

IMPLICATIONS FOR MULTICULTURAL COUNSELING TRAINING: MOTIVATION,
IMPLICIT RACE BIAS, EMPATHY, AND ATTRIBUTION BIAS

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ABSTRACT

Multicultural competency is the crux of training mental health practitioners in order to promote clinical skills, awareness, and knowledge when working with clients of diverse backgrounds; research integrating automatic beliefs about race is limited. Implicit race bias is integrated into the present study to better explain practitioners' multicultural competencies, motivation to respond without prejudice, empathy, and attribution of client concerns. Participants responded to 1 of 2 vignettes that controlled for client race (i.e., African American, European American). Analyses revealed that client race is an important factor for culturally sensitive conceptualization of clients' presenting concerns. Attribution of client responsibility for the cause of the problem is directly related to the relationship between implicit race bias and practitioner level of experience. Post hoc analyses revealed that implicit race bias and motivation to respond without bias significantly influence multiculturally competent case conceptualization. However, implicit race bias did not significantly predict ethnocultural empathy, or significantly relate to a number of the variables in the study. Implications of these results for counseling practice, training, and research are discussed.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Education, have examined the dissertation titled, “Implications for Multicultural Counseling Training: Motivation, Implicit Race Bias, Empathy and Attribution Bias,” presented by Leia Ann Charnin, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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LIST OF ABBREVIATIONS

IAT	Implicit Association Task (Racial)
MCCA	Multicultural Case Conceptualization Ability
MCI	Multicultural Counseling Inventory
MCC	Multicultural Counseling Competence
CSS	Cause and Solution Scales
CSS-C	Cause and Solution Scale-Cause
CSS-S	Cause and Solution Scale-Solution
IMS/EMS	Internal and External Motivation Scales
SEE	Scale of Ethnocultural Empathy
SEE- EFE	Scale of Ethnocultural Empathy-Empathic Feeling and Expression
SEE-EP	Scale of Ethnocultural Empathy-Empathic Perspective Taking
SEE-AC	Scale of Ethnocultural Empathy-Acceptance of Cultural Differences
SEE-EA	Scale of Ethnocultural Empathy-Empathic Awareness
EM	Expectation Maximization
SSIRB	Social Sciences Institutional Review Board
MCAR	Missing Completely at Random
SPSS	Statistical Package for the Social Sciences Software
SDT	Self-Determination Theory
MCAS	Multicultural Counseling Awareness Scale
MAKSS	Multicultural Awareness/Knowledge/Skills Survey
CCCI-R	Cross Cultural Counseling Inventory-Revised
COBRAS	Color-Blind Attitudes Scale
ANCOVA	Analysis of covariance
IRI	Interpersonal Reactivity Index

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CHAPTER 1

INTRODUCTION

The American Psychological Association's (APA's) ethical principles of psychologists and code of conduct (APA, 2010) clearly outlines that practitioners are to act without bias to all people so as to reduce prejudice and act in a multiculturally competent manner. Principle E: Respect for People's Rights and Dignity states:

Psychologists are aware of and respect cultural, individual, and role differences

Psychologists try to eliminate the effect on their work of biases based on those factors, and they do not knowingly participate in or condone activities of others based upon such prejudices. (p. 4)

The principle to address the effect of biases in therapeutic work is easier said than done because of *implicit biases*, which are considered unintentional and automatic attitudes (Greenwald & Banaji, 1995). Such attitudes are difficult to control due to their unconscious nature. In fact, decades of research has revealed that counselors in training continue to demonstrate implicit bias (Abreu, 1999; Boysen, 2010; Boysen & Vogel, 2008; Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007).

Unfortunately, even when trainees are encouraged to demonstrate non-prejudiced attitudes, implicit bias can still negatively affect their behavior. For example, brief and seemingly banal verbal, behavioral, or environmental insults may be consciously or unconsciously communicated in a denigrating manner, which are behaviors referred to as *microaggressions* (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal, & Edquilin, 2007). Multicultural counselor competency models encourage the development of skills, knowledge,

and awareness in order to better understand and challenge biases, but those who engage in microaggressions are typically unaware of their actions and the negative impact on the recipient (Constantine, 2007). Particularly applicable to the therapeutic context, White counselors working with clients of color may exhibit microaggressions that can impair the development of the therapeutic alliance (Sue et al., 2007). In the counselor-client relationship, the counselor has a position of power, which may interfere with the accurate assessment of prejudiced acts that occur in session (Sue et al., 2007). Further, counselors who are unaware of their biases may favor their own cultural worldview and pathologize the cultural values of diverse clients.

Multicultural counseling competence (MCC) refers to the awareness, knowledge, and skills developed by counselors to work with culturally diverse individuals (Sue, Arredondo, & McDavis, 1992). One particularly complex component of MCC training is developing skill in case conceptualization, such that multiculturally competent treatment requires integration of cultural information within conceptualizations of the clients' presenting concerns (Constantine, 2001). Moreover, few studies have investigated the effect of multicultural training on MCCs and implicit biases (e.g., Abreu, 1999; Boysen & Vogel, 2008; Castillo et al., 2007; Chao et al., 2011; Gushue & Constantine, 2007; Kernahan & Davis, 2007), and even fewer studies have investigated the relationship between automatic biases and counseling skills, such as multicultural case conceptualization, counselor attribution of client responsibility, and counselor empathy toward a client (e.g., Burkard & Knox, 2004; Neville, Spanierman & Doan, 2006).

Although the literature linking implicit cognition and multicultural competencies is limited, studies suggest that *color-blind* attitudes play an important role in the development

of counseling skills, awareness, and knowledge given that individuals may deny that racial issues are a prevalent concern. Such an expression of attitudes is known as *color-blindness*, or “the belief that race should not and does not matter” (Neville et al., 2000, p. 60). To date, numerous studies related to counseling psychology have focused on the effect of practitioner color-blindness on a number of variables: counselor empathy and attributions of client responsibility (Burkard & Knox, 2004); multicultural awareness and knowledge (Chao, Wei, Good, & Flores 2011); stereotypic assumptions about culturally diverse clients (Constantine & Sue, 2007); White racial identity (Gushue & Constantine, 2007); and prejudice reduction strategies (Correll, Park, & Smith, 2008) to name a few.

Although color-blindness may negatively affect the therapeutic process (e.g., Sue, Capodilipo, et al., 2007; Utsey, Gernat, & Hammar, 2005), only a handful of studies have directly assessed implicit racial attitudes in the counseling process. This trend is surprising considering that within the past decade, researchers have empirically tested a number of implicit bias reduction strategies in order to decrease behavioral- and affective-biased responses (e.g., Correll, Park, & Smith, 2008; Czopp, Monteith, & Mark, 2006; Devine, Forscher, Austin, & Cox, 2012; Devine, Plant, Amodio, Harmon-Jones, & Vance, 2002) while multicultural training models have explicitly expressed values in developing racial awareness. Because color-blind attitudes can negatively affect counselor multicultural competencies (Burkard & Knox, 2004) similar to implicit race bias (Boysen, 2008), it is possible that implicit attitudes negatively affect multicultural competencies and are moderated by training level and motivation to respond without prejudice.

Multicultural courses are developed with the aim of increasing awareness, skills, and knowledge, and with the hope of decreasing biases (Boysen, 2010; Castillo et al., 2007).

However, there is a lack of understanding of how implicit biases affect MCCs and thus counselors' work with clients. For this reason, the present study attempts to respond to Boysen's (2010) call for addressing counselors' implicit bias as it relates to MCC development and other important factors considered important when working with racially diverse clients (i.e., responsiveness to cultural issues in therapy, counselor attributions of cause and responsibility of cause to a client's problems, and practitioner feelings of empathy).

Conceptual Underpinnings

A few terms pertinent to the study must be clarified before investigating the proposed relationship between implicit attitudes to practitioner case conceptualization, attributions, and empathy. First, the words "beliefs" and "attitudes" are often interchanged in the literature, despite some conceptual difference. An attitude is a positive or negative evaluative reaction in response to something or someone (Myers, 2009). This evaluation is often influenced by a person's beliefs and evidently displayed through their affective, behavioral, or cognitive mannerism. In contrast, a belief is considered a premise that a person holds to be true; however, the degree to which beliefs are intentional remains a common debate (Fiske, 2010). Individuals process information and act in both conscious (*explicit*) and unconscious (*implicit*) ways (Greenwald & Banaji, 1995). Conscious processes are associated with control whereas unconscious processes are considered to be automatic. Similarly, responses are automatic due to the nature of occurring without intention, awareness, effort or control.

It is also important to understand counselors' motivations to respond without prejudice, given the emphasis of racial and cultural awareness in multicultural training.. Motivation to respond without bias may be shaped by internal or external sources, past

experiences, and automatic associations that subsequently affect multicultural competencies, attributions to clients, and ethnocultural empathy. Deeper understanding of the interplay between these characteristics may help in the continued development of counselor MCCs.

Implicit bias. Many counselors are able to develop some awareness about their biases given the emphasis on multicultural competencies in training programs (Chao et al., 2011), however, their ability to develop bias-free skills can be more complicated. Implicit bias may help to distinguish between intentional and unintentional discrimination manifested in aversive racism and microaggressions. Aversive racism refers to forms of racism that are unpleasant to those who hold them. Moreover, it directly relates to rejection of outdated and blatant prejudice by adopting an unbiased or colorblind self-view; however, aversive racism may manifest in subtle discrimination (Dovidio, Gaertner, Kawakami, & Hudson, 2002, Sue et al., 2007) or microaggression that receivers of bias experience; notably, most occur without the sender's intent (Constantine, Smith, Redington, & Owens, 2008; Sue et al., 2007). Microaggressions may occur in therapy when an individual's experiences are invalidated.

Although counselors generally do not exhibit strong and explicit biases, it is possible that they can still hold strong implicit biases (Boysen, 2009). According to social cognitive theory, implicit bias is a related mechanism for aversive racism in that the underlying attitudes function in an ambivalent manner (Dovidio et al., 2002). Greenwald, McGhee, and Schwartz (1998) defined implicit bias as "actions or judgments that are under the control of automatically activated evaluation, without the performer's awareness of that causation" (p. 1464). Beliefs, judgments, and social behaviors are influenced by past experiences, which affect individuals in an implicit or unconscious manner. However, individuals are normally

unaware of experiences that shaped their beliefs (Greenwald & Banaji, 1995). This research on implicit processes provides evidence that a person does not need to consciously endorse a stereotype or be consciously aware of that stereotype in order for their behaviors to be affected. Furthermore, individuals may not be aware of the personal attitudes to which they subscribe. For this reason, a person may not recognize when they experience negative stereotypical beliefs, leaving them unaware of the psychological impact that stereotypes and bias can have on their affect and behaviors. Given that implicit is automatic, it is difficult to prevent or stop the process, given that an automatic response is not competing for resources that control attention (e.g., Devine, 1989; Gawronski, Hofmann, & Wilbur, 2005; Wittenbrink, Judd, & Park, 1997).

Although implicit bias can be considered a specific type of prejudice, the construct can also be used to help elucidate certain mechanisms of discrimination. A person may become increasingly motivated to prevent the expression of bias as they learn new information and start to challenge prejudiced behaviors (e.g., Devine, 1989; Devine et al., 2012; Devine, Plant, Amodio, Harmon-Jones, & Vance, 2002). Specific interventions to reduce implicit biases may include stereotype replacement, perspective taking, individuating, counter-stereotypic imaging, and contact (e.g., Correll, Park, & Smith, 2008; Czopp et al., 2006; Devine et al., 2012). These techniques relate to multicultural competency training by increasing awareness, knowledge, and skills. In fact, a number of multicultural foundations courses utilize experiential exercises, such as those previously listed, in order to increase cultural self-awareness of stereotypes and racial attitudes (Castillo et al., 2007).

Multicultural competency development. The counseling profession has a rich history of developing research and theoretical models related to multicultural competencies.

Seminal research on the development of MCCs and standards (Sue & Sue, 1990), suggests that culturally skilled counselors must develop an awareness about their own personal biases related to one's worldview, in order to actively challenge their judgment and assumptions when working with culturally different clients. In addition, culturally skilled counselors make clear efforts to use select appropriate skills and interventions when working with culturally diverse clients. A general theme throughout the development and practice of multicultural counseling is that counselors must continue to grow and challenge themselves, given that the achieving full multicultural competence is not possible.

Following Sue and Sue's original recommendations in 1990, there was a sharp increase in literature and training that focused on multicultural competence. In particular, Sue, Arredondo, and McDavis (1992) developed a multicultural approach to assessment, practice, training, and research by providing the field with specific standards and competencies. The two main components of multicultural competencies were counselor *characteristics* and *dimensions*. Characteristics are considered to encompass: the following concepts: (a) counselor awareness of his or her values and biases; (b) understanding the worldview of the client's cultural perspective; and (c) selecting culturally appropriate interventions which are considered the tripartite dimensions of beliefs and attitudes, knowledge, and skills. This work served as the impetus for the American Association for Counseling and the Association for Multicultural Counseling and Development to implement multiculturalism throughout their organizations and the modern field of psychology.

Although the tripartite model of multicultural competence has been linked to positive counseling outcomes, there is minimal evidence to support the validity of this conceptual model (Worthington, Soth-McNett, & Moreno, 2007). As a construct, there have been

several measurement concerns regarding MCCs given that traditional surveys and self-report checklists do not account for the ability to conceptualize culturally diverse clients (Constantine & Ladany, 2001). Moreover, self-report measures of MCC and multiple subscales on MCC instruments have been correlated with social desirability (Ponteretto, Fuertes, & Chen, 2000), suggesting that these measures are assessing self-efficacy instead of actual competence. Several arguments have been made to establish a strong empirical base for MCC by means of true experimental research, multi-method studies, mixed designs, and qualitative research (see Atkinson & Israel, 2003). Consequently, Worthington and colleagues (2007) systematically evaluated published empirical studies investigating MCCs. They concluded that there is a paucity of process/outcome research on MCCs and that the limitations in instrumentation (i.e., validity concerns) may interfere with accurate interpretation of MCC research. As a response to such calls, this study employs a between-subjects experimental design to provide more implicit information about counseling-related constructs (i.e., implicit racial biases, attributions of responsibility). Establishing further empirical evidence of such factors may help close the theory-research gap as well as contribute to directions of process/outcome studies.

Characteristics of MCC may be related to the level of self-determination (i.e., the extent to which one is motivated by internal values) among counselors to generate bias awareness. Individuals are considered to engage in a constant evolution for personality development and behavioral self-regulation facilitated by the psychological need to enhance self-motivation: competence, relatedness, and autonomy (Ryan & Deci, 2000). To elaborate, a person is most likely to experience optimal change due to the enhanced conditions of intrinsic motivation: (a) when choice is autonomous; (b) when feelings of competence are

salient; and (c) when proximal relational supports are available to an individual (Ryan & Deci, 2000).

Empathy and attributions. Empathy itself is a significant factor in the effectiveness of therapy (e.g., Bohort et al., 2002; Ho, 1992; Lafferty, Beutler, & Crago, 1989). For example, culturally diverse clients perceive counselors as more culturally sensitive when higher levels of empathy are present during assessment and treatment (Fizcher, Jome, & Atkinson, 1998). To address limitations of general measures of empathy, this study will focus on ethnocultural empathy, which is the capacity to feel empathy for a member of an out-group (Wang, Davidson, Yakushko, Savoy, Tan, & Bleier, 2003). Ethnocultural empathy employs affective and cognitive empathy, including discrimination and prejudice awareness, as well as the capacity to take the perspective of other ethnic groups.

In addition, capacity for empathy and multicultural case conceptualization may be affected by the counselor's attributions of the client's role in the cause of the problem and the responsibility for the solution to the problem. For example, Burkard and Knox (2004) found evidence that practitioners' level of color-blindness is negatively related to empathy, as well as higher attributions of responsibility for African American clients but not European American clients. In other words, respondents were more likely to hold African Americans responsible for their presenting concerns and problems with daily functioning. Although empathy was a critical factor in their clinical judgment, a direct measure of implicit bias was not included in the study. Seem and Johnson (1998) provided evidence that counseling trainees respond in a biased manner when clients displayed nontraditional gender role behavior. That is, counselors were more likely to speculate in a biased manner about the client's presenting and underlying concerns. Culturally sensitive case conceptualizations

have also been linked to higher levels of affective empathy, a more integrated theoretical orientation to counseling, and higher levels of formal multicultural training (Constantine, 2001).

A critical goal of multicultural training is equipping counselors with the ability to differentiate and integrate multicultural knowledge to client treatment. A multiculturally competent case conceptualization is produced by a counselor who is: (a) aware of the effect of cultural factors on the client's presenting issues, while also integrating these factors into case conceptualizations, and (b) selects a treatment plan for the client using this awareness and knowledge (Constantine & Ladany, 2000). Further, social desirability attitudes are related to multicultural competencies. Social desirability functions on a conscious and external level and negatively impacts culturally competent case conceptualization (Burkard & Knox, 2004); but little is known about how automatic processes affect multicultural case conceptualization and empathy. Evidence that implicit biases are connected to these variables may strengthen the value of bias awareness in multicultural training, and promote the need to develop skills to reduce, not just explicit, but negative implicit attitudes.

Dual process model and self-determination theory. In light of the centrality of implicit biases in this study, motivation to respond without prejudice will also be examined. Motivation to attain behavioral goals, like responding without prejudice, may be active or passive and internally or externally driven. Environmental and social factors may influence within and between-person differences in motivation and personal growth (Ryan & Deci, 2000). The source of motivation to reduce prejudicial responses may have substantially different effects on a person's expression and experience of bias. According to Self-Determination Theory ([SDT] Deci & Ryan, 1985), value systems play a significant role in

determining a person's motivation and behaviors, such that people tend to behave in ways that are consistent with their values. Feelings of autonomy and freedom result in self-determined motivation, or motivation that is determined by intrinsic value. This theory posits a continuum of three types of motivation: amotivation, extrinsic, and intrinsic. Each type of motivation is determined by a self-regulation style: (a) amotivation is no regulation; (b) extrinsic motivation is determined by a combination of external regulation, introjected regulation, identified regulation, and integrated regulation; and (c) intrinsic motivation is determined by intrinsic value (Ryan & Deci, 2000). Individuals who are determined to regulate their biases tend to be influenced by intrinsic values, whereas those who are non-self-determined to regulate prejudice have limited regulation or amotivation (Legault, Green-Demers, Grant, & Chung, 2007).

The styles of motivation posited in SDT range on a continuum from non-self-determined to self-determined (Legault et al., 2007). Each style is related to a unique type of regulation. For example, higher levels of self-determination are related to beneficial outcomes, and lower levels of self-determined motivation are related to poor outcomes, such as weak and negative feelings. There is considerable evidence that suggests individuals who are motivated to reduce bias tend to experience guilt when prejudicial thoughts are activated, which in turn, triggers a disruption in self-regulation and further automatic bias (e.g., Amodio et al., 2007; Legault et al., 2007; Ryan & Deci, 2000). For example, those who are high in self-determined and regulation of prejudice are likely to have lower implicit and explicit bias than those who are less self-determined. In relation to motivation to control prejudice, SDT emphasizes the relevance of assessing internal and external motivations that drive individuals' regulatory efforts (Devine et al., 2002). To elaborate, internal motivation to

respond without prejudice is related to an internalized and personal value to demonstrate non-prejudiced in behavior and beliefs, whereas external motivation arises from a desire to avoid negative reactions from others (Plant & Devine, 1998).

By applying the theoretical tenants of SDT in studying race bias regulation, Devine and colleagues (2002) found that individuals who have high self-determination are more effective at regulating race bias on both explicit and implicit measures of motivation to respond without prejudice. Moreover, evidence shows that implicit race bias moderates the interaction of internal and external motivation to respond without prejudice (Devine et al., 2002). Specifically, individuals who are highly self-differentiated (i.e., high internal, low external) tend to exhibit lower levels of implicit race bias when compared to others. Moreover, the source of motivation to respond without prejudice tends to be stronger than the amount of motivation itself (Ryan, Sheldon, Kasser, & Deci, 1996).

A key element of self-determination theory is that a person's autonomy and internalization of regulatory efforts is positively related to their ability regulate responses that are relevant to a goal or value, such as desire to respond without prejudice (Devine et al., 2002). Examining the concepts of implicit and explicit motivation to respond without prejudice within the context of SDT, provides an opportunity to elucidate the degree of autonomy involved with regulating race bias. This knowledge may be applied to multicultural training in order to promote greater self-determination in counselors' motivation to respond without prejudice.

Statement of the Problem

Many counselors are aware that they have biases that may negatively affect counseling in some way, but they may not have the precise knowledge of how their implicit

biases affect their therapeutic judgment and reactions, or how to address their biases. Although measuring implicit bias is more time and resource intensive than using self-reported measures of aversive or explicit bias, it is critical to assess more unconscious responses to working with racially diverse clients. Moreover, the use of an objective and implicit measures in an experimental design will aid in closing the gap between theory and research investigating multicultural competence in graduate trainees.

The primary concern with implicit bias relates to a lack of knowledge about how implicit biases affect counselor factors, such as empathy toward the client, as well as motivation to respond without prejudice as it relates to multicultural competency standards. Specifically, counselor patterns of motivation to respond without prejudices have not yet been identified in a field that highly values multiculturalism. Additionally, researchers do not know if implicit race bias interferes with motivation to respond without bias or capacity for ethnocultural empathy. Moreover, practitioners may attribute client difficulties to faults inherent to the client due to implicit racial bias. Results are intended to help diversify ways to approach culturally competent training and improve counseling services for racially diverse clients.

CHAPTER 2

REVIEW OF THE LITERATURE

Empirical research supporting MCC counseling models is equivocal. A review of the literature points to three types of support for the widely accepted MCC model: (a) professionals widely implement the current constructs; (b) MCCs are often measured with self-report scales; (c) research primarily addresses MCC effects of counselor behavior (Ponteretto et al., 2000). Poor validity and psychometric evidence to support the scales

intended to reflect the model, further contributes to the lack of empirical support for the MCCs. Only a small number of studies investigate culturally responsive counselor behavior (Worthington et al., 2007); thus, there is a gap between the necessary theory and research to guide MCC training, assessment, research, and practice.

Implicit bias has a strong research base in terms of understanding its origins, measurement, effect on social behavior, and reduction strategies (e.g., Devine et al., 2012; Fazio & Olson, 2003; Nosek, Greenwald, & Banaji, 2005). By linking the concept of implicit social cognition to the domain of stereotyping, Greenwald and Banaji (1995) provided the first concise definition of implicit stereotypes: “introspectively unidentified (or inaccurately identified) traces of past experience that mediate attributions of qualities to members of a social category” (p. 8). Theory posits that implicit bias is a mechanism for aversive racism that can manifest in a behavioral manner, called microaggressions (Dovidio et al., 2002). In general, research regarding counselor education and implicit biases is lacking (Boysen, 2010), despite the emphasis on multicultural training for counselors’ awareness of biases, knowledge of multicultural factors, and skills to work with the culturally diverse client (Sue & Sue, 2003).

Literature in counseling psychology is quite populated with research on explicit racism. However, this focus has limitations because demonstrations of explicit prejudice may be buffered by a desire to respond without prejudice (Constantine & Ladany, 2000). In training programs, trainees receive the message that responding with bias is unacceptable because it directly conflicts with multicultural sensitivity; therefore, the expression of explicit bias is in large part uncommon among counselors, perhaps because they intentionally control explicit responses. Boysen (2009) suggests that counselor educators can integrate various

forms of bias (explicit and implicit) into the concepts of multicultural knowledge, awareness, and skill.

Bias responses can manifest in explicit and implicit ways. Recently, a number of researchers have investigated the relationship between implicit bias and multicultural competencies (e.g., Boysen & Vogel, 2008; Dovidio et al., 2002). The differences between explicit and implicit bias aligns with the theoretical construct of aversive racism (Dovidio et al., 2002). According to aversive racism theory, individuals may reject overt racial prejudice and discrimination, yet underlying negative associations continue to influence how they interact and judge people who are of a different race. The implicit and explicit attitudes of counselors may diverge in a similar manner, and the intentional avoidance of bias may be affected by implicit bias. For example, individuals who are highly motivated to respond without bias for external reasons may be less likely to reflect on their biases and develop greater awareness of their personal negative evaluations or attitudes of others.

Overall, the concept of implicit bias has rarely been addressed in counseling research; although there is some emerging research. A lack of knowledge about unconscious biases may hinder multicultural competency development, as lower implicit bias is related to greater multicultural competency (Boysen & Vogel, 2009). In this process, it is important to address implicit biases held by counselors and how they affect application of multicultural competencies to the diverse client. Research on counselor implicit biases may provide insight into how these biases affect practitioners' reactions and future implications for counselor education. In the current investigation, I propose that there are three practitioner factors that are related to implicit bias and multicultural counseling: empathy, counselor

attributions to clients, and multicultural case conceptualization. A better understanding of the characteristics affecting bias will help provide clarity for bias reduction paradigms.

Implicit Attitudes

The term *attitude* has attained much attention in social psychological theory. Early conceptualizations of attitudes were broadly defined as a concept that encompassed cognitive, affective, motivational, and behavioral characteristics. Further, attitudes were thought to operate in a conscious manner (Greenwald & Banaji, 1995). In the 1930s, Gordon Allport (1935) developed the following definition of *attitudes*: "a mental and neural state of readiness, organized through experience, exerting a directive and dynamic influence upon the individual's response to all objects and situations with which it is related" (p. 810). In the 1990s, social psychologists began investigating the operation of attitudes and stereotypes on an unconscious level with indirect measurements, such as out-group exposure, behavioral observations, and ultimately the Implicit Association Task (e.g., Banaji & Greenwald, 1995; Greenwald, 1990; Greenwald & Banaji, 1995).

What makes cognition implicit is the effect of past experience on a performance; the earlier event is not remembered or self-reported but it is influential in some manner. Beliefs, judgments, and social behavior are influenced by past experiences, which affect individuals in an implicit or unconscious manner. However, the individual is normally unaware of the specific experiences that shaped specific beliefs (Greenwald & Banaji, 1995). Past research on implicit processes provides evidence that one does not need to consciously endorse a stereotype, or be conscientiously aware of a stereotype, in order for it to affect behaviors (Greenwald, 1995). Furthermore, individuals may not be aware of the personal attitudes to which they subscribe. For this reason, stereotypes about social groups may be triggered

without awareness. As implicit stereotypes are activated, an individual may not be aware of the impact that those beliefs have on other psychological processes. Once implicit processes begin, it is difficult to interrupt them, because implicit processes are automatic and do not compete for resources that control attention (e.g., Devine, 1989; Gawronski, Hofmann, & Wilbur, 2005; Wittenbrink, Judd, & Park, 1997).

Studies have found that implicit bias is a predictor of subtle and unintentional forms of bias. For example, research suggests that in the therapeutic context, greater levels of implicit bias are associated with being less friendly toward lesbian and gay clients than heterosexual clients (Boysen & Vogel, 2008). Studies using undergraduate participants provide evidence that implicit bias can affect individuals' perceptions of emotions (Hugenberg & Bodenhausen, 2003) and the quality of one-on-one interactions with targets of bias (McConnell & Leibold, 2001). For example, to assess implicit bias, racial categorization, and perceived emotional intensity, Hugenberg and Bodenhausen (2003) presented participants with racially ambiguous faces intended to portray angry, neutral, or happy emotions. Participants who were higher in implicit prejudice, rated the angry faces as Black compared to participants with lower implicit prejudice, which suggested that implicit bias can impact racial judgments of emotions. In addition, McConnell and Leibold (2001) examined the interactions of undergraduate students with White or Black experimenters. Examiners evaluated participant behaviors as more abrupt and generally less physically comfortable (i.e., leaning away, crossed arms) when in the presence of the Black experimenter, especially when the participant had greater implicit race bias (McConnell & Leibold, 2001). These results suggest that implicit bias can impact how a person perceives the emotions of others, which has significant implications to the therapeutic environment.

Abreu (1999) conducted one of the earliest studies investigating the presence of implicit bias in counselors. Participants (i.e., graduate students, interns, and practitioners) were first primed with words related to stereotypes about African Americans. Next, when asked to rate perceived hostility of a client, participants were more likely to rate African American clients higher than participants who were asked to rate White clients. The exposure of negative stereotypes resulted in overestimations of hostility, which led to Abreu's conclusion that implicit bias may negatively influence clinical judgments of hostility. In an attempt to extend Abreu's research, Boysen and Vogel (2008) investigated the effect of training on implicit attitudes. Participants in graduate programs completed a multicultural measure to assess awareness, knowledge, and skill. They also completed a pen and paper implicit association test. The results of the study revealed that implicit bias is present among counselor trainees regardless of high self-reported multicultural competencies. Further, multicultural competencies varied by training level, but implicit bias did not differ significantly across training levels. These findings suggest that, although counselors may gain multicultural competencies, their automatic responses (i.e., implicit biases) may have more permanence.

In fact, additional studies show that implicit bias is present at various levels of training. Castillo and colleagues (2007) administered an African American bias IAT and multicultural counseling competency measures before and after implementing multicultural training courses. In addition, in a quasi-experimental design, Boysen and Vogel (2008) administered African American and homosexuality bias IATs and a multicultural counseling competency measure to counseling trainees who were divided by training level. The results of both studies suggested that trainees demonstrate implicit bias, regardless of training. A

contrast in the studies is that Castillo and colleagues (2007) detected a significant medium effect of training on implicit bias in that it could reduce bias, but Boysen and Vogel (2008) determined that no such effect existed. Thus, conflicting evidence exists regarding the influence of multicultural training on implicit biases.

Due to inconsistencies in results regarding the reduction of implicit and intergroup racial bias with multicultural training, Denson (2009) conducted a meta-analysis of 27 studies and found evidence that diversity activities do, in fact, reduce bias. This bias reduction is reliant on the characteristics of the program, such as diversity-focused, the pedagogical approach (i.e., immersion activities and perspective taking), and the students (White students tend to exhibit greater bias reduction than Black students). The interventions that prove to be most effective at bias reduction employed enlightenment approaches that focus on content-based knowledge of other groups, as well as intergroup contact approaches.

Measurement of implicit attitudes. The integration of implicit bias into the counseling psychology literature has been limited by the heavy reliance on self-report measures. The most commonly used measures are as follows: Multicultural Counseling Awareness Scale ([MCAS]; Ponterotto et al., 1996); Multicultural Awareness/ Knowledge/ Skills Survey (MAKSS; D'Andrea, Daniels, & Heck, 1991); Cross Cultural Counseling Inventory-Revised ([CCCI- R]; LaFromboise, Coleman, & Hernandez, 1991); and Multicultural Counseling Inventory ([MCI]; Sadowsky, Taffe, Gutkin, & Wise, 1994). Implicit measures provide unique information that cannot be gleaned from explicit measures. Attempts to fake or involuntarily control responses are largely ineffective with implicit measures. Further, implicit measures predict biased responses that are subtle and/or behavioral better than explicit measures (Greenwald et al., 2006). For example, implicit bias

has been found to predict physical avoidance of targets by the unconscious decision to sit further away from a person of a different race (Rydell & McConnell, 2006). If implicit bias affects such behavior in an experimental setting, then it may very well affect counselor reactions in a therapeutic context; however, such an assertion would need to employ behavioral observations in therapy.

Implicit measures target automatic responses and attempt to avoid the use of conscious introspection. Perhaps the most notable of such measures is the Implicit Association Test ([IAT]; (Greenwald, McGhee, & Schwartz, 1998). This measure is the most widely used because it has been linked to behavioral discrimination as well as racial preference (McConnell & Leibold, 2001). Moreover, the IAT produces large effect sizes (e.g., Greenwald et al., 1998; Greenwald et al.,). This measure targets efficient association of concepts by instructing individuals to categorize concepts. To elaborate, Greenwald and colleagues (1998) found that most European Americans have negative associations with African American faces and positive associations with European American faces. As a result, the authors divided the IAT into categories that are congruent (European American and Good; African American and Bad) and incongruent (European American and Bad; African American and Good). Implicit bias is measured by reaction times; faster reaction times are associated with congruent categorizations when compared to the incongruent categories. In Greenwald et al. (1998) faster reaction times indicated greater bias and more positive cognitive associations with European Americans than African Americans.

Researchers commonly use several assessments of implicit attitudes. The Implicit Association Task (Greenwald et al.,) is most often administered on a computer; however, a paper-format of the IAT was developed as a supplement to computerized data collection or as

a viable option when computer data collection is not possible. The paper-format of the IAT presents participants with a page of two columns of word stimuli. Participants are instructed to pair stimuli with a left response or right response by darkening circles, and they have 20 seconds to categorize as many items as possible. The score for this form of the IAT is derived from fixing the number of correct categorizations in one condition and comparing it with responses from the second condition. The computer-IAT fixes the number of responses and uses the time to complete an item as the dependent variable.

A study comparing the efficacy of the computerized IAT and paper-formatted IAT showed that the test-retest reliability of both tests is comparable, but the paper-format IAT elicited somewhat weaker mean effects than the computer-format IAT (Lemm, Lane, Sattler, Khan, & Nosek, 2008). The study indicated that the paper-format IAT may be more reactive to the type of stimuli used in the task due to better psychometric properties with all-verbal stimuli, as opposed to stimuli of face pictures. Moreover, the pencil and paper version of the IAT has been associated with high error rates caused by participants who incorrectly follow directions; randomly, quickly, and hence less accurately respond to items; skip items; and fail to complete items (Boysen & Vogel, 2008). The reliability and validity of the pen and paper race IAT is comparable to the computerized version, but the paper and pencil version elicits more errors due to fewer items. The test-retest reliability for the pencil-paper IAT is .62 for the names stimuli, but .49 (poor) for the pictures stimuli (Lemm et al., 2008). Although these correlations are seemingly small for similar measures, they are consistent with reliability coefficients from other studies (test-retest reliabilities = 0.50 [poor]; Lane et al., 2007).

As established, the unconscious operation of racial attitudes is implicit racial prejudice. Research shows that implicit bias affects interpersonal conflicts, interpretations of

emotions and behaviors, perceived friendliness, and multicultural competencies (e.g., Abreu, 1999; Amodio & Devine, 2006; Boysen & Vogel, 2008). However, at this time, two specific counselor reactions that have been studied in relation to aversive racism theory, empathy and practitioners' attributions of clients' responsibility for causing and solving their own problems, have not been studied in regard to implicit bias. These reactions have been established in research focused on color-blind racism, and therefore may also be connected to implicit biases.

Multicultural Competencies as Related to Implicit Biases

In response to a multiracial, multicultural, and multilingual society, counseling training programs have prompted a proactive stance on cultural diversity training (Sue & Sue, 2003). The counselor's worldview is likely to be influenced by historical and current experiences of racism and oppression in the United States (Sue & Sue, 2003). As a result, the minority client may approach counseling with suspicion and apprehension regarding a counselor's conscious and unconscious motives. The European American counselor, as a citizen of a cross-cultural society, is prone to adopt racial and cultural biases from personal experiences (Sue & Sue, 2003). All roles (counselor, client, and supervisor) and the therapeutic process are likely to be influenced by the state of race relations in the larger society. When biases result in restriction of well-being rather than fostering, it may involve overt and covert sources of prejudice and discrimination (Sue & Sue, 2003). Counselors have a responsibility to understand the political and social forces and events that influence their own professional perspectives as well as the perspectives of the client. Counseling professionals should recognize that important components of multiculturalism (e.g., race,

culture, and ethnicity) are functions of each and every person, not “just minorities” (Sue & Sue, 2003).

Perhaps one of the most seminal models of multicultural competency is Sue and colleague's (1982) tri-componential model of MCC, which contains components of MCC and characteristic descriptions within each component to describe the culturally/multiculturally competent counselor. At the time, the three components of cross-cultural counseling competencies were *belief/attitude*, *knowledge*, and *skills* (Sue et al., 1982). In 1990, Sue and Sue published a revised form of MCC components that included the following: (a) counselor *awareness* of own assumptions, values and biases; (b) *knowledge*, or understanding, of the worldview of the racially diverse client; and (c) acquiring *skills*, or developing appropriate intervention strategies and techniques.

Currently, there is a gap in the literature between theory and empirical research investigating multicultural development in graduate trainees. To illustrate, Worthington and colleagues (2000) reviewed 20 years of empirical research (75 articles) and reported findings on 81 different samples. In terms of samples, 27.2% of the studies recruited counselors-in-training (35.8% enrolled counselors and 21% recruited clients). When graduate trainees were investigated, the most frequently employed measures were surveys with self-reported MCCs (63.6%), with a small number of studies using analogue research (13.6%) and even fewer employing a true experimental design (4.5%). The most investigated topic (57.3%) were intrapersonal correlates of counselors' MCCs (i.e., demographic, identity, multicultural training, social desirability). A total of 34.7% of studies investigated clients' perceptions of counselors (16.0% clients' perceptions of counselors' credibility; 12% clients' perceptions of counselors' MCCs). Other topics of interest were scale development (14.7%) and client

outcomes (8.0%; i.e., client self-disclosure, attrition, and satisfaction). The authors recommend that multicultural constructs (e.g., knowledge, awareness, skills, and self-efficacy) should be measured in a manner that targets concepts more implicit in nature, such as biases and empathy based on clients racial background.

Although most research on multicultural counseling competence has been based on the tripartite model, most studies have focused on knowledge attainment instead of the importance of beliefs and attitudes (Minami, 2009). In addition, no researchers have explored *belief/attitude* as a potential fourth component of MCC. As a result, Minami further investigated the nature of attitudes, the differences between attitudes and beliefs, and how these concepts relate to awareness. Various definitions of the term *attitude* exist, including multiple affective, cognitive and behavioral components toward an object (Katz & Stotland, 1959), and a process of latent/trait components as manifestations or responses (Oskamp & Schultz, 2004). Inherent within the conceptualization of attitude is that there is an evaluative process that may take various forms along a continuum, such as good-bad, harmful-beneficial, pleasant-unpleasant, and likeable-unlikable (Ajzen, 2001). Finally, attitudes may be triggered automatically without one's conscious awareness, indicating that attitudes may be both *implicit* and *explicit* (e.g., Greenwald & Banaji, 1995; Greenwald et al., 2002).

A counselor may be aware of his/her explicit beliefs and attitudes, but may not be able to fully acknowledge his/her implicit attitudes (Minami, 2009). Thus, a counselor may be knowledgeable about racial and ethnic minority issues, skillful in intervention selection, highly aware of explicit attitudes toward racial/ethnic minorities, but low in attitude awareness. According to Minami (2009), recognizing the possibility to change one's overt or covert negative racial/ethnic attitudes aligns with the values of "social justice to nurture a

constructive racial/ethnic attitude in anyone” (p. 42). Consequently, Minami (2009) proposed that attitude be considered in a four-componential model of MCC. This attitude component would consist of three subcomponents (affective, behavioral, and cognitive) in order to adopt a constructive attitude toward racial/ethnic minorities.

One purpose of multicultural competency development is to help mental health professionals to conceptualize clients’ concerns by differentiating and integrating multiculturally relevant information (Constantine & Ladany, 2000). Specifically, multicultural conceptualization results in: (a) counselor awareness of cultural factors that affect client presenting concerns, (b) integration of that awareness to client conceptualization, and (c) development of an appropriate treatment plan for working with clients based on this information (Constantine & Ladany, 2000). Greater conceptualization complexity and hypothesized etiologies may indicate appropriate development of multicultural counseling competence.

Constantine (2001) used multicultural case conceptualization vignettes to describe a 32-year-old gay, Native American male stockbroker who was committed to the traditional values of his ethnic group and social justice advocacy for gay men’s rights. Further information was provided regarding the client’s work and romantic relationship stressors, as well as anxiety related to “coming out” to this family, which resulted in recreational drug use. Participants were instructed to: (a) write a conceptualization of at least three sentences regarding the etiology of the client’s presenting concern, and (b) write a conceptualization of at least three sentences addressing perceived effective treatment for addressing the client’s presenting concerns. A coding system was developed by the raters to denote the cultural themes addressed by participants (i.e., racial/ethnic, gender, and sexual orientation).

Constantine (2001) measured multicultural case conceptualization ability by addressing two different cognitive processes: (a) the counselor's ability to generate multiple interpretations of a client's presenting concerns and the course of treatment (i.e., *differentiation*); and (b) the counselor's ability to develop connections between and among differentiated interpretations (i.e., *integration*). Such a method has been found to have moderate to high interrater agreement (ranging from .82 - .93). The researcher controlled for level of training, and was able to detect significant effects of empathy (cognitive and affective) and theoretical orientation on multicultural case conceptualization. Thus, counselors who reported higher multicultural training endorsed greater affective empathy and were better able to conceptualize in a culturally sensitive manner.

Counselors may believe that they are multiculturally competent, but multicultural case conceptualization skills may not match the level of perceived multicultural competence that is often self-reported on measures (e.g., MCKAS, MCI, CCCI-R). To illustrate, using a method similar to Constantine (2001), Constantine and Ladany (2000) found that participants' objective multicultural case conceptualization scores were generally lower than the self-report measures. When the authors examined the relationships between the self-report measures of multicultural competence and multicultural case conceptualization ability, they discovered significant positive relationships between 3 of the 4 measures. Moreover, several of the self-report measures of multicultural counseling competence were significantly positively related to social desirability, such that higher self-reported competency was significantly related to higher social desirability as measured by the Marlowe-Crowne inventory. After controlling for social desirability, these relationships were no longer significantly related to multicultural case conceptualization ability. Other studies have

found evidence that self-reported multicultural competence is not significantly related to multicultural case conceptualization ability (Ladany, Inman, Constantine & Hofheinz, 1997). However, racial identity status of higher White racial consciousness (i.e., pseudoindependence) is significantly related to higher self-reported multicultural competence. These findings support the importance of controlling for social desirability, as well as using an objective, non-self-report measure for multicultural case conceptualization. Moreover, they also suggest that just because a person believes they are multiculturally competent this does not mean that it shows up in practice.

As previously addressed, greater levels of color-blind racial ideology were related to lower self-reported multicultural counseling awareness and knowledge (Neville, Spanierman, & Doan, 2006). Further, greater color-blind racial ideology was related to lower multicultural case conceptualization ability even when the researchers controlled for the number of multicultural courses completed. These results echo Constantine and Gushue's (2003) results that endorsement of contemporary expressions of individual racism is related to lower levels of multicultural case conceptualization skills among school counselors.

Building on the work of Constantine and Ladany (2000), and Neville and colleagues (2006), the present study will include a measure of multicultural case conceptualization ability as a method of assessing the relationship between implicit racial biases and multicultural competencies. Race-related hypotheses are related to greater capacity to conceptualize client concerns in a multiculturally sensitive manner (Ladany et al., 1997). Such a skill would be measured by requesting information about the counselor's perception of: (a) the factors contributing to the etiology of the client's difficulties, and (b) areas to focus on to provide appropriate treatment to the client.

To have understanding of biases indicates a deeper comprehension of the significance of such biases. Awareness on the other hand refers to cognizance of biases, or knowledge that they exist. The lack of focus on a deeper understanding of one's biases is at the root of Minami's (2009) argument, as well as Boysen's (2010), which asserts that biases, especially implicit biases, are not addressed in counselor education research and multicultural competency development. One construct that is better addressed in the multicultural competency and bias literature is the concept of color-blind racism.

Multicultural Competencies and Color-Blind Racism

Color-blind racism is a type of aversive racism that refers to the disregard of race in specific experiences (Bonilla-Silva, 2001). The rationalization that occurs most often with color blind attitudes is that racism and race disparities are no longer a threat to individuals, and that all people are equal. Research examining the relationship between color-blind racism and counseling is fairly extensive.

Burkard and Knox (2004) investigated practitioner level of color-blindness, in order to better understand the relationship between practitioner racial attitudes and decision making processes in counselors. The definition of racism used in Burkard and Knox's (2004) study is a multidimensional construct, which is consistent with contemporary theories of racism, because this definition recognizes not only overt prejudices, but also prejudices that are more subtle and less explicit forms of prejudice. The authors conceptualized color-blind attitudes from the premise that "race should not and does not matter" (Neville et al., 2000, p. 60), and that all individuals should be treated with social and economic equality. Those who endorse color-blind racial attitudes negate the importance of individual, institutional, and cultural experiences of racism, and believe that race is not a relevant issue in people's lives. In

theory, color-blind attitudes may perpetuate prejudice in the therapeutic environment without counselor awareness.

The variables of interest for Burkard and Knox (2004) were counselor feelings of empathy toward clients who are members of a culturally diverse group, and attributions of clients' responsibility for causing or solving their own problems. Attribution of the cause of the problem is the perceived responsibility that an individual has to control the problem of concern, and involves determination of whether the environment or individual is responsible. Attribution of the solution to the problem of concern relates to whether or not the client or the environment has more influence or control over future problem resolution. Color-blind attitudes may negatively affect counselor's attributions because counselor attitudes may influence the accuracy of determining external (e.g., environmental) or internal (e.g., dispositional) causes for the client's presenting concern. Multicultural theory posits that incongruity between the practitioner's and client's attributions of cause of and solution to presenting concerns may be due to differences in client and counselor worldviews (Sue & Sue, 2003). The implications of misattributions may be important to therapeutic outcomes, because misattributions may increase client distress and commitment to treatment interventions, or even therapy altogether.

Burkard and Knox's (2004) study employed vignettes in order to manipulate the race of the client and the source of the client problem. The researchers conducted two ANCOVAs to investigate a 2 (client race) x 2 (client attribution of source of the problem) x 3 (color-blindness: Racial Privilege, Institutional Discrimination, Blatant Racial Issues as measured by the self-reported Color-Blind Attitudes Scale [COBRAS]) interaction, with social desirability as the covariate, for practitioner empathy ratings and practitioner attributions of

responsibility for the cause of and solution to a problem. The results indicated that practitioner color-blind racial attitudes were related to practitioner self-reported ratings of empathy. Specifically, counselors who are high in color-blindness reported experiencing less empathy toward clients. The researchers also found a significant interaction between client race and level of counselor color-blindness on counselors' attributions of client responsibility for the solution to a problem. Specifically, counselors higher in color-blindness attributed more responsibility to the diverse client. Burkard and Knox's (2004) results have important implications that influence the therapeutic process, particularly characteristics of empathy and attributions. However, the study did not address the role of implicit biases in the therapeutic context, nor did it analyze the effect of biases on counselor case conceptualization.

Recently, researchers have become interested in the relationship between color-blindness and multicultural counselor competencies. Evidence demonstrates that color-blind attitudes and MCC have a negative relationship (Neville et al., 2006). However, empirical findings are inconsistent in regard to racial/ethnic differences and MCC. On one hand, research indicates that ethnically and racially diverse individuals tend to have greater MCC than their White counterparts (e.g., Chao et al., 2011; Constantine, 2001; Neville et al., 2006). However, Smith and colleagues (2006) conducted a meta-analysis on multicultural training and determined no significant differences between White and racial/ethnic minority trainees on MCC. It appears that among students with limited to no multicultural training, racial/ethnic minority trainees do have higher MCC scores than Whites (Constantine, 2001; Chao et al., 2011). Boysen and Vogel (2008) provided evidence that counselors exhibit implicit attitudes regardless of training level.

Several studies have examined the relationship between color-blindness and specific MCCs (awareness, knowledge, and skills). Evidence suggests that color-blindness is negatively correlated with multicultural knowledge and awareness (Neville et al., 2006; Spanierman, Poteat, Wang, & Oh, 2008). Further, an analogue study conducted by Gushue (2004) provided evidence that color-blind racial attitudes are positively related to impressions of symptomatology of Black clients but not White clients, such that Black clients were judged as less symptomatic when an individual endorsed greater color-blind attitudes. In 2007, Gushue and Constantine posited that training may change the strength of the relationship between color-blindness and racial identity awareness. Results suggested that trainees who had higher levels of color-blind attitudes were less advanced in their racial identity development.

Chao and colleagues (2011) investigated if multicultural training moderated the effect of racial/ethnic differences on MCC, as well as the relationship between color-blindness and MCC. The results of their quantitative descriptive design provided evidence that race/ethnicity significantly interacted with multicultural training to predict counseling trainee's multicultural awareness, but not knowledge. On the other hand, color-blindness and multicultural training had a significant interaction to predict trainees' multicultural knowledge, but not multicultural awareness. Specifically, when individuals had higher levels of multicultural training, the negative relationship between color-blindness and multicultural knowledge was stronger. Also of note, racial/ethnic minority counseling graduate students who were beginning their multicultural training exhibited significantly greater multicultural awareness than Whites. However, with more training, the level of multicultural awareness increased significantly for White trainees but had limited effect on racial/ethnic minority

trainees' multicultural awareness. One explanation for these findings is that individuals of marginalized groups may have personal experiences of discrimination and more limited access to resources, which may foster greater multicultural awareness and knowledge.

The results of this study (Chao et al., 2011) indicated a significant negative relationship between color blindness and multicultural knowledge, but not awareness. This finding implies that trainees with lower color-blindness are more receptive to multicultural training due to recognition that differences exist between different groups (Chao et al., 2011). However, other findings indicate that color-blindness and multicultural counseling knowledge have a weaker relationship than color-blindness and multicultural awareness (Neville et al., 2006). The fact that level of multicultural training did not moderate the relationship between color-blindness and multicultural awareness may imply that multicultural training should focus on deeper awareness of biases, and slightly less emphasis on knowledge. As Chao and colleagues (2011) argue: "to intellectually understand color-blindness is one thing; to be deeply aware of its presence is quite another" (p. 79). Although this study has important implications for multicultural training, the measure used to assess multicultural competencies did not capture all of the characteristics of Sue and Sue's (1990) tripartite model, because it did not assess skills. In terms of implicit bias research, students may know that implicit biases exist and may negatively affect therapeutic work, but they may not have a deep awareness of their own biases and how to manage them.

Drawing from past research on racial color-blindness, Neville and colleagues (2006) sought to further explore the theoretical relationship between color-blind racial ideology and multicultural competencies. Several controls strengthened the design of the study, including controls for social desirability and the influence of level of multicultural training. Further, a

qualitative section of the study examined participants' definitions of color-blindness as related to race. The sample of this study included mental health workers and applied psychology students ($N = 62$). Results indicated that, on average, participants held low to moderate levels of color-blind racial beliefs, moderate levels of self-confidence in MCC, and low to moderate levels of multicultural case conceptualization ability for a vignette with a hypothetical Latina client. A hierarchical multiple regression analysis revealed a medium-to-strong negative association (-0.49) between color-blindness and self-reported multicultural awareness, and a smaller association with knowledge (-0.29). Color-blindness was uniquely and negatively related to multicultural knowledge and awareness, when social desirability, multicultural training, and participant race were entered into the model. Particularly relevant to the purposes of this study, color-blindness was negatively correlated with multicultural case conceptualization ability for etiology and treatment. Definitions of color-blindness, as provided by participants, fit into the following classifications: seeing people as individuals (e.g., viewing someone as an individual not belonging to a group); denial of race (e.g., ignoring one's race or ethnicity on a regular basis); equality/liberal egalitarianism (e.g., all individuals have the same rights and freedoms regardless of race); humanistic (e.g., there is no discrimination based on ethnicity, but when considering a person, may be thinking about ethnicity); and other (e.g., unaware of the term). Further, participants showed a bias in the attribution of etiology, as evidenced by a significant negative relationship between color-blindness and attribution of client problems to sociocultural factors.

Both Neville and colleagues (2006) and Burkard and Knox (2004) provided evidence that color-blind racial ideology is related to counselor perceptions of a client's presenting concerns, or less consideration of race in case conceptualization. Of note, the results of

Neville and colleagues' (2006) study indicated that greater denial about the existence of systemic racism is related to "internalization of subtle Eurocentric norms about the counseling relationship" (p. 286). Thus, counselors with greater color-blind racial ideology may be less perceptive to subtle and pervasive racism in beliefs that are largely influenced by Westernized culture.

The implication of the aforementioned studies is that a specific type of aversive racism, colorblind attitudes, may have an impact on the practice of therapy (e.g., counseling, supervision). Furthermore, greater understanding of colorblind attitudes may aid in recognizing and defining multicultural dimensions that contribute to racism. As established by researchers, color-blind attitudes are related to multicultural knowledge and awareness, duration of multicultural training, empathy, and attribution for client responsibility of the presenting concern (e.g., Burkard & Knox, 2004; Chao et al., 2011; Neville et al., 2006). Studies often distinguish individuals as holding aversive racist beliefs when they score low in explicit, but high in implicit, prejudice (e.g., Dovidio et al., 2000; Hing, Li & Zanna, 2002). Therefore, we would expect the findings of research with color-blind attitudes to parallel the unstudied hypotheses involving implicit biases in this study. If counselors high in color-blind racial attitudes are less aware of racial issues, counselors high in implicit bias may be unresponsive to racial factors and the effects of racism on clients. A consequence of such a trend may be biased attributions of the cause of the client's presenting concern, as well as the ability of the client to solve his/her problem.

Attribution Theory

Attributions may be described as peoples' explanations that are shaped by past, present, and/or future behavior. These explanations may be formed by beliefs, attitudes, and

values, as well as available information about the person (Young & Marks, 1986). In 1979, Weiner proposed three causal dimensions of attributions: (a) the degree to which the client has control of his/her concerns (*controllability*); (b) the temporary or long term status of the problem (*stability*); and (c) the degree of pervasiveness of the problem in the client's life (*globality*). In 1982, Brickman and colleagues proposed an additional responsibility dimension divided into two categories: (a) responsibility for the cause of the problem, and (b) responsibility for the solution to the problem. These dimensions vary in degree of self-responsibility--high versus low.

Attributions of the cause of the problem may be conceptualized as the responsibility and control that an individual contains over the origin of problem. In other words, it is the determination of whether the individual is personally responsible for the cause of a problem, could have solely avoided the problem, and could have independently controlled the cause of the problem. On a similar note, attribution of responsibility for the solution reflects the belief that another person is responsible for creating a solution to the problem and overcoming the problem alone, and has complete control over the solution to the problem (Karuza, Zevon, Gleason, Karuza, & Nash, 1990). Such attributions may directly affect the efficacy and process of therapy (Brickman, Rabinowitz, Karuza, Coates, Cohn, & Kidder, 1982). To illustrate, premature termination by the client occurs when the source of the presenting concern does not align with that of the practitioner (Tracey, 1988). For example, if the practitioner believes that the person has control/responsibility over the problem, but the client does not, then the therapeutic alliance may become damaged.

Theorists in multicultural counseling have proposed that differences in client and counselor worldviews drive the difference between practitioner and client attributions of

cause of and solution to client presenting concerns (Sue & Sue, 2003). For example, some cultural value systems (e.g., Asian American and Native American) are oriented toward external causes for difficulties in life. Conversely, counselors tend to rely on internal locus of control for client concerns (Tracey, 1988), unless there is an easily identifiable external source (Worthington, Soth-McNett, & Moreno, 2007). These differing perspectives are at odds with how each member of the therapeutic process conceptualizes the presenting concern. To add to these differences, practitioners seldom change their perspectives of responsibility attribution even when presented with clients' perspectives (Hayes & Wall, 1998). Subsequently, therapy may result in poor outcomes for the client, such as premature termination, lack of goal attainment, and an unstable counselor-client rapport (Sue & Sue, 2003). Consequently, developing a better understanding of the mechanisms that moderate counselor attributions in multicultural counseling is important to understanding and facilitating the therapeutic process.

Within the individual and family literature, empirical research on gender bias in marital therapy has been conducted by Stabb, Cox, and Harber (1997). They attempted to determine if the locus, stability, and globality of a practitioner's attribution is assigned differentially to females and males. Although there was no significant effect for gender on locus of causality; some gender-traditional patterns were observed for attributional dimensions of stability and globality. Specifically, participants were more likely to attribute negative relationship events (i.e., relationship events that took place over a greater amount of time and over a variety of different situations) with women than men, whereas participants were more likely to attribute positive relationship events to men (i.e., events that took place across a variety of situations) than women. Moreover, male practitioners may be more stable

over time in attributing negative occurrences to female clients participating in individual therapy (Fisher, 1989). However, a client's gender does not always affect a counselor's attribution of cause of presenting concern. For example, Kernes and McWhirter (2001) found that gender did not significantly influence counselor attributions of causality for clients who experienced either an identity or adjustment problem. It is possible that a gender effect was not found because participants were consciously thinking about the potential influence of gender bias in attempt to respond without bias. Along a similar vein, it is possible that such biases may occur for counselors working with culturally diverse clients.

The concept of *fundamental attribution error* (Amabile, Ross, & Steinmetz, 1977) helps to explain why misattributions occur. This type of error occurs when individuals overestimate the effect of disposition or personality, and underestimate the effect of the situation, in explaining social behavior. Evidence has been established that this type of error occurs in the counseling process. Specifically, counselors rely more heavily on client dispositional factors rather than situational factors when searching for a cause of clients' problems (Batson, O'Quin, & Pych, 1982). Another way in which this dynamic may be conceptualized is the *actor-observer bias*, such that the counselor, as the observer relies on dispositional factors, whereas the client is the actor and may attribute his/her problem to external factors (e.g., work or another individual), thus creating disagreement. This bias may be particularly salient for minority clients who may experience legitimate experiences of external stressors, such as discrimination (Morrow & Deidan, 1992). Other factors that affect cross-cultural misattributions made by counselors include self-serving bias, linguistic/communication factors, and cultural understanding (Salzman, 1995).

According to social psychology theory, individuals tend to overestimate dispositional factors (e.g., personal traits, attitudes, moods, and temperament) when they are evaluating members of an out-group, or those who are not members of one's social group (Fiske, 2010). In addition, ethnocentric perspectives also contribute to causal attributions individuals make about the behavior of other individuals as a function of their social category membership (Brewer & Kramer, 1985). This form of bias has been referred to as the "ultimate attribution error" in causal attributions for socially desirable versus undesirable behaviors (Pettigrew, 1979). The in-group is most often associated with desirable behaviors and tends to be attributed to internal, dispositional causes. On the other hand, the out-group is most often associated with transitory causes, such as situational influences. For example, individuals attribute good characteristics to the disposition of members of the in-group and good qualities of out-group members to situational factors (e.g., "she had a good mother"). As such, undesirable behaviors are more likely to be associated with dispositional factors when exhibited by out-group members than by in-group members. Thus, fundamental attribution error is even more likely to occur when evaluating a member of an out-group, or a diverse individual.

Misattribution of the client's problem may generate conflict between both parties before therapy begins. The research findings seem to suggest that practitioners typically attribute dispositional and internal causes for client presenting concerns (e.g., Burkard & Knox, 2004; Worthington & Atkinson, 1996). As a result, it may be difficult to establish a strong therapeutic rapport, and poor therapy outcomes may occur (Sue & Sue, 2003). Moreover, attributing client problems to dispositional characteristics due to automatic

cognitive connections, as is the case with implicit racial bias, may negatively affect a counselor's ability to empathize with clients for rapport building.

Empathy

Empathy is thought to be one of the most important factors in establishing the therapeutic relationship and determining the efficacy of therapy (Bohart, Elliot, Greenberg, & Watson, 2002; Wampold, 2001). Empathy is demonstrated when an individual has the cognitive and affective capacity to interpret the physical and psychological experience of others. Models of empathy typically divide the construct into two components: affective empathy and cognitive empathy (Hodges & Wegner, 1997). Affective, or emotional, empathy is the capacity to respond to an individual in an emotionally sensitive manner, such as sharing an emotional experience together. Cognitive empathy is the capacity to understand another's perspective, identification of the emotions experienced by another individual, and mentalization of those emotions. The interpersonal process of empathy is a reciprocal and dynamic process that may be affected by a number of factors, such as bias (Shamasundar, 1999).

Much discussion in the field of psychology has evolved around the ability to teach and learn empathy. Empathy is predominantly an automatic or unconscious process, but it is capable of becoming accessible to conscious awareness. Considering that empathy and implicit bias both occur in an automatic manner, it is plausible that both constructs share mechanisms. In other words, practitioners' feelings of empathy toward racially diverse clients may be related to implicit bias.

Empathy is a critical component of cross-cultural therapy. The empathic listener receives a client's messages (including presenting concerns) without judgment, assuming that

all communication is meaningful even if that significance is not immediately apparent (Breggin, Breggin, & Bemark, 2002). The process of dialogue and interaction generates insightful thought for the client and acceptance of the meanings that were previously thought to be unacceptable or unthinkable pieces of the self. Empathic practitioners see each individual experience as meaningful to the client's state of being.

Simply speaking, empathy may be defined as the process of putting oneself in the shoes of another. Conceptualizing empathy in these terms has helped researchers design experimental studies examining the relationship between empathy and counselor bias. For example, Chen, Froehle, and Morran (1997) exposed participants to an instructional videotape addressing attribution processes and empathic perspective taking exercises. Participants completed an attribution scale in order to compare treatments to a control condition. Results of this study indicate that counselor trainees may reduce dispositional bias with empathic perspective taking. To elaborate, counselors often over-rely on the attribution that a client's presenting concern is related to dispositional factors. Consequently, these judgments may hinder counselor competency development. By instructing counselors to take the perspective of the client, or engage in empathic perspective taking, counselors were able to reduce reliance on dispositional attributes for a client's presenting concern.

In an analogue study that explored the influence of ethnicity on mental health practitioners' clinical judgment, White practitioners observed mock intake sessions where clients presented as either non-Hispanic White and Hispanic (Arroyo, 1996). The ethnic identity of clients in the conditions significantly affected rating of prognosis with treatment, ability to empathize with the client, and blunted affect. Specifically, lower expression of empathy, poorer prognosis, and greater blunted affect were related to the client who had

darker skin and spoke English with a Hispanic accent.. The findings of this study provide evidence that ethnicity affects psychotherapy process. However, the study did not deepen the investigation to understand the potential mechanisms driving these results, such as counselor implicit bias.

Counselors who express more empathy during assessments and treatment are perceived as more culturally sensitive among culturally diverse clients (Fischer, Jome, & Atkinson, 1998). Affective empathy is also related to greater awareness of cultural factors in conceptualizing client concerns; counselors low in affective empathy are significantly less culturally aware in case conceptualization (Constantine, 2001). Moreover, greater ability to conceptualize client concerns in a culturally sensitive manner is related to high affective and cognitive empathy in counselors. Constantine (2001) proposed that certain types of empathy attitudes (i.e., affective and cognitive) may help counselors better understand their clients' experiences. The degree to which counselors empathize with their culturally diverse client may directly affect their ability to respond in a culturally sensitive manner. After reviewing the effect of cognitive and affective empathy on multicultural case conceptualization, Constantine (2001) found that individuals with higher affective empathy were rated as more attuned to the cultural factors that affect clients' mental health concerns. A limitation of the study was that self-reported ratings of empathy and attributions were positively related to a measure of social desirability. It would be valuable to have evidence with a measure that is less affected by social desirability, such as the IAT.

Burkard and Knox (2004) set out to better understand the role of client race in assessing a client's presenting concern by examining the effect of color-blind racial attitudes on practitioner's empathy and attributions of client responsibility for the cause of and

solution to a problem when the client attributed the concern to depression (internal cause) or racial discrimination (external cause). The results of this study indicated that practitioners' self-reported ratings of empathy and their attributions of client responsibility for the cause of and solution to a problem were statistically significant and positively related to higher levels of social desirability. However, this result is in contrast to Constantine's (2000) finding that social desirability was not correlated with therapist empathy (as measured by the IRI; Davis, 1983). To clarify this inconsistency, the authors indicated that a potential reason for this result was that the selected measure provided a general assessment of exclusively affective empathy. For this reason, the present study will use a measure of ethnocultural empathy. As a specific type of empathy, ethnocultural empathy involves empathic feelings directed toward members of an out-group (Wang, Davidson, Yakushko, Savoy, Tan, & Bleier, 2003). Ethnocultural empathy employs affective and cognitive empathy, including discrimination and prejudice awareness, as well as the capacity to take the perspective of other ethnic groups.

Considering that empathy and implicit biases may function in an automatic manner (Hoffman, 2002), and that implicit racial bias may interfere with interpersonal bonds, it is plausible that implicit racial bias affects capacity for empathy. Sue and Sue (2003) emphasized the importance of the culturally competent counselor to communicate acceptance, empathy, and positive regard when working with the culturally diverse client. One goal of the present study is to investigate the capacity of implicit biases to interfere with a counselor's capacity to accurately perceive the subjective experience of the client (i.e., to empathize). Moreover, if an individual is high in ethnocultural empathy, it is likely that they have a high personal value of taking the perspective of another individual even if that other

individual is a member of an out-group. In fact, researchers have designed interventions to reduce prejudicial responses with empathic perspective taking (e.g., Aberson & Haag, 2007; Crisp & Turner, 2009; Kernahan & Davis, 2007). Empathy and an examination of internal and external factors that motivate individuals to respond in a non-biased manner may help to explain why some counselors are more open to personal examination of their own biases.

Motivation to Respond Without Prejudice

Several aforementioned studies demonstrate that bias is present in counselors despite multicultural competency values to exhibit unbiased responses. Prejudice may persist because it is automatic, and because responding without prejudice goes against automatic attitude processes (Devine et al., 2002). The reduction and control of prejudice requires effortful steps in order to be successful in responding without prejudice. According to Devine (1989), a conscious decision must first be made in order to respond in egalitarian ways. These values must then be internalized and integrated into one's self-concept. The mere decision to respond without prejudice does not result in such responses in various situations (Monteith, Devine, & Zuwerink, 1993). Controllability is a key factor in responding without prejudice. Individuals who self-report low biased attitudes continue to show bias on items that have less controllability. To illustrate, implicit bias, which operates in an automatic manner, thus negating the ability for conscious control, is present even if an individual self-identifies as non-prejudiced (e.g., Devine, 1989; Greenwald & Banaji, 1995; Greenwald et al., 1998). Guilt arises when individuals are presented with situations in which their non-prejudiced values are countered with prejudiced actions. Guilt instills a need to correct one's responses, or self-regulate in order to reduce prejudice (Monteith et al., 1993).

Devine and colleagues (1992) established theoretical grounds for examining personal motivation to respond without prejudice, and to identify who is more likely to demonstrate effective bias regulation in controllable (e.g., explicit) and less controllable (e.g., implicit) situations. Individuals may exhibit both types of motivation along a continuum. Existing theories posit that more internalized or self-determined values result in responses consistent with those values (Ryan & Deci, 2000). Moreover, individuals often respond with less bias for internal or personal values or sets of standards, whereas external motivation derives from a desire to avoid negative evaluations from others. From this theoretical foundation, Plant and Devine (1998) created a measure to assess sources of motivation called the Internal and External Motivation to Respond without Prejudice Scales (IMS and EMS). Such an instrument provides a resource to measure people along a continuum of internalization to predict the effectiveness at responding without race bias. High IMS indicates high self-determination, whereas high EMS indicates low self-determination.

Research on motivation to respond without prejudice was extended to explicit race bias in Plant and Devine's (1998) study. Results demonstrated that individuals who are high in external motivation regulate expression of prejudice on an explicit measure of race bias only when others who are perceived to be low in prejudice are nearby. In other words, the source of motivation to respond without prejudice affects the response type (e.g., reporting of prejudice-relevant beliefs) depending on environmental factors. Individuals who are high in internal motivation showed low levels of bias on the explicit measure in both private and public conditions. Moreover, individuals who were more likely to violate personal standards scored high on external motivation (EMS) when compared with those who were low in EMS.

To extend the literature, Devine and colleagues (2002) examined the role of external and internal motivation to respond without prejudice on self-reported bias and implicit measures of race bias. In particular, they hypothesized that individuals with high internal motivations would be able to effectively regulate their responses and demonstrate lower explicit and implicit bias. Thus, these individuals would respond congruently to their values and therefore in a non-biased manner. Individuals who have both internal and external motivation to respond without bias would show less explicit bias due to controllability, but more implicit bias due to lower self-determination, and thus, they would violate their values. Lastly, an individual who scores lower in self-determination would report greater bias on both measures, and would have the greatest challenge with responding in a non-prejudiced manner.

Perhaps the most relevant of the three studies to the current discussion is the second, due to the use of the IAT to evaluate people's tendency to associate positive evaluations with White individuals and negative evaluations with Black individuals (Devine et al., 2002). The results provided evidence that the level of implicit bias is moderated by participants' sources of motivation to respond without prejudice. To illustrate, individuals with high IMS and low EMS had lower levels of implicit race bias when compared to other combinations of motivation source. In order to counter the argument that individuals with low levels of race bias may simply rely on very effective, or automatized, control mechanisms, the authors conducted a third study that included a manipulation to target cognitive resources by completing a cognitive business task. Results indicated that the cognitive manipulation slowed response rates, but it did not affect the observed patterns of implicit race bias in previous studies. A limitation of this study is that it used mostly White introductory

psychology students for the sample. The current study aims to extend this research to counselors in training.

Legault and colleagues (2007) identified a taxonomy of motives underlying the desire to regulate prejudice. They took their study a step further by assessing the impact of motivation to regulate prejudice on varying levels of explicit and implicit prejudice. Results of an exploratory factor analysis (then supported by a confirmatory factor analysis with a second sample) revealed a six factor structure including: intrinsic motivation, integrated regulation, identified regulation, introjected regulation, external regulation, and amotivation. Notably, the third component of this study assessed both explicit and implicit racial bias among those with high and low self-determined regulation of prejudice. Results revealed that individuals with high self-determined motivation (i.e., internal motivation) to regulate prejudice displayed less negative affect (a measure of racial prejudice) towards a member of an out-group than those with less self-determined prejudice regulation. Further, results indicated that self-determined motivation to control prejudice was related to situational and external influence; meaning that those with more self-determined motivation to control prejudice were more likely to attribute a client's difficulties to situational factors. One significant implication of the study is related to the relationship between motivation and automaticity: motivations may become internalized, and therefore, less effortful and more automatic. This explanation is proposed as one potential reason that individuals with self-determined prejudice regulation display lower levels of implicit biases. By this logic, constant effort to respond without bias may become automatic and indirectly challenge implicit associations.

In order to better understand the mechanisms that drive individuals who are motivated to respond without prejudice to actively work on reduction of prejudice, Plant and Devine (2009) set out to provide behavioral evidence that the source of motivation (i.e., internal or external) directly influences desire to actively work toward achieving one's intention (e.g., respond without detectable or undetectable prejudice). Results from three studies revealed that individuals who are high in external motivation value responding without prejudice because of the desire to present themselves in a socially desirable manner. On a related note, these individuals are driven to reduce detectable prejudice, but not as interested in reducing undetectable, less subtle, prejudice. Conversely, those who are highly internally motivated showed increased interest in decreasing both undetectable and detectable forms of prejudice. Individuals who were high in both internal and external motivation indicated an interest in participating in a program that targets both types of prejudice (detectable and undetectable).

Plant and Devine (2009) also confronted their participants with evidence of regulatory failure by providing feedback of their race IAT results. When individuals were presented with this information, high IMS individuals, regardless of EMS level, were interested in participating in a prejudice reduction program. Regardless of EMS level, those low in IMS were not as interested in the program. This evidence further supports that high internal (e.g., personal/internalized reasons) motivation and high external motivation (e.g., social desirability) dictates the level of desire to engage in bias reducing processes. Despite the significant findings of this study, two issues limited its generalizability: participants were undergraduate students at a state university, and the IAT results were not used in the analysis of the relationship between implicit bias and motivation to respond without prejudice, as it was only used to provide feedback to participants.

The literature on motivation to respond without prejudice clearly indicates that there are two primary sources of motivation: internal and external. These sources encourage behavior to respond without bias; however, only internal motivation relates to one's personal beliefs. In connection to the counselor education literature, researchers have not studied the patterns of internal and external motivation to respond without prejudice in practitioners. One plausible factor affecting the development of multicultural competencies is individual motivation to respond without prejudice, which corresponds to commitment to addressing personal biases and responding to the culturally diverse client in an empathetic manner. Accordingly, it is important to understand motivation to respond without bias as it relates to implicit racial bias.

Purpose of the Study

Current research has linked the constructs of implicit bias, multicultural competencies, and motivation to respond without bias. Moreover, research provides evidence of the relationship between colorblind attitudes, multicultural competencies, empathy, and attribution bias. Although colorblindness is related to empathy and attribution bias, there is no empirical evidence that implicit bias is related to these concepts despite theoretical support. The relationship between implicit bias and a more specific type of empathy, ethnocultural empathy, would provide more information about cross-cultural counseling and case conceptualization. Moreover, researchers have not investigated the relation of motivation to respond without prejudice to automatic processes in counselors. This lack of empirical research is striking due to the fact that the principles of multicultural training stress the importance of awareness of biases. Moreover, there is a scarcity of studies investigating multicultural competencies with experimental designs and employing variables

that may guide future therapeutic outcome and process research. The current investigation seeks to address whether implicit biases, or automatic attitudes, affect the relationship between these phenomena. Specifically, this project addresses the following hypotheses:

Hypothesis 1: Practitioner implicit race bias will be significantly and negatively related to multicultural competencies when as measured by participant self-report and performance on a multicultural case conceptualization task. Moreover, client race will moderate the relationship between counselor implicit race bias and multicultural competency case conceptualization ability, such that higher implicit bias will have a stronger negative impact on practitioners' multicultural competencies who are presented with a Black client when compared to practitioners who are presented with a White client.

Hypothesis 2: Practitioners with lower implicit race bias will demonstrate higher internal motivation to respond without prejudice and lower external motivation to respond without prejudice.

Hypothesis 3: Client race as presented in the multicultural case conceptualization will moderate the relationship between implicit race bias and responsibility attributions. Specifically, higher implicit race bias will have a stronger and positive impact on attributions of client responsibility when the client is presented as an African American compared a White client.

Hypothesis 4: Implicit racial bias and ethnocultural empathy will be significantly and negatively correlated such that practitioners with higher implicit race bias will express lower ethnocultural empathy. Moreover, the interaction between client race and implicit race bias will have a significant and negative impact on practitioner

ethnocultural empathy, such that practitioners with higher implicit race bias who were presented with Black clients will be less likely to exhibit ethnocultural empathy than practitioners presented with a White client.

Hypothesis 5: Client race and counselor training level will moderate the relationship between implicit race bias and attributions of responsibility and solution to the client problem (i.e., three-way interaction effect for client race, counselor training level and implicit bias). In other words, when presented with a Black client, participants with less training and higher implicit race bias will be more likely to attribute responsibility (cause and solution) to the client as opposed to considering the greater context of community influences. Thus, the impact of implicit race bias (predictor) on client attributions of cause and solution to the problem (criterion) will be strongest for practitioners presented with a Black client.

This study implements a social psychological approach to gain a better understanding of the role of implicit race bias in the field of multicultural counseling by examining the impact on multicultural counselor competencies, ethnocultural empathy, attributions, and motivation to reduce prejudice. Developing insight regarding student motivation to reduce prejudice may aid in the development of MCC training. It is the hope of the researcher that the findings of this study will help contribute to improving the quality of MCC training for all counseling students, and subsequently, the quality of care to all clients.

CHAPTER 3

METHODOLOGY

Participants

Participants in this study were adult graduate students (clinical trainees) or clinical professionals who practiced psychotherapy in the United States. As such, purposive, or targeted sampling was utilized in the current study. Data from 94 participants (female 77.7%, male = 21.3%, other = 1.1%) who reported being enrolled in counseling and clinical psychology master's and doctoral level graduate programs in the United States were analyzed in the present study (see Table 2 for an overview of participant characteristics). The average age of participants was 32.2 years of age (SD = 9.62). Nearly three-quarters (74.5%) of respondents identified as European-American/Caucasian; whereas the remaining participants identified as Black/African-American (7.4%), Hispanic (7.4%), Asian/Pacific Islander (5.3%), Biracial (2.1%), Other (2.1%), and Native American (1.1%). At the time of the study, participants were either enrolled in graduate training (69.1%) or had already graduated and earned their degrees (30%) from the following: doctoral programs in counseling psychology (38.3%), clinical psychology (22.3%), professional psychology (PsyD) (11.7%), and school psychology programs (5.4%). Of the masters-level practitioners, participants represented programs in social work (3.2%) and school counseling (2.1%); whereas 5.3% did not provide information about their graduate training program. In terms of professional accreditation, most respondents were trained in APA or CPA accredited programs (91.5%), while (8.5%) were earning or had earned their degree from a non-accredited program.

In addition, respondents provided information about their program's commitment to multicultural issues as well as the number of courses, research, workshops/seminars, clinical supervision, and diverse clients to which they were exposed. Although 6.4% of participants indicated their training was not formally dedicated to diversity issues and 24.5% indicated that they were unaware, most (69.1%) indicated that their program addressed multicultural

competence in their mission statement. Moreover, 89.4% of respondents indicated that diversity issues were processed during supervision. In terms of curriculum, 62.8% indicated completing one to two courses specific to multicultural issues whereas participation in multiculturally based research was varied (42.6% no participation; 16% currently active) however, of the participants who were currently involved in research, 29.8% noted that they were engaged in two to four multicultural – focused research projects. Most respondents (81.9%) also reported having completed a workshop or seminar that addressed multiculturally relevant information and 89.4% of respondents indicated that diversity issues were processed during supervision.

Procedure

Upon receiving approval from the dissertation committee and the University of Missouri-Kansas City Social Sciences Institutional Review Board (SSIRB), the study was made available to potential participants by emailing a request to participate on various academic and professional psychology listservs. In order to ensure that participants had clinical training, participants had to complete at least one mental health practicum to be included in the study. Participants who chose to acquire additional information about the study were taken to a Survey Monkey page that provided a description of the study. The description also included that participants who completed the survey would be compensated by donating \$1.00 to a local domestic violence shelter for their participation in the study, such that \$200 was donated.

Potential participants who selected to take part in the study activities were provided with an informational script that outlined participant rights, benefits, risks, and the contact information of the researcher and the researcher's supervisor. Because knowledge regarding

the study's purpose may have influenced participant response and outcome data, participants were not informed of the study purpose or instrumentation prior to commencing the study. As such, participants were informed that they were engaging in a task to develop counseling didactics. Participants were fully debriefed regarding the reasoning of the study design. In order to ensure anonymity, no identifying information was included on any of the survey forms. Consent was assumed when participants continued to the second page for the survey, which initiated data collection.

Because it was anticipated that some measures may have affected responses on other items, the items were administered in the following order: demographics, Racial Implicit Association Task ([IAT]; Greenwald et al., 1998), Internal and External Motivation Scales ([IMS/EMS]; Plant & Devine, 1998), Scale of Ethnocultural Empathy Scale ([SEE]; Wang et al., 2003), Multicultural Counseling Inventory ([MCI]; Sadowsky et al., 1994), vignette and Multicultural Case Conceptualization Ability ([MCCA]; Ladany et al., 1997), and Cause and Solution Scales (Karuza et al., 1990). Positioning the randomly assigned condition of the client vignette and MCCA as the second to last measure was imperative to minimize social desirable responding (i.e., administering the IMS/EMS and MCI prior to the vignette and MCCA) and to provide the necessary information to assess participant reactions and evaluation of client responsibility (Cause and Solution Scales after the vignette).

Although participants were determined to be at minimum risk, confronting issues of racial bias has been found to evoke strong emotional reactions (Utsey et al., 2005). Therefore, after completion of the study, participants were fully debriefed in regard to the purpose of this research project. Participants also received information normalizing the endorsement of negative attitudes.

Instrumentation

Demographic data. The demographic form collected information on participants' gender, race, and age (these variables are considered to be significant in the shaping participants' worldview about race, ethnicity, and culture Sue & Sue, 2013) as well as information about their graduate training program and multicultural training experiences.

In terms of assessing multicultural training, previous studies have operationalized the construct differently by averaging the median number of months of supervised clinical experience, mean number of clients (Ladany et al., 1997), and number of completed courses on multiculturalism (e.g., Constantine, 2001; Ladany et al., 2007; Neville et al., 2006). To capture a variety of multicultural training experiences, participants' were asked to indicate number of multicultural courses completed and number of direct contact hours with culturally diverse clients, which was defined as working with clients who are not members of one's in-group. In addition, training level was divided into two groups: low training and high training, such that the criteria for "low training" would classify less experienced graduate students in this group. Participants were categorized in the "low training" group ($N = 48$) when they had not completed a multicultural course or had less than 50 hours of direct contact with culturally diverse clients. Participants were classified as having "High training" ($N = 46$) if they completed more than one multicultural course and more than 50 direct contact hours with culturally diverse clients. In theory, individuals who received more training, regardless of type, should exhibit greater multicultural competencies. No identifying information was collected through the demographic information in order to ensure anonymity of all participants. See Table 1 for a complete list of demographic variables and Appendix A for the demographic questionnaire.

Implicit attitudes. The Implicit Association Test (IAT) was initially based on the tenets of associative learning and representation that instructs participants to categorize stimulus items into one of four superordinate categories (see Appendix B for additional information and sample stimuli). In the present study, participants categorized race-specific stimuli in order to measure automatic beliefs about race, specifically beliefs about white and black individuals. The IAT requires the rapid categorization of various stimulus objects, such that easier pairings (and faster responses) are interpreted as being more strongly associated in memory than more difficult pairings (i.e., slower responses; Greenwald et al., 1998; Greenwald et al., 1998). Through analysis of the IAT, it has been determined that faster response times are associated with stronger associations, or stronger implicit stereotype endorsement. Thus, association strengths are measured by the speed of categorizing stimuli into different sorting conditions (i.e., good or bad).

The race-based IAT was administered to participants online, with the use of Inquisit 3.0 [Computer software]. Using the race attribute example, sorting the stimulus items faster when “African American” and “Bad” and “European American” and “Good” are paired than the alternate combinations indicates a stronger cognitive association strength for the concept congruent pairs (“European American” and “Good”; “African American” and “Bad”), or an automatic preference for “European American” relative to “African American” (see Appendix for stimuli; Nosek, Greenwald, & Banaji, 2005). The Race IAT in the present study included 12 morphed facial photos of African Americans and European Americans (three men and three women for both ethnicities) and 16 pleasant and unpleasant association words (e.g., “good”, “bad”, “joy”, “agony;” see Appendix) for the attribute dimensions (Greenwald et al., 1998).

Investigations of the IAT have consistently provided evidence that results are stable with various procedural designs. There is also evidence that internal validity is consistent (e.g., Greenwald & Banaji, 1995; Greenwald et al., 1998). In a study of approximately 12,000 respondents per data set, four sub-studies investigating the construct validity of the IAT yielded the following results: (a) when the focus of the IAT analysis is a subset, the IAT continues to be a measure of association strength; (b) as few as two stimulus items sufficiently produce valid IAT measures although four stimulus items are ideal due to trial conditions; (c) little to no order effect exists when administering explicit and implicit measures of bias; and (d) extra practice trials significantly reduce the influence of extraneous variables (e.g., pairing order) on the IAT results (Nosek, Greenwald, & Banaji, 2005). Several studies have investigated the psychometric properties of various computer based IATs; various adoptions of the IAT yields internal consistency results between .70 and .90 (e.g., Cunningham, Preacher, Banaji, 2001; Greenwald & Banaji, 1995; Greenwald et al., 1998).

Responses to the IAT have demonstrated acceptable levels of internal consistency of $\alpha = .70$ (Cunningham et al., 2001); however, Cronbach's alpha is usually considered experimental at best, as it is lower than many standard measures of attitudes and beliefs. However, IAT reliability estimates may be affected by fluctuations in response latency across trials, and the fact that difference scores remove reliable variance in the calculation of internal consistency reliability (Cunningham et al., 2001). To help compensate for this disadvantage, estimates of experimental test-retest reliability ($\alpha = 0.60$ to 0.69) have been relatively favorable (Cunningham et al., 2001) as has the convergent validity of the race IAT with other latency-based implicit racial attitude measures and physiological measures of

racial preference. For example, functional magnetic resonance imaging measuring amygdala activation of White participants while viewing photos of African American faces has been correlated with the automatic responses provided during the IAT (Cunningham et al., 2001). More specifically, the strength of amygdala activation to visual race stimuli has been correlated with implicit measures of race, but not with explicit expression of race attitudes. Studies have also found evidence for divergent validity in support of the IAT's implicit qualities, based on weak correlations with explicit measures of bias (e.g., Modern Racism Scale, $r = 0.35$), indicating mostly distinct constructs.

Multicultural competencies. The Multicultural Counseling Inventory ([MCI] Sodowsky et al., 1994) was used to measure respondents' self-reported multicultural counseling competencies (see Appendix C for full scale). The MCI consists of 40 items and was originally created to reflect four subscales of competence (i.e., Awareness, Skills, Knowledge, and Relationship).

The Skills subscale consists of 11 items and is intended to assess multicultural counseling skills ($n = 5$) and general counseling skill ($n = 6$). According to Sodowsky and colleagues (1994), multicultural counseling skills refer to counselors ability to identify and manage cultural mistakes (e.g., *When working with minority clients, I am able to quickly recognize and recover from cultural mistakes or misunderstandings*), use culturally appropriate assessment methods congruent with the client's background, self-monitor, and plan interventions that are sensitive to the needs of minority clients. General counseling skills refer to basic counseling skills, such as analyzing counselor defensiveness, providing crisis interventions, and using concise reflections. (e.g., *When working with all clients, I am able to be concise and to the point when reflecting, clarifying, and probing*). The Skills subscale has

produced acceptable coefficient alphas ($\alpha = 0.77-.80$) across different trainee and counselor populations (Ottavi et al., 1994; Pope-Davis & Dings, 1994; Sadowsky et al., 1994, 1998).

The Knowledge subscale consists of 11 items that assess respondents' understanding of treatment planning, case conceptualization, and research on multicultural counseling topics (e.g., *When working with minority clients, I keep in mind research findings about minority clients' preferences in counseling*). The Knowledge subscale has yielded acceptable reliability estimates, ranging from $\alpha = 0.77$ to $\alpha = 0.80$ (e.g., Ottavi et al., 1994; Pope-Davis & Dings, 1994; Sadowsky et al., 1994) in several studies on different trainee and counselor populations.

The Awareness subscale ($n = 10$) measures respondents' sensitivity to multicultural issues based on their interactions, exposure, and advocacy work (e.g., *I am involved in advocacy efforts against institutional barriers in mental health services for minority clients*). Scores on the Awareness subscale have demonstrated adequate reliability estimates ranging from $\alpha = 0.78$ to $\alpha = 0.80$ in various trainee and counselor populations (e.g., Ottavi et al., 1994; Pope-Davis & Dings, 1994; Sadowsky et al., 1994).

The Relationship subscale consists of eight items that assess respondents' interpersonal process abilities or level of comfort when interacting with minority clients (e.g., *When working with minority clients, I am confident that my conceptualization of individual problems does not consist of stereotypes and biases*). Sadowsky and colleagues (1994) suggest that the Relationship subscale provides an estimate of counselors' cultural and racial attitudes toward multicultural interactions. Further, the subscale reflects the interpersonal process of multicultural counseling. Among various trainee and counselor populations, the

Relationship subscale has produced acceptable reliability estimates ranging from $\alpha = 0.68$ to $\alpha = 0.80$ (e.g., Ottavi et al., 1994; Pope-Davis & Dings, 1994; Sadowsky et al., 1994).

Although the authors of the MCI originally created these subscales to represent a multidimensional measure, the empirical support for this factor structure has been mixed (Constantine et al., 2002). Given the small number of participants retained for the current study sample (see missing data and data screening section) and limited support for the four-factor structure of the MCI (Constantine et al., 2002), the total score of the MCI (cumulative sum of all items) was used for the purposes of the current study. Although the MCI has been considered a potential measure of multicultural counseling self-efficacy as opposed to competency, it was included in the current study to provide an additional check for multicultural competencies, particularly when combined with the MCCA given the inclusion of empathic processes (Relationship). The MCI has demonstrated adequate convergent validity based on significant correlations with other multicultural competency measures, such as the Multicultural Counseling Awareness Scale-Revised (Pope-Davis & Dings, 1994). Criterion-related validity has also been established based on a significant change in students' MCI scores before and after multicultural training (Sadowsky et al., 1994).

Multicultural case conceptualization. To assess practitioner multicultural conceptualization abilities, a modified version of the Multicultural Case Conceptualization Ability (MCCA; Ladany et al., 1997) was used, using vignettes similar to that in other studies (e.g., Constantine & Ladany, 2000; Ladany et al., 1997; Neville et al., 2006) except for two details: DSM diagnosis was excluded in order to decrease potential participant bias in rating the etiology of the client's symptoms, and client gender was male to match the gender presented in the IAT (see Appendix D for vignettes and additional scoring criteria).

Participants were randomly assigned to one of two vignettes, with either White or African American client. Participants were encouraged to assume the role of a counselor who was to working with the client in the vignette. Participants were instructed to write three sentences regarding two ideas: (a) the factors contributing to the etiology of the client's presenting concern, and (b) areas of focus for effective treatment planning to address the client's difficulties.

Multicultural conceptualization ability includes two interrelated cognitive processes: differentiation and integration. Differentiation is the ability to generate alternative hypotheses of, or perspectives on, a client's presenting concern and type of treatment to provide. Greater differentiation is reflected by a greater number of alternative hypotheses, in this case, a number of hypotheses that include race as a factor to consider other diversity factors (e.g., sexual orientation, religion, gender, socioeconomic status, etc.). Integration refers to the ability to integrate differentiated interpretations into case conceptualizations (i.e., connected to either symptoms or treatment). Higher integration is exhibited by higher numbers of racial factor identifications and integrations. We expected that counselors with higher multicultural competencies would consider various diversity factors (e.g., religion, socioeconomic status, gender, etc.) and not exclusively race (differentiation). Moreover, we predicted that participants who read the vignette for an African American client would be more likely to indicate that race may be important to conceptualizing the client's presenting concerns because the client was a racial minority in the college environment (integration).

Similar to previous coding systems (e.g., Ladany et al., 1997; Neville et al., 2006), a specific scoring formula was used (for a complete range of scores, see Appendix D). The range of scores is from 0 (no indication of diversity factors) to 5 (three or more indications of

diversity factors with three or more integrations; high differentiation and integration). Two coders were trained during instructional sessions to score the multicultural case conceptualization task; they received a total of two hours of training on the phone and consultation was available as needed. In order to address potential bias, the coders were not informed of the research hypotheses. The coders received the following instructions to score case conceptualizations: (a) underline and/or highlight all race-related words and/or phrases; (b) count the total of race-related words; (c) identify phrases in which race-related words are connected to symptoms (etiology) or treatment in order to address integration; and (d) count the number of integrations. Coders were provided with examples of case conceptualizations with identified race-related factors and integrations for their reference. All raters provided responses with a score. Interrater reliability coefficients ranged from $\alpha = 0.71$ to $\alpha = 0.93$ for the etiology and treatment multicultural case conceptualizations.

To determine the total score of multicultural case conceptualization ability (MCCA), the author recruited two counseling psychology graduate level trainees to individually code the responses. Similar to the previous coding procedure for the MCCA (e.g., Ladany et al., 1997; Neville et al., 2006), a specific scoring criteria was used (for a complete range of scores, see Appendix). The primary investigator and coders communicated via 2 phone sessions and emails. The first phone session was approximately 1 hour and addressed coding procedure (addressed in Chapter 3). During the second 1-hour phone session, individual analyses were discussed and disagreements or uncertainties were addressed so that a consensus was ultimately attained. An interrater reliability analysis using the Kappa statistic was performed to determine consistency among raters. The rate of agreement among raters was low to moderate, $Kappa = 0.49, p < .001$.

Attribution of responsibility measure. An adapted version of the Cause and Solution Scales ([CSS]; Karuza, Zevon, Gleason, Karuza, & Nash, 1990) was administered to participants as a measure of practitioner attributions regarding client responsibility for the cause of and the solution to the presented problem. The original version of the CSS was created to assess respondent self-beliefs (e.g., *To what extent do you feel that you could have avoided the problems?*); however, for the purpose of the current study, items were modified to assess participants' beliefs about the presenting client (e.g., *To what extent do you feel the client could have avoided the problems?*). The total CSS consists of six-item and represents two subscales (see Appendix E). The Cause Scale ($n = 3$) measures participants' belief that the presented client is personally responsible for the cause of a problem, had the ability to avoid the problem, and had control over the cause of the problem. The Solution Scale ($n = 3$) measures participants' belief that the client is fully responsible for generating a solution to the problem, overcoming the problem, and demonstrating a level of control over the situation. Participants are asked to respond using a 7-point scale ranging from 1 = "not at all" to 7 = "very much." The CSS is scored by summing the total number of items such that higher scores indicate that respondents strongly attribute the client as being responsible for the cause and solution to the presenting issue.

Reliability of the Cause Scale has been deemed acceptable ($\alpha = 0.79$ to $\alpha = 0.86$), as is the reliability of the Solution Scale ($\alpha = 0.70$ to $\alpha = 0.76$; Burkard & Knox, 2004) when measured with a sample of psychologists. The Solution and Cause subscales have a medium correlation of .35. Test-retest reliability after two weeks has been estimated at $\alpha = 0.86$ for the Cause Scale and $\alpha = 0.70$ for the Solution Scale (Bailey & Hayes, 1998). Results from both scales have been correlated with the Derived Cause and Derived Solution scales of the

Helping Coping Orientation Measure (Michlistch & Frankel, 1998), demonstrating concurrent validity. Hayes and Wall (1998) found some evidence for construct validity such that practitioner's used the CSS to deem clients with posttraumatic stress disorder as significantly less responsible for the cause of and solution to their problem when compared to clients diagnosed with bulimia (Hayes & Wall, 1998).

In the current study, a total of six items were included on this scale, which resulted in a two factor solution that explained 55.11% of the amount of the variance. For the original solution, the Kaiser-Meyer Olkin measure verified the sampling adequacy for the analysis, KMO = 0.68, and was considered good. Bartlett's test of sphericity, $\chi^2(15) = 175.31, p < .001$, suggested that the correlations between items were sufficiently large for EFA. Given the EFA criteria, two items were removed (1 and 5) to yield a more stable solution. The standard of 4 items on each subscale was considered (Karuza et al., 1990). However, the researcher retained a two-factor solution, with two items on each factor, given that the recommendation of 0.32 for factor loadings was not met. This final solution of 4 items explained 65.96% of the variance in attribution bias. Cronbach's alpha for attributions of client responsibility were 0.81 and 0.77 for attribution of client solution to the presenting concern.

Ethnocultural empathy. Wang and colleagues (2003) developed the Scale of Ethnocultural Empathy (SEE) to assess levels of empathy toward individuals who are members of races and ethnicities different than their own (see Appendix F for items). The SEE has 31 items rated by a 6-point scale (1 = *strongly disagree that it describes me*; 6 = *strongly agree that it describes me*) and consists of four subscales: (a) Empathic Feeling and Expression (EFE), (b) Empathic Perspective Taking (EP), (c) Acceptance of Cultural

Differences (AC), and (d) Empathic Awareness (EA) (see Appendix G for items). The EFE assesses concern about communication of discriminatory or prejudiced attitudes or beliefs (e.g., *When other people struggle with racial or ethnic oppression, I share their frustration*). Items also focus on affective responses to the emotions expressed by members of a racial or ethnic out-group. The EP subscale assesses an individual's level of effort to understand the experiences and emotions of people from different ethnic backgrounds (e.g., *It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own*). This type of empathy occurs with consideration of another's perspective in experiencing the world. The AC subscale includes items related to understanding, accepting, and valuing the cultural traditions of individuals from other ethnic and racial groups (e.g., *I feel annoyed when people do not speak standard English*). The EA subscale measures the awareness and knowledge that an individual has about the experiences of individuals from different racial or ethnic groups (e.g., *I am aware of how society differentially treats racial or ethnic groups other than my own*). Specifically, this level of awareness is assessed by knowledge of the emotions and experiences of others as related to discrimination or unequal treatment of marginalized groups.

Evidence of concurrent validity for the SEE has been established based on significant and positive correlations with other scales of empathy, such as the Interpersonal Reactivity Index ([IRI]; Davis, 1983) used in Burkard and Knox's (2004) study. Internal consistency for the overall SEE is excellent ($\alpha = 0.91$). Because previous studies have not investigated the relationship between ethnocultural empathy and the other measures in this study, all subscales were used to calculate the total score for this analysis with higher values indicating greater ethnocultural empathy.

Internal and external motivation to respond without prejudice. Plant and Devine (1998) distinguished between internal and external motivations to respond without prejudice. From this theoretical perspective, the authors constructed a two-part scale to measure affective reactions related to a person's reasons for responding without prejudice in a racially salient situation. The Internal Motivation Scale (IMS) consists of 10 items and assesses a person's individual motives to respond to situations without prejudice (e.g., *I am personally motivated by my beliefs to be nonprejudiced toward Black people*). The External Motivation Scale (EMS) also consists of 10 items and assesses the degree that responses are influenced by the status quo and social norms (e.g., *I try to act nonprejudiced toward Black people because of pressure from others*; see Appendix F for all items). Participants are asked to rate their responses using a 1 (strongly disagree) to 9-point (strongly agree) scale. After reversing the scores of negatively stated items, each subscale was scored by summing the 10 items with higher scores reflecting higher levels of respective motivation.

The IMS/EMS model has been supported among several samples of undergraduate students and has produced reliability scores that have ranged from acceptable to good (IMS $\alpha = 0.81$ to 0.85 ; EMS $\alpha = 0.76$ to 0.80), as well as acceptable estimates of test-retest reliability (IMS $r = 0.77$; EMS $r = 0.60$). Correlations between the IMS and EMS scales are typically small and negative ($r = -0.14$ to -0.15), indicating divergence of sources of motivation.

Factor analysis initially included all 10 items of this scale, which produced a three-factor solution and explained 51.01% of the variance. However, two items on factor 3 cross-loaded on the IMS subscale with factor 2. As such, a second EFA was conducted that suppressed factor structures to two (Plant & Devine, 1998). This two-factor solution explained 43.89% of the variance and all items loaded on the expected factors. The Kaiser-

Meyer Olkin measure verified the sampling adequacy for the analysis, $KMO = 0.73$, which is acceptable. The correlations between items were sufficiently large, as indicated by Bartlett's test of sphericity, $\chi^2(45) = 339.76, p < .001$. Cronbach's alpha for the EMS scale was 0.86 and 0.58 for the IMS.

CHAPTER 4

RESULTS

Missing Data and Data Screening

Upon completion of data collection, 324 individuals accessed the survey in total. Examination of these cases indicated that 140 of these respondents stopped responding to the survey when prompted with the case vignette; thus, these cases were removed from the data. A total of 82 cases were deleted due to excessive amounts of missing data (at least 50% of the responses). Of the remaining 108 cases, 76 cases had complete data; whereas 32 participants only completed a portion of the survey items (did not complete the IAT see Discussion section for further detail). Expectation maximization (EM) imputation was used to address missing data items (Tabachnick & Fidell, 2007) for all cases (including the 32 missing cases for the IAT). Results of Little's test on all individual scale items (i.e., from the CSS, SEE, IMS/EMS, IAT and MCI) results were non-significant, $\chi^2(1525) = 1565.37, p = .231$. As such, it was assumed that the data were missing completely at random; thus, the missing values that were computed through EM imputation were retained and used for subsequent analyses.

Completion of a power analysis for the analysis in the current study suggested a sample of 200 participants for sufficient power to correctly identify statistical significance for the regression analyses. However, following the completion of data cleaning, a smaller

sample was retained than desired. Additionally, the sample size potentially poses a problem for the probability of correctly identifying the true factor structure of the instruments used in the study. The recommended item ratio for factor analysis is 20:1 (Costello & Osborne, 2005), but the item ratio in the current study is less than 2:1. These limitations are considered as the results of this study are analyzed and interpreted.

The statistical analyses were performed using Statistical Package for the Social Sciences (SPSS) Software. The recommendations of Kline (2011) were used as a reference to guide the data screening process. Univariate outliers were examined for each instrument's subscale scores, with the exception of the IAT because that was a cumulative score for response latencies. Skewness values were expected to be in the range of $|\leq 3.0|$ and kurtosis values were expected in the range of $|\leq 10.0|$. A total of 4 respondents' data were removed due to z-score values above $|\leq 3.0|$. The relationship between predictor variables was reviewed with Pearson's correlations and collinearity statistics. The highest correlation was .66 and collinearity was not a threat as there were no VIF scores were greater than 3.0. Multivariate outliers were analyzed with Mahalanobis test and cases with a value above 20 were dropped from the study (Field, 2009). After observing a plot of Mahalanobis distances with the MCI, 2 cases were dropped from the study. Linearity was observed with scatterplots and determined to be satisfactory. Homogeneity of variance was investigated through Levene's test, which was non-significant for all predictor variables (MCI: $F(1, 92) = .02, p = .90$; EMS: $F(1, 92) = .05, p = .82$; IMS: $F(1, 92) = .54, p = .47$; SEE: $F(1, 92) = 1.30, p = .26$; CSS, SolResp: $F(1, 92) = 1.68, p = .20$; CSS, CIResp: $F(1, 92) = .82, p = .37$; IAT: $F(1, 92) = .31, p = .58$) Thus, equality of variances was assumed. The final sample included 94 cases;

see Table 1 to view descriptive statistics for all variables, as well as covariances and correlations between all variables.

In order to ensure that the manipulation of client race obtained the desired group differences between those who were presented with a White client and those presented with a Black client, an ANOVA was conducted, with the MCCA as the criterion variable. Results indicate a significant effect for condition, $F(1, 92) = 19.31, p < .01$. Thus, the desired client condition manipulation was achieved.

Primary Analyses

To prepare the data for testing the study hypotheses, the IAT score (predictor variable), was mean - centered. Because of the small sample size for moderation analysis, the researcher chose to run multivariate multiple regressions with race as the categorical IV in order to increase the likelihood of detecting significant interaction effects.

Hypothesis 1: Implicit race bias and practitioner multicultural competency.

Hypothesis 1 proposed that implicit race bias (IAT) would be significantly and negatively related to counselor multicultural competencies (as measured by MCCA and MCI). As shown in Table 1, results of the bivariate correlations indicated that the IAT was not significantly related to the MCCA ($r = -0.04, p = .45$) or MCI ($r = -0.12, p = .35$).

A second point of investigation examined the moderating effect of client race in the relationship between implicit race bias and multicultural competencies. It was expected that client race would significantly moderate the relationships between implicit race bias and both multicultural competencies (MCI) and multicultural case conceptualization (MCCA), such that the relationship would be stronger for participants presented with African American clients than when presented with White clients. Two separate multiple regressions, with a

categorical IV of client race, were performed to predict multicultural case conceptualization ability (MCCA) and self-reported multicultural competencies (MCI); see Table 3 for all effect values. First, a multiple regression analysis was conducted with the MCI as the criterion variable. This analysis revealed no significant main effects for client race, $F(1, 63) = 0.38, p = .54$, or IAT, $F(1, 63) = 0.44, p = .51$. The interaction between client race and IAT was not significant, $F(1, 63) = 0.27, p = .61$. Next, a multiple regression was performed to determine the moderation effect of client race on the relationship between IAT and MCCA. This interaction was not statistically significant: $F(1, 90) = 2.16, p = .20$, suggesting that client race did not make a difference in the relationship between participants' implicit race bias on their multicultural case conceptualization. The power for this interaction term was poor, 0.25. The main effect for client race in the model suggested a statistically significant effect: $F(1, 90) = 19.07, p < .00$. Thus, practitioners who were presented with African American clients were more likely to have higher multicultural case conceptualization scores than practitioners who were presented with White clients. The observed power for this effect was 0.99 and the effect size was moderate, $\eta^2 = .18$. The effect of implicit race bias on multicultural case conceptualization was not significant, $F(1, 90) = 0.08, p = .78$, and had poor power at 0.06. Overall, these results suggest that implicit race bias does not significantly affect multicultural conceptualization of clients or self-reported practitioner multicultural competencies; however, client race appears to have a significant overall effect on conceptualization.

Hypothesis 2: Implicit race bias and motivation to respond without prejudice.

The second hypothesis of this study proposed that counselors with lower implicit race bias would be more internally motivated (i.e., high IMS, low EMS), resulting in a negative

correlation between the IAT and IMS and a positive correlation between IAT and EMS. Although the relationship between the IAT and IMS was expected to be significant and negative, the correlation was negligible ($r = -0.08, p = .43$). The relationship between implicit race bias and external motivation to respond without prejudice was observed to have a moderately strong positive correlation ($r = 0.27, p < .01$). Contrary to hypothesis two, implicit race bias was not related to internal motivation; however, it was significantly related to external motivation.

Next, a multiple regression was conducted in order to determine the moderating effect of client race on the relationship between implicit race bias and external motivation to respond without bias. It was anticipated that practitioners presented with an African American client would be more externally motivated to respond without prejudice than those presented with White clients because visible race would act as a prime for external motivation to respond without prejudice. Results indicated that the IAT significantly predicted external motivation to respond without prejudice, $F(1, 90) = 5.93, p < .05$. The effect size of IAT on EMS was small, $\eta^2 = 0.06$, and the observed power was 0.67. Surprisingly, client race did not have a significant main effect on external motivation to respond without prejudice, $F(1, 90) = 0.01, p = .93$ (power of .05). Moreover, the interaction between IAT and EMS was not significant, $F(1, 90) = 0.44, p = .51$, with an observed power of 0.10.

Similar analyses were conducted to review the effect of client race on the relationship between implicit race bias and internal motivation to respond without prejudice. Specifically, it was hypothesized that practitioners presented with Black clients would demonstrate higher IMS only when IAT was low; whereas, practitioners presented with White clients would

have comparable levels of IMS at all levels of IAT. Results yielded no main effects for client race, $F(1, 90) = 0.47, p = .50$, or implicit race attitudes, $F(1, 90) = .45, p = .50$, nor was the interaction effect of the IAT x client race significant $F(1, 90) = 0.08, p = .77$. The power for this analysis ranged from 0.06 to 0.12. These results suggest that client race did not make a difference in the relationship between participants' implicit race bias on their motivation to respond without prejudice.

Hypothesis 3: Implicit race bias and practitioner's attribution for client problems. It was anticipated that participants' with higher implicit race bias would be more likely to attribute responsibility for causing and solving the problem to the client when presented with an African American client as opposed to a White client. Separate multiple regressions were conducted in order to determine the moderating effect of client race on the relationship between implicit race bias and practitioner attributions (both CCS-C and CCS-S).

Correlations were first analyzed in order to better understand the relationship between implicit race bias and the subscale scores of the CCS: attribution of responsibility and attribution of solution. Although it was anticipated that the IAT and both subscale scores would be positively and significantly correlated, the relationship between implicit race bias and CCS-C was negative not statistically significant ($r = -0.11, p = .29$). Likewise, the correlation between implicit race bias and CCS-S was negative and not significantly significant ($r = -0.06, p = .55$). Regression analysis confirmed that implicit race bias and client race did not have a significant impact on participants' attribution of client cause of, $F(1, 90) = 0.88, p = .77$, or solution to, $F(1, 90) = 1.07, p = .30$ the client's presenting concern. Results also revealed no main effect for implicit race bias and client race on both

forms of attribution for responsibility (i.e., cause of and solution to the presenting concern). Although literature suggests that client race typically makes a difference on counselors' attitudinal bias on their attributions of client responsibility for the solution to a problem; these results suggest that implicit bias may not have such an effect. Also, poor power (0.08 to 0.28) may be responsible for the non-significant relationship between the IAT and both forms of attributions. Altogether, the study results suggest that attribution of client's responsibility to, and solution for, the presenting concern is not significantly influenced by implicit race bias or client race.

Hypothesis 4: Implicit race bias and ethnocultural empathy. Given that literature supports a significant relationship between implicit bias and empathic perspective taking, hypothesis four proposed that implicit race bias would be (a) negatively related ethnocultural empathy (SEE). In addition, it was expected that client race would moderate the relationship between IAT and SEE, such that participants with higher implicit race bias who were presented with a Black client would have less ethnocultural empathy than participants presented with a White client. First, the correlation between implicit race bias and ethnocultural empathy was tested and suggested a negative, yet non-significant relationship ($r = -0.20, p = .10$). Next, the main effects for client race and implicit race bias on ethnocultural empathy were tested. Results of the multiple regression were non-significant $F(1, 64) = 0.69, p = .40$; $F(1, 64) = 2.10, p = .15$., indicating that client race and implicit race bias did not individually impact participants' ethnocultural empathy. In addition, the interaction of implicit race bias and client race was also non-significant, $F(1, 64) = 0.23, p = .63$, suggesting that client race did not impact the relationship between implicit race bias and ethnocultural empathy. The power for these analyses was low, ranging from 0.07 to 0.31.

Contrary to the hypothesis, results suggest that implicit race bias and client race did not significantly affect the level of empathy that practitioners have for culturally diverse clients in this sample.

Hypothesis 5: Implicit race bias and attribution for client concerns as moderated by training. The final hypothesis posited that the client race and training level would moderate the relationship between participants' implicit race bias and attributions of responsibility and solution to the client problem (three-way interaction effect for client race, training level and implicit bias). In other words, training level (low and moderate) was expected to interact with client race (Black, White) and impact implicit race bias and attributions of responsibility. It was expected that participants with lower levels of training, regardless of client race, would be more likely to attribute the cause of the presenting concern and solution to the problem directly to the client than participants with more training, as these clinicians would be least likely to consider external system issues. Participants with more training who were presented with a Black client would be less likely to attribute the cause of the presenting concern and solution of the problem exclusively to the client than those presented with a White client, as they would consider more external factors that may influence the presenting concern based on client race. Based on the recommendations for three-way interactions (Aiken & West, 1991; Dawson, 2014), a multivariate multiple regression analysis was conducted and revealed that the three way interaction of interest (training level x client condition x implicit race bias) did not have a significant effect on attribution of client responsibility for the problem, $F(1, 86) = 1.07, p = .30$. Likewise, the three-way interaction of training level x client condition x implicit race bias on counselor attribution of client solution to the presenting concern was not significant, $F(1, 86) = 1.92, p$

= .17. However, it is important to note that interaction between implicit race bias and counselor multicultural training was significant for attribution of client solution, $F(1, 86) = 4.03, p < .05$. The observed power for these analyses ranged from 0.08 to 0.57, indicating that the probability of correctly rejecting the null hypothesis is low. Although participant attributions were expected to vary at different levels of training, client race, and implicit bias, these results do not support a three-way interaction effect. However, results do suggest that participants' attributions regarding the client as the solution to their presenting problem, may depend on the level of practitioner bias and training, as results suggest that implicit race bias accentuated the impact of training level on this form of attribution.

Post-Hoc Findings

Because of the non-significant findings for all hypotheses and research questions, further exploratory analyses were reviewed to provide some context for the results. An examination of the correlations revealed that multicultural case conceptualization (MCCA) was significantly and negatively related to attribution of client solution to the problem (CSSS; $r = -0.24, p < .05$), ethnocultural empathy (SEE; $r = 0.29, p < .01$), and internal motivation to respond without prejudice (IMS; $r = -0.24, p < .05$). This suggests a small-to-medium effect of attribution bias, ethnocultural empathy, and internal motivation to respond without prejudice on multicultural counseling conceptualization. With these relationships in consideration, the researcher returned to the literature to determine additional analyses.

The literature supports that explicit measures of prejudice vary as a function of motivation (Plant & Devine, 1998) and practitioner empathy (Burkard & Knox, 2004). To better understand the aforementioned significant correlations, the researcher wondered about the potential of a moderation effect of implicit race bias on the relationship between

motivation to respond without prejudice and multicultural case conceptualization. It is possible that higher levels of implicit bias could significantly minimize a person's internal motivations to respond without bias on their case conceptualization abilities. Two separate univariate multiple regression analyses were conducted with MCCA as the criterion variable, IMS and EMS as the predictor variables in their respective models, and IAT as the moderating variable. The first model addressed the moderating role of the IAT on the relationship between IMS and MCCA. Although results suggested that IMS had a positive and significant main effect on MCCA, $F(1, 90) = 5.05, p < .05$; the IAT did not $F(1, 90) = .12, p = .73$. Furthermore, the interaction effect of the IMS x IAT on the MCCA was not significant, $F(1, 90) = 0.09, p = .77$ (power ranged from .06 to .60), suggesting that implicit race bias did not significantly impact the positive effect of participants' internal motivations to respond without prejudice on their multicultural case conceptualization abilities. For the second model (power ranged from .05 to .98), the main effects of the EMS ($F(1, 90) = 0.49, p = .48$) and the IAT ($F(1, 90) = 0.03, p = .88$) on the MCCA were not significant, nor was the interaction effect of EMS x IAT ($F(1, 90) = .00, p = .97$), indicating that external motivation to respond without prejudice was not significantly related to participants' case conceptualization abilities and that their implicit race bias did not make a difference in this relationship.

CHAPTER 5

DISCUSSION

The present study was intended to extend the current research on multicultural competence in the field of counseling. The primary objective was to better understand the effect of implicit race bias and client race on practitioner empathy, motivation to respond

without bias, and attributions about the client's responsibility for the presenting concern and solution to their problems. Although the study hypotheses were not statistically supported, the results support the notion that practitioner automatic beliefs play an important role in counseling diverse clients. Results suggest that client race is more salient for practitioners in conceptualizing client presenting concerns when the client is of a visibly minority racial group. In terms of practitioner training, these results suggest that implicit race bias may promote practitioner beliefs about a client's ability to resolve a problem, which may limit their consideration of contextual barriers that clients face in the everyday world.

Hypothesis 1: Multicultural Competencies

Conceptually, attitudes shape one's knowledge and awareness of culturally relevant information. As such, a significant relationship between implicit race bias and multicultural competencies, as measured by both self-report and case conceptualization, was expected (hypothesis 1). In the present study, this relationship between multicultural counseling competencies and case conceptualization was considerably weak, and contrary to established findings (e.g., Castillo et al., 2007; Legault et al., 2007). However, a significant inverse relationship between implicit race bias and ethnocultural empathy emerged such that practitioners whose implicit attitudes about African American clients are more negative, also had less empathy for people who are racially different from them. This suggests that practitioners who have stronger implicit stereotypes about non-white clients may have greater difficulty empathizing with the experiences and emotions of racially diverse, which may negatively impact the therapeutic relationship. However, in their case conceptualization, practitioners were more likely to consider client race as a contextual factor when the client was clearly presented as a visible minority (e.g., Burkard & Knox, 2004).

Relatedly, practitioners may be less inclined to consider culturally relevant information, such as racial-ethnic experiences, when minority status is not visible which may also be linked to their motivation to respond without bias.

Hypothesis 2: Motivation to Respond Without Prejudice

Implicit race bias was strongly related to practitioner external motivation to respond without prejudice such that higher implicit bias accounted for greater external motivation; however, implicit bias was not significantly related to internal motivation to respond without bias. As expected, practitioners with higher implicit race bias were more concerned about the avoiding negative judgments from others. However, contrary to the findings of Devine and colleagues (2002), practitioners who were more self-determined and intrinsically inclined to respond without prejudice, did not demonstrate significantly lower levels of implicit race bias.

Although the relationship between implicit race bias and motivation to respond without prejudice has been clearly established (Plant & Devine, 1998); this pattern did not manifest in the context of a hypothetical counseling situation. It was expected that when presented with a racially diverse client, practitioners would pay greater attention to the implications of client race, particularly when they are intrinsically inclined to respond without prejudice and have more training. However, the results of this study indicate that client race was not a factor in the relationship between practitioners' levels of implicit race bias and general desire (internal and external) to respond without prejudice (hypothesis 2). This may reflect the automatic nature of implicit processes (Legault et al., 2007) or that practitioners may have been desensitized to the racialized content due to their experiences

with training and clinical work. At the same time, results may have also been affected by the study's low power which will be addressed in the limitations section of this discussion.

Regardless, the strong link between high levels of implicit race bias and external motivation to respond without bias is notable. Given that the current sample included a larger proportion of graduate students, it is possible that many were externally motivated based on their training status and have yet to personally internalize a desire to respond without prejudice. It is likely that training level and personal values are key elements in practitioners' internal motivation to respond without prejudice; thus, it is possible that self-determination develops as practitioners gain more experience. As practitioners gain more professional experience, their multicultural competencies and attitudes about race will also continue to evolve, which in turn, affect their clinical decision making about racially diverse clients.

Hypotheses 3 & 4: Practitioner Attributions for Client's Presenting Concerns and Empathy

In the present study, it was anticipated that when presented with Black clients, practitioners with high implicit race bias would be more likely to attribute responsibility (for the problem and solution) to the client as opposed to considering other external factors. (hypotheses 3). It was also predicted that practitioners who had higher implicit race bias and were presented with a Black client would be less empathic toward racially – diverse clients than practitioners who were presented with a White client (hypotheses 4). Surprisingly, findings did not support this hypothesis, even when the client was a racial minority. The results also negated the hypothesis that client race and implicit race bias would interact to affect practitioners' level of ethnocultural empathy. Although studies have found that client

race tends to impact counselors' explicit racial attitudes on their attributions of client responsibility (Burkard & Knox, 2004); study results suggest that implicit race bias may not have such an effect.

Theoretically, practitioners who have lower levels of implicit race bias generally demonstrate greater empathy, regardless of client race or attributions of the clients concerns. Although this may be a true representation of the relationship between implicit bias and attributions and empathy, it is possible that this result is specific to the study sample due to several limitations which will be addressed. However, if this relationship does not exist, a few alternative explanations may support these findings. First, theoretical orientation may play an important role in attributing the clients' presenting concerns and solution to the problem, as some theories promote consideration of multicultural and contextual factors more than others. Theoretical orientation may also explain the non-significant relationship between implicit race bias and empathy, as many theories are rooted in common factors of psychotherapy, such as rapport, validation, and empathy (Wampold, 2001). Put differently, practitioners may be able to experience empathy for a client in pain because they value these core tenets of counseling, which may be exclusive from automatic associations of race. These considerations suggest that practitioners may be able to express empathy and consider client contextual factors, regardless of their level of implicit race bias and the client race. Level of training is related to the development of multiculturally competent clinical skills (e.g., Constantine, 2001; Ladany et al., 2007; Neville et al., 2006); as such, the final variable of consideration is multicultural clinical experience.

Hypothesis 5: Multicultural Training Level

In the present study, it was expected that when presented with a Black client, practitioners with less training and high implicit race bias would be more likely to attribute responsibility (cause and solution) to the client as opposed to considering the greater context of community influences. Results suggest that the 3-way interaction did not have a significant impact on practitioners' attributions of the client's problem and solution. However, implicit race bias accentuated the effect of counselor multicultural training on practitioners' attribution of the client solution, but not for client responsibility. Results indicate that practitioners' automatic racial beliefs varied based on their level of experience with diverse clients, as they considered the client's level of personal responsibility. It is possible that practitioners, who have more experience working with racially diverse clients, are more likely to focus on client agency and will encourage clients to work on changing their behaviors. Although this approach is in line with empowerment and CBT based interventions, it is also possible that time limited interventions may overemphasize a client's responsibility and ability to control their problem. Although, behavioral and time-limited approaches may deemphasize the impact of uncontrollable environmental stressors (i.e., discrimination, microaggressions, etc.), it is also possible that depending on counseling approach, some practitioners may focus on helping client's change their behaviors while also validating their experiences with systemic barriers.

In addition, it is important to note that lower implicit race bias did not impact participants' multicultural training level on their beliefs about the client's presenting concern. It is possible that practitioners' with high levels of implicit race bias also had less experience working with diverse clients and were more likely to attribute presenting concerns to individual factors (i.e., depression, adjustment, etc.) as opposed to systemic considerations

(i.e., discrimination); however, results suggested that practitioners did not vary in their attributions toward the client's presenting concern based on training level or implicit race bias. Thus, practitioners' attributions of client responsibility for their presenting issue were consistent across all levels of implicit race bias and training level. In terms of conceptualizing a client's presenting issue, practitioners may rely on preconceived attributions regardless of their implicit beliefs and clinical experience. At the same time, these findings can only be interpreted within the context of the current sample. If these results are, indeed, a true representation of the relationship between implicit race bias, training level, and attribution bias, it appears that training and bias reduction measures may be a way to enhance practitioner's beliefs in client's self-actualizing tendencies.

Furthermore, the interaction of client race, multicultural training, and implicit race bias did not significantly influence practitioners' perceptions of clients' responsibility for causing or solving their concerns (hypothesis 5). Results suggest that the impact of multicultural clinical experience did not vary based on client race or at different levels of implicit race bias (high or low) to the degree of significantly influencing practitioner attribution bias. This question was originally posed given that multicultural training has been associated with reducing automatic beliefs about race, while an individual's race has been found to activate biased attitudes (Devine et al., 2012). Overall, results suggest that the relationships between these variables may be more complex than originally theorized.

Taken together, the present study provides mixed support for the use of automatic beliefs about race in understanding the development of practitioner multicultural competency but does indicate that client race is a significant factor in conceptualization. Although implicit beliefs about race, practitioner attribution bias, empathy, and motivation to respond

without prejudice appear to be meaningful factors in the context of multicultural competency development, results of the current study did not support the expected relationships. It appears that client race is most salient in the context of conceptualizing the client's concerns; specifically, practitioners paid greater attention to race and systemic issues when the client was a member of a minority race. Moreover, client race and practitioner experience had a unique effects on practitioners' decisions about the cause of the presenting concern; however, the interaction effect was not statistically significant, the directionality of this relationship is not interpretable. Practitioners' source of motivation to respond without bias and learn multiculturally sensitive counseling skills appear to at least partially influence implicit race bias, when responding to external influences to reduce prejudice. One potential explanation for these results is that heightened attention to race and perceived differences tends to stimulate feelings of anxiety, discomfort, and stress (Kawakami & Gaertner, 2002; Stephan et al., 1996; 2000; 2002; Voci & Hewstone, 2003). In addition, for majority group members, intergroup anxiety has been related to the desire to avoid and distance oneself from out-groups (Ickes, 1984; Van Zomeren, Fischer & Spears, 2007), increasing the likelihood that people will focus their attention toward stereotypical stimuli (Stephan Dias-Loving, et al., 2000).

Post-Hoc Findings

The exploratory findings from the current study provide some theoretical context regarding the interaction between implicit race bias, motivation to respond without prejudice, and multicultural case conceptualization. Of note, the results suggest that internal motivation to respond without bias has a significant effect on multicultural case conceptualization; however, the exact relationship remains unclear because of a non-significant interaction

between motivation and implicit race bias. These results are consistent with previous research (Legault & colleagues, 2013; Plant & Devine, 1998) and provide some evidence that motivation to regulate prejudice is an important factor in clinical work with diverse clients. It is all the more important to address trainees' automatic beliefs and motivation in pluralistic curriculum given that practitioners' conceptualization of clients appear to be directly influenced by motivation and automaticity of bias.

Implications for Practitioner Training

Results of the current study are particularly conducive to practitioner training. First, given that results suggest that implicit race bias is related to external motivation to respond without prejudice, but not internal motivation (or not related to self-determined motivation), promoting self-determination may be particularly important to practitioner training. As practitioners gain more experience and motivation to provide multiculturally competent services, they may be more likely to engage in behaviors that reduce implicit race bias (e.g., empathic perspective taking) and attribution bias. This may be done by encouraging practitioner trainees to explore their motivational drives and their personal reasons for wanting to respond to clients in a multiculturally sensitive way. By doing so, opportunities for discussion may arise and provide a stepping stone in developing self-determined motivation.

In addition, given that client race appears to play a significant important role in case conceptualization and attribution to the solution of the presenting, training programs may want to specifically help trainees understand the importance of contextual factors related to non-visible minority clients. The results of this study suggest that practitioners tend to consider sociocultural context of the client when clients are visible minorities. Practitioners

must be mindful to assess for the degree to which their own beliefs influence treatment and rapport building with clients.

Strengths, Limitations and Future Directions

The present study makes an exploratory contribution to the literature regarding the importance of considering automatic beliefs about race when examining practitioner multicultural competencies, attribution bias, motivation, and empathy; by doing so, multiculturally sensitive case formulation and treatment may be modified to include reflections on motivations to reduce bias. Although study results indicated that implicit race bias did not fully apply to practitioners' attributions of client responsibility, motivation, or empathy,, results provide some initial information about the relevance of implicit factors to multiculturally competent counseling. Despite some strengths, the findings are not dramatically robust, which may be related to the lack of the power and other limitations of the present study.

An important impetus for the present study was to understand how empathy for individuals of diverse backgrounds interacts with their implicit biases in the context of motivation to respond without prejudice. Results provide limited evidence that implicit race bias is related to empathy for others. This finding is puzzling as empathy is a common factor for rapport building in therapy (e.g., Burkard & Knox, 2004). However, past studies have used a general measure of interpersonal empathy, such as the Interpersonal Reactivity Index (Davis, 1983), as opposed to a measure of empathy specifically toward individuals who are members of races and ethnicities different than their own. It is possible that because ethnocultural empathy was not directly connected to the client presented in the vignette; empathic perspective taking was not activated in the practitioner. However, ethnocultural

empathy does appear to be significantly related to multicultural case conceptualization and attributions of the cause of the client's presenting concern. Gaining a better understanding of processes related to practitioners' ethnocultural empathy appears to be an important direction for future research as the demographics of society become increasingly pluralistic. In multicultural counseling research however, studies have rarely considered the affective process of the counselor that may account for their ability to work with diverse clients.

Several issues inherent with the sample arose with this study. First, it is important to recognize that the sample was primarily white women. Individuals who identify with both of these demographics are likely to receive cultural messages that are different than those received by individuals from other genders, ethnicities and races. Considering that this study is observing biased beliefs endorsed by practitioners, a more diverse sample would be desirable to generalize the findings. Moreover, there is high likelihood of participants controlling and censoring their reports (Dambrun, Despres, & Guimond, 2003), given the negative implications of demonstrating multicultural *incompetence* as a counselor preparing to work with diverse client populations. In fact, studies have found that several measures of multicultural competency have produced scores that are positively and significantly related to social desirability (Dunn et al., 2006).

Although several statistically significant relationships were found in the analyses, power was an apparent issue in detecting the true relationship among the variables of interest. The power analysis indicated that a sample of 200 participants would yield sufficient power to find statistical significance; however, after data cleaning, only 94 respondents were retained for analysis. One of the reasons for such limited participant data was the format of the IAT. The researcher received feedback from a number of respondents that compatibility

with the IAT software inhibited them from completing the measure. Upon further observation, a number of subjects did not complete the remainder of the study after the IAT; thus, suggesting that software created a barrier for completing the study. With this limitation of sample size in mind, the observed power for a number of the tests was considerably low, with the lowest observation at 0.06; thus, it is likely that the study did not have enough power to find significant results for all of the hypotheses.

Considering measurement issues, an additional limitation of this study is the psychometric properties of a number of the scales. The IMS had a particularly low reliability such that the measures used for attribution bias and internal motivation to respond without prejudice may be poor measures for these constructs. Use of a better tool for this sample may have resulted in a more reliable analysis of the relationship between implicit race bias and internal motivation to respond without prejudice. It is important to note that multiple items were dropped from the MCI, CSS, and SEE because of poor factor loadings; this is further suggestive of the need to better understand the structure of these scales, as it may be that these constructs warrant different conceptualization. Moreover, the interrater reliability for the MCCA was low, suggesting that more training and support for raters may be needed to accurately capture the relationships examined in this study. As an additional area for future work, additional constructs related to motivation to regulate prejudice, such as amotivation (Legault et al., 2007), may be studied in the context of practitioner's multicultural competencies.

Another limitation worth consideration is the fact that the current study is related to implicit race bias, which may limit generalizability to other implicit stereotype constructs. Future studies should explore other types of bias in order to better understand multicultural

competency development. For example, it is possible that other psychosocial factors, such as gender and disability, may also affect counselor beliefs about client presenting concern. Moreover, counselors may be motivated differently to address different attitudes. Given the current social emphasis on race bias reduction, it is possible that counselors are more motivated to address racial biases and less motivated to address biases about other factors, such as invisible minority status.

The present study supports the notion that promotion of internal sources of motivation to respond without prejudice are necessary when considering the training of multiculturally competent practitioners. The exact relationships among empathy, multicultural competencies, training level, and motivation remain unclear. It is possible that using criterion variables that predict behavior or other implicit mechanisms may be more sensitive to capturing the role of implicit race bias in multicultural counseling competency development. As the literature continues to develop in the context of practitioner training, researchers are encouraged to consider the impact of implicit biases as they appear to influence, at least in part, attributions that practitioners make about the client's control of the resolution of a presenting concern.

Table 1

Means, standard deviations, correlations, covariance, variances, minimum scores, maximum scores, and 95% mean confidence intervals of all variables (N = 94)

Scale	Mean	SD	Min	Max	1	2	3	4	5	6	7	8
1. MCCA	1.10	1.25	0	5	<u>N/A</u>							
2. IAT	.17	.37	-.85	1.17	-.08	<u>N/A</u>						
3. CSS-C	4.72	1.99	2	10	-.17	.02	<u>3.94</u>					
4. CSS-S	9.22	2.67	3	14	-.24*	-.17	.33*	<u>2.67</u>				
5. SEE	38.24	3.27	30	45	.28**	-.20	-.31**	.04	<u>110.94</u>			
6. MCI	50.01	4.20	37	60	.18	-.12	-.20**	-.25*	.51**	<u>22.57</u>		
7. EMS	20.13	10.02	5	45	-.11	.30**	-.01	.13	-.23	-.09	<u>100.33</u>	
8. IMS	40.15	5.02	25	45	.23*	-.10	-.32**	.09	.53**	.25**	.13	<u>25.23</u>

Note. MCCA = Multicultural Case Conceptualization; IAT = Implicit Association Task; CSS = Cause and Solution Scales; CSS-C = Cause Scale; CSS-S = Solution Scale; SEE = Scale of Ethnocultural Empathy; MCI = Multicultural Competence Inventory; EMS = External Motivation Scale; IMS = Internal Motivation Scale. Diagonal with underlined coefficients represents item variances; data below diagonal represents correlations; data above diagonal represents covariances. * denotes $p < .05$; ** denotes $p < .01$

Table 2
Select Demographic Characteristics

Characteristic	<i>N</i> = 94
Age	<i>M</i> = 32.18 (<i>SD</i> = 9.62)
Gender	<i>n</i> (%)
Female	73 (77.7)
Male	20 (21.3)
Participant Ethnicity	<i>n</i> (%)
Asian/Pacific Islander	5 (5.3)
Black/African-American	2 (2.1)
Latino(a)/Hispanic	7 (7.4)
Native American	1 (1.1)
White/Non-Hispanic	70 (74.5)
Biracial	2 (2.1)
Other	2 (2.1)
Training Program	<i>n</i> (%)
Clinical Psychology	21 (22.3)
Counseling Psychology	36 (38.3)
Doctor of Psychology	11 (11.7)
School Psychology, PhD	11 (11.7)
Master in Social Work	3 (3.2)
Master's in Counseling	5 (5.3)
Master's in School Counseling	2 (2.1)
Degree Completed	<i>n</i> (%)
Yes	29 (30.9)
No	65 (69.1)
APA/CPA Accredited	<i>n</i> (%)
Yes	86 (91.5)
No	8.5 (8.5)
# MC Courses Completed	<i>n</i> (%)
0	16 (17)
1	42 (44.7)
2	19 (20.2)
> 3	17 (18.1)
# MC Research Projects Completed	<i>n</i> (%)
0	40 (42.6)
1-2	30 (32.0)
> 3	24 (25.4)
# MC Workshops/Seminar	<i>n</i> (%)

0	17 (18.1)
1-5	51 (54.8)
> 6	26 (21.1)
# Diverse Clients	<i>n</i> (%)
0	8 (8.5)
1-15	20 (21.5)
16-30	20 (21.5)
> 30	46 (48.5)
MC Mission Statement in Program	<i>n</i> (%)
Yes	65 (69.1)
No	6 (6.4)
Do not Know	23 (24.5)
Diversity Issues in Supervision	<i>n</i> (%)
Yes	84 (89.4)
No	9 (9.6)

Table 3
Multiple Regression and Moderation Effects

Hypothesis	Criterion	Predictor	R^2	β	SE	t	P	95% CI	Power
1	MCCA	IAT	.19	.33	.51	.64	.52	(-.69, .34)	.10
		Cond.	–	-1.04	.24	-4.37	.00*	(-1.51, -.56)	.99
		IAT \times Cond.	–	-.84	.65	-1.28	.20	(-2.14, .46)	.25
2	EMS	IAT	.08	4.95	4.35	1.14	.26	(-3.69, 13.58)	.20
		Cond.	–	.18	2.02	.10	.93	(-3.84, 4.20)	.05
		IAT \times Cond.	–	3.71	5.60	.66	.51	(-7.39, 14.81)	.10
	IMS	IAT	.01	-.56	2.25	-.25	.80	(-5.04, 3.92)	.06
		Cond.	–	-.72	1.05	-.68	.50	(-2.80, 1.37)	.10
		IAT \times Cond.	–	-.82	2.90	-2.8	.78	(-6.58, 4.93)	.06
3	CSS-C	IAT	.02	-.42	.89	-.48	.64	(-2.18, 1.34)	.08
		Cond.	–	.40	.41	.96	.34	(-.42, 1.22)	.16
		IAT \times Cond.	–	-.34	1.14	-.30	.78	(-2.60, 1.93)	.06
	CSS-S	IAT	.03	-1.46	1.18	-1.23	.22	(-3.81, .90)	.23
		Cond.	–	.74	.55	1.34	.18	(-.36, 1.84)	.27
		IAT \times Cond.	–	1.58	1.52	1.04	.30	(-1.45, 4.60)	.18
4	SEE	IAT	.03	-3.03	4.68	-.65	.52	(-12.33, 6.27)	.10
		Cond.	–	-2.32	2.18	-1.06	.29	(-6.64, 2.01)	.18
		IAT \times Cond.	–	-1.05	6.02	-.17	.86	(-13.00, 10.91)	.05
5	CSS-C	IAT	.05	1.23	1.44	.86	.39	(-1.63, 4.10)	.14
		Cond.	–	.38	.60	.64	.52	(-.81, 1.58)	.10
		Training	–	-.07	.59	-.12	.90	(-1.25, 1.10)	.05
		IAT \times Cond.	–	-1.90	1.70	-1.11	.27	(-5.28, 1.49)	.20
		IAT \times Training	–	-2.70	1.84	-1.47	.15	(-6.35, .96)	.31
		Cond. \times Training	–	.00	.84	.00	1.00	(-1.68, 1.68)	.05
		Cond. \times Training \times IAT	–	2.46	2.37	1.04	.30	(-2.26, 7.17)	.18

Hypothesis	Criterion	Predictor	R^2	β	SE	t	P	95% CI	Power
5	CSS-C	IAT	.10	1.75	1.88	.94	.35	(-1.98, 5.48)	.15
		Cond.	–	.26	.78	.34	.74	(-1.29, 1.82)	.06
		Training	–	-.07	.77	-.09	.93	(-1.60, 1.47)	.05
		IAT \times Cond.	–	-1.34	2.22	-.61	.55	(-5.76, 3.07)	.09
		IAT \times Training	–	-5.24	2.40	-2.19	.03*	(-10.00, -.48)	.58
		Cond. \times Training	–	1.09	1.10	.99	.33	(-1.10, 3.28)	.17
		Cond. \times Training \times IAT	–	4.28	3.09	1.38	.17	(-1.87, 10.43)	.28

Appendix A

Demographic Questionnaire

Age

Gender

Race

Training Program: Clinical Psychology, Counseling Psychology, Social Work, Master of Mental Health, PsyD, Other

Generation of immigration into USA

Number of multicultural courses taken

Number of multicultural research projects engaged

Number of multicultural workshops/seminars participated/conducted

Number of sessions conducting with clients with other racial backgrounds

Does your program mission statement address multiculturalism?

Have you had supervisory experiences in which diversity was addressed in some manner (e.g., minority identity development models, examination of differences between self and client, etc.)

Appendix B

Race Implicit Association Test Stimuli (Nosek, Greenwald, & Mahzarin, 2005)

Instructions: In the next task, you will be presented with a set of words or images to classify into groups. This task requires that you classify items as quickly as you can while making as few mistakes as possible. Going too slow or making too many mistakes will result in an interpretable score. This part of the study will take about 5 minutes. The following is a list of category labels and the items that belong to each of those categories.

Keep in mind

- Keep your index fingers on the “e” and “i” keys to enable rapid response.
- Two labels at the top will tell you which words or images go with each key.
- Each word or image has a correct classification. Most of these are easy.
- The test gives no results if you go slow. Please try to go as fast as possible.
- Expect to make a few mistakes because of going fast. That's OK.

For best results, avoid distractions and stay focused.

Category	Items
Good	Joy, Love, Peace, Wonderful, Pleasure, Glorious, Laughter, Happy
Bad	Agony, Terrible, Horrible, Nasty, Evil, Awful, Failure, Hurt
African American	Faces of African American people
European American	Faces of European American people

Note: Administration and Scoring: The IAT consists of five steps (or blocks), from which researchers most often use data in Steps 3 and 5 (Nosek, Greenwald, & Banaji, 2005): learning the concept dimension (step 1); sorting items into an attribute dimension (e.g., “terrible” for “Bad” and “wonderful” for “Good”; step 2); developing concept-attribute pairing (step 3); practicing to switch the spatial locations of the concepts (step 4); concept-attribute pairing, built upon from previous steps (step 5). Subsequently, participants sort items from the attribute and target concept categories with the alternate keys (e.g., Good and European American are paired, and Bad and African American are paired) which is the opposite association from the third block. Each set of stimuli is presented in a randomized manner. The IAT effect is measured by response latency from Steps 3 and 5. The basic concept is that the difference between response latencies from the two sorting steps is divided by the standard deviation of all latencies for both sorting tasks. Hence, the IAT effect (D) may be compared to Cohen’s d calculation of effect size for an individual’s responses in the task.

Appendix C

Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994)

Instructions: The following statements cover counselor practices in multicultural counseling. Indicate how accurately each statement describes you as a counselor, psychologist, or student in a mental health training program when working in a multicultural counseling situation. Give ratings that you actually believe to be true rather than those that you wish were true.

The Scale ranges from 1 (very inaccurate) to 4 (very accurate). The Scale indicates the following:

- 1- Very Inaccurate
- 2- Somewhat Inaccurate
- 3- Somewhat Accurate
- 4- Very Accurate

When working with minority clients.....

1. I perceive that my race causes the clients to mistrust me.
2. I have feelings of overcompensation, over solicitation, and guilt that I do not have when working with majority clients.
3. I am confident that my conceptualizations of client problems do not consist of stereotypes and biases.
4. I find that differences between my worldviews and those of the clients impede the counseling process.
5. I have difficulties communicating with clients who use a perceptual, reasoning, or decision-making style that is different from mine.
6. I include the facts of age, gender roles, and socioeconomic status in my understanding of different minority cultures.
7. I use innovative concepts and treatment methods.
8. I manifest an outlook on life that is best described as “world-minded” or pluralistic.
9. I examine my own cultural biases.
10. I tend to compare client behaviors with those of majority group members.
11. I keep in mind research findings about minority clients’ preferences counseling.
12. I know what are the changing practices, views, and interests of people at the present time.
13. I consider the range of behaviors, values, and individual differences within a minority group.
14. I make referrals or seek consultations based on the clients’ minority identity development.
15. I feel my confidence is shaken by the self-examination of my personal limitations.
16. I monitor and correct my defensiveness (e.g., anxiety, denial, minimizing, overconfidence).
17. I apply the sociopolitical history of the clients’ respective minority groups to understand them better.
18. I am successful at seeing 50% of the clients more than once, not including intake.
19. I experience discomfort because of their different physical appearance, color, dress, or socioeconomic status.

20. I am able to quickly recognize and recover from cultural mistakes or misunderstandings.
21. I use several methods of assessment (including free response questions, observations, and varied sources of information and excluding standardized tests).
22. I have experience at solving problems in unfamiliar settings.
23. I learn about clients' level of acculturation to understand the clients' better.
24. I understand my own philosophical preferences.
25. I have a working understanding of certain cultures (including African American, Native American, Hispanic, Asian American, new Third World immigrants, and international students).
26. I am able to distinguish between those who need brief, problem-solving structured therapy and those who need long-term, process-oriented, unstructured therapy.
27. When working with international students or immigrants, I understand the importance of the legalities of visa, passport, green card, and naturalization.

Evaluate the degree to which following multicultural statements can be applied to you.

28. My professional or collegial interactions with minority individual are extensive.
29. In the past year, I have had a 50% increase in my multicultural case load.
30. I enjoy multicultural interactions as much as interactions with people of my own culture.
31. I am involved in advocacy efforts against institutional barriers in mental health services for minority clients (e.g., lack of bilingual staff, multicultural skilled counselors, and outpatient counseling facilities).
32. I am familiar with nonstandard English.
33. My life experiences with minority individuals are extensive (e.g., via ethnically integrated neighborhoods, marriage, and friendship).
34. In order to be able to work with minority clients, I frequently seek consultation with multicultural experts and attend multicultural workshops or training sessions.

When Working with all Clients.....

35. I am effective at crisis interventions (e.g., suicide attempt, tragedy, broken relationship).
 36. I use varied counseling techniques and skills.
 37. I am able to be concise and to the point when reflecting, clarifying, and problems.
 38. I am comfortable with exploring sexual issues.
 39. I am skilled at getting a client to be specific in defining and identifying problems.
 40. I make my nonverbal and verbal responses congruent.
-

Appendix D

Multicultural case conceptualization ability score range (Ladany et al., 1997)

Instructions: Imagine that you are a practitioner for a client whose intake session notes you are about to read.

Vignette: Sam is a 19 year-old African American/European American male undergraduate student who is attending a predominantly White university. This is his first time living in a resident hall. He is seeking counseling services because he feels isolation from other students in her residence hall. Additionally, he recently ended a romantic relationship. He reported symptoms of social isolation, active avoidance of social connection, feelings of sadness, and lack of interest in pleasurable activities. He also has strong feelings of homesickness. Sam's impetuous for seeking help is because he is considering transferring from his college.

Imagine that your supervisor requested that you write a brief statement describing what you believe to be the etiology or origins of the client's psychological difficulties and an effective treatment plan or strategy for the client's psychological difficulties. You will have to write at least 3 sentences to discuss your evaluation with your supervisor.

Instructions After Reading Vignette: Write three sentences regarding: (1) the factors contributing to the etiology of the client's presenting concern and (2) areas of focus for effective treatment planning to address the client's difficulties.

MCCA Scoring:

0 = no differentiation, no integration, i.e., no indication of cultural issues in conceptualizing the client's problems

1 = low differentiation, no integration, i.e., one reference to cultural issues in conceptualizing the client's problems

2 = low differentiation, low integration, i.e., two references to cultural issues in the conceptualization of the client's problems, with one connection made between the two differentiated concepts

3 = moderate differentiation, low integration, i.e., three references to cultural issues in the conceptualization of the client's problems, with one connection made between the three differentiated concepts

4 = moderate differentiation, moderate integration, i.e., four references to cultural issues in the conceptualization of the client's problems, with two connections made between the four differentiated concepts

5 = high differentiation, moderate integration, i.e., five references to cultural issues in the conceptualization of the client's problems, with three connections made between the five differentiated concepts

6 = high differentiation, high integration, i.e., six or more references to cultural issues in conceptualizing the client's problems, with three or more connections made between differentiated concepts

Note. The original MCCA employed a brief intake report (i.e., case vignette) presenting a 19-year old African American college student seeking counseling to address his emotional reactions to a recent breakup with her boyfriend. The intake provided further information that the student attends a university with a predominantly White population, exhibited signs of depression (i.e., tearfulness, difficulty concentrating, and suicidal ideation), and has interpersonal difficulties. Multicultural conceptualization ability includes two interrelated cognitive processes: differentiation and integration. Differentiation is the ability to generate alternative hypotheses of, or perspectives on, a client's presenting concern and type of treatment to provide. Greater differentiation is reflected by a greater number of alternative hypotheses, in this case, a number of hypotheses that include race as a factor to consider other diversity factors (e.g., sexual orientation, religion, gender, socioeconomic status, etc.). Integration refers to the ability to integrate differentiated interpretations into case conceptualizations (i.e., connected to either symptoms or treatment). Higher integration is exhibited by higher numbers of racial factor identifications and integrations.

Appendix E

Cause and Solution Scale (Karuaz, Zevon, Gleason, Kurza, & Nash, 1990)*

Instructions: Think about the case study that was presented to you in this study. The items below concern your clinical impression of the cause or causes of your client's presenting concern. Select one item for each of the following questions.

Attributions of Client Responsibility

To what extent do you feel the client is personally responsible for the cause of the problems?

To what extent do you feel the client could have avoided the problems?

To what extent do you feel the client could have controlled the cause of the problems?

Attributions of Responsibility for the Solution to Client Problems

To what extent do you feel the client is personally responsible for creating a solution to the problems?

To what extent do you feel the client can overcome the problems alone?

To what extent do you feel the client can control the solution to the problems?

Note. *Scale adapted for counseling participants to consider work with a client. Participants rate 6 items ranging from 1 (*not at all*) to 7 (*very much*).

Appendix F

Internal Motivation to Respond Without Prejudice Scale (IMS)

and External Motivation to Respond Without Prejudice Scale (EMS) (Plant & Devine, 1998)

Instructions: The following questions concern various reasons or motivations people might have for trying to respond in nonprejudiced ways toward Black people. Some of the reasons reflect internal-personal motivations whereas others reflect more external-social motivations. Of course, people may be motivated for both internal and external reasons; we want to emphasize that neither type of motivation is by definition better than the other. In addition, we want to be clear that we are not evaluating you or your individual responses. All your responses will be completely confidential. We are simply trying to get an idea of the types of motivations that students in general have for responding in nonprejudiced ways. If we are to learn anything useful, it is important that you respond to each of the questions openly and honestly. Please give your response according to the scale below.

External motivation items

Because of today's PC (politically correct) standards I try to appear nonprejudiced toward Black people.

I try to hide any negative thoughts about Black people in order to avoid negative reactions from others.

If I acted prejudiced toward Black people, I would be concerned that others would be angry with me.

I attempt to appear nonprejudiced toward Black people in order to avoid disapproval from others.

I try to act nonprejudiced toward Black people because of pressure from others.

Internal motivation items

I attempt to act in nonprejudiced ways toward Black people because it is personally important to me.

According to my personal values, using stereotypes about Black people is OK. (R)

I am personally motivated by my beliefs to be nonprejudiced toward Black people.

Because of my personal values, I believe that using stereotypes about Black people is wrong.

Being nonprejudiced toward Black people is important to my self-concept.

Note. (R) indicates reverse coded item. Participants rate 10 items ranging from 1 (*strongly disagree*) to 9 (*strongly agree*). When participants complete the scales, the IMS and EMS items are intermixed. Internally motivated individuals tend to express less prejudiced attitudes than those who are more externally motivated. The IMS had strong correlations with measures of prejudiced attitudes, but had weak relationships with measures of social evaluation and self-presentation. On the other hand, the EMS had small to moderate correlations with items that measure prejudiced attitudes and social evaluation; indicating that the EMS is related to different constructs.

Appendix G

Scale of Ethnocultural Empathy (Wang et al., 2003)

Empathic Feeling and Expression

1. When I hear people make racist jokes, I tell them I am offended even though they are not referring to my racial or ethnic group.
2. I don't care if people make racist statements against other racial or ethnic groups. (R)
3. I rarely think about the impact of a racist or ethnic joke on the feelings of people who are targeted. (R)
4. When other people struggle with racial or ethnic oppression, I share their frustration.
5. I feel supportive of people of other racial and ethnic groups, if I think they are being taken advantage of.
6. I share the anger of those who face injustice because of their racial and ethnic backgrounds.
7. I share the anger of people who are victims of hate crimes (e.g., intentional violence because of race or ethnicity).
8. When I know my friends are treated unfairly because of their racial or ethnic backgrounds, I speak up for them.
9. I get disturbed when other people experience misfortunes due to their racial or ethnic backgrounds.
10. I am touched by movies or books about discrimination issues faced by racial or ethnic groups other than my own.
11. When I see people who come from a different racial or ethnic background succeed in the public arena, I share their pride.
12. I am not likely to participate in events that promote equal rights for people of all racial and ethnic backgrounds. (R)
13. I seek opportunities to speak with individuals of other racial or ethnic backgrounds about their experiences.
14. When I interact with people from other racial or ethnic backgrounds, I show my appreciation of their cultural norms.
15. I express my concern about discrimination to people from other racial or ethnic groups.

Empathic Perspective Taking

16. It is easy for me to understand what it would feel like to be a person of another racial or ethnic background other than my own.
17. It is difficult for me to relate to stories in which people talk about racial or ethnic discrimination they experience in their day to day lives. (R)
18. It is difficult for me to put myself in the shoes of someone who is racially and/or ethnically different from me. (R)
19. I know what it feels like to be the only person of a certain race or ethnicity in a group of people.

20. I can relate to the frustration that some people feel about having fewer opportunities due to their racial or ethnic backgrounds.
21. I feel uncomfortable when I am around a significant number of people who are racially/ethnically different than me. (R)
22. I don't know a lot of information about important social and political events of racial and ethnic groups other than my own. (R)

Acceptance of Cultural Differences

23. I feel irritated when people of different racial or ethnic backgrounds speak their language around me. (R)
24. I feel annoyed when people do not speak standard English. (R)
25. I get impatient when communicating with people from other racial or ethnic backgrounds, regardless of how well they speak English. (R)
26. I do not understand why people want to keep their indigenous racial or ethnic cultural traditions instead of trying to fit into the mainstream. (R)
27. I don't understand why people of different racial or ethnic backgrounds enjoy wearing traditional clothing. (R)

Empathic Awareness

28. I am aware of how society differentially treats racial or ethnic groups other than my own.
29. I recognize that the media often portrays people based on racial or ethnic stereotypes.
30. I can see how other racial or ethnic groups are systematically oppressed in our society.
31. I am aware of institutional barriers (e.g., restricted opportunities for job promotion) that discriminate against racial or ethnic groups other than my own.

Note: Reverse-scored items are indicated (R).

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VITA

Leia Charnin grew up in Charlotte, North Carolina. She developed her interest in stereotype and prejudice formation while obtaining her Bachelor of Arts degree in Psychology from the University of North Carolina at Chapel Hill in 2007. During her undergraduate work, Ms. Charnin completed an honors thesis which addressed memory for emotional information. Shortly after completion of her undergraduate work, Ms. Charnin served as a research coordinator with the Cystic Fibrosis and Pulmonary Research and Treatment Center at the University of North Carolina-Chapel Hill. After holding this position for two years, Ms. Charnin began doctoral training in Counseling Psychology at the University of Missouri – Kansas City. She received numerous training experiences in child and adult clinical psychology and went on to complete her pre-doctoral internship at the Center for Counseling and Student Development at the University of Delaware.

The next part of Ms. Charnin's professional journey will include a post-doctoral psychology fellowship, specializing in Posttraumatic Stress Disorder, with the Veterans Affairs Boston Healthcare System. Upon completion of her postdoc, Ms. Charnin intends to continue serving individuals through clinical work, research, training, and social justice advocacy as a licensed psychologist.

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