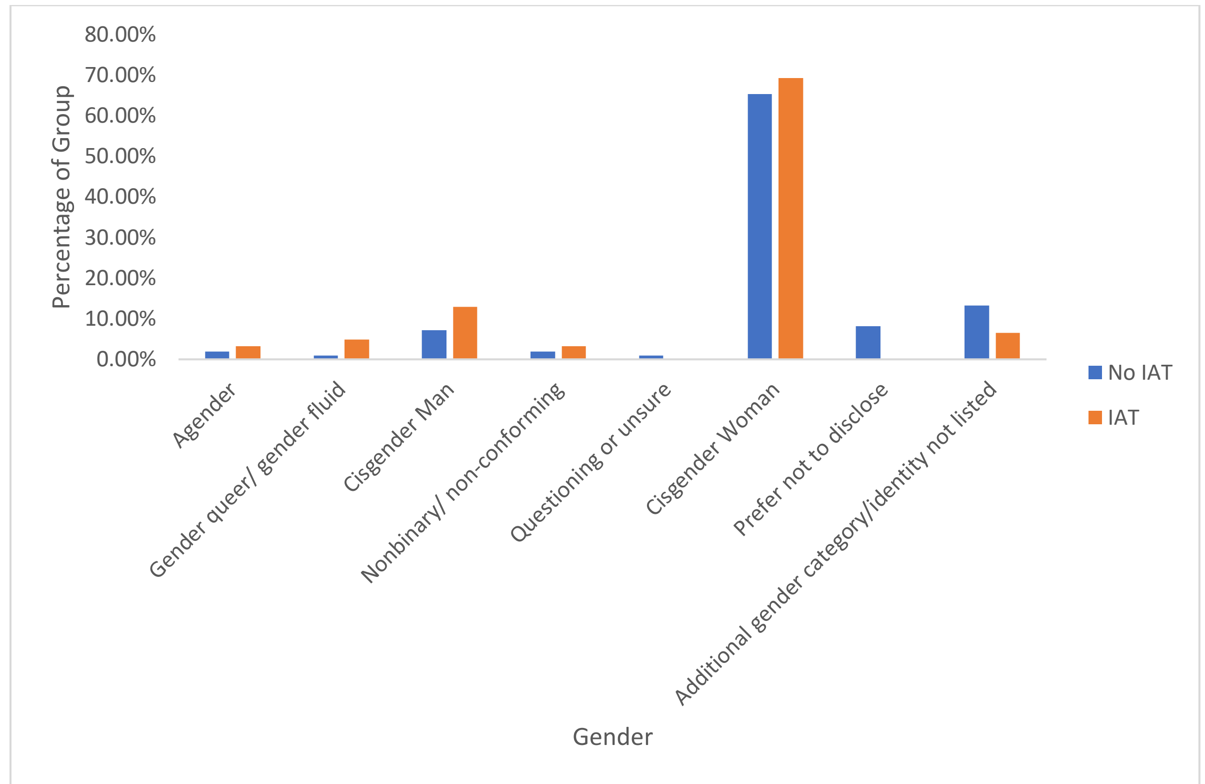
Participant Group	Race/ Ethnicity					Total
	Black/ African descent	White/ European descent	Native/ Indigenous or Alaska native	Asian/Asian decent	Hispanic / Latin descent	
No IAT	18.81% (19)	73.27% (74)	2.00% (2)	0.00% (0)	5.94% (6)	101
IAT	18.18% (12)	72.72% (48)	1.51% (1)	1.51% (1)	6.06% (4)	66
Total	100.00% (31)	100.00% (122)	100.00% (3)	100.00% (1)	100.00% (10)	100.00 % (167)

Note. Table of race/ethnicity of participants who did not take the implicit bias measure compared to those who did.

Across gender, from Figure 4.39 and Table 42 below, similar amounts of participants chose to take the IAT as did not, except with cisgender men, cisgender women, those who preferred not to disclose and the additional category. Again, in the additional category almost all the responses except one read “female” or “woman”. The other additional one read “male”. Even still, while keeping with the integrity of respondent data and excluding those responses from the cisgender woman count, it can be garnered that in addition to the above list, someone most likely to not take the IAT was also a cisgender woman across various racial or ethnic groups. This is also true for those that did take the IAT.

Figure 4.39

Participants Who Did Not Take the IAT Compared to IAT Takers: Gender



Note. Histogram of gender of participants who did not take the implicit bias measure compared to those who did.

Table 42

Participants Who Did Not Take the IAT Compared to IAT Takers: Gender

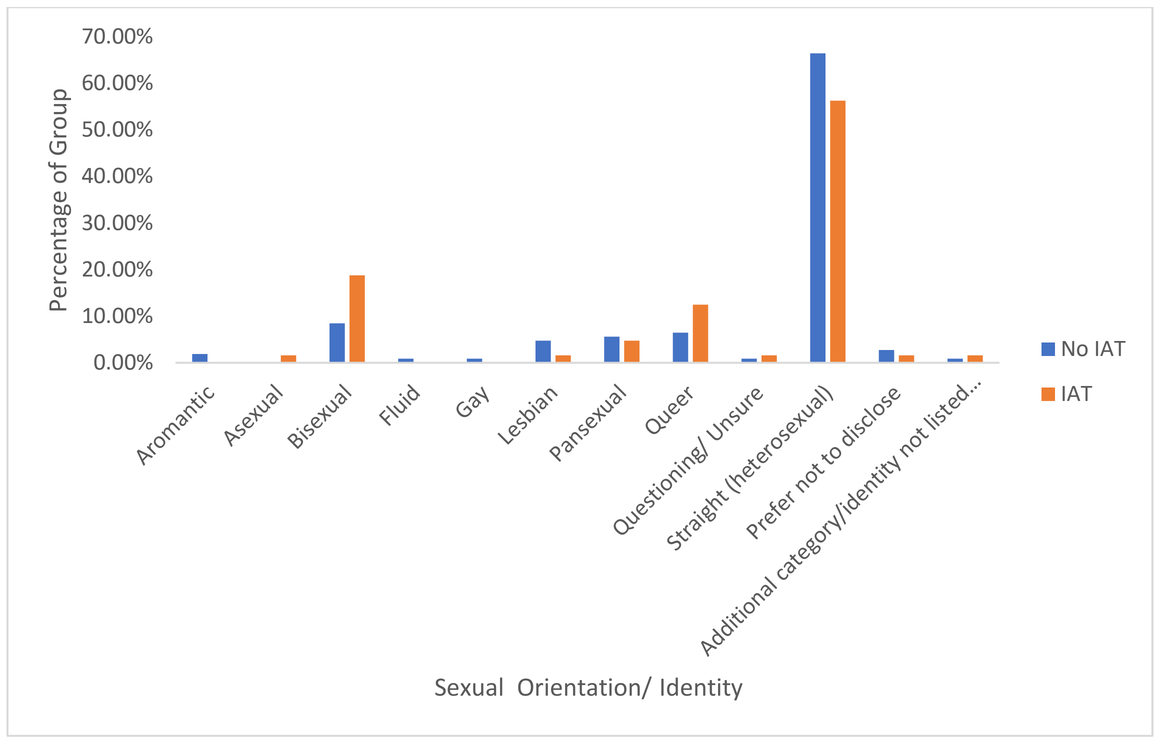
Gender	Participant Group		Total
	No IAT	IAT	
Agender	2.04% (2)	3.23% (2)	100.00% (4)
Gender queer/ gender fluid	1.02% (1)	4.84% (3)	100.00% (4)
Cisgender Man	7.14% (7)	12.90% (8)	100.00% (15)
Nonbinary/ non-conforming	2.04% (2)	3.23% (2)	100.00% (4)
Questioning or unsure	1.02% (1)	0.00% (0)	100.00% (1)
Cisgender Woman	65.31% (64)	69.35% (43)	100.00% (107)
Prefer not to disclose	8.16% (8)	0.00% (0)	100.00% (8)
Additional gender category/identity not listed	13.27% (13)	6.45% (4)	100.00% (17)
Total	100.00% (98)	100.00% (62)	100.00% (160)

Note. Table of gender of participants who did not take the implicit bias measure compared participants who did.

Additionally, across sexual orientation/sexual identity, as seen in Figure 4.40 and Table 43, more respondents did not take the IAT than those that did except within the bisexual, asexual, questioning/unsure and the additional categories. Further, almost twice as many heterosexual respondents did not take the IAT than heterosexual respondents who did. So, it is likely that among the above, a respondent who did not take the IAT was part of the sexual majority.

Figure 4.40

Participants Who Did Not Take the IAT Compared to IAT Takers: Sexual Orientation



Note. Histogram of sexual orientation of participants who did not take the implicit bias measure compared participants who did.

Table 43

Participants Who Did Not Take the IAT Compared to IAT Takers: Sexual Orientation

Sexual Orientation/ Identity	No IAT	IAT	Total
Aromantic	1.87% (2)	0.00% (0)	100.00% (2)
Asexual	0.00% (0)	1.56% (1)	100.00% (1)
Bisexual	8.41% (9)	18.75 % (12)	100.00% (21)
Fluid	0.93% (1)	0.00% (0)	100.00% (1)
Gay	0.93% (1)	0.00% (0)	100.00% (1)
Lesbian	4.67% (5)	1.56% (1)	100.00% (6)
Pansexual	5.60% (6)	4.69% (3)	100.00% (9)
Queer	6.54% (7)	12.50 % (8)	100.00% (15)
Questioning/ Unsure	0.93% (1)	1.56% (1)	100.00% (2)
Straight (heterosexual)	66.36% (71)	56.25 % (36)	100.00% (107)
Prefer not to disclose	2.80% (3)	1.56% (1)	100.00% (4)
Additional category/identity not listed	0.93% (1)	1.56% (1)	100.00% (2)
Total	100.00% (107)	100.00 % (64)	100.00% (171)

Note. Table of sexual orientation of participants who did not take the implicit bias measure compared participants who did.

Finally, altruism scores were analyzed between those who took the implicit bias measure and those who did not. As data was treated as nonnormal, a nonparametric test was used. Kendall's Tau C indicated that there is not a statistically significant relationship between the altruism scores of those who took the IAT and those who did not ((r (61) = -0.02, p= 0.80).

Qualitative Results

The overarching question guiding the qualitative portion of the current study was "What else should be included in NIH's implicit bias training to adapt it for counselors?". Participants reported on thoughts related to altruism and implicit bias in the counseling profession interrupting effective care with clients of diverse cultures, mainly of color. Responses were then thematically analyzed and used to adapt the National Institutes of Health (NIH) Implicit Bias Training Module (2022), adding a section specifically tailored to counselors. A total of five questions were asked in the focus groups and interviews to comprehensively answer the overarching research question. A complete list of specific questions is listed below:

1. Let's discuss the survey & IAT- what are your thoughts?
2. The counseling profession is trying its best to better help diverse clients. Through research it seems that how we culturally define help may be helpful to discuss. What are your thoughts on altruism in the counseling profession?
3. How do you think altruism (definitions of how we help and who in our culture) could impact unintentional biased decision making?
4. Let's review the NIH implicit bias training and see if there are things we can add based off of our thoughts on altruism and how our culture defines it.
5. Based off our discussion related to bias, altruism, and the training, is there anything else related to such that should be added to better help counselors care for clients of color?

In total, five participants were involved in the qualitative portion of the study. Participants were gathered on the volunteer basis from the original group of participants who took the survey from the quantitative portion of the study. While initial plans were to have multiple focus groups, based on limited sampling and scheduling, there was a mixture of groups and interviews. The

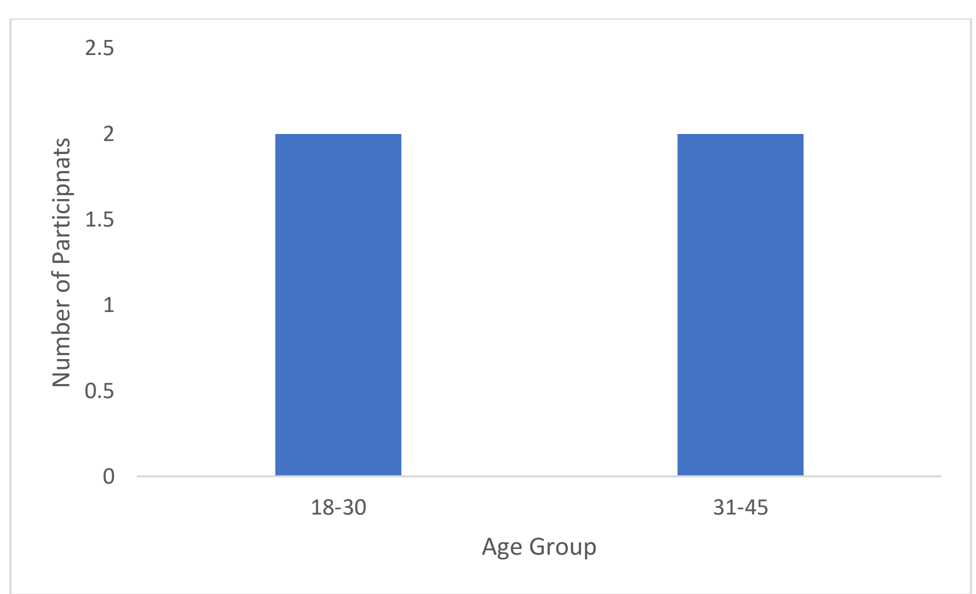
first group was comprised of two participants while the remaining three other meetings were with individual participants and considered semi-structured interviews. Qualitative participants were told their survey would be tracked via personal links in order to gather demographic information, discussed below.

Demographics

Figures 4.41 and 4.42 below display the age and roles of the those who participated in focus group or interview discussions. Participants were mostly representative of the population for the 157 total participants of the study. Two participants were between 18 and 30 years old, two were between 31 and 45 years old and one was between ages 46 and 60. Most of the participants except one were counselors in training. The others were either a counseling supervisor or provisionally licensed counselor.

Figure 4.41

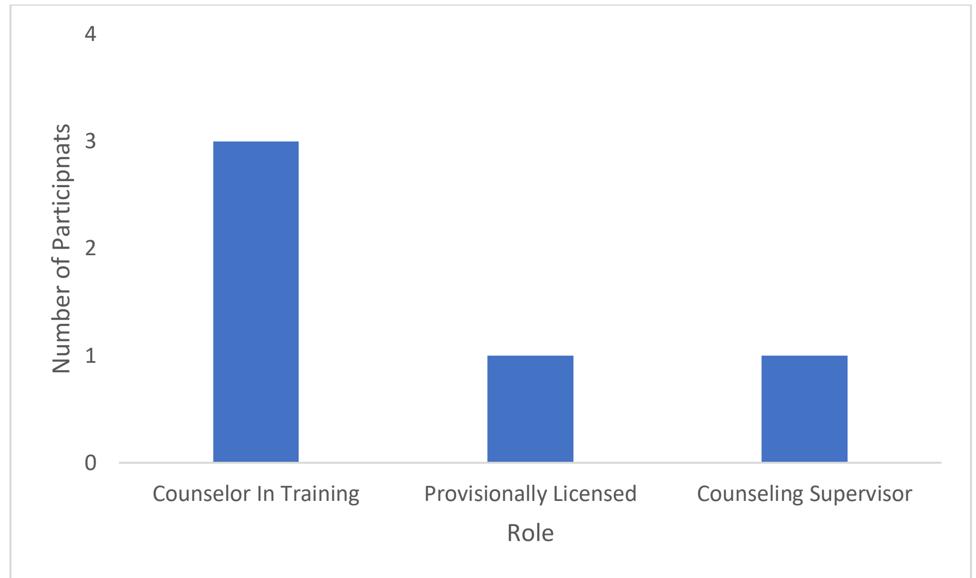
Demographic Data: Age of Qualitative Participants



Note. Histogram of age of participants from the qualitative portion of the study.

Figure 4.42

Demographic Data: Roles Occupied in North Carolina Counseling Field of Qualitative Participants

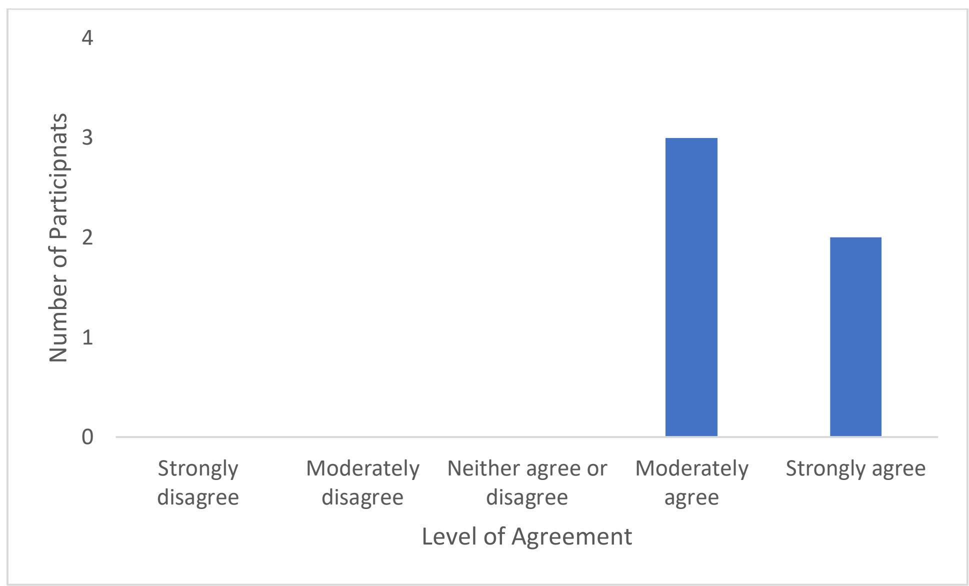


Note. Histogram of the roles in the counseling field of participants from the qualitative portion of the study.

Figures 4.43 and 4.44 display the confidence in treating diverse cultures and CACREP status of master's program attended of participants who contributed in the qualitative portion of the study. Participants were generally confident in their ability to treat diverse clients with ratings of either four or five on a Likert scale of one to five (one being "strongly disagree" and five being "strongly agree") with the statement "I have the ability to work with clients of diverse backgrounds effectively). This is representative of the total 157 participants as well. Most of the participants in the qualitative portion, with the exception of one went to or are currently attending a CACREP accredited master's program, again similar to the original 157 participants.

Figure 4.43

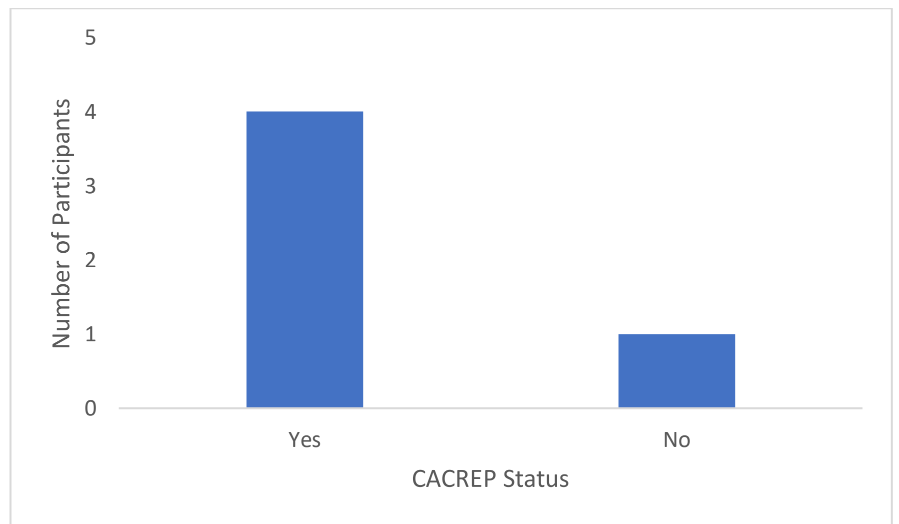
Demographic Data: Survey Participant Response to "I have ability to work with clients of diverse backgrounds effectively" of Qualitative Participants



Note. Histogram of the comfort with working with diverse cultures of participants from the qualitative portion of the study.

Figure 4.44

Demographic Data: CACREP Status of Master's Counseling Program of Qualitative Participants

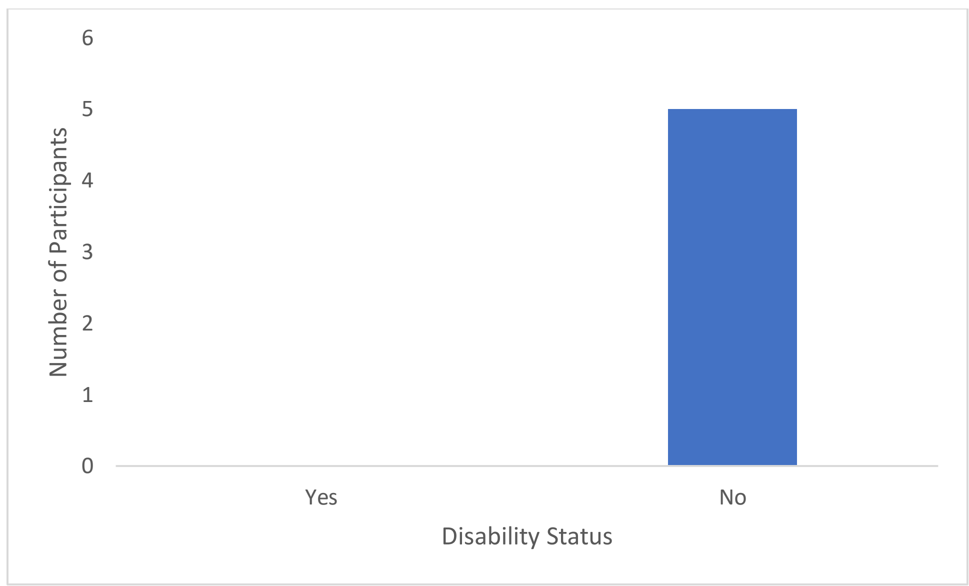


Note. Histogram of the CACREP status of the counseling master's program of participants from the qualitative portion of the study.

Additionally, regarding disability status, qualitative participants were also similar to the original 157 with all reporting they did not describe themselves as a person with a disability. Regarding religion however, participants who participated in the qualitative portion were mostly not religious as opposed to the original population which had polarized responses either being very religious or variations of not being religious. This information is displayed in Figure 4.45 and Figure 4.46 respectively.

Figure 4.45

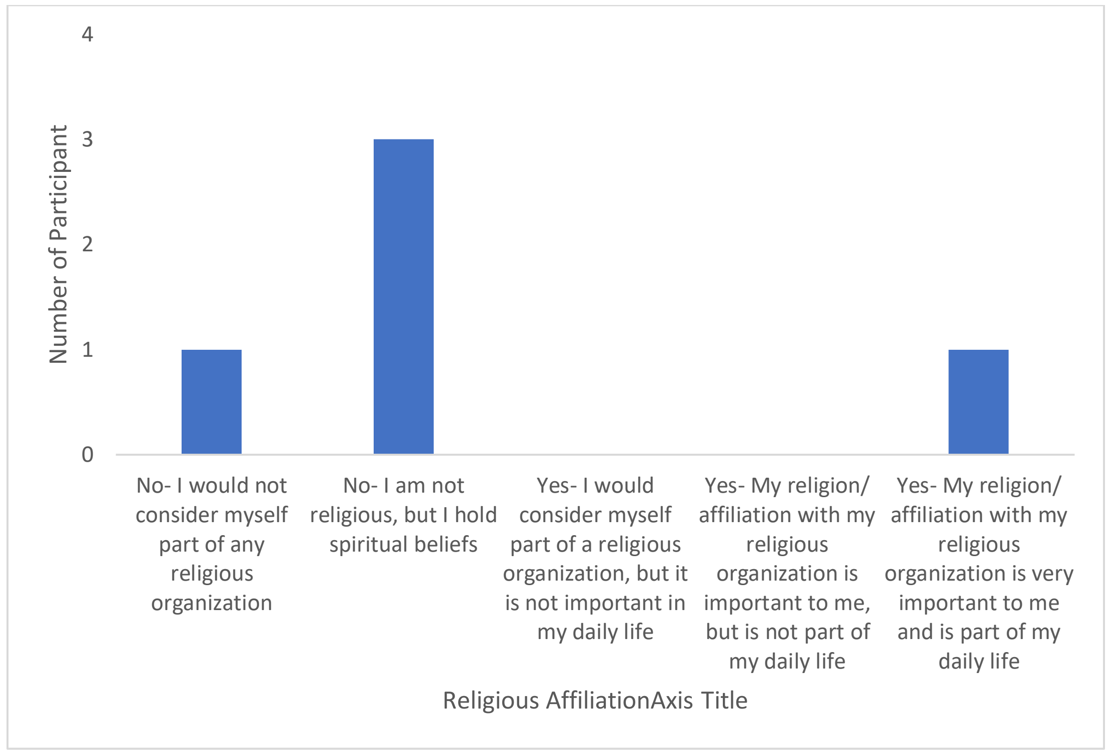
Demographic Data: Disability Status of Qualitative Participants



Note. Histogram of the disability status of participants from the qualitative portion of the study.

Figure 4.46

Demographic Data: Religious Affiliation of Qualitative Participants

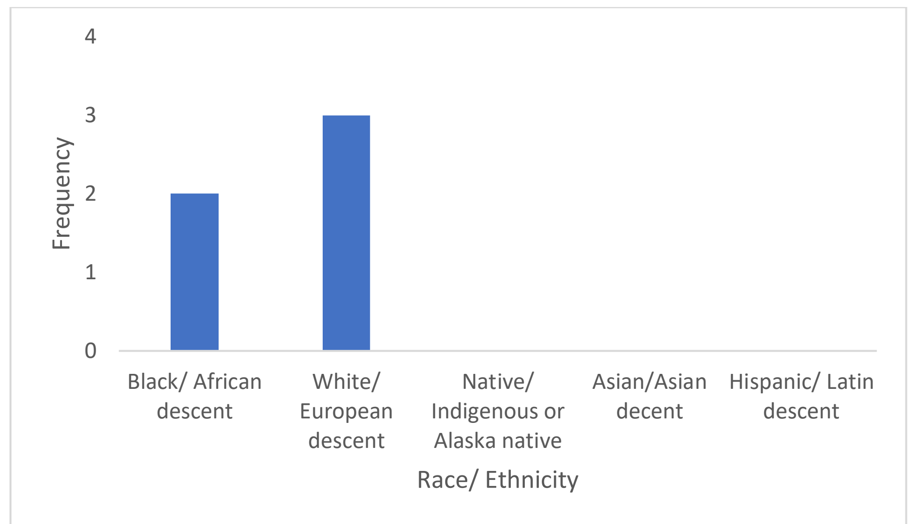


Note. Histogram of religious affiliation of participants from the qualitative portion of the study.

Participants either Black/African descent or White/European descent with most being the latter (from Figure 4.47) and were all cisgender women (from Figure 4.48). Again, as cisgender women and White/European descent were the largest demographics relating to gender and race/ethnicity respectively, this is also representative of the total original 157 participants.

Figure 4.47

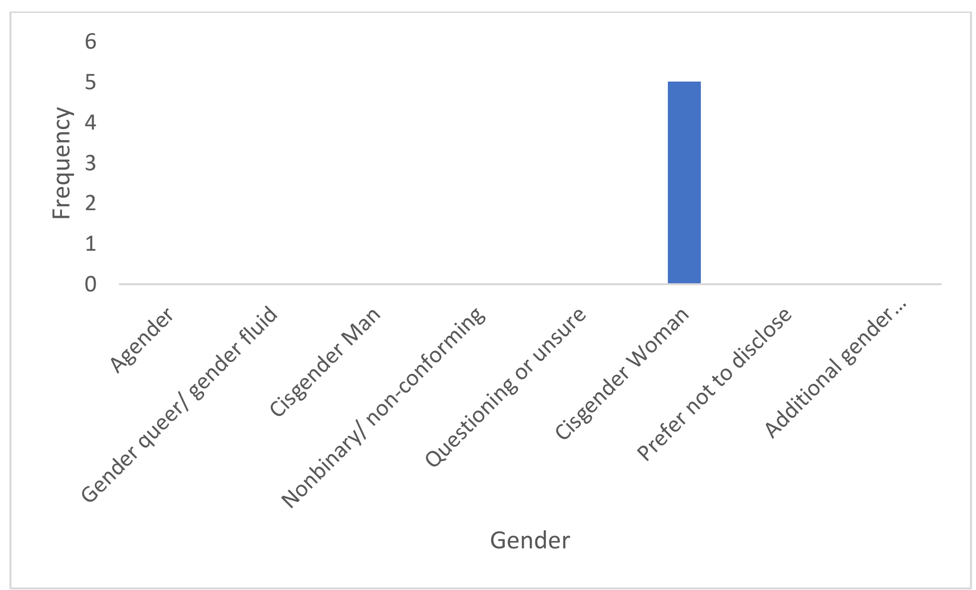
Demographic Data: Racial/ Ethnic Identity of Qualitative Participants



Note. Histogram of race/ethnicity of participants from the qualitative portion of the study.

Figure 4.48

Demographic Data: Gender Identity of Qualitative Participants

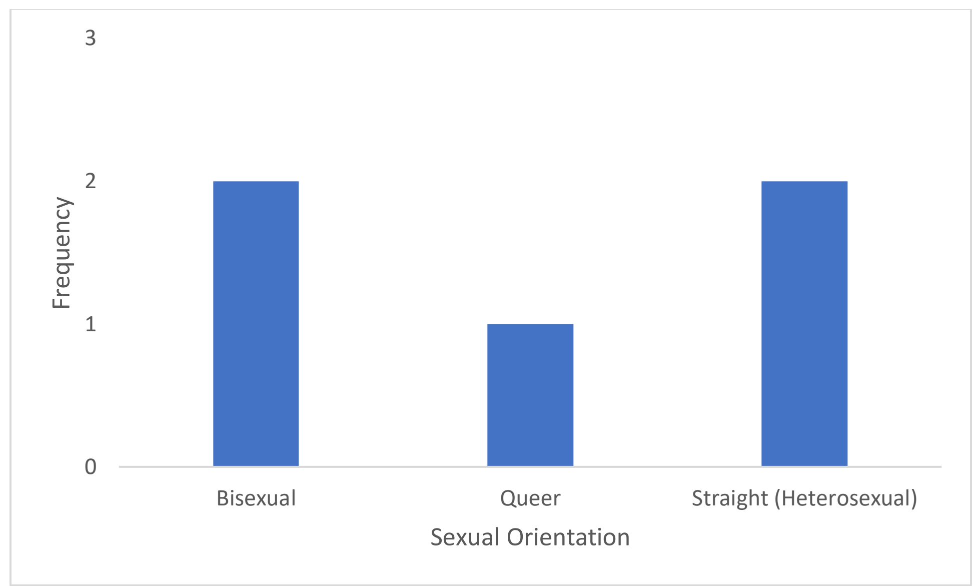


Note. Histogram of gender of participants of the qualitative portion of the study.

Regarding sexuality, found in Figure 4.49, two participants were straight/heterosexual, two were bisexual and one was queer. Regarding sexual orientation, qualitative participants were also representative of the original 157. As analysis of the total participants in the study showed participants being mostly heterosexual with increased amounts of participants being bisexual and/or queer, this is also true of qualitative participants. Though, there were equal amounts of straight and bisexual participants in this portion of the study, different than the overall total of the current study.

Figure 4.49

Demographic Data: Sexual Identity/ Orientation of Qualitative Participants



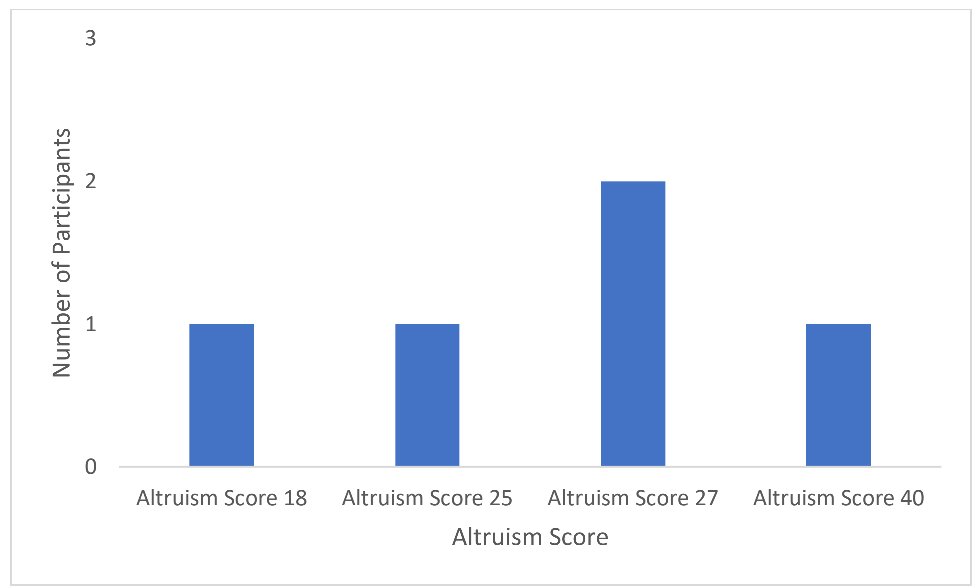
Note. Histogram of sexual orientation of participants of the qualitative portion of the study.

Participants also represented altruism scores similar to the representation of total participants for the whole study and those who took the implicit bias measure. Average altruism scores across the original 157 were about 27, while those who took the IAT were around 25. Both are represented in this population with two having an altruism score of 27 and one at 25. The participant with the second highest altruism score from the entire study participated in the

focus group with an altruism score of 40. The least altruism score in the overall study was 14. A participant in this portion of the study was close with an altruism score of 18. Finally, regarding implicit bias results, most participants who participated in the qualitative portion had a moderate preference, while others had an equal preference. Two participants had a moderate preference toward White while two did not prefer either race. One participant had a moderate preference for Black. These results were similar in comparison to the total participants across the study as well. Both the altruism and IAT scores can be found in Figure 4.50 and Figure 4.51 below.

Figure 4.50

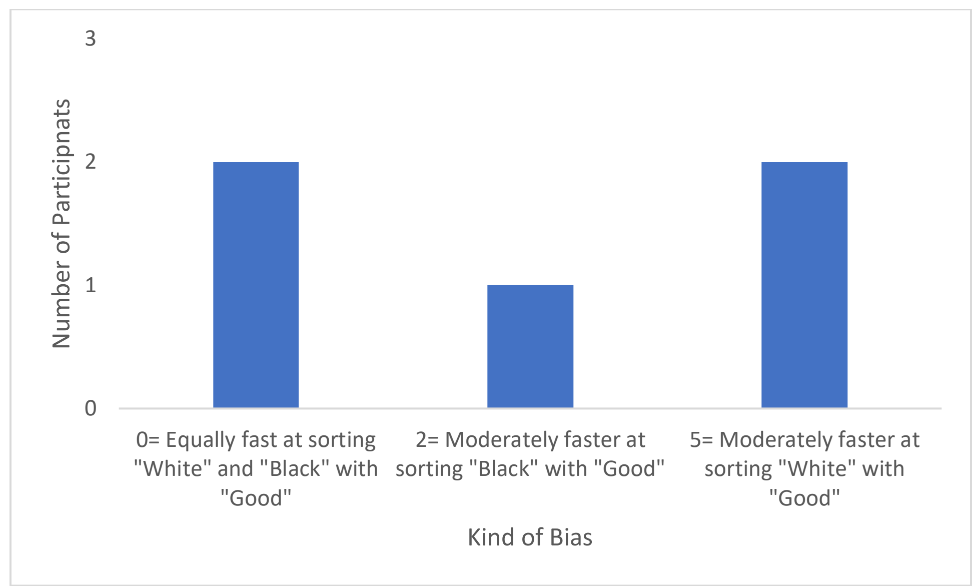
Participant Altruism Scores of Qualitative Participants



Note. Histogram of altruism scores of participants of the qualitative portion of the study.

Figure 4.51

Kind of Implicit Bias of Qualitative Participants



Note. Histogram of implicit bias results of participants of the qualitative portion of the study.

For the purposes of better contextualizing participant responses, here is a description of participant demographics with pseudo names. In keeping with the integrity of research suggestions for proper reporting of implicit bias scores, individual IAT scores will be left out of the descriptions.

Participant one is given the pseudo name Victoria moving forward. Victoria is between the ages of 31 and 45 and is a White bisexual cisgender woman who does not have a disability. Victoria is a counselor in training currently attending a CACREP accredited program. Victoria is very confident in her ability to treat clients of diverse cultures, "strongly agreeing" with the statement "I have the ability to work with clients of diverse backgrounds effectively". Victoria is also not religious but holds spiritual beliefs and scored a 27 out of 45 on the altruism scale.

Participant two will be known as Geri moving forward and is between the ages of 18 and 30. Geri is a queer, Black cisgender woman who is a counselor in training currently attending a

CACREP accredited program. She does not have a disability. Geri reported her confidence in treating diverse clients effectively a four out of five, “somewhat agreeing” with the statement. Geri is also not religious, but she does hold spiritual beliefs. Geri also scored a 25 out of 45 on the altruism scale.

Participant three is given the pseudo name Mel B. Mel B is a heterosexual cisgender White woman who is between the ages of 31 and 45 and does not have a disability. Mel B is also a counselor in training currently attending a CACREP accredited program. She is also fairly confident in her ability to effectively treat clients of diverse backgrounds reporting she “somewhat agrees” with the statement. Mel B does not consider herself a part of any religious organization and scored a 27 out of 45 on the altruism scale.

Participant four, pseudo named Melanie C, is also a heterosexual White cisgender woman who does not have a disability. She is between the ages of 46 and 60 and is a counseling supervisor. Melanie C is the only qualitative participant who did not attend a CACREP accredited master’s level counseling program. She is also fairly confident in her ability to effectively treat clients of diverse backgrounds reporting she “somewhat agrees” with the statement. Finally, Melanie C is very religious reporting “My religion/ affiliation with my religious organization is very important to me and is part of my daily life”. Melanie C scored a 40 out of 45 on the altruism scale.

Finally, participant five, pseudo named Emma, is a Black bisexual cisgender woman without a disability who is between the ages of 18 and 30. Emma is a provisionally licensed counselor (LCMHCA) who attended a CACREP accredited master’s program for counseling. She is also very confident in her ability to effectively treat clients of diverse backgrounds reporting she “strongly agrees” with the statement. Emma is not religious, but she does hold spiritual beliefs and scored an 18 out of 45 on the altruism scale.

As stated previously, due to sampling limitations there was one focus group followed by three subsequent semi structured interviews that took place on separate days and times virtually. All groups utilized the same core questions, but additional questions may have been asked for clarifying purposes. Victoria and Geri attended the first focus group together, Mel B, the second taking the format of a semi-structured interview, the third (another semi-structured interview) was with Melanie C and the last meeting (semi-structured interview) was with Emma.

Focus Group and Semi Structured Interview Responses

In assessing what should be added to the NIH implicit bias training for counselors, Victoria, Geri, Mel B, Melanie C and Emma were asked several questions in context with the study. Virtual meetings were scheduled and recorded. Transcripts were automatically generated and systematically analyzed for codes and saturated trends for themes. A finalized table of themes by discussion question can be found below in Table 44. Given there were only five participants, a majority (three of five) was used for saturation as participants organically and individually brought up several similar themes throughout discussion. Even still, with most themes all participants mentioned certain concepts or ideas achieving the typical goal of five for saturation, as with the first focus group/interview question.

Table 44

Focus Group and Unstructured Interview Saturated Themes

Question	Theme
Question 1	IAT validity
Question 2	Altruism definition: self-sacrifice
	Counselors have altruistic core
	Altruistic characteristics before profession
	Some counselors don't sacrifice self but claim altruism
	Altruistic drive vs. altruistic intention
Question 3	Altruism aids bias
	Counselor dominance
	Counselors prioritize altruism over clients
	Silencing clients
	Multicultural knowledge and humility
	Bias is informed by individual preferences and surrounding culture
	Altruism affects how counselors perceive a client's problem

Note. Themes emerged from qualitative discussion.

Questioning validity of IAT. Initially, respondents were asked their thoughts on the IAT (Question: Let's discuss the survey & IAT- what are your thoughts?). Across all participants, they all raised questions about the validity of the measure. Victoria reported "It felt elementary" (Victoria, personal communication, June 1, 2023). While some reported they had taken the measure before (Geri and Emma) or praised the idea of the measure and felt the results were accurate (Geri), overall, they were unsure if it measured what it should. For example, Emma reported that the measure was too "simple" and that it felt like you could "outsmart the system if [you] wanted to" (Emma, personal communication, October 3, 2023).

Characteristics of altruism and counseling coincide. Following, participants were asked about their thoughts on altruism in the counseling profession through the lens of

counseling diverse clients (Question: The counseling profession is trying its best to better help diverse clients. Through research it seems that how we culturally define help may be helpful to discuss. What are your thoughts on altruism in the counseling profession?). Participants typically began answering the question by giving their own definition of altruism. Common definitions described altruism as self-sacrificing. For example, Victoria reported that altruism is “helping without any gain” (Victoria, personal communication, June 1, 2023). Mel B reported “it's doing something about others needs before your own” (Mel B, personal communication, June 9, 2023). Emma expanded further in the second question on the role of morality in altruistic intention, reporting that altruism is “feeling a moral obligation to help others in some way. And often I think that includes some sort of self-sacrifice” (Emma, personal communication, October 3, 2023). Overall participants felt that altruism is self-sacrificial.

In answering the second question (The counseling profession is trying its best to better help diverse clients. Through research it seems that how we culturally define help may be helpful to discuss. What are your thoughts on altruism in the counseling profession?) participants also believed that altruism is foundational to the counseling profession and that people join the counseling profession for altruistic reasons. Melanie C plainly explained “...if someone is altruistic, it means that they're, that they're a helper” drawing a synonymous relationship between helping as an identity and the act of being altruistic (Melanie C, personal communication, June 8, 2023). Emma reported “altruism plays a huge role of why people get into this field” (Emma, personal communication, October 3, 2023)and Mel B reported “Altruism within the counseling profession, I think most people get into the counseling profession because they are altruistic people, and they really want to do their best to help others” (Mel B, personal communication, June 9, 2023).

There was a general consensus that people who are drawn to the counseling field identify as altruistic helpers before joining the profession. At a base level, they all reported that they had a drive to help out of self-sacrifice having an idea of how helping should go before joining the profession. They believed that the counseling profession was the perfect marriage of their (and other counselors) drive to help and the characteristics needed for the profession. Emma further explained altruism's role in the field reporting "Altruism is the main reason why people stay", "...the drive to want to help others and to be willing to make some of those sacrifices is what keeps people in the game for so long", "...that joy of seeing clients change and knowing that they had a role in that somewhere along the journey". She further explained that altruism is vital to the work of counseling as it "shields burnout" because it "connects you to your why" (Emma, personal communication, October 3, 2023).

The counselor's struggle when trying to help altruistically (two altruisms). From the above comment we start to see participants allude to the idea that helping in a counselor role is not entirely self-sacrificial because they get something out of it. In other words, they identified as altruistic helpers before joining the profession, joined with altruistic intentions and then became aware of the rewards that come with helping in the profession. Emma continued with the indication reporting "...because I think like that at a surface level, like, of course, we want to help others..." and "I think we're also trying to help ourselves in some way too" (Emma, personal communication, October 3, 2023). Geri reported similarly but spoke more directly on the struggle of purely altruistic intention once counselors become aware of the rewards of helping. Geri reported that counselors have an "altruistic nature" and "have to work hard to separate this form their role as counselors" (Geri, personal communication, June 1, 2023). Geri said that counselors "see all the ways they can help" and "project that onto the client". She reported that she "struggle(s)" with her "need to help" "often".

All participants except Emma brought up an awareness of a struggle with what they would like to do altruistically versus what they learn in the counseling program. Though Geri reported that she actively has to fight against the urge, within the group, Victoria noted that she is beginning to learn how to funnel her altruism in a way that is more helpful to the client. Victoria noted that “altruism looks different based on the client base” and is “informed by the type of population” (Victoria, personal communication, June 1, 2023). She reported that counselors should “look to the client for what they need and then you offer what you can based on the role”. She also noted that altruistic help in general is “informed by previous life experiences”.

Again, all the participants acknowledged that there is a frustration that arises when counseling students find out that they cannot express all of their altruism within the profession due to ethical codes established in the profession and admit that not acting out of their altruism is “difficult and taxing”. Victoria and Geri discussed specifically a type of “unlearning” of what they think helping is once they start their master’s program (Geri & Victoria, personal communication, June 1, 2023). Participants agreed that some counselors grow to understand throughout their programs that helping is defined by the client and readily accept that role in counseling while others do not. For example, Mel B reflected “...what I believe is right, and the right way to do things is not going to necessarily be the right choice for someone else” (Mel B, personal communication, June 9, 2023). All participants in the study reported watching classmates and others in the profession struggle between the two roles. Mel B said the following related “...that they would have difficulty not intervening when they see something they thought was a problem. But that, their client thought was a good thing” (Mel B, personal communication, June 9, 2023).

That is in one scenario, the inclination to act out of altruism places strain and restricts what they previously believed was the role of the counselor leading to a constant taxing in decision making. In this scenario altruism suggests that the counselor should be the one to define helping in the act of altruism, but what they've learned about the profession says the client should define the helping instead. This clinician has a constant battle within themselves and according to the participants, the inclination to define the help through counselor driven altruism wins often. However, with a type of directed and refined altruism, the role of counselor acts in harmony with altruism by placing the power of defining the type of help back onto the client. Here there is less room for previous life experiences to inform the counselor's brand of helping, so the altruistic intention works however the client wants it to. Victoria reported this route is less taxing but requires a repeated conscious decision.

Melanie C struggled to string together complete sentences but generally tailored her responses toward more of an activism lens. Though a different approach, it still echoed similar thoughts of the other participants. For example, in answering the question, she explained "[counselors are] supposed to help people of all identities and cultures... we may not be going about it the right way". Melanie C then said "[Some counselors] don't try hard enough or completely dismiss differences that they may have...", "I believe that altruism is a genuine concern, for, you know, wanting to help and for meeting needs of other people. And I believe there is a great lack of that in the counseling profession. Okay, that we are not as a profession, we are not working hard enough to help the best", "...so, if we are as counselors are helpers that we should be aware of other people's needs that may be different from ours" (Melanie C, personal communication, June 8, 2023). Overall, she echoed similarly that there is a disconnect between altruistic intentions and truly behaving in a way that is out of altruism and beneficial to clients of diverse backgrounds.

Counselor authority results in silenced clients. Respondents reported on how counselors engage in a form of dominance and authority that can silence clients resulting in them not getting their needs met. Mel B alluded to potential feelings of superiority counselors may have in helping, reporting “We have to be careful about helping others, not being condescending, um, and helping others in the way that's best for them”. She reported that she feels “... [counselors] may be helping the way they want instead of the way the client wants” (Mel B, personal communication, June 9, 2023). She reported counselors should ask clients “Tell me where you see the problems are, and let's figure out how to solve them together”.

Participants expanded more on the above theme of potential counselor abuse of authority in decision making in responses to the third question “How do you think altruism (definitions of how we help and who in our culture) could impact unintentional biased decision making?”. Victoria shared a personal story from when she saw a past therapist to underscore how altruism “aids in making assumptions and doesn’t allow the client to address their concerns” (Victoria, personal communication, June 1, 2023). She reported that her counselor was ineffective because she made assumptions about what needed to be addressed. Further she reported that because she knew her counselor was “trying to help” she did not voice her concerns. Melanie C, in a separate interview, reported similar, reflecting on someone she knew, “...She felt like the counselor wasn't listening, but because this person was a doctor, she was a psychologist, um, that she was really smart. And so, even though she didn't get her, she kept going to her because of her credentials” (Melanie C, personal communication, June 8, 2023). Further she reported on her own guilt with her positions of authority in the profession reporting this about the person “And I thought that was a shame and, and it took her a year before she would even tell me that”.

Overall, participants shared their frustration reporting that some counselors may exert authority taking over counseling sessions. These counselors prioritize their altruistic drive and

intention to help over the client and their needs. In this environment it is difficult for clients to advocate for themselves due to the awareness of the differing power dynamics reinforced by the counselor’s actions. Respondents reported that in this environment bias thrives unchecked even when the client can see it and is aware of the counselor’s inefficacy.

Importance of multicultural knowledge and humility. Mel B reported that in dealing with diverse cultures it is important to have a general understanding of the culture and listen to the client’s perception of their problem, that you have to “put on the client’s lens to understand them and frame your questions in a way that allows for the client’s own uniqueness in the space” (Mel B, personal communication, June 9, 2023).

Melanie C had quite a bit to share in her experience reporting “Well, Caucasian female therapists, we have to work harder at doing the best we can to connect and to connect with people who don't look like us” and that “there are a lot of counselors that don't do that and don't attempt” (Melanie C, personal communication, June 8, 2023). In general participants shared the frustration of the counselor’s lack of efficacy when it came to effectively helping diverse cultures. Melanie C continued to underscore potential reasons why those counselors are not effective reporting “...I think there are some, some bias that they're either that they may be unaware of, but they need to, they need to figure that out if they really care and really want to help people”. Continuing, she reported “You can be altruistic and still make biased decisions and that it's up to you to do continued research and expand your knowledge base so that you don't do that”. Melanie C continued by saying “They need to get outside of themselves they need to be uncomfortable and maybe have uncomfortable conversations to understand where they stand” and that “Cultural competence is a lifelong process”.

Participants generally reported that there is a need for counselors to practice continued efforts in educating themselves on diverse cultures and their own biases in order to not cause

harm. Additionally, counselors should be open to critique and not hide behind their good intentions. Participants challenged the idea of altruism consistently revisiting two ideas of altruism, an altruism that both the client and counselor experience versus a pseudo altruism that the counselor wholly believes is true for themselves but does not garner the desired results when it comes to multiculturally competent care.

Counselor bias in helping is shaped by external influence. Throughout discussions, participants reported on how bias is informed by individual preferences and surrounding culture. Further, how that bias may influence counselor decision making unconsciously. Here again, Melanie C brought up a battle of altruisms reporting “there's the altruism that we're supposed to do, and then altruism that, like, is informed by bias in culture that you have to educate yourself away from” (Melanie C, personal communication, June 8, 2023). She reported that counselors gather information from their social context about who needs to be helped, and how sometimes it can overwrite what the person in front of you was saying “...or what they actually need, you're not hearing them because you're assuming yeah”, continuing “...Right and with altruism is because it's so embedded in a social context, it can also come with it. It can also have stereotypes and microaggressions”.

In a separate interview, Emma noted “Our views of what is going to be helpful is made up of our backgrounds and our biases...We may be aware or unaware that this is happening. The kind of help we provide in some ways may be unintentional” (Emma, personal communication, October 3, 2023). Emma continued giving an example, “An example, being I'm a super organized person so I think the answer to a lot of problems is to work on organization. And so, in my effort to try to help people, like, make sense of their lives... I think it is helpful to work on organization, but that comes from, like, my stuff, not their stuff. So, I think if we're not being mindful of, like, what's my stuff, what's my values and what's their stuff and their values...”.

Across discussions, participants reported that altruism affects how counselors perceive a client's problem. Emma reported "So that, while you're creating like, your treatment plan or just your course of action, what you perceive, as the problem, that's the kind of help that you're gonna provide and hopefully that's a very collaborative process. And hopefully you're using trauma informed care principles" (Emma, personal communication, October 3, 2023). She continued, "[Counselors] need additional information to check that you are truly being collaborative in your process. Biases that we're unaware of if not mindful can make parts of the process not so collaborative". Throughout, woven is a theme between counselor views of what they are doing disconnected from the experiences of the client influenced by internalized societal or individual biases.

Additional adaptation suggestions. Questions four and five relate to review of the NIH training and additional aspects to add for the adaptation. In collaboration the first group with Victoria and Geri agreed that an adaptation for counselors should also include a "toolbox of resources", discussion on what to do in supervision based on the previous discussion, discussion on behaviors of supervisors and counselors to protect diversity of thought, how our own personal stories/beliefs about helping can interrupt competent decision making, continued inclusive discussion that is action oriented, and specific case scenarios of counselors (Geri & Victoria, personal communication, June 1, 2023). Outside of the adaptation, as they are both counselors in training, they raised concerns for supervision wanting "more organization" and to have "diverse groups of individuals in supervision together".

Mel B discussed adding the distinction between the types of altruism practiced within the counseling profession from the discussion with specific examples. Melanie C reported she would like to change the definition of diversity saying, "I don't like the emphasis on diversity is good because it leads to innovation...It is good and we're diverse culture and we need to represent

everyone" (Melanie C, personal communication, June 8, 2023). She also wanted more examples of a psychologically safe environment specifically related to counseling, to change the mission to that of counselors, and add counselor specific examples. She also reported she would like to add altruism because "I think it is important that counselors examined their own motivation and being diverse, and in serving diverse populations and clients, because if they're doing it for the wrong reasons, because they, they have this guilt, or because they have the need to feel like they're helping someone. Then, it's not going to be as helpful as doing it, because they value diversity, and they want to do what's best for their clients". Additionally, she reported "...microaggressions affect people of color, even if there was no intent. It's, it's like the routines you were talking about...just because it's your habit or what you're comfortable with and you don't have any ill intent does not mean that it's not causing harm".

Emma wanted to add "psychoeducation on systemic barriers to diversity" noting "there may be a lot of people who want to live in, like, a more expensive area, but they do not have the financial means to do so" (Emma, personal communication, October 3, 2023). She also reported it would be helpful to define diversity of clients with my layers noting "It's not just "we like to be around people who look like us". Additionally, she thought it may be helpful to add "core principles of white supremacy culture", give examples "from life, offices and counseling", and "how white supremacy culture is even infiltrated the practice of psychology and counseling".

Saturated additions from the participant responses to question four and five were the following:

- Definition of diversity for counselors
- Specific examples/ case scenarios of counselors
- Analyze counselor bias in altruism effecting care of diverse cultures

Notable Behaviors

There were a few behaviors that are worth noting from some of the participants during focus group and interview discussion that add to the analysis. For instance, Victoria and Geri were in a group together. There may have been personality or demographic differences that effected Geri's behavior. Throughout discussion Victoria seemed to view clients as people who have agency in the helping process as displayed by her answers whereas Geri seemed to view clients simply as people who need to be helped. Geri may have become aware of this difference in her responses coupled with the subject matter. By question three, Geri stopped adding organic thought altogether and instead began referring to Victoria for answers and nodding in agreement afterward with no additional feedback. Even when specifically prompted, Geri would decline referring to Victoria for additional insight.

A few of the participants (Emma and Melanie C) were cautious to define altruism asking for definitions from the researcher. The researcher encouraged them to define instead as to not interfere with data collection.

Finally, Melanie C required continuous validation and feedback from the researcher that took extended amounts of time. She regularly interrupted the interviewer extremely anxious if she was "helping" or "saying the right thing" (Melanie C, personal communication, June 8, 2023). She reported being worried repeatedly that she was "being offensive". At one point she asked to pause the discussion to reflect and let the researcher know that she is "actively doing the work" and wants "to be an ally and help but it feels uncomfortable". The researcher offered to cancel the interview or reschedule, but the participant was adamant about continuing though she continued to repeatedly pause for feedback.

Adaptations to the NIH Implicit Bias Training

The above discussion responses were coded and thematically analyzed to create an adaptation to the NIH implicit bias training. Adaptations were later approved by the qualitative participants and meant to be used in conjunction with the NIH implicit bias course. They include saturated themes from discussion and saturated explicit suggestions from participants. A table of figure numbers and PowerPoint slides associated with themes and suggestions for the adaptation can be found below in Table 45. Following are the adaptions in Figures 4.52- 4.77. The full adaptation can be found in Appendix K.

Table 45

Qualitative Themes with Corresponding Adaptations

Theme	Figure number
Altruism definition: self-sacrifice	Figure 4.57 (PowerPoint slide 7)
Counselors have altruistic core	Figure 4.57 (PowerPoint slide 7), Figure 4.58 (PowerPoint slide 8)
Altruistic characteristics before profession	Figure 4.62 (PowerPoint slide 12)
Some counselors don't sacrifice self but claim altruism	Figure 4.58 (PowerPoint slide 8)
Altruistic drive vs. altruistic intention	Figure 4.58 (PowerPoint slide 8), Figures 4.63- 4.77 (PowerPoint slides 14-28)
Altruism aids bias	Figure 4.59 (PowerPoint slide 9), Figures 4.63- 4.77 (PowerPoint slides 14-28)
Counselor dominance	Figures 4.63- 4.77 (PowerPoint slides 14-28)
Counselors prioritize altruism over clients	Figure 4.58 (PowerPoint slide 8), Figure 4.60 (PowerPoint slide 10), Figure 4.61 (PowerPoint slide 11)
Silencing clients	Figures 4.70- 4.76 (PowerPoint slide 21-27)
Multicultural knowledge and humility	Figure 4.55 (PowerPoint slide 5)
Bias is informed by individual preferences and surrounding culture	Figure 4.54 (PowerPoint slide 4), Figures 4.63- 4.77 (PowerPoint slides 14-28)
Altruism affects how counselors perceive a client's problem	Figure 4.57 (PowerPoint slide 7), Figures 4.63- 4.77 (PowerPoint slides 14-28)
Suggestions	**Figure number**
Definition of diversity for counselors	Figures 4.52 and 4.53 (PowerPoint slides 2 and 3)
Specific examples/ case scenarios of counselors	Figures 4.63- 4.77 (PowerPoint slides 14-28)
Analyze counselor bias in altruism effecting care of diverse cultures	PowerPoint slide 7, 14-28

Note. A table of themes and suggestions from focus group and interview discussions.

Figure 4.52

Adaptation of Implicit Bias Training (PowerPoint Slide 2)

Mission of Counseling

- The American Counseling Association provides ethical codes for counselors practicing in the United States.
- The mission of the American Counseling Association is
  - "...to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity."(American Counseling Association, 2014)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.53

Adaptation of Implicit Bias Training (PowerPoint Slide 3)

Diversity in American Counseling

- Diversity within counseling also includes recognizing the various intersections of identities within the counseling relationship.
- For example, who a counseling educator or counseling supervisor is in the combination of their race, ethnicity, nationality, culture gender, sexual orientation, environment, socioeconomic status, religion, and multicultural awareness influences who they are as an educator.
  - Their identities then effect the combination of identities of counselors in training.
  - These counselors in training go forth as counselors to eventually become fully licensed.
  - Their combination of identities influence how they show up as a counselor to clients with additional combinations of identities.
- Therefore, in counseling, diversity includes the whole person and how it impacts others.
- CACREP defines multicultural as "denoting the diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation; and religious and spiritual beliefs, as well as physical, emotional, and mental abilities" (CACREP, 2015, p. 42)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.54

Adaptation of Implicit Bias Training (PowerPoint Slide 4)

Implicit Bias Threatens Diversity in American Counseling

- Additionally, as the United States counseling profession is embedded within American culture, it is important to consider how a counselor's identity may have influenced their person based on their American environment.
- As race has been a salient factor in the United States, it is likely that the person of a counselor is influenced unconsciously by American culture as it relates to race.
- Historical disenfranchising and marginalizing beliefs related to gender, sexual orientation, class, religion, ability and many other identities in the United States may also unconsciously influence a counselor's behaviors
- It is important for counselors to remain open to any way in which they may have been influenced consciously or unconsciously in order to better meet the needs of diverse clients.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.55

Adaptation of Implicit Bias Training (PowerPoint Slide 5)

Development of Multicultural Competence

- Multicultural competency is continually evolving but has only been part of the field since the 1970s (Korman, 1974; Sue & Sue, 1977).
- Since standards were only placed on rising counselors, veterans in the field were not given the same information (Brown & Brown- Landrum, 1995; Constantine, 1997; D'Andrea & Daniels, 1997; Fukuyama, 1994; Leong and Wagner, 1994)
  - Continuing education did not and still does not require counselors to increase their knowledge with the continued evolving standards.
  - New information continues to develop that helps counselors better help your clients of diverse backgrounds such as implicit bias and its effect on effective helping in counseling diverse cultures.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.56

Adaptation of Implicit Bias Training (PowerPoint Slide 6)

What is the helping equation

- The relationship of helping can be described in two parts
  - The person helping
  - The person being helped
- Just like 1+1=2
  - Person helping +Person being helped = Help
- Unfortunately, there are many nuances that can complicate the helping equation

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.57

Adaptation of Implicit Bias Training (PowerPoint Slide 7)

Altruism

- One major part of counseling is its altruistic characteristics (Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982)
  - Altruism is typically defined as help that is self-sacrificing and is for the gain of others (Batson, 2011) but it is also prosocial meaning that people behave altruistically with a keen awareness of its rewards (Robinson & Curry, 2007)
  - Many counselors are drawn to the field from altruistic characteristics
- Though seemingly good on the surface, altruism is also influenced by surrounding culture
- Beliefs of who needs help and who gets to help in a culture have historical bias, even in the counseling field (North, 2000; Plummer, 1970; Szasz, 1971)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.58

Adaptation of Implicit Bias Training (PowerPoint Slide 8)

Altruism May Interrupt the Helping Equation

- Many counselors have a deep desire to help with altruistic intention.
- However, after entering the counseling profession, they get a taste of how good the rewards of helping feel.
  - Sometimes counselors exchange altruistic intention for altruistic drive
- Altruistic drive is the need to help due to personal rewards rather than a true desire to be of help
- Acting from a desire to help (rather than to be helpful) requires us to make assumptions that lessen our collaboration with clients
- In this way, some counselors may believe they are helping altruistically because of their intention but may actually be causing harm through their own desire of helping
  - This complicates the helping relationship even more
- Person helping +Person being helped = Help instead becomes...
- <u>Person who has a need to help (altruistic drive) + Person being helped = help</u>

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.59

Adaptation of Implicit Bias Training (PowerPoint Slide 9)

Implicit Bias and Counseling

- Implicit bias can complicate the job of helping even further
  - Implicit bias is based in unconscious assumptions/beliefs and is also informed by surrounding context (Greenwald et al., 1998)
- Who you are as an individual is impressionable at the unconscious level
  - Our environments can shape our unconscious thoughts effecting our behaviors sometimes without our knowledge
- A combination of implicit bias (Boysen & Vogel, 2008; Katz & Hoyt, 2014) and the altruistic drive to help can negatively impact decision making specifically with clients of marginalized, disenfranchised and minority backgrounds

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.60

Adaptation of Implicit Bias Training (PowerPoint Slide 10)

How bias and altruism interrupt the helping equation

- Let's revisit the helping equation.
- We've already established that a counselor's drive to help can sometimes interrupt the process of helping because the need to help becomes more important than actually being helpful.
- However, even further, a counselor's unconscious bias can interrupt the target of the helping behavior.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.61

Adaptation of Implicit Bias Training (PowerPoint Slide 11)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.62

Adaptation of Implicit Bias Training (PowerPoint Slide 12)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.63

Adaptation of Implicit Bias Training (PowerPoint Slide 14)

The Desire to Help: The Case of Michelle

- Michelle is a white cisgender woman (female) graduate student in a CACREP accredited counseling program starting internship. From a rural area in North Carolina, throughout her life, Michelle has always struggled financially. Finally, being in a better position financially with graduation in sight, Michelle is extremely proud of her accomplishments and excited to finally be able to help others in the profession.

Here we establish Michelle's intersection of identities described in our discussion of diversity earlier and her drive to help others.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.64

Adaptation of Implicit Bias Training (PowerPoint Slide 15)

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.65

Adaptation of Implicit Bias Training (PowerPoint Slide 16)

The Desire to Help: The Case of Michelle

- Michelle believes she knows just how to help given her background of financial struggle. She feels she has had exposure to most difficult circumstances in life. She will finally be able to help people in the ways she needed throughout her life.

Here again, we see Michelle's genuine desire to help, though it is from her own personal views that she desires to help.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.66

Adaptation of Implicit Bias Training (PowerPoint Slide 17)

The Desire to Help: The Case of Michelle

- In session, she allows the client to vent while she begins setting goals in her head. The client reveals he is a senior and is not sure if he wants to graduate and continue his education or drop out. He is exhausted emotionally and does not have any support.
- Michelle resolves that the one and only goal should be that they find a way to remove him from his unsupportive mother who is pushing him to drop out and get a job. She believes that if he could just get a college degree, all his problems would be solved. He would not be depressed, and he would have so much on his plate with school that he would not have time to think about anything else just like she did. She begins looking at college sites with him.

Here, Michelle allowed her desire to help to disrupt her duty to goal set with the client.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.67

Adaptation of Implicit Bias Training (PowerPoint Slide 18)

The Desire to Help: The Case of Michelle

- Though he is apprehensive she continues telling him that it is the best thing for him. The client leaves the session without addressing his concerns.
- Michelle is proud of herself for thinking on her feet and believes she used motivational interviewing to help the client come to his senses regarding college. Michelle is unaware that she holds an implicit regarding the intersection of identities of her client and is blinded by her own bias toward higher education.

Here, ultimately Michelle is ineffective though she believes that she was effective because she had a need to help rather than a desire to be helpful based on the clients wants.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.68

Adaptation of Implicit Bias Training (PowerPoint Slide 19)

Analysis of Michelle

- Based on the case scenario, Michelle, like many beginner counselors in training, feels an intense altruistic need and excitement to help her client. Altruistic characteristics are prosocial and shaped by perceptions of power and privilege driven by the surrounding culture (Fehr & Fischbacher, 2003).
- In Michelle's case she has made implicit assumptions about her client's position in the cultural context especially in relation to her role of power and authority. She assumes a role of power to best help him and has access to additional moral authority, contributing to the client's hesitation of challenging her, allowing her to push her own agenda unchallenged.
- She feels called to this role of moral authority because of her plight and likely her race in relation to the client's. She then utilizes her power and authority within the counseling dynamic to perpetuate her sociocultural understandings. She has made assumptions about his role as the one being helped based on his circumstances and identities differing from the rules of wellness within her context. And Michelle has done all this genuinely believing she is being helpful.
- Even still, with the best intentions, she is ineffective.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.69

Adaptation of Implicit Bias Training (PowerPoint Slide 20)

What Could Have Michelle Done?

- What Michele could have done was first be aware of her desire to help and trade it with the desire to be helpful based on the client's needs. This would have allowed her to check her own biases and gather from the client what they'd like to accomplish.
- Further, analyzing potential biases from her background, Michelle may have been more likely to recognize what she was doing before it negatively impacted the session. Cues like the client's discomfort may have triggered her to question her actions a bit more in session.
- In a different case scenario let's look at Aaliyah.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.70

Adaptation of Implicit Bias Training (PowerPoint Slide 21)

The Desire to Help: The Case of Aaliyah

- Aaliyah is a Black cisgender woman (female), fully licensed LCMHC, and has been practicing for the last 15 years. Aaliyah lives a higher middle-class life with her husband and two children. Her favorite part of the weekend includes dressing up and going to church. She was raised Baptist but now goes to a nondenominational church with her family regularly.
- She is very active in her community between her volunteering at church and within her children's school mentoring- she tends to be rather busy.

Here we establish Aaliyah's intersection of identities described in our discussion of diversity earlier, her drive to help others and her role within the counseling profession.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.71

Adaptation of Implicit Bias Training (PowerPoint Slide 22)

The Desire to Help: The Case of Aaliyah

- Aaliyah has always been the one her family and friends turn to for advice and felt “called” to the counseling field by God.
- As a clinician she is regularly awarded for her efforts within the Black community increasing access to care for the underserved. Those in the profession especially turn to her because she is great at organizing and they use those skills to organize events for underserved communities.

Here again, we see an extension of Aaliyah’s roles, her strengths in the field and her ability to help.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.72

Adaptation of Implicit Bias Training (PowerPoint Slide 23)

The Desire to Help: The Case of Aaliyah

- Today in session Aaliyah has on her schedule a younger female client that she has been seeing for months who is having difficulty with a romantic relationship. The client has been experiencing symptoms of anxiety and depression on top of these concerns. Despite repeated attempts to get the client to assess her values and determine if the relationship is even a good fit for her, the client continues to struggle which is frustrating to Aaliyah.
- On telehealth, Aaliyah notices that the room behind her is a bit more "junky" than usual and reads this as a hint from God. While she's been frustrated by previous approaches, she sees an easier way she can help since she is great at organizing. She feels she can use her gift with the extra insight from God to help.

Here we see Aaliyah's personal beliefs begin to influence her perception of the problem. Her desire to help for personal relief of stress also begins to supersede the client's needs here as well.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.73

Adaptation of Implicit Bias Training (PowerPoint Slide 24)

The Desire to Help: The Case of Aaliyah

- In an attempt to get through to the client from a different approach (and relieve her own personal frustration of not being able to help (from her own assessment)), Aaliyah asks about “the mess” in the background. She segues into a brief lecture about how “the mess” is a metaphor to her priorities being “a mess” and focuses on helping the client strategize a way to clean up.
- While she was slow to speak and allowed the client to talk, the client’s attempts to discuss her long-term tumultuous relationship were met with Aaliyah’s comparisons to the literal “mess” in the background disguised as reflections of meaning and reflections of feeling.

Here we see Aaliyah utilize counseling strategies in a way that is highly influenced by her own cultural lens in order to relieve her own frustration of potentially not helping the client.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.74

Adaptation of Implicit Bias Training (PowerPoint Slide 25)

The Desire to Help: The Case of Aaliyah

- While the client went along with the change, she didn't really believe the session was helpful. Aaliyah asked the client for feedback as she always did after the session. The client said that the session was helpful even though she wasn't entirely satisfied because of their good rapport. She believed Aaliyah's heart was in the right place, so she didn't speak up.
- Additionally, since Aaliyah is well known in the community for her ability to help Black women specifically, the client felt that she may need to listen to Aaliyah's expertise. This was further heightened by the fact that Aaliyah is older than her, shares similar religious beliefs to her and based on her culture she didn't want to be perceived as "disobedient". Ultimately the client's needs were not met but Aaliyah's need to relieve her own frustration was. Her desire to help superseded her ability to be helpful is influenced by her cultural beliefs.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.75

Adaptation of Implicit Bias Training (PowerPoint Slide 26)

Analysis of Aaliyah

- In this context, Aaliyah occupied many positions of power in relation to the client which allowed her to take leadership of the session and interrupted the client's ability to give true feedback. Aaliyah's relying on her religion allowed her to justify her outside approach to relieve her frustration rather than to seek the expertise of the client on their own personal life. She assumes a role of conscious power from her religious beliefs but unconscious power from the client's response to her intersectional identities. Aaliyah's call to the profession gives her access to authority and power in a way that harms efficacy with her clients unchecked. While she may feel that she is acting altruistically, in this case she mostly acted out of personal interest to be feel like she is helping, minimize her own frustration and validate her religious call to the field.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.76

Adaptation of Implicit Bias Training (PowerPoint Slide 27)

What Could Have Aaliyah Done?

- What Aaliyah could have done was acknowledge her frustration by reflecting with the client and assessing their level of frustration. Aaliyah could have then gathered a sense of how the client would have liked to accomplish in that session. Rather than turning to her religion as the expert source for a solution, turning to the client would have likely yielded more effective results.

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

Figure 4.77

Adaptation of Implicit Bias Training (PowerPoint Slide 28)

What Can You Do?

- In session
  - Ask and Believe the client's perception of the problem
  - Be open to critique and feedback from the client
    - Broach conversations and genuinely invite the feedback over time
  - Broach conversations about power in counseling with clients
    - Client to counselor, racial/ethnic, age, etc.
- Out of Session
  - Continue to educate yourself about the history of the field
  - Accept that there are biases you hold that may not be your fault, but they are your responsibility

Note. The adaptations have been approved by qualitative participants to use in conjunction with the NIH implicit bias training.

CHAPTER V: DISCUSSION

This chapter concludes the current study. In this chapter is a summary of the problems addressed with the current research and a summary of all research findings. Following is an interpretation of the research findings including any comparisons with previous research. After is a discussion of implications of the research findings in context with the counseling field and how findings may be applied. Limitations of the study follow with a conclusion comprised of recommendations for continued research.

Summary

The current study sought to help address the persistent concern in the counseling field of appropriately and effectively treating clients of color (Foster, 2022; Graham et al., 2022; Kugelmass, 2016), specifically Black American clients (Adebayo et al., 2022; Kemet et al., 2022). Despite developments in multicultural competence, counselors continue to make enough biased decisions that impact efficacy with Black American clients. Further, though research has established the existence of implicit bias and its implications in the counseling field (Boysen, 2009), it has not been included in competency standards (Boysen, 2009) likely contributing to the persistent difficulties in treating clients of color. Counselors have been resistant to correction stalling progress, so this study sought to explore why.

Posited is a connection between counselor implicit bias and altruism. In order to do such, this study sought to help reestablish the roots of implicit bias research as well. As criticism set in regarding implicit bias and its measures (Jussim, 2022; Mason, 2020; Pritlove et al.,2019) many have been turned off from the notion of implicit bias and what the root of social cognition research originally sought to address, which is in part the effect of power and authority in its effect on social interactions. In analyzing the counseling field's inadequacies regarding competent treatment of Black American clients, the effect of power and authority in implicit bias

was married to the same in altruism. Altruism served as a surrogate due to its relevance in describing aspects of counselor behavior, such as decision making rooted in social desirability (Constantine & Landany, 2000; Pope-Davis et al., 2001), and overall connections in the field (Elliot et al., 2018). Finally, this study gathered insight in order to adapt the National Institutes of Health (NIH) implicit bias training (2020,) but for counselors, to address the above concerns related to counselor implicit bias and intersections of such with altruism contributing to ineffective care.

The above concerns were addressed with the following research questions:

(For the quantitative portion of the study)

1. What is the relationship between counselor implicit bias scores and altruism scores?
2. What is the relationship between counselor demographic data and implicit bias scores?
3. What is the relationship between counselor demographic data and altruism scores?

(For the qualitative portion of the study)

1. What else should be included in NIH's implicit bias training to adapt it for counselors?

Summary of Quantitative Findings

Implicit Bias

Quantitative results revealed significant relationships between measure of bias and altruism scores with a slight positive correlation between the two. Analysis of relative frequency indicated that there are some trends regarding counselor roles and implicit bias with increasing measures of implicit bias toward White as counselors move to higher levels of leadership in the counseling profession. Additionally, participants across racial/ethnic groups generally had more of a preference toward White except Black participants who were evenly distributed across each unconscious preference and Asian participants who had an unconscious preference toward Black. With respect to gender, cisgender men and women had similar implicit bias that decreased

through preferences toward Black and increased through preferences toward White. Other races had mixed findings that were either polarized between racial implicit preference or general preferences toward White. Interactions between sexual orientation and implicit bias generally showed that overall, there are preferences toward White. Across most sexual orientations data followed an upside down bell curve where they were more neutral or equally unconsciously preferential toward Black and were more preferential toward White than neutral.

Altruism

Demographic data was also analyzed for its relationship with altruism scores. Overall, findings indicated relationships between age, role in the counseling profession, disability, racial/ethnic group, and sexual orientation. Altruism scores generally increased with age and increased with leadership or authority in the counseling profession. Findings also indicated that altruism scores decreased as people did not have a disability and therefore increased when they did. Slight differences between altruism scores of racial ethnic/groups were present as well with White participants having generally higher altruism scores than other groups, Though Black participants were closely behind. Additionally, regarding sexual orientation, heterosexual participants were indicated to have higher altruism scores overall.

Summary of Qualitative Findings

Within focus group and personal interview interactions, several themes emerged. First, participants confirmed cultural beliefs regarding the uncertainty in validity of implicit bias measures, specifically the IAT. Participants also confirmed posited beliefs about the connection between altruism and counselor identity even drawing a synonymous relationship between the two. Participants reported that counselors are altruistic at their core before ever joining the field and are drawn to the profession because they perceive counseling to be an altruistic profession. Participants then discussed two different types of altruism that they have seen among their peers,

in the profession and within themselves, an altruism that the counselor believes they are practicing but is not effective and an altruism that is collaborative and effective. Participants confirmed an altruism exists in the profession that is based in a counselor's need to help and other egoic preservation. These counselors are blinded by the drive to help and the reward of helping so much so that they are ineffective with their clients.

Participants discussed connections between implicit bias and altruism as well, confirming that there is a type of altruism that can aid in biased decision making as it thrives off of assumptions. Participants relayed that counselors can be so blinded by the drive and need to help that they ignore the client, pulling from personal experiences and implicit biases to make decisions. Additionally, these counselors will even exert authority, silencing their clients to do so. Participants discussed that the counselor bias can also be informed by culturally imbedded biases. Further, participants reported that the counselors genuinely believe that they are helping and that some clients will not communicate differently because they are intimated by the counselor's authority or aware of their good intentions. Participants reported that both altruism and bias work together within counselor's, influencing what they perceive as the problem. If counselors are not aware, knowledgeable, and mindful they can cause harm while thinking they are being effective.

From focus group discussion and additional suggestions given by the participants, an adaptation to the NIH implicit bias training was created including the concepts above with a definition of diversity that was more pertinent for counselors and examples of counselors specifically with analysis of altruism and bias effecting clients of color.

Interpretations

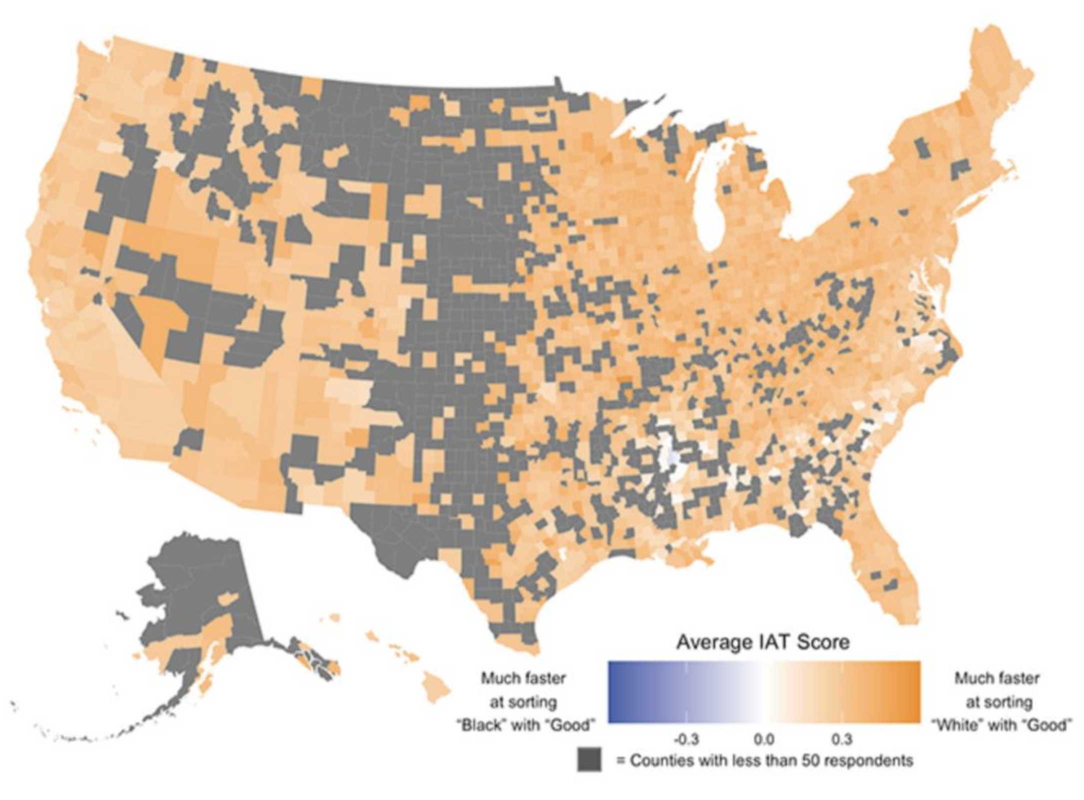
Implicit Bias

The current study was exploratory in nature, in part due to the dearth in research as it relates to counselors and researched implicit bias trends regarding counselor behavior. While research on connections of altruism and implicit bias is slim, a previous study found that individuals who are typically high in altruism are low in prejudiced attitudes (Hale, 2016). However, the current study found that counselors high in altruism tended to have increasing levels of implicit bias, though there were not statistically significant results for the race they have bias toward.

There is also research regarding implicit bias trends that the current findings can be compared to. For example, regarding the first question of the current study relating to implicit bias and demographic data, the current study's findings are somewhat similar to that of Project Implicit, the nonprofit organization of the IAT. Figure 5.1 shows Project Implicit's findings from across the United States. It appears not a single state or region has strong preference toward Black as a whole. While within the study, some individuals had varying preferences toward Black or neutral preferences, most participants had preferences toward White. North Carolina is represented in the figure below as well. Again, though some had preferences toward Black and neutral preferences, more had preferences toward White within the study as indicated in Figure 5.1.

Figure 5.1

Project Implicit Findings: Nationwide Implicit Bias



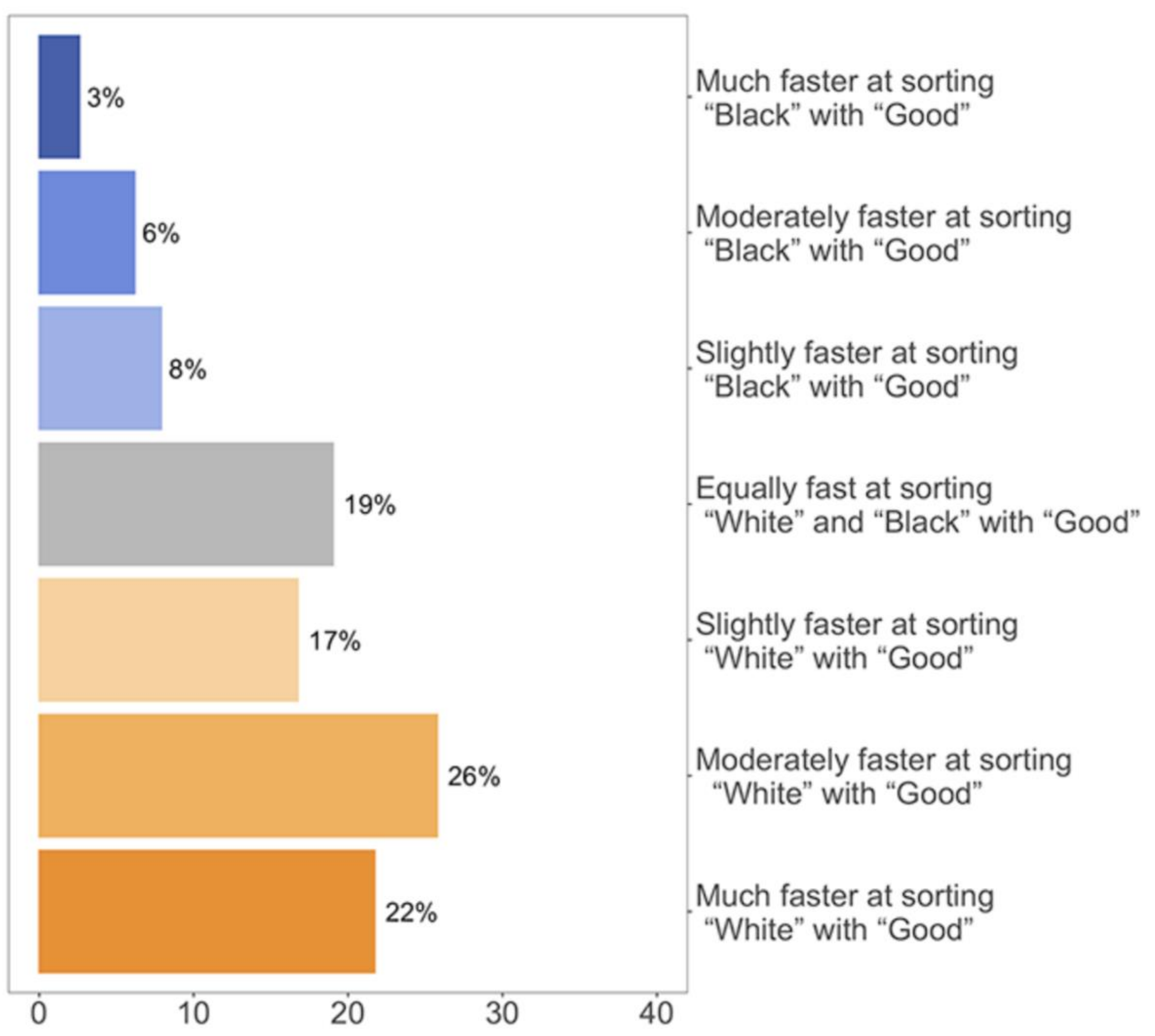
Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Project Implicit's findings, presented below in Figure 5.2 are generally more consistent with findings form the current study. While in the current study, more participants had a preference toward Black than equal/neutral preferences, findings are relatively similar across Project Implicit's findings from 3.6 million people who had taken the survey in general. In figure

5.2 below, depicted is that most participants who took the race IAT had a preference toward White which is true of the participants who took the measure in the current study.

Figure 5.2

Project Implicit Findings: From 3.6 million People



Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Table 46 is a key describing changes to the order of previous charts in the current study to compare with Project Implicit's graphs more seamlessly. The neutral group (labeled zero to indicate equal preference) from the current study is shifted to the middle to match more closely the one presented in Project Implicit. Additionally, the "slight" and "much" categories are shifted to match Project Implicit's as well.

Table 46

Key of Order Changes in Implicit Bias for Comparison

Previous ordering	Current ordering to match Project Implicit
0= Equally fast at sorting "White" and "Black" with "Good"	3= Much faster at sorting "Black" with "Good"
1= Slightly faster at sorting "Black" with "Good"	2= Moderately faster at sorting "Black" with "Good"
2= Moderately faster at sorting "Black" with "Good"	1= Slightly faster at sorting "Black" with "Good"
3= Much faster at sorting "Black" with "Good"	0= Equally fast at sorting "White" and "Black" with "Good"
4= Slightly faster at sorting "White" with "Good"	4= Slightly faster at sorting "White" with "Good"
5= Moderately faster at sorting "White" with "Good"	5= Moderately faster at sorting "White" with "Good"
6= Much faster at sorting "White" with "Good"	6= Much faster at sorting "White" with "Good"

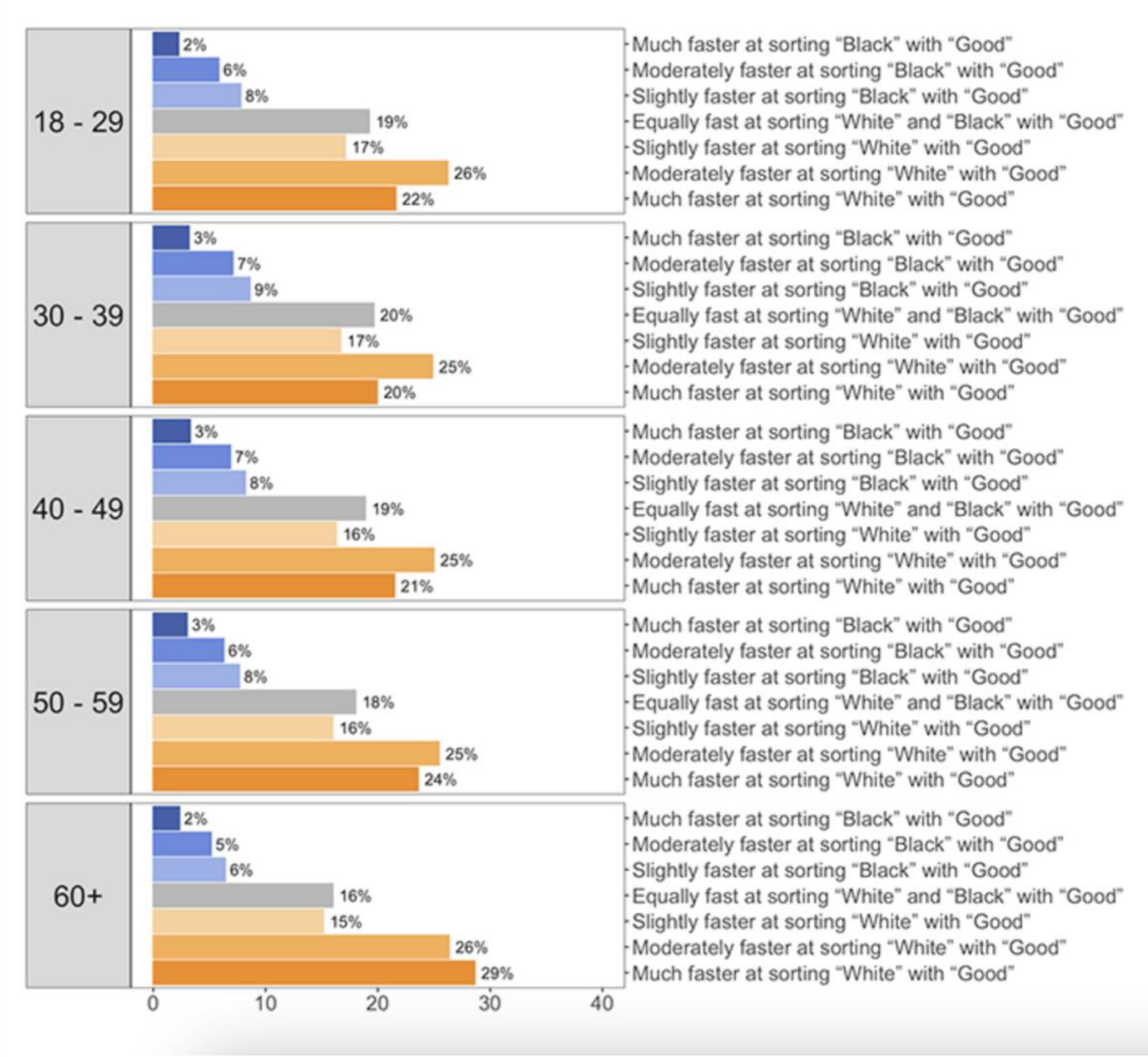
Note. Key of order changes for the sake of comparison.

Figure 5.3 below shows Project Implicit's IAT findings by age group. It shows that preferences as measured by the IAT remain generally constant across all age groups. Figure 5.4 displays relative frequencies of age groups and implicit bias scores from counselors in the current study in a similar format to the graph of the one in Figure 5.3 of Project Implicit's findings.

Although the range of age categories is slightly different in the current study, graphs are generally similar except regarding the "Much faster at sorting "White" with "Good". In the current study, the strongest preference toward White increases with each age group. Additionally, preferences for Black generally stay consistently low until a slight increase in the age group of 46-40 and an even greater increase by age 61-70 which is not true of Project Implicit's findings. It appears within the current study, counselors hold similar implicit preferences as those found in Project Implicit until later years. Though, there were less participants in these age groups so there may be some limitations here explored further below.

Figure 5.3

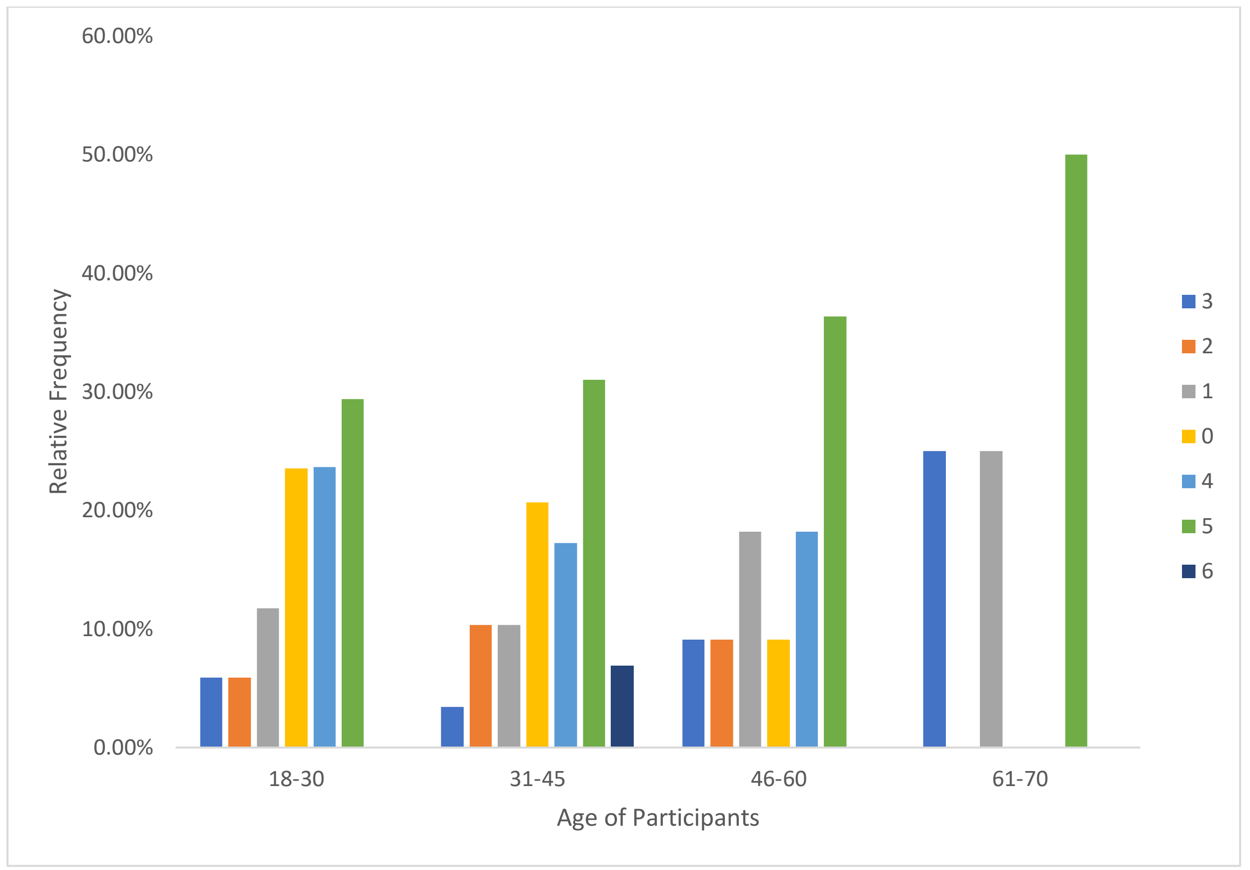
Project implicit Findings: Implicit Bias by Age



Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Figure 5.4

Current Study: Relative Frequency of Implicit Bias by Age



Note. Histogram depicting relative frequency of implicit bias by age group.

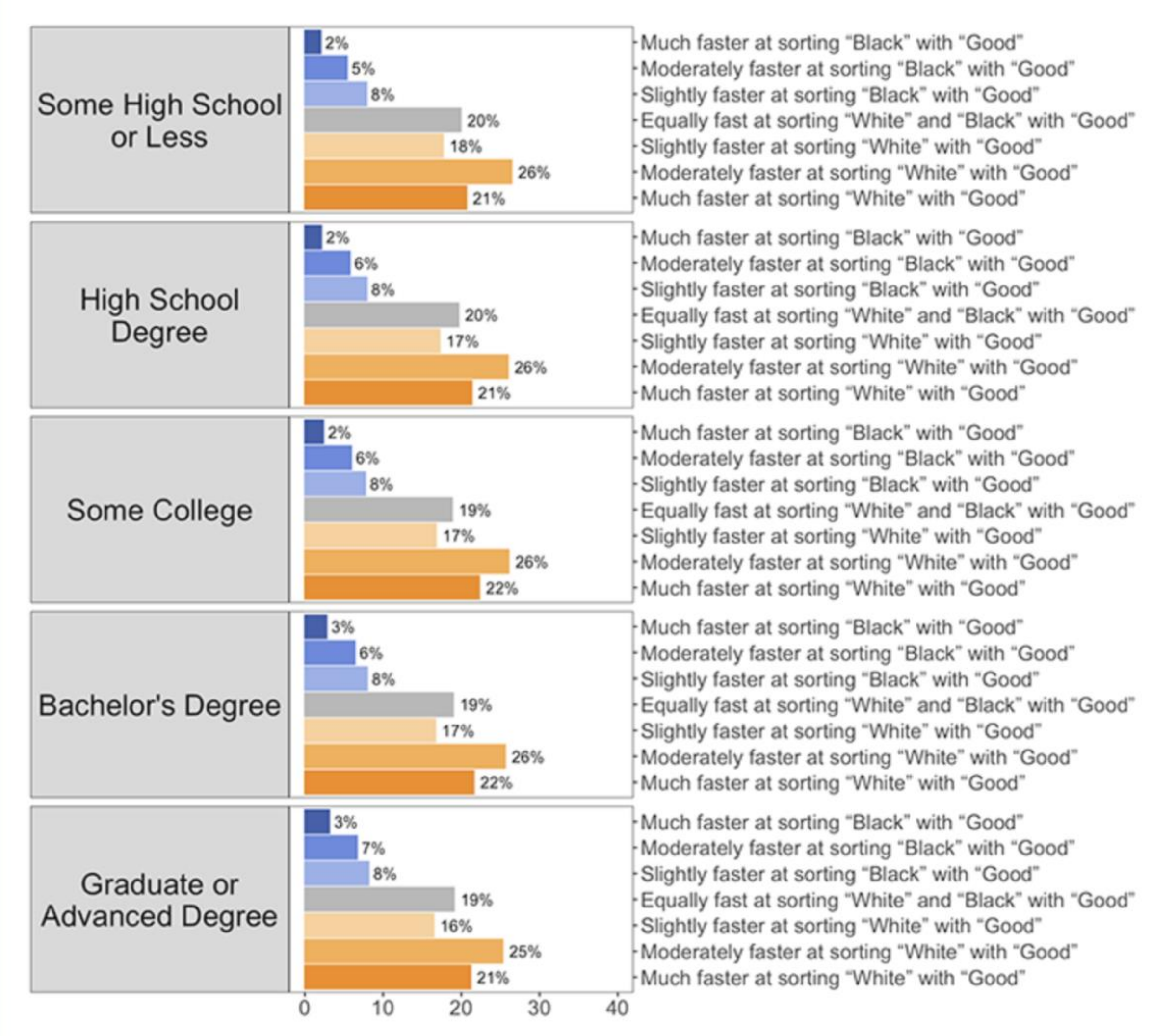
While this study did not collect explicit information on education, counselors in the North Carolina counseling field have to have at least a master's level degree. Counselors in training may have a combination of levels of education but have at least a bachelor's degree. Additionally, counselor educators likely have a doctoral level degree. Project Implicit has collected information analyzing implicit bias by education level found in Figure 5.5 below. Again, generally across education level, implicit bias scores stay consistent with more holding unconscious preferences (implicit bias) toward White. In Figure 5.6 below, a graph of implicit

bias scores of the participants who took the measure in the current study is provided. As they all have a combination of bachelor's and advanced or graduate degrees, comparing the two graphs provides some insight. Again, the implicit bias categories are reordered according to the key above in Table 45 in order to compare with Project Implicit's findings more seamlessly.

Results of the current study are similar to those of Project implicit regarding Bachelor's and Graduate or advanced degrees regarding low amounts numbers of participants having implicit bias toward Black. However, in the current study there are just as many participants that have an equal or neutral score as those that have a slight unconscious bias toward White which is different than Project Implicit (though percentages are roughly similar in the two categories with Project Implicit). Moderate implicit bias toward White is similar to that of Project Implicit's findings. A major difference is in the "Much faster at sorting White with Good" category. While Project Implicit's results here are generally similar to those with an equal/neutral unconscious preference, in the study's current findings it is below slight preferences toward Black.

Figure 5.5

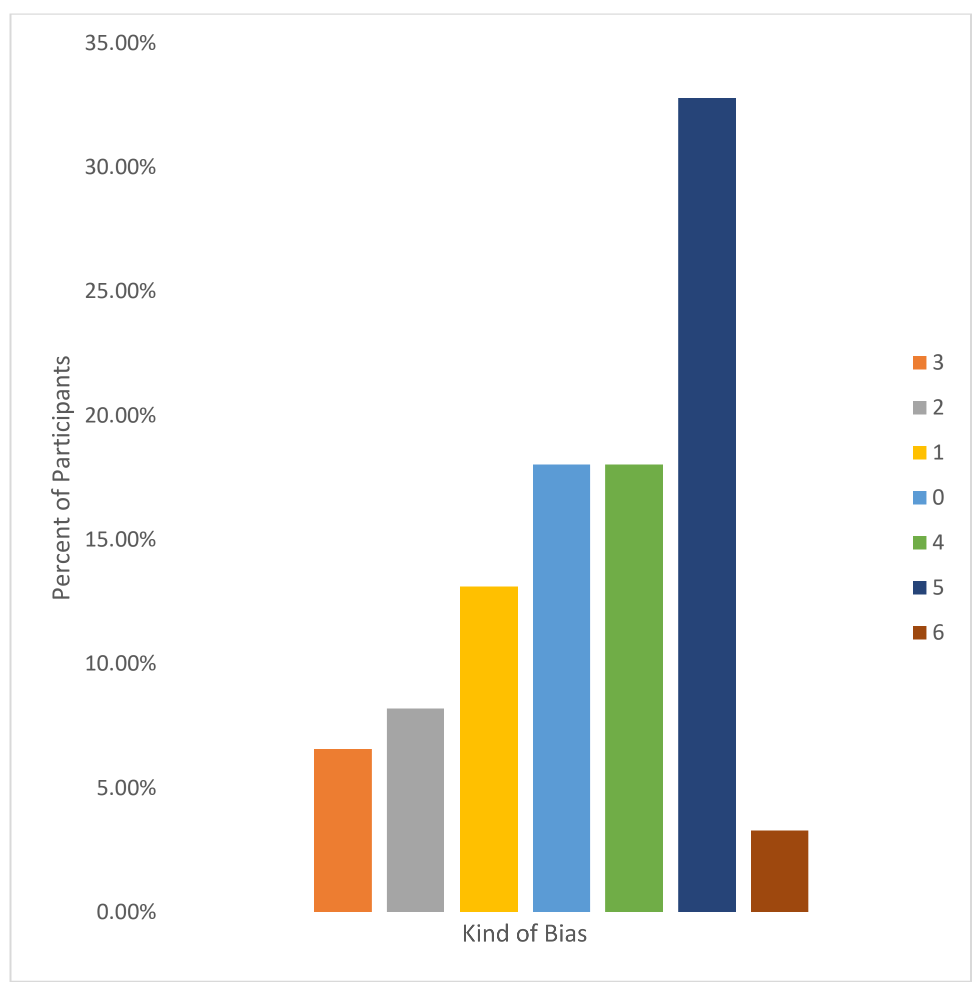
Project Implicit Findings: Implicit Bias by Education Level



Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Figure 5.6

Current Study: Implicit Bias



Note. Histogram depicting implicit bias of participants.

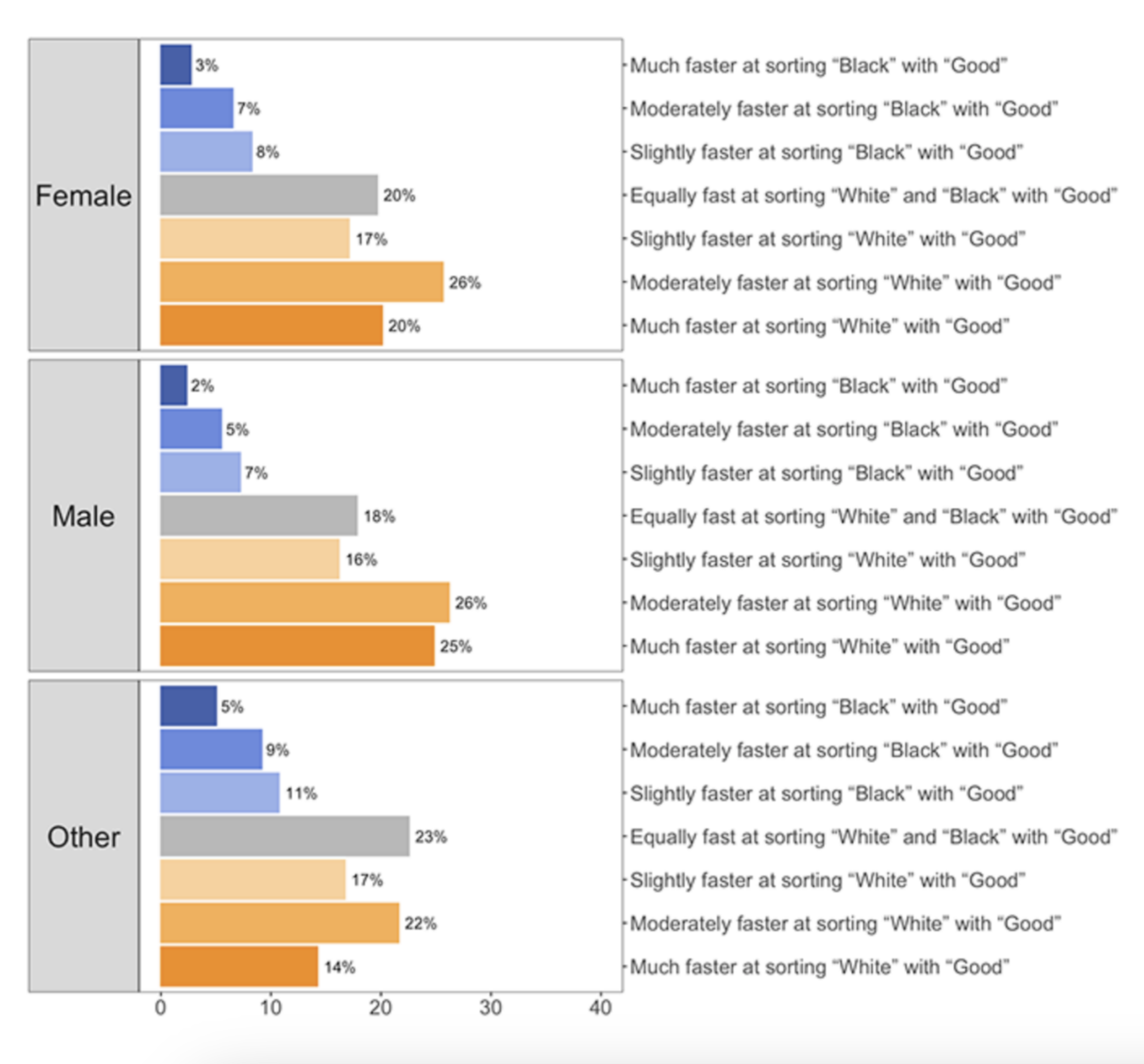
Project Implicit has also shared data between genders and implicit bias scores presented below in Figure 5.7. Data from the current study is displayed in Figure 5.8 below as well for comparison. Data for genders other than cisgender woman and cisgender men were collapsed into one category labeled as "other" to mimic that of Project implicit for comparison purposes. Additionally, as previously, categories were reordered for the same concern.

This study's findings for cisgender women were similar to those of Project implicit, but the findings for cisgender men were quite different. In the current study, men were more neutral

than they were unconsciously preferential to White. Counselors in varying other genders in the current study were more polarized in their unconscious preferences than those of Project Implicit. With Project implicit, those of "other" genders were more neutral but this study did not find that any participants of varying other genders were neutral. More had implicit bias toward White.

Figure 5.7

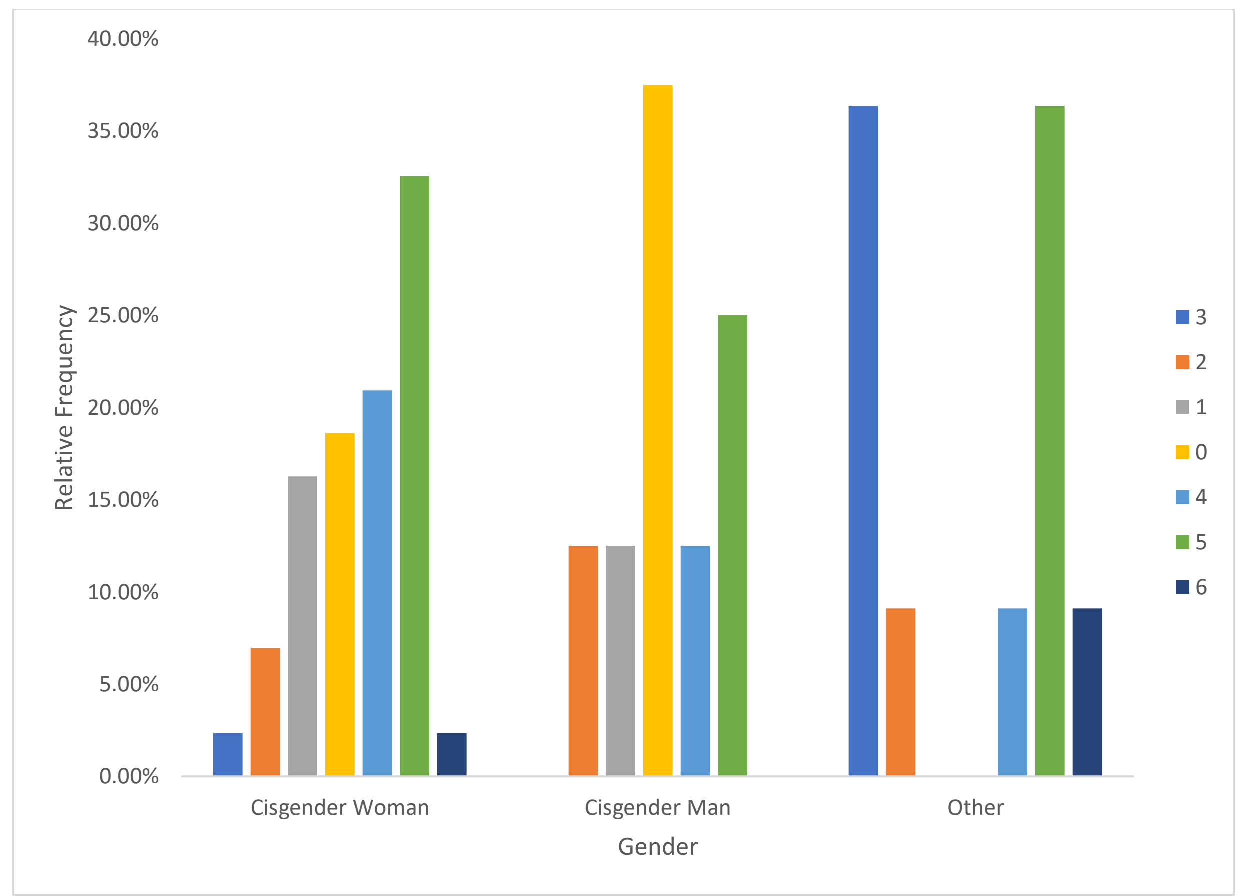
Project Implicit Findings: Implicit Bias by Gender



Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Figure 5.8

Current Study: Relative Frequency of Implicit Bias by Gender



Note. Histogram depicting relative frequency of implicit bias by gender.

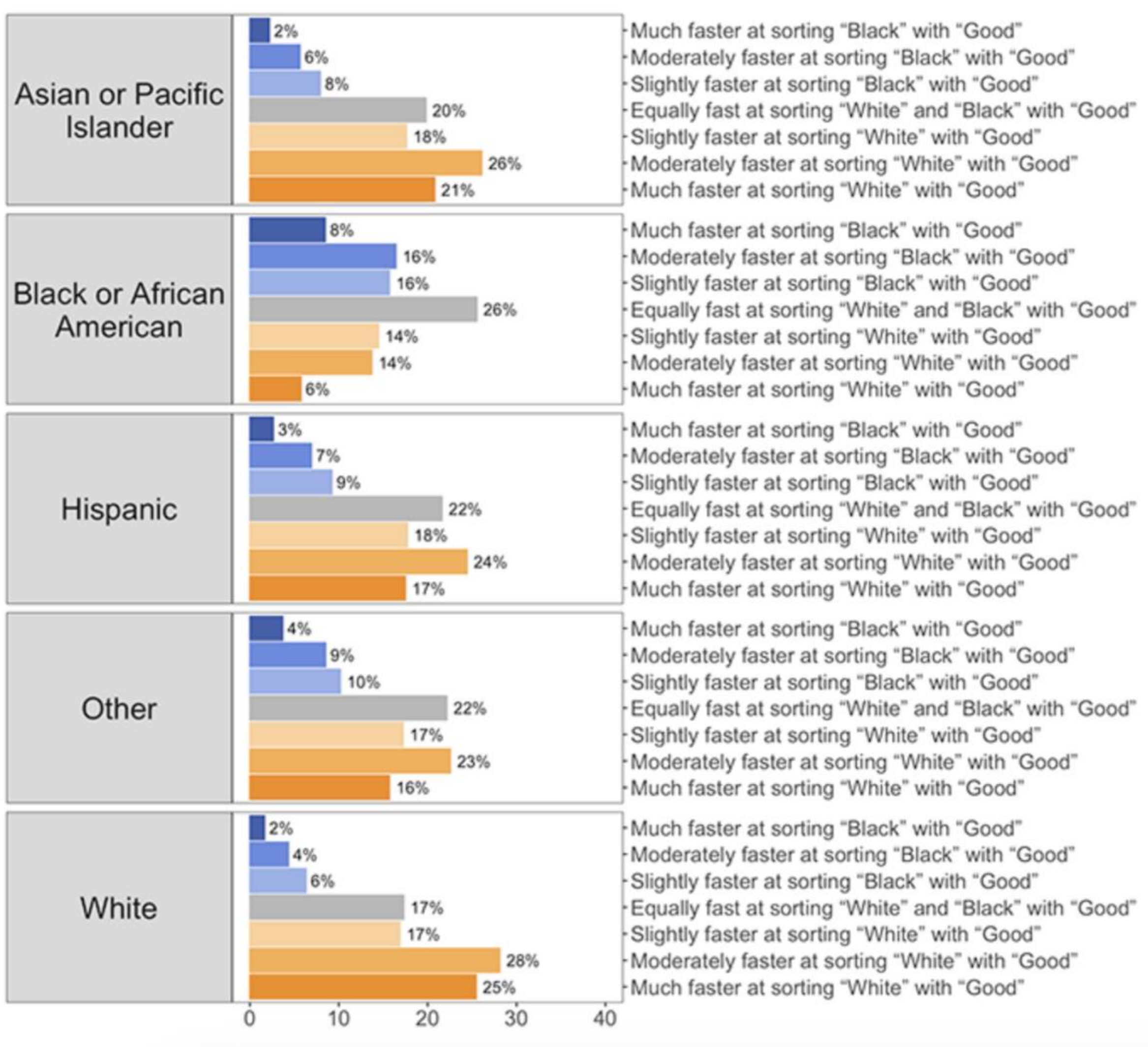
Finally, also relevant to the current study is Project Implicit's findings across racial/ethnic groups in Figure 5.9 below. With Project Implicit, generally across racial groups findings were similar with more having implicit bias result toward White except Black/ African American who had generally even implicit bias towards both races with more having

neutral/equal unconscious preferences. Data for the current study can be found in Figure 5.10 below displays relative frequencies of racial/ethnic groups' implicit bias results reordered for comparison.

Figure 5.10 shows implicit bias scores across racial/ethnic groups in the current study to be generally similar regarding Black/ African descent and White/ European participants. Low samples sizes likely influence the other racial groups though the few scores collected of participants who were Hispanic/Latin descent are slightly different than the findings of Project Implicit with more unconscious bias toward Black than Project Implicit's findings.

Figure 5.9

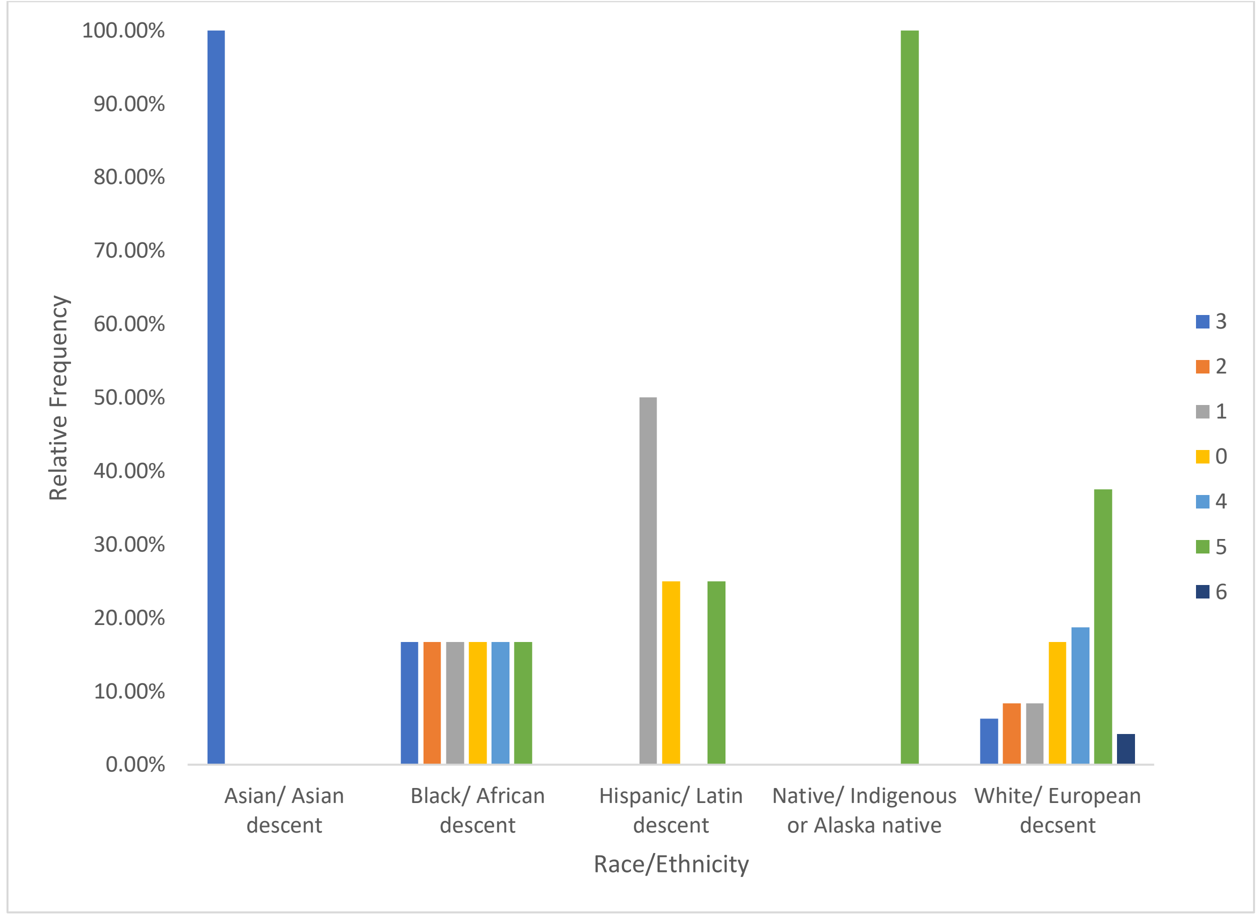
Project Implicit Findings: Implicit Bias by Race



Note. The image is from Project Implicit's race IAT by Xu, K., Nosek, B. A., Greenwald, A. G., Ratliff, K. A., Bar-Anan, Y., Umansky, E., … Frost, N., 2023. Retrieved from https://doi.org/10.17605/OSF.IO/Y9HIQ Depicted is the spread of IAT scores across the United States. Reprint for educational purposes only.

Figure 5.10

Current Study: Relative Frequency of Implicit Bias by Race/ Ethnicity



Note. Histogram depicting relative frequency of implicit bias by race/ethnicity.

Overall findings are generally similar to those of Project Implicit. In other words, counselors in the study are not overwhelmingly different when compared to overall findings of implicit bias scores. Previous research has found that counselors do tend to have implicit bias toward White people (Ivers et al., 2021; Liu, McRee et al., 2022) which is generally consistent with the findings of the current study. This indicates that counselors are generally products of their environment- that counselor implicit beliefs are shaped from the surrounding culture which is Eurocentric implicitly. Based on the results, counselors are not less implicitly biased than the

surrounding American context. So, in a field that is supposed to be culturally competent and inclusive, implicit bias scores are similar to those of the general population.

Altruism

Demographics of counselor altruism do match gender trends of altruism from previous research as well. For instance, research indicates that women tend to be more altruistic than men (Valentine et al., 2009). Data for the current study supports this claim with women having slightly higher altruism scores than men of the counselors who took the altruism scale. The highest altruism score of men in the current study was 34 whereas for women it was 40 (with the highest score of the altruism scale itself being 45). The mean altruism scale for men was 24.87 while for women the mean score was 26.29. Regarding racial differences, a previous study examined charitable giving among 16, 429 employees at a university and found that White people tended to perform more altruistically through donating more than other minority races (Asian, Black, Hispanic, and Native American) (Leslie et al., 2013). With the current study participants of White/ European descent did tend to have higher altruistic scores as well.

Additionally, focus group and interview discussions helped establish cultural attitudes of altruism about the counseling profession. While it has been noted that altruism is part of the counseling field (Bohart et al., 2002; Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982), participants helped clarify perceptions of counselors as altruistic. Participants reported that they and many of their classmates and peers flock to the counseling profession because they view it as an altruistic role. In their eyes, counseling and altruism are the same thing.

Moreover, regarding altruistic behavior, focus group and interview discussions helped clarify egoic ties in altruism posited in this study and discussed in previous studies. While previous studies argue that one cannot engage in altruism when receiving money for their

services (Burks & Kobus, 2012), discussions with participants helped illuminate an egoic drive potentially unique to counselors not noted in previous literature. Participants spoke of counselors having altruistic intentions before entering the field but when presented with the social rewards that come with an identity shift of being a "helper" as a profession, some counselors exchange pure intention for the social rewards of helping.

While this shift is not noted in literature, the power of social desirability interrupting counselor decision making is (Constantine & Ladany, 2000). It may be likely that a combination of new authority in the elevated helper role aids in bias due to the egoic needs of some counselors. Previous social cognition research does note that increased authority lends itself to increased bias as those in authority do not have to pay attention (Fiske, 1993) making them more likely to make decisions based from unconscious assumptions. While increased authority may be in part contributing to the shift from truly altruistic behavior, participants in the qualitative portion of the study reported that how good helping feels and knowing that you played a part in someone's life can drive a counselor to exchange effective helping for egoic validation.

In this way counselors prep the perfect environment for implicit bias to function impacting their decision making. Participants relayed that within this closed system, some counselors, who are informed by their own unconscious biases and personal preferences, may unknowingly project them onto the client. Feeling the positive effects of ego validation in their elevated authority as a counselor, some counselors become closed to feedback as well. Participants further shared stories of how clients feel this elevation in authority and respond by submitting themselves to the counselor's role, believing that even in their inefficacy and bias, counselors are correct in their judgements. Respondents believed that counselors even in this switch to egoic indulgence did not have malicious intentions, they simply prioritized their needs unknowingly onto the client. In this way, the client is made a caretaker of the counselor's ego

rather than a recipient of the help they came for. All the while, the counselor genuinely believes they are being helpful.

Implications

These findings are new in literature as it relates to intersections of counselor altruism, implicit bias and decision making. Results from this study help to analyze the harmful effects of altruism more accurately within the profession. As previous fields have begun to acknowledge the presence of altruism and the shortcomings it brings to collaborative patient centered care, counseling must follow suit. The findings of the current study help us understand the driving forces in counselor behavior better. While previous research, noted above, had inclinations that altruism existed in the profession, none draw the synonymous relationship between altruism and the counseling profession as did the participants of this study.

The results of the IAT help clarify counselor trends in comparison to the surrounding culture. Findings indicated that counselors are indeed representative of their surrounding culture, generally holding implicit bias toward White people just like most other populations across gender, race/ethnicity, the state, and the nation. As such, it is imperative that counselors accept that they are like their surrounding culture to address disparities within mental healthcare across diverse cultures.

Telling of counselor discomfort with concerns pertaining to racial bias are the large number of participants who did not take the implicit bias measure. There are likely a variety of reasons why participants did not participate as analyzed above in the results section. However, with given information from the focus group discussion and what is already researched of counselor behavior, for many who did not take the measure it may be likely that in an attempt to not report bias, counselors decided to simply not take the test. It is already established in literature that counselors overestimate cultural competence and underreport bias to save face

(Boysen & Vogel, 2008; Constantine & Landany, 2000; Pope-Davis et al., 2001) aware of what it may mean for the rewards that they are counting on in the counseling profession (in social desirability). Self-report data shows that counselors in the study were generally confident in their ability to effectively treat diverse clients (except those that did not take the IAT) and had high altruism scores. It may be likely that some counselors in the current study shifted their responses to confidence in treating diverse cultures aware of the subject matter. Then, they chose not to report their IAT result once there was a non-self-reported measure of bias, reminded of their morality with the immediately previous altruism scale.

From the study, introduced is a type of helper that believes they are genuinely altruistic but works from a biased lens informed by their surrounding culture and ego preservation. There is a marriage of ideologies that allows a helper not to question their lens of helping rooted in egoic needs. Some counselors are drawn to the altruism in the field because of their deep desire to help. However, their desire to help is more attached to being the one that helps rather than being effective. In this way, they are driven by the increase of moral power that the profession provides. Unconsciously, they are driven by the access to validation of those outside of the field who perceive counselors to be purely altruistic intentioned and are given a vehicle to band aid their insecurities in clientele, especially of marginalized groups.

It is a practice informed by their own desires and implicit biases as they look within themselves to help rather than outwardly to the population or individual client they are serving. This inward looking stops them from seeing the effects and they are unable to receive critique. As racial injustice is a deeply embedded disparity in American context, it also serves a deeply ingrained threat to their understanding of their own morality, especially if it exists within them unconsciously. As such, it is easier to ignore any shortcoming related, sweeping any mistake under the rug of "good intention".

Bias of all forms, including implicit, thrives in this system of masking imperfection making counselors resistant to correction and helping to explain the ineffectiveness of multicultural competencies. As such, these counselors genuinely feel they can treat diverse backgrounds effectively even though they cannot. Fearing letting go of the internal validation of their good intentions and the removal of external filtered approval, they continue doing harm all the while thinking they are doing good work.

The adapted NIH implicit bias training from this study would help counselors analyze behaviors like these, rooted in ego management. Ideally, the adapted measure would serve as a growing point for researchers to continually add to and adapt additional versions of the training as we learn more about counselor decision making tied to altruism and implicit bias. Currently it offers a starting tool for counselors to question more intimately their behaviors and decisions especially within a counselor to client relationship.

There are salient ties of egoic tendencies and wielding of authority throughout counselor altruism and implicit bias resulting in ineffective care for Black American clients. Though it appears the sentiment is to do good, for some counselors the sentiment masks a need to be perceived as good tied to an intricate reward system. The grouping of altruism and implicit bias together to describe counselor behavior specifically regarding treatment of clients of color helped further illuminate power dynamics connecting the counselor's personal and professional identities. Overtime, through continued research and application, the hope is that counselors in a variety of roles across the profession learn to be mindful of potential hazards when treating clients of diverse groups increasing efficacy.

Limitations

A salient limitation in the current study related to sampling. Initially, difficulties were met due to the timing of data collection. Data collection began in the summer where counselor

educators and students were likely on vacation. As such, data collection was extended into the fall, when school was back in session, to allow for more robust sampling. Even still, gathering data from counselor educators proved consistently difficult, likely due to their busy schedules. Additionally, in attempts to gather more participants, a variety of strategies were used that may have impacted the results of the study. Initial recruitment efforts included sending information to department chairs of counseling programs and directors of counseling clinics all in North Carolina to distribute to faculty, students, and practicing clinicians. Participants of the study likely participated because they had keen interest in the subject matter which could have led to biased results as well. Though, this approach yielded minimal results.

By the fall, the researcher was granted access to the North Carolina Board of Counselors listserv information where emails were then randomized and sent for initial recruitment. This approach considerably increased sampling but likely expanded the research to counselors who may not have been biased toward the subject matter. As such, once participants began the quantitative portion, an additional sampling limitation occurred. More participants did not take the implicit bias measure than those that did, raising questions. While some reported the IAT site was not working, or they had difficulty with the many links provided (despite the issue being difficult to replicate), others left responses in the blank space provided attesting to their cultural awareness but not wanting to take the survey.

Others however, who sent frustrated emails written in unsupportive tones, gave additional insight with the disparity between those that finished the survey and those that did not. Several emails were received that were generally mean spirited and a bit personal, questioning why people were still doing implicit bias research because it is “not real”, and voicing that they would not support due to the research being part of the “liberal agenda”. Counselors in supervisor, educator, editorial and other leadership positions in the field sent these messages after receiving

initial recruitment emails sent by the researcher. Undoubtedly there are a group of helpers who believe they are doing good work as “champions of change” who have fascinating limitations to what they view as such. Even still, there do seem to be some intersections in politics and general unsettled feelings about the topic of race that some counselors have continuing to stall progress by simply being resistant.

Other limitations included group dynamics. Within the focus group, White cisgender woman participants seemed to both look for validation and be wary of saying the wrong thing. Similar was found in a previous study (Allen, 2020). There were also some concerns with demographics where a comparatively small group of participants had difficulty with gender terms likely slightly influencing results.

There are also some concerns regarding the reporting of implicit bias scores. Given the apparent discomfort with the IAT there may have been participants who took the IAT, were unsettled by their scores and simply did not report. Discussion above noted that findings were generally similar to Project Implicit except in the strongest category of preference toward White. Given the immense difference with no other major differences, it raises some concerns. Likely more research could shed insight on the phenomenon.

Recommendations for Future Research

Continued exploration of demographics connected to implicit bias and altruism would be helpful in clarifying relationships between aspects of a counselors’ identity and unconscious preferences that may impact decision making. The largest demographic of the current study was heterosexual white cisgender women. Continued research should explore aspects of those intersections of identity in their connection to the counseling field in general.

Additionally, while the current study explored a wide range of demographic data, based on the information from participants who actively voiced concern for the subject matter, an

exploration of political preferences may also be helpful in clarifying counselor implicit beliefs that interrupt efficacy with clients of color. Given the same, continued research to find more indirect ways to assess and address potential bias and mindset of counselors would be helpful. This study helps clarify characteristics of counselors that are similar to early helpers in their drive for altruism rooted in prejudiced beliefs of the surrounding culture. Likely, there are additional connections to explore to better help clients of color.

Finally, as mentioned previously, the adaption is the first of its kind intervening in implicit bias adapted specifically for counselors from suggestions of those in the field. Continued research is necessary to explore additions moving forward to address counselor implicit bias effecting decision making more comprehensively.

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Appendix A

IRB Approval

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Initial Approval: Expedited

From:	Social/Behavioral IRB
To:	Crissa Allen
CC:	Paul Toriello
Date:	5/3/2023
Re:	UMCIRB 23-000555 Exploring Counselor Altruism and Implicit Bias

I am pleased to inform you that your Expedited Application was approved. Approval of the study and any consent form(s) occurred on 5/3/2023. The research study is eligible for review under expedited category # 6, 7. The Chairperson (or designee) deemed this study no more than minimal risk.

As the Principal Investigator you are explicitly responsible for the conduct of all aspects of this study and must adhere to all reporting requirements for the study. Your responsibilities include but are not limited to:

1. Ensuring changes to the approved research (including the UMCIRB approved consent document) are initiated only after UMCIRB review and approval except when necessary to eliminate an apparent immediate hazard to the participant. All changes (e.g. a change in procedure, number of participants, personnel, study locations, new recruitment materials, study instruments, etc.) must be prospectively reviewed and approved by the UMCIRB before they are implemented;

2. Where informed consent has not been waived by the UMCIRB, ensuring that only valid versions of the UMCIRB approved, date-stamped informed consent document(s) are used for obtaining informed consent (consent documents with the IRB approval date stamp are found under the Documents tab in the ePIRATE study workspace);

3. Promptly reporting to the UMCIRB all unanticipated problems involving risks to participants and others;

4. Submission of a final report application to the UMICRB prior to the expected end date provided in the IRB application in order to document human research activity has ended and to provide a timepoint in which to base document retention; and

5. Submission of an amendment to extend the expected end date if the study is not expected to be completed by that date. The amendment should be submitted 30 days prior to the UMCIRB approved expected end date or as soon as the Investigator is aware that the study will not be completed by that date.

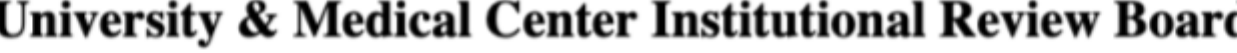
The approval includes the following items:

Name	Description
Allen_Approved Dissertation Proposal.docx	Study Protocol or Grant Application
Appendix L-Focus Group Questions.docx	Interview/Focus Group Scripts/Questions
Dissertation- Email Scripts and Qualtrics Directions.docx	Recruitment Documents/Scripts
Dissertation_Survey-_CAllen(1).docx	Surveys and Questionnaires
No More Than Minimal Risk-Informed Consent-Dissertation.doc	Consent Forms
Survey Consent Paragraph for Exempt Research 2 20 20.doc	Consent Forms

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

EAST CAROLINA UNIVERSITY

University & Medical Center Institutional Review Board

Willis Building · Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Amendment Approval

From:	Social/Behavioral IRB
To:	Crissa Allen
CC:	Paul Toriello
Date:	10/16/2023
Re:	Ame4_UMCIRB 23-000555 UMCIRB 23-000555 Exploring Counselor Altruism and Implicit Bias

Your Amendment has been reviewed and approved using expedited review on 10/13/2023. It was the determination of the UMCIRB Chairperson (or designee) that this revision does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must submit a Final Report application to the UMCIRB prior to the Expected End Date provided in the IRB application. If the study is not completed by this date, an Amendment will need to be submitted to extend the Expected End Date. The investigator must adhere to all reporting requirements for this study.

Approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Document	Description
Changing the Faculty Investigator from Paul Toriello to William Atherton.	

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

IRB00000705 East Carolina U IRB #1 (Biomedical) IORG0000418
IRB00003781 East Carolina U IRB #2 (Behavioral/SS) IORG0000418

Appendix B

Altruism Scale Survey Permission

Re: Request Permission to Use 9-Item Simplified Self Report Altruism Scale

Allen, Crissa Jewel <allenc13@students.ecu.edu>
Sun 02/19/2023 03:07 PM
To: Sergio Andres Olavarrieta <solavar@uchile.cl>

Thank you so much!

Crissa Jewel Allen MA, LCAS-A
Doctoral Candidate
Department of Addictions and Rehabilitation Studies
East Carolina University

email: allenc13@students.ecu.edu

"*Make your vision so clear that your fears become irrelevant*." - *anonymous*

If you are experiencing a life-threatening emergency, please call 911 or go to your nearest emergency room.
Confidentiality notice: E-mail is not a safe means to transmit confidential information. This e-mail, including any attachments, is for the sole use of the intended recipients(s) and may contain confidential and privileged information. If you are not the intended recipient, please contact the sender (Crissa Allen) by e-mail and destroy all copies of the original message. Other university departments, including information technology, may have access to the content of any e-mail correspondence with staff members.

From: Sergio Andres Olavarrieta <solavar@uchile.cl>
Sent: Sunday, February 19, 2023 10:16:59 AM
To: Allen, Crissa Jewel <allenc13@students.ecu.edu>
Subject: Re: Request Permission to Use 9-Item Simplified Self Report Altruism Scale

You don't often get email from solavar@uchile.cl. Learn why this is important

This email originated from outside ECU.

Dear Crissa
thanks for writing and for your interest on the simplified 9-SRA scale. Of course your more than welcome to use it
Cordially
Sergio

El sáb, 18 feb 2023 a las 1:08, Allen, Crissa Jewel (<allenc13@students.ecu.edu>) escribió:

> Good Evening Dr. Manzur and Dr. Olavarrieta,
>
> I hope this email finds you well.
>
> My name is Crissa Allen and I am a doctoral candidate at East Carolina University in North

Carolina. I am writing to request permission to use your Simplified Self Report Altruism Scale in my dissertation study. I am researching counselor behavior as it relates to how altruistic tendencies can influence decision making when counseling diverse clients.

Your scale would play a pivotal role. I would simply put it into a private Qualtrics online survey and only use it for research purposes with suggested administration while citing appropriately.

Please let me know if you would like more information.

I hope to hear from you soon.

Best,

Crissa Jewel Allen MA, LCAS-A
Doctoral Candidate
Department of Addictions and Rehabilitation Studies
East Carolina University
email: allenc13@students.ecu.edu
"Make your vision so clear that your fears become irrelevant." - anonymous

If you are experiencing a life-threatening emergency, please call 911 or go to your nearest emergency room.

Confidentiality notice: E-mail is not a safe means to transmit confidential information. This e-mail, including any attachments, is for the sole use of the intended recipients(s) and may contain confidential and privileged information. If you are not the intended recipient, please contact the sender (Crissa Allen) by e-mail and destroy all copies of the original message. Other university departments, including information technology, may have access to the content of any e-mail correspondence with staff members.

Appendix C

Initial Recruitment Email

Good Afternoon,

I hope this email finds you well.

My name is Crissa Allen and I am a doctoral candidate enrolled in the counseling PhD program at East Carolina University. I got your information from a North Carolina counseling listserv and could use your help.

Currently, I'm in the middle of data collection for dissertation and I need counselors, counselor supervisors, counselor educators and graduate level counseling students all who either practice in, have licenses in or are going to school in NC to virtually participate in my dissertation study (either by online survey, virtual focus group, or both).

You can find more information about the study and inclusion criteria below.

Survey: After reviewing the information below, if you'd like to participate but only in the survey, you can access that here:
https://ecu.az1.qualtrics.com/jfe/form/SV_1ZC79KBHc5LD1LU

Directions to complete the survey are attached. Informed consent is attached as well. There is no need to sign for survey participation only.

Focus Group: If you'd also like to help even further by participating in focus group discussion, please let me know any availability you have during the week at or after 4pm.

You can find the information about the study below.

Thank you for your consideration.

Best,

Study information:

Hello,

I hope all is well. My name is Crissa Allen and I am a doctoral candidate and the principal investigator for a dissertation research study at East Carolina University in the Department of Addictions and Rehabilitation Studies chaired by Dr. Paul Toriello of the same department.

I am in need of counselors, counselor educators, counselors in training (students in master's and doctoral counseling programs) and counselor supervisors to participate in a study to understand counselor behaviors to more effectively help clients of color and could use your help!

Participation in the study would include:
completing a 15-20 minute survey (option to complete online on your own or virtually with the principal investigator) AND
Optional participation in 30-minute focus group discussion (All focus group discussions are virtual and recorded (audio and visual) for research purposes only.)

Those who would like to participate must meet the following criteria:
Participants should be a counseling instructor, counselor, counselor educator, counseling supervisor or counselor in training in North Carolina.
Other inclusion criteria are as follows:
At least 18 years old
Counselors in training are defined as being currently enrolled in a master's level counseling program in North Carolina or having graduated from a counseling program in North Carolina and practicing under provisional licensure
Supervisors must hold certification in North Carolina (regardless of location of schooling)
Practitioners must currently practice in North Carolina (location of schooling does not matter if you currently practice in NC)

If you meet criteria and would like to help in this research to better counsel clients of color, please refer to the directions above.

My email is allenc13@students.ecu.edu should you have additional questions or would also like to participate in the focus group.

Thank you for your consideration and I hope to hear from you soon.

Sincerely,

Appendix D

Recruitment Email Follow Up

Thank you for reaching out,

Again, my name is Crissa Allen and I am a doctoral candidate and the principal investigator for a dissertation research study at East Carolina University in the Department of Addictions and Rehabilitation Studies.

Attached are a few documents detailing the current study.

As stated previously, as a participant, should you volunteer, you would

completing a 15-20 minute survey (option to complete online on your own or virtually with the principal investigator) and

optional participation in focus group discussion.

After reviewing the documents, please let me know if you'd like to attend a scheduled virtual session to complete the survey (this is for your convenience in order to answer any questions you may have) or if you'd like to complete the survey on your own (if so, I'll simply send a survey link and directions that will walk you through). Should you have questions, you can reach out and come back to the survey at a later date (the information will save for you).

Appendix E

Informed Consent

East Carolina University

Informed Consent to Participate in Research

Information to consider before taking part in research that has no more than minimal risk.

Title of Research Study: Exploring the Role of Altruism on Counselor Implicit Bias and Adapting the National Institutes of Health Implicit Bias Training for Counselors in the United States

Principal Investigator: Crissa Allen (Person in Charge of this Study)
Institution, Department or Division: East Carolina University, Department of Addictions and Rehabilitation Studies
Address: 4425 Health Sciences Building, Greenville, NC 27834
Telephone #: (252) 375-3670

Researchers at East Carolina University (ECU) study issues related to society, health problems, environmental problems, behavior problems and the human condition. To do this, we need the help of volunteers who are willing to take part in research.

Why am I being invited to take part in this research?

The purpose of this research is to better understand how counselors make decisions. Specifically, I seek to improve the quality of counseling for people of color by analyzing the influence of altruism on automatic/subconscious (implicit) bias. This study will help us better understand how characteristic behavior of counselors may be improved to increase the quality of counseling services. You are being invited to take part in this research because you are a member of the counseling field (a counselor, counselor educator, counseling supervisor or counselor in training in North Carolina). To be eligible for participation you must also be at least 18 years of age or older. The decision to take part in this research is yours to make. By doing this research, we hope to learn more about the relationship between counselor characteristics that contribute to biased decision making in counseling.

If you volunteer to take part in this research, you will be one of about 85 people to do so.

Are there reasons I should not take part in this research?

I understand I should not volunteer for this study if I am under 18 years of age, a psychotherapist in a field other than counseling (such as a psychologist, social worker, or psychiatrist), and am not at least one of the following: Counselor in North Carolina with a full or provisional (LCMHC/ LCMHCA) license, counselor educator defined as currently teaching counseling courses in North Carolina, a counseling supervisor defined as having an active North Carolina supervisor's license (LCMHCS) or a counselor in training defined as a counseling student currently enrolled in a Master's level counseling program in North Carolina.

What other choices do I have if I do not take part in this research?

You can choose not to participate.

Where is the research going to take place and how long will it last?

The research will be conducted online via survey and an optional Webex virtual meeting. You will need to come to have access to a stable internet connection during the study. The total amount of time you will be asked to volunteer for this study is 15-20 minutes to complete a survey and if you choose to do so, 30 minutes for focus group discussion at a scheduled time on a later date.

What will I be asked to do?

You will be asked to do the following:

1. Complete an online survey (15-20 minutes).
2. You have the option to participate in a focus group discussion (30 minutes).

The online Qualtrics survey includes demographic information (age, status in counseling field, gender, race/ ethnicity, multicultural competence, CACREP status of school attended for master's degree at the time of incurred degree, ability, religious affiliation, sexual orientation). It also includes a scale measuring level of altruism called the Simplified Self Report Altruism Scale (Manzur & Olavarrieta, 2021). Finally, included is a separate implicit bias online activity through Project Implicit (Xu et al., 2022) to measure unconscious bias. The score from this site will be recorded in the Qualtrics survey and will conclude the survey portion of the study. This portion will take 15-20 minutes altogether. This portion can be completed on your own with supplied directions. However, you do have the option to schedule a virtual meeting with the principal investigator for a live walk through with other participants via WebEx. The purpose of the survey is to gather information on the characteristics of counselors that may help us better understand behavior impacting decision making with clients from diverse backgrounds. A total number of 85 participants are needed.

Additionally, 25 of the original 85 participants are needed to volunteer to participate in focus group discussion. This is to help adapt an implicit bias training for counselors. In focus group discussion you would discuss thoughts on the survey components and review the National Institutes of Health's current implicit bias training for edits given what you learned in the survey components. The purpose of the focus group is to modify a tool to better help counselors work with clients of color. Focus group discussion will be audio and video recorded for research purposes only. Of interest in focus group discussion is the status in the profession of the participant (counselor educator for example) and discussion regarding altruism and implicit bias in counseling. All information concerning the study will be kept confidential. Only the principal investigator will have access to video recordings of focus group discussion. Recordings are used to gather and code relevant information as described above. Identifiable characteristics will not be gathered. After gathering and coding relevant information, the recording will be destroyed and deleted from the confidential password protected device it is stored on. The recording itself will not be published. Should you not want to be recorded you have the option to not participate in this portion of the research. Below are the questions asked in focus group discussion:

1. Let's discuss the survey & IAT- what are your thoughts?
2. The counseling profession is trying its best to better help diverse clients. Through research it seems that how we culturally define help may be helpful to discuss. What are your thoughts on altruism in the counseling profession?
3. How do you think altruism (definitions of how we help and who in our culture) could impact unintentional biased decision making?
4. Let's review the NIH implicit bias training and see if there are things we can add based off of our thoughts on altruism and how our culture defines it.
5. Based off our discussion related to bias, altruism, and the training, is there anything else related to such that should be added to better help counselors care for clients of color?

What might I experience if I take part in the research?
We don't know of any risks (the chance of harm) associated with this research. Any risks that may occur with this research are no more than what you would experience in everyday life. We don't know if you will benefit from taking part in this study. There may not be any personal benefit to you but the information gained by doing this research may help others in the future.

Will I be paid for taking part in this research?
We will not be able to pay you for the time you volunteer while being in this study.

Will it cost me to take part in this research?
It will not cost you any money to be part of the research.

Who will know that I took part in this research and learn personal information about me?
ECU and the people and organizations listed below may know that you took part in this research and may see information about you that is normally kept private. With your permission, these people may use your private information to do this research:

How will you keep the information you collect about me secure? How long will you keep it?
All information collected for the current research is confidential. Data collected will only be used for research purposes. All data collected will be coded and will not have identifying information.
To ensure confidentiality, the signed consent forms will be stored in a locked password protected device and file. Surevey data, tapes and transcripts will be kept in a separate locked file on a password protected device. Only the principal investigator will have access to the password protected device. No individual participant will be identified in any report or publication of the study or its results.

Focus group recordings will be kept long enough to gather transcripts and discussion content before being destroyed and deleted from the password protected device. Regarding others utilizing Webex during the focus group and survey- Full confidentiality cannot be guaranteed as the behavior of others cannot be guaranteed. However, the following measures will be taken to increase confidentiality: Participants will be instructed to be in an isolated indoor environment away from the presence of others. Should others come into their area, they will be instructed to minimize the screen, mute themselves and turn down the volume to protect the identity of others. Repeated interruptions (2 or more will result in removal from the WebEx. In signing this consent form you agree to such terms should you opt to participate in virtual aspects of the study. Additionally, you agree to not discuss the study, or identify anyone participating in the study outside of the virtual meeting.

Anyone who is working with any of the information you give us has to sign an agreement not to share what you tell us. No one else will know these are your answers. In reports from this research your answers will always be grouped with answers from other people or disguised to protect you from being recognized. However, there are two exceptions to confidentiality: 1) if you tell us that you are about to hurt yourself or someone else; and 2) if you are involved in the neglect and/or abuse of a child, we will report that information to the appropriate authorities.

What if I decide I don't want to continue in this research?
You can stop at any time after it has already started. There will be no consequences if you stop and you will not be criticized. You will not lose any benefits that you normally receive.

Who should I contact if I have questions?

The people conducting this study will be able to answer any questions concerning this research, now or in the future. You may contact the Principal Investigator at (252) 375-3670 Monday- Friday between 11am and 5pm.

If you have questions about your rights as someone taking part in research, you may call the University & Medical Center Institutional Review Board (UMCIRB) at phone number 252-744-2914 (days, 8:00 am-5:00 pm). If you would like to report a complaint or concern about this research study, you may contact the Director for Human Research Protections, at 252-744-2914.

Is there anything else I should know?

Most people outside the research team will not see your name on your research record. This includes people who try to get your information using a court order.

I have decided I want to take part in this research. What should I do now?

The person obtaining informed consent will ask you to read the following and if you agree, you should sign this form:

- I have read (or had read to me) all of the above information.
- I have had an opportunity to ask questions about things in this research I did not understand and have received satisfactory answers.
- I know that I can stop taking part in this study at any time.
- By signing this informed consent form, I am not giving up any of my rights.
- I have been given a copy of this consent document, and it is mine to keep.

____

Participant's Name (PRINT) **Signature** **Date**

Person Obtaining Informed Consent: I have conducted the initial informed consent process. I have orally reviewed the contents of the consent document with the person who has signed above, and answered all of the person’s questions about the research.

____

Person Obtaining Consent (PRINT) **Signature** **Date**

Appendix F

Qualtrics Survey

Start of Block: Default Question Block

Q1 Informed Consent- This information is used for research purposes only. Your responses are anonymous and will be kept private and secure. The information will not be used for a discriminatory purpose. You can change this information in the future by contacting the principal researcher by email: allenc13@students.ecu.edu

○ Yes, I consent and wish to continue the survey (1)

○ No, I do not consent and wish to exit the survey now (2)

Skip To: Q28 If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = No, I do not consent and wish to exit the survey now

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = No, I do not consent and wish to exit the survey now

Q28 You have opted out of the study. Thank you for your consideration. You may close the survey screen.

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

Q2 Please select the best choice that represents your current age.

- ◯ Below 18 (1)
- ◯ 18-30 (2)
- ◯ 31-45 (3)
- ◯ 46-60 (4)
- ◯ 61-70 (5)
- ◯ 71-80+ (6)

Skip To: Q29 If Please select the best choice that represents your current age. = Below 18

Page Break

Display This Question:

If Please select the best choice that represents your current age. = Below 18

Q29 Unfortunately you do not meet criteria for the current study. Thank you for your consideration. You may close the survey screen.

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

Q3 Select which roles you occupy within the counseling field. Mark all that apply.

- ▢ Counselor in training- defined as a student currently enrolled in a Master's level counseling program (1)
- ▢ Counselor who currently holds provisional licensure in North Carolina (2)
- ▢ Counselor who currently holds full licensure in North Carolina (3)
- ▢ Counselor educator teaching at a college/university in North Carolina (4)
- ▢ Counseling supervisor who holds licensure in North Carolina (5)
- ▢ None of the above (6)

Skip To: Q30 If Select which roles you occupy within the counseling field. Mark all that apply. = None of the above

Page Break

Display This Question:

If Select which roles you occupy within the counseling field. Mark all that apply. = None of the above

And Please select the best choice that represents your current age. = Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. = None of the above

Q30 Unfortunately you do not meet criteria for the current study. Thank you for your consideration. You may close the survey screen.

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q4 I have the ability to work with clients of diverse backgrounds effectively.

◯ 1-Strongly Disagree (1)

◯ 2- Moderately disgree (2)

◯ 3- Neither agree/ Disagree (3)

◯ 4- Moderately agress (4)

◯ 5- Strongly agree (5)

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q5 Was/is the master's program you attended/are attending for your counseling degree CACREP accredited?

◯ Yes (1)

◯ No (2)

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q6 Would you describe yourself as a person who has a disability?

- Yes (1)
- No (2)

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q7 Are you strongly affiliated with a religion?

- No- I am not religious at all (1)
- No- I am not religious, but I hold spiritual beliefs (2)
- Yes- I hold some religious beliefs, but it is not important in my daily life (3)
- Yes- My religious beliefs are important to me, but are not part of my daily life (4)
- Yes- My religious beliefs are very important and are part of my daily life (5)

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q9 How would you describe your race/ethnicity? Mark all that apply.

- ☐ Black/ African descent (1)
- ☐ White/ European decsent (2)
- ☐ Native/ Indigenous or Alaska native (3)
- ☐ Asian/ Asian descent (4)
- ☐ Native Hawaiian or another Pacific Islander descent (5)
- ☐ Hispanic/ Latin descent (6)

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q11 Gender identity (check all that apply):

- ▢ Agender (1)
- ▢ Gender queer/ gender fluid (2)
- ▢ Māhū (3)
- ▢ Cisgender Man (4)
- ▢ Transgender man (5)
- ▢ Muxe (6)
- ▢ Nonbinary/ non-conforming (7)
- ▢ Questioning or unsure (8)
- ▢ Two-spirit (9)
- ▢ Cisgender Woman (10)
- ▢ Transgender woman (11)
- ▢ Prefer not to disclose (12)
- ▢ Additional gender category/identity not listed (please specify below) (13) ____

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q10 Sexual Identity/Sexual Orientation (select all that apply):

- ▢ Aromantic (1)

- ☐ Asexual (2)
- ☐ Bisexual (3)
- ☐ Fluid (4)
- ☐ Gay (5)
- ☐ Lesbian (6)
- ☐ Pansexual (7)
- ☐ Queer (8)
- ☐ Questioning/ Unsure (9)
- ☐ Same-gender-loving (10)
- ☐ Straight (heterosexual) (11)
- ☐ Stud (12)
- ☐ Prefer not to disclose (13)
- ☐ Additional category/identity not listed (please specify below) (14)

____

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q11 Select one- I have given money to a charity

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q14 Select one- I have donated goods or clothes to a charity.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q15 Select one- I have done volunteer work for a charity.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q20 Select one- I have helped carry a stranger's belongings.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q21 Select one- I have made change for someone I did not know.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q22 Select one- I have helped an acquaintance to move houses.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q23 Select one- I have let a neighbor I did not know well borrow an item of some value to me.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q24 Select one- I have offered to help a disabled or elderly stranger across a street.

- 1- Never (1)
- 2- Rarely (2)
- 3- Sometimes (3)
- 4- Frequently (4)
- 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q25 Select one- I have offered my seat to a stranger who was standing.

- ○ 1- Never (1)
- ○ 2- Rarely (2)
- ○ 3- Sometimes (3)
- ○ 4- Frequently (4)
- ○ 5- Always (5)

Page Break

Display This Question:

If Informed Consent- This information is used for research purposes only. Your responses are anonymo... = Yes, I consent and wish to continue the survey

And Please select the best choice that represents your current age. != Below 18

And Select which roles you occupy within the counseling field. Mark all that apply. != None of the above

Q26
Please Navigate to Project Implicit's website:

https://implicit.harvard.edu/implicit/takeatest.html

Once completed, please type the full result of the Race IAT in the box below

(example: "moderate automatic preference toward white")

____

End of Block: Default Question Block

Appendix G

Directions for Survey

Step 1:

Click the link below to navigate to Qualtrics website and begin the survey.

*Complete until question **"26"** and **DO NOT CLOSE** the survey window.

Step 2:

Open a separate internet tab

Step 3:

In the separate internet tab navigate to the following website:

https://implicit.harvard.edu/implicit/takeatest.html

Step 4:

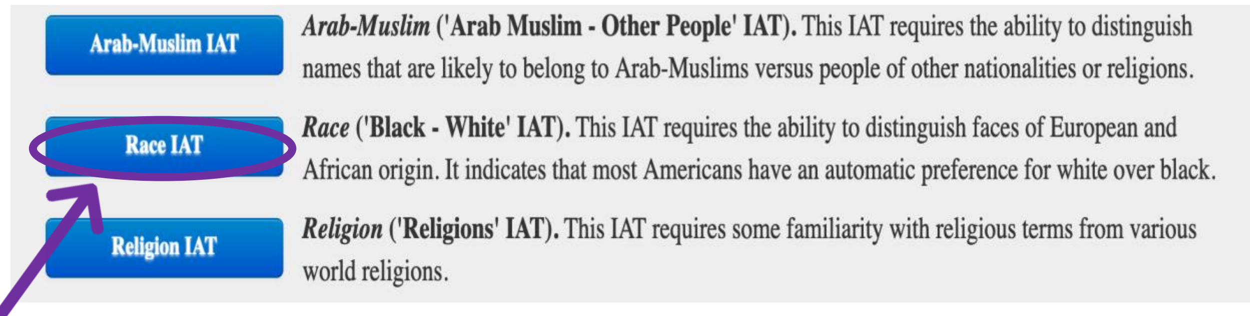
Review the preliminary information, scroll to the bottom and click in blue **"I wish to proceed"**

Tonya R. Moon, Ph.D.
Chair, Institutional Review Board for the Social and Behavioral Sciences
One Morton Dr Suite 500
University of Virginia, P.O. Box 800392
Charlottesville, VA 22908-0392
Email: irbsbshelp@virginia.edu
Website: https://research.virginia.edu/irb-sbs
Website for Research Participants: https://research.virginia.edu/research-participants

I am aware of the possibility of encountering interpretations of my IAT test performance with which I may not agree. Knowing this, I wish to proceed

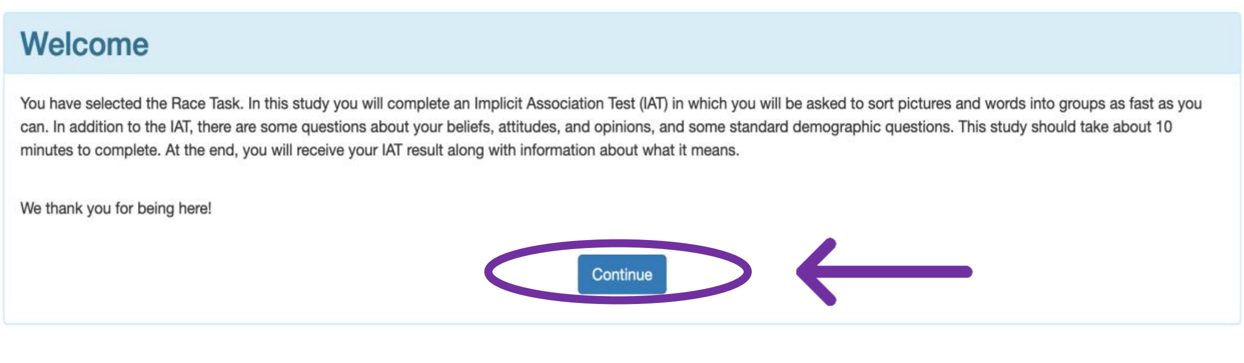
Step 5:

After clicking "I wish to proceed", the page will take you to a list of IATs. Scroll and select **"Race IAT".**



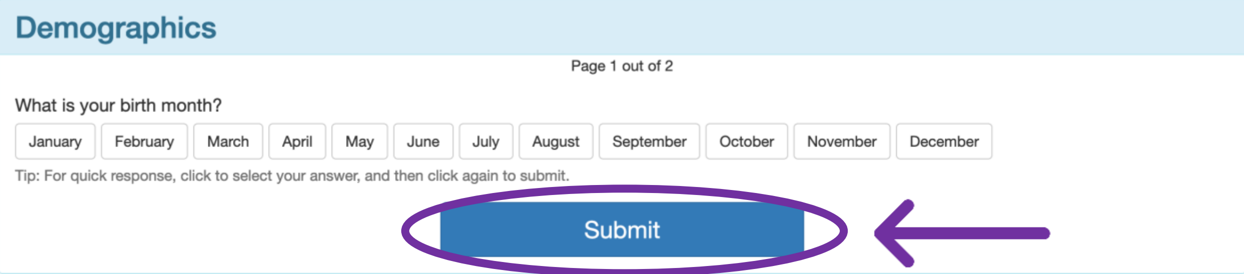
Step 7:

After selecting "Race IAT", you will be navigated to a white and blue welcome page. Read the excerpt and press **"continue".**



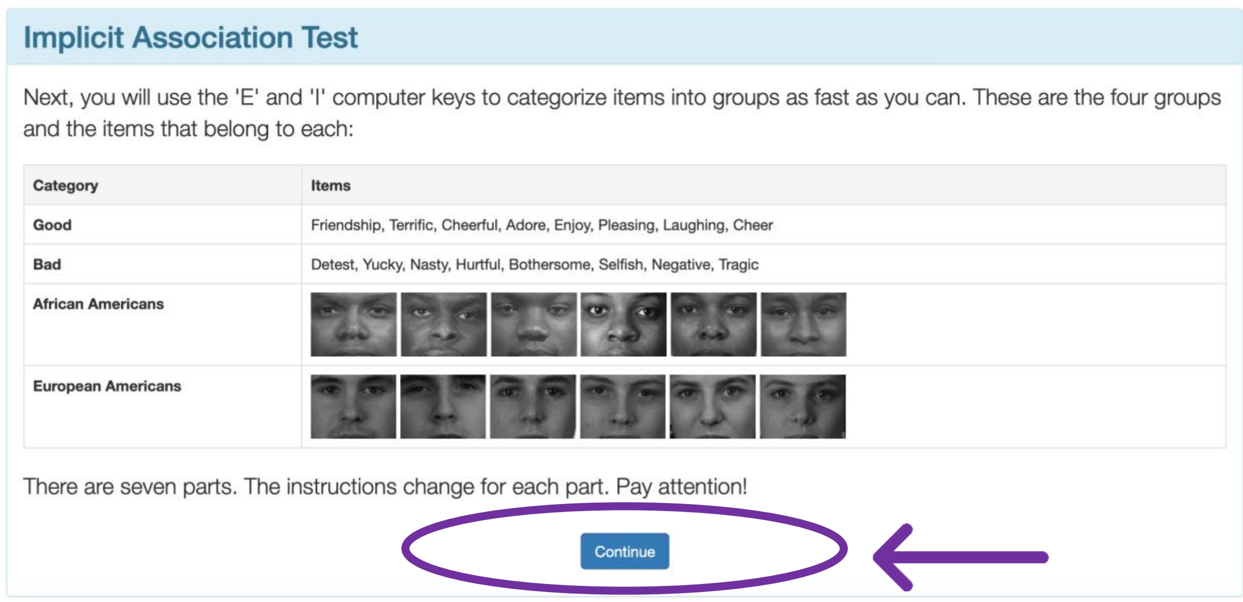
Step 8:

After pressing "continue", you will be navigated to a demographics page. Answer each of the demographic questions and press **"submit".** You can also decline to answer each and still be able to take the IAT. That button is on the right hand side.



Step 9:

After answering the final demographics question, it will give you directions to take the IAT. Follow the directions to take the IAT. The IAT should take about 10 minutes.



Step 10:

- After completing, you will be given a result of "**slight,**" "**moderate,**" **or** "**strong**" automatic preference toward a certain group.

Navigate back to your tab in Qualtrics and record the **full result** into the corresponding question in qualtrics **(ex: slight preference toward white people"**

Press the "next" arrow on the Qualtrics survey

Congratulations, you have completed the survey. Thank you for your participation.

Appendix H

Focus Group Questions

Focus Group Questions are derived by considering the SAMHSA guide (2022), recommendations for order of focus group questions (Krueger, 1994) and the research question for the qualitative portion of the study. Considerations of each are noted below their corresponding question.

Focus Group Questions

1. **Let's discuss the survey & IAT- what are your thoughts?**
    - (Opening question (Krueger, 1994)- discussion regarding their IAT scores, altruism scores, implicit bias interventions)
2. **The counseling profession is trying its best to better help diverse clients. Through research it seems that how we culturally define help may be helpful to discuss. What are your thoughts on altruism in the counseling profession?**
    - (Transition question (Krueger, 1994) & define the problem while engaging the population (SAMHSA, 2022))
3. **How do you think altruism (definitions of how we help and who in our culture) could impact unintentional biased decision making?**
    - (Key question driving research and closely related to purpose (Krueger, 1994)
4. **Let's review the NIH implicit bias training and see if there are things we can add based off of our thoughts on altruism and how our culture defines it.**
    - (Key question driving research and closely related to purpose (Krueger, 1994); feasibility and adaptation (SAMHSA, 2022); Research question for the

study: “What else should be included in NIH’s implicit bias training to adapt it for counselors?”)

5. **Based off our discussion related to bias, altruism, and the training, is there anything else related to such that should be added to better help counselors care for clients of color?**
    - (Follow up and ending question (Krueger, 1994); adaptation (SAMHSA, 2022))

Appendix I

Focus Group Follow Up for Intervention Feedback

Hello,

This is Crissa Allen, the principal researcher in the dissertation study.

Thank you for opting to participate in focus group discussion.

After focus group discussion, I've added everyone's feedback to adapt the NIH implicit bias training for counselors. Attached is the training with the noted additions highlighted. Please review and let me know your thoughts. Is this reflective of what we discussed in group?

Thank you,

Appendix J

Dr. Jaroslaw Kriukow CV

JAROSLAW KRIUKOW

PERSONAL DETAILS

Nationality: Polish
Address: 6 Parkhead Grove, Edinburgh EH11 4RZ

Telephone number: +44 7450 227922
E-mail address: J.Kriukow@sms.ed.ac.uk
Date of birth: 17.02.1985

PROFILE

- A pro-active and creative researcher with excellent planning, organisational and negotiation strengths, experienced in conceiving and conducting research projects, with proven analytic skills and the ability to use software for quantitative and qualitative data analysis.

- Familiar with, and experienced in, all of the aspects and challenges of conducting research, from funding bids preparation and designing research to data collection and analysis, and disseminating research, networking and facilitating knowledge exchange.

EDUCATION

2013 - 2017 PhD Education (Full-time)

The University of Edinburgh: Supervised by Dr Nicola Galloway and Dr Joan Cutting

Thesis title: 'I can express *myself*, but not *my self*': Investigating the English Language Identity of Polish migrants in Scotland'

Research suggests that the Polish migrants in Scotland do not integrate well with the local communities and tend to work below their qualification and education level. This is alarming, given the Government's goal of retaining migrants as a way to address the issues of Scotland's aging population and insufficient labour force. I investigated the relationship between the migrants' sense of self and the English language to test the hypothesis of the way they perceive themselves as users of the language influences many aspects of their experience, including socialization practices and professional standing. I used the findings to initiate a project entitled *"Teaching English to Speakers of Other Languages (TESOL) Community Engagement: facilitating collaboration with the current TESOL provision in Scotland"* (see the Other Relevant Experience section).

2011 – 2012 MSc TESOL (Teaching English to Speakers of Other Languages) (Full-time)

The University of Edinburgh

Dissertation: 'The relationship between having a native English teacher and identity as an English speaker'

This Master's programme prepared me well to both work and conduct research in the context of teacher education, course design, materials development and language assessment. I developed knowledge of how to apply the theories of language teaching and learning to classroom instruction, assessment, materials development and curriculum design.

2006-2009 **BA English Language Teaching**

The University of Zielona Gora (Poland)

EXPERIENCE (RSEARCH)

2017 January – 2018 January **Research Assistant -** University of Oxford

I worked on a project entitled *"Global Englishes Language Teaching (GELT): Bridging the gap between theory and practice"*.

This is an investigation into the attitudes, and the reasons underlying these attitudes, of pre-service English teachers on an MSc TESOL programme towards GELT before and after taking the Global Englishes for Language Teaching option course via questionnaires, interviews and focus groups.

My responsibilities included:

- compiling literature reviews,
- conducting interviews and moderating focus groups,
- transcribing interview data,
- analysing interview (n=40) and focus group (n=6) data,
- analysing open-ended questionnaire responses (n=82),
- developing thematic frameworks,

- conducting within- and cross-case comparisons in NVivo,
- running data queries in NVivo,
- composing data tables and visualisations,
- describing the data analysis procedures and results for 2 book chapters and 3 academic articles,
- creating lists of references in Mendeley.

2015-2017 **Research Assistant** - The University of Edinburgh

I was employed by Dr Nicola Galloway to help with a variety of projects. The most recent project was entitled "Internationalisation, Higher Education and the growing demand for English: an investigation into the global English Medium of Instruction (EMI) movement and the use of academic English as a

Lingua Franca (ELF) in non-Anglophone Higher Education Institutes (HEI)" (funded by the British Council English Language Teaching Research Partnership Awards).

My responsibilities included:

- conducting and writing literature reviews,
- analysing the data from 63 interviews, 13 focus groups and open-ended responses from 600 collected questionnaires,
- reporting on the data analysis procedures and results for 6 different journal articles and a report for the British Council.

2016 **Research Assistant** - The University of Edinburgh

Dr Heath Rose (University of Oxford) and Dr Nicola Galloway (The University of Edinburgh) employed me as a research assistant for two funded projects that would lead to book and article publications. My responsibilities included:

- Typing a large amount of written material (39 students' reflections on presentations about the global varieties of English, 46 students' reflections on a debate about the same

topic and 129 students' poems about the global spread of English), - Inputting the data into NVivo, - Organising and sorting the data.

2013-2016 **PhD Research** - The University of Edinburgh

My PhD study was a mixed methods research, consisting of both qualitative and quantitative components, and included interviews, electronic journals and questionnaires. I used a detailed grounded theory approach to analyse the qualitative data set (20 participants) and to create a theoretical framework, which was later tested with a quantitative questionnaire (378 respondents). I used *NVivo10* for the qualitative, and *SPSS22* for the quantitative, data analysis.

OTHER RELEVANT EXPERIENCE

2016

"**Teaching English to Speakers of Other Languages (TESOL) Community Engagement:** facilitating collaboration with current TESOL provision in Scotland"

This research project I conceived aimed to develop a partnership and collaboration between The University of Edinburgh and several public and private sector organisations involved in English language teaching policy and provision, migrants' well-being and social research in Scotland. The goal of this collaboration was to investigate the ways that EU migrants are

currently taught English in Scotland, to investigate whether these classes provide the opportunity for the students' selfgrowth and self-esteem and, ultimately, to improve the quality and effectiveness of the English language education provided to migrants in Scotland.

2015 - 2016

ELF Teacher Development Project

I collaborated with Dr Nicos Sifakis (Hellenic Open University) and Prof Yasemin Bayyurt (Boğaziçi University) to introduce their large ERASMUS + funded project aimed at educating English teachers in light of the global spread of English as a lingua franca to the Polish context. I developed partnerships with secondary schools in Poland, recruited participants, organised and jointly co-ordinated teacher development workshops and was responsible for monitoring the participants' progress throughout the programme.

PUBLICATIONS AND PRESENTATIONS

Publications

Kriukow, J. (in press). "I can express *myself*, but not *my self*" – English Language Identity of Polish migrants living in Scotland. *Journal of Language, Identity & Education.*

Kriukow, J. & Galloway, N. (in press). Internationalisation and the growing demand for English in Japanese Higher Education: Undertaking doctoral study in English. In K. Murata (Ed.), *English Medium Instruction from an ELF perspective.* Taylor & Francis.

Galloway, Kriukow and Numajiri (2017). Internationalisation, higher education and the growing demand for English: an investigation into the English medium of instruction (EMI) movement in East Asia. *ELT Research Papers*. A report for British Council.

Galloway, Kriukow and Numajiri (2017). Pre-service teacher attitudes towards English as an International Language: An exploratory study of MA TESOL students studying Global Englishes". Manuscript submitted for publication.

Lectures and presentations

September, 2017. Polish Psychologists' Association (PPA) Open Day event in London. I was invited by PPA to deliver a series of workshops devoted to communication in English. The workshop was aimed at Polish migrant community in London and covered the topics of links between self-esteem and the language, language anxiety, stereotyping and prejudice, and the role of English as a global lingua franca.

June, 2017. "I can express *myself*, but not *my Self*" - Investigating the English Language Identity of

Polish migrants in Scotland. *Unheard Voices, Unseen Communities: Perspectives on Polish Ethnicity in Scotland*. I was invited by Dr David Worthington to give a talk at this one-day workshop at University of Highlands and Islands.

March, 2016, 2017. English and identity. A lecture delivered to MSc TESOL students in the *Global Englishes for Language Teaching* option course at The University of Edinburgh.

January, 2016. Managing supervision: the PhD students' perspective. *PhD Induction Day*, The University of Edinburgh.

2015 – 2017. ETAL "Think & Drink" seminars. I was in charge of organising Edinburgh TESOL and Applied Language (ETAL) "Think & Drink" seminars – a series of social events comprised of research presentations followed by group discussions. The speakers (both students and established academics) presented on areas related to teacher education, reflective practice, language studies, language policy, language education, intercultural communication and the internationalisation of higher education.

September, 2015. Investigating the English Language Identity of Polish migrants in Scotland: the case for ELF-oriented pedagogy. *Moray House Interweaving Conference*, The University of Edinburgh.

July, 2015. Investigating the English Language Identity of Polish migrants in Scotland: initial findings. *Cutting Edges Research Conference*, Canterbury Christ Church University, Canterbury.

June, 2015. Investigating the English Language Identity of Polish migrants in Scotland: initial findings. *Linguistics and English Language Postgraduate Conference*, The University of Edinburgh.

June, 2015. Managing dissertation writing and research time. *ETAL Dissertation Training Day*, The University of Edinburgh.

March, 2015. Two studies of non-native English speaker identity in light of English as a Lingua Franca. A presentation for MSc TESOL students at The University of Edinburgh.

September, 2014. Two studies of non-native English speaker identity in light of English as a Lingua Franca. *7th International Conference of English as a Lingua Franca*, Athens, the American College of Greece.

REFERENCES (AVAILABLE ON REQUEST)

Dr Heath Rose

Associate Professor of Applied Linguistics

Department of Education

University of Oxford

15 Norham Gardens

Oxford, OX2 6PY

Tel: +44-1865-274033

Email: heath.rose@education.ox.ac.uk

Dr Nicola Galloway

Lecturer in TESOL

The University of Edinburgh

Charteris Land, Holyrood Road

Edinburgh, EH8 8AQ

Email: Nicola.galloway@ed.ac.uk

Dr Joan Cutting

Senior Lecturer in TESOL

The University of Edinburgh

Charteris Land, Holyrood Road

Edinburgh, EH8 8AQ

Email: Joan.cutting@ed.ac.uk

Appendix K

Adaptation of the NIH Implicit Bias Training Module for Counselors

Implicit Bias Training for Counselors

An Adaptation of the NIH Implicit Bias Training Module (2022)

Mission of Counseling

- The American Counseling Association provides ethical codes for counselors practicing in the United States.
- The mission of the American Counseling Association is
  - "...to enhance the quality of life in society by promoting the development of professional counselors, advancing the counseling profession, and using the profession and practice of counseling to promote respect for human dignity and diversity."(American Counseling Association, 2014)

Diversity in American Counseling

- Diversity within counseling also includes recognizing the various intersections of identities within the counseling relationship.
- For example, who a counseling educator or counseling supervisor is in the combination of their race, ethnicity, nationality, culture gender, sexual orientation, environment, socioeconomic status, religion, and multicultural awareness influences who they are as an educator.
  - Their identities then effect the combination of identities of counselors in training.
  - These counselors in training go forth as counselors to eventually become fully licensed.
  - Their combination of identities influence how they show up as a counselor to clients with additional combinations of identities.
- Therefore, in counseling, diversity includes the whole person and how it impacts others.
- CACREP defines multicultural as “denoting the diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation; and religious and spiritual beliefs, as well as physical, emotional, and mental abilities” (CACREP, 2015, p. 42)

Implicit Bias Threatens Diversity in American Counseling

- Additionally, as the United States counseling profession is embedded within American culture, it is important to consider how a counselor's identity may have influenced their person based on their American environment.
- As race has been a salient factor in the United States, it is likely that the person of a counselor is influenced unconsciously by American culture as it relates to race.
- Historical disenfranchising and marginalizing beliefs related to gender, sexual orientation, class, religion, ability and many other identities in the United States may also unconsciously influence a counselor's behaviors
- It is important for counselors to remain open to any way in which they may have been influenced consciously or unconsciously in order to better meet the needs of diverse clients.

Development of Multicultural Competence

- Multicultural competency is continually evolving but has only been part of the field since the 1970s (Korman, 1974; Sue & Sue, 1977).
- Since standards were only placed on rising counselors, veterans in the field were not given the same information (Brown & Brown- Landrum, 1995; Constantine, 1997; D'Andrea & Daniels, 1997; Fukuyama, 1994; Leong and Wagner, 1994)
  - Continuing education did not and still does not require counselors to increase their knowledge with the continued evolving standards.
  - New information continues to develop that helps counselors better help your clients of diverse backgrounds such as implicit bias and its effect on effective helping in counseling diverse cultures.

What is the helping equation

- The relationship of helping can be described in two parts
  - The person helping
  - The person being helped
- Just like 1+1=2
  - Person helping +Person being helped = Help
- Unfortunately, there are many nuances that can complicate the helping equation

Altruism

- One major part of counseling is its altruistic characteristics (Dugatkin, 2006; McGuire, 2003; Robinson & Curry, 2007; Rushton, 1982)
  - Altruism is typically defined as help that is self-sacrificing and is for the gain of others (Batson, 2011) but it is also prosocial meaning that people behave altruistically with a keen awareness of its rewards (Robinson & Curry, 2007)
  - Many counselors are drawn to the field from altruistic characteristics
- Though seemingly good on the surface, altruism is also influenced by surrounding culture
- Beliefs of who needs help and who gets to help in a culture have historical bias, even in the counseling field (North, 2000; Plummer, 1970; Szasz, 1971)

Altruism May Interrupt the Helping Equation

- Many counselors have a deep desire to help with altruistic intention.
- However, after entering the counseling profession, they get a taste of how good the rewards of helping feel.
  - Sometimes counselors exchange altruistic intention for altruistic drive
- Altruistic drive is the need to help due to personal rewards rather than a true desire to be of help
- Acting from a desire to help (rather than to be helpful) requires us to make assumptions that lessen our collaboration with clients
- In this way, some counselors may believe they are helping altruistically because of their intention but may actually be causing harm through their own desire of helping
    - This complicates the helping relationship even more
- Person helping +Person being helped = Help instead becomes...
- <u>Person who has a need to help (altruistic drive) + Person being helped = help</u>

Implicit Bias and Counseling

- Implicit bias can complicate the job of helping even further
  - Implicit bias is based in unconscious assumptions/beliefs and is also informed by surrounding context (Greenwald et al., 1998)
- Who you are as an individual is impressionable at the unconscious level
  - Our environments can shape our unconscious thoughts effecting our behaviors sometimes without our knowledge
- A combination of implicit bias (Boysen & Vogel, 2008; Katz & Hoyt, 2014) and the altruistic drive to help can negatively impact decision making specifically with clients of marginalized, disenfranchised and minority backgrounds

How bias and altruism interrupt the helping equation

- Let's revisit the helping equation.
- We've already established that a counselor's drive to help can sometimes interrupt the process of helping because the need to help becomes more important than actually being helpful.
- However, even further, a counselor's unconscious bias can interrupt the target of the helping behavior.

Helping Equation Transformed

- In this way the helping equation shifts
- Need to help + person being helped = help becomes...
- What counselor sees as problem + Counselor fixes the problem = help
- With this change, the client is then entirely removed from the helping equation. It solely becomes about the counselor, their need to help and their perspective of what needs to be helped.

The Desire to Help

- While those entering the counseling profession may want to engage in self sacrificial helping, the strong desire to help may be influencing the care they give interrupting effective care and causing harm to those of diverse cultures.
  - There are definitions of helping that you may come into the counseling field with that may not be entirely altruistic. These definitions may be influenced by your intersectional identities. Within American context, race is a major influence in the foundation of American systems specifically within various types of helping relationships.
- The desire to help must be regularly managed in case it is influenced by implicit bias or self-serving tendencies
  - It is important for counselors to analyze their own relationship with their characteristic drive to help others in order to best help clients of diverse backgrounds.

Let's Practice

The Desire to Help: The Case of Michelle

- Michelle is a white cisgender woman (female) graduate student in a CACREP accredited counseling program starting internship. From a rural area in North Carolina, throughout her life, Michelle has always struggled financially. Finally, being in a better position financially with graduation in sight, Michelle is extremely proud of her accomplishments and excited to finally be able to help others in the profession.

Here we establish Michelle's intersection of identities described in our discussion of diversity earlier and her drive to help others.

The Desire to Help: The Case of Michelle

- At her internship in a clinic that offers medically assisted treatment for substance abuse, she is assigned an 18-year-old Black male client who suffers from depression and uses various substances to cope.

Here we've established that Michelle is a counselor in training within the therapeutic relationship.

The Desire to Help: The Case of Michelle

- Michelle believes she knows just how to help given her background of financial struggle. She feels she has had exposure to most difficult circumstances in life. She will finally be able to help people in the ways she needed throughout her life.

Here again, we see Michelle's genuine desire to help, though it is from her own personal views that she desires to help.

The Desire to Help: The Case of Michelle

- In session, she allows the client to vent while she begins setting goals in her head. The client reveals he is a senior and is not sure if he wants to graduate and continue his education or drop out. He is exhausted emotionally and does not have any support.
- Michelle resolves that the one and only goal should be that they find a way to remove him from his unsupportive mother who is pushing him to drop out and get a job. She believes that if he could just get a college degree, all his problems would be solved. He would not be depressed, and he would have so much on his plate with school that he would not have time to think about anything else just like she did. She begins looking at college sites with him.

Here, Michelle allowed her desire to help to disrupt her duty to goal set with the client.

The Desire to Help: The Case of Michelle

- Though he is apprehensive she continues telling him that it is the best thing for him. The client leaves the session without addressing his concerns.
- Michelle is proud of herself for thinking on her feet and believes she used motivational interviewing to help the client come to his senses regarding college. Michelle is unaware that she holds an implicit regarding the intersection of identities of her client and is blinded by her own bias toward higher education.

Here, ultimately Michelle is ineffective though she believes that she was effective because she had a need to help rather than a desire to be helpful based on the clients wants.

Analysis of Michelle

- Based on the case scenario, Michelle, like many beginner counselors in training, feels an intense altruistic need and excitement to help her client. Altruistic characteristics are prosocial and shaped by perceptions of power and privilege driven by the surrounding culture (Fehr & Fischbacher, 2003).
- In Michelle's case she has made implicit assumptions about her client's position in the cultural context especially in relation to her role of power and authority. She assumes a role of power to best help him and has access to additional moral authority, contributing to the client's hesitation of challenging her, allowing her to push her own agenda unchallenged.
- She feels called to this role of moral authority because of her plight and likely her race in relation to the client's. She then utilizes her power and authority within the counseling dynamic to perpetuate her sociocultural understandings. She has made assumptions about his role as the one being helped based on his circumstances and identities differing from the rules of wellness within her context. And Michelle has done all this genuinely believing she is being helpful.
- Even still, with the best intentions, she is ineffective.

What Could Have Michelle Done?

- What Michele could have done was first be aware of her desire to help and trade it with the desire to be helpful based on the client's needs. This would have allowed her to check her own biases and gather from the client what they'd like to accomplish.
- Further, analyzing potential biases from her background, Michelle may have been more likely to recognize what she was doing before it negatively impacted the session. Cues like the client's discomfort may have triggered her to question her actions a bit more in session.
- In a different case scenario let's look at Aaliyah.

The Desire to Help: The Case of Aaliyah

- Aaliyah is a Black cisgender woman (female), fully licensed LCMHC, and has been practicing for the last 15 years. Aaliyah lives a higher middle-class life with her husband and two children. Her favorite part of the weekend includes dressing up and going to church. She was raised Baptist but now goes to a nondenominational church with her family regularly.
- She is very active in her community between her volunteering at church and within her children's school mentoring- she tends to be rather busy.

Here we establish Aaliyah's intersection of identities described in our discussion of diversity earlier, her drive to help others and her role within the counseling profession.

The Desire to Help: The Case of Aaliyah

- Aaliyah has always been the one her family and friends turn to for advice and felt “called” to the counseling field by God.
- As a clinician she is regularly awarded for her efforts within the Black community increasing access to care for the underserved. Those in the profession especially turn to her because she is great at organizing and they use those skills to organize events for underserved communities.

Here again, we see an extension of Aaliyah’s roles, her strengths in the field and her ability to help.

The Desire to Help: The Case of Aaliyah

- Today in session Aaliyah has on her schedule a younger female client that she has been seeing for months who is having difficulty with a romantic relationship. The client has been experiencing symptoms of anxiety and depression on top of these concerns. Despite repeated attempts to get the client to assess her values and determine if the relationship is even a good fit for her, the client continues to struggle which is frustrating to Aaliyah.
- On telehealth, Aaliyah notices that the room behind her is a bit more "junky" than usual and reads this as a hint from God. While she's been frustrated by previous approaches, she sees an easier way she can help since she is great at organizing. She feels she can use her gift with the extra insight from God to help.

The Desire to Help: The Case of Aaliyah

- In an attempt to get through to the client from a different approach (and relieve her own personal frustration of not being able to help (from her own assessment)), Aaliyah asks about "the mess" in the background. She segues into a brief lecture about how "the mess" is a metaphor to her priorities being "a mess" and focuses on helping the client strategize a way to clean up.
- While she was slow to speak and allowed the client to talk, the client's attempts to discuss her long-term tumultuous relationship were met with Aaliyah's comparisons to the literal "mess" in the background disguised as reflections of meaning and reflections of feeling.

Here we see Aaliyah utilize counseling strategies in a way that is highly influenced by her own cultural lens in order to relieve her own frustration of potentially not helping the client.

The Desire to Help: The Case of Aaliyah

- While the client went along with the change, she didn't really believe the session was helpful. Aaliyah asked the client for feedback as she always did after the session. The client said that the session was helpful even though she wasn't entirely satisfied because of their good rapport. She believed Aaliyah's heart was in the right place, so she didn't speak up.
- Additionally, since Aaliyah is well known in the community for her ability to help Black women specifically, the client felt that she may need to listen to Aaliyah's expertise. This was further heightened by the fact that Aaliyah is older than her, shares similar religious beliefs to her and based on her culture she didn't want to be perceived as "disobedient". Ultimately the client's needs were not met but Aaliyah's need to relieve her own frustration was. Her desire to help superseded her ability to be helpful is influenced by her cultural beliefs.

Analysis of Aaliyah

- In this context, Aaliyah occupied many positions of power in relation to the client which allowed her to take leadership of the session and interrupted the client's ability to give true feedback. Aaliyah's relying on her religion allowed her to justify her outside approach to relieve her frustration rather than to seek the expertise of the client on their own personal life. She assumes a role of conscious power from her religious beliefs but unconscious power from the client's response to her intersectional identities. Aaliyah's call to the profession gives her access to authority and power in a way that harms efficacy with her clients unchecked. While she may feel that she is acting altruistically, in this case she mostly acted out of personal interest to be feel like she is helping, minimize her own frustration and validate her religious call to the field.

What Could Have Aaliyah Done?

- What Aaliyah could have done was acknowledge her frustration by reflecting with the client and assessing their level of frustration. Aaliyah could have then gathered a sense of how the client would have liked to accomplish in that session. Rather than turning to her religion as the expert source for a solution, turning to the client would have likely yielded more effective results.

What Can You Do?

- In session
  - Ask and Believe the client's perception of the problem
  - Be open to critique and feedback from the client
    - Broach conversations and genuinely invite the feedback over time
  - Broach conversations about power in counseling with clients
    - Client to counselor, racial/ethnic, age, etc.
- Out of Session
  - Continue to educate yourself about the history of the field
  - Accept that there are biases you hold that may not be your fault, but they are your responsibility

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