QUANTITATIVE STUDY OF COUNSELOR CULTURAL COMPETENCE, IMPLICIT RACIAL BIAS, AND RACE

by

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Abstract

The purpose of this correlational study was to ascertain if statistically significant mean differences existed between races of mental health counselors for cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey (MAKSS) and implicit racial bias as measured by the Implicit Association Test (IAT). It also pursued an examination of any statistically significant relationship that existed between the scores of cultural competence as measured by the MAKSS and implicit racial bias as measured by the IAT within each racial category. The study addressed the gap in research that had not evaluated self-reported cultural competence and implicit bias solely with a 'Black/White' IAT. The criterion variables were cultural competence and implicit bias. The predictor variable was the self-identified race of the mental health counselor. This nationwide, web-based study was completed by 59 licensed mental health counselors over age 18. There were two research questions for this study. The first research question was: is there a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test? The second research question was: is there a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test within each racial category? A one-way MANOVA and correlations were employed to analyze the data collected. Finding a significant statistical difference required a post-hoc to determine where differences might lie in the components of the MAKSS or IAT. The null hypothesis was rejected for the overall total cultural

competence on the MAKSS and racial preference on the IAT. The null hypothesis was rejected for Euro-Americans as they demonstrated a statistically significant relationship between the MAKSS and IAT. Final analysis provided recommendations for counselor education and supervision professionals to use in education and supervision in the development of future mental health counselors.

Dedication

Whenever I feel weak, I remember those who make me strong. Moreover, whenever I start to doubt myself, I remember those who believe in me. When I am strong, I give to those around me who are weak because I believe in them.

I dedicate this work to my family and friends who were hugely supportive during this long and arduous process. My friends, Lakisha, Thoressa, and Cokeitha (SAM), for making me laugh and allowing me to be vulnerable. My cousin, Ciarra Jean-Marie Dortche, for quantitative support. A very specific dedication goes to my mother and grandparents, who taught me the value of education. My husband-Franklin Muhammad, you endured all my emotional moments and made me feel safe.

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CHAPTER 1. INTRODUCTION

Since the 20th century, racial disparities in mental health care have increased (Benuto, Singer, Newlands, & Casas, 2019; Bilkins, Allen, Davey, & Davey, 2016; Cuevas, O'Brien, & Saha, 2016; Owen et al., 2016; Walker, 2020). African American clients have reported a deep mistrust of mental health counselors due to historical events (Cuevas et al., 2016; Schaa, Roter, Biesecker, Cooper, & Erby, 2015; Walker, 2020). As a result, African Americans are twice as likely to perceive discrimination by mental health counselors that demonstrate a lack of care or desire to understand the African American plight (Albert, 2016; Belgrave & Abrams, 2016; Cruz, Rodriguez, & Mastropaolo, 2019; Duguid & Thomas-Hunt, 2015). This lack of care, coupled with African Americans identifying behaviors from clinicians that demonstrate stereotypical beliefs taught in society about the culture, leads to a lack of cultural competence (Bloombaum, Yamamoto, & James, 1968; Cruz et al., 2019). A mental health counselor is fully licensed by the state of residence to provide mental health therapy (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). In addition, for the purposes of this study, a mental health counselor is not a social worker, psychologist, psychiatrist, or physician.

Cultural competence is the ability to counsel clients from other cultures with awareness, knowledge, and skill; to ensure quality mental health care, counselors must set aside cultural barriers that might exist between themselves and their clients (Benuto, Singer, Casas, González, & Ruork, 2018b; Dillon et al., 2016; Flynn, Betancourt, Emerson, Nunez, & Nance, 2019; Lu, 2017; Ratts, 2017; Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016; Tormala, Patel, Soukup, & Clarke, 2018). A lack of cultural competence is evident through the use of non-collaborative language, stereotyping behavior, and dismissiveness when discussing

discriminatory experiences (Belgrave & Abrams, 2016; Bilkins et al., 2016; Cruz et al., 2019; Cuevas et al., 2016; Owen et al., 2016). Furthermore, a culturally competent counselor understands how cultural conditioning establishes their implicit bias and impacts their worldview and interactions with their African American clients (Benuto, Casas, & O'Donohue, 2018a; Dillon et al., 2016; Flynn et al., 2019; Lu, 2017; Ratts et al., 2016; Tormala et al., 2018).

Cultural conditioning is steeped in society through the constant influx of institutional, socio-political, and culturally symbolic narratives, whether negative or positive (Neblett, 2019). Tormala et al. (2018) posited that cultural conditioning is established in mental health counselors through the intergenerational transmission of racial beliefs about power and privilege. Sue (2004) asserted:

> to challenge that worldview as being only partially accurate, to entertain the notion that it may represent a false illusion, and to realize that it may have resulted in injustice to others make seeing an alternative reality frightening and difficult. (p. 762)

Therefore, the prevalence of cultural conditioning is often denied and rejected based on an individual's worldview and may be present in the implicit bias underlying a counselor's actions. A healthcare professional who exhibits behaviors based on cultural conditioning derails the therapeutic alliance that clients need to continue treatment and discourages clients from seeking help in the future (Cuevas et al., 2016; Hyatt, 2019). Implicit bias is a perspective that is sometimes unconsciously attributed by the counselor to a person, place, or thing and that may not express the belief system of the counselor (Carpenter et al., 2019; Charnin, 2015; Greenwald, McGhee, & Schwartz, 1998). Implicit biases take many forms that are explicit to the counseling client even if not noticed by the mental health counselor (Mendonça, Mata, & Vohs, 2019). In an

attempt to avoid implicit bias, some mental health counseling professionals lean toward colorblindness in an attempt to demonstrate equality (Sue, 2013).

Hook et al. (2016b) and Jerald, Cole, Ward, and Avery (2017) agreed that a counselor who adopts the viewpoint of not seeing race may make a client feel that their identity as an African American is being erased and dismissed in therapy. Arguing that cultural worldviews are vastly different and require different treatment modalities opens an opportunity for counselor education and supervision (CES) professionals to enhance mental health counseling training and practice by embracing multicultural counseling competence through the use of the multicultural counseling theory (MCT) and finally multicultural cultural and social justice counseling competencies (MCSJCC).

Multicultural Counseling Competencies (MCC; Sue, 2004; Sue, Arredondo, & McDavis, 1992a, b; Sue & Sue, 1990, 2013) began their rise in the 1950s to bring more awareness to the concept of cultural stereotyping (Thomas, 1962), which was later called cultural conditioning (Bloombaum et al., 1968), by looking at a counselor's therapeutic acumen for working with marginalized communities. MCT was enhanced when the Association for Multicultural Counseling and Development (AMCD) established a committee to expand MCC in the 1990s, more recently updated to the Multicultural and Social Justice Counseling Competencies (MCSJCC; Ratts et al., 2016; Sue, 1982). The MCSJCC requires CES professionals to assist future counselors in considering how their "attitudes and beliefs, knowledge, skills, and actions" (Ratts et al., 2016, p. 3) intersect with the worldview of the client, thus impacting the therapeutic alliance. In counseling, cultural competence presumes that a counselor educator's role is to ensure new counselors acquire skills that empower their ability to seek social justice by allowing them to create treatment plans, work in minority communities, and advocate for equitable

systemic policies for those who suffer the most significant disparities (Memon et al., 2016; Neblett, 2019; Sleeter, 2017; Volpe, Dawson, Rahal, Wiley, & Vesslee, 2019; Walker, 2020).

Duguid and Thomas-Hunt (2015) pointed out that the dichotomy between cultural conditioning and therapeutic outcomes experienced in mental health treatment is a result of the interaction between cultural competence and implicit racial bias. Duguid and Thomas-Hunt argued that educators must improve counselor education in order to increase access to quality mental healthcare in marginalized communities. This study uses a quantitative methodology and a correlational research design to examine whether a statistically significant mean difference exists between and within the races of mental health counselors as measured by the Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) and the Implicit Association Test (IAT) to assess implicit bias.

Chapter 1 provides a detailed background and statement of the problem regarding how African Americans experience dismissive attitudes, microaggressions, and invalidations of culture in therapy. Chapter 1 also discusses the purpose and significance of this study. The researcher will identify the research design, research questions, assumptions, and limitations of this multicultural counseling research, along with the definition of terms. Chapter 1 ends with a summary of the organization of the remainder of the study.

Background of the Problem

Cultural conditioning arguably challenges the notion that all mental health counselors operate from a foundation of equality (Hayes, Owen, & Bieschke, 2015; Miyamoto et al., 2019). Many minority clients have voiced feelings of mistrust when working with counseling professionals of a different race (Bilkins et al., 2016; Castro et al., 2015; Hayes et al., 2015; Miyamoto et al., 2019; Tajeu et al., 2015). Often, these feelings of mistrust result from dismissed

narratives and demonstrations of ambiguous disrespect related to the clients' values and beliefs (Graham, Calloway, & Roemer, 2015; Mann & Ferguson, 2015; Cuevas et al., 2016). Moreover, the teachers identified that microaggressions, invalidations, racial erasure, and treatment through the cultural lens of westernized conditioning can be detrimental to African American clients in particular (Cuevas et al., 2016; Graham et al., 2015; Mann & Ferguson, 2015; Phillips, 2020; Samuel, 2020; Walker, 2020; Williams, 2020).

Chae et al. (2020) identified that racial discrimination contributes to racial disparities in healthcare and "addressing health inequities will require efforts to curtail endemic racial discrimination" (p. 216). Even African Americans with higher socioeconomic status and health insurance equal to their Euro-American counterparts continue to experience disparities similar to African Americans in poverty (Conway, Lipsey, Pogge, & Ratliff, 2017; Cortland et al., 2017; Cuevas et al., 2016; Raines, 2015; Walker, 2020). Therefore, counselors who do not recognize that discrimination still exists for African Americans may struggle with clients who did not grow up in an impoverished urban neighborhood or who are affluent (Miyamoto et al., 2019; Ratts et al., 2016). The authors further agreed that the counselor may find that their client does not return to counseling due to the counselor imposing the counselor power/privilege dynamic to set aside the client's experience. Volpe et al. (2019) expressed that African American experiences are generally absent from mental health theories. They acknowledged that "when given the same weight as psychological science's more traditional forms of evidence, [the African American experience] will combat the notion that individual responsibility, rather systemic racism, is the fundamental cause of racial health disparities" (p. 310). Cruz et al. (2019), Hook et al. (2016a, b), and Shih, Wout, and Hambarchyan (2015) echoed the same findings by arguing that

dismissing the client's experience communicates a lack of multicultural awareness through verbal microaggressions, stereotyping, and microinvalidation.

Benuto and O'Donohue (2015) expressed that many evidence-based theories promoting established cultural competencies have not demonstrated effectiveness in minority communities because Western attitudes, beliefs, and values infiltrate cultural modifications to interventions. However, Charnin (2015) argued that beyond theory, counselors' perspectives impact the diagnosis and treatment of clients. Barlow (2016) agreed and identified that an institution may enable cultural conditioning by promoting subtle rather than overt challenges to a student's negative cultural beliefs. Theories that lack non-Western cultural perspectives affect how students build therapeutic alliances and incorporate treatment plans (Yamaguchi & Beattie, 2019).

Yamaguchi and Beattie (2019) demonstrated that social bias was a tremendous influence on a student's judgement on the "Black/White" implicit bias assessment, where students generally chose the majority culture even when attempting to overcome their inherent social bias. Sleeter (2017) argued that students were experiencing "white fatigue" and "false empathy" (p. 56) when discussing racial disparities and experiences of oppression among other cultures during course work (Ogunyemi et al., 2020; Samuel, 2020; Sue, 2004; Walker, 2020). Recognizing that cultural competence is affected by cultural conditioning and implicit bias, researchers have implemented multicultural counseling programs designed to educate students on critical thinking, implicit bias, and cultural conditioning (Flynn et al., 2019).

Prior to Sue (2004) studying multicultural competence in mental health counseling, researchers were discussing the effects of stereotyping and cultural conditioning for minority communities seeking counseling services (Bloombaum et al., 1968; Thomas, 1962). In order to

address this issue, coursework, seminars, and conferences were implemented that introduced counselors to differences in cultural communication styles, proxemics, kinesics, paralanguage, high and low contexts, and non-verbal microaggressions (Hansen, Pepitone-Arreola-Rockwell, & Greene, 2000; Mays, 1985; Sue, 1990; Sue & Sue, 1999). As the new guidelines were developed to deviate from a Western theory on counseling competency, a new direction was implemented through CACREP which began its rise during the multicultural counseling revolution of the 1950s and 1960s (Sue & Sue, 1990, 1992a, b, 2013; West & Moore, 2015).

The new guidelines required accredited schools to administer a culturally sensitive education, invoking critical thought toward diversity and setting the standard for professionalism (CACREP, 2016). West and Moore (2015) expressed that CACREP accreditation was designed to ensure that counseling programs were evaluated and structured and provided students relevant multicultural guidance. However, CACREP (2016) removed the diversity self-awareness component for counseling programs that once existed in the 2009 version. These multicultural programs aim to help new counselors recognize and move beyond decades of negative stereotyping and cultural conditioning (Cuevas et al., 2016; Kumar, Karabenick, & Burgoon, 2015; Ratts et al., 2016; Schmidt & Axt, 2016; Sue & Sue, 2013; Sue, 1990; Sue & Sue, 1999; Tormala et al., 2018; Wang, Otgaar, Bisback, Smeets, & Howe, 2019).

Cultural Conditioning

Cultural conditioning is the influence of authority figures, institutions, and media in developing, defining, and determining societal norms that impact daily interactions (Duguid & Thomas-Hunt, 2015; Tormala et al., 2018, Patel et al., 2018). Thomas (1962) explained that "22.6% [of the counselors interviewed] were culturally stereotypic in terms of imputations of superstitiousness, changeability in impulse, grasp of abstract ideas, and distinction between

illusion and facts" (p. 898) concerning Mexican Americans, African Americans, Japanese Americans, Chinese Americans, and those of Jewish descent. Seventy-nine percent of the same counselors interviewed exhibited a worldview of more "subtle stereotypic attitudes" (Bloombaum et al., 1968, p. 99). Tormala et al. (2018) argued that in order to understand cultural competency, a shared understanding that cultural conditioning shapes the attitudes, beliefs, and worldview of the counselor and client is necessary.

Throughout history, cultural conditioning has shaped implicit biases that could compromise cultural competence and cultural humility (Duguid & Thomas-Hunt, 2015; Tormala et al., 2018). Samuel (2020), Sue et al. (2007), Velez, Cox, Polihronakis, and Moradi (2018) and Walker (2020) agreed that the most common racial microaggressions reported by clients were that counselors dismissed stereotyping and implicit bias experiences or avoided discussing cultural issues entirely. Scholars have recognized a dichotomy between cultural competence and implicit bias in mental healthcare and advocated for institutional interventions, particularly in African American communities (Ahmed, Wilson, Henrikson, & Jones, 2011; Sue, 1990; Wade & Bernstein, 1991). Advocacy has resulted in studies that investigated the connection between cultural competence and implicit bias (Boysen, 2009; Charnin, 2015).

The literature revealed that counselors, educators, and supervisors are exhibiting explicit behaviors that are more ambiguous (e.g., microaggressions, dismissiveness, or microinvalidations) and embracing colorblindness as a new form of covert racism (Flynn, 2015; Fong, Ficklin, & Lee, 2017; Haskins & Singh, 2015; Hyatt, 2019; Mann & Ferguson, 2015; Samuel, 2020; Sue et al., 2007; Walker, 2020). Flynn (2015) recognized that cultural conditioning affects institutional access to care for marginalized communities. Fong et al. (2017) expressed that microaggressions in the classroom, lack of minority mentorship, adverse campus

climates, and tokenism are established in the culture and policies of many universities. Researchers have reported that students have experienced fatigue, guilt, and anger when confronted with assignments that requested they challenge their worldview toward minority culture (Flynn, 2015; Fong et al., 2017; Ogunyemi et al., 2020). Students often dismissed discussions of racial disadvantage, with the reasoning that African Americans gained socioeconomic and educational advantages and class elevation with the election of an African American president (Schmidt & Axt, 2016; Skinner & Cheadle, 2016; Ogunyemi et al., 2020; Sleeter, 2017).

A thorough assessment of mental health counselors' cultural conditioning could enhance a counselor's ability to understand how implicit racial bias empowered their worldview and diminished their clients' perspectives (Edwards, 2016; Lu, 2017). At the same time, acknowledging, assessing, and adjusting to multicultural competencies that embrace cultural humility, cultural sensitivity, and cultural competence may further encourage quality care, minimize implicit biases that hinder a successful therapeutic alliance, and increase help-seeking behaviors from African American clients (Edwards, 2016; Hook et al., 2016a; Lu, 2017). These evaluations require a clear theoretical focus to move the research forward. There is a need for research that examines self-assessments of multicultural competence, implicit bias, and race to enhance multicultural counseling ideology, pedagogy, practicums, and internships that challenge cultural conditioning and promote multicultural counseling competence (Chan, Cor, & Band, 2018; Lu, 2017; Ratts et al., 2016).

Multicultural Counseling Competencies

In the 1960s, MCC expanded counselor development to include a comprehension of the therapist's worldview through a cultural conditioning lens (Bloombaum et al., 1968; Ratts et al.,

2016; Sue, 1999; Thomas, 1962). Sue (1990, 1999) espoused that the culturally conditioned counselor is "culturally biased against people whose values differ from those of Western societies" (p. 816). Throughout the 1990s, MCC were studied extensively by presidential task forces and in universities (Sue, 1999). The MCC sought to develop innovative perspectives on theories that would move marginalized communities into the forefront of mental health counseling proficiencies (Sue & Sue, 1999). In conferences and research, counselor educators and supervisors initiated racial dialogue, dissected minority psychology and promoted social justice advocacy (Sue, 1999; Sue & Sue, 1999; Sue & Sue, 2013).

MCT and MCC were further expanded in 2015 when the AMCD expressed a desire to assist mental health counselors in updating their perspectives on multicultural competency (Ratts et al., 2016). A committee was formed to develop MCSJCC that illuminated how power, privilege, and oppression influence a counselor's cultural competence (Ratts et al., 2016). Benuto et al. (2018b) reflected on MCT and MCSJCC and voiced that the lack of cultural sensitivity as a main tenet diminished the counselor's attempts at reversing cultural conditioning. The current research utilized the MCSJCC with a focus on the cultural conditioning tenet as the theoretical foundation.

Alexander Thomas (1962) researched the pseudo-transference of a counselor's cultural stereotyping worldview onto the client. Thomas posited that counselors hold immense responsibility for acknowledging "the possibility of culturally influenced, unhealthy stereotypes expressing themselves with any patients toward whom such prejudices might exist" (p. 898). Thomas expressed that cultural competence required the mental health counselor to be aware of their worldview and responsible for the challenges it may present for clients in therapy. Thomas discussed the management of worldview, stereotyping, and bias as qualities of mental health

counselors that had a direct impact on the therapeutic alliance. In 1968, cultural stereotyping was termed cultural conditioning by Bloombaum et al. (1968). Cultural conditioning is defined as learned associations, connotations, and stereotypes propagated by institutions, television, magazines, authoritative bodies, and personal experiences throughout the life of the counselor; these elements develop into the counselor's internalized beliefs about a culture (Bloombaum et al., 1968; Edwards, 2016; Miyamoto et al., 2019; Spencer, Charbonneau, & Glaser, 2016; Tormala et al., 2018). Well after Thomas (1962) and Bloombaum et al. (1968), counseling terminology began to shift from stereotyping and cultural conditioning to cultural competence (Sue et al., 1982) and MCC (Ratts et al., 2016) to express a mental health counselor's capacity to work with marginalized communities.

Beyond the Bloombaum et al. (1968) study, there is no research so far that has utilized MCSJCC's cultural conditioning tenet as a lens to investigate self-reported scores of cultural competence, implicit bias, and race among mental health counselors. It is vital to understand how cultural competence training is affected by bias and how the concept of cultural conditioning provides a commonality among counselors to begin the discussion (Barlow, 2016; Mays, 1985; Sue, 1990; Sue & Sue, 1999; Wade & Bernstein, 1991). Gillem et al. (2016) posited that most self-assessments allow counselors to look at the external factors that challenged cultural competence (e.g., institutional racism, the Black church, and stigma), resulting in personal bias (e.g., cultural conditioning) often being dismissed in counseling sessions (Bilkins et al., 2016; Conway et al., 2017; Duguid & Thomas-Hunt, 2015; Eyal, Steffel, & Epley, 2018; Sandage, Jankowski, Beilby, & Frank, 2015; Taylor & Kuo, 2018). Overcoming cultural conditioning empowers CES professionals as they guide future mental health counselors.

Counselor Education

CES professionals are tasked with educating and supervising new mental health counselors. The certifying body for counselors, CACREP, states that programs must have a contextual understanding of cultural diversity and include the concept in the curriculum of theories and models (CACREP, 2016). They do not, however, require explicit practice or demonstration of knowledge and skill through immersion within internships or residencies (CACREP, 2016). Mental health is the representation of the emotional, psychological, and social well-being of an individual (Furnham & Swami, 2018). Furnham and Swami (2018) reported that mental health is assessed by trained mental health counselors for the purpose of offering treatment when the client is experiencing a disruption in their mental well-being. Ingram (2012) and Sue (1990) agreed that treatment and case formulation must be assessed according to the cultural context of the client, requiring acumen in MCC and MCSJCC (Ratts et al., 2016).

The MCSJCC provides counselor educators with the tools required to teach new counselors skills that prepare them to enter the world of intersectionality as effective counselors and advocates with diverse populations. Counseling minority communities requires the counselor educator and mental health counselor to exhibit the capacity to express empathy, tolerance, and a relativistic perspective while adapting to ambiguity without dismissing the client's story in the therapeutic process (Burdine & Koch, 2019). Holcomb-McCoy (2000) posited that mental health counseling professionals needed to bring interventions to the therapy environment that incorporated and considered the intersectionality of a client's race, background, gender, values, socioeconomic status, and beliefs in an effort to balance strategies that work within their clients' culture and universal settings. The MCSJCC urges CES professionals and future mental health counselors to scrutinize their worldview through (a) gaining self-awareness, (b) obtaining an

understanding of their clients' worldviews, (c) facilitating a healthy counseling relationship, and (d) implementing counseling and advocacy interventions (Ratts et al, 2016; Sue & Sue, 1990; 1999).

Researchers expressed in multiple studies that a lack of multicultural perspectives in treatment contributed to mental health dysfunction for African American clients (Graham et al., 2015; Holmes, Facemire, & DaFonseca, 2016). Researchers acknowledged that ignoring the societal perspectives that influence cultural ineptitude would make the task of training new multi-culturally astute counselors challenging (Abbott, Pelc, & Mercier, 2019; King et al., 2019; Sue & Sue, 2013). King and Borders (2019) argued that counseling students experience a range of emotions that contribute to their reactions to various cultures, making reluctance difficult to comprehend for many counseling educators. Acknowledging a cultural competence deficiency requires CES professionals to evaluate their own cultural competence without providing socially acceptable responses on the researcher's assessments (Cuevas et al., 2016; Neblett, 2019; Tormala et al., 2018). Sue (1995) expressed that culturally competent CES professionals should transfer skills that encourage new counselors to think critically and obtain knowledge of other cultures.

Benuto et al. (2018a) expanded the call for CES professionals to promote skills that consider the client's diverse circumstances beyond the counselor worldview. Enhanced multicultural competence counseling coursework was intended to guide students toward providing quality mental health services to diverse communities. Many challenges exist in evaluating multicultural learning: (a) curricula assumed that the educator was culturally competent as outlined in the MCSJCC standards (Barlow, 2016), (b) participants of studies are generally graduate students (Benuto et al., 2018a), (c) assessments are often self-reporting tools

(Dillon et al., 2016; Gillem et al., 2016) and (d) after matriculation, there is a lack of assessment for growth in action, awareness, knowledge, skills, or attitudes and belief.

The 1990s and 2000s brought assessments to mental health counseling that presented a pre-post depiction of graduate students. D'Andrea, Daniels, & Heck's (1991) MAKSS found that students increased their multicultural awareness, knowledge, and skills with an additional 36 to 45 hours of multicultural training in both classroom and workshop settings. Though much has been accomplished, more work is required as researchers and marginalized clients continue to report disparities in mental health care (Albert, 2016; Belgrave & Abrams, 2016; Conway et al., 2017; Cortland et al., 2017; Cruz et al., 2019; Rodriguez & Mastropaolo, 2019; Cuevas et al., 2016; Duguid & Thomas-Hunt, 2015; Raines, 2015; Samuel, 2020; Walker, 2020).

Statement of the Problem

There is a problem in marginalized communities where disparities in mental healthcare have increased disproportionately over the last decade across socio-economic status, class, education, and access to treatment (Dillon et al., 2016; Volpe et al., 2019). These disparities produce more anxiety, depression, and relationship discord in families (Cruz et al., 2019; Cuevas et al., 2016; Miyamoto et al., 2019; Velez et al., 2018; Walker, 2020). What is known is that marginalized communities have experienced barriers limiting access to quality care through perceived microaggressions and documented institutional racism, diminishing their desire to seek therapy (Cuevas et al., 2016; Memon et al., 2016; Neblett, 2019; Rikard, Hall, & Bullock, 2015; Samuel, 2020; Walker, 2020). Yet, it is unknown how cultural competence and implicit racial bias differ across racial identities or if there is a correlation between cultural competence and implicit bias within the racial groups (Cuevas et al., 2016; Duguid & Thomas-Hunt, 2015; Houshmand, Spanierman, & De Stefano, 2017; Katz & Hoyt, 2014; Mendonca et al., 2019).

Researchers have speculated about the reasons for this increase, such as medical mistrust, inadequate access to treatment, stigma, loss of faith, the mental illness itself, social conditioning (Bilkins et al., 2016; Eyal et al., 2018) and lack of culturally competent mental health counselors (Cuevas et al., 2016; Dillon et al., 2016; Flynn et al., 2019; Tormala et al., 2018).

The research on mental health counselor's cultural competence indicated their self-reported high cultural competence is based on the level of training they have attained (Duguid & Thomas-Hunt, 2015; Eyal et al., 2018). Mental health counselors dismissed personal implicit bias (Benuto et al., 2019; Conway et al., 2017; Flynn et al., 2019; Mendonca et al., 2019; Paone, Malott, & Barr, 2015). The evaluation of a possible significant statistical difference between cultural competence on MAKSS (D'Andre et al., 1991) and implicit racial bias on IAT (Greenwald et al., 1998a) may assist in understanding their relationship and contribution to mental healthcare disparities in the African American community (Samuel, 2020; Walker, 2020).

Disparities in mental health care have increased disproportionately in the African American community over the last century across socioeconomic status, class, education, and access to treatment (Dillon et al., 2016; Volpe et al., 2019). A host of researchers have established that cultural conditioning has a tendency to solidify barriers in counseling and reduce the quality of mental healthcare in marginalized communities (Bilkins et al., 2016; Conway et al., 2017; Duguid & Thomas-Hunt, 2015; Eyal et al., 2018; Sandage et al., 2015). Moreover, many African Americans have encountered mental health counselors who were not equipped to understand minority circumstances and contexts (Barden, Sherrell, & Matthews, 2017; Cuevas et al., 2016; Davis et al., 2016). Researchers have speculated about the reasons for this increase, such as medical mistrust, inadequate access to treatment, stigma, perceived loss of faith, the mental illness itself, cultural conditioning (Bilkins et al., 2016; Eyal et al., 2018; Mays, 1985),

and lack of culturally competent mental health counselors (Cuevas et al., 2016; Dillon et al., 2016; Flynn et al., 2019; Tormala et al., 2018).

Purpose of the Study

The purpose of this quantitative correlational study was to contribute to the body of knowledge regarding CES by addressing the relationship between the implicit racial bias and cultural competence of mental health counselors. Over the years, counseling professionals were asked to implement cultural competence interventions and advocate for dialogue that embraces cultural competence (Ratts et al., 2016) as they worked to understand how their unconscious bias imprinted on the therapy they provided within marginalized communities (Baker, Gaulke, & Smith, 2015; Dunac & Demir, 2017; Velez et al., 2018; Volpe et al., 2019). However, researchers posited that if counselors continued ignoring the relationship between implicit racial bias and cultural competence, they would make it difficult for any marginalized clients to experience a safe environment to express their challenges and concerns (Bilkins et al., 2016; Cuevas et al., 2016; Mendonca et al., 2019).

Paone et al. (2015) indicated that counselors often gave socially acceptable responses, sometimes unconsciously, about their cultural competence to protect themselves and the industry. For African American students, current multicultural competence curriculum material produces anger and frustration as their experiences are dismissed and minimized (King & Borders, 2019). Prior to MCSJCC coursework, many new counselors were not aware of or rejected the notion that they have implicit bias or that it affected their daily interactions with minorities (Memon et al., 2016; Mendonca et al., 2019).

Previous studies discovered that counselors tend to express elevated cultural competence in self-assessments (Gillem et al., 2016; Miyamoto et al., 2019) such as the MAKSS (D'Andrea

et al., 1991). In the literature, there is no universal assessment tool accepted within the mental health profession that represents the unconscious side of self-reporting (Mendoca et al., 2019). Therefore, the IAT allows for the representation of subtle attitudes stemming from implicit bias that contribute to the diminished help-seeking behaviors of marginalized clients (Kumar et al., 2015; Mendoca et al., 2019; Owen et al., 2016; Sleeter, 2017; Tormala et al., 2018). Although CES professionals hope that the IAT may become more accepted within the CES profession by making a connection between cultural competence and implicit bias for future counselors, this research is not seeking to make the IAT a universal tool, as that is outside the scope of this study.

Significance of the Study

The significance of this study is in its appraisal of mental health counselors' implicit racial bias in relation to their self-reported cultural competence (Duguid & Thomas-Hunt, 2015; Eyal et al., 2018). The results are expected to address the gap in research that explores cultural competence in self-report assessments with respect to qualitative discussions of therapeutic misalignment in clients' self-reports (Cruz et al., 2019; Cuevas et al., 2016; Edwards, 2016). The current research informs professionals and organizations like CES, the AMCD, the American Counseling Association (ACA), the American Association of Marriage and Family Therapy (AAMFT), the American School Counselor Association (ASCA), and the International Association of Marriage and Family Counselors (IAMFC) of the influence of cultural conditioning on counselors and their clients. Furthermore, the findings will help to guide CES in recognizing and addressing implicit bias within the teaching and supervision of new counselors across mental health professions in order to diminish the health care disparities that exist in the African American community (Haskins & Singh, 2015; Neblett, 2019; Quiros, Varghese, & Vanidestine, 2019; Samuel, 2020; Walker, 2020).

The organizations AMCD, ACA, AAMFT, ASCA, and IAMFC and CES professionals can utilize this research to illuminate approaches to education and supervision that more effectively instill cultural competence across the mental health discipline, establish standards for a global worldview for counselors, increase advocacy for marginalized communities with contextual insight, and transform counseling interventions across institutions. From counselor education to postgraduate supervision and industry organizations, programs are encouraged to promote education change as counselors dissect and understand how their implicit racial biases diminish their cultural competence (Hook et al., 2016a, b; Houshmand et al., 2017; Neblett, 2019). Mental health counselors and clients benefit when counselors practice culturally competent therapy and social advocacy (Hoover, 2016; Johnson & Possemato, 2019; Quiros et al., 2019; Volpe et al., 2019).

Research Questions

Q1 - Is there a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test?

H1 - There is a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test.

H0 - There is no statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test.

Q2 - Is there a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test within each racial category?

H1 - There is a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test within each racial category.

H0 - There is no statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test within each racial category.

Definition of Terms

Awareness. Awareness refers to the counselor's recognition of their bias, misconceptions, stereotypes, and prejudices about marginalized communities and cultures. MAKSS (D'Andrea et al., 1991) scores are the construct for cultural awareness. MAKSS reflects an understanding of collective and individual culture; negative consequences of stereotyping; cultural background; personal versus other person's culture; comparison of personal culture and

ambiguity and stress due to uncertainty and knowing how a counselor's cultural worldview influences their perception of the minority culture's worldview (D'Andrea et al, 1991; Dillon et al., 2016; Lu, 2017; Ratts, 2017; Sue, 1982, 1990, 1999; Sue & Sue, 2013).

Mental health counselor. A mental health counselor in this study is a fully licensed mental health counselor (CACREP, 2016). In this research, a mental health counselor is not a social worker, psychologist, psychiatrist, or physician.

Cultural competence. Cultural competence refers to the mental health counselor's ability to counsel clients from other cultures with awareness, knowledge, and skills. MAKSS (D'Andrea et al., 1991) scores are the construct for cultural competence. The MAKSS highlights mental health counselors who report they are not dismissive, micro-aggressive, or invalidating of culture and experiences. These counselors express understanding of how their own cultural bias impacts their worldview and interaction with minority clients (D'Andrea et al., 1991; Benuto et al., 2018b; Dillon et al., 2016; Flynn et al., 2019; Lu, 2017; Tormala et al., 2018).

Cultural conditioning. Cultural conditioning refers to the learned associations, connotations, and stereotypes shaped by media, authoritative bodies, and personal experiences throughout the life of the counselor that developed into the counselor's internalized beliefs about that culture (Bloombaum et al., 1968; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Edwards, 2016; Miyamoto et al., 2019; Spencer et al., 2016; Tormala et al., 2018). MCSJCC is the theoretical construct of cultural conditioning in the development of the counselor's worldview (Ratts, 2017).

Implicit bias. Implicit bias refers to the strength of cognitive associations and preference for concepts (e.g., Black people, fat people, elderly) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy; Blanton, Jaccard, Strauts, Mitchell, & Tetlock, 2015; Boysen,

2009; Boysen & Vogel, 2008; Charnin, 2015; Devos & Sadler, 2019; Mendonca et al., 2019; Spencer et al., 2016). The IAT (Greenwald et al., 1998) is the construct of implicit bias. IAT scores of implicit racial bias does not indicate a single person's behavior at a single point in time; however, across many people, implicit racial bias may predict behavior in areas such as discrimination in hiring and promotion, housing, medical treatment, and decisions related to criminal justice (Greenwald et al., 1998; Greenwald, Nosek, & Banaji, 2003; Karpinski & Hilton, 2001).

Knowledge. Knowledge refers to the counselor's education attained through lectures, webinars, advanced reading, or presentation of factual data-driven knowledge of cross-cultural dynamics within marginalized communities (D'Andrea et al., 1991). Knowledge is the fact or condition of knowing one's personal identity, power, and privilege; understanding oppression and strength; recognizing one's own beliefs, attitudes, and values; and having experienced the cultural worldview of minority populations (Dillon et al., 2016; Lu, 2017; Ratts et al., 2016).

Race. Race refers to a category of humankind that shares certain distinctive physical traits; a class or kind of people unified by shared interests, habits, or characteristics (Delgado & Stefancic, 2012; Dunac & Demir, 2017; Linley, 2018). The races referred to by this study include African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, and Other. The category of "Other" was utilized to indicate that the participant's racial identity was not listed in the options provided. For example, a participant who held a multi-racial category not listed. The Black/White IAT was utilized in this study.

Racial preference. Racial preference refers to the strength of cognitive associations and bias for racial groups (e.g., Black people, White people, Hispanic people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy, violent; Blanton et al., 2015; Boysen, 2009;

Boysen & Vogel, 2008; Charnin, 2015; Devos & Sadler, 2019; Mendonca et al., 2019; Spencer et al., 2016). Racial preference does not indicate a single person's behavior at a single point in time; however, across many people, racial preference may predict behavior in areas such as discrimination in hiring and promotion, medical treatment, and decisions related to criminal justice (Greenwald et al., 1998; Greenwald et al., 2003; Karpinski & Hilton, 2001).

Skill. Skill refers to the counselor's ability to translate tangible training (role play, theory orientation, critique through two-way mirror and video) into culturally appropriate behavioral models utilized in therapy sessions (D'Andrea et al., 1991). Skill is a learned power to do something competently; a developed aptitude and ability to implement therapeutic interventions consistent with the client's worldview and culture for African American clients (Dillon et al., 2016; Lu, 2017).

Research Design

This study employed a quantitative methodology and a survey approach to increase participation and the efficiency of the data collection process and reduce the burden of tallying results manually (Creswell, 2013; Leedy & Ormrod, 2016; Priviera, 2016). The investigation involved the use of a quantitative methodology to facilitate the broad cross-sectional sampling of the population of mental health counselors required to ensure adequate and generalized correlation analysis (Creswell, 2014; Leedy & Ormrod, 2016; Priviera, 2016). This study was designed to reveal a scientific post positivistic connection between the variables and to assess any correlation between the mental health counselors' cultural competence, implicit bias, and race (Creswell, 2014). Scientifically objective data were gathered via this quantitative method to answer questions pertaining to statistically significant differences and correlations between and

within race for cultural competence and implicit bias (Creswell, 2013; Leedy & Ormrod, 2016; Priviera, 2016).

The surveys used were the MAKSS and IAT. The correlational design sought to illuminate the relationship and frequency between the variables, rather than the allowing for variability of interpretation of results in a qualitative narrative, which has the potential to appear the same as self-reporting (Babones, 2016). Quantitative in this research design is most advantageous because (a) two or more variables were involved, (b) surveys were not manipulated, and (c) it employed a non-randomized sample (Creswell, 2013; Priviera, 2016). The purposive sample was recruited by Qualtrics via social media (LinkedIn, Instagram, Facebook, and Twitter). Qualtrics is a paid online data collection and research company which formed a panel of participants based on the inclusion criteria and distributed the assessments on their web portal to collect data. The MAKSS, IAT, and a self-identified racial demographic question were used to gather data on counselors' multicultural awareness, knowledge, and skills (D'Andrea et al., 1991) and implicit bias (Greenwald et al., 1998). The data were exported from Qualtrics via a secure platform and entered into the Statistical Package for Social Sciences (SPSS v.26) for analysis. The analysis produced descriptive statistics, multiple analysis of variance (MANOVA), and correlations that assessed whether there were any statistically significant mean differences between and within the races of mental health counselors as measured by the MAKSS and the IAT to assess implicit bias.

Assumptions and Limitations

Assumptions were grounded in the expectation that truth exists in empirical investigation (Creswell, 2014). This section presents general assumptions about the participants, methodology,

and theoretical foundation. This section delivers general, theoretical, topic specific, and instrument assumptions as well as limitations.

The current research applied a quantitative methodology, which finds its philosophical origins in the positivist tradition from the historical Enlightenment period (Ponterotto, 2005). Positivist tradition approaches research through the social and behavioral sciences which gained popularity in the logical positivism of Comte in the 1800s and the empirical positivism of Popper in the 1950s (Babones, 2016). Epistemological, ontological, axiological, methodological, and philosophical assumptions differ significantly from the interpretive or constructivist perspectives that direct qualitative research (Creswell, 2013; Daly, 2007; Leedy & Ormrod, 2016; Ponterotto, 2005).

General Methodological Assumptions

This research utilized a quantitative design to gather and analyze data (Ponterotto, 2005). In the positivist methodological approach, statistical formula regulations are implemented to determine the impact of predictor variables on criterion variables (Babones, 2016; Ponterotto, 2005). Adequate samples produce data that can be generalized across the population (Leedy & Ormrod, 2016; Ponterotto, 2005; Priviera, 2016).

Epistemology dissects what is valid knowledge and how that knowledge is obtained (Creswell, 2014; Ponterotto, 2005). Epistemology presents a positivist paradigm between the researcher, participant, and topic studied (Miller & Johnson, 2014; Ponterotto, 2005). This paradigm requires the researcher to utilize rigorous objectivity in their representation of procedures and results (Creswell, 2014; Miller & Johnson, 2014; Ponterotto, 2005).

Ontology is the individual's understanding of the nature of reality and being real and true in the context of their knowledge base (Miller & Johnson, 2014; Ponterotto, 2005). Ontology

adheres to the perception that there is one true reality that is clearly plausible, identifiable, and measurable (Creswell, 2014; Ponterotto, 2005). Ontology is molded by gender, age, race, and shifts in cultural conditioning (Katz & Hoyt, 2014; Mendonca et al., 2019; Ponterotto, 2005).

Axiology requires the researcher to remove their personal perspectives, value, beliefs, and expectations of society from the study (Miller & Johnson, 2014; Ponterotto, 2005). Quantitative studies require the researcher to set aside axiological assumptions to allow the data to present itself in the purest form (Ponterotto, 2005; Priviera, 2016). Axiology requires the research to be independent of manipulation and brings forth the mutual balance of decision making in human nature and societal forces (Katz & Hoyt, 2014; Mendonca et al., 2019; Ponterotto, 2005).

In this research, MANOVA and correlations were applied to the data to ascertain any statistically significant mean differences between races for cultural competence as measured by the MAKSS and implicit bias as measured by the IAT for mental health counselors (Creswell, 2014; Leedy & Ormrod, 2016; Priviera, 2016). Significant statistical differences and correlations were assessed to deduce where the differences were most prevalent and causality was not possible to ascertain in this study (Creswell, 2013; Leedy & Ormrod, 2016; Priviera, 2016). This quantitative approach was most appropriate for examining the hypothesis of the study and providing a statistical deductive analysis (Charmaraman, Woo, Quach, & Erkut, 2014) that reveals levels of cultural competence and bias in relation to cultural competence from a positivist perspective (Ponterotto, 2005).

Theoretical Assumptions

The MCSJCC utilizes MCC and assumes that effective counseling requires mental health counselors to attain awareness, knowledge, and skill that encompasses a recognition of power,

privilege, and oppression in marginalized communities (Benuto, 2018b; Ratts et al., 2017; Ratts et al., 2016; Sue, 1990, 1999, 2013). The theory (Sue & Sue, 1999) is assumed to expand the counselor's ability to provide treatment that is culture specific, advocate for diverse clients, acknowledge unique identities, and avoid stereotypes established in cultural conditioning found in "employers, educators, neighbors … organizational policies or practices in schools, mental health agencies, government, business, and our society" (p. 814). This depth of understanding is best realized in the recognition and validation of cultural conditioning (Bloombaum et al., 1968; Benuto, 2018b; Thomas, 1962; Sue et al., 2006).

Cultural conditioning is discussed in literature as a concept rooted in social distance that allows stereotypes to create beliefs about a group of people (Bloombaum et al., 1968; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Edwards, 2016; Miyamoto et al., 2019; Spencer et al., 2016; Tormala et al., 2018). Cultural conditioning assumes that even minorities experience cultural conditioning that promotes dislike of a stigmatized group (Devos & Sadler, 2019; Greenwald, Banaji, & Nosek, 2015; Wang et al., 2019). As a result of this stigma, counselors need to be educated to consider how their worldview has impacted implicit bias through the associations they might make because of their experiences (Bloombaum et al., 1968; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Edwards, 2016; Miyamoto et al., 2019; Spencer et al., 2016; Tormala et al., 2018; Wang et al., 2019).

Topic-Specific Assumptions

Cultural competence presupposes that a counselor acknowledges the existence of cultural differences with a genuine curiosity and knowledge beyond the Western perspective (Dillon et al., 2016; Hook et al., 2016b; King et al., 2019; Shih et al., 2015; Sue & Sue, 2013; Waalkes et al., 2018). Cultural competence is informed by cultural conditioning which may manifest

through implicit bias, attitudes, and behaviors and is believed to vary by the cultural background of the mental health counselor (Charnin, 2015; Childers-McKee & Hytten, 2015; Eyal et al., 2018; Haskins & Singh, 2015; Johnson & Possemato, 2019; Nagai, 2017; Velez et al., 2018; Volpe et al., 2019; Walck, 2017). The client's social and cultural context is vital to the reality of their circumstance, belief system, and values (Bilkins et al., 2016; King et al., 2019; Waalkes et al., 2018). It is essential for the culturally competent professional to understand specific cultural contexts and universal cultural perspectives to ensure they are helping the client to function within their cultural and universal systems (Ratts et al., 2016; Sue & Sue, 2013).

Cultural competence helps a counselor avoid assuming that everyone within a culture believes and functions monolithically (Hook et al., 2016a, b). Cultural competence then necessitates appropriate cultural strategies for managing stressors (Owen et al., 2016). Implementing appropriate cultural strategies creates the opportunity to develop a greater therapeutic alliance and diminishes the effect of implicit bias (Katz & Hoyt, 2014; Owen et al., 2018; Taylor & Kuo, 2018).

Research on mental health counselors' cultural competence in relation to implicit bias has placed greater responsibility on the therapist to provide the same culturally safe environment to all client communities (Ratts et al., 2017). Miller et al. (2018) reported that a considerable amount of the literature documenting racism, microaggressions, or invalidations toward minorities from mental health counselors provides little to no theoretical recommendations for eliminating this barrier to mental health care. This research assumes that implicit bias is synonymous and has a direct relationship with a mental health counselor's worldview, power, and privilege (Ratts et al., 2016; Samuel, 2020; Walker, 2020).

Assumptions About Measures

Assumptions about measures included choosing those that corresponded to the general interest of the study, ease of distribution in the selected online format, simplicity of instructions, and adequate sample size for the community assessed (Creswell, 2014; Luh & Guo, 2016; Leedy & Ormrod, 2016). In this study, the MAKSS was selected for its design to measure cultural competence across the three variables individually and provide an overall score for the collective cultural competence of the mental health counselor (D'Andrea et al., 1991). It is assumed that every mental health counselor has attained a self-assessed level of cultural competence. The Black/White IAT was designed to assess an individual's implicit bias for Black or White people based on picture and word associations (Greenwald et al., 1998). The IAT (Greenwald et al., 1998) is an objective assessment rooted in recognizing the existence of implicit bias, learned through cultural conditioning. It was assumed that every mental health counselor who took the IAT would present with implicit bias. Finally, the racial demographic question was designed to allow the participant to self-identify their racial demographic group (Kubota, Peiso, Marcum, & Cloutier, 2017). A comprehensive assessment of each measure is delineated in Chapter 3.

Limitations

This study has theoretical and design limitations consistent with the use of Qualtrics, a research data collection firm, as an online tool. Qualtrics (2019) could only recruit participants who utilized social media platforms, which prevented the recruitment of mental health counselors who do not use social media. The Qualtrics platform also assumed that those who chose to participate were technologically savvy, eliminating valuable information from counselors who do not utilize technology either because of personal beliefs or disability. Though this limited the study to those who have social media accounts, it also allowed the researcher to

meet the required sample size. The internet was required to access all measures through the Qualtrics software platform (Qualtrics, 2019). Qualtrics offered incentives to the panelists. Additionally, the convenience of the internet allowed for larger sample sizes but created difficulties in confirming that all participants were mental health counselors. Social workers, physicians, psychiatrists, and psychologists were excluded. Completion time for the assessments was 15 minutes. Greenwald et al. (2003) posited that testing fatigue might develop, and unfinished assessments may require deletion.

Design limitations. There are four design limitations for this non-experimental research. The first is that non-experimental research removes the ability to manipulate the predictor variable (Laerd, 2019; Leedy & Ormrod, 2016; Priviera, 2016). The second limitation is that race was assessed by the participant in a single demographic question that lies between the MAKSS and IAT assessments. The choices for race were limited to African American, Euro-American, Hispanic American, Asian American, Native American, and Other. The category "Other" was utilized to allow participants to acknowledge their racial identity when none of the specified options accurately indicated the participant's preference. For example, a participant who identified with multiple identities might select "Other" if they were not comfortable with the specific options provided. The third limitation was the outliers of the MANOVA analysis due to the limited options of race. Outliers represent the possibility of both Type I and II errors with no indication of the error occurring. Outliers in MANOVA can be mitigated with Mahalanobis distance values of regression and boxplots to demonstrate where the errors lie (Laerd, 2019; Leedy & Ormrod, 2016; Priviera, 2016). The fourth limitation is that this research assesses implicit bias and not counseling behavior. Mendonca et al. (2019) recognized that this limitation

allowed mental health counselors to ignore the relationship between implicit bias and perceived cultural competence.

Delimitations. The study did not entail a pre- and post-cultural competence assessment based on case study reviews or delineate cultural competence based on age or length of time in the mental health profession. The study did not seek qualitative explorations of counselor/client relationships that assessed explicit attitudes or behaviors. While there is a separation of the components of the MAKSS score (awareness, knowledge, and skill), this research provided an analysis of the total score for cultural competence. It did not separate or inquire about the mental health counselors' graduate studies in CACREP and non-CACREP approved programs. No qualitative discussions were assessed and no in-therapy explicit behaviors were observed for this study. The current research did not assess the relationship between variables based on the amount of cultural competence-based coursework completed, gender, or age. Finally, the current research did not measure cultural competence based on socioeconomic status or geographical location in the United States.

Organization of the Remainder of the Study

The first chapter outlined the need for assessing cultural competence and implicit bias via the MAKSS (D'Andrea et al., 1991) and the IAT (Greenwald et al., 1998) to ascertain counselors' levels of multicultural competence. While there are limitations, the new knowledge should assist the counseling profession in advocating for education change, increasing help-seeking behaviors, and decreasing disparities in the African American community. Chapter 2 will present literature relevant to understanding this study's theoretical framework through the history of racism as a foundation of America and the impact of cultural conditioning on cultural competence. Chapter 3 will provide a chronological guide to the methodology and procedures

utilized so that future researchers may expand on the knowledge presented. Chapter 4 will report the results collected through the MAKSS, IAT, racial demographics, and statistical analysis. Finally, Chapter 5 will provide a summary of implications, assumptions, and recommendations for future research.

CHAPTER 2. LITERATURE REVIEW

This chapter discusses the search methods and the theoretical orientation of the study. This chapter also contains a review of previous literature and a critique of the research methods used therein. This chapter aims to provide an understanding of the history of the MCSJCC's cultural conditioning tenet and its impact on cultural competence and implicit racial bias (Barlow, 2016; Bell, 1980, 1987, 1992; Bell, Crenshaw, Gotanda, Peller, & Thomas, 1995; Brown & Jackson, 2017; Crenshaw, 1991, 2011; Mays, 1985; Sue, 1990; Sue & Sue, 1999; Ratts et al., 2016; Wade & Bernstein, 1991). This chapter will present literature regarding the tenets of the MCSJCC that are crucial to specific areas of cultural competence to help the reader connect the historical perspectives to the findings in the IAT (Greenwald et al., 1998) and MAKSS (D'Andre et al., 1991). This chapter will end with a summary of the overall perspectives delineated in previous literature.

Methods of Searching

The researcher conducted an exhaustive review of the literature regarding mental health counselors' cultural competence and implicit racial bias. However, there is no concentrated research specifically pertaining to counselors regarding the MCSJCC's cultural conditioning tenet, implicit racial bias, cultural competence, and race (Boysen, 2009; Burdine & Koch, 2019; Charnin, 2015; Davis et al., 2016; Mendonca et al., 2019; Ratts et al., 2016). The following literature review can increase awareness of cultural conditioning in CES, the interaction of cultural conditioning with the counseling profession, the impact cultural conditioning has on cultural competence, and implicit racial bias in counseling.

Literature about multicultural competency was acquired through internet searches at public libraries and in the databases Counseling and Therapy with Video, CQ Research,

Dissertations @Capella, Dissertations and Theses Global, Education Database, Education Research Complete, and Global Scholar. Additional resources used to locate appropriate peer-reviewed articles and books were the Criminal Justice Database, Health and Medical Collection, Health Management Database, Nursing and Allied Health, ProQuest Central, PsycArticles, PsycBooks, PsychologDatabase, PsycInfo, PsycTests, Public Health Database, PublicMed Central, Sage Journals Online, Sage Knowledge, SocIndex with Full Text, and Sociology Database.

The keywords and phrases used most often were *African American clinicians, African American disparities, CACREP curriculum, CES pedagogy, civil rights history, counseling, counseling and cultural competence, counselor education and supervision and cultural competence, counseling education, counseling training, cultural bias, cultural competence pedagogy, cultural conditioning, cultural conditioning and counseling, cultural conditioning and education, cultural conditioning and pedagogy, diversity in therapy, explicit bias, Euro American clinicians, implicit association, implicit bias, institutional racism, Jim Crow history, mental health disparities, mental health counselors, microaggressions, microinvalidations, multiculturalism, multicultural competence, multicultural education, multicultural pedagogy, multicultural and social justice cultural competencies, multicultural theory, multicultural training, teaching cultural competence*, and *teaching multiculturalism*.

Theoretical Orientation for the Study

Cultural stereotyping was introduced in 1962 by Alexander Thomas and later changed to cultural conditioning in 1968 when Bloombaum, Yamamoto, and James studied psychotherapists' worldviews. They found that psychotherapists had a specific stereotypic perspective toward African Americans, Mexican Americans, Asian Americans (Chinese and

Japanese), and Jewish Americans (Bloombaum et al., 1968). Bloombaum et al. (1968) posited that psychotherapists are impacted by social conditioning in the same way that the rest of society experiences and operates from the influence of stereotyping. Cultural conditioning expanded the examination of cultural competence and implicit racial bias in this research.

The MCC's cultural conditioning tenet (Thomas, 1962) is rooted in the understanding that the lived experience of minorities in American society cannot be separated from the societal norms (Brown & Jackson, 2017; Delgado & Stefancic, 2012; Dunac & Demir, 2017; Neblett, 2019; Sleeter, 2017). Researchers utilized cultural conditioning as a framework for counselor educators to espouse responsibility for adding cultural humility to curricula and demanding that counseling education reflects on the history of marginalized communities (Abbott et al., 2019; Davis et al., 2016; Hook et al., 2016a, b; Tormala et al., 2018; Owen et al., 2016). Race, class, and economic power are impacted by cultural conditioning (Neblett, 2019; Tormala et al., 2018). The MCSJCC's cultural conditioning tenet expands the awareness, knowledge, and skills of cultural competence to include the historical context of wealth disparities, Whiteness as property, counter storytelling, and interest convergence resulting from unconscious emotional bias (Thomas, 1962; Delgado & Stefancic, 2012; Ratts et al., 2017; Sue, 2004).

This current research sought to evaluate any significant statistical difference or relationship between the MAKSS and IAT according to the race of the mental health counselor. The intent was to discover whether race was a factor in self-report assessments and implicit racial bias. MCC provided a foundation for understanding how cultural conditioning (Barlow, 2016; Brown & Jackson, 2017; Crenshaw, 1991, 2011; Ratts et al., 2017) contributed to mental health counselors' levels of cultural competence when disparities in mental health care were significantly disproportionate in the African American community (Cuevas et al., 2016; Delgado

& Stefancic, 2102; Devos & Sadler, 2019; Tormala, 2018). The MCSJCC posited that the history of cultural conditioning illuminates how behaviors such as microaggressions, microinvalidations, and dismissiveness exist in the therapy room (Thomas, 1962; Barlow, 2016; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Edwards, 2016; Miyamoto et al., 2019; Ratts et al., 2016; Samuel, 2020; Tormala et al., 2018; Walker, 2020). A counselor who espouses colorblindness, globalizes the narrative of the African American experience, expresses false empathy, or downplays the power of Whiteness is not operating from a multicultural framework (Linley, 2018; McCoy & Rodricks, 2015; Memon et al., 2016; Ratts et al., 2017; Samuel, 2020; Sleeter, 2017; Sue, 2004).

MCC emerged in the 1950s but did not begin to affect specific guidelines in the counseling community until the early 1990s (Sue & Sue, 2013). The theory's epistemology presents opportunities to understand cultural diversity and how a counselor's worldview impacts therapeutic alliances and treatment (Sue & Sue, 2013). Researchers in counseling sought to implement standards that influenced curricula toward a greater understanding of how the cultural context of clients and counselors' power, privilege, and oppression impacts therapy (Ratts et al., 2016; Sue, 1990, 1999; Sue & Sue, 2013; Tormala et al., 2018). The tenets of the MCSJCC broaden the focus of CES professionals and the counselor role to include social justice advocacy (Lerma, Zamarripa, Oliver, & Cavazos Vela, 2015; Ratts et al., 2016; Sue & Sue, 2013; Tormala et al., 2018). The MCSJCC uses modalities that assist in the development of counselors as they consider the impact of personal beliefs and values, cultural conditioning, and advocacy on their cultural competence toward gender, race, sexual orientation, culture, and ethnicity (Ho, Kteily, & Chen, 2017; Sue & Sue, 2013; Tormala et al., 2018). For example, an African American who visits a therapist who assumes they go to church might feel judged when asked about their

church's perspective on the concerns they bring to counseling. This encounter is a microaggression against the client's individuality (Bilkins et al., 2016; Chan et al., 2018; Cruz et al., 2019; Hook et al., 2016a, b). The counselor may believe that all African Americans have a spiritual support system. Multicultural competency asks the counselor to assess how she came to believe this myth as a fact. Counselors who do not recognize that discrimination exists for African Americans who did not grow up in an impoverished urban neighborhood or who are affluent may find that their client does not return to counseling. This encounter can become a microinvalidation of the client's experience. These infractions communicate a lack of multicultural awareness (Cruz et al., 2019; Hook et al., 2016a, b; Shih et al., 2015).

The axiology of the MCSJCC requires the counselor to acknowledge the existence of cultural differences with a genuine curiosity and knowledge beyond the Western perspective (Barlow, 2016; Chan et al., 2018; Cruz et al., 2019; Dillon et al., 2016; Mays, 1985; Shih et al., 2015; Sue, 1990; Sue & Sue, 2013; Sue & Sue, 1999; Wade & Bernstein, 1991). The client's social and cultural context is essential to the reality of their circumstance, belief system, and values (Bilkins et al., 2016). The MCSJCC educates counselors with greater authority and penetration of thought, belief, and cultural conditioning when counselors explore the historical layers presented by the MCSJCC (Sue & Sue, 2013; Sue & Sue, 1999; Taylor & Kuo, 2018; Volpe et al., 2019; Wade & Bernstein, 1991).

The awareness, knowledge, and skill base of counselors is expanded through MCC (Barlow, 2016; Mays, 1985; Sleeter, 2017; Sue, 1990; Sue & Sue, 1999; Wade & Bernstein, 1991). An accurate assessment of cultural competence for mental health counselors holds inherent power in ensuring they can think critically about the dynamics of their client's narrative without excluding culture and race (Barlow, 2016; Cruz et al., 2019; Dillon et al., 2016; Mays,

1985; Sleeter, 2017; Sue, 1990; Sue & Sue, 1999; Wade & Bernstein, 1991). The MCSJCC in learning institutions allows educators and supervisors the opportunity to evaluate counselors beyond their understanding of power and privilege into a cauldron of experiences that are often invisible to Western perspectives (Barlow, 2016; Boysen & Vogel, 2008; Haarhoff, Thwaites, & Bennett-Levy, 2015; Miyamoto et al., 2019; Sleeter, 2017; Sue, 1990, 1999). As a result, counselors must consider how MCSJCC assists them in understanding the impact of cultural conditioning in their lives and behaviors in the therapy room (Brown & Jackson, 2017; Lindsay, 2015; Ratts, 2017; Sleeter, 2017; Smith, 2015; Volpe et al., 2019). Studying the history of MCSJCC provides a new perspective on the influence of implicit racial bias on cultural competence.

Review of the Literature

Increased disparities in mental healthcare are affecting the ability of marginalized communities to access treatment for all socio-economic status, class, education levels (Dillon et al., 2016; Samuel, 2020; Volpe et al., 2019; Walker, 2020). Mental health issues in the African American community include anxiety, depression, and relationship discord in families that are already impacted by institutional racism (Cruz et al., 2019; Cuevas et al., 2016; Miyamoto et al., 2019; Samuel, 2020; Velez et al., 2018; Walker, 2020). Past studies on the cultural competence of counselors have used various cultural competence and implicit bias assessments across several demographics. The literature review was an exhaustive examination of what is known about MCSJCC (Sue, 1990, 1999; Sue & Sue, 1999), cultural conditioning, the predictor variables (MAKSS and IAT), and race (criterion variable).

Cultural Competence

Cultural competence in mental health counseling means a mental health counselor has the ability to treat clients from cultures not like their own through cultural awareness and knowledge with skills that are not dismissive, micro-aggressive, or invalidating of the client's culture or experiences within that culture (Ahmed et al., 2011; D'Andrea et al., 1991; Benuto et al., 2018b; Dillon et al., 2016; Flynn et al., 2019; Lerma et al., 2015; Lu, 2017; Ratts et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). The counselor possesses an awareness and understanding of how their own experiences and cultural bias affect their worldview and interactions with minority clients (Killian, 2017; Moon & Sandage, 2019; Ratts et al., 2016). Cultural competence is important because it supports the ability of mental health counselors to avoid assuming that everyone within a culture believes, behaves, and experiences difficulties similarly (Hook et al., 2016a, b). Cultural competence entails possessing the skill to provide appropriate diagnosis and treatment strategies for managing distress according to the cultural context of the client (Moon & Sandage, 2019; Owen et al., 2016; Sue & Sue, 2013). Cultural competence increases positive treatment outcomes (Flynn, 2019). "All counselors must be prepared to address systems of oppression, discrimination, and privilege at multiple levels, and this requires that they have the necessary awareness knowledge and skills to do so" (Decker, Manis & Paylo, 2016, p.2).

How is it attained? Cultural competence is attained through graduate school courses and life experience (Killian, 2017; Reinders, 2017; Sue & Sue, 2013). Graduate schools offer courses in various mental health counseling programs and CES professionals are charged with ensuring that graduates are adequately prepared through didactic, immersion, and experiential training (Decker et al., 2016; Killian, 2017; Ratts et al., 2016; Reinders, 2017; Sue, 1990; Sue & Sue,

1999; Sue & Sue, 2013; Tormala et al., 2018). As CES professionals, it is important to assist in a mental health counselor's skill development so they may set aside any beliefs, perspectives, or dismissive narratives that may minimize the experiences of a marginalized community (Paone et al., 2015; Ratts et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018).

How does a counselor know they have it? A mental health counselor will recognize they have a modicum of cultural competence when they learn to acknowledge how their own biases toward various genders, sexual orientations, race, disabilities and other marginalized social categories affect treatment and are open to acquiring new knowledge about other cultures (Dillon et al., 2016; Lu, 2017; Peters, 2017; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). Through role play, theory orientation, critique through two-way mirrors and video, practicums, and internships, the mental health counselor may practice their cultural competence skills (Boysen & Vogel, 2008; Gillem et al., 2016; Miyamoto et al., 2019; Sue & Sue, 2013). Licensed mental health counselors and CES professionals attend conferences and workshops to ensure maintenance and enrichment of multicultural awareness, knowledge, and skill as well as social justice advocacy (Freeman, Garner, Fairgrieve, & Pitts, 2016; Ratts et al., 2016; Sue & Sue, 2013; Sue, 1990; Sue & Sue, 1999; Tormala et al., 2018). These activities along with personal experience allow mental health counselors to move from basic knowledge and recognition of cultural differences to crafting unique treatment strategies for positive outcomes in marginalized communities (Decker et al., 2016; Owen et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). Assessment of cultural competence may also be accomplished through the use of self-assessments designed to measure levels of competence (D'Andrea et al., 1991; Sodowsky et al., 1994).

Counselors may take a cultural competence self-assessment to ensure they have attained and maintained cultural competence (Benuto & O'Donohue, 2015; D'Andrea et al., 1991; Gillem et al., 2016; Dalal & Hackel, 2016; Katz & Hoyt, 2014; Sodowsky et al., 1994). Cultural competence can be measured by various assessments such as the MAKSS, the Cultural Competence Self-Assessment Questionnaire (CCSAQ), the Multicultural Competence – Arab Americans (MCCAA), the Multicultural Counseling Knowledge and Awareness Scale (MCKAS), and the Multicultural Counseling Inventory (MCI; Benuto & O'Donohue, 2015; Gillem et al., 2016; Dalal & Hackel, 2016; Katz & Hoyt, 2014). These assessments were implemented to evaluate the counselor's perspective on their cultural competence through self-reporting (D'Andrea et al., 1991; Gillem et al., 2016; Katz & Hoyt, 2014; Miyamoto et al., 2019). Self-report studies of counselors' cultural competence have documented increased awareness, knowledge, and skill among counselors who work with minority communities in relation to the amount of multicultural education (Boysen & Vogel, 2008; Gillem et al., 2016; Miyamoto et al., 2019; Reinders, 2017). Boysen and Vogel (2008) and Reinders (2017) reported that the counselors' levels of competence varied by training levels. Many mental health counselors self-reported greater cultural competence than their clients experienced (Cuevas et al., 2016; Ratts et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). Flynn et al. (2019) expressed that cultural competence is crucial to removing clients' feelings of embarrassment, shame, and stigma that decrease positive client outcomes. The two self-report assessments most used in research are MAKSS and MCI; they are discussed in greater detail later in this review of literature.

Counselors who possess cultural competence and implement interventions in the counseling environment take into consideration the intersectionality of a client's race,

background, gender, socio-economic status, values, and beliefs to balance strategies that work within the client's culture and universal settings to create change that is congruent for the client (Cuevas et al., 2016; Ratts et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). The client's social and cultural contexts are vital to the reality of their circumstances (Barden et al., 2017; Edward, 2016; Flynn et al., 2019). It is crucial for the culturally competent professional to understand the marginalized client's culture to ensure the counselor is meeting the client's need within the subcultural and universal systems (Cruz et al., 2019; Effron & Knowles, 2015; Hook et al., 2016b). Additional evaluation tools are necessary for both CES and students as cultural competence is developed.

The CES profession is crucial to the development of new mental health counselors nationwide. CES professionals are the gatekeepers of quality mental health counselors, capable of assisting clients regardless of race, ethnicity, religion, gender, or sexual orientation (Freeman et al., 2016; Gibson, 2016; Peters, 2017). A competent supervisor is believed to be culturally attuned and able to shift within cultures authentically (Peters, 2017). As a gatekeeper, the responsibility of a CES professional is to ensure the honor and integrity of the profession (Celinska & Swazo, 2016).

CACREP (2016) accreditation standards require that "counselor education programs have and follow a policy for student retention, remediation, and dismissal from the program consistent with institutional due process policies and with the counseling profession's ethical codes and standards of practice" (CACREP, 2016, p. 5). Freeman et al. (2016) posited that CES professionals are responsible for correcting behaviors and perspectives that are incongruent with building a professional atmosphere and reporting unethical practices between staff that prohibit quality performance. Stark and Greggerson (2016) stated that the counseling student cannot

assume the role of passive bystander and must be allowed to speak up when their needs are being stifled. At the same time, ensuring confidentiality and eliminating the opportunity for retaliation is crucial to each relationship (Freeman et al., 2016; Stroud, Olguin, & Marley, 2016). The CES professional should be open to constructive feedback that allows the mental health counseling student to meet their individual and collective goals as they build a therapeutic alliance that is not biased toward any mental health counseling student (Williams, 2020). This feedback should be mutual as the mental health counseling student offers the same throughout the education relationship (Stroud et al., 2016; Williams, 2020). If the mental health counseling students are not proactive and open, their multicultural education may become ineffective and the public might be harmed (Stark & Greggerson, 2016; Williams, 2020).

A multicultural CES professional should bring interventions to the classroom environment that incorporate and take into consideration the intersectionality of the student's race, background, gender, values and beliefs, age, socio-economic status, and support system in an effort to balance strategies that work within the client's culture and universal perspective (Lindsey et al., 2017; Killian, 2017; Ratts et al., 2016; Reinders, 2017). A multicultural curriculum may then be implemented that minimizes the disparities that exist in providing quality culturally competent mental health care services to minority communities (Ratts et al., 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018; Williams, 2020). Well-rounded interventions allow the mental health counselor to work with evidence-based best practices as they provide culturally competent diagnosis and treatment to future clients (Cuevas et al., 2016; Lindsey et al., 2017; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018).

The ACA Code of Ethics (2014) requires "counselor educators, through ongoing evaluation, [to be] aware of and address the inability of some students to achieve counseling competencies" (p. 15). Freeman et al. (2016) expressed that many institutions struggle to provide adequate evaluations of CES professionals beyond a self-assessment and counseling student evaluations. Often the student evaluation of multicultural training is negative due to White fatigue (Flynn, 2015; Han & Leonard, 2017). Though not openly emphasized in the counseling profession, students have contended that they experience White fatigue (conscientious misconception of how racism functions or exists) when lessons include racial and cultural dynamics that demonstrate institutional and systemic racism toward marginalized communities (Flynn, 2015; Han & Leonard, 2017). The challenge for White mental health counselors is to not succumb to White fatigue and thus disengage from conversations and advocacy (Flynn, 2015). Though CES professionals are the gatekeepers of counselors in training, Freeman et al. (2016) posited that sometimes CES professions may pass a counseling student and hope that the next educator or supervisor will fix the student's incompetence.

Additionally, researchers recognized that studying cultural competence isolated from implicit racial bias created a gap in understanding the challenges that exist for marginalized communities (Boysen, 2009; Boysen & Vogel, 2008; Edwards, 2016; Fazio & Olson, 2003). Literature reveals that mental health counselors self-report higher cultural competence than their clients revealed about them in qualitative studies and the counselor reported more excellence in skill than awareness and knowledge; this difference exists across racial demographics (Barden et al., 2017; Devos & Sadler, 2019; Paone et al., 2015).

Evaluations. Self-reporting tools have been utilized most frequently in evaluating cultural competence. Various instruments are utilized to assess a student's cultural competence.

The MAKSS and MCI are most popular in research. The MAKSS (D'Andrea et al., 1991) has been used by multiple researchers to assess counselors' perceptions of their level of multicultural counseling awareness, knowledge, and skills as delineated by Derald Wing Sue. D'Andrea et al. (1991) developed the assessment as a pre- and post-test within a multicultural counseling course. They assessed multicultural (self) awareness through student attitudes, stereotypes, and biases (D'Andrea et al., 1991). Multicultural knowledge involved learning more about cultural and ethnic groups via classroom assignments and discourse; multicultural skills involved learning through therapeutic interactions with cultural groups through role-plays (CACREP, 2016; Sue et al., 1982; Killian, 2017). D'Andrea et al. (1991) found that student cultural competence increased with the number of courses specific to cultural competence pedagogy they received. Boysen (2008) and Katz and Hotz (2015) agreed and further noted that these evaluations when used with fully licensed counselors often demonstrated a skewed self-elevation of competence. Researchers found this to be true across multiple self-assessments of cultural competence, arguing that "counselor training programs rarely address self-awareness as it relates to MCSJCC, and this could be a result of the profession's focus on the acquisition of knowledge and skills as opposed to self-reflection and exploration" (Isom et al., 2015, p. 3).

Self-assessments alone should not be the only measure; qualitative explorations of cultural competence and examinations of clients' experiences of implicit racial bias research are vital to ensuring that the assessments of mental health counselors' cultural competence are accurate (Cuevas et al., 2016; Greenwald et al., 1998; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018). In this study, the Black/White IAT was utilized to assess for implicit racial bias. The Black/White IAT was developed by Greenwald et al. in 1998. The IAT is a time-latent assessment that indicates implicit bias based on inherent preferences (Greenwald et al.,

1998). It has been utilized to measure biases toward gay men, ice cream flavors, Presidents, religion, and in this research, race (Boysen & Vogel, 2008; Katz & Hotytz, 2014; Mendoca et al., 2019). The IAT does not predict explicit bias or prejudicial and discriminatory behavior as implicit and explicit behaviors are assessed as separate and distinct constructs (Greenwald et al., 1998; Karpinski & Hilton, 2001; Yamaguchi & Beattie, 2019). The IAT captures the strength of a bias associated with a particular stimuli and is considered a better predictor of implicit unconscious attitudes, beliefs, biases, preferences, and stereotypes than a self-report assessment like the MAKSS (Carpenter et al., 2019; Greenwald, Poehlman, Uhlmann, & Banaji, 2009; Mendonca et al., 2019; Yamaguchi & Beattie, 2019).

Mental health cultural competence can be assessed through the MCI, Cross Cultural Counseling Inventory-Revised (CCCI-R), or MAKSS. The MCI is a 40-item psychometric assessment developed by Sodowsky et al. (1994). The MCI assesses four subscales: skills, awareness, knowledge, and relationship (Sodowsky et al., 1994). The Cross-Cultural Counseling Inventory-R, a 20-item assessment, was offered in 1983 as a psychometric assessment of the client's perspective of the mental health counselor's cultural competence (LaFromboise, Coleman, & Hernandez, 1991). This study sought to understand cultural competence through the MAKSS, a 60-item psychometric assessment where counselors evaluate their own awareness, knowledge, and skill.

Population differences. Each instrument provides a glimpse of differences across diverse student and mental health counselor groups. Boysen (2008) reviewed CCCI-R via a pre-post-test of mental health counselors in training and master's and doctoral level interns to evaluate their cultural competence. A control group of counselors-in-training attended a multicultural education course for 13 weeks. Boysen found no increase in cultural competence

between those in the control group (course takers) and those who took a multicultural competence course previously. Instead, cultural competence increased overall, leading Boysen to conclude that "enrollment in a multicultural course was unrelated to specific increases in self-reported multicultural competency" (Boysen, 2008, p. 58). Reinders (2017) surveyed the cultural competence of 201 university students enrolled in a multicultural counseling course utilizing the Ethnic Identity Scale, Color Blind Racial Attitudes Scale, Everyday Multicultural Competencies Scale, and California Brief Multicultural Competence Scale. Reinders expressed that of the 201 students surveyed, "students of color enter multicultural counseling courses with higher levels of multicultural competence, but White students generally catch up over the course of the semester" (p. 65-66). At the beginning of the semester, White students had lower levels of cultural competence than students of color except when evaluated for colorblindness, resentment and cultural dominance, and anxiety and lack of multicultural self-efficacy (Reinders, 2017). Reinders found no difference in overall cultural competence on the California Brief Multicultural Competence Scale throughout the course between students of color and White students. The statistically significant differences were expressed in the individual components of competence. For example, students of color and White students shared similar resentment and cultural dominance as White students' levels lowered and the levels of students of color increased (Reinders, 2017).

Killian (2017) used a pre-post-test to examine the cultural competence of 60 students who decided to either take a didactic, experiential, or community service course. These students were similar in their exposure to diverse populations and initial assessment of cultural competence, but significantly different in previous experiences as mental health counselors. The pre-post-tests demonstrated there were no statistically significant differences in cultural

competence by pedagogical approach individually in the development of awareness, knowledge, skill, and advocacy (Killian, 2017). Therefore, neither race nor education level was an indicator for degree of cultural competence by the end of each course (Killian, 2017). Killian's research diverged from the previous literature for two reasons: (1) Killian sought to understand the effects of individual pedagogical interventions on awareness, knowledge, skill, relationship, and advocacy and (2) no student took all three courses, eliminating the ability to recognize the impact of each course on a single student.

Unique challenges and opportunities exist in developing cultural competence for mental health counselors. An overwhelming number of Americans believe negative characterizations about marginalized people, as most have little to no connection to the culture beyond the globalized cultural conditioning (Cox, Navarro-Rivera, & Jones, 2016; Linley, 2018; Lu, 2017; Squire, 2015). According to the Public Religion Research Institute (2017) report on race and ethnicity, on average, each White person in America has only one Black friend compared to eight White friends for each Black person. Counselors have the unique opportunity to demolish this narrative by broadening their theoretical scope to include the guidelines set by CACREP (2016), ACA (2014), AMCD (2017), and other organizations that espouse culture-specific treatment. Counselors, in general, have struggled to promote equality in access to quality mental health in marginalized communities (Conway et al., 2017; Duguid & Thomas-Hunt, 2015; Johnson & Possemato, 2019; Lindsay, 2015; Neblett, 2019). Whether due to a lack of minority counselors (BLS, 2016), resistance to recognizing privilege (Conway et al., 2017; Flynn, 2015; Flynn et al., 2019), or lack of exposure and interaction (Cox et al., 2016; Flynn, 2015; Flynn et al., 2019), having cultural competence has been vital to combating mental healthcare disparities in marginalized communities (Belgrave, 2016; Cuevas et al., 2016; Hyatt, 2019).

All mental health counselors, counseling students, and CES professionals possess a level of bias (Devos & Sadler, 2019; Mendonca et al., 2019; Nagai, 2017). Boysen (2008), Gillem et al. (2016), Mendonca et al. (2019), and Sue (1982) recognized that bias is inherent in the fabric of American society and institutions, making it virtually impossible to experience a worldview without bias. People of color are challenged by continuous exposure to bias in many forms (Chae et al., 2020). Chae et al. (2020) expressed that bias in all its forms is detrimental to the livelihood of African American people in particular. Concerns of racial guilt, anxiety, fear, and a lack of understanding cultural dynamics have a tendency to reduce empathy, challenging the mental health counselor's building of a therapeutic alliance (Bailey et al., 2016; Hook et al., 2016a, b; Tormala et al., 2018) and promoting the disparities in access within marginalized communities (Rikard, 2015). Researchers have explored bias and found that many factors contribute to its development.

Bias

Individuals are not born with innate biases (Sue, 1982; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013). Bias is taught through cultural conditioning that establishes a worldview (Sue & Sue, 2013). Cultural conditioning occurs when authority figures and the media influence, develop, define, and determine societal norms that affect daily interactions (Bloombaum et al., 1968; Duguid & Thomas-Hunt, 2015; Mendonca, 2019; Miyamoto, 2018; Sue, Lin, Torino, Capodilupo, & Rivera., 2009; Thomas, 1962; Tormala et al., 2018). Continuous cultural conditioning shapes implicit racial biases that challenge cultural competence and humility (Duguid & Thomas-Hunt, 2015; Sue et al., 2009; Tormala et al., 2018; Velez et al., 2018; Volpe et al., 2019). The consistency of the message embeds these narratives as a truth about the marginalized community in the psyche of American society (Polletta, 2015; Squires, 2015;

Volpe et al., 2019). Terms such as welfare queen, anchor babies, at-risk youth, and all lives matter seek to discredit the struggle of marginalized communities and create a narrative of monolithic dysfunction across the marginalized culture (Conway et al., 2017; Howell, Redford, Pogge, & Ratliff, 2017; Johnson & Possemato, 2019; Nagai, 2017; Polletta, 2015; Squires, 2015; Volpe et al., 2019). Media representations and perspectives of hypersexual, angry, impoverished, destructive, uneducated, criminal, and marginalized communities supported the cultural conditioning message for hundreds of years (Bloombaum et al., 1968; Duguid & Thomas-Hunt, 2015; Effron & Knowles, 2015; Johnson & Possemato, 2019; Spencer et al., 2016; Thomas, 1962; Volpe et al., 2019). Cultural conditioning has created bias that shows up in two ways: explicit or implicit (Greenwald et al., 1998; Kumar et al., 2015; Schmidt & Axt, 2016; Wang et al., 2019).

Explicit bias "is conscious, intentional, and measured by self-report. The negative beliefs, judgments, and stereotypes to which an individual has conscious access are all part of explicit bias" (Boysen, 2009, p. 240). Implicit bias occurs without conscious intention and is not self-reported; it is "actions or judgements that are under the control of automatically activated evaluation, without the performer's awareness of that causation" (Greenwald et al., 1998, p. 1464). Researchers expressed that implicit bias is demonstrated in ambiguous actions like microaggressions, microinvalidations, or dismissiveness that may deter client from seeking help in an effort to avoid further trauma and impact of these behaviors on the client's psyche (Cuevas et al., 2016; Kumar et al., 2015; Ratts et al., 2016; Samuel, 2020; Schmidt & Axt, 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018; Walker, 2020; Wang et al., 2019). Explicit bias is demonstrated in racial profiling and slurs, church bombings, lychings, and policies that limit access to health care, employment, housing, financial assistance, education,

and other institutions that redline marginalized communities (Alexander, 2012; Barlow, 2016; Bell, 1980, 1987, 1992; Bell et al., 1995; Brown & Jackson, 2017; Crenshaw, 1991, 2011; Mays, 1985; Ratts et al., 2016; Sleeter, 2017; Spencer et al., 2016; Squires, 2015; Sue, 1990; Sue & Sue, 1999; Wade & Bernstein, 1991). Implicit bias does not guarantee explicit behaviors but more ambiguous displays of bias (Boysen, 2009; Boysen & Vogel, 2008; Cuevas et al., 2016; Kumar et al., 2015; Ratts et al., 2016; Schmidt & Axt, 2016; Sue & Sue, 2013; Sue, 1990; Sue & Sue, 1999; Tormala et al., 2018; Wang et al., 2019). CES professionals are challenged to find opportunities to provide experiences that assist new mental health counselors in recognizing and working to change how their implicit bias affects their work with marginalized communities (Charnin, 2015; Childers-McKee & Hytten, 2015; Eyal et al., 2018; Haskins & Singh, 2015; Nagai, 2017; Walck, 2017).

Implicit racial bias impedes access to quality mental health care for marginalized communities (Alexander, 2012; Barlow, 2016; Bell, 1980, 1987, 1992; Boysen, 2009; Boysen & Vogel, 2008; Brown & Jackson, 2017; Charnin, 2015; Crenshaw et al., 1995; Crenshaw, 1991, 2011; Mays, 1985; Ratts et al., 2016; Sleeter, 2017; Squires, 2015; Sue, 1990; Sue & Sue, 1999; Wade & Bernstein, 1991). Researchers have speculated that implicit racial bias is an unconscious construct composed of positive and negative evaluations that garner attitudes and stereotypes that are revealed in microaggressive and invalidating words or deeds (Cunningham, Preacher, & Banaji, 2001; Greenwald et al., 1998; Karpinski & Hilton, 2001). However, Blanton et al. (2015), Boysen (2009), Fazio and Olson (2003), Kumar et al. (2015), and Mendonca et al. (2019) posited that those who exhibit implicit racial bias lack authentic introspection or are unenthusiastic about acknowledging implicit racial bias within the profession.

Katz and Hoyt (2014) studied bond and prognosis in relation to anti-Black sentiment based on specific cases to unearth potential racial bias in the counseling community. The researchers provided counselors with case studies and asked them to evaluate the client, provide a diagnosis, and create a treatment plan. To assess the counselor's cultural competence and implicit racial bias, they utilized the MCI, Working Alliance Inventory (Horvath & Greenberg, 1989), Therapist Expectancy Inventory (Bernstein et al., 1983), Should Would Discrepancy Scales (Devine et al., 1991), IAT (Greenwald et al., 1998), and Balanced Inventory of Desirable Responding (Paulhs, 1984). They found that many of the cultural competence scales provided a broader scope of diversity beyond the singular dimension of race presented in the IAT. However, the IAT presented a stronger prediction of implicit racial bias that manifested in the diagnostic scores, particularly with case studies for depression and anxiety.

Boysen and Vogel (2008) studied 105 graduate students at universities throughout the Midwestern United States. In this quantitative research, Boysen and Vogel sought to understand (a) whether a counselor's cultural competence increased with multicultural education, (b) whether significant implicit racial bias existed among these students toward homosexuality and African Americans, and (c) whether that bias varied by training. They utilized the IAT and CCCI-R along with demographic information. Boysen and Vogel found that there was a significant increase in cultural competence with increased multicultural education. This is congruent with studies conducted by D'Andrea et al. (1991) and Benuto et al. (2018a). Boysen and Vogel also found that there was significant racial bias against homosexual African Americans among students and there was no decrease in implicit racial bias with an increase in multicultural education.

Researchers have found that regardless of the bias indicator (gay, elderly, food, or race), participants in the IAT become defensive concerning the results when they are not individually favorable (Howell et al., 2015, Perry et al., 2015). Mendonca et al. (2019) completed six IAT experiments to test how the participants perceived the validity of results for themselves and others. They found that participants viewed the IAT results as valid for others but only valid for themselves if the results were positive (Mendonca et al., 2019).

The IAT is essential to showing how bias manifests in a response latency assessment as there is no way to conceal the strength of implicit racial bias in the timed responses presented in the implicit racial bias assessment (Devos & Sadler, 2019; Greenwald et al., 2015; Wang et al., 2019). Dissenting research states that the IAT is not an indicator of prejudice or discriminatory behavior (Blanton et al., 2015; Kumar et al., 2015; Mendonca et al., 2019). Charnin (2015) sought to understand whether there was a relationship between implicit racial bias and client race that affected "practitioner empathy, motivation to respond without bias, and attributions about the client's responsibility for the presenting concern and solution to their problems" (p. 75). Charnin posited that there was no relationship between client race and the multicultural competence of the mental health counselor. Additionally, Charnin determined that "implicit race bias did not significantly influence practitioners' perceptions of clients' responsibility for causing or solving their concerns" (p. 81). Each of these assessments is incongruent with the state of racial interaction in America as a whole. Since the counselor population is a small representation of America, CES professionals are challenged to transform student perspectives beyond the classroom into real-life practicums and internships in marginalized communities (CACREP, 2016; Killian, 2017). The design of these practicums and internships is crucial reframing Eurocentric approaches to counseling.

Eurocentric approaches. Eurocentric or Western education has led to approaches to cultural competence that are based on individualistic perspectives that devalue the collectivistic ideals of other cultures and are dismissive of the power of race and racism as a factor in mental health treatment (Brown & Jackson, 2017; Crenshaw, 2011; Delgado & Stefancic, 2012; Diggles, 2014; Dunac & Demir, 2017; Haskins & Singh, 2015; Tummala-Narra, 2015; Walck, 2017). Warren (2012) posited that

> the United States' nearly 400 year investment in the social construction of race to create a stratified society; as well as White supremacy, have created a society in which non-white children continue to bear the brunt of racial trauma through educational inequality, institutional racism through Eurocentric curriculum and pedagogy, and race-based teacher bias. (p. 197)

Memon et al. (2017) further expressed that as a result of Eurocentric education, mental health clients from marginalized communities

> perceived ethnicity as a major influence on their experience of acute care, and … can be acutely aware of the 'whiteness' of institutions and perceive mental health services to reinforce a White Euro-centric model of healthcare with little consideration or understanding of ethnicity. (p. 7)

The consistency of Eurocentric education often embedded stereotypical narratives as a truth in the psyche of American society about marginalized communities (Polletta, 2015; Squires, 2015). Terms such as welfare queen, anchor babies, at-risk youth, all lives matter, seek to discredit the struggle of African Americans and create a narrative of monolithic dysfunction across the culture (Conway et al. 2017; Howell, 2017; Nagi, 2017; Polletta, 2015; Squires, 2015). Media portrayals of African Americans as hypersexual, angry, impoverished, destructive, and

uneducated support the Eurocentric message (Duguid & Thomas-Hunt, 2015; Effron & Knowles, 2015; Spencer et al., 2016). An overwhelming number of Euro-American people believe many of these negative characterizations and attitudes about African American people since they have no connection to the culture beyond the centralized message presented (Cox et al., 2017; Squire, 2015).

Mental health counselors have the unique opportunity to demolish this narrative by broadening their theoretical scope to include multicultural education (Bell,1980, 1987; Moon & Sandage, 2019; Owen et al., 2018; Walker, 2020). Counselors, in general, have struggled to promote equality in access to quality mental health in African American communities (Conway et al. 2017; Duguid & Thomas-Hunt, 2015). Many mental health counselors' struggles involve the following:

> (a) topics of race, gender, and sexual orientation may evoke strong reactions of embarrassment, discomfort, anger, defensiveness, anxiety, and other emotions; (b) academicians and students operate from "academic and politeness protocols" and are ill prepared to facilitate such difficult dialogues when intense emotions are provoked; (c) instructors and supervisors may feel they lack expertise on the subject matter and, indeed, may experience discomfort themselves; (d) the dilemma of which groups and how many groups to fit into a course requires unenviable decisions; and (e) the inclusion of diversity and multiculturalism entails using new paradigms that may challenge traditional Euro-American assumptions. (Sue et al., 1999, p. 1066)

Whether due to a lack of African American counselors (BLS, 2016), resistance to recognizing White privilege (Conway et al. 2017), or lack of exposure interaction (Cox et al. 2017), having

cultural competence is vital to combating mental healthcare disparities in marginalized communities.

Eurocentric approaches to mental health counseling dismiss evaluations of client experiences as the mental health counselor's understanding of power and privilege is often unable to believe life encounters invisible to Western perspectives (Haarhoff et al., 2015; Sleeter, 2017; Miyamoto et al., 2018). These differences in cultural experiences challenge mental health counselors to explore research around the cultural stressors that are precursors to anxiety, depression, mood disorders, and mental health dysfunction that impact cultures not like their own (Cruz et al., 2019). For example, a mental health counselor who espouses colorblindness could make a client feel their identity as an African American is being erased and dismissed in therapy (Hook et al., 2016b; Jerald et al., 2017). A mental health counselor with western feminist ideology, advocating for wage increases and accepting a percentage that still leaves women of color below the poverty line, represent meritocracy, incremental change, and false empathy rather than advocacy for equality (Hoover, 2016; Sleeter, 2017; Velez et al., 2018).

It is important for the culturally competent professional to understand "culture-specific and culture-universal" perspectives in an effort to ensure they are helping the client to function within their cultural system as well as the universal system (Sue & Sue, 2013). Broaching is an intervention for cross-cultural counseling. Broaching is the act of approaching discussions of cultural differences and similarities and privilege and power to the forefront of education and supervision of mental health counselors (King & Borders, 2019). King and Borders (2019) found that even as the foundational tenets of cultural competence are taught to mental health students, the students experience difficulty with inviting clients of color to discuss racial concerns. King and Borders found that there were few statistically significant differences between the success of

African American and Euro-American students who used the broaching technique. This was particularly true when clients assessed the working alliance and willingness to continue as statistical difference was noticed with cultural humility, cultural (missed) opportunities, and cross-cultural counseling. New approaches to Eurocentric counseling education are necessary to combat the depth of disparities in mental healthcare for marginalized communities. Broadening the counseling perspective to focus on cultural competence is particularly important to the African American experience with mental health counseling.

African American experiences. Researchers of African American history and mental health counseling theory recognize that racism is an institutional staple, counter storytelling is crucial to diverse knowledge, and progress is made in communities of color when the inequity affects non-minority populations and intersectionality is rarely granted to African American communities (Crenshaw, 2011; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Diggles, 2014; Dunac & Demir, 2017; Haskins & Singh, 2015; Walck, 2017). Bell et al. (1989) and Ratts et al. (2016) posited that Euro-American people experience their Whiteness as holding value and privilege much like that of property. Professing to a colorblind race-neutral perspectives and lacking relationships with other cultures allows oppression to continue, and there is a need for commitment to advocacy and social justice in the African American community beyond civil rights to establish a worldview that is contextual and current (Crenshaw, 2011; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Diggles, 2014; Dunac & Demir, 2017; Haskins & Singh, 2015; Walck, 2017). As a result, counseling professionals are asked to implement interventions and advocate for and promote dialogue that embraces the tenets of MCSJCC as

they work to understand how their unconscious bias imprints on the therapy they provide in these communities (Baker et al., 2015; Dunac & Demir, 2017; Ratts et al., 2016).

Studies of the African American community experiences in mental health generally center around negative therapeutic outcomes, poor communication, microaggressions, dismissive language, medical mistrust, and monolithic perspectives of the counselors it is important to use a more diverse approach to counseling (Benuto et al., 2018; Cuevas et al., 2016; Hyatt, 2019). These challenges are often judged by the mental health counselor as an internal locus of control for the African American client because the mental health counselor reverts to their Eurocentric training and worldview (Charnin, 2016). It has been speculated that the African American client is not interested in therapy due to their faith, stigma perpetuated by the community, or historical mistrust of the therapeutic process or due to the client's own mental illness (Bilkins et al., 2016; Dillon et al., 2016; Eyal et al., 2018; Flynn et al., 2019; Tormala et al., 2018). African American participants of research reported low levels of race discordance and stated they simply wanted someone who was culturally competent (Cuevas et al. 2016). Cuevas et al. (2016) agreed and discovered that medical mistrust, poor communication, and race discordance were societal norms developed over time that prevented African Americans from receiving the same quality care as their European counterparts. CES has recognized that change is needed for marginalized communities and made changes to counselor training that promote cultural awareness, knowledge, and skill in mental health counseling.

Euro-Americans who possess equalitarian perspectives in their treatment of others have reported feeling repulsed, uncomfortable, and guilty when perceived as prejudiced or racist (Blanton et al., 2015; Conway et al., 2017; Howell, 2017). The current political climate has revealed and allowed for the expression of racial prejudice toward African Americans; however,

most Euro-Americans express concern that there will be consequences for publicly racist behavior (Conway et al., 2017; Howell, 2017). Euro-American perspectives result from the normalization of racial bias to ensure superiority through cultural conditioning (Hook et al., 2016a; Tormala et al., 2018). Owen et al. (2018) stated that 51-81% of African Americans in therapy experience at least one microaggression, and more than 75% of clients do not examine the emotions they experience with the counselor. Recent research demonstrates that images and narratives were exchanged and conveyed over generations, often hyperbolized to establish foundational fear as a control mechanism (Duguid & Thomas-Hunt, 2015; Jerald et al. 2017). Duguid and Thomas-Hunt (2015) espoused that those exposed to frequent stereotyping information tend to hold and act on biases explicitly. Though there are studies of implicit associations between cultures (e.g., German to Turkish, Italian to African), there are few with the racial history of Euro-American and African Americans (Hook et al., 2016a).

Often, minority students in mental health counseling are overlooked in the cultural competence conversation. CES professionals and mental health students assumed that they possess the necessary skills to treat clients from marginalized communities (Sue & Sue, 2013). Though the minority mental health counselor population is small (BLS, 2016), CES has attempted to broach classroom conversations of cultural competence within the intersectionality of the curriculum (Sue & Sue, 2013). It is important not to dismiss minority students' experiences and allow them the opportunity to assist in the expansion of evidence-based strategies beyond Western perspectives (Sue & Sue, 2013).

Counselor Training

Mental health counselor training is instrumental in the development of cultural competence and recognition of implicit racial bias. Multicultural competence for CES is key to

ensuring new mental health counselors are aware of their own biases as they begin assessing clients of similar and different cultures (Ratts et al., 2016; Sue & Sue, 2013). A mental health counselor's worldview is important beyond race or ethnicity and stretches toward gender, sexual orientation, socio-economic status, and religion (Owen et al., 2016; Ratts et al., 2016; Sue & Sue, 2013). As a mental health counselor, it is important that master's-level programs incorporate coursework that moves beyond the classroom and into the communities with practicum requiring immersion in marginalized communities (Killian, 2017; Owen et al., 2016; Flynn et al., 2018). If not, mental health counselors can find themselves completely detached from their client's reality and the counseling sessions were void of progress because the mental health counselor does not understand the dominant discourse of the client (Owen et al., 2016; Ratts et al., 2016; Sue & Sue, 2013). Research has shown that instilling cultural competence may work best for CES professionals who use a parallel, isomorphism, and relationship process to shift the individual counselor's perspective toward cultural competence (Abbott et al., 2019; Hook et al., 2016a, b; Kumar et al., 2015; Scott, Gage, Hirn, & Han, 2018; Stroud et al., 2016). These methods provided a consideration of how Western cultural conditioning has shaped both CES professionals and mental health counselors' understandings of marginalized communities (Abbott et al., 2019; Hook et al., 2016a, b; Kumar et al., 2015; Scott et al., 2018).

Parallel process is the recognition that the mental health counseling student is the common denominator in both CES and client relationships (St Arnaud, 2017; Stroud et al., 2016). Mental health counselors tend to carry both positive and negative dynamics from their relationships with CES professionals and clients based on their own life experiences (Killian, 2017; St Arnaud, 2017; Stroud et al., 2016). The parallel process, if acknowledged by the CES, may have the ability to challenge multicultural education by creating feelings of angst and

irritation when the multicultural needs of the client and mental health counseling student are not being met in counseling and training (Hook et al., 2016a, b; Killian, 2017; St Arnaud, 2017). The transference may be isomorphic in training mental health counselors.

Isomorphism, according to Weir (2009), occurs when the mental health counselor and CES take on near synonymous perspectives. It is a mirroring or mimicking of the interactions between the mental health counseling student and CES professional in the relationship between the client and the mental health counseling student (Hook et al., 2016a, b; Killian, 2017; St Arnaud, 2017; Stroud et al., 2016; Weir, 2009). In mental health counseling, isomorphism means that where implicit racial bias or stereotypes exist in the mental health counseling student/client relationship, they may also exist with the CES (Stroud et al., 2016).

The third element of the CES process is the relationship (Stroud et al., 2016). This can be summed up in the attitude the CES professional takes toward the mental health counseling student (Hook et al., 2016a, b; St Arnaud, 2017; Stroud et al., 2016). Hook et al. (2016a, b) expressed that CES professionals are the gatekeepers of the counseling profession and if they lord their power and influence in a way that deters a potentially excellent mental health counselor, they have done immense harm across the community as a whole. An understanding of these three processes is important in training mental health counselors.

It is vital for a CES professional to understand how important their role is as a gatekeeper (Hook et al., 2016a, b; Killian, 2017; St Arnaud, 2017; Stroud et al., 2016). Not only to ensure the competency and confidentiality of the mental health counseling student, it is also to protect the client from harm (ACA, 204; CACREP, 2016; Hook et al., 2016a, b; Killian, 2017; St Arnaud, 2017; Stroud et al., 2016). They reported that the CES is instrumental in training mental health counselors as they transform their worldview to acknowledge the need for cultural

competence (Hook et al., 2016a, b; Killian, 2017; St Arnaud, 2017; Stroud et al., 2016). CES professionals are required to be knowledgeable, culturally attuned, and empathic to ensure the cultural competency of mental health counselors (ACA, 204; CACREP, 2016; Stroud et al., 2016). CES has acknowledged and created a path for cultural competence advancement.

Counselor requirements. The CES profession recognized that culturally competent mental health counseling professionals increase opportunities for access to care and promote help-seeking behaviors; they safeguard, advocate for, and encourage their profession through contextual relevance of individual intersectionality and validation regardless of racial or ethnic background, gender, sex or socioeconomic status (Bowleg et al., 2016; Eyal et al., 2018; Flynn et al., 2019; Memon et al., 2016; Ratts et al., 2017; Sleeter, 2017; Wang, Koh, & Song, 2015). As a result, the AMCD instituted a committee to revise the MCC utilized in the industry (Ratts et al., 2016). Ratts et al. (2016) found that it was vital to move beyond the ideals of awareness, knowledge, and skill to begin implementing pedagogies that understood the context of how the marginalized and privileged experience mental healthcare. They devised the framework of MCSJCC. These competencies began cultivating students and counselors who acknowledged their own implicit racial bias, recognized the client's worldview, encouraged the counselor to foster a healthy relationship with their client, and embraced the ideals of social advocacy (Ratts et al., 2016). The MCSJCC did not eliminate the ideals of awareness, knowledge, and skill; rather, it expanded the concepts to include action and understanding one's own attitudes and beliefs (Ratts et al., 2016). The latter, attitudes and beliefs, were described as the "values, beliefs, biases, and the different statuses they [counselors] hold as members of marginalized and privileged groups" (Ratts et al., 2016, p. 38). The MCSJCC kept Sue et al.'s (2009) perspective

that discussing cultural conditioning and inherent bias is crucial to exposing honest dialogue that promotes increased cultural competence.

To instigate social transformation, MCSJCC (Ratts et al., 2016) moved beyond the subtle discussions of justice and started to permeate pedagogical thought in many professions (Dunca & Demir, 2017; Piercy et al., 2016). Incorporating MCSJCC in mental health counseling curriculum facilitates the implementation of legislative advocacy and understanding of cultural norms that promote healing in mental health (Charnin, 2015; Cone & Ferguson, 2015; Conway et al. 2017). The certifying bodies of CACREP and COAMFTE state that programs must have a contextual understanding of cultural diversity and inclusion in the curriculum, but do not require practice or demonstration of knowledge and skill within internships or residencies through immersion (CACREP.org and COAMFTE.org). When mental health counseling professionals are culturally competent, they increase opportunities for access to care and help-seeking behaviors and provide safety, advocate for, and encourage their clients through psychoeducation and validation in a therapeutically stable environment regardless of ethnic background or socioeconomic status (Bowleg et al., 2016; Memon et al., 2016; Wang et al, 2015).

Under the new guidelines, mental health counselors were required to build a successful therapeutic alliance through advocacy, empathy, tolerance, and a relativistic perspective (Paone et al., 2015). Counselors, counseling supervisors, and educators may advocate for advanced CACREP curriculum development that includes immersion in marginalized communities during internship and coursework with a depth of historical context and robust discussions of implicit racial bias in a safe academic setting (Edwards, 2016; Haskins & Singh, 2015; Lu, 2017). Research illustrated that there are significant stressors in minority communities that produce anxiety, depression, relational dysfunction, and marital discord in families (Chae et al., 2020;

Cuevas et al., 2016). African Americans, in particular, have discussed experiencing barriers limiting access to quality care through perceived microaggressions, globalization of narratives, and documented institutional racism, diminishing their desire to seek therapy (Cruz et al., 2019; Edward, 2016; Flynn et al., 2019; Memon et al., 2016; Rikard et al., 2015; Samuel, 2020; Walker, 2020). Mental health counselors who do not understand these challenges have difficulty connecting their cultural assumptions and perceptions to the client's worldview and culture and have developed neither the skills nor introspection needed to work with African American populations (Conway et al., 2017; Spencer et al., 2016; Tormala et al., 2018). Such clients may find that the sessions are not progressing because the mental health counselor does not understand the dominant discourse and seeks to dismiss the clients' narratives (Dillon et al., 2016). The MCSJCC perspective is a drastic change from where counseling began (Sue & Sue, 2013; Ratts et al., 2016).

Civil rights and MCSJCC. Cultural competence ideals began to surface during the Civil Rights Movement of the 1950s, as counselors desired to meet the culture-specific needs of marginalized communities (Sue, 1990). The ACA and CACREP focused their attention on developing new guidelines that incorporated the effects of cultural communication styles, proxemics, kinesics, paralanguage, high and low context, and non-verbal microaggressions on marginalized communities (Hansen et al., 2000; Mays, 1985; Sue, 1990, 2004; Wren, 1962, 1985). West and Moore (2015) expressed that CACREP accreditation was designed to ensure that counseling programs were evaluated and structured and provided students with relevant

multicultural guidance that ultimately led to measures that assess success. Changes in these organizations meant changes in curriculum.

In the counseling and CES profession, textbooks, journal articles, practicums, and research embrace diversity and multiculturalism, requiring students to specifically consider race as a tenet of treatment across communities (CACREP, 2016; Freeman et al., 2016). As such, multicultural training requires a counselor educator to assist in building skills to help counselors process cultural conditioning and implicit bias (Haarhoff et al., 2015) as they become more aware of how microaggressions and institutional racism affect the lives of their marginalized clients (Freeman et al., 2016). Barden et al. (2017) postulated that many counselors lack self-awareness and find multicultural classes inadequate for working with clients of differing cultures. What counselors learn in multicultural pedagogical studies is often insufficient to create a paradigm shift in cultural conditioning perspectives (Sleeter, 2017). This is particularly true as Euro-American students often report disappointment with educators who weave multicultural perspectives into curricula. These students stated that though their professor was passionate about providing services to African Americans, the students did not see the benefit of multiculturalism as they do not plan to work with minority communities (Han & Leonard, 2017; Eyal et al. 2018; Linley, 2018). This research suggests that CACREP should implement adjustments in its curriculum that assist in challenging bias and micro-aggressive behaviors in counseling professions (Cone & Ferguson, 2015; Eyal et al. 2018; Mann & Ferguson, 2015; Scott et al., 2018). There have been successes in multicultural counseling education.

Success of training. CES professionals have increasingly implemented policies and pedagogies that promote amplified cultural competence in both privileged and marginalized communities (D'Andrea et al., 1991; Dillon et al., 2016; Katz & Hoyt, 2014; Ratts et al., 2016;

Sue, 1990, 1999, 2004; Sue et al., 2009, 2010, 2013). Researchers expressed in multiple studies that a lack of multicultural perspectives in treatment contributed to mental health dysfunction for African American clients (Graham et al., 2015; Holmes et al., 2016). Researchers acknowledged that ignoring the societal perspectives that influence cultural ineptitude would make the task of training new multi-culturally astute counselors challenging (Abbott et al., 2019; King et al., 2019; Sue & Sue, 2013). King and Borders (2019) argued that counseling students experience a range of emotions that contribute to their reactions to various cultures. These emotions made a student's reluctance to acknowledge challenges with cultural competence difficult to assess for many counseling educators and made CES professionals focus on broaching cultural competence hit or miss (King and Borders, 2019). Acknowledging a cultural competence deficiency requires CES professionals to evaluate their own cultural competence without providing socially acceptable responses on the researcher's assessments (Cuevas et al., 2016; Neblett, 2019; Tormala et al., 2018). Sue (1995) expressed that culturally competent CES professionals transfer skills that encourage new counselors to think critically and obtain knowledge of other cultures. Yet, often the weaknesses in training so greatly impact marginalized communities that they overshadow attempts at successful forward movement.

Weakness of training. The weakness of mental health counseling stems from the vagueness of education standards. Mental health counseling students' curricula present a basic understanding of cultural conditioning and cultural humility as they are not woven throughout counseling tutelage (Conway et al., 2016; Dillon et al. 2016; Owen et al., 2018). Courses that incorporate cultural studies cannot assess the proficiency of the student beyond self-assessment (Sleeter, 2017). The downfall is that the curriculum without practice teaches "false empathy" (Sleeter, 2017, p. 159) and does not challenge the student's beliefs and biases nor focus on the

therapeutic alliance of African American clients. Hook et al. (2016b) expressed that exploring cultural conditioning and implicit racial bias in the context of the mental health counselor's family history with institutional racism is vital to ensuring barriers to treatment are diminished in marginalized communities. A lack of understanding reduces the counselor's aptitude for the intricacies of how societal and institutional racism affects the ability of African American clients to maneuver beyond the boundaries they perceive concrete (Rikard et al., 2015). These studies ask the counselor to become more informed and introspective of their worldview as they move beyond their comfort zone (Rikard et al., 2015) in counseling sessions (Flynn, 2015; Rats, 2017; Taylor & Kuo, 2018). The research posits that if counselors go beyond their social location, classrooms, and the walls of their office, they can press toward advocacy that is transformative for African American communities (Cortland et al. 2017; Holmes et al., 2016). Curriculum change might have the potential to propel mental health counselors and CES professionals into marginalized communities as they advocate for services and appropriate legislation (Baker et al., 2015). Curriculum and legislative change may begin to move the needle toward equality, removing barriers and disparities in mental health care for African American families (Baker et al., 2015). Dillon et al. (2016) posited that counselors rate their cultural competence higher than their client's assessment of counselor cultural competence. This is consistent with the pervasive perspective that counselors are minimally affected by cultural conditioning and implicit racial bias and possess high levels of cultural competence (Tormala et al. 2018).

Current trends. The current trends in multicultural education are to include multicultural competence courses in counseling training that incorporate experiential learning, didactic classrooms, and community immersion in internships and practicum (Charnin, 2015; Killian, 2017; Reinders, 2017). Each area is necessary to ensure appropriate guidance in cultural

competence. Though didactic has been considered the most passive approach (Kolh, 1984), it is utilized more than experiential or community immersion (Killian, 2017). The aforementioned challenges of weaving cultural competence and implicit racial bias discussions into curricula is being mitigated by new definitions of the role of mental health counselors (Moon & Sandage, 2019).

This study will examine the relationship between implicit racial bias, race, and cultural competence. The assumption is that cultural competence and implicit racial bias will vary according to the self-identified race of the mental health counselor; the statistical difference will be significant, thereby demonstrating a greater need for multicultural training for counselors (Conway et al., 2017; Delgado & Stefancic, 2012; Sleeter, 2017). The current study also assumes that minority communities are equally subject to cultural conditioning and exhibit an implicit racial bias toward these same communities.

Synthesis of the Research Findings

Some counselors recognize institutional racism and cultural conditioning as concepts adversely impacting mental health (Hoover & Morrow, 2016; Mendonca et al., 2019). Many of the mental health counselors found in various studies believe there is only an internal locus of control for their clients' feelings of alienation, depression, or self-hatred (Charnin, 2013; Hoover & Morrow, 2016; Linley, 2018; Mendonca et al., 2019). Nagai (2017) and Neblett (2019) posited that racism had become overt and unconscious and permeated the counseling institution, creating more significant distress in communities of color. Charnin (2013) dismissed this perspective and posited that counselors recognized the systems that marginalized communities exist in and did not exhibit bias.

The pedagogy of mental health counseling students presents a basic understanding of cultural conditioning and cultural humility woven throughout counseling tutelage (Conway et al., 2016; Dillon et al., 2016; Owen et al., 2018). Courses that incorporate cultural studies cannot assess the proficiency of the student beyond self-assessment (Sleeter, 2017). The downfall of the counseling programs, according to Sleeter (2017), is that a curriculum without practice teaches false empathy, does not challenge the student's beliefs and biases, and does not focus on the therapeutic alliance of minority clients.

Hook et al. (2016b), Quiros et al. (2019) and Walck (2017) expressed that exploring cultural conditioning and implicit racial bias in the context of the counselor's family history with institutional racism is vital to ensuring that barriers to treatment diminish in marginalized communities. A lack of understanding reduces the counselor's aptitude for the intricacies of how societal and institutional racism affects the African American client's ability to maneuver beyond the boundaries they perceived as concrete (Rikard et al., 2015). These studies asked the counselor to become more informed and introspective of their worldview as they moved beyond their comfort zone in counseling sessions (Flynn, 2015; Ratts, 2017; Rikard et al., 2015; Taylor & Kuo, 2018). Research posited that if counselors go beyond their social location, classrooms, and eventually, the walls of their office, they can press toward advocacy that is transformative for African American communities (Cortland et al., 2017; Holmes et al., 2016; Quiros et al., 2019). Educator intervention and supervision change has the potential to propel counselors and CES professionals into marginalized communities as they advocate for services and appropriate legislation (Baker et al., 2015; Cruz et al., 2019; Linley, 2018). Curriculum and legislative change can begin to move the needle toward equality by removing barriers and disparities in mental healthcare for African American families (Baker et al., 2015).

In the counseling and CES professions, textbooks, journal articles, practicums, and research embraced diversity and multiculturalism, requiring students to specifically consider race as a tenet of treatment across communities (Freeman et al., 2016). As such, multicultural training requires a counselor educator to assist in building skills to help counselors process cultural conditioning and implicit bias (Davis et al., 2016; Haarhoff et al., 2015; Mendonca et al., 2019; Sleeter, 2017) as they become more aware of how microaggressions and institutional racism impact the lives of their African American clients (Freeman et al., 2016). Barden et al. (2017) postulated that many counselors lack self-awareness and find multicultural classes inadequate for working with clients of differing cultures. An immersion requirement would significantly impact the counselor's ability to transition into an advocacy capacity; express empathy, tolerance, and a relativistic perspective; and build a successful therapeutic alliance (Paone et al., 2015).

The CES profession is crucial to the development of new counselors nationwide. CES professionals are gatekeepers of quality counselors, making them capable of assisting couples regardless of race, ethnicity, religion, gender, or sexual orientation (Freeman et al., 2016; Gibson, 2016; Peters, 2017). A competent supervisor is believed to be culturally attuned to and able to shift within cultures authentically (Peters, 2017). As a gatekeeper, the responsibility of a CES professional is to ensure the honor and integrity of the profession (Celinska & Swazo, 2016). The MCSJCC provides a platform for counselors to explore their implicit racial bias, foster an understanding of the institutional systems, and advocate for change (McCoy & Rodricks, 2015; Ratts et al., 2016; Sue, 1990, 1999). The literature demonstrated that operating within the framework of MCSJCC can assist counselors in seeking additional training; they can immerse themselves in cultures and purposefully work to overcome biases that could derail

advocacy as they create an atmosphere for greater access and positive outcomes for marginalized communities (Cortland et al., 2017; Memon et al., 2016; Ratts et al., 2017).

Implicit racial bias that influences the treatment mental health counselors provide to marginalized communities and thus has the potential to influence help-seeking behaviors (Cuevas et al., 2016; Duguid & Thomas-Hunt, 2015; Houshmand et al., 2017; Mendonca et al., 2019). Help-seeking behaviors are important to the client's ability receive quality mental healthcare that promote healthier families, thereby stifling socioeconomic advancement, reinforcing educational and geographic barriers (Cuevas et al., 2016; Duguid & Thomas-Hunt, 2015; Houshmand et al., 2017; Mendonca et al., 2019), and breaking a counselor's oath to do no harm (ACA, 2014). Minorities who visit counselors who exhibit the smallest hint of bias often avoid interactions to relieve the additional anxiety and depression these biased encounters produce (Cuevas et al., 2016; Neblett, 2019). Implicit racial bias brings marginalization in the therapy room to life (Fong et al., 2017; Mendonca et al., 2019). Counselors assume the responsibility of providing non-judgmental, empathic, and multiculturally competent treatment to all who seek services (Neblett, 2019; Sharf, 2017). Many counselors do not recognize a problem exists, and those who do find it more comfortable to blame the disparity on religion, cultural oversensitivity, or the idea that the mentally ill are not always capable of recognizing quality care (Bilkins et al., 2016; Conway et al., 2017; Cuevas et al., 2016; Duguid & Thomas-Hunt, 2015; Houshmand et al., 2017).

Critique of Previous Research Methods

The dominant discourse of most literature surrounding cultural competence is verbalized through social justice advocacy, cultural humility, or the power/privilege phenomenon muddled with the intersectionality of large cross-sections of marginalized communities and seen through

the eyes of Western society. Very little research focuses specifically on the African American experience of cultural competence beyond demonstrating the existence of disparities and the denial of racial bias in all its forms by mental health counselors. The literature reviewed for this study was qualitative and quantitative as it demonstrated a greater understanding of what it is to exhibit cultural competence or implicit racial bias.

Prior quantitative studies have established the number of perceived microaggressive experiences member of marginalized communities have encountered (Cruz et al., 2019), analyzed students' perspectives on multicultural education (Flynn et al., 2019; O'Hara & Cook, 2018; Paone et al., 2015), provided pre-and post-tests of cultural competence for mental health counselors, and captured implicit bias toward various marginalized groups (Boysen & Vogel, 2008; Edward, 2016; Lal & Hakel, 2016). Qualitative studies were performed to assess clients and counselors' counter-storytelling of perceived microaggressions and counselor cultural competence. None of them sought a MANOVA quantitative inferential study that demonstrates through statistical inference a relationship between the cultural competence of mental health counselors and their implicit racial bias (Davis, 2016; Leedy & Ormrod, 2016).

The majority of the literature succumbed to the socially acceptable responses of the counselor (Lal & Hakel, 2016). Without the benefit of the time latent instrument (IAT; Greenwald et al., 1998) none of the reviewed literature sought to identify a statistically significant difference between scores on the MAKSS (D'Andre et al., 1991) and the IAT across the self-identified race of mental health counselors. Much of the research was focused solely on the cultural competence of student counselors and their ability to become more culturally competent through their studies in multicultural competence curricula.

In the reviewed quantitative research, where multicultural competence and implicit racial bias are measured simultaneously, the assessment was generally limited by the purpose of understanding therapeutic outcomes or in combination with gender bias or gay/lesbian bias (Berger, Zane, & Hwang, 2014; Katz & Hoyt, 2014). Assessments that were singularly focused on revealing implicit racial bias were generally dismissed as invalid (Mendoca et al., 2019). Socially acceptable responses tended to skew the accuracy of assessments that measured a counselor's cultural competency (Boysen & Vogel, 2008; Edward, 2016; Flynn et al., 2019; Lal & Hakel, 2016; Paone et al., 2015), possibly camouflaging lower cultural competency scores (Katz & Hoyt, 2014). Solely relying on cultural competence assessments caused researchers to dismiss the need for further pedagogy in multicultural competency or counselor-specific research that may unmask further reasons for disparities in the African American community (Cuevas et al., 2016; Neblett, 2019; Ratts et al., 2017; Sleeter, 2017; Sue, 1982, 1990, 1999; Sue & Sue, 2013).

Research on mental health counselors' cultural competence was generally performed utilizing MCC or MCSJCC (Boysen, 2009; Boysen & Vogel, 2008; Charnin, 2015). Other variations of counseling professions represented cultural competence through many theoretical frameworks (i.e., critical race theory, systems theory, social theory, or reality theory) (Brown & Jackson, 2017; Delgado & Stefancic, 2012; Edwards, 2016; Mendonca et al., 2019; Miyamoto et al., 2019; Haskins & Appling, 2017; Volpe et al., 2019). The current researcher examined the cultural competency of mental health counselors utilizing the MAKSS and Black/White IAT without additional intersectionality. This researcher surveyed licensed mental health counselors rather than graduate students. Mental health counselors who are currently practicing may provide

insight for CES professionals to see how or if the multicultural curricula diminish disparities by increasing awareness of implicit bias.

Summary

Self-report tools utilized in previous research revealed that counselors perceived that they have greater multicultural awareness than personal knowledge of other cultures and believed they have been taught proficient therapeutic skills to counsel clients from other cultures (Barden et al., 2017; Paone et al., 2015). Counselors believed that recognizing their own bias and worldview constituted multicultural awareness (Yang, 2015). Paone et al. (2015) posited that counselors provided socially acceptable responses that protected individual and industry reputation.

The literature review illustrated that implicit racial biases are revealed in assessments like the IAT (Gawronski, 2002; Greenwald et al., 1998; Owen et al., 2016). Blanton et al. (2015) expressed that the IAT is biased in its assessment of implicit racial bias. The IAT oversimplifies the idea that scores representing an implicit racial bias speak to the propensity of any group to exhibit discriminatory behavior (Blanton et al., 2015). Gawronski (2002) and Owen et al. (2016) argued that IAT scores are not meant to guarantee that a counselor's implicit racial bias will manifest explicitly. Instead, it was an opportunity for researchers to expose the existence of bias and rectify any discrepancies in behavior with pedagogies that challenge cultural norms (Houshmand et al., 2017; Shotwell, 2016; Vess, 2016). Cultural competence was examined in self-report studies with general statistics for counseling professionals and few researchers studied the multicultural competence of mental health counselors and implicit racial bias (Benuto et al., 2019; Katz & Hoyt, 2014). Understanding implicit racial bias was crucial to increasing awareness of the gap between cultural competence on the MAKSS (D'Andre et al., 1991) and

implicit racial bias (Greenwald et al., 1998) across the self-identified race of the mental health counselors in this research.

Chapter 3 delineates the purpose of the study and research question. The research design and established population and sample are assembled with an emphasis on the power analysis utilized in securing the sample size. There is a discussion of the participant selection, their protection, and the data collection and analysis process. Chapter 3 illuminates the structure of the instruments, examines the ethical considerations, and wraps up with a summary of the overall chapter.

CHAPTER 3. METHODOLOGY

This quantitative research methodology provided the opportunity to present assessment results that illustrated differences that might occur in cultural competence and implicit racial bias. The quantitative research design was employed because it offered a measurable depiction of cultural competence's impact on the disparities experienced in mental healthcare for marginalized communities (Creswell, 2013). The survey approach utilized the MAKSS, IAT, and a single demographic question. The assessments were disseminated through the Qualtrics web-based platform for ease of sampling. Chapter 3 focuses on the purpose of the study, research question and hypothesis, and design. There is a review of the target population and sample, procedures, and power analysis employed to obtain the sample. This chapter considers the instruments, their validity and reliability, and the ethical considerations for the research.

Purpose of the Study

The purpose of this quantitative correlational study was to contribute to the body of knowledge regarding CES by addressing the relationship or significant difference between the implicit racial bias and cultural competence of mental health counselors. The practical implications of this non-experimental correlational study are that it demonstrated that CES may utilize it for change to curriculum, and assist mental health students with developing additional cultural competence perspectives or worldview. The results may impact how mental health care professionals advocate for institutional change to promote more minority counselors with experiential knowledge of cultural competence and implicit racial bias in the CES profession (Peters, 2017; Sleeter, 2017; Volpe et al, 2019).

Theoretically, counselors having a greater understanding of how their implicit racial bias may correlate with cultural competence may facilitate their ability to create a therapeutic alliance

that promotes help-seeking behaviors in marginalized communities (Belgrave & Abrams, 2016; Bilkins et al., 2016; Cuevas et al., 2016; Owen et al., 2016). Studies have demonstrated that mental health counselors expressed considerably more multicultural skill associated with providing therapeutic services than they conveyed in awareness of their cultural differences or knowledge of how those cultural perspectives impacted the counselor's worldview regarding the client and treatment (Barden et al., 2017; Paone et al., 2015). However, African American clients are more likely to have experienced dismissiveness, microaggressions, and microinvalidations and harbor a deep mistrust of mental health counselors, creating a chasm of disparities in the mental health services received (Belgrave & Abrams, 2016; Bilkins et al., 2016; Cuevas et al., 2016; Owen et al., 2016; Samuel, 2020; Velez et al., 2018; Walkers, 2020).

This new knowledge may lead to the use of theories that appreciate the perspective that change may occur through recognition of an interaction between racial bias and multicultural competence (Greenwald et al. 1998; Cuevas et al., 2016; Cunningham et al., 2001; Karpinski & Hilton, 2001; Paone et al., 2015). That recognition might have the potential to generate advocacy for education and supervision modifications that create a cognitive shift in multicultural counseling perspectives (Cruz et al., 2019; Linley, 2018; Lu, 2017). Counselors, counseling supervisors, and educators may advocate for advanced multicultural development that includes immersion in marginalized communities during internship, practicum, and post-graduate supervision and pedagogy that encompasses a depth of historical context and robust discussions of implicit racial bias in a safe academic setting (Cruz et al., 2019; Edwards, 2016; Haskins & Singh, 2015; Lu, 2017). The research question set the stage for opening this dialogue.

Research Questions and Hypotheses

The research questions for this study were:

Q1 - Is there a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test?

H_1 - There is a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) for cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test for mental health counselors.

H_{01} - There is no statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) for cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test for mental health counselors.

Q2 - Is there a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test within each racial category?

H_2 - There is a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test within each racial category.

H_{02} - There is no statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test within each racial category.

Research Design

A quantitative methodology and a survey approach was conducted to analyze cultural competence and implicit racial bias without altering circumstances, events, people, or situations. The research design provided the format to confer inferential analysis between the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998) across racial identities, utilizing a MANOVA and correlation analysis to test the hypothesis. The rationale for using a MANOVA and correlation was established in their ability to test three variables, two dependent (MAKSS and IAT) and one independent (race), and provide statistical significance assessments from which inferences could be determined (Creswell, 2014; Leedy & Ormrod, 2016; Priviera, 2016). The inference is essential to the current research as no causation is possible without the manipulation of participants or data in a control group, and the results for this research sample can infer commonalities for the population overall (Creswell, 2014; Priviera, 2016). The web-based survey provided the opportunity to access a broader community of mental health counselors to meet the desired 0.95 confidence interval (Creswell, 2014; Rice, Winter, Doherty, & Milner, 2017). The data is presented in a quantitative format to remove any bias in the research, as numerical values furnished objective perspectives of the participants' self-ascribed beliefs (Dillon, 2016; Gillem et al., 2016; Priviera, 2016). The subjective nature of a qualitative design would not have satisfied the current research (Creswell, 2014).

The current research utilized the web-based survey MAKSS to assess the multicultural awareness, knowledge, and skill of mental health counselors and ended this survey with a racial

identity question. The options for the racial identity question included African American, Euro-American, Hispanic American, Asian American, Native American, and Other. The survey was manually entered into Qualtrics and tested for accuracy. The second survey utilized the IAT in a new generation (IATGen) format, coded explicitly for use on the Qualtrics website (Carpenter et al., 2019). The IAT measured the participants' racial bias for "Black" or "White" people based on the participants' response time to a series of pictures and words. Anonymity and privacy were assured by Qualtrics with numerical coding for each participant, eliminating IP addresses and other personally identifiable information (Qualtrics, 2019). Finally, Qualtrics offered an entry into a drawing for one $50 gift card incentive to all who fully completed the three surveys (Qualtrics, 2019).

Target Population and Sample

Using a Qualtrics survey platform, a survey was distributed nationwide to mental health counselors willing to participate in the study. The Qualtrics platform utilized social media (LinkedIn, Facebook, and Instagram) and the Qualtrics database to build a participant panel (2019). The participants completed preliminary questions of inclusion for age, profession, and agreement to provide quality information before being advised that they could move forward and complete the surveys. If the potential participants did not meet the criteria or attempted to use their cell phone to complete the survey, a message appeared advising that they were ineligible. Though previous research illustrates that online surveys limit the pool of participants to those who are internet savvy (Rice et al., 2017; Toninelli & Revilla, 2016), research posits that online surveys are cost-effective and efficient methods for capturing the data necessary for research (Rice et al., 2017).

Population

According to the Bureau of Labor Statistics (2016), there are approximately 552,000 mental health practitioners (excluding physicians) practicing in the United States. Of that number, 140,600 are mental health counselors. These counselors represent 27% of mental health professionals who have received specific training in culturally astute, CACREP, and COAMFTE approved graduate programs to work with minority clients. The number does not include psychologists, psychiatrists, social workers, and medical professionals. The racial and ethnic breakdown of mental health counselors in the United States is approximately 87% (122,322) Euro-American, 5% (7,030) African American, 3% (4,218) Hispanic/Latino, 2% (2,812) Asian, and 3% (4,218) Other (BLS, 2016).

Sample

This non-experimental correlational research utilized a non-randomized convenience sample recruited by Qualtrics via social media (e.g., LinkedIn, Instagram, Facebook, and Twitter). Qualtrics, an online data collection and research company, collected a panel of participants based on the inclusion criteria and distributed the assessments on their web portal. A sample of 48 licensed mental health counselors over the age of 18 (AAMFT, 2016; ACA, 2014; APA, 2010), of any race, gender, or ethnicity, working either in private practice or an agency, and using the internet self-selected for this study. The mental health counseling profession consists of a relatively small group that spans various degrees, experience, and titles. The participants needed to self-identify as mental health professionals to continue to the informed consent phase. With such a small community of mental health counselors, hiring Qualtrics to locate and survey the participants was time-saving and cost-effective (Rice et al., 2017).

Power Analysis

A free GPower calculator was downloaded and utilized to determine the sample size before hiring Qualtrics. A confidence interval of 0.05%, a standard error of 0.05, and a relative standard error of 5.10 suggested a sample size of 54 participants (Buchner, Erdfelder, Faul, & Lang, 2013; Faul, Erdfelder, Buchner, & Lang, 2009; Faul, Erdfelder, Lang, & Buchner, 2007; Priviera, 2016).

Procedures

The Institutional Review Board approved the use of convenience sampling for this research. It should be noted that Qualtrics guaranteed access to the required sample of mental health counselors across the United States. This section delineates the procedures and details the process of instrument re-creation on the Qualtrics platform. This section has been further categorized into seven sub-sections: (a) participant selection, (b) protection of participants, (c) data collection, (d) means of recruiting, (e) screening and contact, and (f) data analysis.

Participant Selection

Qualtrics, a data collection and research company, performed convenience sampling to ensure mental health counselors were invited to participate in the MAKSS, IAT, and racial demographic surveys. Qualtrics sought participants through social media platforms (e.g., Instagram, Facebook, and LinkedIn) and created participant panels throughout the United States. Participants who agreed moved forward and were offered an incentive from Qualtrics.

Each participant received a link to the surveys that began with an informed consent notification, a list of qualifying questions, and a statement asking for a commitment to honest answers. The informed consent notification detailed the following inclusionary criteria: participants must be over 18; of any race, gender, or ethnicity; working either in private practice

or in an agency; licensed; and able to use the internet to take the surveys. The participants also had access to the researcher and Capella University's email and phone numbers, in case they had any questions regarding the research process or data collection. The informed consent notification stated that it would take approximately 15 minutes to complete the surveys and noted the desired sample size of 48. Next, the participants were asked the following set of questions:

1. We care about the quality of our survey data and hope to receive the most accurate measures of your opinions, so it is important to us that you thoughtfully provide your best answer to each question in the survey. Do you commit to providing thoughtful and honest answers to the questions in this survey?
2. Please indicate your age.
3. Which of the following best describes your current profession?

For Question 1, participants could select one of three responses: (a) I will provide my best answers, (b) I will not provide my best answers, or (c) I can't promise either way. Question 3 included a list of professions from which participants selected a response. Participants who did not select the "therapist" or "mental health counselor" option received the following message: "Thank you for taking the time to answer a few questions. Unfortunately, you do not qualify for this particular survey, but we do hope to hear from you in the future." Qualtrics tracked the IP addresses of all participants to ensure they did not take the survey twice or attempt to restate their profession. The message conveying one's ineligibility was also received by participants who attempted to take the surveys on their cellular phones. The IAT cannot be administered by cellular phones (Greenwald et al., 1998), as it requires a keyboard.

Participants who indicated they were a therapist or mental health counselor were automatically directed to begin the MAKSS. Each step in the procedures was tested before the

full launch of recruitment by Qualtrics. Whether participants agreed to participate or not, their information remains protected.

Protection of Participants

Participant protection is vital to the success of this research study. Confidentiality and informed consent are a priority for the sample of mental health counselors (ACA, 2014). Confidentiality especially is a staple requirement of this study. The surveys are directly administered through Qualtrics. Qualtrics neither revealed the IP addresses of the participants nor provided the researcher with direct access to any personal information that may aid in identifying the participants. Throughout the surveys, the responses to the surveys were numerically coded and assigned to corresponding responses to the MAKSS, racial identification, and IAT. In 2014, the ACA mandated that participants must not be harassed or exploited to return research materials. Thus, no participant was contacted by the researcher. Participants were contacted only twice by Qualtrics via social media over a span of three weeks. Participants must also have the option to decline to participate in or withdraw from the study at any time before or during the research period (AAMFT, 2016). Therefore, those who disengaged from the research were not contacted any further. During and after research completion, it is vital to maintain confidentiality. Thus, the survey data were stored on a secure laptop in the researcher's office after being downloaded from Qualtrics platform. The data will remain secure for seven years.

Data Collection

The entire data collection process was facilitated and performed through the Qualtrics portal. Participants were required to use a laptop or desktop computer to take the surveys. Laptop or desktop usage was particularly crucial because the IAT (Greenwald et al., 1998) requires a keyboard to complete. Participants needed 15 minutes to complete the assessments utilizing the

instruments, and all who completed both instruments were entered into a drawing to receive an incentive gift from Qualtrics.

The researcher programmed the MAKSS and IAT within the Qualtrics platform. Qualtrics administered both the MAKSS (D'Andre et al., 1991) and the IAT (Greenwald et al., 1998) through their website. The IAT (Greenwald et al., 1998) programming began in a separate platform and was uploaded to the Qualtrics platform. The Qualtrics platform requires JavaScript coding to process surveys that are time latent, such as the IAT. Shinyapp allowed the researcher to code JavaScript from Harvard University's IAT for Black/White implicit racial bias (Carpenter et al., 2019). Shinyapp was coded by a programmer directly into the Qualtrics platform and tested for accuracy. The IAT was programmed into Qualtrics using the Shinyapp developed by IATGen and uploaded in Qualtrics for a seamless page that could connect to the MAKSS (Carpenter et al., 2019). Qualtrics then connected the MAKSS, along with the race-selection question at the end, to the IAT without requiring the participant to exit their website to enter Harvard University's website to access the IAT. Coding the IAT in this way also allowed Qualtrics to protect the identity and responses of the participants without exposing their IP addresses.

Participants were invited to participate in this research via social media platforms (e.g., Instagram, Facebook, and LinkedIn). Once participants entered the Qualtrics platform, they encountered the informed consent notification with the inclusion and exclusion criteria. If they agreed to participate, they simply had to click a button indicating their decision and were immediately directed to the consent page. Participants who met the requirements agreed to the informed consent and began the MAKSS (D'Andre et al., 1991). Participants were asked to indicate their racial identity at the end of the MAKSS, which was utilized to delineate

participants in the study. The participants continued to the next portal to take the IAT (Greenwald et al., 1998). Qualtrics provided the output data to the researcher via Excel. The researcher reviewed all data for possible errors (e.g., missing data, invalid ranges, incomplete surveys). The data was then separated into MAKSS, race, and IAT, retaining the participant ID number assigned throughout each survey. The IAT data was then uploaded to the IATGen analytics and received a preferential score (Pro Black or Pro White). Each Excel file from Qualtrics was password protected to ensure only the researcher has access.

Data Analysis

In order to analyze the responses, the data were downloaded from Qualtrics as a Microsoft Excel spreadsheet. Once downloaded, the data were screened for invalid and missing values and removed prior to the statistical analysis, as recommended by Priviera (2016). The invalid or missing data consisted of participants who did not complete all required assessments within the survey. To ensure that each participant's information was kept confidential, each participant received a numerical ID code and the ID code remained the same across all instruments. The data were divided into three Excel spreadsheets for the MAKSS scores, IAT scores, and racial demographic data. Once it was determined that all data were viable, the data were imported into SPSS v. 26. The analysis included descriptive statistics, a one-way MANOVA statistical analysis, and a correlational analysis. Data analysis was crucial to answering the first question that examines whether there were statistically significant mean differences among scores of cultural competence on the MAKSS and Black/White IAT between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors.

One-Way MANOVA

A one-way MANOVA was utilized to determine the existence of a statistically significant difference between results from the MAKSS and Black/White IAT across racial demographics (D'Andre et al., 1991; Greenwald et al., 1998; Laerd, 2019; Priviera, 2016). The statistical approach to compare the dependent variables (MAKSS and IAT) by the self-selected races (independent variable) of the mental health counselors (Laerd, 2019). The MANOVA tests whether or not the race variable simultaneously explains a statistically significant amount of variance in cultural competence and implicit racial bias. Prior to running the MANOVA analysis, logistic testing was performed to ensure assumptions were met: (a) there exists continuous dependent variables (MAKSS and IAT), (b) the independent variable is categorical with two or more independent groups (race groups: African American, Euro-American, Hispanic American, Asian American, Native American, Other), (c) there is independence of observations (Creswell, 2014; Priviera, 2016), (d) there exists a linear relationship between the dependent variables (MAKSS: D'Andre et al., 1991 and IAT: Greenwald et al., 1998) for each group of the independent variable (race), (e) there is no multicollinearity, (f) there are no univariate or multivariate outliers, (g) multivariate normality exists among variables, (h) the sample size is adequate, (i) there is homogeneity of variance-covariance matrices, and (i) there is homogeneity of variances (Creswell, 2014; Laerd, 2019; Priviera, 2016). Hypothesis testing was then conducted to delineate any statistical significance between the race of a mental health counselor and their implicit association and cultural competence, which allowed an inferential evaluation of the descriptive statistics.

Then the researcher rendered an additional analysis for a second question about any statistically significant relationship between the scores of cultural competence as measured by

the MAKSS and implicit racial bias as measured by the Black/White IAT within each racial category. A Pearson's *r* two-tailed correlational study was employed to determine the strength (negative or positive) of the linear relationship between the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998; Laerd, 2019; Priviera, 2016). Statistically significant negative relationships were delineated with asterisks (Laerd, 2019). The MAKSS and IAT were assessed across the self-identified racial categories of the mental health counselor.

Descriptive Statistics

In order to describe the demographic race data, the researcher calculated descriptive statistics. Race was the only demographic data collected as numerical data translated into ordinal data (i.e., 1 = *African American*, 2 = *Euro-American*, 3 = *Hispanic American*, 4 = *Asian American*, 5 = *Native American*, and 6 = *Other*). The race demographic data was summarized by computing the frequencies in each category. The descriptive statistics for the total MAKSS score for cultural competence and the Black/White IAT for implicit racial bias (mean, and standard deviation) were analyzed accordingly for each race. Conclusive quantitative results provided a descriptive analysis of the data by specifying the means and standard deviations for the MAKSS cultural competence scores and Black/White IAT, predictor and outcome variables.

Hypothesis Testing

H_{01} examined the statistically significant mean difference between the races of mental health counselors for cultural competence and implicit racial bias using the multivariate outcome. The MANOVA took into account multiple continuous dependent variables (cultural competence and implicit racial bias), and combined them into a weighted linear combination (Laerd, 2019). Then, the amalgamated weighted linear combination was investigated by the independent variable (race); testing whether or not the race of the mental health counselor

simultaneously explains a statistically significant amount of variance in the cultural competence and implicit racial bias of the same mental health counselors (Laerd, 2019). H_{02} inspected the statistically significant relationship between the scores of cultural competence and implicit racial bias within each racial category using univariate Pearson's *r* analysis. The results of a Pearson's *r* correlation may demonstrate a linear relationship between cultural competence and implicit racial bias. If a statistically significant relationship exists, a Post-Hoc analysis is necessary to ascertain where that relationship lies (Laerd, 2019).

Post Hoc Analysis

A Fisher's Least Significant Difference (LSD) test post hoc analysis was completed where a significant statistical difference was demonstrated in the data analysis. Additionally, because the sample sizes in each independent variable (race) category were different, and LSD was best suited for analysis of significantly statistical correlations (Laerd, 2019). The LSD post hoc can be seen in Table 9 of Chapter 4.

Table 1

Data Analysis Summary

Research Question	Type of Analysis	Descriptive Statistics	Hypothesis Testing	Post Hoc Analysis
RQ1	MANOVA	Frequencies Means Standard Deviations	H_0: β_1, $p < 0.05$ H_A: β_1, $p \leq 0.05$	N/A
RQ2	Pearson's *r*	Correlations	H_0: β_1, $p < 0.025$ H_A: β_1, $p \leq 0.025$	LSD

Software Used in Data Analysis

Analyzing the components of the MAKSS (D'Andrea et al., 1991), race, and IAT (Greenwald et al., 1998) required the use of multiple software tools. Each tool had a role to play

in either collection, delineation of data, or actual analysis. Qualtrics XM, Microsoft Excel, IATGen, and IBM SPSS v.26 Statistics were used to analyze the data.

IATGen. IATGen is an analytics software that allows researchers to create JavaScript to upload to the Qualtrics platform. IATGen then converts time latency from the response captured in Qualtrics and translates them to numerical racial bias (Carpenter et al., 2019). The IATGen software's codes were zero-sum as a neutral bias, negative sums as a bias for Euro-Americans, and positive sums as a bias for African Americans.

IBM SPSS v.26 Statistics. Neither Qualtrics nor IATGen nor Excel are capable of providing the analytic detail that delineates statistical significance between the MAKSS and IAT across racial demographics. SPSS v.26, however, allows for descriptive hypothesis testing and the use of MANOVA to answer the research question. It should be noted that data was manually uploaded into the program. A one-year subscription was purchased for this research.

Microsoft Excel for Mac. Version 15.32 of Microsoft Excel for Mac was utilized to download responses provided by Qualtrics. A master file was delineated into three spreadsheets: MAKSS, race, and IAT scores. The MAKSS scores were further separated to analyze awareness, knowledge, skill, and the overall total to measure competence. Race was categorically translated numerically when exported to SPSS v.26. The IAT was saved as a .csv file and exported to IATGen.

Qualtrics XM. In July 2019, the researcher acquired the licensed services of Qualtrics. Qualtrics was hired (a one-year student subscription) to assist with the dissemination of the three surveys and data collection. Qualtrics worked with the researcher to upload the verbiage for the MAKSS and race survey and ensure that the JavaScript coding functioned within the platform they offered. Matching the JavaScript was crucial to ensure a seamless flow between each

survey. Within two weeks, Qualtrics collected enough completed surveys to meet the research requirements. Qualtrics then provided an Excel spreadsheet that included individual responses to an ID number to ensure proper separation of responses across surveys.

Shinyapp. Shinyapp allowed the researcher to import the JavaScript code into the Qualtrics platform (Carpenter et al., 2019). The researcher set the positive and negative attributes for the words and pictures according to the Black/White Harvard University IAT study (Carpenter et al., 2019). The full Black/White study was then uploaded directly into the Qualtrics platform and connected to the MAKSS for seamless survey presentation.

Instruments

MAKSS

MAKSS was developed by D'Andre, Daniels and Heck in 1991 and permission to utilize the survey was sought and obtained from the authors for use in this research. MAKSS assesses a counselor's multicultural awareness, knowledge, and skills (D'Andre et al., 1991). It is a 60-item self-assessment survey revealing a mastery of course work to real-world implementation (Kim, Cartwright, Asay, & D'Andrea, 2003). MAKSS is a nominal dependent variable (Piveria, 2016). The total score a mental health counselor can obtain on the MAKSS is 240, with a score of less than 180 representing a lack of cultural competence. Eighty is the highest possible score per subcategory of the MAKSS. A score of less than 69 in any of the three categories represents a lack of cultural competence in terms of that category. Likert scales are used to allot points from one to four, with responses ranging from *very good* to *limited* in the subscale areas. Higher scores depict greater competence, even in reverse-scored items. It is worth noting that MAKSS' validity and reliability have been tested continually in the counseling community. The mental health community recognizes that socially acceptable responses are prevalent (D'Andre et al.,

1991; Kim et al., 2003), yet demonstrates the MAKSS is comparable to other multicultural scales.

Validity

Validity confirms whether assessment tools do what they say. Content-related validity is essential for working with criterion-referenced instruments that assess human behavior. Criterion-referenced instruments are not designed to compare a counselor's ability to another counselor's, but rather compare each counselor's ability to their mastery of a skill (Priviera, 2016). Construct validity is the extent to which an instrument measures a theoretical or hypothetical trait or construct. For example, does the MAKSS (D'Andrea et al., 1991) measure the total cultural competence of counselors? After comparing the MAKSS (D'Andrea et al., 1991) to a host of other cultural competence surveys (e.g., the MCKAS [Ponterotto et al., 2002] and MCI [Sodowsky et al., 1994]), content and construct validity were established at 0.59 and 0.51, respectively.

Reliability

The reliability of the MAKSS was also crucial to this study. It provided the researcher with the ability to ensure that self-assessed mastery of cultural competence was accurately analyzed with the aid of the MAKSS (D'Andrea et al., 1991; Piveria, 2016). As per the definition for reliability, if a counselor takes the same test at a different time, it should yield similar results. In this regard, the reliability of the MAKSS (D'Andre et al., 1991) was verified with coefficients of 0.71 (awareness), 0.85 (knowledge), 0.87 (skill), and 0.82 (total competence) in comparison with the MCKAS (Ponterotto et al., 2012) and MCI (Sodowsky et al., 1994).

Race

The participants self-selected their racial identity. Race is an ordinal independent variable (Piveria, 2016). According to the most recent United States Census (2018), approximately 12.7% of the United States' population are African American (~41m), 18.3% are Hispanic (~60m), 72.2% are Euro-American (~236m), 0.9% are Native American 0.9% (~3m), and two percent are others (~9.6m). The United States Census accounted for individuals who responded with more than one race. The racial and ethnic breakdown of the mental health counselors in the United States with the potential to participate in a research study are as follows: approximately 87% (122,322) Euro-Americans, 5% (7,030) African Americans, 3% (4,218) Hispanics/Latinos (a), 2% (2,812) Asians, and 3% (4,218) Other (BLS, 2016). The current study sought to capture mental health counselors from the represented United States Census population and have them self-select their racial demographic.

At the end of the MAKSS (D'Andrea et al., 1991), participants selected their racial identity (African American, Euro-American, Hispanic American, Asian American, Native American, and Other). Qualtrics reported race through ordinal values, and the researcher translated the data into nominal statistics and analyzed them using SPSS v.26. The race variable was translated accordingly: 1 = *African American*, 2 = *Euro-American*, 3 = *Hispanic American*, 4 = *Asian American*, 5 = *Native American*, and 6 = *Other*. This variable followed the ID number set by Qualtrics to ensure that the participants' race carried forward with their answers to the MAKSS (D'Andre et al., 1991). The race variable aided in answering the question about the statistically significant relationship between the MAKSS and IAT in terms of race.

Answering the self-selecting racial question was required to move forward in the survey. The question was asked in a user-friendly selection format. No permission was requested from

an institution or organization to ask the racial demographic question. Apart from this, no other demographic information was requested. Reliability and validity were based on the truthfulness of the participants.

Black/White Implicit Association Test

The IAT was developed by Greenwald, McGhee, and Schwartz in 1998 and permission to utilize the survey was sought and obtained from the authors for use in this research. The IAT (Greenwald et al., 1998) is a time-latent (the length of time it takes to answer) assessment that automatically indicates racial bias based on cultural conditioning. The Black/White IAT is a nominal dependent variable (Piveria, 2016). It measures the unconscious beliefs attributed to African Americans or Euro-Americans by a counselor. Instructions were provided to participants requiring them to use the "E" or "I" key on the keyboard to indicate *good* or *bad* for pictures and words that appear randomly on the screen. The instructions indicated when to utilize each key to assess *good* or *bad*. Their response time aids in assessing how the participants attributed immediate automatic positive or negative stereotypes to African Americans or Euro-Americans based only on one picture and one word at a time.

The responses to the IAT in Qualtrics were exported into the IATGen analytics software to convert time latency to racial bias. The IATGen software's codes were zero-sums for neutral bias, negative sums as a bias for Euro-Americans, and positive sums as a bias for African Americans. This is based on the fact that African Americans are programed as Target A and Euro-Americans as Target B. As previously stated in the data collection section of this study, targets A and B are coded into Qualtrics using the JavaScript provided by the IATGen from Harvard University's Implicit Project platform (Carpenter et al., 2019). The scores of the IAT

(Greenwald et al., 1998) aided in determining the level at which the mental health counselors had the potential to exhibit behaviors that are biased or discriminatory toward African Americans.

Validity

Cunningham et al. (2001) found the IAT (Greenwald et al., 1998) to possess context and criterion validity, implying that it measures what it intends to—implicit racial bias. They found the IAT capable of bypassing socially acceptable responses provided on the Modern Racism Scale (McConahay, 1986). The research on the IAT completed by Cunningham et al. (2001) revealed that participants had associated bad with African American and good with Euro-Americans more often than reported in the self-reporting tool. Furthermore, Cunningham et al. (2001) demonstrated a validity mean alpha of 0.78 compared to the response-window priming alphas ranging from 0.63 to 0.69. The time-latency aspect of the IAT results in a validity of 0.86 (Blanton et al., 2015; Greenwald, 1998) across implicit and explicit measures of racial bias and discrimination. However, Blanton et al., (2015) prefer a metric for explicit rather than implicit reporting. They found that 90% of those exhibiting bias for Euro-Americans to African Americans in the implicit study exhibited behaviors in the explicit discriminatory behaviors at a rate of 70%.

Reliability

The IAT (Greenwald et al., 1998) assessment tool assists a counselor in predicting future behavior. The tool can help counselors to understand mental health care disparities in the African American community. The tool can also aid CES professionals in assessing a student's interaction with a particular population and determining a student's cultural competence.

Reliability assisted in determining the ability of the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998) to find real variance or consistency. The coefficient alpha was

calculated utilizing a range of options on a Likert scale such as *greatly dislike* to *strongly like* (Priviera, 2016). The IAT (Cunningham et al., 2001; Greenwald et al., 1998) was found to have a reliability of 0.68. The research study demonstrated that the lack of socially acceptable responses makes the IAT more reliable; however, the metric cannot predict behavior (Blanton et al., 2015; Lal & Hakel, 2016; Nosek, Bar-Anan, Sriram, Axt, & Greenwald, 2014).

Ethical Considerations

Capella University's Institutional Review Board reviewed and approved this research. No risk of participation was found, and no population was considered vulnerable or sensitive if they agreed to participate in the survey (ACA, 2014; Wheeler, 2020). Qualtrics was instrumental in ensuring that participants did not expose their IP addresses; all participants were assigned an ID number that carried through each survey. According to the AAMFT's (2016) code of ethics, if an alternative hypothesis exists in a research study, a detailed analysis must present the null, as there would otherwise be a misrepresentation of the research. Confidentiality and informed consent were a priority for the sample of mental health counselors (ACA, 2014; Wheeler, 2020). Participants were protected from harassment and exploitation to return research materials (ACA, 2014). Participants were also provided with the option to decline to participate in or withdraw from the study at any time before or during the research period (AAMFT, 2016).

The author of this research is an African American marriage and family therapist. She has experienced microaggressions, microinvalidations, and dismissiveness both in her coursework and state-required post-graduate training. Fellow counselors who profess to be highly culturally competent have been challenged with acknowledging and understanding how they disconnect with minority clients in terms of language, both verbal and non-verbal. As a result, to remain unbiased about the findings, it was crucial that the researcher journaled her own experiences

before, during, and after writing to taper emotional triggers during the study (Keightley, Pickering, & Allett, 2012).

The CES profession and affiliated associations and institutions (ACA, APA, AAMFT, and Capella University) are keen on implementing evidence-based practices. As a result, this study utilized instruments that possess high levels of validity and reliability when compared to similar instruments (ACA, 2014; AAMFT, 2016; APA, 2010). This eliminated the need to create instruments and provide field testing to demonstrate the validity and reliability of a new instrument.

Qualtrics ensured an adequate participant panel (Qualtrics, 2018). They segregated the data and mitigated any loss due to incomplete surveys by continuing to send surveys to the intended population (Qualtrics, 2018). They also provided an incentive opportunity for each participant. Qualtrics ensure data security, eliminating any personally identifiable information and providing data to the researcher immediately upon completion. During and after research completion, it is vital to maintain confidentiality. Thus, the survey responses have been stored on a secure server within the research office.

Summary

Chapter 3 outlined the purpose of this study and delineated the research question and hypotheses. It expounded on the research design and provided a detailed description of the population sample and the power analysis that was used to identify the needed sample size. Chapter 3 detailed how participants were selected and protected during the study. This chapter presented an exhaustive record of the data collection and analysis processes and specifics about the instruments utilized. Finally, the chapter ended with ethical considerations for ensuring the study is comprehensive.

CHAPTER 4. RESULTS

Chapter 4 details the results of the two research questions. The first research question was: are there statistically significant mean differences between races for cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test for mental health counselors? The second research question was: is there a statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test within each racial category? Chapter 4 presents the background of the study, a description of the sample, and the hypothesis testing. Finally, this chapter delineates the descriptive statistics, MANOVA, and correlations, detailing any statistical difference utilizing the IBM SPSS v.26 to conduct an analysis.

Description of the Sample

The acquired sample (n = 59), which was larger than needed sample size, consisted of mental health counselors over the age of 18 who were licensed to provide services to an agency or conduct private practice at the time of data collection. The participants were recruited by Qualtrics via various social media platforms. The GPower 3.1 tool allowed a confidence level of 95%, a confidence interval of 0.05%, a standard error 0.03, and a relative standard error of 5.10% for a sample of 48 participants (Buchner, 2013; Faul, 2007, 2009). Table 2 revealed the racial demographics of this research population: 11% (6) African American; 71% (41) Euro-American, 8% (5) Hispanic and Asian American, 1% (1) Native American, and 1% (1) Other. In descriptive statistics, race was coded and translated from numerical data to nominal data to ensure both descriptive statistics and MANOVA captured the racial data's connection to the MAKSS and IAT. The study excluded the 18 incomplete responses, resulting in a final sample of

59 mental health professionals. The races were coded as follows: 1 = *African American*, 2 = *Euro-American*, 3 = *Hispanic American*, 4 = *Asian American*, 5 = *Native American*, and 6 = *Other* (Table 2).

Table 2

Descriptive Statistics: Population Sample

Race	N	Percentage
African American	6	11
Euro-American	41	71
Hispanic American	5	8
Asian American	5	8
Native American	1	1
Other	1	1
Total	59	100

Qualtrics did not provide data for the number of mental health counselors who were invited to participate or the response rate of the participants. Qualtrics provided the results two weeks after the launch of the project. SPSS v.26 was utilized to present summaries of the descriptive statistics, assumptions, and MANOVA statistical analysis. The results of the study were not intended to identify age, gender, socio-economic status, education levels, location, or length of time in practice as that information was outside the scope of this study

Hypothesis Testing

Preparation of the data set required calculating subscores for each component, totaling the scores of the MAKSS (D'Andrea et al., 1991), IAT (Greenwald et al., 1998), and racial bias question, and transcribing race from numerical to nominal. The findings are demonstrated through (a) underlying assumptions of hypothesis testing, (b) descriptive statistics of the data (i.e., means, standard deviations, and percentages), (c) a one-way MANOVA indicating any statistical significance for MAKSS and IAT across self-identified racial demographics, and (d) Pearson's correlation to assess the relationship between the MAKSS and IAT.

Descriptive Statistics

The overall descriptive statistics of the MAKSS (dependent variable) and IAT (dependent variable) are illustrated in Tables 2 and 3. Utilizing the MAKSS, the maximum score a mental health counselor can obtain is 240, with a score of less than 180 representing a lack of cultural competence. The highest possible score per subcategory of the MAKSS is 80. Thus, a score of less than 69 represents a lack of cultural competence in terms of the individual awareness, knowledge, and skill subscales.

In Table 3, Hispanic Americans (M =58.2, SD = 3.27) demonstrated greater cultural awareness than Asian Americans (M = 57, SD = 3), Euro-Americans (M = 55.4, SD = 4.43), African Americans (M = 53.3, SD = 3.20), Native Americans (M =50, SD = 0.0) and those in the Other category (M =56, SD = 0.0). The total MAKSS Awareness scores were M = 55.4, SD = 4.20. African Americans demonstrated (M = 63.3, SD = 8.01) greater cultural competence in the knowledge category than Hispanic Americans (M = 63.2, SD = 5.80), Asian Americans (M = 54.6, SD = 7.72), Euro-Americans (M = 55.41, SD = 4.43), Native Americans (M = 59, SD = 0.0), and those in the Other category (M = 57, SD = 0.0). The total MAKSS Knowledge scores were M = 56.6, $S D$ = 7.90. Hispanic Americans (M = 73.6, SD = 5.32) exhibited greater skill in cultural competence than African Americans (M = 73.1, SD = 4.57), Asian Americans (M = 66.6, SD = 1.949), Euro-Americans (M = 63.6, SD = 9.531), Native Americans (M = 76, SD = 0.0), and those in the Other category (M = 65, SD = 0.0). The total MAKSS Skill scores were M = 65.9, SD = 9.098.

Table 3

Descriptive Statistics: MAKSS Subscore Demographics by Race

Competence Tenet	Race	Mean	Std. Deviation	N
Awareness	African American	53.33	3.204	6
	Euro-American	55.41	4.438	41
	Hispanic American	58.20	3.271	5
	Asian American	57.00	3.000	5
	Native American	50.00	.	1
	Other	56.00	.	1
	Total	55.49	4.203	59
Knowledge	African American	63.33	8.017	6
	Euro-American	54.68	7.722	41
	Hispanic American	63.20	5.805	5
	Asian American	57.20	5.762	5
	Native American	59.00	.	1
	Other	57.00	.	1
	Total	56.61	7.902	59
Skill	African American	73.17	4.579	6
	Euro-American	63.61	9.531	41
	Hispanic American	73.60	5.320	5
	Asian American	66.60	1.949	5
	Native American	76.00	.	1
	Other	65.00	.	1
	Total	65.92	9.098	59

Table 4 evaluated the descriptive statistics for the MAKSS total score (awareness, knowledge and skill combined) and IAT racial bias. Cultural competence scores were represented from highest to lowest as Hispanic Americans (M = 195, SD = 12.806), African Americans (M = 189.8, SD = 13.512), Native Americans (M = 185, SD = 0.0), Asian Americans (M = 180.8, SD = 3.033), Other category (M = 178, SD = 0.0), and Euro-Americans (M = 173.7, SD = 18.418). The overall total MAKSS scores for cultural competence were M = 178, SD = 17.76.

IAT scores in Table 4 represent pro-White and pro-Black racial bias for the sample. The highest pro-White scores were held by Asian Americans (M = -0.8877, SD = 0.2322) followed by Euro-Americans (M = -0.5457, SD = .3987), Hispanic Americans (M = -0.4376, SD =

0.2174), Native Americans (M = -0.5646, SD = 0.0) and those in the Other category (M = -0.3494, SD = 0.0). African Americans demonstrated a pro-Black racial bias (M = 0.1171, SD = 0.3614). The overall IAT racial bias score was pro-White; M = -0.4951, SD = 0.4272.

Table 4

Descriptive Statistics: MAKSS Total and IAT Demographics by Race

Instrument	Race	Mean	Std. Deviation	N
MAKSS	African American	189.83	13.512	6
	Euro-American	173.71	18.418	41
	Hispanic American	195.00	12.806	5
	Asian American	180.80	3.033	5
	Native American	185.00	.	1
	Other	178.00	.	1
	Total	178.02	17.764	59
IAT	African American	.1171761	.36140530	6
	Euro-American	-.5457717	.39874483	41
	Hispanic American	-.4376488	.21742159	5
	Asian American	-.8877470	.23226768	5
	Native American	-.5646300	.	1
	Other	-.3494000	.	1
	Total	-.4951626	.42721707	59

Underlying Assumptions

There are 10 underlying assumptions when conducting a MANOVA inferential analysis. Of those 10, the following three were met: (a) there exists a continuous dependent variable(s) (i.e., MAKSS and IAT), (b) the independent variable is categorical with two or more independent groups (race groups: African American, Euro-American, Hispanic American, Asian American, Native American, Other), and (c) there is independence of observations

(Creswell, 2014; Priviera, 2016). The remaining seven assumptions were met: (a) there exists a linear relationship between the dependent variables (MAKSS: D'Andre et al., 1991 and IAT: Greenwald et al., 1998) for each group of the independent variable (race), (b) there is no multicollinearity, (c) there are no univariate or multivariate outliers, (d) multivariate normality exists among variables, (e) the sample size is adequate, (f) there is homogeneity of variance-

covariance matrices, and (g) there is homogeneity of variances (Creswell, 2014; Laerd, 2019; Priviera, 2016).

The MAKSS total score for cultural competence and the IAT racial bias scores demonstrated normality of distribution for each race as assessed by a Shapiro-Wilk's test ($p > .05$). Normal distribution was apparent in the Q-Q plots. There were no univariate outliers in the data as assessed by an inspection of a box plot for values greater than 1.5 box lengths from the edge of the box. There was a linear relationship between the MAKSS total score for cultural competence and the IAT racial bias scores by race, as assessed by the scatter plot. There was no multicollinearity for cultural competence and racial bias, as assessed by the Pearson correlation ($r = 0.371$, $p = 0.004$). There were no multivariate outliers in the data, as assessed by Mahalanobis distance ($p > .05$), for the MAKSS total score for cultural competence nor the IAT racial bias scores. There was homogeneity of variance matrices for the MAKSS total score for cultural competence and the IAT racial bias scores, as assessed by Box's test of equality of covariance matrices ($p = 0.050$ respectively).

Pearson's correlation has five assumptions required to determine correlation: (a) three continuous variables, (b) each variable had to have a numerical value, (c) linear relationship, (d) multivariate normality, and (e) no significant univariate or multivariate outliers (Creswell, 2014; Laerd, 2019; Leedy & Ormrod, 2016; Priviera, 2016). Though Pearson's correlation is not absolute in its authority to depict causation, it can indicate influence (Leedy & Ormrod, 2016). The data set met the assumptions. With the assumptions of the one-way MANOVA and Pearson's correlation met, the researcher began testing for statistical significance.

Hypothesis Testing 1

H_{01}: There is a statistically significant mean difference between the races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) of mental health counselors for cultural competence as measured by the Multicultural Awareness, Knowledge, and Skills Survey and implicit racial bias as measured by the Black/White Implicit Association Test.

The descriptive statistics for the MAKSS illustrated self-reported cultural competence scores were lower for Euro Americans (173.71) mental health counselors than African Americans (189.83), Hispanic Americans (195), and Asian Americans (180.80) mental health counselors. In the descriptive statistics the overall IAT scores are recognized in addition to IAT scores by race. The scores demonstrated a mean racial preference score of 0.1171 for African Americans, Euro American participants at -0.0545, Hispanic American -0.4376, and Asian Americans at -0.8877. Native American and others did not present significant numbers as the population sample was too small to assess a mean or standard deviation for either race. In addition, the one-way MANOVA multivariate test represented a statistically significant difference between the independent variable (race) on the dependent variable MAKSS total score and IAT racial bias $F(10, 104) = 3.042$, $p < 0.05$; Wilks $\Lambda = 0.599$; partial $\eta^2 = 0.226$ (Table 5). Therefore, the null hypothesis was rejected and the alternative hypothesis retained where there was a statistically significant difference between races (African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, or Other) for MAKSS and IAT for mental health counselors.

Table 5

MANOVA: MAKSS Total and IAT by Race Statistical Difference

Effect		Value	F	Hypo-thesis df	Error df	Sig.	Partial Eta Squared
Intercept	Wilks' Lambda	.026	981.052[b]	2.000	52.000	.000	.974
Race	Wilks' Lambda	.599	3.042[b]	10.000	104.000	.002	.226

There was a statistically significant difference between the independent variable (race) and the MAKSS total score for cultural competence (dependent variable), $F(9,124) = 2.524$, $p < .025$; Wilks $\Lambda = 0.665$; partial $\eta^2 = 0.127$ (Table 6). Therefore, the null hypothesis was rejected and the alternative was retained. This demonstrated that cultural competence and implicit racial bias varied according to the participants' self-selected racial identity.

Table 6

MANOVA: MAKSS Total by Race Statistical Difference

Effect		Value	F	Hypo-thesis df	Error df	Sig.	Partial Eta Squared
Intercept	Wilks' Lambda	.010	1626.893[b]	3.000	51.000	.000	.990
Race	Wilks' Lambda	.665	2.524	9.000	124.271	.011	.127

a. Design: Intercept + Race
b. Exact statistic
c. The statistic is an upper bound on F that yields a lower bound on the significance level.

There was a statistically significant difference for the independent variable (race) and racial bias on the IAT, $F(6,104) = 4.992$, $p < .025$; Wilks $\Lambda = 0.603$; partial $\eta^2 = 0.224$ (Table 7). The significant main effect of the individual and aggregate scores on the MAKSS and IAT suggested a need for a Fisher's LSD test post hoc analysis, as the sample sizes in each independent variable (race) category were different.

Table 7

MANOVA: IAT by Race Statistical Difference

Effect		Value	F	Hypo-thesis df	Error df	Sig.	Partial Eta Squared
Intercept	Wilks' Lambda	.013	1931.208[b]	2.000	52.000	.000	.987
Race	Wilks' Lambda	.603	4.992[b]	6.000	104.000	.000	.224

a. Design: Intercept + Race
b. Exact statistic
c. The statistic is an upper bound on F that yields a lower bound on the significance level.

Post hoc analysis. In Table 8, a post hoc analysis was performed. The post hoc LSD demonstrated the difference between the mean score on the MAKSS and IAT, which have been cross-tabulated with the self-identified race of each participant. LSD specifically demonstrated where the statistical difference lies, as it compares the means of the MAKSS and IAT to reveal differences across the self-identified race of mental health counselors (Laerds.com, 2019). In this study, LSD for each dependent variable was evaluated at an alpha level of 0.05 for significance. A significant statistical difference was found to exist in the total score of the MAKSS and IAT. The MAKSS' total score revealed a significant difference of $p = 0.034$ for African Americans and Euro-Americans and $p = 0.010$ for Hispanic Americans and Euro-Americans. The most considerable statistical significance was that the IAT scores for African Americans differed from Euro-Americans, Hispanic Americans, and Asian Americans with $p = 0.000$, 0.018, and 0.000, respectively.

Table 8

LSD: Multiple Comparisons MANOVA

Dependent Variable		(I) Race	(J) Race	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound
IAT	LSD	African American	Euro-American	.66294773*	.16352434	.000	.3349594
			Hispanic American	.55482485*	.22653575	.018	.1004517
			Asian American	1.00492305*	.22653575	.000	.5505499
		Euro-American	African American	-.66294773*	.16352434	.000	-.9909360
			Hispanic American	-.10812288	.17721604	.544	-.4635732
			Asian American	.34197532	.17721604	.059	-.0134750
		Hispanic American	African American	-.55482485*	.22653575	.018	-1.0091980
			Euro-American	.10812288	.17721604	.544	-.2473275
			Asian American	.45009820	.23660888	.063	-.0244791
		Asian American	African American	-1.00492305*	.22653575	.000	-1.4592962
			Euro-American	-.34197532	.17721604	.059	-.6974257
			Hispanic American	-.45009820	.23660888	.063	-.9246755
Total	LSD	African American	Euro-American	16.126*	7.396	.034	1.29
			Hispanic American	-5.167	10.246	.616	-25.72
			Asian American	9.033	10.246	.382	-11.52
		Euro-American	African American	-16.126*	7.396	.034	-30.96
			Hispanic American	-21.293*	8.015	.010	-37.37
			Asian American	-7.093	8.015	.380	-23.17
		Hispanic American	African American	5.167	10.246	.616	-15.38
			Euro-American	21.293*	8.015	.010	5.22
			Asian American	14.200	10.701	.190	-7.26
		Asian American	African American	-9.033	10.246	.382	-29.58
			Euro-American	7.093	8.015	.380	-8.98
			Hispanic American	-14.200	10.701	.190	-35.66

Hypothesis Testing 2

H_{02}: There is no statistically significant relationship between the scores of cultural competence as measured by the Multicultural Awareness Knowledge and Skill Survey and implicit racial bias as measured by the Implicit Association Test within each racial category.

A Pearson's *r* was run individually for each mental health counselor self-selected race category to assess the relationship between the scores of cultural competence on the MAKSS and implicit racial bias on the IAT. Fifty-nine participants were recruited. The preliminary Pearson's *r* correlation analyses demonstrated a linear relationship for the MAKSS and IAT. Additionally, both variables were normally distributed, as assessed by Sapiro-Wilk's test ($p > 0.05$) and there were no outliers.

Table 9 demonstrated a statistically significant negative correlation for the IAT (r [57] = 0.37, $p = 0.004$). Racially, there was no statistical significant correlation between the MAKSS and IAT for African American (r [6] = 0.11), $p = 0.82$), Hispanic American (r [5] = 0.68, p = 0.209) and Asian American (r [5] = 0.83, p = 0.082) mental health counselors (see Table 9).

A pro-Black score is demonstrated with a positive numerical figure and the pro-White score is revealed with negative numerical figures. The descriptive statistics found that Euro-Americans (-1.34120) and Asian Americans (-1.34120) illustrated greater implicit racial bias. The MAKSS scores for Euro American mental health counselors is low (173.71) and Asian American mental health counselors higher (180). Therefore, there is a statistically significant negative correlation between MAKSS and IAT scores for Euro-American mental health counselors, r (41) = 0.34, p = 0.031 (see Table 9) and not for Asian Americans as previously mentioned. Implicit racial bias statistically explained 11% of the variability in cultural competence for Euro-American mental health counselors. The null hypothesis was retained

where there was not a statistically significant relationship between the MAKSS and IAT for African American, Hispanic American and Asian American mental health counselors. The null hypothesis was rejected where there was a statistically significant relationship between the MAKSS and IAT for Euro-Americans.

Table 9

MAKSS and IAT Correlation –By Race

MAKSS & IAT		Total	IAT
MAKSS	Pearson Correlation	1	.373**
	Sig. (2-tailed)		.004
	N	57	57
IAT	Pearson Correlation	.373**	1
	Sig. (2-tailed)	.004	
	N	57	57
African American		Total	IAT
MAKSS	Pearson Correlation	1	.122
	Sig. (2-tailed)		.818
	N	6	6
IAT	Pearson Correlation	.122	1
	Sig. (2-tailed)	.818	
	N	6	6
	N	6	6
Hispanic American		Total	IAT
MAKSS	Pearson Correlation	1	.678
	Sig. (2-tailed)		.209
	N	5	5
IAT	Pearson Correlation	.678	1
	Sig. (2-tailed)	.209	
	N	5	5
	Sig. (2-tailed)	.001	.306
	N	5	5
Asian American		Total	IAT
MAKSS	Pearson Correlation	1	.830
	Sig. (2-tailed)		.082
	N	5	5

Table 9 continued

MAKSS & IAT		Total	IAT
IAT	Pearson Correlation	.830	1
	Sig. (2-tailed)	.082	
	N	5	5
Euro-American		Total	IAT
MAKSS	Pearson Correlation	1	.337*
	Sig. (2-tailed)		.031
	N	41	41
IAT	Pearson Correlation	.337*	1
	Sig. (2-tailed)	.031	
	N	41	41

Summary of the Hypothesis Testing

The one-way MANOVA and Pearson's *r* correlation presented the following findings for the research questions: The hypothesis examined whether there was a statistically significant difference between races for MAKSS and IAT for mental health counselors and the finding identified that a statistically significant difference existed between the Euro-American cultural competence and African American, Hispanic American, and Asian American mental health counselors. The hypothesis investigated whether there was a statistically significant relationship between the MAKSS and IAT for African American, Euro-American, Hispanic American, and Asian American mental health counselors and the findings identified that a statistically significant relationship existed for Euro-Americans.

Summary

In conclusion, this research rejected the null hypothesis for a significant statistical difference between races for cultural competence as measured by the MAKKS and implicit racial bias as measured by the IAT for mental health counselors. The research also retained the null hypothesis for a statistically significant relationship between the scores of cultural competence as

measured by the MAKSS and implicit racial bias as measured by the IAT within African American, Hispanic American, and Asian American mental health counselors. However, the null hypothesis was rejected for Euro-Americans regarding the relationship between the mental health counselor's race, cultural competence, and implicit racial bias. Chapter 5 delineates a discussion and interpretation of the statistical findings, reveals recommendations and implications for incorporating these results in future research and provides closing remarks.

CHAPTER 5. DISCUSSION, IMPLICATIONS, RECOMMENDATIONS

This chapter provides a discussion of the findings presented in Chapter 4. The discussion of inferences pertaining to the statistical significance between the MAKSS (D'Andre et al., 1991) and the IAT (Greenwald et al., 1998) across racial demographics was vital to this study's connection to cultural conditioning (Bloombaum et al., 1968; Ratts et al., 2016; Sue & Sue, 2013; Thomas, 1962). Following a summary and discussion of the results, Chapter 5 will discuss the limitations of the study, meaning and implications for practice, and recommendations for further research.

Summary of the Results

Disparities in mental healthcare have increased disproportionately over the last decade across socio-economic status, class, education, and access to treatment in marginalized communities (Dillon et al., 2016; Volpe et al., 2019). These disparities may produce more mental health challenges that lead to anxiety or depression, disrupted family relationships, and increased dysfunction within the community as a whole (Cruz et al., 2019; Cuevas et al., 2016; Miyamoto et al., 2019; Velez et al., 2018). Understanding any variance in mental health counselor cultural competence or the existence of implicit racial bias could provide CES professionals and mental health counselors with additional opportunities to evaluate how to better serve marginalized populations (Cuevas et al., 2016; Memon et al., 2016; Neblett, 2019; Rikard et al., 2015).

This research is significant in its appraisal of mental health counselors' implicit racial bias in relation to their self-reported cultural competence (Duguid & Thomas-Hunt, 2015; Eyal et al., 2018). It is expected that the results will address the gap in research regarding the assessment of cultural competence via self-report implicit bias assessments utilizing race as the dependent variable (Cruz et al., 2019; Cuevas et al., 2016; Edwards, 2016). CES, the AMCD, the ACA, the

AAMFT, the ASCA, and the IAMFC may connect this research to other pertinent studies and connect the influence of cultural conditioning and implicit racial bias on a mental health counselor's cultural competence and the quality of care their clients receive. Furthermore, the findings may help to guide CES professionals in recognizing and addressing implicit racial bias within the pedagogy of new mental health counselors and the continuing education of licensed mental health professions in order to diminish the health care disparities in marginalized communities (Haskins & Singh, 2015; Neblett, 2019; Quiros et al., 2019).

The need for this research was verified by previous literature that demonstrated that (a) African Americans were twice as likely to experience mental health concerns due to institutional discrimination, (b) disparities in mental health care prevailed despite current pedagogical interventions and (c) minority clients continued to express a lack of cultural competence in treatment (Belgrave & Abrams, 2016; Benuto et al., 2019; Bilkins et al., 2016; Cuevas et al., 2016; Owen et al., 2016; Sameuel, 2020; Phillips, 2020; Walker, 2020). The two questions in this research have not been examined exclusively as generally research is designed to look at pre-post testing of students (Boysen, 2008; D'Andrea et al, 1991; Katz & Hotz, 2014; Killian, 2017), the effects of different pedagogical methods (King & Borders, 2019; Killian, 2017), whether bias affects treatment (Charnin, 2015), a variety of cultural competence variables beyond basic awareness, knowledge, and skill (Reinders, 2017), and how culturally competent a mental health counselor is based on the client's perspective (Belgrave & Abrams, 2016; Bilkins et al., 2016; Cruz et al., 2019; Cuevas et al., 2016; Owen et al., 2016; Samuel, 2020; Walker, 2020). Therefore, the researcher sought to determine whether a statistically significant difference exists in cultural competence based on scores from the MAKSS (D'Andre et al., 1991) and implicit racial bias based on scores from the Black/White IAT (Greenwald et al., 1998) and

whether there is any relationship between the two according to the self-identified race of the same mental health counselors surveyed in Question 1.

This research utilized a quantitative analysis to determine whether there were statistically significant differences in the scores of mental health counselor's cultural competence and implicit racial bias among counselors of different racial demographics. A significant statistical difference existed among the cultural competence scores for mental health counselors who self-identified as Euro-American but not for African Americans, Hispanic American, Asian Americans, Native Americans, or Others. The analysis also determined that there was a mix of negative (pro-White) and positive (pro-Black) relationships within the mental health counselors' self-identified racial demographics. There was a negative relationship between cultural competence and implicit racial bias against African Americans for Euro-Americans and a positive relationship between cultural competence and implicit racial bias for African Americans for Hispanic Americans, Asian Americans, Native Americans, Others, and African Americans.

These analyses led to Question 2, which asked about cultural competence's connection to implicit racial bias at a very basic level. Ninety percent of mental health counselors who participated in the study demonstrated an implicit racial bias toward Black people in general. There was a statistically significant negative relationship between Euro-American cultural competence and implicit racial bias. No statistically significant relationship existed between cultural competence and implicit racial bias for Hispanic Americans, Asian Americans, Native Americans, Others, or African Americans.

Discussion of the Results

The first question investigated the statistical mean differences between mental health counselors' cultural competence and implicit racial bias scores as measured by the MAKSS and

Black/White IAT. This question mirrored the hypothesis that posited that mean statistical differences existed between mental health counselors who were African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, and Others for cultural competence and implicit racial bias. A one-way MANOVA indicated a statistically significant difference existed between African Americans, Hispanic Americans, Asian Americans, Native Americans, and Others as it pertains to Euro-Americans, but not between African Americans, Hispanic Americans, Asian Americans, Native Americans, and Others.

The variances in the results are inconclusively supported by previous literature for the first question. Boysen (2008) expressed that cultural competence existed equally for the students in his study. Reinders (2017) stated that students of color were more culturally competent at the beginning of multicultural competence courses than White students; however, both populations were equally competent by the end of the course. Killian (2017) posited that cultural competence remained equal across race and type of pedagogical instruction (didactic, community service, or immersion). Finally, Charnin (2015) also found that there was no relationship between client race and cultural competence. Because the literature sought to compare cultural competence between groups via a pre-post survey, prior assessments evaluated different aspects of cultural competence beyond awareness, knowledge, and skill (e.g., empathy, resentment, advocacy, and case conceptualization) and therefore scored differently. Thus, it is difficult to ascertain a firm understanding of cultural competence when comparing the current study to previous literature.

The second question evaluated whether there was a statistically significant relationship between the scores of cultural competence on the MAKSS and implicit racial bias on the Black/White IAT across the self-selected racial category of the same mental health counselors surveyed in question one. A Pearson's *r* correlation resulted in mixed findings. There was an

overall negative statistically significant relationship for the Black/White IAT in connection to the MAKSS. However, racially, there was no statistical significant correlation between the MAKSS and IAT for African American, Hispanic American, and Asian American mental health counselors. There was a statistically significant negative correlation between MAKSS and IAT scores for Euro-American mental health counselors.

These findings were echoed by Katz and Hoyt (2014) who found that implicit bias existed in mental health counselors and toward minority clients and was a strong predictor of misdiagnosis. Stroud et al. (2016) expressed that there is a significant presence of implicit racial bias in the relationship between the mental health counselor and their client. Hook et al. (2016 a, b), Quiros et al. (2019), Tormala et al. (2018), St. Arnaud (2017), and Mendonca et al. (2019) recognized significant implicit racial bias toward marginalized communities. At the same time, Charnin (2015) stated that implicit racial bias had no bearing on treatment outcomes as mental health counselors were able to maintain empathy without prejudice.

There is a gap in the literature regarding the investigation of self-reporting cultural competence and implicit racial bias in combined formats that include many other variables (Boysen, 2008; Charnin, 2015; Katz & Hoyt, 2014; Killian, 2017; Reindeer, 2017). Separately, self-reporting assessments and IATs have presented results that indicate a need to understand their potential interaction (Katz & Hoyt, 2014). The new information offered in the current research posited that the disparities in access to care and diminished help-seeking behaviors for clients in the African American community may place greater responsibility on the mental health counselor to provide the same culturally safe environment they provide to clients who are not African American (Kumar et al., 2015; McCoy & Rodricks, 2015; Samuel, 2020; Tormala et al., 2018; Walker, 2020). When seeking to determine a statistically significant difference among

scores of cultural competence, as measured by the MAKSS, and racial bias, as measured by the IAT, while accounting for the self-identified race of mental health counselors, this study accepted the hypothesis and rejected the null hypothesis. The research findings identified that self-reported assessments of high cultural competence are not supported by a positive implicit racial bias toward African Americans. In other words, 90% of participants in this study were identified as pro-White, having negative implicit racial bias toward African American clients through ambiguous microaggressions, invalidations, and dismissive statements on an unconscious level in their counseling sessions (Cuevas et al., 2016; Kumar et al., 2015; Ratts et al., 2016; Samuel, 2020; Schmidt & Axt, 2016; Sue, 1990; Sue & Sue, 1999; Sue & Sue, 2013; Tormala et al., 2018; Walker, 2020; Wang et al., 2019).

Charnin (2015) and Cone and Ferguson (2015) stated that most mental health counselors assess their cultural competence primarily through self-reporting surveys versus the IAT (Greenwald et al., 1998). The IAT removes socially acceptable responses (Braden et al., 2017; Conway, 2017; Melnikoff & Bargh, 2018; Yamaguchi & Beattie, 2019). Studies completed by Devos and Sadler (2019), Dillon et al. (2016), Flynn et al. (2019), and Tormala et al. (2018) stated that counselors with higher scores of cultural competence on self-reporting instruments often had clients who disagreed with the counselor's reported cultural competence. Barden et al. (2017), Samuel (2020), and Walker (2020) posited that counselors possess knowledge about the existence of other cultures and some of the dynamics therein, yet lack the skill for treatment and intervention (Phillips, 2020; Samuel, 2020; Walker, 2020). Studies differed in determining whether immersion helped increase cultural competence. Killian (2017) reported no increases. Yet, Barden et al. (2017) expressed that mental health counselors of non-accredited programs with greater emphasis on immersion reported increases in cultural competence (Barden et al.,

2017). Although the IAT (Greenwald et al., 1998) does not espouse to predict or indicate discriminatory behavior, it reveals negative and positive associations. Research identified that implicit racial bias had the potential to allow cultural conditioning and bias in both ambiguous and explicit learned behaviors (Blanton et al., 2015; Duguid & Thomas-Hunt, 2015; Cuevas et al., 2016; Houshmand et al., 2017).

Conclusions Based on the Results

This section compares the findings of the research with the theoretical framework and literature from Chapter 2. This study advanced the current literature through its findings that there are statistically significant differences between both the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998) scores across the self-identified race of mental health counselors. This section focuses on the effects of those statistical differences on the counseling community.

Comparison of the Findings and Theoretical Framework

The MCSJCC expanded the CES profession toward the development of new counselors who not only espoused cultural awareness, knowledge, and skills acumen but added culturally sensitive cultural conditioning perspectives over 12 decades (Benuto et al., 2018b, Kaplen, 2020; Sue, 1990, 1999). This research utilized the cultural conditioning tenet of multicultural theory as a theoretical foundation to focus mental health counselors on their implicit racial bias and worldviews (Sue, 1990, 1999; Thomas, 1962). The mental health counselor's worldview is crucial to revealing degrees of cultural competence, as mental health professionals evaluate their implicit racial bias in relation to their client's worldview. For example, a mental health counselor who embraces colorblindness erases the culture and heritage of an African American client. To further illustrate, a Euro-American mental health counselor who asks an African American client

to accept that if they work hard, they will automatically excel, espouses the myth of meritocracy and commits a gross microinvalidation of the client's experience. Each tenet of MCSJCC challenges the mental health counselor to dissect their Western worldview and expand their awareness and knowledge to include their client's culture, history, and intersectionality in connection to institutional and systemic racism and prejudices that are created through cultural conditioning in society (Brown & Jackson, 2017; Crenshaw, 2011; Delgado & Stefancic, 2012; Dunac & Demir, 2017; Haskins & Singh, 2015; Tormala et al., 2018; Walck, 2017). Seeking to understand any significant difference between the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998) across the self-identified race of mental health counselors is a step toward eliminating disparities in mental health care in the African American community.

Counselor introspection on multicultural awareness, knowledge, and skills and their interaction with implicit racial bias prompts the profession to consider that cultural conditioning does not preclude same-race client-counselor interactions from being swayed by the same implicit racial bias that the privilege of Whiteness offers (Owen et al., 2016, 2018). Cultural conditioning has the potential to influence cultural competence across racial demographics equally through implicit racial bias (Bowleg et al., 2016; Greenwald et al., 2015; Han & Leonard, 2017). Education in America has forced African Americans to experience the dichotomy of believing stereotypes about themselves as much as Euro-Americans (Squires, 2015). Despite self-reports of high cultural competence among mental health counselors, there is a disconnect in treatment (Chan et al., 2018; Haskins & Singh, 2015; Holmes et al., 2016; Reynolds & Mayweather, 2017; Sleeter, 2017; Volpe et al., 2019). This study illustrates the disconnect between multicultural competence and implicit racial bias. Spencer et al. (2016) and Wang et al. (2019) demonstrated that an individual's implicit racial bias stems from cultural

conditioning that often results in explicit behavior. Despite self-reports of high cultural competence among mental health counselors, there is a disconnect in treatment (Chan et al., 2018; Haskins & Singh, 2015; Holmes et al., 2016; Reynolds & Mayweather, 2017; Sleeter, 2017; Volpe et al., 2019).

These findings are representative of the cultural conditioning discussed in Chapter 2. Authority figures, media, cultural isolation, segregation, systemic and institutional discrimination, and racism assist in developing, defining, and determining social norms (Duguid & Thomas-Hunt, 2015; Tormala et al., 2018). These norms affect conscious and subconscious thoughts and daily interactions, creating an implicit racial bias in the psyche of human beings (Mendonca et al., 2019; Tormala et al., 2018). Even mental health counselors who possess egalitarian perspectives find that they have a racial bias for Euro-American people on the IAT (Howell et al., 2017; Spencer et al., 2016). Mendonca et al. (2019) and Volpe et al. (2019) posited that many who receive negative results on the IAT reject the findings. They report feeling repulsed, uncomfortable, and guilty from being perceived as prejudiced or racist (Blanton et al., 2015; Conway et al., 2017; Mendonca et al., 2019; Spencer et al., 2016). Rather than focusing on the inward dichotomy of disgrace, this is an opportunity for mental health counselors to utilize multicultural theory's cultural conditioning tenet for institutional change (Crenshaw, 2011; Brown & Jackson, 2017; Delgado & Stefancic, 2012; Dunac & Demir, 2017; Haskins & Singh, 2015; Sue, 1990, 1999; Tormala et al., 2018; Walck, 2017).

The MCSJCC's cultural conditioning tenet utilized foundational principles that counselors can employ to acknowledge the need for veritable cultural competence (Benuto et al., 2018a, Kaplen, 2020; Sue, 1990, 1999). These principles can also be used to implement education and supervision that offers effective culturally sound interventions, increases self-

awareness, allows an understanding of the precursors to MCC through the lens of historical culture (Freeman et al., 2016; Haarhoff et al., 2015), and ultimately decreases disparities in the African American community (Chan et al., 2018; Haskins & Singh, 2015; Holmes et al., 2016; Reynolds & Mayweather, 2017; Sleeter, 2017). To use the MCSJCC's cultural conditioning tenet as a foundation for supervision would require mental health counselors to gain greater access to the historical context of African American culture. It would challenge and question a mental health counselor's worldview through the tenet of cultural advocacy and force counselors to acknowledge the existence of unique identities, support differences, balance individualist and collectivistic context, and dismantle the institutional racism and discrimination formulated in the cultural conditioning of their lives (Benuto et al., 2018a; Delgado & Stefancic, 2012; Hook et al., 2016a; Kaplen, 2020; Mendonca et al., 2019; Sue, 1999; Tormala et al., 2018; Volpe et al., 2019).

Interpretation of the Findings

This research study demonstrated a significant statistical difference between scores on the MAKSS (D'Andre et al., 1991) and IAT (Greenwald et al., 1998) across the self-identified race of mental health counselors. Hispanic Americans (n = 5) represented the highest levels of cultural competence (M = 195) out of 240 possible points. Euro-Americans (n = 41) represented the lowest levels of cultural competence (M = 173.71). Even the low cultural competence scores demonstrated that mental health counselors are not completely void of cultural competence. However, what might need greater visibility in counselor education is that there was a significant difference in MAKSS scores and IAT scores where a lack of competence might be inferred by greater degrees of implicit racial bias.

In the MAKSS/IAT MANOVA, the IAT scores were significantly lower than anticipated if they were to be congruent with reported high cultural competence. Most previous research explored higher or equal expressions of cultural competence across all racial groups (Boysen, 2009; Charnin, 2015; Cuevas et al., 2016; Killian, 2017). Thus, it may be logical to propose that implicit racial bias assessments like the IAT would demonstrate pro-Black sentiments. Positive values represent pro-Black. With the same consideration, it may be inferred that the higher the negative value on the IAT, the lower the cultural competence and higher the negative values may represent implicit racial bias toward African Americans in the therapy room. Negative numbers represent pro-White.

In this study, 13% (8) of the mental health counselors had scores lower than -1. Only 10% (6) of the mental health counselors had positive IAT scores. Four of them were African American and two were Euro-American mental health counselors. None of the Hispanic American, Asian American, Native American, or Other mental health counselors had a pro-Black implicit racial bias. Notably, 33% (2) of the African American mental health counselors had negative scores. This is significant in demonstrating that cultural conditioning can infiltrate every race, ethnicity and culture.

The results presented in this research illustrate a necessity for understanding that cultural conditioning begets institutional racism which, in turn, begets microaggressions, micro-invalidations, and ambiguous or explicit behaviors toward African Americans (Hook et al., 2016a; Shih et al., 2015; Walker, 2020). These explicit behaviors do not show up in mental health counselors' self-reporting on the MAKSS (D'Andre et al., 1991); past researchers have speculated that counselors felt pressured to provide socially acceptable responses (Braden et al., 2017; Conway et al., 2017; Melnikoff & Bargh, 2018; Yamaguchi & Beattie, 2019). However,

on the IAT, socially acceptable responses are eliminated, revealing the implicit racial bias of mental health counselors (Melnikoff & Bargh, 2018; Mendonca et al., 2019). Melnikoff and Bargh (2018) and Yamaguchi and Beattie (2019) posited that in an instrument like the IAT, mental health counselors may not realize that their bias is being tested, even though they are aware that they have a bias. Merely labeling photos of African American people or Euro-American people as good or bad challenges their ability to hide the bias (Melnikoff & Bargh, 2018; Yamaguchi & Beattie, 2019).

Limitations

This study has theoretical and design limitations. The MCC and MCSJCC were limited by their original focus on awareness, knowledge, and skill (Ratts et al., 2016; Sue, 1990, 1999). A translation of the tenets of MCC and MCSJCC required counselors to move beyond the terminology and question cultural conditioning's presence in their worldview (Benuto et al., 2018a; Delgado & Stefanic, 2012; Hook et al., 2016a, b; Kaplen, 2020; Mendonca et al., 2019; Sue, 1999; Tormala et al., 2018; Volpe et al., 2019). An additional limitation was found in the definition of the racial demographics for this study which included African Americans, Euro-Americans, Hispanic Americans, Asian Americans, Native Americans, and Other. The category "Other" was used to indicate that the participant's racial identity was not listed in the options provided. For example, a participant who identified with a multi-racial category not listed would select "Other."

Qualtrics sought licensed mental health counselors who utilized the Internet and did not seek counselors specifically in academia, non-profit organizations, or associations (Qualtrics, 2019). Qualtrics offered an incentive to the panelist. The incentive limited the researcher's ability to know whether the participants desired to complete the assessments out of interest in the

topic or in the pursuit of potential personal gain. While the Internet is convenient, not all potential participants have access nor are all technologically savvy; some may even have an impairment that inhibits their ability to complete the IAT due to its required time-latency score (Greenwald et al., 1998). Completion time for the assessments was 15 minutes; Greenwald et al. (2015) posited that those who take longer are likely distracted. Finally, there were not enough self-identified mental health counselors in the Native American and Other categories to present a full analysis or determine whether any statistically significant differences existed between the MAKSS (D'Andre et al., 1991) and the IAT for these groups.

Delimitations

There are two delimitations to this study. First, the research centered on mental health counselors who are not social workers, psychologists, psychiatrists, or physicians. Second, the racial categories did not include bi-racial as an option.

Implications for Practice

This study has the potential to increase the dialogue among CES professionals and mental health counselors about how cultural competence is influenced by cultural conditioning and may be represented in ambiguous behaviors that diminish the quality of care in marginalized communities (Phillips, 2020; Samuel, 2020; Walker, 2020). After reviewing this research, CES professionals and counselors may become more intentional advocates, educators, supervisors, and champions for the global recognition of systematic oppression within the mental health counseling profession as a reality for marginalized communities (Haskins & Singh, 2015; Neblett, 2019; Phillips, 2020; Samuel, 2020; Walker, 2020).

For the CES profession, MCC, MCT, and MCSJCC (Benuto et al., 2018b, Kaplen, 2020; Sue, 1990, 1999) are foundational theories that can be utilized to acknowledge the need for a

more intense immersion in multicultural instruction. Recognition of MCSJCC as foundational theory may focus the attention of CES professionals and mental health counselors on utilizing this research of cultural competence and implicit racial bias to implement effective culturally sound interventions in pedagogy. Acknowledging the impact of cultural conditioning on cultural competence and implicit racial bias across all races means that CES professionals might benefit from considering that every mental health counseling student needs to attend to their cultural competence skills regardless of the student's race (Abbott et al., 2019; Ahmed et al., 2011; Benuto et al., 2019; Haskins & Singh, 2015; Hook et al., 2016a, b; King & Borders, 2019; Reinders 2017; Walker, 2020).

Mental health counselors may find that the combination of multicultural theories increase awareness and allow for an understanding of predictive behavior through the lens of cultural humility and bias (Eyal et al., 2018; Haskins & Singh, 2015; McCoy & Rodricks, 2015; Owen et al., 2016). Though Killian (2017) found no increase in cultural competence with participation in community services, it might be posited that cultural competence can be achieved through more immersive training in internships, fellowships, and postgraduate supervision that utilizes cultural conditioning and broaching as a platform for discussing institutional racism and bias that is ingrained in the culture of American society (Cone & Ferguson, 2015; Mann & Ferguson, 2015; Phillips, 2020; Samuel, 2020; Walker, 2020; William, 2020). CES professionals may find immersion and broaching allows students the opportunity for exposure to different cultural experiences (King & Boarder, 2019; Mann & Ferguson). The more apparent implications for CES and mental health counselors include improving the therapeutic alliance, improving social support, increasing social justice advocacy, decreasing stigma, and deepening empathy (Charnin,

2015; Cuevas et al., 2016; Davis et al., 2015; Phillips, 2020; Samuel, 2020; Walker, 2020; William, 2020), leading to increased help-seeking behaviors in marginalized communities.

Recommendations for Future Research

Research pertaining to cultural competence and implicit racial bias in the mental health profession is presented with many surrounding variables and instruments (Boysen, 2008; Charnin, 2015; Katz & Hoyt, 2014; Killian, 2017; Reinders, 2017). If cultural competence and implicit racial bias are assessed in exclusivity across the counseling profession, it may be easier to ascertain where the weaknesses in multicultural counseling are with more certainty. This study advocates for an intensive examination of power and privilege among mental health counselors that may allow CES professionals to develop paradigm shifts in counseling students' worldview. This study further recommends that counselors should acknowledge cultural conditioning's effect on cultural competence. This may include social change as mental health counselors, educators, and supervisors understand how their implicit racial bias diminishes their cultural competence regardless of their explicit behaviors in the counseling room (Chan et al., 2018; Devos & Sadler, 2019; Haskins & Singh, 2015; Holmes et al., 2016; Phillips, 2020; Reynolds & Mayweather, 2017; Samuel, 2020; Sleeter, 2017; Walker, 2020; William, 2020). This study recommends recruiting more mental health counselors from marginalized communities and providing a platform for research with an ethnocentric perspective to address the needs of marginalized communities.

Conclusion

In conclusion, the MAKSS provided individual scores for awareness, knowledge, and skill that were included in the final overall cultural competence scores for mental health counselors. The scores for implicit racial bias were calculated based on the IAT. There were

statistically significant differences and a negative linear relationship within the Euro-American racial group. Charnin (2015) and Reinders (2017) found that there was no difference in cultural competence between racial groups and in some cases, cultural competence was equal across all racial groups. It is believed the studies differ because this study assessed concepts beyond awareness, knowledge, and skill (resentment, case study, etc.) and were scored with a variety of quantitative analyses.

Understanding cultural, institutional, and societal implicit racial bias allows a multi-culturally competent mental health counselor to transform how they assess a client's challenges and diagnosis (Houshmand et al., 2017; Samuel, 2020; Walker, 2020), nurturing the therapeutic alliance and help-seeking behaviors of the marginalized client (Taylor & Kuo, 2018; Walker, 2020). Families in marginalized communities are significantly affected by cultural conditioning throughout society (Alexander, 2012; Cuevas et al., 2016; Hayes et al., 2015). Cultural conditioning is infused in homes, institutions, and society, inhibiting a community's ability to sustain mental wellness across generations (Belgrave & Abrams, 2016; Phillips, 2020; Samuel, 2020; Walker, 2020). Elements of cultural conditioning exist in multiple media forms (e.g., TV news, social media, commercials, magazines) and are hidden in the subliminal messaging of advertisements and depictions of African Americans (Duguid & Thomas-Hunt, 2015; Jerald et al., 2017). The behaviors associated with cultural conditioning are then exhibited in ambiguous behaviors of implicit racial bias through microaggressions, microinvalidations, or dismissiveness. These behaviors create a chasm in opportunities to gain access to quality mental health services that may assist in promoting economic stability, increased opportunities for employment, decreased incarceration rates, and overall public safety (Cortland et al., 2017; Phillips, 2020; Samuel, 2020; Tormala et al., 2018; Walker, 2020).

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