EXAMINATION OF DISPARITY IN ACCESSING COUNSELLING SERVICES FOR MUSLIM MEN: AN AUDIT STUDY

by

Ava Outadi

B.A., Simon Fraser University, 2016

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF ARTS

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Counselling Psychology)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

December 2020

The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, a thesis entitled:

Examination of disparity in accessing counselling services for Muslim men: an audit study

submitted by Ava Outadi in partial fulfillment of the requirements for

the degree of Master of Arts

in Counselling Psychology

Examining Committee:

Robinder Bedi, Counselling Psychology, The University of British Columbia

Supervisor

Toni Schmader, Psychology, The University of British Columbia

Supervisory Committee Member

William Borgen, Counselling Psychology, The University of British Columbia

Supervisory Committee Member

Abstract

Since the events of September 11th 2001, Muslims have been under increased scrutiny experiencing discrimination, prejudice, and hate crimes. The consequences of this day have had a negative affect on Muslims and their communities' mental health, making it imperative to ensure Muslims are able to access mental health professionals when needed. However, contemporary counselling and psychotherapy are still criticized for being Eurocentric, and research has shown that disparities in mental health services based on sociocultural variables have continued to persist. It has been noted that religion is an area that has not received much attention in the literature on mental health service disparities leading to a dearth in knowledge on how Eurocentric approaches impact Muslim clients. It is this broader context that highlights the pressing need to investigate the possibility of religious disparities and implicit bias in access to mental health services for Muslims. The goal of this study was to examine if there is possible implicit bias by counsellors and psychologists against Muslims who access counselling and psychotherapy services. An audit methodology utilizing emails examined the effects of clients' perceived religion on counsellors and psychologists in Greater Vancouver in their openness to provide services. A total of 470 practitioners received an email either from a Muslim male or non-Muslim male potential client, requesting an appointment. The main analyses showed that perceived religion was not a statistically significant predictor of whether a response is received nor how receptive a practitioner will be. Exploratory analyses showed that perceived religion was associated with how long it takes practitioners to respond, with the Muslim man receiving statistically significant quicker responses, compared to the non-Muslim man. This study was the first Canadian study examining mental health services disparities using an audit methodology, as

well as the first North American study examining mental health services disparities based on religion, which can help inform future research in this area.

Lay Summary

Since the events of September 11th 2001, Muslims have been under increased scrutiny experiencing discrimination, prejudice, and hate crimes. The consequences of this day has had a negative affect on Muslims and their communities' mental health, making it imperative to ensure Muslims are able to access mental health professionals when needed. The goal of this study was to examine if there was a possibility of implicit bias that counsellors and psychologists may have held against Muslims who are accessing services. The results showed that practitioners responded quicker to the client with a Muslim name, compared to the non-Muslim client. Practitioners also responded at a comparable rate and displayed similar level of receptiveness to both clients.

Preface

This thesis is an original, unpublished, and independent work by the author, Ava Outadi. All data was collected and analyzed by Ava Outadi under the supervision of Dr. Robinder P. Bedi. Ethical approval was granted by University of British Columbia's Behavioural Research Ethics Board Certificate number H20-00695.

Table of Contents

List of Tables

List of Figures

Acknowledgements

This research project and my learnings throughout the past three years have taken place on the traditional, ancestral, and unceded territory of the hən̓q̓əmin̓əm̓ and the Sḵwx̱wú7mesh people.

I am grateful for all the support and insights I have received from my committee. I wish to acknowledge and thank Dr. Robinder Bedi for his guidance, encouragement, and mentorship. I am also grateful for Dr. William Borgen and Dr. Toni Schmader for their support and invaluable feedback throughout this process. I am very appreciative of the support from Nicole Chapdelaine and Ali Margulius who volunteered their time to support the data collection process.

A special thanks are owed to my family and friends for their unwavering support throughout this journey. My gratitude to my parents for their enduring patience and their eternal support, helping me in any way they could. Many thanks to my brother, Arash, who not only was a sounding board for ideas and emotional support, but I am also indebted to him for his impressive technological expertise that helped me during data collection. To my friends Arian, Anastasia, and Nicole who cheered me on from the sidelines but also reminded me from time to time to get out my academic life bubble. Lastly, to my other friends, classmates and colleagues for their encouragement and support. Thank you!

Dedication

This work is dedicated to my beloved grandparents, Kobra and Yahya, who have always believed in me and showed their never-ending support in my endeavours.

Chapter 1: Introduction

Canada is often praised as a multicultural and mosaic nation (Leber, 2017). This diversity is evident by looking at its demographics. In 2016, about 22% of the population were foreign-born Canadians, and there were around 200 mother tongue languages spoken (Statistics Canada, 2017). Further, it is predicted that by 2036, a third of Canadians between ages of 15 to 64, will be of "visible minority" status, a status given to non-Aboriginal individuals who are "non-Caucasian in race or non-white in colour" (Statistics Canada, 2017). Moreover, Canada has an official legislated multiculturalism policy called the *Canadian Multiculturalism Act*, which promotes a mosaic viewpoint that allows individuals to preserve their heritage cultural background while being part of the larger Canadian society as a whole (Minister of Justice, 1985). Canada's diverse population is indisputable, yet there is a disconnect between celebrating this diversity and how individuals are viewed and treated in Canadian society. Many have criticized this multiculturalism policy for being a lot of "smoke and mirrors" in which those not part of the dominant culture (e.g., visible minorities) are still racialized, marginalized, and controlled within the state (Gunew, 2004; Tang & Browne, 2008; Tator, 1996).

There are statistics that confirm the less than welcoming side of this nation. Police reports in 2017 showed that 43% and 41% of reported hate crimes were motivated by race/ethnicity and religion, respectively (Statistics Canada, 2018). Compared to the previous year, this was a 32% increase in hate crime based on race/ethnicity, noting that the majority of these hate crimes were towards Black, and Arab or West Asian populations. Further, there was an 83% increase in hate crimes based on religion, with a 151% increase in reported hate crimes against Muslims, compared to the previous year (Statistics Canada, 2018).

The underpinning of hate crimes becomes evident when considering that the image of a "Canadian" is still predominantly based on whiteness, where being a white (male) Anglo-Saxon Christian is normalized and everyone else is seen as an "Other" (Moodley, 2005). From this dominant perspective, it is this Other that needs to be better integrated into the dominant Canadian culture. As an example of this Othering, the previous prime minister, Stephen Harper, described his view of the prototypical Canadian, in 2013, when he said "I believe, and I think most Canadians believe, that it is offensive that someone would hide their identity at the very moment where they are committing to join the Canadian family" (Orwin, 2015). This statement was made after Zunera Ishaq, a Muslim immigrant who wished to take her citizenship oath, protested the ban on niqabs during this ceremony (Orwin, 2015). Hence, to be Canadian, according to the previous prime minister and many others, for Muslims and other non-White and non-Christian individuals, seems to signify assimilation into the dominant culture by the way of dressing, behaving, and changing one's belief system; a contradiction to what the federal multiculturalism policy stands for.

Muslims, followers of Islam, make up 3.2% of the Canadian population and are one of the fastest growing religions in Canada (Statistics Canada, 2015). Muslims are a heterogeneous and diverse group that includes Arabs, Asians, Africans, Europeans, and Latinos (Pew Research Center, 2017c). About a third of all Muslims in Canada are Canadian-born and many are proud of their Canadian identity and see this as an important part of their Muslim identity (Hamdani, 2015). However, this group has been placed under increased scrutiny and surveillance since the terrorist attacks of September 11th, 2001 in the United States, for which some Muslim individuals were widely considered to be the culprits. Since then, there have been reports of increased anti-

Muslim sentiment in most, if not all Western societies (Abu-Ras & Abu-Bader, 2008; Ahmed & Reddy, 2007; Barkdull et al., 2011; Padela & Heisler, 2001).

There has also been increased vilification of Muslims in the media since the events of September 11th, 2001 (Joshi, 2006; Shaheen, 2003; Zaal, 2012). Muslim men are often portrayed as patriarchal angry bearded Arabs and/or terrorists, while the women are depicted as helpless and submissive, in need of saving from their violent patriarchal society (Shaheen, 2003). Muslims as a group have been strongly racialized, whereby Islam has become synonymous with extremism and violence by the popular media (Joshi, 2006).

Islamophobia is the irrational fear and stigma towards Islam and Muslims and belief that all Muslims are extremists (Samari et al., 2018). Islamophobia is analogous to the Orientalist[1] perspective, with the much celebrated democracy of the West clashing with the alleged barbaric and backwardness of Muslims (Karim & Eid, 2012; D. Kumar, 2010). It is not just the mainstream media that has popularly painted a picture of Muslims as perils to Western society, especially since the events of 9/11, many Western nations have seemingly put in place new laws to implicitly police those who are or resemble Muslims (i.e., Middle Eastern, Arabs, or those with brown coloured skin). For example, in 2015, Canada passed bill C-51, the *Anti-terrorism Act, 2015* which allows the government to easily share information about individuals suspected of terrorism between Canadian government agencies. While racial profiling is against the Canadian Charter Rights and Freedom (1982), it has been argued that this act has specifically been targeting the Muslim communities in Canada (Payton, 2015).

[1] Orientalism is a term popularized by Edward Saïd who criticized Oriental studies for essentializing the Middle East, Asian and African societies as undeveloped. He argued this was created by the West to dominate and control, the East. See "Orientalism" by Edward Saïd (1978).

Such laws and the many negative media images of Muslims in Quebec and Canada more broadly appear to have had an impact on the public's view of Islam, where 46% of Canadians view Islam negatively (Angus Reid Global, 2017), and one in four Canadians agree with an immigration ban of Muslims to Canada (McInnis, 2017). More importantly, these misconceptions of Muslims as terrorists and extremists has led to many Muslim, and non-Muslim individuals who resemble the media's portrayal of Muslims such as Baptized Sikhs, to be racialized and subject to prejudice, discrimination, and hate-based violence (Ahluwalia & Alimchandani, 2013; Basu, 2016; Bhasin, 2012; Birk et al., 2015; Leber, 2017; Rieger, 2018). Increased discriminatory acts, since the events of 9/11, have been correlated with decreased mental health well-being, such as depression, anxiety, post traumatic stress disorder (PTSD), and lower self-esteem, for those affected directly or indirectly (Abu-Ras & Abu-Bader, 2009; Ghaffari & Çiftçi, 2010; Husain & Howard, 2017; Moradi & Hasan, 2004; Nadimpalli et al., 2016). Thus, it is crucial that Muslims are able to access mental health professionals when needed and requested, especially those who can provide appropriate, and culturally and religiously sensitive services to these individuals.

In line with their ethical guidelines (e.g., BC Association of Clinical Counsellors, 2014; Sheppard, Schulz, & McMahon, 2007), counsellors and psychotherapists have long been perceived as unbiased practitioners providing equitable services to all, regardless of clients' identities and sociocultural variables, including race, ethnicity, and religion. However, it was not until the civil rights movement of the 1960s in North America that multicultural counselling as a specialization came to the forefront of counselling services and research (Baruth & Manning, 2016). Before this time, sociocultural variables were often overlooked in counselling, and the majority of clients were white middle and upper-class; neglecting those from lower classes and

different cultural backgrounds. This changed notably by the mid-1970s, when researchers started to focus on the effects of race in the counselling session (Baruth & Manning, 2016).

In recent years there has been a call for change, with a shift towards more multicultural approaches (Baruth & Manning, 2016; Collins & Arthur, 2010). Despite efforts to bring multicultural processes and understandings to the forefront in training mental health professionals, contemporary counselling and psychotherapy have still been criticized for being Eurocentric (Bedi, 2018; Lago & Thompson, 2002; Moodley, 2005; Pedersen, 1979). Further, research has shown that disparities in mental health services based on sociocultural variables have continued to persist in this day and age of alleged greater cultural sensitivity. For example, research has shown that racial/ethnic minorities, including Blacks, Hispanics, and Asians, receive unequal mental health services (Budge et al., 2016; Kugelmass, 2016; Shin et al., 2016; Woo, 2017).

Unlike race/ethnicity and gender, religion has been one area that has not received much attention in terms of mental health service disparities (Haque, 2004). Researchers and scholars have begun to demonstrate the positive effects of acknowledging and working with the client's religion/spirituality, such as improved psychological wellbeing, within mental health services (Balbuena et al., 2013; Worthington et al., 2011). Hence, there has been a call for counsellors and psychologists to integrate religion/spirituality into their multicultural competence models (Plumb, 2011). Regardless, there remains a dearth of research examining if religious minorities, such as Muslims, are receiving equal access to mental health services in the first place.

It is this broader context and social climate which highlights the pressing need to investigate the possibility of religious disparities and implicit bias affecting access to mental health services for Muslims. With the increased number of Muslims facing discrimination and

prejudice in Canada (Statistics Canada, 2018), affecting their own and their communities' mental health (Abu-Ras & Abu-Bader, 2009; Ghaffari & Çiftçi, 2010; Husain & Howard, 2017; Moradi & Hasan, 2004; Nadimpalli et al., 2016), it becomes imperative to ensure that they are receiving needed mental health services. This study will examine if Muslims have equal access to counselling services compared to the dominant group (i.e., those perceived to be "Canadian"; typically seen as White/European Christians). Specifically, I propose to investigate whether there are disparities in access to counselling services for Muslim individuals, by using a common Muslim male name. Since Muslims are often racialized through marginalization and reducing their identity to their race/ethnicity (Joshi, 2006), the use of a common Muslim first and last name will help to highlight these individuals as a distinct religio-racial/ethnic group in the study (Crabtree & Chykina, 2018).

Chapter 2: Literature Review

This chapter will first describe Islam, Muslims in North America and the state of their mental health, and services provided to them. The focus will be North America, rather than Canada, since most of the research with Muslims has been done in the U.S. This will be followed by examining some prevalence and incidence rates surrounding mental health disparities. Subsequently, implicit bias will be discussed with a section specifically on implicit bias in counselling, followed by the methodological design to examine mental health disparities.

Islam and Muslims

Islam is an Abrahamic religion which follows the teaching of the Qur'an, that is considered the direct word of Allah (God) through Muhammad, the last prophet (Hedayat-Diba, 2014). The term "Islam" itself means both "submission" and "peace" where Islam teaches that one can find peace by submitting to Allah; this is an important tenet which seems to play a role in help seeking behaviour when in psychological distress. There are five pillars in Islam: (a) Shahaadah which is the testimony of faith; (b) Salat which refers to the daily five prayers; (c) Zakkat is the specific donation of wealth based on one's income, to be given once a year; (d) Sawn which means fasting that happens during the month of Ramadan; and (e) Hajj is the obligation to perform pilgrimage to Mecca, the holy site for Muslims. These five pillars are common among all Muslims regardless of their denominations (Hedayat-Diba, 2014).

As of 2015, there are an estimated 1.8 billion Muslims in the world which is about 24% of the world population (Pew Research Center, 2017b). It has been estimated that about 1 million Muslims lived in Canada in 2011, making up approximately 3.2% of the Canadian population, and this number is expected to nearly triple by 2030, making up 6.6% of the Canadian population (Pew Research Center, 2011; Statistics Canada, 2011). Muslims make up a smaller proportion of

the population in the United States (U.S.) with an estimated 3.4 million living in the country in 2017, making up 1.1% of the population; where it is estimated that by 2050, Muslims will constitute 2.2% of the population (Lipka, 2017). Therefore, it is evident that Muslims are a large and growing segment of the Canadian population, especially in comparison to the U.S. Although a smaller percentage of the population is Muslim in the U.S., there is more data and information on Muslims in the U.S. compared to Canada. In the U.S., the Pew Research Center (2017a) has found that while 78% of U.S. Muslims have always been Muslims, 21% have converted to Islam from another faith. Of those born in the U.S., 54% said they had always been a Muslim and the remaining 44% had converted to Islam, where Black-Americans constitute 67% of those converting to Islam (Pew Research Center, 2017a).

As noted in the introduction section, Muslims are a heterogenous group from different ethnicities, cultures, and nationalities. In the U.S. and Canada, Muslims constitute Asians, Hispanics, White, and those from African descents amongst other groups (Hamdani, 2015; Pew Research Center, 2018). Further, 28% of Muslims in Canada were Canadian born in 2011, a notable increase from 23.8% in 2001 (Hamdani, 2015). In the 2011 National Household Survey, about 12% of Muslims in Canada self-identified as a "non-visible minority." This group includes Muslims from European descents, some from the former Soviet Union, as well as likely a small number of White Canadians who had converted to Islam (Hamdani, 2015).

While scholarly sources are starting to recognize that Muslims are a diverse heterogenous group, most have focused on newly migrant Muslims, not capturing the lives of Muslims born and raised in North America (Hamdani, 2015; Khan et al., 2015; Padela et al., 2012). Due to this lack of recognition in scholarly views and research, as well as stereotypical images in mainstream media, Muslims are often perceived as non-Western Arabs or Middle Eastern

(Karim & Eid, 2012; Shaheen, 2003; Zaal, 2012). Contrary to this image, statistics show that only about 25% of Muslims in Canada self-identified as Arab and 13% as West Asian (Iranian, Afghani, former Soviet Union) in 2011 (Hamdani, 2015). Further, the Pew Research Center (2011) has found that the largest number of Muslims in the world in 2010 were in Indonesia, Pakistan, and India respectively. This data is consistent with the Canadian Muslim population where South Asians made up the largest Muslim community (36%), with Pakistanis and Indians dominating this group based on 2011 statistics (Hamdani, 2015). Therefore, inaccurate stereotypical images of Muslims as foreigners from the Arab and Middle-Eastern countries has led to the race of individuals to be used as a proxy for religion (Joshi, 2006). In other words, racialization of Muslims in Canada has conflated race with other sociocultural factors such as religion, nationality, and ethnicity.

This stereotypical and inaccurate generalization of Islam followers as foreigners of a far away land has created a divide between "us" and "them," where Western civilization is commonly considered separate and opposite to Islam and those perceived to be Muslim (i.e., Arabs, Middle Easterners, Sikhs, South Asians; Karim & Eid, 2014; Samari et al., 2018). Keeping the above in mind, it is then important to highlight that this study is not only about possible direct religious bias but also about the possibility of racial bias based on the individual's name representing a Muslim; because to be associated with Islam based on one's name is often to be a racialized "Other." The racialization of those perceived to be Muslims has been explored by researchers examining the state of their mental health after the events of September 11th, 2001.

Mental Health Post 9/11. The events of September 11, 2001 (also known as 9/11) is the day when an al-Qaeda group hijacked U.S. airplanes crashing them into the World Trade Center

in New York, the Pentagon Building in Washington, DC, and in Shanksville, Pennsylvania, killing about 3,000 people ("September 11 Fast Facts," 2019). Since the events of this day, there have been reports of increased discrimination against Muslims and those perceived to be Muslims in Western societies (Abu-Ras & Abu-Bader, 2009; Ahmed & Reddy, 2007; Liepyte & McAloney-Kocaman, 2015; Martin, 2015). Overt discrimination against Muslims during their every day lives has taken the form of verbal attacks, such as being called names, as well as non-verbal discriminatory acts, such as being avoided or receiving looks of disapproval (Livengood & Stodolska, 2004). While violent discriminatory acts and hate crimes, including physical attacks and vandalism of mosques and other places of prayer have been documented (CAIR, 2019; Statistics Canada, 2018), implicit bias manifests itself through covert prejudice and discrimination; one form of such prejudice is through microaggressions, or daily subtle acts of discrimination towards a minority group (Sue et al., 2007). A microaggression against Muslims would be, for example, to tell a Muslim individual that they must feel liberated living in [insert name of Western nation]. Research has demonstrated the negative effects of both overt discrimination and microaggressions on this population's mental health (Abu-Ras & Abu-Bader, 2008, 2009; Barkdull et al., 2011; Husain & Howard, 2017; Nadal et al., 2012).

Abu-Ras and Abu-Bader (2008) conducted eight focus groups with Arab Americans in New York where the majority of the groups were comprised of local imams, mental health professionals, educators, social workers, and physicians. They found that many of the participants stated fear and anxiety around increased hate crimes as the biggest reactions to the events of 9/11. Further, while the attacks brought Americans together through their shared sense of grief, trauma, and loss, the participants expressed feeling isolated because of the stigmatization placed on Arabs and Muslims where they felt they were excluded from the

grieving process. Participants also not only spoke about not having access to any mental health resources in the community because they were now the "enemy camp" (p. 226), but they also spoke about their places of worship, which had been a source of spiritual and psychological support, being shut down or vandalized because of stigmatization of being associated with terrorism (Abu-Ras & Abu-Bader, 2008).

Similarly, another qualitative study by Barkdull and colleagues (2011) conducted individual semi-structured interviews with 34 Muslims from four different countries: Australia, Canada, United States, and Argentina. Most of the participants were well-educated and professionals, and 90% were immigrants who had been living in their host countries for ten years or more. What they found was that participants from Canada, United States, and Australia expressed more life stressors and anxiety after the events of 9/11. They felt stigmatized and were subjected to verbal harassments on a daily basis. Participants also reported discrimination while travelling, especially at airports, as well as during their everyday life such as at work or when shopping. Further, participants spoke about needing more mental health services that are more culturally appropriate (Barkdull et al., 2011).

What seems to be common between these two studies (Abu-Ras & Abu-Bader, 2008; Barkdull et al., 2011) is the experience of increased discrimination and hate crimes against Muslims and those perceived to be Muslims (i.e., Arabs); not only in New York or the U.S. but also in other Western countries like Canada and Australia. However, both studies' participants were well-educated and professional individuals, therefore speaking from a place of socioeconomic privilege. What is missing from these two studies is the perspective of working class and those in lower socioeconomic status (SES).

In another study by Abu-Ras and Abu-Bader (2009), a majority Muslim sample (88%) was used, with half of the participants being from New York, where about 38% of the participants were unemployed at the time of the survey and 19% reported an income of under $20,000. The average number of years residing in the U.S. was 14.7 years. The researchers surveyed participants about their discriminatory experiences after 9/11. What the researchers found was that 77% of the sample of 350 participants reported experiencing negative consequences of the attacks, where 63% said they experienced workplace discrimination and bad treatment. Further, about 62% of the sample scored in the clinical depression range (between 16 and 48) based on the Center for Epidemiological Studies Depression Scale (CES-D). Those who stated not having access to any community support reported significantly higher levels of depression and post-traumatic stress disorder (PTSD), compared to those that mentioned having access to services. Participants who viewed the events of September 11th, 2001 as negatively impacting their lives, as well as those who experienced increased anxiety after 9/11, experienced significantly higher levels of depression and PTSD. No significant differences were found in the levels of depression and PTSD across individuals' gender or religion (Abu-Ras & Abu-Bader, 2009).

This study by Abu-Ras and Abu-Bader (2009) was able to capture the experiences of those from lower SES as well as the working-class, something that was missing in the previous two studies. It is also interesting that no association was found between depression and PTSD and individuals' gender or religion. With a majority Muslim sample (88%), these results still point to an important issue that the events of 9/11 impacted most individuals similarly. Yet, some groups (i.e., non-Muslims and those not prototypically resembling Muslims) were allowed to grieve and process this event publicly and as a community, including by having access to mental

health services, while some, such as ostensibly visible Muslims, were typically excluded because of their perceived identity being possibly similar to the attackers (Abu-Ras & Abu-Bader, 2008, 2009).

These feelings of fear and anxiety, and the sense of isolation presented in the above research have been echoed by Muslims from Europe and Australia as well (Allen & Nielsen, 2002; Pascoe & Smart Richman, 2009; Sheridan, 2006). For example, a study in the United Kingdom (U.K.) with 222 participants self-identifying as Muslims, used a mixed method approach, and found that there was an increase in reported implicit racism and discrimination, since the events of 9/11, as well as a positive association between high scores on the General Health Questionnaire (GHQ) and the reporting of abusive events related to 9/11(Sheridan, 2006). The author also highlighted the fear and anxiety felt by participants post 9/11, where many had reported being stared at by strangers or being on the receiving end of a microaggression or an overt discriminatory comment.

What the above studies point to is the common fear and anxiety of being ostensibly Muslim or being perceived as Muslim after the events 9/11 in Western societies such as U.S., Canada, U.K., and Australia. There has been increased rates of depression and PTSD after the 9/11 attacks, especially when the attacks were viewed as negatively impacting one's life. Yet, three studies spoke about scarcity of appropriate mental health services available for Muslims (Abu-Ras & Abu-Bader, 2008, 2009; Barkdull et al., 2011). All of the studies described are at least eight years old, making such research outdated given the current sociopolitical climate for North American Muslims where Islamophobia has more explicitly become part of the political agenda around the world (Bayrakli & Hafez, 2019; DeSimone, 2019). Nonetheless, there is no available research (to the author's knowledge) which explores if Muslims still have less access to

mental health resources in the past few years, particularly research that does not rely on self-report data, which is subject to various social cognitive biases and open to critiques of objectivity (Riach & Rich, 2006). What is available is national data from health disparities based on race/ethnicity, which is highly relevant to the issue at hand and will be explored below.

Mental Health Disparities

There are many different definitions on what constitutes a "disparity." For the purposes of this study, I am defining a mental health disparity using a combination of Mental Health Commission of Canada's (MHCC) and the Institute of Medicine's (IOM) characterisation. A mental health disparity in this study refers to avoidable discrepancies between different populations in terms of accessibility, quality, and outcomes of mental health care, which can be rooted in inequalities: (a) in the climate within which healthcare systems operate in a society; and (b) in discrimination at the individual level by professionals (Institute of Medicine [U.S.] Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health, 2003; Mckenzie, Agic, Tuck, & Antwi, 2016). Using this definition, the focus of this research project will be on the disparities in accessing mental health services possibly rooted at the individual level due to discrimination or prejudice towards certain groups. I am defining accessibility of services as the number of people from a group who are offered mental health services; it can include utilization of services, but it does not have to.

In the last two decades, there has been a surge in research examining mental health disparities (Safran et al., 2009), and there is research on mental health disparities for a multitude of groups. I will only be looking at race/ethnicity, gender, and religion in this literature review, as these three sociocultural characteristics are the focus of my research project. Sociocultural factors are characteristics that can impact individuals' thoughts, behaviour, or feelings based on a

cultural group rather than being based on biological factors (Proctor et al., 2010); gender, race/ethnicity, and religion are all considered sociocultural factors.

There are few things that need to be noted. First, although I will separately examine disparity research based on race/ethnicity, religion, and gender, these sociocultural factors do not operate in isolation but rather they intersect with each other. Therefore, it is not possible to assume or conclude that a certain problem is based on only one of these factors; it seems impossible to fully detangle the complexity of these social issues. Second, most prevalence and incidence studies do not provide information about cultural difference of their sample such as language barriers of participants, level of acculturation, and effects of oppression, making the interpretation of the results less clear cut. Third, the data provided below is based on mostly national and epidemiological surveys, which are limited to providing surface level information about varying levels of access to health services by race/ethnicity, gender, and religion.

Race/Ethnicity. While the focus of this research is on religion, not race or ethnicity, as pointed out above, Muslims are often racially associated with Arabs, South Asians, or Middle Eastern individuals. Therefore, race and ethnicity have often been a proxy for religion for this group. Some definition of terms is needed here: Culture is defined as any behaviour, attitude, or values that is shared by a group of people (Smedley & Smedley, 2005). Further, race (a social construction of Europe in sixteenth century) has often referred to the physical attributes that are shared between groups of people and is frequently used as a way to separate people into groups (often whites vs others; Smedley & Smedley, 2005). While race does not indicate one's ethnicity or culture, it is regularly used as the indicator of the cultural belonging of an individual. Closely related, ethnicity refers to the connectedness of individuals based on specific aspects of cultural patterns that are shared and passed on over time to create a common history and ancestry, which

establishes a sense of belonging. However, ethnicity is, at times, ascribed by outsiders based on one's race (Smedley & Smedley, 2005); giving rise to the often conflation of race and ethnicity in everyday life and research.

Accessing Services. This is the area in the health disparities literature that has been the most researched (Padela & Raza, 2011). When looking at statistics of nationally representative surveys, it is clear that there are disparities in accessing mental health services between White Americans compared to Black Americans, Hispanics, and Asians (Lê Cook et al., 2010; Matsuoka et al., 1997; Miranda et al., 2008; Woo, 2017). Such research is limited in the causal inferences that can be made from it due to its survey nature, which can be better addressed by experimental designs. Recent research has demonstrated such disparities using an experimental research design (Kugelmass, 2016; Shin et al., 2016). For instance, two separate research groups examined the disparities of access to counselling services among Black and non-Hispanic White Americans, using stereotypical Black and White names. Results consistently showed that Black individuals were less likely to receive appointment times than White individuals (Kugelmass, 2016; Shin et al., 2016).

Further, it is important to not generalize ethnic groups into a binary of White and non-White groups. Such monolithic categorization of race can lead to erasure of many different experiences and insightful data in research. For example, a national study looked at different rates of mental health needs between African Americans and Caribbean Black Americans, finding that African Americans were more likely to seek help from psychiatrists, while Caribbean Black Americans were more likely to seek help from non-psychiatric mental health services (Neighbors et al., 2007). Interestingly, the authors also found that, being insured for Caribbean Blacks participants was associated with more use of services compared to all

uninsured groups (uninsured Caribbean Blacks and African Americans), yet, insurance status had no impact on use of services for African Americans (Neighbors et al., 2007).

Gender. When examining gender differences, it is important to differentiate between sex and gender. Sex refers to an individual's biological characteristics such as physical anatomy, whereas gender refers to one's self-identification and cultural socialization of what it means to be male or female, based on set of behaviours and expectations (Connell & Pearse, 2014), and therefore is a sociocultural factor. Yet, it is not fully possible to separate sex and gender when looking at disparities due to the intersectionality of the two variables, whereby they are highly overlapping. This literature review, however, will attempt to only focus on research looking at gender rather than sex disparities in mental health care because the current study will be based on individuals' names which is a gender variable. Therefore, I will not look at genetical/biological differences between males and females such as the affect of hormones on the brain, or how males and females behave, think, or feel in relation to mental health care.

Accessing Services. Gender differences in accessing mental health services have been found when accounting for social determinants of health (Astbury, 2001; Denton et al., 2004). However, as previously mentioned in the beginning of this section, it is extremely difficult to isolate and tease apart the different variables playing into access to services. While some of the research presented below has attempted to understand the gender disparity in accessing services, this is a complex issue that is difficult to detangle and is outside the scope of this literature review.

It has been reported that women have less accessibility to services, yet they seek for and utilize services more often than men (Addis & Mahalik, 2003; Astbury, 2001; Courtnay, 2000; Denton et al., 2004; Turcotte, 2011). Here accessibility is the extent to which an individual has

access to services, while utilization refers to the extent that an individual actually uses services. It has frequently been hypothesized that women have less access to services because of family obligations such as child care, as well as due to being more likely to have lower SES, which is associated with having less accessibility to mental health services (Lasser et al., 2006; Olah et al., 2013; Wang et al., 2005). Yet, they seek and utilize health care services more frequently because to take care of oneself is feminized and therefore is a more acceptable behaviour for women (Courtnay, 2000).

On the other hand, men face another kind of barrier in accessing services. While, men have more accessibility to services, they utilize services much less (Courtnay, 2000). One explanation of this disparity points to the hegemonic (or dominant) masculinity in North America which involves men being seen as tough, strong, and independent often leading to denial of any vulnerability, physical dominance, and dismissal of needing any help (Courtnay, 2000). Therefore, to reach out for help would usually be seen as being weak. These statistics seem to be consistent in many other ethnicities and nationalities (Addis & Mahalik, 2003; Neighbors et al., 2007). For instance, Neighbors and colleagues (2007), using a national survey (n = 5191), examined usage of mental health services by African Americans and Caribbean Blacks Americans in the past 12-months, and found that women in general were more likely to report seeking out some type of mental health help, compared to men.

Deeper examination of issues around gender provides greater illumination. A nationally based survey conducted by Statistics Canada called the Canadian Community Health Survey (CCHS) was used to analyze differences in gender for accessing mental health services. Researchers in 2009 used the CCHS data from 2002 to examine gender differences in accessing mental health services, finding that women were more likely in general to access mental health

services when controlling for "the need for services" based on psychiatric diagnoses (Drapeau et al., 2009). Further, they found that the difference was largest for access to general practitioners compared to specialized services such as psychologists and psychiatrists (Drapeau et al., 2009). Similarly, a more recent analysis of CCHS data (2011) indicated that women were more likely to consult about their mental health with a general practitioner than men (Cox, 2014). However, these differences became much smaller when individuals were accessing psychologists and psychiatrists (Cox, 2014). Therefore, it seems that while women may be talking about their mental health more with general practitioners, the gender gap becomes much smaller as the service become more specialized. Yet, these studies are limited in their generalizability given the small percentage of Canadians overall reporting utilization of services for their mental health.

Comparably, another large cross-sectional survey (n = 10,842) in England, using the General Health Questionnaire (GHQ-12), reported that men were less likely to report reaching out for help even from friends or family, compared to woman (Oliver et al., 2005). Further, they found that being a woman and having a higher GHQ-12 score was the most strongly associated with help-seeking behaviours. Yet, the authors also noted that there was no interaction between GHQ-12 score of ≥ 4 (the cut-off point for mental health disorders), any form of help-seeking behaviour, and gender (Oliver et al., 2005). What this means is that while men were less likely to report reaching out when asked a dichotomous "yes" or "no" question, there were no differences in gender when it came to actually seeking help when there were clear signs of a likely mental health problems (GHQ-12 score of ≥ 4).

Although, there is no report of race, ethnicity, immigration, religion, or acculturation level of participants, the results of the aforementioned studies point to an important issue that the dichotomous conceptualization of "men seek out help less because of gender roles" does not take

into consideration the contextual situation of individuals. In addition, it takes away men's agency by stating that men universally and inevitably conform to these gender roles (Addis, Mansfield, & Syzdek, 2010; Connell & Messerschmidt, 2005).

Lastly, a study by Kugelmass (2016) found that therapists were more likely to offer prime appointment times (i.e., weekday afternoon) to women compared to men. Such results point to the ambiguity of this issue. Therefore, it is not clear why men utilize services less often in general and the question remains, is the disparity due to gender roles, or are there other factors playing a role such as bias by the health care provider. Therefore, the current study will focus on men help seekers since there is comparatively scarce research specifically examining men in the mental health treatment field (Bedi et al., 2016; Hoover et al., 2012).

Religion. In recent years, religion has been recognized as an important sociocultural factor effecting therapy, with research showing religion/spirituality's general positive effect when acknowledged within services. For example, research has found that religion is a protective factor towards various mental health illnesses, as well as a positive contributor to the psychological well-being of clients (Balbuena et al., 2013; Worthington et al., 2011). Additionally, research has frequently shown the positive relationship between the integration of the client's religion into therapy and therapy outcome (Worthington, Hook, Davis, & McDaniel, 2011). Hence, there has been a call for counsellors to integrate religion/spirituality into their multicultural competence models (Daniels & Fitzpatrick, 2013).

Yet, there is a surprising paucity of research examining mental health disparities based on religious affiliation. This area in health disparities has not been well researched since most of the literature has focused on race/ethnicity disparities (Padela & Raza, 2011). Padela and Raza (2011) note that this may be due to the assumption that researchers presume those sharing race

and ethnicity will have similar social experiences and cultural backgrounds (perhaps extrapolating to religion). The authors maintain that such assumptions possibly miss important minority groups that are not from the same race and ethnicity background yet share values and social experiences, such as religious minorities. Further, the authors had taken on a literature review on health disparities for Muslims in United States and Canada, from the MEDLINE database. However they were not able to find any such research, only finding studies with specific nationalities which included Muslims as part of those groups (i.e., South Asians and Arabs; Padela & Raza, 2011). These results still appear to hold true as I was also not able to find any research examining health disparities for Muslims specifically.

The research that is available has instead focused on views and experiences of individuals within a religious group towards mental health and mental health services. For example, a study looking at help-seeking behaviours, spirituality, stigma, and mental illness knowledge amongst African Americans who attend church, found that most participants had a negative view of mental health help-seeking behaviours, believing that it would not be worth the time and money to invest in mental health services. Further, the respondents overwhelmingly stated that trust in God is what keeps them healthy but acknowledged their own personal responsibility as well as the need to stay healthy (Neely-Fairbanks et al., 2018).

Such research examining Western Muslims' help-seeking behaviours is scarce. Most of the available literature on Muslims' experience is based on Arab Westerners and South Asian Westerners where some are Muslims (Padela & Raza, 2011). Therefore, there has not been any direct epidemiological or national studies examining the health (or lack of thereof) of Muslims (Padela & Raza, 2011) in North America. Abu-Ras and Abu-Bader (2008), in their focus groups on the events of September 11th, 2001 (i.e., 9/11), asked participants what they thought were the

biggest barriers to accessing mental health services faced by Arab Americans. Participants responded by stating that not only did they feel excluded from the grieving process of the 9/11 events, they were not provided any mental health services to address problems in their communities. Further, an imam indicated being ill-equipped to deal with severe mental health problems as well as trauma. Thus, the lack of resources provided to this community after the events of September 11th, 2001 created a huge barrier in accessing needed services (Abu-Ras & Abu-Bader, 2008).

On the other hand, research has shown that Muslims may not seek mental health services as their first choice of getting help. For example, a review of literature by Padela and Curlin (2013) found that many Muslims view disease as a will of God which is not a condition in need of medicine or psychological treatment. Participants in Abu-Ras and Abu-Bader's (2008) study specifically stated that negative cultural attitudes towards counselling, lack of belief in mental health services, and fear of being stereotyped by mental health professionals as part of the reason for not accessing services (Abu-Ras & Abu-Bader, 2008).

As shown above, there is a paucity of research examining the help-seeking behaviour of Muslims and their access to mental health services such as counselling. Scholars have pointed out that this may be due to the reliance on race and ethnicity in surveys and studies to identify different cultural experiences (Padela & Curlin, 2013; Padela & Raza, 2011). However, as stated in the previous section, using the example of Muslims, religion cuts across race, ethnicity, SES, and other sociocultural factors yet creates common cultural experiences. Thus, there needs to be peer-reviewed research providing an assessment of accessibility of services, especially to mental health services for stigmatized groups such as Muslims, to ensure that equal and equitable services are being offered to those who may need them.

Further, what the above cited research points to is the support for the claim that access to mental health services is not fully a personal choice but rather it is impacted by people's sociocultural characteristics such as race/ethnicity, gender, and religion (i.e., some are more easily able to access services while others will face barriers in seeking help based on sociocultural characteristics). However, as already mentioned, clear separation of these issues is not possible because all sociocultural characteristics and other life factors interact with each other, creating a matrix of opportunities and oppression. While the studies mentioned in this section are important and point to issues within the health care system of North America in general, not only is most of this research from epidemiological data taken from national surveys, or cross-sectional self-report surveys, there is also a lack of research examining access to other health professionals, such as counsellors and psychologists. Therefore, experimental approaches to explore causal factors related to mental health disparities for Muslim clients are sorely lacking. As well as it is not clear how other health professionals, such as counsellors and therapists are approaching clients and possibly contributing to these disparities in accessing mental health services.

Lastly, there is scarcity of mental health disparity research with Canadian populations. Most of the Canadian research that is available has focused on physical health disparities (Adelson, 2005; Lasser et al., 2006; Olah et al., 2013). For example, it has been reported that Canadians have more access and better health care than their U.S. counterparts (particularly the uninsured U.S. individuals; Lasser et al., 2006). While, this may seem like promising news for Canadians, a study conducted in Toronto during December of 2010 found that family physicians and their office staff were more likely to give appointments to those that were from a higher socioeconomic status (SES), which was indicated by occupation (Olah et al., 2013). Although

this research is from more than six years ago, it shows that disparities in healthcare likely still exist in Canada even with a national healthcare system. One way researchers have started to investigate disparities in the mental health field has been through examining implicit biases.

Implicit Bias

A common theory for understanding biases is based on the Schema theory, where in the simplest terms, biases are based on cognitive schemas (DiMaggio, 1997). Cognitive schemas are formed automatically and relate new knowledge to already stored knowledge. Schemas about a group of people are called stereotypes. Stereotypes can be positively or negatively charged, and characteristics that are stereotypically consistent are conjured up much quicker (Dovidio, Hewstone, Glick, & Esses, 2010). For example, Muslims in Western cultural stereotypes are often associated with having brown skin, being terrorists and with acts of terrorism in mainstream media (Joshi, 2006). Therefore, stereotypes give information about group characteristics (e.g., race), social roles or norms, as well as the degree to which members share a quality (ingroup homogeneity; Dovidio et al., 2010). These group stereotypes also get assigned to individual group members (overgeneralization), creating an ingroup "us" and outgroup "them" categories. An ingroup is defined as identifying oneself with others who share similar thoughts, feelings and act in a similar way in social situations, while outgroup is defined as comparing one's ingroup with others not fitting into that ingroup (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) . Negative attitudes towards a group is called prejudice. Since stereotypes and prejudicial attitudes are automatically activated, they have the potential to affect behaviour; Acting on prejudicial attitudes is called discrimination (Dovidio et al., 2010).

Since Allport's (1954) influential work, "The Nature of Prejudice", there has been a lot of scholarly attention on this phenomena (e.g., Dovido et al., 2005; Greenwald et al., 1995). Today,

overt expressions of prejudice against most groups is seen as socially unacceptable and is often frowned upon (Dovido, Gaertner, Kawakami, & Hodson, 2002; Krysan & Moberg, 2016). Yet, more subtle forms of prejudice persevere (Dovido et al., 2002). In 1995, Greenwald and Banaji linked the concept of implicit social cognition to the idea of stereotyping. They defined implicit stereotypes as "introspectively unidentified (or inaccurately identified) traces of past experience that mediate attributions of qualities to members of a social category" (Greenwald & Banaji, 1995, p. 8). Indicating that while an individual may not ascribe to stereotypes consciously, they may think and behave based on stereotypical beliefs without being aware of it (automatically).

This concept of implicit stereotypes (now termed implicit bias) has been subject to much research in the last few decades (Boysen, 2010; Boysen & Vogel, 2008; Chao, Wei, Good, & Flores, 2011; DeAngelis, 2019; Greenwald & Krieger, 2006; Greenwald, McGhee, & Schwartz, 1998; Gushue, 2004; Gushue & Constantine, 2007; Kosloff, Greenberg, Schmader, Dechesne, & Weise, 2010; Nosek, Greenwald, & Banaji, 2007; Régner, Thinus-Blanc, Netter, Schmader, & Huguet, 2019; Sabin, Riskind, & Nosek, 2015). Given the automatic nature of stereotypes and prejudicial attitudes, they are often used to examine implicit biases.

One theory which explains the process of implicit biases is called Aversive Racism (Dovidio & Gaertner, 2004). Aversive Racism theory speaks to the new ways that racism is expressed, which is no longer blatant and explicit. Aversive racism is a subtle form of racism which stems from unconscious negative thoughts and feelings, while seeing oneself as a sincerely egalitarian individual and therefore denying and concealing one's racism from oneself and others (Gaertner et al., 2005). These unconscious feelings and thoughts can lead to negative behaviour towards minorities, through avenues such as avoidance of interpersonal contact or in

the form of microaggressions (e.g., Constantine, 2007; Gaertner et al., 2005; Morton, 2012). Aversive racism is often researched through examination implicit biases.

Implicit bias is often measured using reaction time-based measures where the purpose of the study is concealed from participants or the stigmatized variable is obscured by another task (Boysen & Vogel, 2008; Greenwald et al., 1998). One of the most well known measures of association of implicit bias is the Implicit Association Task (IAT; Greenwald et al., 1998). In the IAT, the reaction time (speed and accuracy) of participants is measured by asking them to respond to some stigmatized stimulus and a neutral stimulus, such as black and white faces, using positive and negative words (Greenwald et al., 1998). For example, in 2007, Nosek and colleagues reviewed six years of IAT data (July 2000 to May 2006) with over two and half million subjects, on 17 different subject areas, with 70% of the sample identifying as White and 62% identifying as female. What the authors found was that, generally, the IAT evoked a stronger effect of stigmatized stimulus across different topics and demographics, compared to the self-report measure (indicating explicit bias). There were two exceptions to this finding: the Arab-Muslims and thin-fat people IATs (Nosek, et al., 2007). For example, in the Arab-Muslims IAT, Arab-Muslim names were compared to "*other people,*" which represented names from around the world that would be unfamiliar to the American audience, the "*other people*" names were prefered more in the IAT test. However, during the self-report measure, the explicit effect magnitude (d = .58) was larger than the implicit effect magnitude (d = .38). What this shows is that participants expressed more explicit bias (self-reported) against Muslims than during the IAT (measuring implicit bias). However, the results of this study should be interepreted with caution given that the sample was self-selected, and a low median test-retest reliability has been reported for the IAT, in general (Nosek et al., 2007).

Implicit Bias in Counselling. While it might be an attractive idea to assume counsellors are not susceptible to such prejudice, as noted in the mental health disparities section, disparities in accessing mental health services have persisted (Lê Cook et al., 2010; McGuire & Miranda, 2008; Padela & Raza, 2011). Counsellors are not immune from such prejudicial attitudes, because they are part of the larger society and, for many, it has been instilled in their cultural conditioning to view whiteness as the norm (Sue et al, 2007). One way the counselling field has attempted to mitigate these disparities and the possible prejudice that might result from explicit and implicit biases, has been through multicultural competency (MCC) trainings (Sue et al., 1992). MCC trainings have been implicitly promoted by the different counselling regulation bodies (see BC Association of Clinical Counsellors; College of Psychologists of BC, 2014; Sheppard, Schulz, & McMahon, 2007).

Given the emphasis on MCC in counselling programs, counsellors self-reported cultural competency seems to increase with more training, yet research shows that biases in the counselling process are still present even after MCC training (Boysen & Vogel, 2008; Castillo, Brossart, Reyes, Conoley, & Phoummarath, 2007; Constantine, 2007). It is argued that this is likely due to the social desirability of training counsellors wanting to be seen as culturally competent, therefore it may not truly reflect their underlying feelings, thoughts, and actions (Boysen, 2009).

Research on implicit bias in the counselling field has often focused on microaggressions, within the counselling sessions, most of which are from the client's perspective (Constantine, 2007; Davis et al., 2016; Hook et al., 2016; Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Owen et al., 2011; Owen, Tao, & Rodolfa, 2010; Owen, Tao, Imel, Wampold, & Rodolfa, 2014). Microaggressions are the subtle commonplace events or statements that communicate

discrimination against a target individual or group (Sue et al., 2007). For example, the study by Constantine (2007), likely one of the most influential research studies in the field of microaggression (Davis et al., 2016), found that racial microaggression was negatively correlated to working alliance, general competence and multicultural competence of the counsellor, and had the biggest negative impact on counselling satisfaction for the client across these same four variables (racial microaggression, working alliance, general competence, multicultural competence).

Racial microaggression has been negatively correlated with working alliance in the counselling session, and intentions to seek counselling in other studies (e.g., Morton, 2011; Crawford, 2011). Further, Nadal, Griffin, Wong, Hamit (2014) examined the impact of racial microaggressions on individuals' mental health, finding that expressed microaggressions negatively predicted participants' mental health. In addition, they found that microaggression was negatively correlated with depressive symptoms and negative affect. While such research has been important in highlighting the negative effects of microaggression on the counselling process, most of this research has been through retrospectively measuring client's self-report of their perception in the counselling process. Much less research has focused on more direct measures of counsellors' implicit biases compared to retrospective reports from clients. The biggest benefit of using direct measures is non-reliance on self-report which is susceptible to self-report biases in general.

Abreu's (1999) research is likely one of the most well-known studies using an experimental design to examine counsellors' implicit bias. There were 60 counsellors/psychologists as participants, where they were randomly assigned to either a high primed condition related to African Americans (e.g., Black, lazy, ghetto) or low primed

condition (e.g., water, about, television) where such words would flash on a screen. Afterwards, participants were given a vignette about a therapy session with a client and asked to rate the client on a general impression measure where six items were related to hostility. The results showed that those in the high prime condition rated the client as more hostile, compared to the low prime condition (Abreu, 1999). What the results of this study point to is the observation that when practitioners are primed with common stereotypical biases towards a group, they respond more negatively towards that group, giving rise to (implicit) biases.

More recently, after the publication of "Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists" (American Psychological Association, 2003), more research has focused on the effects of MCC on implicit bias. A study by Castillo and colleagues examined the effects of a multicultural training course compared to those in foundational counselling courses (control group) with a sample of 84 counselling graduate students, on a multicultural competence measure and the Race IAT (African American vs. European Americans); looking at pre and post scores (15 weeks apart) on both measures. What the researchers found was that participants who had completed the multicultural courses, compared to those in the control group, exhibited statistically less bias in the IAT, as well as had statistically higher Awareness scores on the multicultural competence measure (Castillo et al., 2007). The increase in the Awareness subscale of the multicultural competence measure could have been due to social desirability bias because counsellors, especially those who have gone through multicultural training, may want to present themselves as more culturally competent (Boysen, 2009). Further, the increased scores in the IAT indicating lowered implicit bias could have been due to participants wanting to answer in socially desirable ways since experience with IAT, although difficult, can increase the ability of being able to fake one's results as participants

completed it in a pre-post design (Nosek et al, 2007). In addition, it is considered unethical to not be sensitive to diversity in the counselling process, providing further motivation for socially desirable responding. On the other hand, this increase could have been due to deliberate evaluative judgement since the MCT had likely changed their explicit attitudes, and such attitudes are conscious validation of evaluations and beliefs, as suggested by the Associative-Propositional Evaluation Model (APE) theorized by Gawronski and Bodenhausen (2007).

Similarly, Boysen and Vogel (2008) examined the relationship between implicit bias, MCC, and the amount of multicultural training counsellors in training have. A sample of 105 training counsellors completed a multicultural competency measure as well as a pen and paper IAT. What the researchers found was that, high levels of MCC were reported across the sample, with those furthest in their program (who had taken a multicultural course in the previous year) reporting the highest level of MCC. Yet, the researchers found that implicit bias measured using IAT did not differ based on the amount of multicultural training. Overall, there was still significant levels of implicit bias towards African Americans. The authors concluded that counsellors have diverging explicit and implicit attitudes towards African Americans, where they may had been responding in socially desirable way on the multicultural competency measure. Lastly, the authors point out that the high implicit bias detected in the counsellor trainees is consistent with attitudes of non-counsellor populations, previously researched (Boysen & Vogel, 2008). Hence, the above research has shown that counsellors can have implicit bias towards racial minority groups despite explicit training against these biases and codes of ethical practice that prohibit such attitudes. However, all of the presented research above have used laboratory experiments to show implicit bias in counsellors, lacking external validity using real world

settings which could help in establishing if there is actual impact in the counselling process in the community.

Before going further, it is important to highlight the connection between counsellor implicit bias and Muslims. While there is no research on counsellor implicit bias against Muslims that was locatable, research has shown that Muslims are viewed, by general populations, negatively both explicitly (e.g., Angus Reid Global, 2013, 2017; Nosek et al., 2007) and implicitly (Nosek et al., 2007). Further, since Muslims are a highly stigmatized minority group in much of the world (Qasqas & Jerry, 2014), it is important for counsellors working with Muslims to stay aware of their own biases and ensure they are culturally competent when providing services. Therefore, given the research cited above, it is expected that counsellors' general implicit biases and those found with other racialized groups also extend to Muslim clients.

Accordingly, the present study will explore if counsellors and psychologists behave in a manner consistent with implicit bias against Muslims in Vancouver, Canada, using an innovative prospective methodology that justifies making causal research claims and guards against social desirability: the audit study design. This design is also intended to promote studies that are conducted outside of strict laboratory conditions in realistic world-conditions, maximizing the external validity of the results.

Audit Study Methodology

Audit studies have been around since the 1960s. This methodology has become especially popular in the last decade, as a way to study and explore questions that are sensitive and sometimes impossible to answer using other designs such as observational studies or self-report surveys (Gaddis, 2018). An audit study is a type of field experiment where the researchers

control and randomize one or more sociocultural variables (such as name, race, religion, or socioeconomic status) and send individuals into the "field" to test the effect of these characteristics on an outcome. Therefore, the purpose of audit studies is to provide more defensible causal evidence of bias and discrimination *in real-world settings* than most other empirical methods, such as surveys or laboratory studies.

Inferences about race/ethnicity or religious bias in health disparities literature is often drawn from self-report surveys or rates of access to health care collected for national statistics or epidemiological research. While such statistics are useful for the bigger picture (i.e., examining population level patterns), they do not identify the reasons differences in rates for accessing services exist, such as cultural beliefs or possible health professional bias. Further, non-experimental research designs, such as surveys and interviews are susceptible to social desirability or self-selection bias (Althubaiti, 2016). Thus, it may not elicit truthful or accurate responses from service providers, given the officially prohibited nature of bias by mental health professionals or due to the unconscious nature of bias (Gaddis, 2018).

Laboratory studies have been able to circumvent some of the problems associated with survey data and interviews, through isolation and controlling for variables of interest, but the extent of external validity for such research has been questioned (Levitt & List, 2007). Field experiments such as those following audit methodology are a suitable alternative to laboratory studies since they take place in the "real world," while still providing substantial control over variables of interest. It also allows for controlling the number of people per condition eliminating the different rates of individuals per group, often seen in surveys.

History of Audit Studies. In the early days of this method, the researcher would conduct in-person audit studies where, for example, individuals were sent to job interviews with

race/ethnicity of the interviewees controlled (Daniel, 1968). However, since the early 2000s, when many communications processes have slowly started to rely on the internet, the method for audit studies have also shifted from in-person to correspondence audits (Gaddis, 2018). The correspondence audit design uses names or other individual signifiers to convey sociocultural characteristics such as race, gender, and socioeconomic status (SES). Most of the early research in correspondence audits have been within the labour market studies, where researchers send identical fictious resumes to employers only altering the variable(s) of interest (e.g., race), and since employers are unaware of being studied, this methodology elicits behaviour that employers exhibit in actual hiring decisions (Gaddis, 2018).

One of the most well-known early correspondence studies is Bertrand and Mullainathan's (2004) examination of racial discrimination by employers in the U.S. They sent out almost 5,000 resumes by responding to over 1,300 employment ads in two Chicago based newspapers, between July 2011 and May 2002. In their study, the researchers used names to signify race and gender, using postal codes to signify social class, as well as altering resume quality (low vs high) by, for example, noting gaps in employments or labour market experience. The researchers randomly assigned names to resumes to ensure that the results were due to perceived race rather than the content of the resumes. What they found was that White resumes were significantly more likely (around 50% higher chance) to get a callback compared to African-American resumes. Further, resumes with White-sounding names who had high quality resumes or lived in wealthier neighbourhoods received more callbacks than White resumes with low quality or those living in poorer neighbourhoods; these differences were much smaller or non-existent for African-American resumes (Bertrand & Mullainathan, 2004). Therefore, the quality of resumes did not make a difference in the rate of callbacks for African American resumes.

Another early study by Pager (2003) conducted a correspondence audit study with 350 resumes representing White men and Black men testers who either had a criminal record or not. What he found was that Whites with no criminal record had a 34% callback rate, whereas Blacks with no criminal record had a 14% rate of callback. Further, Blacks with no criminal record also had a lower rate of callback than Whites with a criminal record (14% vs 17%; Pager, 2003). A few months after the study, all 350 employers were called and presented with a vignette similar to the characteristics of testers in the audit study (Pager & Quillian, 2005). With 199 respondents, they found that employers expressed an equal openness to hiring black and white applicants, and those with criminal records. The researchers expressed the stark difference between the audit study results and what was said when asked the same scenario in a survey (Pager & Quillian, 2005), showing that while employers promoted equality in their hiring procedures when directly asked, this was not the reality during the audit study. This highlights the usefulness of correspondence studies in examining discriminatory behaviour, that would not be possible through use of survey or interviews.

Muslims in Audit Studies. As already stated, in recent years, there has been a surge in audit studies (Gaddis, 2018). Some of these studies have focused on religious affiliation, including Islam. The data from these studies were from United States, France, Germany, and India, and all of the studies were looking at employment discrimination. The majority of these studies found affiliation with Islam yielded lower callbacks in general (Adida et al., 2010; Banerjee et al., 2009; Pierné, 2013; Wallace et al., 2014; Weichselbaumer, 2016; Widner & Chicoine, 2011; Wright et al., 2013). However, one study found no discrimination against Muslims applying for call-center and software jobs in particular (Banerjee et al., 2009). This study was conducted in India, which may suggest that biased attitudes are more prevalent in

Western societies, given the lower percentage of Muslims (India has the second largest Muslim population after Indonesia; Pew Research Center, 2015). Lastly, an in-person audit study in the United States found that women who wore traditional Islamic headscarves (intervention group) and those who did not wear headscarves (control group) did not differ in the number of interview offers (King & Ahmad, 2010). What they did find was that women wearing Muslim identifying attire had shorter interactions with potential employers and the interactions were viewed as more negative (King & Ahmad, 2010). What the results of this study may suggest is that while employers did not exhibit explicit bias, there seemed to be an implicit bias in the form of microaggressions towards the Muslim women.

Audit Studies in Counselling. While most of the research using audit methodologies has been in looking at workplace or housing market discrimination (Gaddis, 2018), recently, there were two studies which looked at counsellors bias against potential clients (Kugelmass, 2016; Shin et al., 2016). Kugelmass' (2016) study used a correspondence audit methodology. Participants were 320 therapists in New York City. The controlled variables were social class (middle or working), gender (male or female), and race (black or white). The researcher created four groups, based on class and gender combination, where each subject was exposed to both a black and white helpseeker. A total of 640 calls were made, combining 2 waves of phone calls made to each subject (Kugelmass, 2016).

Overall, there was a much larger accessibility disparity between race than social class or gender (Kugelmass, 2016). The white middle class helpseekers received more appointment offers, compared to the black middle class helpseekers calling the same therapist (a within-subject design). Further, while all of the middle-class pairs (white and black) helpseekers received more appointment offers, regardless of race, compared to the working class helpseekers,

racial disparity was much larger for middle-class men compared to middle-class women. Therefore, therapists were overall more willing to give middle-class helpseekers an appointment compared to the working class. Yet, white middle-class men were much more likely than black middle-class men to receive an appointment offer. Moreover, when it came to callback frequency, therapists called back middle-class helpseekers significantly more, regardless of race or gender. Yet, whites were more likely to receive a callback than blacks (Kugelmass, 2016).

A similar study by Shin and colleagues (2016) used a correspondence audit methodology, where subjects were 371 therapists in an East Coast and Mid-Atlantic state. The researchers made one call to each of the subjects, using the same female confederate alternating between using a white or black name. One hundred and ninety-eight calls were made for the white condition and 173 were made for the black condition. Researchers found no significant difference between number of callbacks for each condition. However, when examining the content of the callbacks, the white helpseekers received statistically significantly more invitations for a phone conversation, compared to the Black helpseekers (Shin et al., 2016).

Current Study

The current study is an extension of the studies done by Kugelmass (2016) and Shin and colleagues (2016), examining if there is disparity in accessing counselling for those with Muslim names, in the Vancouver area of British Columbia (B.C.). Specifically, the study is examining whether services are being offered to Muslims equally, by examining two dependent variables (a) email-back response rates; and (b) the content of the responses (identifying responses that promote receptiveness, or potential for services, such as offering an appointment). The following hypotheses were formed based on the reviewed research:

1. Muslim and non-Muslim names will have a comparable number of return emails from practitioner.
2. Having a Muslim name, rather than a non-Muslim name, will lead to less receptiveness by the practitioner to promote the potential for services.

This is hypothesized on the basis of past research which has shown that practitioners often callback potential clients at a comparable rate (Shin et al., 2016), or the difference is smaller than receptiveness (Kugelmass, 2016). Further, given that the study will be conducted in Vancouver, a multicultural city (e.g., about 49% of the city belongs to an ethnic minority group; Statistics Canada, 2017) and with a population that widely considers itself low in prejudice, the Aversive Racism theory (Dovido & Gaertner, 2004) would likely come into play here. Based on this theory, it is expected that practitioners will email back both potential clients, yet the content of the emails may reflect their ambivalence and implicit bias towards Muslims, given the current sociopolitical climate.

This research project is likely the first study in psychology or related fields (e.g., social work) examining access to mental health services for Muslims. This is an important topic to investigate given the current sociopolitical climate in the Western nations for Muslims and the repercussions of being ostensibly Muslim, requires increased appropriate and accessible mental health services for Muslims. Lastly, this study is interested in examining if practitioners' personal characteristics are related to accessibility and receptiveness towards potential clients. Thus, the following exploratory research questions will be asked:

1. Does the condition, counsellors'/psychologists' gender, type of registration type (RCC, CCC, and R. Psych), and mention of multicultural counselling on their profile, relate to the difference in time to respond by practitioners?

2. Does the counsellors'/psychologists' gender, type of registration type (RCC, CCC, and R. Psych), and mention of multicultural counselling on their profile, relate to the accessibility of the practitioner towards the potential client?
3. Does the counsellors'/psychologists' gender, type of registration (RCC, CCC, and R. Psych), and mention of multicultural counselling on their profile, relate to the receptiveness of the practitioner towards the potential client?
4. Does the counsellors'/psychologists' gender, type of registration type (RCC, CCC, and R. Psych), and mention of multicultural counselling on their profile, moderate receptiveness of the practitioner towards the potential client?

Chapter 3: Method

The current research project used a quantitative methodology to examine if there were mental health disparities for Muslims accessing counselling services in Vancouver, which could show the possibility of implicit bias against Muslims. Specifically, the project examined if potential clients with Muslim and non-Muslim names differed in the number and content of emails they received back from practitioners after an appointment had been requested. A correspondence audit design was used to explore these effects.

Sample

The participants for the present study were 470 counsellors' and psychologists' practices in the Metro Vancouver area of British Columbia. The sample was selected by using systematic random sampling, where all names from three different directories were pulled and placed in a randomizer and every 3rd name was selected until the desired number of participants were chosen. The first 235 names were placed in the Muslim condition and the remaining 235 names were placed in the non-Muslim condition.

The sample size was calculated based on an alpha level of .05, at a power of .90, and an effect size of $d = 0.2$ (small effect size). This was calculated using G*power's Analysis of Covariance (ANCOVA), as recommended by Lahey and Beasely (2018) since it allows for consideration of covariance. To establish a sample size, a few decisions needed to be made. First, the effect size of $d = 0.2$ was chosen based on Cohen's (1988) conventions. Cohen (1988) himself generally advised against using these conventions blindly because the somewhat arbitrary conventions are not only relative to each other (i.e., 0.2 is only considered small because 0.5 is considered medium, and 0.8 is considered large) but also to the topic and research method of the study (e.g., effect size of 0.2 may be seen as clinically insignificant in one field,

while in another it may be clinically significant). Nevertheless, Cohen (1988) notes that these conventions can be useful when there are no better estimates of the effect size available for the related field of study. For this study, $d = .20$ as an indicator of a small effect was chosen since there have been no previous studies examining Muslims access to counselling services using email and using audit field experiments. Further, the research in social psychology in general, have small effect sizes (Schäfer & Schwarz, 2019).

Second, a decision was made to conduct a between-subject design. This was based on the recommendation of Vuolo, Uggen, and Lageson (2018) who highlighted the need to know the expected response rate as well as accounting for feasibility of each design, when deciding on using either a matched or unmatched approach to maximize statistical power and efficiency. They used graphs to demonstrate what sample size would be most efficient using power of .90 and alpha level .05 for both matched and unmatched designs. They established that, if the proportion of results (e.g., receptiveness to giving appointments) is in high concordance, above .50 (.50 representing chance of a coin toss) between the two groups, then a matched-pair design is more statistically efficient in terms of required sample size (Vuolo et al., 2018). Otherwise, if the proportion of results is low in concordance, below .50 (50%), between the two groups, then a between-subjects design would be more appropriate. In other words, .5 (50%) is the point where half of the participants respond either similarly or differently to the presented conditions, which is one deciding point for the sample size calculation and experimental design.

The decision between matched and unmatched design also needs to consider feasibility of the design with the population of interest and the specific context. Vuolo and colleagues (2018) point out that a matched design may not be appropriate if there would be a risk of the study being discovered by the participants. If there is notable risk that the participants could realize that they

are being studied due to repeated contact, then a repeated measure design is not advisable. This was an important consideration for the current study since this was an online correspondence audit study where the emails sent cannot be altered in the same way a resume could be (the variable used by most audit studies), without likely jeopardizing the internal validity of the study. This is because, in resumes, which are normally one to two pages, chance of detection can be reduced because there are opportunities to make slight and inconsequential changes to the tester's work experiences which are different but still would theoretically be valued similarly by an employer. However, since within this study, the body of the email (see appendix A) was only a few lines, it would have been difficult to a) ensure practitioners do not get suspicious due to similarity of the emails and how they are worded; and b) create alternative forms of the email which would be perceived in a similar way.

An unmatched design lowers the chances of the study being discovered. With an unmatched design, participants are less likely to realize that emails sent to them are fictitious, during the data collection phase. However, an unmatched design may require more participants, than a matched design, which may be more than the population of interest (Vuolo et al., 2018). Nonetheless, given that this project had only one main independent variable with two levels (Muslim and non-Muslim), the sample size required did not exceed the sampling frame (N = 22,139; as of October 29th, 2019[2]). Therefore, given the above considerations, an unmatched experimental design was implemented to lower the chances of the study being discovered.

The names were pulled from the following directories: (a) British Columbia Association of Clinical Counsellors' (BCACC) website's "Find a Counsellor" directory, which includes

[2] Total number of RCCs working in Metro Vancouver (based on the online directories)= 1193, Total number of RPsychs working in Metro Vancouver (based on the online directory)= 176, Total number of CCCs working in Metro Vancouver (based on provided list on the CCPA website) = 869 for a total of 2139.

Registered Clinical Counsellors (RCCs); (b) British Columbia Psychological Association's (BCPA) website's "Find a Psychologist" directory, which includes Registered Psychologists (R.Psychs); (c) counsellingbc.com directory for inclusion of those with a Canadian Certified Counsellors (CCCs), as well as RCCs and R.Psychs. These directories were sought to mimic a client looking for a counsellor/psychologist by choosing the top three directories from Google results using the following terms: "BC Counsellors" and "BC Psychologists". While the Canadian Counselling and Psychotherapy Association (CCPA) website and the College of Psychologists of British Columbia (CPBC) do also come up in the top Google results, the lists only provide names of registrants, rather than contact information and the type of counselling provided. Therefore, they were excluded from the list of directories.

The sample did not include psychiatrists. Psychiatrists were excluded because they are usually accessed through referral of other professionals, rather than self-referral from the client themselves (*Medical Services Plan*, 2020). Private practices, including solo and group practices, were targeted for this study because counsellors and psychologists working in the public sector likely have less choice on their caseloads due to the requirements and expectations of publicly funded agencies (e.g., clients are assigned by staff to practitioners on a first come, first serve basis or based on urgency of the case as decided by an intake worker). Since there are office staff (other than practitioners themselves) working at some private practices, especially group practices, they were included in the sample because the goal was to examine possible bias in accessing counsellors and psychologists, rather than targeting individual practitioners.

Moreover, the sample did not include practitioners who only work with women. If a practitioner only works with women, they will likely not respond to emails sent to them with a male name. Therefore, such practitioners were excluded given that the fictious potential clients

are both men. The decision to have only have men sounding names in the study as the potential clients is based on previous research that has shown that there is comparatively scarce research specifically examining men in the mental health treatment field (Bedi et al., 2016; Hoover et al., 2012). This exclusion criterium was ensured by examining participant profiles for the following keywords: “woman”, “women”, “female” to see if they exclusively serve this clientele group.

Practitioners’ Demographics. About 82.1% of participants had a RCC, 1.9% had CCC, and 16% had R. Psych registration (*n* = 470). There were also 16 (3.4%) practitioners who were from the same group practice as another respondent. Further, 76.8% were identified as women, 20.4% as men, 0.9% as non-binary, and the gender of 1.9% of participants was unidentifiable (missing data; *n* = 470). Pair-wise deletion (*n* = 9) was used as the approach to dealing with the missing data. Lastly, 23.2% had mentioned multicultural counselling competencies on their profiles and/or website (*n* = 470). This is presented in Table 1.

In the Non-Muslim condition, 195 (83%) had RCC, 5 (2.1%) had CCC, and 35 (14.9%) had R.Psych. In addition, 175 (74.5%) were women, 51 (21.7%) were men, 3 (1.3%) were non-binary, with 6 (2.6%) unidentified gender. Sixty-seven (28.5%) had specifically mentioned multicultural competence in their profiles/websites and 168 (71.5%) had not (*n* = 235). In the Muslim condition, 191 (81.3%) were RCC, 4 (1.7%) were CCC, and 40 (17%) were R.Psych. Moreover, 186 (79.1%) were women, 45 (19.1%) were men, 1 (.4%) were non-binary, with 3 (1.3%) were of an unidentified gender. Forty-two (17.9%) had mentioned multicultural competence specifically in their profiles/websites and 193 (82.1%) did not (*n* = 235). This is presented in Table 2.

Table 1

Participants’ Characteristics

	Respondents (N = 410)		All Practitioners (N = 470)	
	N	**%**	**N**	**%**
Type of Certification				
RCC	338	82.4	386	82.1
CCC	8	2.0	9	1.9
R. Psych	64	15.6	75	16
Gender				
Woman	314	76.5	361	76.8
Man	85	20.7	96	20.4
Non-binary	4	0.9	4	0.9
Unidentifiable	7	1.7	9	1.9
Multicultural				
Any mention	97	23.7	109	23.2
No mention	313	76.3	361	76.4

Note. Some numbers may not add up to 100% due to rounding

Table 2

Participants' Characteristics based on Condition

	Muslims		Non-Muslims		Total	
	N	%	N	%	N	%
Type of Certification						
RCC	191	81.3	195	83	386	82.1
CCC	4	1.7	5	2.1	9	1.9
R. Psych	40	17	35	14.9	75	16
Gender						
Woman	186	79.1	175	74.5	361	76.8
Man	45	19.1	51	21.7	96	20.4
Non-binary	1	.4	3	1.3	4	.9
Unidentified	3	1.3	6	2.5	9	1.9
Multicultural						
Any mention	42	17.9	67	28.5	109	23.2
No mention	193	82.1	168	71.5	361	76.8

Note. Some numbers may not add up to 100% due to rounding

The religious background of these service providers (RCC, CCC, R.Psych) was not available from their licensure or certification bodies (BCACC, 2017; CPBC, 2018). However, it may be relevant to consider that Greater Vancouver's largest religious affiliation is Christianity (42%) followed by no religious affiliation (41%), Sikhism (7%) and Islam (3%; Statistics Canada, 2013). Christianity is also the dominant and most favoured religion in Canada. About 67% of the Canadian population are affiliated with Christianity and 66% view Christianity

favourably (Angus Reid Global, 2017; Statistics Canada, 2011). This claim further is supported by considering the nature of the majority of national statutory holidays in Canada such as Christmas and Good Friday, which are clearly rooted in Christian traditions. Therefore, it can be assumed and perhaps asserted that practitioners (as well as most individuals in Canada), even those who do not identify as Christians, likely perceive Judeo-Christian names as the norm due to their pervasiveness in Canadian daily life (R. H. Nelson, 2015).

Procedure

This project was a computerized audit study. Two fictitious potential clients were created with the following characteristics: a) Muslim man and b) non-Muslim man. Thus, the characteristic manipulated (independent variable) was perceived religion (Muslim or non-Muslim).

Table 3

Audit Design Matrix- Names with Corresponding Conditions

Name	**Religion**
Lucas Smith	Non-Muslim
Muhammad Al-Husain	Muslim

Two email addresses using Gmail were created: 1) AHusain.Muhammad@gmail.com for the Muslim condition and 2) Smith.LucasR@gmail.com for the non-Muslim condition. There was also a master email account created so that all of the responses were forwarded to this email address. This allowed for all of the responses to be kept in one place to ensure there is a master copy of the data as well as helping to create an easier data collection process.

Lucas was chosen as the non-Muslim first name. This name was chosen based on Health Canada's list of most common baby names in BC, where it was the second most common name in 2018 (*Top Baby Names in B.C. for 2018*, 2018). The top name was Liam. Lucas was chosen because it has Judeo-Christian roots while Liam does not, and since this study is using names that possibly signify religion, it makes more sense to choose a name with roots in the Judeo-Christian religion. Smith was chosen as the non-Muslim last name, based on a 2008 report done by the Vancouver Sun (Skelton, 2008). Smith was the fourth most common last name in Vancouver, where the top three were Lee, Wong, Chan respectively. However, Lee is a last name that is common in a few different regions with most individuals being from a Chinese background, as are Wong and Chan (Skelton, 2008). Therefore, these last names were not chosen to avoid confounding Chinese ethnicity in the study.

For the Muslim condition, the first and last name were taken from a guide to naming practices for around the world (*A Guide to Names and Naming Practices*, 2006). Muhammad was chosen as the Muslim first since it was the most repeated name in the guide for Muslim countries, and Al-Husain was chosen as the last name since Al is a common prefix to Muslim last names and Husain is another common Muslim name (*A Guide to Names and Naming Practices*, 2006).

All practitioners were randomized to receive either an email from the Muslim condition or the non-Muslim condition. The content of this email included a request for an appointment time. In each email, the potential client first introduced themselves using either the Muslim or non-Muslim first and last name selected, briefly stating their problem (i.e., having trouble sleeping) followed by asking for an appointment time. Falling asleep was chosen as the main concern of the potential client because it is broad but also is a very common concern for those

dealing with a mental health problem (Parekh, 2018). The sample script is presented in Appendix A.

All emails were sent during the day sometime between 10 am and 2 pm on a Sunday. Two emails were sent out every minute from each email account by using Gmail's scheduled email option. Emails were staggered out in this manner to avoid being flagged as spam by Gmail. Contact boxes were sent out manually one by one. This time frame was chosen because the goal is to have the emails be near the top of practitioners' mailbox. This was based on the assumption that most counsellors or psychologists in private practices will likely check their emails in the morning, even if they do not work that day or start in the morning. Therefore, it was assumed that an e-mail would be noticed much earlier if sent around this time compared to if it was sent at 6am (which would be pushed down by emails arriving during early business hours i.e. 10am) or sometime in the early evening, such as 5pm.

Variables

Independent variable (IV). The study manipulated the perceived religion of potential clients. Religion was conveyed using either a Muslim name or a non-Muslim name, the latter of which represented a common Judeo/Christian name, embodying the dominant majority of individuals in the metropolitan Vancouver area.

Dependent variables (DV). There were three dependent variables in the current study. Response rate, and time to respond as the secondary dependent variables, and the main dependent variable, practitioner's receptiveness. Response rate was defined as the frequency at which practitioners will return the potential client's email compared to the failure to respond at all. Hence, if a practitioner emailed back the potential client, regardless of the message content, it was counted as eliciting a response. Time to respond was defined as any difference in the time it

takes practitioners to respond. This was measured by noting when the email was sent out and when a response was received counted in hours. Given that this variable was not examined in Kugelmass (2016) and Shin and colleagues' (2016) studies, it was exploratory in nature in the present study.

Further for descriptive purposes, I coded whether an e-mail response came from an office staff or practitioner, including if (a) it was from an individual practitioner's email address (e.g., JohnSmith@gmail.com) or signed off by the practitioner directly; or 2) a general email (e.g., info@counselling.com) or signed off by the admin team. The number of actual appointment times offered compared to the general mention of available appointment times were also counted.

The main dependent variable, receptiveness, is the extent to which the practitioner promotes the potential for services. This was chosen as the main DV because previous research using Black and White names has shown that there were no statistically significant differences in frequency of callbacks from counsellors (Shin et al., 2016) or the statistically significant results were much more muted in frequency of callbacks compared to receptiveness (Kugelmass, 2016). The largest statistically significant differences were seen when examining the responses of practitioners (Kugelmass, 2016; Shin et al., 2016). Receptiveness was measured by examining the content of the emails, which is operationalized through openness of the counsellor to provide an appointment slot (as clarified in later in this section).

Audit methodology is dependent on the context in which the study takes place (Lahey & Beasley, 2018). Since there have been no studies done with minority religious groups in Vancouver or Canada using an email audit methodology, this study was the first of its kind. Therefore, there was no previous literature to directly inform and guide expectations of the

common responses that were received from practitioners (i.e., what is a normal response) and because the goal of this project was to examine accessibility to counselling services rather than analyzing the type of responses received, any response from practitioners that was potentially positive regarding offering an appointment or explicitly offered an appointment time was coded as receptiveness. Responses with no mention of booking an appointment or explicitly rejecting the potential client was coded as non-receptiveness, along with non-responders.

The following are some examples of what the responses could look like based on Shin and colleagues' (2016) and Kugelmass' (2016) studies: 1) counsellor/psychologist states that they are not currently taking new clients and/or are not available; 2) counsellor/psychologist asks for potential client's phone number or gives their phone number to call with no further information; 3) counsellor/psychologist mentions availability of appointments and asks for potential client's phone number to speak with them; 4) counsellor/psychologist mentions availability of appointments and asks about potential client's availability; and 5) counsellor/psychologist offers specific appointment day/time. Responses similar to categories one and two, and non-responders, were coded as 0. Responses similar to categories three, four and five were coded as 1 (indicating receptiveness).

Covariates. Broadly a covariate is defined as a variable that is related to the DV, but is not the main interest in the study (Salkind, 2010). Covariates can be theoretically driven or based on previous research (Gerber & Green, 2012). Covariates are constants that are not affected by the treatment assignment (i.e., Muslim or Non-Muslim group), making randomization an important step in this study to lower the chances of biased results by ensuring that the Muslim name and non-Muslim name are similar in every way except for the manipulated variable (Gerber & Green, 2012; Salkind, 2010). The inclusion of covariates in this study in addition to

randomization allowed for better control and account for some of the confounding effects of other variables (Gerber & Green, 2012).

There were four covariates that were included in the analysis, all of which were exploratory since there is little to no research around these variables and their association to practitioner receptiveness. These four covariates are characteristics of the professionals: type of registration/certification the professional has (RCC, CCC, and R.Psych), the gender of the professional (woman, man, and non-binary), respondent of emails (practitioner or office staff), and if they have included a self-reported multicultural competence on their profile. These covariates were chosen because they are: based on previous research (type of practitioner and gender, Kugelmass, 2016), are a potentially notable constraint of the study (e.g., who actually responds), or are related to the highly problematic nature of unethical practice (i.e., advertising multicultural counselling when not trained). Further, while there are other variables which may have been important to include, the chosen covariates were all readily available characteristics of the practitioners from their websites.

The type of registration/certification the professional holds was chosen since this resembled one of the covariates (type of practitioner related to degree/training) included in the Kugelmass (2016) study. While she looked at practitioners' choice of doctoral program (PhD versus PsyD), the current study examined practitioners' choice of registration/certification (RCC, CCC, R. Psych). Because practitioners' information was collected from their webpages and it would not have always been clear if a psychologist had a PhD or PsyD degree, their registration type was used (R.Psych), since this is regulated in BC and entry into the profession requires a R.Psych designation which has a doctoral degree prerequisite in BC. Further, psychologists often have at least four more years of schooling than counsellors (RCC/CCC; CPBC, n.d.). In contrast,

master level counsellors are provincially unregulated in BC, so both RCCs and CCCs were included, rather than including one or the other. Hence, because of this difference in type (psychology or counselling) and amount of education, it is possible that there may be differences between how R. Psychs and RCC/CCCs respond.

With the acknowledgement that gender socialization impacts how individuals think, feel, and behave, the gender of the professionals was chosen as another covariate. For example, research has shown that women tend to have a higher in-group bias than men, which suggests that women more favour other women over men (Rudman & Goodwin, 2004). Given the much larger population of women as counsellors and psychologists (Canadian Psychological Association, 2016; Cole et al., 2018), gender may be a highly relevant variable for clients when accessing services.

Lastly, self-reported multicultural competence was included. Since it is unethical to offer services that one is not competent in, I will assume that practitioners who have reported multicultural counselling on their profile are multiculturally competent. If there is any mention of cultural counselling (i.e., cross-cultural, multicultural, or culturally sensitive counselling) in the practitioners' online profile (i.e., website or directory), it was recorded as the practitioner being multiculturally competent. Further, if the practitioner specified working with Muslims as a population in their profile, this was also be recorded as multiculturally competence as well.

Type of registration/certification and multicultural competence was pulled directly from the directories. Gender of practitioners was pulled from the BCPA and BCACC directories since there was an option to choose the gender of the practitioner, and for those practitioners included from the counsellingbc.com directory, their profiles and websites were looked at to examine

what gender they have identified through their use of pronouns. If no gender is identified, their gender was considered missing data.

Data collection. Information (i.e., registration/certification type, gender, email address) about practitioners was collected from their websites with the help of two Research Assistants (RAs). Duplicate names that appeared on more than one directory were removed, as well as when more than one practitioner was included from the same group practice with the exception of those in a group practice who had their own personal emails.

Responses received were coded on a daily basis, and data collection stopped after two weeks (June 14, 2020). There was one bounced email, this respondent was replaced by another. If an email was not found, another respondent was randomly selected. Data collection continued until the desired number of participants based on the priori power analysis (N = 470) was obtained. Further, when more than one response email was received from a practitioner, it was responded to on June 14th with an email stating that the client no longer needed an appointment (see Appendix B).

Data Analyses

Descriptive statistics were calculated for the DVs (response rate, receptiveness, and time to respond) and covariates (practitioners' gender, certification type, and inclusion of multiculturalism) based on perceived religion and in total. Further, the number of actual appointment times offered (vs. the general mention of appointment times) was counted.

Exploratory Analyses. Mann Whitney U tests were conducted to look at the difference in practitioners' response time based on the independent variable (Muslim or non-Muslim) and the covariates; this test was used because the data was not normally distributed. Chi-square tests of independence were run to establish if there was a relationship between the covariates and

receptiveness. Fisher's exact test was used for registration type since one of the categories had an expected value less than 5.

Main Analysis. A binary logistic regression analyses examined the main hypotheses and research questions two and three. All covariates were controlled for in the logistic regression final models. The final research question examined the interaction of the predictor variable with each of the covariates.

Ethical considerations

Using an audit study design requires deception to ensure external validity of the experiment. In this audit study, the deception was observing practitioners' responses without letting them know they were in a research study. Deception can be an ethical concern. However, if the benefits of the study outweigh the risks, it can be used in a research study (Tri-Council Policy Statement, 2018). In this study, there was minimal risk/inconvenience to participants who are counsellors and psychologists working within Greater Vancouver. Some of the minimal risks/inconveniences include time spent reading the email of the fictious potential client or feeling hassled for having to email the fictious potential client back. Yet, since practitioners may receive inquiries from potential clients who afterwards change their mind and decline services, receiving an email from me should not be unusual or distressing to them (Nicholson, 2011).

With that said, the name and personal information of practitioners will stay confidential and will not be shared with anyone outside of the research team. This information will only be used for the purposes of this study, and the information will be stored in an encrypted hard drive at the UBC laboratory.

Additionally, minimal inconveniences caused to practitioners' time will be addressed by debriefing practitioners within one year of final data collection time frame. It should also be

noted that, the results of this study which will provide information about possible bias based on religion within the mental health sector of British Columbia, will outweigh the minimal inconvenience that may be caused to the practitioners (Rich & Riach, 2004). It is important to note that the audit study methodology aims to examine potential discrimination across a sample, looking for a pattern, rather than highlighting discrimination by a single individual, and examining such discrimination is not possible at the same degree or confidence through another research method (Rich & Riach, 2004). Other research methods, such as surveys or laboratory experiments, would require informed consent from participants, where it would not be possible to examine discrimination without the risk of obtaining socially desirable response from practitioners and being unable to uncover implicit biases beyond the conscious awareness of the practitioner.

The deception within this study can be further justified because the practitioners are well-educated (master's degree or higher) individuals who are likely not considered a vulnerable population with limited capacity or access to power, opportunities, or rights; the goal is not to put practitioners personally under scrutiny but rather to look at if there is a broad pattern of bias in the Vancouver area by counsellor and psychologists against those with Muslim names.

Chapter 4: Results

Descriptive

Across both conditions, a total of 410 emails were returned from practitioners, representing 87.2% of emails sent out (n = 470). In the study, 279 (59.4%) of practitioners expressed receptiveness, representing 68% of those who responded (n = 410). Of those who expressed receptiveness (n = 279), 137 (49.1%) offered an appointment (date and time), 87 (31.2%) mentioned availability of appointment with no actual appointment given, and the other 55 (19.7%) were responses that did not fit into the above two, yet they indicated receptiveness in an ambiguous manner such as emailing more than once, inquiring about more information or wanting to have to a phone conversation first. In terms of all participants (n = 470), this expressed receptiveness represents 29.1%, 18.5%, and 11.7% respectively. About 91.2% of respondents were practitioners themselves and 8.8% were their staff. On average, it took respondents 19.17 hours (SD = 29.22 hours) to respond.

Based on the total number of practitioners contacted (n = 470), Lucas received a total of 207 (88.1%) responses, Muhammad received 203 (86.4%) of responses. Of those who responded (n = 410), 139 (67.1%) expressed receptiveness to Lucas and 140 (69%) expressed receptiveness to Muhammad. Of those who expressed receptiveness, 71 (51.1%) offered an appointment to Lucas (n = 139), and 66 (47.1%) offered an appointment to Muhammad (n = 140). Further, for Lucas 48 (34.5%) respondents mentioned availability of an appointment with no actual appointment given, and 39 (28%) did the same for Muhammad. In the ambiguous receptiveness category, Lucas received 20 (14.4%, n = 139) messages of this type. Of those 3 (15%) were practitioners emailing more than once, while 7 (35%) messages offering phone consultation, and the remaining 10 (50%) asked for more information such as if online or face-to-face was

preferred, or asking for more personal information . For Muhammad, 35 (25%, *n* = 140) messages were coded as ambiguous. Of those, 8 (22.9%) emailed more than once, 19 (54.3%) offered phone consultation, and remaining 8 (22.9%) asked for more information (messages are included in Appendix C). Of those who responded to Lucas, 191 (92.3%) were the practitioners themselves, whereas, for Muhammad, 183 (90.1%) of respondents were practitioners (*n* = 410). This information is presented in Table 4. Lastly, practitioners took an average of about 18.35 hours (SD = 21.06 hours) to respond to Lucas, while they took close to 20 (19.99) hours (SD = 35.72 hours) to respond to Muhammad.

Table 4

Frequency and Percentage of Practitioners' Receptiveness

	Non-Muslim		Muslim		Total	
	N	%	N	%	N	%
Receptiveness						
Non-receptiveness	68	32.8	63	31	131	31.9
Receptiveness	139	67.1	140	69	279	68
Appointment Type [a]						
General Mention	48	34.5	39	28	87	31.2
Actual Time Offered	71	51.1	66	47.1	137	49.1
Ambiguous *	20	14.4	35	25	55	19.7
Emailing more than once	3	15	8	22.9	11	20
Offering phone consultation	7	35	19	54.3	26	47.3
Asking for more information	10	50	8	22.9	18	32.7
Respondents						
Staff	16	7.7	20	9.8	36	8.8
Practitioner	191	92.3	183	90.1	374	91.2

Note. Percentages for Totals is based on those who responded (n =410), except for Appointment Type

*Significance level was set at p = .05

[a] Percentages for Totals for Appointment Type is based on those who were receptive in each condition and in total

Exploratory Analyses

Chi-Square Tests of Associations. Chi-square tests of associations were performed between the main dependent variable (receptiveness) and all covariates (respondent, gender of practitioner, multicultural competence, and type of registration), as well as between response rate and covariates (gender of practitioner, multicultural competence, and type of registration). All expected cell frequencies were greater than five, except for type of registration. All tests were statistically not significant.

Some additional tests were done to look at if there was any association between different levels of receptiveness and condition: general mention of an appointment, those offering appointments, and receptiveness categorized as ambiguous (those not mentioning or offering appointments), as well as looking at the association between the combination of general mention of an appointment and actual appointment offers with condition, all tests were not significant, except for receptiveness categorized as other. Receptiveness categorized as ambiguous was statistically significant, where Muhammad received significantly more of this type of receptiveness, compared to Lucas $\chi^2([1], N = 410) = 5.069$, $p = .024$, $V = .111$

The association between receptiveness and respondents (practitioner or staff) was not statistically significant, $\chi^2([1], N = 410) = .874$, $p = .350$, $V = .046$. No test was performed between response rate and respondents given that response rate would only have one value (i.e., yes) for type of respondents.

The association between receptiveness and gender (woman or man) of practitioner was not statistically significant $\chi^2([1], N = 457) = 2.577$, $p = .108$, $V = .075$. The association between response rate and gender was also not statistically significant $\chi^2([1], N = 457) = .167$, $p = .683$, $V = .019$. Non-binary individuals were removed from the analyses, given the small sample size.

The association between receptiveness and multicultural competence was not statistically significant, $\chi^2([1], N = 470) = .914$, $p = .339$, $V = .044$. The association between response rate and multicultural competence was also not statistically significant, $\chi^2([1], N = 470) = .393$, $p = .531$, $V = .029$.

The association between receptiveness and registration type was not statistically significant, as assessed by Fisher-Freeman-Halton exact test, $p = .452$, $V = .055$. The association between response rate and registration type was not statistically significant, as assessed by Fisher-Freeman-Halton exact test, $p = .834$, $V = .025$.

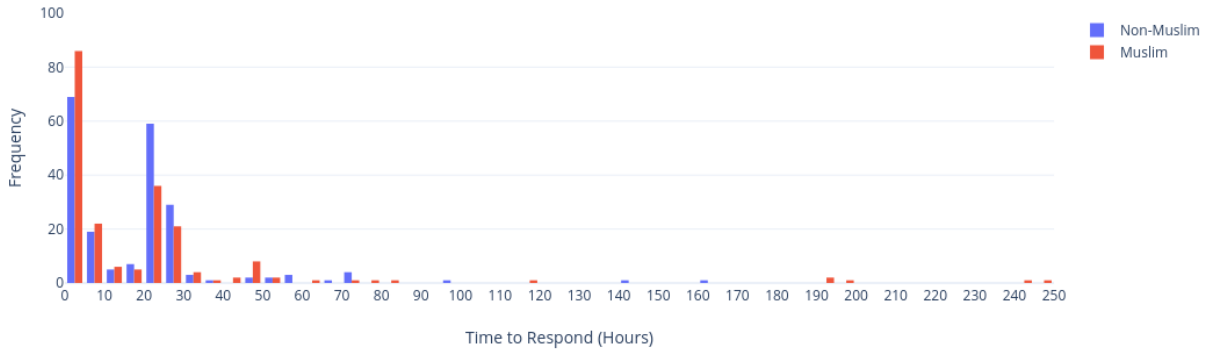
T-test Assumptions. A visual examination of the plotted data on the Q-Q plot and the Shapiro-Wilk test of normality was used to check the distribution of time to respond variable. Results indicated that the variables- independent variable and all four covariates- were not normally distributed. Homogeneity of variance was assessed with Levene's test. The assumption was met for all variables except for the independent variable, perceived religion ($F = 5.196$, $p = .023$).

Analyses. Because the assumption of normality was violated for the independent variable and all four covariates, Mann-Whitney *U* tests were conducted to examine the difference in means for time to respond variable based on the independent variable (Muslim or non-Muslim), and the covariates (respondent, gender of practitioner, multicultural competence, and type of registration). All tests had non-significant results.

Time to respond was not statistically significantly different between non-Muslim (Mdn = 20.45 hours) and Muslim (Mdn = 8.75 hours), $U = 22964$, $z = 1.628$, $p = .103$, $r = .08$. However, after removing five extreme data points all in the non-Muslim condition (any response after a week; $n = 5$), time to respond was statistically significantly different between Non-Muslim (Mdn

= 20.45 hours) and Muslim (Mdn = 8.17 hours), U = 22964, z = 2.098, p = .036, r = .10. It should also be noted that frequency of time to respond for the Muslim condition was more aggregated in the ends of the histogram, where for example about 68% of those who responded in the first 30 minutes were from the Muslim group, as well as 100% of those taking longer than 7 days to respond (see Figure 1).

Figure 1



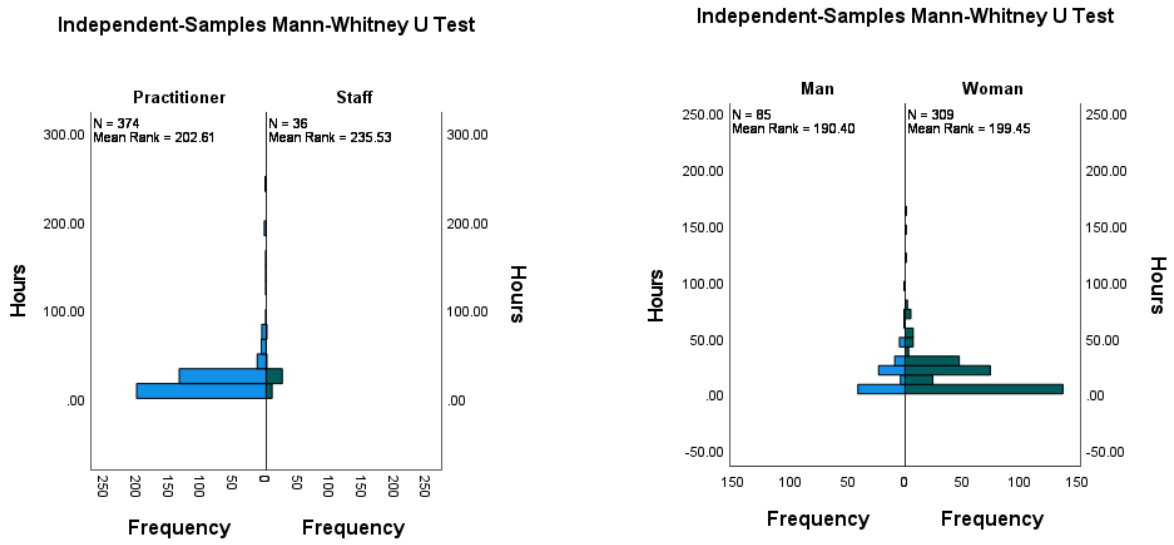
Note. The frequency of time to respond for each condition is in hours. Each bin is 5 hours.

Distributions of the time to respond for practitioner and staff were not similar, as assessed from the population pyramid graph (Figure 2). Time to respond was not statistically significantly different between practitioners (mean rank = 202.61) and staff (mean rank = 235.53) who responded, U = 5651, z = -1.592, p = .111, r = -.08. After removing extreme points (any response after a week), all of which were practitioner respondents, time to respond was still not significantly different between practitioners (mean rank = 199.83) and staff (mean rank = 235.53), U = 5471, z = -1.747, p = .081, r = -.09.

Time to respond was not statistically significantly different between women (Mdn = 12.10 hours) and men (Mdn = 10.01 hours), U = 14161, z = .865, p = .387, r = .04. Those identifying as non-binary were removed from analysis given that there were only 4 data points.

After removing extreme points (any response after a week), all of whom were women, time to respond was still not statistically significantly different between women (Mean rank= 199.45) and men (Mean rank = 190.40), U = 13736, z = .649, p = .516, r = .03. Since distributions of the time to respond for women and men were not similar, as assessed from the population pyramid graph (Figure 2), mean ranks are provided above.

Figure 2

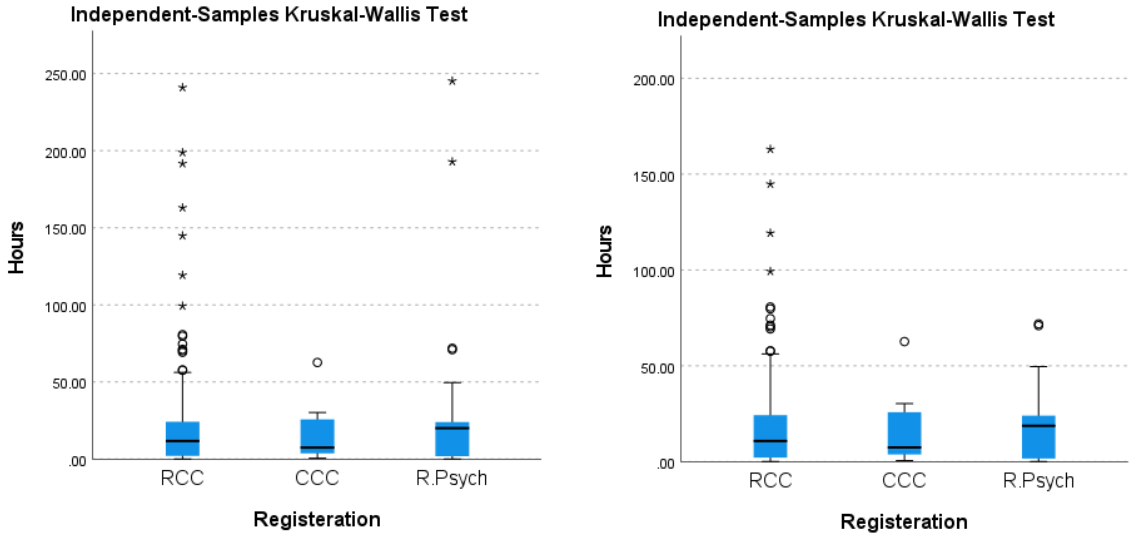


Note. Time to respond population pyramid for practitioner and staff (left), and man and woman (right)

Time to respond was not statistically significantly different between those not mentioning multicultural competence (Mdn = 11.47 hours) and those mentioning multicultural competence (Mdn = 18.1 hours), U = 15195.5, z = .015, p = .988, r = .0007. After removing extreme points (any response after a week), time to respond was still not statistically significantly different between those not mentioning multicultural competence (Mdn = 10.65) and those mentioning multicultural competence (Mdn = 17.32 hours), U = 14886.5, z = .054, p = .957, r = .003.

A Kruskal-Wallis test was run to look at the difference in means for time to respond and type of registration. Distribution of time to respond was not similar between the three groups, as assessed by box plots (Figure 3). Time to respond was not statistically significantly different between the three groups, $\chi^2(2) = .031$, $p = .985$, $r = .00008$. After removing extreme points (any response after a week), distribution of time to respond was still not similar between the three groups with respect to time to respond. Time to respond was not statistically significantly different between the three groups, $\chi^2(2) = .036$, $p = .982$, $r = .00009$.

Figure 3

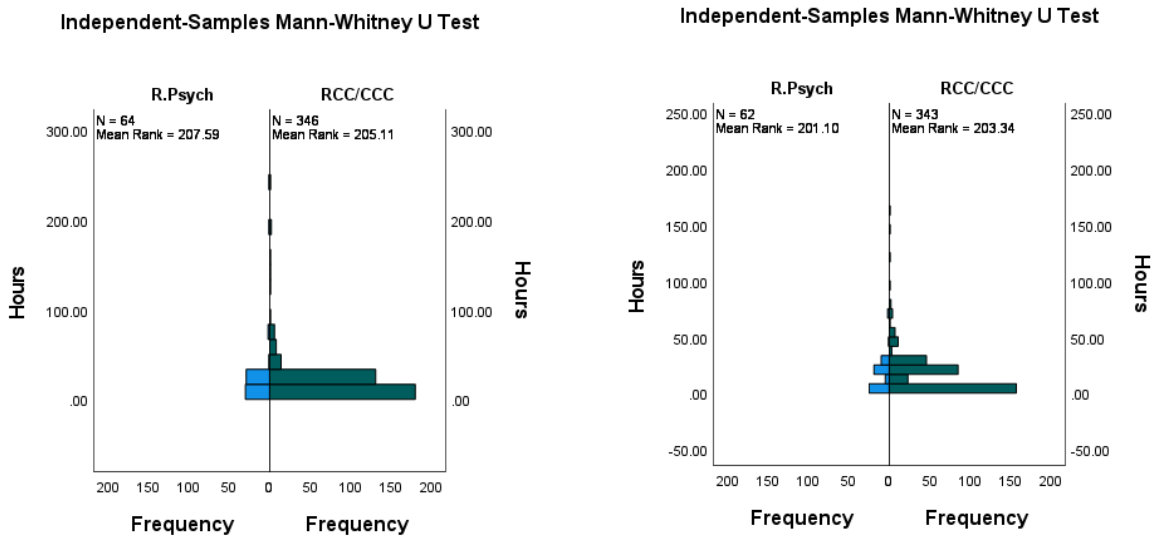


Note. Time to respond box Plot for registration type. Box plot on the left has all of the data points *(n* = 410). Box Plot on the right is after removing extreme points (*n* = 405).

A Mann-Whitney *U* test was also conducted comparing those with RCC/CCC and R.Psych. There was no statistically significant difference between RCC/CCC (Mean rank = 205.11) and R. Psych (Mean rank = 207.59) *U* = 11205.5, *z* = .153, *p* = .878, *r* = .007. After removing extreme points (any response after a week), time to respond was still not statistically significantly different between RCC/CCC (Mean rank = 203.34) and R.Psych (Mean rank =

201.10) U = 10515, z = -.139, p = .890, r = -.007. Since distributions of time to respond for RCC/CCC and R. Psych were not similar, as assessed from the population pyramid graph (Figure 4), mean ranks are provided. Table 4 represents Mann Whitney U Tests described above.

Figure 4



Note. Time to respond population pyramid graph for RCC/CCC and R.Psych. Population pyramid graph on the left is with all of the data points *(n* = 410). Population pyramid graph on the right is after removing extreme points (*n* = 405).

Table 5

Non-parametric Comparison of Time to Respond with IV and Covariates

	Before removing extreme cases				After removing extreme cases			
Variable	Median Time to Respond (in Hours)	Mann-Whitney *U*	*Z*	p-value	Median Time to Respond (in Hours)	Mann-Whitney *U*	*Z*	p-value
Non-Muslim	20.45	22964	1.628	.103	20.45	22964	2.098	.036*
Muslim	8.75				8.17			
Practitioner	202.61[a]	5651	-1.592	.111	199.83[a]	5471	-1.747	.081
Staff	235.53[a]				235.53[a]			
Woman	12.10	14161	.865	.387	199.45[a]	13736	.649	.516
Man	10.01				190.40[a]			
No mention of MC	11.47	15195.5	.015	.988	10.65	14886.5	.054	.957
MC	18.1				17.31			
RCC/CCC	205.11[a]	11205.5	.153	.878	203.34[a]	10515	-.139	.890
R. Psych	207.59[a]				201.10[a]			

Note. *Significance level was set at $p = .05$.

[a] This is the mean rank. When the distribution of groups are not similar, it would not make sense to use medians because Mann-Whitney *U* Test ranks raw data; without similar distributions, mean ranks are used.

Main Analysis

A logistic regression analysis was utilized to predict the likelihood of Muslims receiving an indication for an appointment through email while controlling for respondent of emails, type of registration, gender of practitioner, and self-reported multicultural competence of

practitioners. The results of the hierarchical regression model was not statistically significant $\chi^2(5) = 5.351$, $p = .375$. The model explained 1.9% (Nagelkerke $R2$) of the variance in receptiveness and correctly classified 68.2% of cases. There were three points which were identified as having extreme leverage; the critical value was set at >3, as suggested by Rahmatullah Imon and Hadi (2008). After running the model without these three points the model did not improve. Therefore, it was concluded these points were not exerting an undue influence on the model.

Additional logistic regression analyses were conducted which included the interaction between perceived religion (Muslim or non-Muslim) and 1) degree type, 2) gender, and 3) multicultural competence, while controlling for all covariates. No significant interaction results were found.

A logistic regression analysis was utilized to predict the likelihood of Muslims receiving a response from practitioners while controlling for type of registration, gender of practitioner, and self-reported multicultural competence of practitioners. Respondents of emails (Staff or Practitioner) variable was removed from this analysis given that this variable was only valid for those who had responded, therefore there would only be one level to response rate (i.e. yes for those who had responded). The results of the hierarchical regression model was not statistically significant $\chi^2(4) = 1.379$, $p = .848$. The model explained .6% (Nagelkerke $R2$) of the variance in receptiveness and correctly classified 87.3% of cases. There were no points that the model fit poorly. There were three points which were identified as having extreme leverage, however, after running the model without these three points the model did not improve. Therefore, it was concluded these points were not exerting an undue influence on the model.

Table 6

Logistic Regression Predicting Practitioner Receptiveness Controlling for Practitioner Variables

Potential Client Variable	B (SE)	Wald χ^2	df	OR	*p*	95% *CI OR*
Muslim (ref: Non-Muslim)	.143 (.218)	.431	1	1.154	.512	[.752, 1.770]
Practitioner Variables						
Degree type- RCC/CCC (ref: R. Psych)	.339 (.299)	1.287	1	1.404	.257	[.781, 2.522]
Gender- Man (ref: woman)	.510 (.284)	3.215	1	1.665	.073	[.954, 2.906]
Not Multicultural (ref: Multicultural)	-.070 (.263)	.071	1	.932	.789	[.556, 1.562]
Staff (ref: Practitioner)	-.267 (.374)	.508	1	.766	.476	[.368, 1.595]
Muslim x RCC/CC	.120 (.288)	.419	1	1.127	.675	[-.444, .685]
Muslim x Man	.360 (.572)	.628	1	1.433	.530	[-.762, -1.480]
Muslim x Not Multicultural	.431 (.525)	.821	1	1.539	.412	[-.598, 1.459]
Constant	.387 (.374)	1.067	1	1.472	.302	
N	399					

Table 7

Logistic Regression Predicting Practitioner Response Rate Controlling for Practitioner Variables

Potential Client Variable	B (SE)	Wald χ^2	df	OR	*p*	95% *CI OR*
Muslim (ref: Non-Muslim)	-.195 (.285)	.468	1	.823	.494	[.471, 1.438]
Practitioner Variables						
Degree type- RCC/CCC (ref: R. Psych)	.211 (.369)	.325	1	1.234	.568	[.599, 2.545]
Gender- Man (ref: woman)	.168 (.361)	.215	1	1.182	.643	[.582, 2.401]
Not Multicultural (ref: Multicultural)	-.089 (.351)	.064	1	.915	.801	[.460, 1.820]
Constant	1.893 (.485)	15.219	1	6.636	.000	
N	457					

Chapter 5: Discussion

Counsellors have been criticized for being Eurocentric, and disparities in mental health services based on sociocultural variables have been documented. Two recent research studies in the mental health field using an audit methodology found implicit bias against Black individuals looking to access mental health services in the U.S. (Kugelmass, 2016; Shin et al., 2016). The present study, an extension of these two aforementioned studies, was the first study, to the researcher's knowledge, looking at possible religious bias in Canada using an audit methodology in the mental health field. The study sought to explore if there was a disparity in accessing counselling for those with Muslim names, in the Greater Vancouver area of BC. Specifically, the study examined whether services were being offered to Muslims equally, by looking at three dependent variables (a) email-back response rates; (b) receptiveness (identifying responses that promote potential for services, such as offering an appointment); and (c) time it takes practitioners to respond. Findings from the present study suggest that practitioners respond at a similar rate and are not more receptive towards a male non-Muslim client. However, they may respond more quickly to those with a Muslim man name.

The first hypothesis predicted that Muslim and non-Muslim names will have a comparable number of return emails from practitioners. This hypothesis was supported. Response rate of counsellors was not predicted by condition (Muslim or Non-Muslim). The results remained consistent after controlling for the effects of covariates (i.e. gender of respondent, registration/certification type of respondent, and multicultural competence), where being a Muslim man decreased the odds of getting a response by .82 or 18%. This hypothesis was on the basis of the past research which has shown that practitioners often callback potential clients at a comparable rate (Shin et al., 2016), or the difference is smaller than receptiveness

(Kugelmass, 2016). Further, based on Aversive Racism theory (Dovido & Gaertner, 2004), which states that in a population that widely considers itself low in prejudice, it would be expected that respondents would email back both potential clients at a similar rate. However, in the current study the model for response rate only accounted for .6% of the variance in data which indicates that there were other variables not included that accounted for predicting the results.

This first hypothesis was in line with Shin and colleagues (2016) audit study with counsellors which also found no statistically significant relationship between number of callbacks from practitioners for the Black and White client. In the study, the authors used chi-square association test, reporting *phi* of .092, which is 9.2% of the mean percentage difference between the number of responses received for the two groups (Shin et al., 2016); this represents an odds ratio of .68 suggesting that the Black client was 32% less likely to receive a response (but also noting that the relationship between these variable was also not found to be statistically significant). In Kugelmass' (2016) study, the difference for callbacks between the Black and White clients was much more muted compared to receptiveness. In that study, Black clients are .76 or 24% less likely to a receive response compared to the White client. However, it is not clear how much of the variance was accounted for by the models presented in that study (only odds ratios were provided).

The second hypothesis predicted that having a Muslim name, rather than a non-Muslim name, would lead to less receptiveness of practitioners to promote the potential for services. This hypothesis was not supported. The results remained consistent after controlling for the effects of covariates (i.e. gender of respondent, registration/certification, type of respondent, and multicultural competence), indicating that practitioners possibly responded without bias towards

Muslims when responding to e-mails requesting an appointment. The odds ratio shows that being a Muslim man actually increased the odds of getting a receptive email by 1.15 times or 15%. The model for hypothesis two only accounted for 1.9% of the variance in the data, which indicates that there were other variables not included in the model accounting for the results of the study. The very low variance accounted for in the current study may be explained by the unexpected situational events which took place during the span of the study (discussed later on in this chapter), as well as other variables not looked at in the current study.

The results for this hypothesis were inconsistent with the findings of previous audit studies with counsellors, which had focused on race, specifically African Americans (Kugelmass, 2016; Shin et al., 2016). It is not clear how much of the variance was accounted for by the models presented in Kugelmass' (2016) study, however she reported that the Black clients are about 40% less likely to receive an appointment compared to their White counterpart. Shin and colleagues (2016) used chi-square association test, reporting *phi* of .123, which is 12.3% of the mean percentage difference between the number of responses eliciting receptiveness for the two groups; this translates to an odds ratio of .60 suggesting that the Black client was 40% less likely to receive a receptive callback.

There were also exploratory analyses done looking at practitioners' response time based on the main independent variable (Muslim or non-Muslim) and the covariates (respondent, gender of respondent, registration/certification type of respondent, and multicultural competence). This variable was exploratory in nature, given that it had not been looked at in similar audit methodology studies (Kugelmass, 2016; Shin et al., 2016).

The first research question asked, if there was an association between time to respond and perceived religion, as well as if time to respond was associated with each of the covariates

(respondent, gender of respondent, registration/certification type of respondent, and multicultural competence). The results showed that there was a statistically significant difference in time to respond between the Non-Muslim and Muslim condition. Overall, participants responded quicker to the Muslim condition and there was a small effect size (r = 0.10). While not significant, the data further showed that practitioners responding to Muhammad either overwhelmingly responded immediately (within the first thirty minutes), or took longer than seven days to respond (these latter cases were excluded from the analyses given that they were considered extreme points). This was an interesting finding since there was a distinct pattern between how practitioners responded to Muhammad compared to Lucas. This data can be seen in Figure 1. It is possible that there was a moderating variable that was not looked at in the current study, which led to some responding very quickly to Muhammad while others taking a long time to respond.

Research question two asked if any of the covariates were associated with response rate. The results showed that none of the covariates were statistically related to the response rate. Question three asked if any of the covariates were associated with receptiveness of practitioners to promote the potential for services. None of the covariates were statistically related to receptiveness. Overall, all tests for research question two and three were non-significant and all of the effect sizes' (Cramer V's) were very small, indicating that there is not much association between response rate/receptiveness and each of the covariates. The Cramer's V for the association between receptiveness and each of the covariates were very small ranging from V =.019 to V = .075, which is considered below the small effect size (V = .1) for tables with one degrees of freedom (df). It should be noted, the effect sizes for response rate and each of the covariates were smaller than those for receptiveness. Therefore, it can be assumed that there is not much of a relationship between response rate and each covariate, and future research should

look at other covariates with response rate and receptiveness. Although, the current study's sample was not taken directly from the population, rather from directories, this could indicate self-selection, and therefore there is a chance of selection bias that cannot be ruled out. Comparatively, Kugelmass (2016) found no relationship between gender of practitioners and their degree type in her sample for the receptiveness outcome variable.

The last research question asked if any of the covariates moderated receptiveness. The were no significant interaction results between the perceived religion variable and each of the practitioner characteristics (i.e. gender, certification/registration type, and multi-cultural competence).

Lastly, an exploratory analysis that was not part of the research questions showed that Muhammad was significantly more likely to receive ambiguous receptiveness, where majority of the practitioners in this category offered a consultation phone call to Muhammad (54.3%), and equally asking for more information and emailing more than once (22.9%)without providing an actual appointment or any mention of it. This type of response can be seen as ambivalent in nature, as it seems that practitioners wanted to talk to the client more before deciding on if an appointment should be offered to him.

However, compared to the previous audit studies with counsellors, the findings from the current study mostly diverged. In the previous two studies it was found that counsellors are less receptive to Black clients compared to White clients (Kugelmass, 2016; Shin et al., 2016). This difference in results may have been due to differences in study design such as difference in the country the study took place, the experimental manipulation of the study (i.e., race vs religion), the communication medium for the study (phone vs. email), or the sociopolitical climate when the study took place (i.e., Black Lives Matter protests and the coronavirus pandemic).

The location of the current study compared to the previous counselling audit studies may have played a role in the difference found in the results. The current study took place in Canada and the previous audit studies took place in the U.S. Canada and U.S. are similar in many important ways, including provision of outpatient mental health as the primary source of care in both countries (Vasiliadis et al., 2007), and having more women than men as psychological practitioners (Hunsley et al., 2013; Lin et al., 2018). However, they also hold important differences such as: Canada having basic universal healthcare services which is not the case in the U.S., as well as counsellors are not regulated in some provinces in Canada while they are regulated by each state in the U.S. (ACA, 2020).

On one hand, Canada is often touted for its multicultural society (Leber, 2017), and assumed to be less racist and religiously biased than the United States (Gismondi, 2017). Given, that the current study found no evidence of bias against a client with a Muslim name, it is highly possible that Vancouver-area mental health professionals, especially those who advertise in directories, and likely those who participated in this study, were not biased against Muslim clients, at least in terms of responding back to a request for an appointment and offering an appointment. For example, using the Intergroup Contact Hypothesis which was developed by Gordon Allport (1954), can help explain the lack of bias detected in the current study (Pettigrew & Tropp, 2005).

There are four conditions that need to be met for positive effects of intergroup contact to occur. The four conditions are: 1) equal status where there is no hierarchal relationship between individuals, 2) intergroup cooperation where individuals are working together in a non-competitive environment 3) common goals, which is the reliance on others to achieve a shared goal and 4) support by social or institutional authorities, where there is no explicit or implicit

sanction of contact between individuals (Pettigrew & Tropp, 2005). It has been argued that even when Allport's optimal conditions were not met, intergroup contact was still strongly associated with reduced prejudice (Pettigrew & Tropp, 2006). Therefore, since Vancouver is a multicultural city with a sizeable Muslim population, and one of the largest in Canada (Statistics Canada, 2011, 2017), where there are no explicit social or institutional sanctions against Muslims, and it is possible that practitioners in this study have had contact with Muslims either as clients or in their personal life (i.e. friends or romantic relationship) which would satisfy all of Allport's conditions, has allowed practitioners to become less prejudice; an effect that is reflected in the results of this study.

Further, a recent set of studies done at the University of Wisconsin-Madison found that, in general, Muslim students were not less likely to receive help or get contacted when applying for a job on campus (Campbell & Brauer, 2020). The authors speculated that this finding provides support for the concentrated discrimination account, where it is a minority of individuals who discriminate against a marginalized group. Therefore, it is possible that in the current study what is seen, is a concentrated discrimination, where only a small number (a minority) of practitioners discriminated against Muhammad. On the other hand, it has also been argued that Canadians are not any less racist than their American counterparts, they are just less overt about it (Gismondi, 2017; Nelson, 2017). This difference in mannerism (i.e., more covertness in racism and bias by Canadians) may explain some of the difference in the results of the study, where the current study did not find the same type of bias found in the previous audit studies. If Canadians, especially those living Vancouver, express racism in a less explicit way, this could explain why no statistically significant difference was found between receptiveness between the Muhammad and Lucas.

For instance, it may be that the operational definition of receptiveness used in this study, did not pick up on the bias in the same way that it did for Kugelmass' (2016) and Shin and colleagues' studies[3]. In the current study, any response that had any indication of promoting services was categorized as receptiveness. It could be that the operational definition was too broad and open. It is possible that, for example, the responses received were standard replies which practitioners have for all potential clients, hence the study was not able to pick up on the nuances of the responses that may have set them apart. This is partly reflected in the finding that Muhammad received significantly more of the ambivalent type of receptiveness, where practitioners wanted more information about Muhammad before offering an appointment. Since this category of receptiveness was created to encompass the types of receptiveness which were not the provision of an appointment, it seems that this may be a subtle way that practitioners in Vancouver decide who they want to work with, when unsure about a client.

Moreover, the current study examined religious bias, which for Muslims is often conflated with race; someone of Middle Eastern or Arab descents(Karim & Eid, 2012; Shaheen, 2003; Zaal, 2012), whereas the previous studies directly looked at race (specifically Black individuals). This difference in the content of the experimental manipulation could explain why similar results were not found. It is possible that there is less bias against religion than race, particularly when compared to Black individuals, noting the highly racialized climate and huge disparity in health for Black individuals in the U.S. (Lê Cook et al., 2010; McGuire & Miranda, 2008). I believe that it is also possible that Muslims are viewed as less racialized and negatively than Black individuals, and future research should assess this claim. Further, these null findings

[3] Kugelmass (2016) defined receptiveness as offer of an appointment (either through vague mention of some availability, or an unambiguous offer of an appointment. Shin and colleagues (2016) defined receptiveness as an "invitation for a conversation" showing counsellor's interest in providing services (p. 1194).

could be specific to Canada, since much of the increased negative anti-Muslim sentiment in the U.S. can be traced to the September 11th, 2001 terrorist attacks in the U.S. (Abu-Ras & Abu-Bader, 2008; Ahmed & Reddy, 2007; Barkdull et al., 2011; Padela & Heisler, 2001), so perhaps the same extent of anti-Muslim sentiment is not present in Canada.

Alternately, it is possible that there is less implicit bias against Muslim individuals by those who are more educated, particularly in subjects that learn deeply about racism, prejudice, and bias, such as counsellors and psychologists, compared to the general public (Wodtke, 2012). It is possible that in the current study, seeing a Muslim name did not conjure up the same type of racialization, stereotype or negative perception in counsellors or psychologists as it would for someone from the general public.

Muslims are also often stereotyped in the media based on their clothing (i.e. head scarf, burka, or turban), their use of Qur'an scripture which often stereotypically includes the word "Allah", and they are often seen as outsiders who are recent immigrants or refugees (Hamdani, 2015; Joshi, 2006; Shaheen, 2003). The current study attempted to present a Muslim client who was similar to the non-Muslim Canadian counterpart, where they were not noticeably religious (no email signing off using a religious quote, for example), there was no image of them with Islamic clothing, nor did they come across as a recent migrant (for example, through their grammar or writing style). It may have been that only changing the name was too subtle to be picked up by practitioners or, as mentioned above, the name was not enough to conjure up an image of a stereotypical Muslim for this sample. Therefore, it is possible that since the current study was looking at bias based on a religion that is often racialized, rather than race directly, the experimental manipulation was not strong enough for the current sample (which is more

educated than the general population), especially since this was done through email, rather than phone.

The use of emails in the current study may have affected the results. The current study used emails to reach out to practitioners, whereas the previous two audit studies had used phone calls. Emails allow for more time and opportunity to think about and process on how to respond, compared to phone calls. When writing an email there is time to process or think about how to best articulate responses, whereas in phone calls individuals often do not have the time to think about every word they are saying. Therefore, it may be that in the previous two studies, the lack of time to think about and process responses to the potential client led to practitioners displaying implicit biases they may have had against Black individuals, especially since expressed biases can occur spontaneously and automatically (Dovidio, 2001).

Further, it could be that responding to potential clients' request emails has become habitual for many practitioners (more so than answering phone calls from potential clients; Kumar & Epley, 2020). Practitioners may have responded without much attention to the details of the emails, looking for familiar heuristic cues (i.e. client asking for availability of appointments) to determine the way they should respond, or as mentioned previously, practitioners may have set emails which they send to all potential clients which would get around displaying any kind of bias. Therefore, the current study was not able to find any difference between type of responses between the Lucas and Muhammad, while previous studies found significant difference in type of responses between the two groups. However, the results also showed that there was a statistically significant difference between the time it took practitioners to respond to Muhammad and Lucas, as well as the type receptiveness received which would speak to the likelihood that some practitioners perceived the email from Lucas differently than

those receiving one from Muhammad. That is, there might be an effect based on the names used, representing perceived religion of the clients. This may indicate the experimental manipulation was possibly strong enough to be noticed by some practitioners. Such nuanced findings fit well with what has been posited in the Aversive Racism theory (Dovidio & Gaertner, 2004).

Aversive Racism theory speaks to the new ways that racism is often expressed as no longer blatant and explicit (Dovidio & Gaertner, 2004). Instead, what is more common is a subtle form of racism that stems from negative thoughts and feelings which may not be apparent to the individual on the surface. While, at the same time, the individual still understands themselves as a sincerely egalitarian individual, and therefore denies and conceals one's racism from oneself and others. For this reason, Aversive Racism has been linked to political liberalism (Gaertner & Dovidio, 2005; Nail et al., 2003). These unconscious feelings and thoughts can lead to negative behaviour towards minorities. There are five characteristic responses which aversive racists typically use in intergroup situations: 1) endorsement of equality and fair treatment for all groups; 2) avoidance of interactions with a member of an outgroup, due to their unconscious feelings of uneasiness; 3) when the interaction cannot be avoided, they will disengage as quick as possible due to feelings of discomfort and anxiety; 4) dogmatic adherence to clear and overt rules and codes of behaviour in such interactions since part of their discomfort is the fear of coming across as prejudice; 5) the expression of their underlying feelings in a subtle and unintentional behaviour which generates unfair advantage to their ingroup or disadvantages the outgroup, in a rationalized way (i.e., promotion of an ingroup member over an outgroup member; Gaertner et al., 2005).

Greater Vancouver over the past 12 years has become increasingly more politically liberal leaning (National Post, 2015) which, as the Aversive Racism theory postulates, is the type

of climate where aversive racism often takes place (i.e. among egalitarian politically liberal individuals; Nail et al., 2003). It can then be assumed that it is likely practitioners in this sample were more liberal leaning, especially since psychology as a field that has been labelled as extremely liberal (Duarte et al., 2015), and psychologists are much more liberal leaning agendas (e.g. Baruth & Manning, 2016; Collins & Arthur, 2010). In the current study, the receptiveness of practitioners towards Muhammad, which was similar to that received by Lucas, could indicate intentional strong adherence to rules and codes of behaviour (one of the characteristics of aversive racism as outlined above) of the counselling/psychology ethics guidelines, because part of their discomfort is the fear of coming across as prejudice. Adhering to these guidelines "to the letter of the law" is one way that they could have reduced their discomfort or deny their true implicit bias (Gaertner & Dovidio, 2005). Further, Dovidio and Gaertner (2004) point out that because such individuals (i.e., liberal practitioners) consciously strive hard to be non-prejudice, they will not discriminate in situations where there are firm social norms and when discrimination would be obvious to themselves and others, such as other staff at their practice.

Likewise, the Aversive Racism model asserts that individuals will behave in a more positive manner when the topic of race/religion is salient and cues against discriminatory behaviour are strong or prominent (Nail et al., 2003). Considering that the study took place during an extreme upheaval around racial justice in North America where the topic of race and racism had become very salient in the media, it is possible that this event played a part in the results of the current study.

The emails for this study were sent out on May 31st 2020, six days after the death of George Floyd (May 25th 2020). By May 30th, there were protests not only in North America but also around the world, both in Western nations as well as Africa, the Middle-East and South

America (Haddad, 2020), against police brutality and in support of the Black Lives Matter movement[4]. During this time, discussions around racism and implicit biases and their roles in the unequal treatment of minorities had extremely intensified. For example, looking at Google Trends[5], the phrase "implicit bias" had a score of 100 (representing peak interest in a term) between May 31st to June 6th (between May 24th to 30th the score was 22; *Implicit Bias*, 2020). Accordingly, while not the intentions of this study, it may be that participants were primed with the topic of race and the negative association of racism in everyday life, during the data collection time frame.

Aversive Racism theory speculates that when conditions such as saliency of race and strong cues against acting in discriminatory ways are present, individuals from the dominant group (counsellors and psychologists, who are primarily racially White and religiously Christian; e.g., Bedi, Christiani, & Sinacore, 2020) will respond by behaving in a more positive manner than usual, towards the minority group (i.e., Muslims; Frey & Gaertner, 1986; Nail et al., 2003). This is a way for those in the dominant group to protect their self-concept from being labelled as prejudice; this is to prove to themselves and others that they are egalitarian and benevolent, non-racist and non-religiously biased individuals (Nail et al., 2003). This may explain why practitioners responded much quicker to Muhammad, compared to Lucas.

Further, the quicker response time to Muhammad can also fit into a theory closely connected to Aversive Racism, termed Ambivalent Racism as pioneered by Katz (1981). This theory proposes that when White individuals have ambivalent attitudes toward an outgroup (like

[4] Black Lives Matter (BLM) is an organization founded in 2013 operating in US, UK, and Canada to fight White supremacy, and give voice and space to marginalized Black communities that have been repeatedly silenced and subject to violence by those in power (Black Lives Matter, 2020).
[5] Google Trends is a search analysis website which analyzes top search queries on Google with graphs. The ratings are out of a 100 indicating peak popularity for a term.

racialized Muslims) that becomes salient after being primed with discriminatory acts (similar to what was seen in the popular media after the death of George Floyd), this can cause psychological tension for this group leading to their reaction being amplified (negative or positive) to the outgroup (Katz & Hass, 1988). For example, an ambivalent individual may amplify positive emotions towards an outgroup when they learn or experience something (often expressed in a form of sympathy) about this outgroup (e.g., they are helpless or too submissive). Conversely, if an ambivalent individual learns or experiences something negative about the outgroup (e.g., they are thieves or too demanding), this individual may amplify negative emotions towards this outgroup. This outward amplification of emotions allows the individual to become devoid of the initial ambivalence felt where this discomfort of having opposing feelings for the outgroup is no longer salient for the individual. Therefore, in the current study, practitioners may have had ambivalent feelings towards Muslim men and with the saliency of racial justice in the media (which may have conjured up feelings of sympathy), led to the over-eagerness of practitioners to show their non-prejudicialness and to alleviate their psychological tension by responding much quicker to Muhammad.

The current study, however, also found that all of those who took longer than a week to respond (n = 5) were from the Muslim condition. Since it is a small number of individuals who took longer to respond, it is possible that random sampling did not work well to standardize this variable across the conditions. It may be that all of those who responded after a week were on vacation or not checking their emails regularly, for example. On the other hand, it may be that these individuals' ambivalence towards Muhammad led to them to responding late. If, for example, they viewed the George Floyd protests happening as a negative event (i.e. minorities being too demanding and looting cities), it could have led to reacting negatively against

Muhammad; the amplification of their feelings from seeing the protests on media could have contributed to responding much later than expected from a mental health practitioner. This ambivalence may also explain the significantly more ambiguous receptiveness responses received by Muhammad. These practitioners responded, rather than not responding at all, possibly because by responding it allowed for a relief of some psychological tension and ambivalence felt (Katz et al., 1975).

It is also important to note that this study also took place during an unprecedented time where most of the world was in a lockdown or subject to severe mobility restrictions due to a pandemic caused by a coronavirus disease (COVID-19). In May 2020, the unemployment rate was at a record high (13.7%) with many individuals applying for Canadian Emergency Response Benefit (CERB) and Canada Emergency Wage Subsidy (CEWS; The Canadian Press, 2020a, 2020b). The current study took place on May 31st, 2020. At this time, many counsellors and psychologists had reduced clientele due to the therapy sessions moving exclusively online where many practitioners needed extended time off to shift their practice online. Further, client reluctance or reduced willingness to attend online sessions, their inability to attend online sessions (possibly due to lack of privacy, the required technological skills, or internet issues), or possibly not being able to afford sessions any longer as many individuals had lost their jobs, could have all impacted the reduced client hours for practitioners (Chan, 2020; Jurcik et al., 2020). As evidence of the impact of COVID-19 on the employment of practitioners, on BCACC (2020) website's page on COVID information and FAQs for BC counsellors, they listed and responded to the question of "where do I find information about government benefits?" Information about CERB and CEWS was also repeatedly discussed on the BC Psychological Association list-serve (e.g., who qualifies and under what circumstances).

This slowing down of provision of services for counsellors and psychologists led, possibly, to many practitioners being more open to taking on any client out of financial necessity, even if the client is someone from a race or religion that they do not feel comfortable with. Hence, it is possible that there was a large response rate and receptiveness towards Muhammad, due to the lack of other options as clients and a strong financial need by counsellors and psychologists. It is also possible that since most practitioners were providing online services, they were more open to seeing Muhammad because there is a sense of safety that is ensured when having clients remotely, rather than in person (Bocci, 2019). Therefore, due to the pandemic and its impact on practitioners' provision of mental health services, it is possible many practitioners were more open to accepting Muhammad as a client because it was an avenue of needed income for them, as well as the possibility of feeling more safe providing services to Muhammad since it would be online rather than in person.

Yet, it is also possible that practitioners recognized that, during this pandemic, the public needs support more than before (Rajkumar, 2020), and provided support to both Muhmmad and Lucas similarly without harbouring any biases against Muhammad. The COVID-19 pandemic forced many into isolation away from their family, friends, and their loved ones, including counsellors and psychologists, and increased anxiety around contracting a deadly disease and dying, as well as causing a state of unpredictability and uncertainty. The negative effects of the pandemic have been documented on the mental health of individuals across the world (Rajkumar, 2020). It is possible that practitioners in the study recognized this universal anxiety in the two clients and responded positively to do their part, during this difficult time. This could have possibly been further promoted by the heightened awareness and resultant empathy, and

shared humanity that the practitioners could have felt for all individuals regardless of religion or race during the time of a global pandemic (Burkard & Knox, 2004)

Nevertheless, practitioners may have also only supported Muhmmad because they believed they were the only ones contacted by him. A key point in Aversive Racism theory and research is around helping and responsibility, and the moderating effect of context (Gaertner et al., 2005). Since practitioners do not discriminate or show biases when there are strong norms on how to behave and they genuinely want to be egalitarian and compassionate to all, it is possible that they responded as equally positive to Muhmmad, when they believed that Muhammad needed help and that they were the only ones asked to help him. Hence, because there are strong normative and ethically prescriptive rules for practitioners when responding to a potential client, and this being especially true during a time when the general public needed more mental health support than before, in addition to the belief that they were perhaps the sole helper in the situation, led to them responding positively to Muhammad and Lucas at a similar rate.

Based on the Aversive Racism theory, if practitioners knew that Muhammad had contacted other practitioners (and not just them), it would be predicted that practitioners would respond with less receptiveness towards Muhmmad because they would be able to find a justifiable excuse to not get involved because someone else could help out (Gaertner et al., 2005; Gaertner & Dovidio, 1977). Thus, it is possible that practitioners responded as receptively to Muhammad as Lucas because there are not only strong norms around how to respond for practitioners which were highlighted more due to the pandemic, but also due to practitioners' belief that they were the only ones responsible in this situation (and the ethical dictate of not to abandon clients); there was no one else in the situation to take responsibility which could have justifiably excused the practitioner from helping.

Limitations

The current study was the first Canadian study in the mental health field using a correspondence audit methodology with a large sample, which allowed for an experimental design that has actual world realism (i.e., high external validity) without the risk of socially desirable responding. This study is also first in examining possible implicit bias against a religious minority group, rather than race. However, this study also has limitations.

Audit studies are context dependent where the results should not be generalized until similar studies are conducted in different contexts. This study was carried out during an expectedly unique sociopolitical climate in North America where: (1) it was the early stages of a pandemic, and (2) during a pivotal moment for the racial equality movement. These events likely impacted the results of the study.

Further, Metro Vancouver is a very ethnically/racially diverse city with Muslims representing about 3% of the city's population (and about 7% of the Canadian Muslim population; Statistics Canada, 2012), as well as being one of the most liberal cities in Canada (Vigliotti, 2019). Therefore, this research cannot be generalized to other cities in Canada that may be less liberal and multicultural, such as Abbotsford, Calgary, and Quebec.

Moreover, the current study only looked at possible bias at the entry point of counselling services, it does not gauge potential prejudice and discrimination at later stages of counselling such as possible microaggressions in the counselling session, counselling outcome, or termination (Hook et al., 2016; Owen et al., 2014). Therefore, this study cannot speak to practitioners' possible bias in its entirety, only what is observed as Muslim male clients who may be seeking access to services.

In terms of the sample, the practitioners were pulled from directories where counsellors/psychologists had chosen to include their names in these lists, therefore the study did not pull names at random from the whole population. This limits the external validity of the study given that this was not a random selection from the population, and the reason individuals had chosen to be included in the directories may be playing a role in the results (as a confounding variable). It may be that those on the directories are practitioners who are actively looking for clients, and possibly newer less established practitioners. This can create bias in the data because it is representing a sub-sample of the practitioner population.

Additionally, some practitioners contacted were from the same group practices who had their own personal emails. It is a possibility that although each practitioner in the group practice had unique emails addresses, they all went to a master or central email address, therefore causing suspicion on the sender of these emails which would introduce additional bias into the study. However, looking at the data, this is very unlikely given that most of the practitioners who were part of a group practice responded to the emails sent, which would have likely not happened if they were suspicious of the emails.

The religious/ethnicity of practitioners could also be a confounding variable in this study, where the way practitioners behave could be affected based on their own religious/ethnicity background. However, this information is not publicly available. The current study also excluded data from those who had identified themselves as non-binary, given the small sample size (n =4).

Furthermore, while unlikely given the response rate (87.2%), it is possible that some practitioners did not respond when contacted through the contact boxes because the contact boxes on their website did not work, since in most cases there was no confirmation email was received from the practitioner's contact box. It is also possible that the lack of phone number in

the email script may have played role in the number of emails received, since some practitioner may be more comfortable or willing to book appointments after talking to the potential client on the phone. Lastly, it may be possible that the emails went to practitioners' spam box. However, in this instance it would be expected that they would eventually check their spam folder and respond to the email.

Future Research

The current study was the first email correspondence audit study in the area of counselling/psychotherapy, which set the path for future research in this area. Firstly, future research should replicate the current study when practitioners are operating under normal circumstances to get a sense of how they respond when there is no mass unemployment, there is less of a financial pressure on practitioners to respond, as well as ensuring it does not coincide with international upheaval around racial equality or a pandemic.

Future research should also consider using a within-subject design, given that there were high concordance levels between the two conditions. If the total concordance rate (the total of all positive and negative responses from both conditions), based on Vuolo and colleagues (2016), is above .50 (.5 representing a chance of coin toss) then it would be more efficient to conduct a within-subject design. While the contextual setting of future studies will most likely not be the same as the current study (i.e., going through the early stages of pandemic lockdown and heightened racial justice upheaval), it may still benefit from a within-subject design given that the practitioners likely will respond in higher total concordance (> 0.5). However, researchers should beware of the risk of being "caught" by the participants. To avoid this, it would be beneficial to include slightly different versions of the email script with the modification of inconsequential details. This risk might also be reduced by separating out the two e-mails by

several weeks. Closely related, future research should consider doing a phone audit as well as in person audit with counsellors, and possibly examining if the different mediums of communication for requesting an appointment affects the results.

Further, given that practitioners will likely be conducting most sessions online for the next foreseeable future, future research should examine if there is difference in responses and receptiveness when the client directly asks for a face-to-face meeting. Based on the Aversive Racism theory, it would be predicted that practitioners may be more willing to offer in person appointment to the non-Muslim client, because their uncomfortableness with the Muslim client could lead to sticking to the recommended health guidelines and only offering an online appointment to this client; to provide online services ensures a sense of safety, that may not be there in person (Bocci, 2019).

Likewise, to test out Aversive Racism theory more in depth, specifically looking at if practitioners would excuse themselves from helping a Muslim client if they know they are not the only ones who have been asked to help, future research could design a similar study where awareness of not being the sole helper is presented to some practitioners but not others, and observing if results are consistent with the Aversive Racism theory. It would be hypothesized that the individuals aware of the Muslim client reaching out to multiple practitioners would be less likely to be receptive or willingly to help this potential client, compared to his non-Muslim counterpart.

Aversive Racism is also often associated with more liberal leaning individuals (Nail et al., 2003). Future research could examine if practitioners who self-identify as more liberal leaning compared to those are more conservative respond differently to a potential Muslim client. It would be hypothesized that those who are more liberal leaning would show more

favouritism towards the Muslim client, compared to the non-Muslim client. While, those who are more conservative leaning would be less receptive to the client, based on the Modern Racism theory (McConahay, 1986).

In the same vein, it would be important to conduct this study in places where the population is less culturally diverse such as Calgary or Quebec City, to see if the results hold up or are effected by certain contextual factors such as percent of Muslims in the local area or the conservatism of the general population in these cities. For example, based on Modern Racism theory (McConahay, 1986) which has been linked to political conservativism (Nail et al., 2003), it would be predicted that in Calgary and Quebec City, which are more conservative (Vigliotti, 2019), practitioners may respond less positively towards a Muslim client overtly. Therefore, it is possible that the Muslim client may receive less responses as well as less receptiveness, and receptiveness at a bigger time gap than what would be found in Vancouver, under normal circumstances.

Moreover, future research should examine the differences in responses through examination of the content of emails. The current study coded all messages that communicated the continuation of services as receptiveness, and those that did not communicate such a message and non-responders as non-receptiveness. While this type of coding served the purpose of setting up a baseline of what responses would look like, future research can take a deeper look into the type of responses received which would help to identify ambiguous or ambivalent responses and make sense of what such responses might indicate.

Similarly, it may be important to account for standardized responses from practitioners. The current study did not control for the use of standardized emails by practitioners who may send the same body of email to all potential clients. It would be important for future research to

send an initial email using either an ambiguous or Canadian name to get a baseline of common responses, which would consequently allow for deeper examination of type of responses received.

Closely related, future studies should include a more highlighted religious signifier such as including a religious quote at the end of the emails, similar to what has been done previously by Wright and colleagues (2013) and Wallace and colleagues (2014) who were looking at hiring practices of the Northeast and South of U.S. The current study avoided using such signifiers as the goal was to examine if a Muslim name, without the indication of high religiosity, would lead to implicit bias against such Muslim men.

Moreover, the current study should be replicated in the U.S. to further assess if the same extent of anti-Muslim sentiment is present in the States as well. It may be that, given the current sociopolitical climate of U.S., there will be more evident disparity of accessibility to counselling services for Muslims. It would be hypothesized that a Muslim client in America would receive less receptiveness from practitioners.

Additionally, in the current study, time to respond was looked at in an exploratory way, since it had not been examined previously. Future research should consider examining time to respond as a main outcome since there was a statistically significant difference between the time it took practitioners to respond to Muhammad and Lucas. Time to respond can be seen as a type of reaction time, an outcome that is often used in psychological research studies to measure variables that are hard to examine concretely or when the researchers want to look at a variable without introducing social desirability bias. Examining response time in this manner can help open up this area of research on what may be an average time that it takes a practitioners to

respond to emails, and what are the characteristics and responses that are associated with this normal range of response time.

Further, since that the current study did not find any statistically significant interaction between the covariates and receptiveness, future research should examine if there are other variables which may moderate the relationship between perceived religion and receptiveness and response rate. Notably, given that the logistic regression models accounted for a very small amount of the variance in the study, the examination of possible moderators can help provide a better picture of what could be effecting the relationship between how practitioners' perception of the client's religion and if they are receptive to the client.

Future research should also consider examining gender of the Muslim client as a main independent variable, since previous research has shown that practitioners are more likely to give prime appointments to women compared to men (Kugelmass, 2016). This would be an important variable to look at given the stereotypical portrayal of Muslim women, as a submissive and helpless person under the control of their patriarchal culture and religion, while the Muslim men are portrayed of terrorists or aggressive individuals (Joshi, 2006; Shaheen, 2003). Hence, it might be hypothesized that practitioners would provide more appointments to Muslim women compared to Muslim men, since they may be pitied or viewed as those needing the most help.

It would also be important to look at other client variables and its effect on response rate and receptiveness. This could be done by adding a variable to account for immigration status or social class based on grammar used in the email (Derwing & Waugh, 2012), or by using more specific anxiety and depression symptoms as the chief problem for seeking therapy. This additional client variables would allow for better understanding of what factors effect practitioners decision making on how they respond to a potential client.

Lastly, more demographic information of practitioners should also be considered in future research as variables of interest. For example, since non-binary respondents had to be removed from the analysis due to low sample size, future research should try to get a better representation of practitioners who do not adhere to binary gender norms and include them in such research. Beyond gender, religious/ethnic background, or political leaning of practitioners may be of interest. Future research should try to find a way, for example, to determine practitioners' religion and ethnicity and replicate the study to see if these variables play a role in the results of the study.

References

A Guide to Names and Naming Practices. (2006). https://www.fbiic.gov/public/2008/nov/Naming_practice_guide_UK_2006.pdf

Abreu, J. M. (1999). Conscious and nonconscious African American stereotypes: impact on first impression and diagnostic ratings by therapists. *Journal of Consulting and Clinical Psychology*, *67*, 387–393. https://doi.org/10.1037//0022-006x.67.3.387

Abu-Ras, W., & Abu-Bader, S. H. (2008). The Impact of the September 11, 2001, Attacks on the Well-Being of Arab Americans in New York City. *Journal of Muslim Mental Health*, *3*, 217–239. https://doi.org/10.1080/15564900802487634

Abu-Ras, W., & Abu-Bader, S. H. (2009). Risk factors for depression and posttraumatic stress disorder (PTSD): The case of Arab and Muslim Americans Post-9/11. *Journal of Immigrant and Refugee Studies*, *7*, 393–418. https://doi.org/10.1080/15562940903379068

ACA. (2020). *State Professional Counselor Licensure Boards*. American Counseling Association. https://www.counseling.org/knowledge-center/licensure-requirements/state-professional-counselor-licensure-boards

Addis, M. E., & Mahalik, J. R. (2003). Men, Masculinity, and the Contexts of Help Seeking. *American Psychologist*, *58*, 5–14. https://doi.org/10.1037/0003-066X.58.1.5

Addis, M. E., Mansfield, A. K., & Syzdek, M. R. (2010). Is " Masculinity " a Problem ?: Framing the Effects of Gendered Social Learning in Men. *Psychology of Men & Masculinity*, *11*, 77–90. https://doi.org/10.1037/a0018602

Adelson, N. (2005). The Embodiment of Inequity: Health Disparities in Aboriginal Canada. *Canadian Journal of Public Health*, *96*, S45–S61. https://doi.org/10.2307/20028049

Adida, C. L., Laitin, D. D., & Valfort, M.-A. (2010). Identifying barriers to Muslim integration

in France. *Proceedings of the National Academy of Sciences of the United States of America*, *107*, 22384–22390. https://doi.org/10.1073/pnas.1015550107

Ahmed, S., & Reddy, L. A. (2007). Understanding the Mental health needs of american Muslims: recommendations and considerations for practice. *Multicultural Counseling and Development*, *35*, 207–218. http://islam.about.com/od/basicbeliefs/p/intro.htm.

Allen, C., & Nielsen, J. S. (2002). *Summary Report on Islamophobia in the EU after 11 September 2001*.

Althubaiti, A. (2016). Information bias in health research: Definition, pitfalls, and adjustment methods. In *Journal of Multidisciplinary Healthcare* (Vol. 9, pp. 211–217). Dove Medical Press Ltd. https://doi.org/10.2147/JMDH.S104807

American Psychological Association. (2003). Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. *American Psychologist*, *58*, 377–402. https://doi.org/10.1037/0003-066X.58.5.377

Angus Reid Global. (2013). *Canadians view non-Christian religions with uncertainty, dislike*. 1–8.

Angus Reid Global. (2017). *Religious Trends: Led by Quebec, number of Canadians holding favourable views of various religions increases*. http://angusreid.org/wp-content/uploads/2017/04/2017.04.04_Religion.pdf

Astbury, J. (2001). *Gender Disparties in Mental Health*. https://www.who.int/mental_health/media/en/242.pdf

Balbuena, L., Baetz, M., & Bowen, R. (2013). Religious attendance, spirituality, and major depression in Canada: A 14-year follow-up study. *Canadian Journal of Psychiatry*, *58*, 225–232. https://doi.org/10.1177/070674371305800408

Banerjee, A., Bertrand, M., Datta, S., & Mullainathan, S. (2009). Labor market discrimination in Delhi: Evidence from a field experiment. *Journal of Comparative Economics*, *37*, 14–27. https://doi.org/10.1016/J.JCE.2008.09.002

Barkdull, C., Khaja, K., Queiro-Tajalli, I., Swart, A., Cunningham, D., & Dennis, S. (2011). Experiences of Muslims in Four Western Countries Post—9/11. *Affilia*, *26*, 139–153. https://doi.org/10.1177/0886109911405491

Baruth, L. G., & Manning, M. L. (2016). Multicultural counseling and psychotherapy: A lifespan approach: Sixth edition. In *Multicultural Counseling and Psychotherapy: A Lifespan Approach: Sixth Edition*. Taylor and Francis Inc. https://doi.org/10.4324/9781315659961

Bayrakli, E., & Hafez, F. (Eds.). (2019). *European Islamophobia Report*. Pelin Ofset. www.setav.org/en

BCACC. (2017). *Planning for the Future: 2017 Annual Report*. https://doi.org/10.1038/nenergy.2017.129

Bedi, R. P., Christiani, K. D., & Sinacore, A. L. (2020). A Survey of the Characteristics and Professional Practices of Members in the Canadian Psychological Association's Section on Counselling Psychology. *Counselling Psychology Quarterly*, *33*, 345–363. https://doi.org/10.1080/09515070.2018.1538935

Bedi, R. P., Young, C. N., Davari, J. A., Springer, K. L., & Kane, D. P. (2016). A Content Analysis of Gendered Research in the Canadian. *Canadian Journal of Counselling and Psychotherapy*, *50*, 365–383.

Bertrand, M., & Mullainathan, S. (2004). Are Emily and Greg More Employable Than Lakisha and Jamal? A Field Experiment on Labor Market Discrimination. *The American Economic Review*, *94*, 991–1013.

https://www2.econ.iastate.edu/classes/econ321/orazem/bertrand_emily.pdf

Black Lives Matter. (2020). *What Matters*. Black Lives Matter. https://blacklivesmatter.com/about/

Bocci, G. S. (2019, January 28). 13 Benefits of Teletherapy for Therapists | Psychology Today Canada. *Psycholog Today*. https://www.psychologytoday.com/ca/blog/millennial-media/201901/13-benefits-teletherapy-therapists

Boysen, G. (2009). A Review of Experimental Studies of Explicit and Implicit Bias Among Counselors. *Journal of Multicultural Counseling and Development, 37*. https://onlinelibrary.wiley.com/doi/pdfdirect/10.1002/j.2161-1912.2009.tb00106.x

Boysen, Guy. (2010). Integrating implicit bias into counselor education. *Counselor Education and Supervision*, *49*, 210–227. https://doi.org/10.1002/j.1556-6978.2010.tb00099.x

Boysen, Guy, & Vogel, D. (2008). The Relationship Between Level of Training, Implicit Bias, and Multicultural Competency Among Counselor Trainees. *Training and Education in Professional Psychology*, *2*, 103–110. https://doi.org/10.1037/1931-3918.2.2.103

Budge, S. L., Thai, J. L., Tebbe, E. A., & Howard, K. A. S. (2016). The Intersection of Race, Sexual Orientation, Socioeconomic Status, Trans Identity, and Mental Health Outcomes. *The Counseling Psychologist*, *44*, 1025–1049. https://doi.org/10.1177/0011000015609046

Burkard, A. W., & Knox, S. (2004). Effect of Therapist Color-Blindness on Empathy and Attributions in Cross-Cultural Counseling. *Journal of Counseling Psychology*, *51*(4), 387–397. https://doi.org/10.1037/0022-0167.51.4.387

CAIR. (2019). *Annual Legal Report 2019*. https://ca.cair.com/wp-content/uploads/2019/11/2019-Legal-Report.pdf

Campbell, M. R., & Brauer, M. (2020). Is Discrimination Widespread? Testing Assumptions

About Bias on a University Campus. *Journal of Experimental Psychology: General*. https://doi.org/10.1037/xge0000983

Canadian Psychological Association. (2016). *2015 Psychology Graduate Survey: Final Report*. https://cpa.ca/docs/File/Publications/PGS_Final_Report_7Dec2016_ENFinal.pdf

Castillo, L. G., Brossart, D. F., Reyes, C. J., Conoley, C. W., & Phoummarath, M. J. (2007). The Influence of Multicultural Training on Perceived Multicultural Counseling Competencies and Implicit Racial Prejudice. *Journal of Multicultural Counseling and Development*, *35*, 243–255. https://doi.org/10.1002/j.2161-1912.2007.tb00064.x

Chan, A. (2020, June 5). B.C. has seen more than 350K job losses due to COVID-19 | CTV News. *CTV News*. https://vancouverisland.ctvnews.ca/b-c-has-seen-more-than-350k-job-losses-due-to-covid-19-1.4971024

Chao, R. C. L., Wei, M., Good, G. E., & Flores, L. Y. (2011). Race/Ethnicity, Color-Blind Racial Attitudes, and Multicultural Counseling Competence: The Moderating Effects of Multicultural Counseling Training. *Journal of Counseling Psychology*, *58*, 72–82. https://doi.org/10.1037/a0022091

Code of Ethical Conduct. (2014). https://bc-counsellors.org/wp-content/uploads/2015/09/BCACC-Code-of-Ethical-Conduct-2014.pdf

Cole, K., Catherine Costigan, Rp., Lindsey Jack, Rp., Sandra James, Rp., Member Pippa Lewington, P., Marlene Moretti, Rp., & Wormeli, C. T. (2018). *Chronicle*. http://www.communitylivingbc.ca/about-us/policies/eligibility-for-clbc-february-2009/

Collins, S., & Arthur, N. (2010). Culture-infused counselling: A model for developing multicultural competence. *Counselling Psychology Quarterly*, *23*, 217–233. https://doi.org/10.1080/09515071003798212

Connell, R., & Pearse, R. (2014). *Gender: In World Perspective* (Third). Wiley. https://www.wiley.com/en-us/Gender:+In+World+Perspective,+3rd+Edition-p-9780745680712

Connell, R. W., & Messerschmidt, J. W. (2005). Rethinking the Concept. *Gender and Society*, *19*, 829–859. https://doi.org/10.1177/0891243205278639

Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology*, *54*, 1–16. https://doi.org/10.1037/0022-0167.54.1.1

Courtnay, W. (2000). Constructions of masculinity and their influence on men's well-being: a theory of gender and health. *Social Science & Medicine*, *50*, 1385–1401.

Cox, D. W. (2014). Gender differences in professional consultation for a mental health concern: A Canadian population study. *Canadian Psychology*, *55*, 68–74. https://doi.org/10.1037/a0036296

CPBC. (n.d.). *What is the difference between Psychologists, Psychiatrists and Counsellors? | BC Psychological Association*. Retrieved October 23, 2019, from https://www.psychologists.bc.ca/faq/what-difference-between-psychologists-psychiatrists-and-counsellors

CPBC. (2018). *College of Psychologists of BC Annual Report*.

CPBC Code of Conduct. (2014). www.collegeofpsychologists.bc.ca

Crabtree, C., & Chykina, V. (2018). Last name selection in audit studies. *Sociological Science*, *5*, 21–28. https://doi.org/10.15195/v5.a2

Daniel, W. W. (1968). *Racial discrimination in England: based on the P.E.P. report*. Harmondsworth, Penguin.

http://webcat2.library.ubc.ca/vwebv/holdingsInfo?bibId=1023839

Davis, D. E., DeBlaere, C., Brubaker, K., Owen, J., Jordan, T. A., Hook, J. N., & Van Tongeren, D. R. (2016). Microaggressions and Perceptions of Cultural Humility in Counseling. *Journal of Counseling and Development, 94*, 483–493. https://doi.org/10.1002/jcad.12107

DeAngelis, T. (2019). How does implicit bias by physicians affect patients' health care? *Monitor on Psychology, March*, 22. https://www.apa.org/monitor/2019/03/ce-corner

Denton, M., Prus, S., & Walters, V. (2004). Gender Differences in Health: A Canadian Study of the Psycho-social, Structural and Behavioural Deteminants of Health. *Social Science & Medicine, 58*. https://www3.carleton.ca/casr/denton.pdf

DeSimone, V. (2019). From the Ground Up: Combatting the Rise of Right-Wing Terror. *New Perspectives in Foreign Policy*. https://www.csis.org/ground-combatting-rise-right-wing-terror

DiMaggio, P. (1997). Culture and Cognition. *Annual Review of Sociology, 23*(1), 263–287. https://doi.org/10.1146/annurev.soc.23.1.263

Dovidio, John F. (2001). On the Nature of Contemporary Prejudice: The Third Wave. *Journal of Social Issues, 57*, 829–849.

Dovidio, John F., & Gaertner, S. L. (2004). Aversive Racism. *Advances in Experimental Social Psycholog, 36*, 1–52. http://www.psych.purdue.edu/~willia55/392F-%2706/Dovidio&Gaertner.pdf

Dovidio, John F., Hewstone, M., Glick, P., & Esses, V. M. (2010). Prejudice, stereotyping and discrimination: Theoretical and empirical overview. In John F. Dovidio, M. Hewstone, P. Glick, & V. M. Esses (Eds.), *The SAGE Handbook of Prejudice, Stereotyping and Discrimination* (pp. 3–28). SAGE Publications Inc.

https://doi.org/10.4135/9781446200919.n1

Dovido, J. F., Gaertner, S. L., Kawakami, K., & Hodson, G. (2002). Why can't we just get along? Interpersonal biases and interracial distrust. *Cultural Diversity and Ethnic Minority, 8,* 88–102. https://doi.org/10.1037//1099-9809.8.2.88

Dovido, J. F., Gaertner, S. L., & Pearson, A. . (2005). On the nature of prejudice: The Psychological Foundations of Hate. In J. F. Dovidio, P. Glick, & L. A. Rudman (Eds.), *On the nature of prejudice: Fifty years after Allport* (pp. 211–234). Blackwell Publishing. https://research.pomona.edu/sci/files/2013/08/The-Psychology-of-Hate-Nature-of-prejudice.pdf

Drapeau, A., Boyer, R., & Lesage, A. (2009). The influence of social anchorage on the gender difference in the use of mental health services. *Journal of Behavioral Health Services and Research, 36,* 372–384. https://doi.org/10.1007/s11414-009-9168-0

Duarte, J. L., Crawford, J. T., Stern, C., Haidt, J., Jussim, L., & Tetlock, P. E. (2015). Political Diversity will Improve Social Psychological Science. *Behavioral and Brain Sciences, e130,* 1–58. https://doi.org/10.1017/S0140525X14000430

Fitzpatrick, K. M. (2017). Circumstances, religiosity/spirituality, resources, and mental health outcomes among homeless adults in northwest Arkansas. *Psychology of Religion and Spirituality, 10,* 195–202. https://doi.org/10.1037/rel0000150

Frey, D. L., & Gaertner, S. L. (1986). Helping and the Avoidance of Inappropriate Interracial Behavior. A Strategy That Perpetuates A Nonprejudiced Self-Image. *Journal of Personality and Social Psychology, 50*(6), 1083–1090. https://doi.org/10.1037/0022-3514.50.6.1083

Gaddis, S. M. (2018). *Audit Studies: Behind the Scenes with Theory, Method, and Nuance*. https://doi.org/10.1007/978-3-319-71153-9

Gaertner, S. L., & Dovidio, J. F. (1977). The Subtlety of White Racism, Arousal, and Helping Behavior. *Journal of Personality and Social Psychology*, *35*, 691–707. https://doi.org/10.1037/0022-3514.35.10.691

Gaertner, S. L., & Dovidio, J. F. (2005). Understanding and Addressing Contemporary Racism: From Aversive Racism to the Common Ingroup Identity Model. *Journal of Social Issues*, *61*(3), 615–639.

Gaertner, S. L., Dovidio, J. F., Nier, J., Hodson, G., & Houlette, M. A. (2005). Aversive Racism: Bias without Intention. In *Handbook of Employment Discrimination Research* (pp. 377–393). Springer New York. https://doi.org/10.1007/978-0-387-09467-0_19

Gerber, A. S., & Green, D. P. (2012). *Field experiments : design, analysis, and interpretation*. W.W. Norton.

Ghaffari, A., & Çiftçi, A. (2010). Religiosity and Self-Esteem of Muslim Immigrants to the United States: The Moderating Role of Perceived Discrimination. *International Journal for the Psychology of Religion*, *20*, 14–25. https://doi.org/10.1080/10508610903418038

Gismondi, M. (2017, August 18). Is racism different in Canada? *Maclean's*. https://www.macleans.ca/society/is-racism-different-in-canada/

Greenwald, A. G., Banaji, M. R., Bargh, J., Bhaskar, R., Blair, I., Bernstein, R., Brewer, M., Crowder, R., Doob, L., Fazio, R., Fiedler, K., Fra-ble, D., Gilbert, D., Glaser, J., Hackman, R., Hardin, C., Hughes, R., Jost, J., Jacoby, L., … Wilson, T. (1995). Implicit Social Cognition: Attitudes, Self-Esteem, and Stereotypes Implicit Social Cognition: Introduction and Overview. In *Psychological Review* (Vol. 102). https://faculty.washington.edu/agg/pdf/Greenwald_Banaji_PsychRev_1995.OCR.pdf

Greenwald, A, & Krieger, L. H. (2006). Implicit Bias: Scientific Foundations. *California Law*

Review, *94*. https://scholarship.law.berkeley.edu/cgi/viewcontent.cgi?article=1250&context=californialawreview

Greenwald, Anthony, & Banaji, M. (1995). Implicit Social Cognition: Attitudes, Self-Esteem, and Stereotypes. *Psychological Review*, *102*, 4–27. http://www.people.fas.harvard.edu/~banaji/research/publications/articles/1995_Greenwald_PR.pdf

Greenwald, Anthony, McGhee, D. E., & Schwartz, J. L. K. (1998). Measuring individual differences in implicit cognition: The implicit association test. *Journal of Personality and Social Psychology*, *74*, 1464–1480. https://doi.org/10.1037/0022-3514.74.6.1464

Gunew, S. (2004). *Haunted Nations: The colonial dimesnions of multiculturalisms*. Routledge.

Gushue, G. (2004). Race, Color-Blind Racial Attitudes, and Judgments About Mental Health: Shifting Standards Perspective. *Journal of Counseling Psychology*, *51*, 398–407. http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=1&sid=e55b6066-df17-47ea-850c-cfb8aadb1f73%40sdc-v-sessmgr02

Gushue, G. V., & Constantine, M. G. (2007). Color-Blind Racial Attitudes and White Racial Identity Attitudes in Psychology Trainees. *Professional Psychology: Research and Practice*, *38*, 321–328. https://doi.org/10.1037/0735-7028.38.3.321

Haddad, M. (2020, June 7). *Mapping anti-racism solidarity protests around the world | George Floyd protests*. Al Jazeera. https://www.aljazeera.com/indepth/interactive/2020/06/mapping-anti-racism-solidarity-protests-world-200603092149904.html

Hamdani, D. (2015). *Canadian Muslims: A Statistical Review*. www.cdndawnfoundation.ca

Haque, A. (2004). Religion and Mental Health: The Case of American Muslims. In *Journal of Religion and Health* (Vol. 43, Issue 1). https://s3.amazonaws.com/academia.edu.documents/5611771/American_Muslims_Mental_Health.pdf?AWSAccessKeyId=AKIAIWOWYYGZ2Y53UL3A&Expires=1537749531&Signature=z2h%2BMvQex1EW7fItaChj4BA5p7Y%3D&response-content-disposition=inline%3B filename%3DReligion_and_mental_health_The_case_of_A.pdf

Hedayat-Diba, Z. (2014). Psychotherapy with Muslims. *Handbook of Psychotherapy and Religious Diversity (2nd Ed.).*, 287–317. https://doi.org/10.1037/14371-012

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, *63*, 269–277. https://doi.org/10.1037/cou0000114

Hoover, S. M., Bedi, R. P., & Beall, L. K. (2012). Frequency of Scholarship on Counselling Males in the "Canadian Journal of Counselling and Psychotherapy". *Canadian Journal of Counselling and Psychotherapy*, *46*, 292–297.

Hunsley, J., Ronson, A., & Cohen, K. R. (2013). Professional Psychology in Canada: A Survey of Demographic and Practice Characteristics. *Professional Psychology: Research and Practice*, *44*(2), 118–126. https://doi.org/10.1037/a0029672

Husain, A., & Howard, S. (2017). Religious Microaggressions: A Case Study of Muslim Americans. *Journal of Ethnic and Cultural Diversity in Social Work*, *26*, 139–152. https://doi.org/10.1080/15313204.2016.1269710

Implicit bias. (2020). Google Trends. https://trends.google.com/trends/explore?q=implicit bias&geo=US

Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic

Disparities in Health. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. In B. D. Smedley, A. Y. Stith, & A. R. Nelson (Eds.), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press (US). https://doi.org/10.17226/12875

Joshi, K. Y. (2006). The racialization of hinduism, islam, and sikhism in the united states. *Equity and Excellence in Education*, *39*, 211–226. https://doi.org/10.1080/10665680600790327

Jurcik, T., Jarvis, G. E., Doric, J. Z., Krasavtseva, Y., Yaltonskaya, A., Ogiwara, K., Sasaki, J., Dubois, S., & Grigoryan, K. (2020). Adapting mental health services to the COVID-19 pandemic: reflections from professionals in four countries. *Counselling Psychology Quarterly*. https://doi.org/10.1080/09515070.2020.1785846

Karim, K. H., & Eid, M. (2012). Clash of Ignorance. *Global Media Journal -- Canadian Edition*, *5*, 7–27. https://search-proquest-com.ezproxy.library.ubc.ca/docview/1037903702/fulltextPDF/4428B2E7A0C64E73PQ/1?accountid=14656

Karim, K. H., & Eid, M. (2014). Re-Imagining the Other. In M. Eid & K. H. Karim (Eds.), *Re-Imagining the Other* (pp. 217–231). Palgrave Macmillan US. https://doi.org/10.1057/9781137403667_11

Katz, I., Cohen, S., & Glass, D. (1975). Some determinants of cross-racial helping behavior. *Journal of Personality and Social Psychology*, *32*, 964–970. https://doi.org/10.1037/0022-3514.32.6.964

Katz, I., & Hass, R. G. (1988). Racial Ambivalence and American Value Conflict: Correlational and Priming Studies of Dual Cognitive Structures. *Journal of Personality and Social Psychology*, *55*, 893–905. https://doi.org/10.1037/0022-3514.55.6.893

Khan, M., Kobayashi, K., Lee, S. M., Vang, Z., Khan, M. ;, Kobayashi, K. ;, & Lee, S. M. ; (2015). *(In)Visible Minorities in Canadian Health Data and*. https://ir.lib.uwo.ca/pclchttps://ir.lib.uwo.ca/pclc/vol3/iss1/5

King, E. B., & Ahmad, A. S. (2010). An experimental field study of interpersonal discrimination toward muslim job applicants. *Personnel Psychology*, *63*, 881–906. https://doi.org/10.1111/j.1744-6570.2010.01199.x

Krysan, M., & Moberg, S. (2016). *Trends in racial attitudes*. University of Illinois Institute of Government and Public Affairs. https://igpa.uillinois.edu/programs/racial-attitudes

Kugelmass, H. (2016). "Sorry, I'm Not Accepting New Patients": An Audit Study of Access to Mental Health Care. *Journal of Health and Social Behavior*, *57*, 168–183. https://doi.org/10.1177/0022146516647098

Kumar, A., & Epley, N. (2020). It's Surprisingly Nice to Hear You: Misunderstanding the Impact of Communication Media Can Lead to Suboptimal Choices of How to Connect With Others. *Journal of Experimental Psychology: General*, 1–13. https://web-a-ebscohost-com.ezproxy.library.ubc.ca/ehost/pdfviewer/pdfviewer?vid=1&sid=3fe2c97c-ba6f-4489-8902-161d4cd46e2e%40sdc-v-sessmgr02

Kumar, D. (2010). Framing Islam: The resurgence of orientalism during the Bush II era. *Journal of Communication Inquiry*, *34*, 254–277. https://doi.org/10.1177/0196859910363174

Lahey, J., & Beasley, R. (2018). Technical Aspects of Correspondence Studies. In S. M. Gaddis (Ed.), *Audit Studies: Behind the Scenes with Theory, Method, and Nuance* (pp. 81–101). Springer International Publishing. https://doi.org/10.1007/978-3-319-71153-9_4

Lasser, K. E., Himmelstein, D. U., & Woolhandler, S. (2006). Access to care, health status, and health disparities in the United States and Canada: results of a cross-national population-

based survey. *American Journal of Public Health*, *96*, 1300–1307. https://doi.org/10.2105/AJPH.2004.059402

Lê Cook, B., McGuire, T. G., Lock, K., & Zaslavsky, A. M. (2010). Comparing Methods of Racial and Ethnic Disparities Measurement across Different Settings of Mental Health Care. *Health Services Research*, *45*, 825–847. https://doi.org/10.1111/j.1475-6773.2010.01100.x

Levitt, S. D., & List, J. A. (2007). What Do Laboratory Experiments Measuring Social Preferences Reveal About the Real World? *Journal of Economic Perspectives*, *21*, 153–174. https://doi.org/10.1257/jep.21.2.153

Liepyte, S., & McAloney-Kocaman, K. (2015). Discrimination and religiosity among Muslim women in the UK before and after the Charlie Hebdo attacks. *Mental Health, Religion and Culture*, *18*, 789–794. https://doi.org/10.1080/13674676.2015.1107890

Lin, L., Stamm, K., & Christidis, P. (2018). *Demographics of the U.S. Psychology Workforce Findings from the 2007-16 American Community Survey American Psychological Association Center for Workforce Studies*.

Lipka, M. (2017). *Muslims and Islam: Key findings in the U.S. and around the world | Pew Research Center*. Pew Research. https://www.pewresearch.org/fact-tank/2017/08/09/muslims-and-islam-key-findings-in-the-u-s-and-around-the-world/

Livengood, J. S., & Stodolska, M. (2004). The Effects of Discrimination and Constraints Negotiation on Leisure Behavior of American Muslims in the Post-September 11 America. *Journal of Leisure Research*, *36*, 183–208. https://doi.org/10.1080/00222216.2004.11950019

Martin, M. B. (2015). Perceived Discrimination of Muslims in Health Care. *Journal of Muslim Mental Health*, *9*. https://doi.org/10.3998/jmmh.10381607.0009.203

Matsuoka, J. K., Breaux, C., & Ryujin, D. H. (1997). National utilization of mental health services by Asian Americans/Pacific Islanders. *Journal of Community Psychology*, *25*, 141–145. https://doi.org/10.1002/(SICI)1520-6629(199703)25:2<141::AID-JCOP3>3.0.CO;2-0

McConahay, J. (1986). Modern Racism, Ambivalence, and the Modern Racism Scale. In J.F. Dovidio & S. L. Gaertner (Eds.), *Prejudice, discrimination, and racism* (pp. 91–125). Academic Press. https://psycnet.apa.org/record/1986-98698-004

McGuire, T. G., & Miranda, J. (2008). New evidence regarding racial and ethnic disparities in mental health: policy implications. *Health Affairs (Project Hope)*, *27*, 393–403. https://doi.org/10.1377/hlthaff.27.2.393

McInnis, A. (2017, March 13). Most Canadians favour values test for immigrants, while 23 per cent think Muslims should be banned: poll. *National Post*. https://nationalpost.com/news/politics/most-canadians-favour-values-test-for-immigrants-while-23-per-cent-think-muslims-should-be-banned-poll

Mckenzie, K., Agic, B., Tuck, A., & Antwi, M. (2016). *The Case for Diversity Building the Case to Improve Mental Health Services for Immigrant, Refugee, Ethno-cultural and Racialized Populations*. http://www.mentalhealthcommission.ca

Medical Services Plan. (2020). Goverment of BC. https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp

Minister of Justice. (1985). *Canadian Multiculturalism Act*.

Miranda, J., McGuire, T. G., Williams, D. R., & Wang, P. (2008). Mental Health in the Context of Health Disparities. *American Journal of Psychiatry*, *165*, 1102–1108. https://doi.org/10.1176/appi.ajp.2008.08030333

Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of

discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology*, *51*(4), 418–428. https://doi.org/10.1037/0022-0167.51.4.418

Morton, E. (2012). *The incidence of racial microaggressions in the cross-racial counseling dyad*. https://psycnet.apa.org/record/2012-99080-516

Nadal, K. L., Griffin, K. E., Hamit, S., Leon, J., Tobio, M., & Rivera, D. P. (2012). Subtle and Overt Forms of Islamophobia: Microaggressions toward Muslim Americans. *Journal of Muslim Mental Health*, *6*. https://doi.org/http://dx.doi.org/10.3998/jmmh.10381607.0006.203

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling and Development*, *92*, 57–66. https://doi.org/10.1002/j.1556-6676.2014.00130.x

Nadimpalli, S. B., Kanaya, A. M., McDade, T. W., & Kandula, N. R. (2016). Self-reported discrimination and mental health among asian indians: Cultural beliefs and coping style as moderators. *Asian American Journal of Psychology, 7*, 185–194. https://doi.org/10.1037/aap0000037

Nail, P. R., Harton, H. C., & Decker, B. P. (2003). Political Orientation and Modern Versus Aversive Racism: Tests of Dovidio and Gaertner's (1998) Integrated Model. *Journal of Personality and Social Psychology*, *84*(4), 754–770. https://doi.org/10.1037/0022-3514.84.4.754

National Post. (2015, October 19). Canadian election results 2015: A riding-by-riding breakdown of the vote. *National Post*. https://nationalpost.com/news/politics/canadian-election-results-2015-a-live-riding-by-riding-breakdown-of-the-vote

Neely-Fairbanks, S. Y., Rojas-Guyler, L., Nabors, L., & Banjo, O. (2018). Mental Illness

Knowledge, Stigma, Help-Seeking Behaviors, Spirituality and the African American Church. *American Journal of Health Studies*, *33*, 162.

Neighbors, H. W., Caldwell, C., Williams, D. R., Nesse, R., Taylor, R. J., Bullard, K. M., Torres, M., & Jackson, J. S. (2007). Race, Ethnicity, and the Use of Services for Mental Disorders. *Archives of General Psychiatry*, *64*, 485. https://doi.org/10.1001/archpsyc.64.4.485

Nelson, C. (2017, July 21). The Canadian Narrative about Slavery Is Wrong | The Walrus. *The Walrus*. https://thewalrus.ca/the-canadian-narrative-about-slavery-is-wrong/

Nelson, R. H. (2015). The Secularization Myth Revisited Secularism as Christianity in Disguise. In *Journal of Markets & Morality* (Vol. 18, Issue 2). https://search-proquest-com.ezproxy.library.ubc.ca/docview/1770213152?accountid=14656&pq-origsite=summon

Nicholson, I. (2011). New Technology, Old Issues: Demonstrating the Relevance of the Canadian Code of Ethics for Psychologists to the Ever-Sharper Cutting Edge of Technology - ProQuest. *Canadian Psychology*, *52*, 215–224. https://search.proquest.com/docview/885052063?accountid=14656&pq-origsite=summon

Nosek, B. A., Greenwald, A. G., & Banaji, M. R. (2007). The Implicit Association Test at Age 7: A Methodological and Conceptual Review. In J. Bargh (Ed.), *Frontiers of social psychology. Social psychology and the unconscious: The automaticity of higher mental processes* (pp. 265–292). Psychology Press. https://doi.org/10.1016/j.mrfmmm.2009.01.007

Nosek, B. A., Smyth, F. L., Hansen, J. J., Devos, T., Lindner, N. M., Ranganath, K. A., Smith, C. T., Olson, K. R., Chugh, D., Greenwald, A. G., & Banaji, M. R. (2007). Pervasiveness and correlates of implicit attitudes and stereotypes. *European Review of Social Psychology*, *18*, 36–88. https://doi.org/10.1080/10463280701489053

Olah, M. E., Gaisano, G., & Hwang, S. W. (2013). The effect of socioeconomic status on access

to primary care: an audit study. *CMAJ : Canadian Medical Association Journal*, *185*, E263-9. https://doi.org/10.1503/cmaj.121383

Oliver, M., Pearson, N., Coe, N., & Gunnell, D. (2005). Help seeking behaviour in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry*, *186*, 297–301.

Orwin, C. (2015). Stephen Harper's veiled attack on religious freedom. *The Globe and Mail*. https://www.theglobeandmail.com/opinion/stephen-harpers-veiled-attack-on-religious-freedom/article23044095/

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research*, *11*, 204–212. https://doi.org/10.1080/14733145.2010.491551

Owen, J., Tao, K., & Rodolfa, E. (2010). Microaggressions and Women in Short-Term Psychotherapy: Initial Evidence. *The Counseling Psychologist*, *38*, 923–946. https://doi.org/10.1177/0011000010376093

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice*, *45*, 283–290. https://doi.org/10.1037/a0037420

Padela, A. I., & Curlin, F. A. (2013). Religion and Disparities: Considering the Influences of Islam on the Health of American Muslims. *Journal of Religion and Health*, *52*, 1333–1345. https://doi.org/10.1007/s10943-012-9620-y

Padela, A. I., Gunter, K., Killawi, A., & Heisler, M. (2012). Religious Values and Healthcare Accommodations: Voices from the American Muslim Community. *Journal of General*

Internal Medicine, *27*, 708–715. https://doi.org/10.1007/s11606-011-1965-5

Padela, A. I., & Heisler, M. (2001). The Association of Perceived Abuse and Discrimination After. *American Journal of Public Health*, *100*, 284–291. https://doi.org/10.2105/AJPH.2009

Padela, A. I., & Raza, A. (2011). *American Muslim Health Disparities: The State of the Medline Literature*. http://digitalscholarship.unlv.edu/jhdrp/

Pager, D. (2003). The Mark of a Criminal Record. *American Journal of Sociology*, *108*, 937–975. https://scholar.harvard.edu/files/pager/files/pager_ajs.pdf

Pager, D., & Quillian, L. (2005). Walking the Talk? What Employers Say Versus What They Do. *American Sociological Review*, *70*, 355–380. https://doi.org/10.1177/000312240507000301

Pascoe, E. A., & Smart Richman, L. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychol Bull*, *135*(4), 531–554. https://doi.org/10.1037/a0016059.supp

Payton, L. (2015, February 2). Muslim groups "troubled" by Stephen Harper's mosque remark. *CBC News*. https://www.cbc.ca/news/politics/muslim-groups-troubled-by-stephen-harper-s-mosque-remark-1.2940488

Pettigrew, T. F., & Tropp, L. R. (2005). Allport's Intergroup Contact Hypothesis: Its History and Influence. In John F. Dovidio, P. Glick, & L. A. Rudman (Eds.), *On the Nature of Prejudice* (pp. 262–277). Blackwell Publishing Ltd. https://doi.org/10.1002/9780470773963

Pettigrew, T. F., & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology*, *90*(5), 751–783. https://doi.org/10.1037/0022-3514.90.5.751

Pew Research Center. (2011). *The Future of the Global Muslim Population*. Pew Research Center. https://www.pewforum.org/2011/01/27/the-future-of-the-global-muslim-population/

Pew Research Center. (2015). *10 Countries With the Largest Muslim Populations, 2010 and 2050 | Pew Research Center*. https://www.pewforum.org/2015/04/02/muslims/pf_15-04-02_projectionstables74/

Pew Research Center. (2017a). *American Muslims' religious beliefs and practices*. https://www.pewforum.org/2017/07/26/religious-beliefs-and-practices/#one-in-five-muslims-are-converts

Pew Research Center. (2017b). *The Changing Global Religious Landscape*. https://www.pewforum.org/2017/04/05/the-changing-global-religious-landscape/#global-population-projections-2015-to-2060

Pew Research Center. (2017c). *U.S. Muslims Concerned About Their Place in Society, but Continue to Believe in the American Dream*.

Pew Research Center. (2018). *Muslim Americans: Immigrants and U.S. born see life differently | Pew Research Center*. Pew Research Center. https://www.pewforum.org/essay/muslims-in-america-immigrants-and-those-born-in-u-s-see-life-differently-in-many-ways/

Pierné, G. (2013). Hiring discrimination based on national origin and religious closeness: results from a field experiment in the Paris area. *IZA Journal of Labor Economics*, *2*, 1–15. https://doi.org/10.1186/2193-8997-2-4

Plumb, A. (2011). Spirituality and Counselling: Are Counsellors Prepared to Integrate Religion and Spirituality into Therapeutic Work with Clients? *Canadian Journal of Counselling and Psychotherapy*, *45*. https://cjc-rcc.ucalgary.ca/article/view/59300

Proctor, S. L., Collins, A. S., Harper, E. A., & Truscott, S. D. (2010). Race. In C. S. Clauss-Ehlers (Ed.), *Encyclopedia of Cross-Cultural School Psychology* (pp. 775–779). Springer US. https://doi.org/10.1007/978-0-387-71799-9_341

Qasqas, M. J., & Jerry, P. (2014). Counselling Muslims: A Culture-Infused Antidiscriminatory Approach Musulmans en counseling : une approche antidiscriminatoire tenant compte des références culturelles. *Canadian Journal of Counselling and Psychotherapy*, *48*, 57–76. https://search-proquest-com.ezproxy.library.ubc.ca/docview/1507831471/fulltextPDF/35433F647D89446BPQ/1?accountid=14656%0Ahttp://cjcp.journalhosting.ucalgary.ca/cjc/index.php/rcc/article/viewFile/960/2507

Rahmatullah Imon, A. H. ., & Hadi, A. S. (2008). Identification of Multiple Outliers in Logistic Regression. *Communications in Statistics-Theory and Methods*, *37*(11), 1697–1709. https://doi.org/10.1080/03610920701826161

Rajkumar, R. P. (2020). COVID-19 and mental health: A review of the existing literature. *Asian Journal of Psychiatry*, *52*. https://doi.org/10.1016/j.ajp.2020.102066

Riach, P. A., & Rich, J. (2006). An Experimental Investigation of Sexual Discrimination in Hiring in the English Labor Market. In *The B.E. Journal of Economic Analysis & Policy* (Vol. 6). http://feminism.martinsewell.com/RiachRich2006.pdf

Rudman, L., & Goodwin, S. (2004). Gender Differences in Automatic In-Group Bias: Why Do Women Like Women More Than Men Like Men? *Journal of Personality and Social Psychology*, *87*, 494–509. https://doi.org/10.1037/0022-3514.87.4.494

Sabin, J. A., Riskind, R. G., & Nosek, B. A. (2015). Health care providers' implicit and explicit attitudes toward lesbian women and gay men. *American Journal of Public Health*, *105*, 1831–1841. https://doi.org/10.2105/AJPH.2015.302631

Safran, M. A., Mays, R. A., Huang, L. N., McCuan, R., Pham, P. K., Fisher, S. K., McDuffie, K. Y., & Trachtenberg, A. (2009). Mental health disparities. *American Journal of Public*

Health, *99*, 1962–1966. https://doi.org/10.2105/AJPH.2009.167346

Salkind, N. (2010). Covariate. In *Encyclopedia of Research Design*. SAGE Publications, Inc. https://doi.org/10.4135/9781412961288.n85

Samari, G., Alcalá, H. E., & Sharif, M. Z. (2018). Islamophobia, health, and public health: A systematic literature review. *American Journal of Public Health*, *108*, e1–e9. https://doi.org/10.2105/AJPH.2018.304402

Schäfer, T., & Schwarz, M. A. (2019). The Meaningfulness of Effect Sizes in Psychological Research: Differences Between Sub-Disciplines and the Impact of Potential Biases. *Frontiers in Psychology*, *10*, 813. https://doi.org/10.3389/fpsyg.2019.00813

September 11 Fast Facts. (2019). *CNN*. https://www.cnn.com/2013/07/27/us/september-11-anniversary-fast-facts/index.html

Shaheen, J. (2003). Reel Bad Arabs: How Hollywood Vilifies a People. *The Annals of the American Academy of Political and Social Science*, *588*. https://doi.org/10.1177/0002716203255400

Sheppard, G. W., Schulz, W. E., & McMahon, S. A. (2007). *Code of Ethics*. https://www.ccpa-accp.ca/wp-content/uploads/2014/10/CodeofEthics_en.pdf

Sheridan, L. P. (2006). Islamophobia Pre-and Post-September 11th, 2001. *Journal of Interpersonal Violence*, *21*(3), 317–336. https://doi.org/10.1177/0886260505282885

Shin, R. Q., Smith, L. C., Welch, J. C., & Ezeofor, I. (2016). Is Allison More Likely Than Lakisha to Receive a Callback from Counseling Professionals? A Racism Audit Study. *Counseling Psychologist*, *44*, 1187–1211. https://doi.org/10.1177/0011000016668814

Skelton, C. (2008). Lee is the most common surname in the Lower Mainland. *Vancouver Sun*. http://www.vancouversun.com/most+common+surname+Lower+Mainland/1096963/story.h

tml

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real : Anthropological and historical perspectives on the social construction of race. *American Psychologist*, *60*(1), 16–26. https://doi.org/10.1037/0003-066X.60.1.16

Statistics Canada. (2011). Immigration and Ethnocultural Diversity in Canada. In *National Household Survey*. https://www12.statcan.gc.ca/nhs-enm/2011/as-sa/99-010-x/99-010-x2011001-eng.cfm#a6

Statistics Canada. (2012). *Focus on Geography Series, 2011 Census - Census metropolitan area of Vancouver*. https://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma-eng.cfm?LANG=Eng&GK=CMA&GC=933

Statistics Canada. (2017). *Greater Vancouver A, RDA [Census subdivision], British Columbia and Canada [Country] (table). Census Profile.* https://doi.org/Statistics Canada Catalogue no. 98-316-X2016001.

Statistics Canada. (2018). *Police-reported hate crime , 2017*.

Sue, D. W., Arredondo, P., & McDavis, R. (1992). Multicultural Counseling Competencies and Standards: A Call to the Profession. *Journal of Counseling and Development*, *70*, 477–486.

Sue, D. W., Capodilupo, C. M., Torino, G. C., Bucceri, J. M., Holder, A. M. B., Nadal, K. L., & Esquilin, M. (2007). Racial microaggressions in everyday life: Implications for clinical practice. *American Psychologist*, *62*, 271–286. https://doi.org/10.1037/0003-066X.62.4.271

The Canadian Press. (2020a, April 27). Coronavirus: Almost 10K businesses apply for wage subsidy as applications open. *GlobalNews*. https://globalnews.ca/news/6871558/coronavirus-wage-subsidy-program/

The Canadian Press. (2020b, June 23). Coronavirus: CERB extension to cost $17.9B, budget

officer says. *GlobalNews*. https://globalnews.ca/news/7096481/coronavirus-cerb-extension-budget/

Top baby names in B.C. for 2018. (2018). BC Gov News. https://news.gov.bc.ca/releases/2018HLTH0118-002475

Tri-Council Policy Statement. (2018). *Chapter 3: The Consent Process*. Ethical Conduct for Research Involving Humans – TCPS 2 . http://www.pre.ethics.gc.ca/eng/tcps2-eptc2_2018_chapter3-chapitre3.html

Turcotte, M. (2011). Women in Canada: A Gender-based Statistical Report Women and Health. In *Social and Aboriginal Statistics Division Women*. Minister of Industry. https://doi.org/Catalogue no. 89-503-X

Turner, T. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. Blackwell Pub. https://psycnet.apa.org/record/1987-98657-000

Vasiliadis, H. M., Lesage, A., Adair, C., Wang, P. S., & Kessler, R. C. (2007). Do Canada and the United States Differ in Prevalence of Depression and Utilization of Services? *Psychiatric Services*, *58*(1), 63–71. https://doi.org/10.1176/ps.2007.58.1.63

Vigliotti, M. (2019, October 23). Here's How the Parties Fared in Canada's Major Cities. *IPolitics*. https://ipolitics.ca/2019/10/23/heres-how-the-parties-fared-in-canadas-major-cities/

Vuolo, M., Uggen, C., & Lageson, S. (2018). To Match or Not to Match? Statistical and Substantive Considerations in Audit Design and Analysis. In S. M. Gaddis (Ed.), *Audit Studies: Behind the Scenes with Theory, Method, and Nuance* (pp. 119–140). Springer International Publishing. https://doi.org/10.1007/978-3-319-71153-9_6

Wallace, M., Wright, B. R. E., & Hyde, A. (2014). Religious Affiliation and Hiring Discrimination in the American South. *Social Currents*, *1*, 189–207. https://doi.org/10.1177/2329496514524541

Wang, P. S., Berglund, P., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*, 603–613. https://doi.org/10.1001/archpsyc.62.6.603

Weichselbaumer, D. (2016). *Discrimination against Female Migrants Wearing Headscarves*. http://ftp.iza.org/dp10217.pdf

Widner, D., & Chicoine, S. (2011). It's All in the Name: Employment Discrimination Against Arab Americans1. *Sociological Forum*, *26*(4), 806–823. https://doi.org/10.1111/j.1573-7861.2011.01285.x

Wodtke, G. T. (2012). The Impact of Education on Intergroup Attitudes: A Multiracial Analysis. *Social Psychology Quarterly*, *75*, 80–106. https://doi.org/10.1177/0190272511430234

Woo, B. K. (2017). Comparison of Mental Health Service Utilization by Asian Americans and Non-Hispanic Whites versus Their Cardiovascular Care Utilization. *Cureus*, *9*, e1595. https://doi.org/10.7759/cureus.1595

Worthington, E. L., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. *Journal of Clinical Psychology*, *67*, 204–214. https://doi.org/10.1002/jclp.20760

Wright, B. R. E., Wallace, M., Bailey, J., & Hyde, A. (2013). Religious affiliation and hiring discrimination in New England: A field experiment. *Research in Social Stratification and Mobility*, *34*, 111–126. https://doi.org/10.1016/J.RSSM.2013.10.002

Zaal, M. (2012). Islamophobia in Classrooms, Media, and Politics. *Journal of Adolescent &*

Adult Literacy, *55*, 555–558. https://doi.org/10.1002/JAAL.00066

Appendices

Appendix A

Subject line: Counselling Availability

Hi [first name of practitioner],

My name is [Lucas/Muhammad] and I have been having trouble falling asleep lately. I would like to see someone about this. I'm wondering if you have any availabilities for this next week?

Thanks,

[Lucas Smith/Muhammad Al-Husain]

Appendix B

Subject line: No Longer Need Appointment

Hi [Practitioner's name]

Thanks for your email.

I just wanted to let you know I don't need an appointment anymore because I have been feeling better.

Thanks,

[Muhmmad Al-Hussain/ Lucas Smith]

Appendix C

Lucas		**Muhammad**	
Offering Phone Consultation	*Asking for More Information*	*Offering Phone Consultation*	*Asking for More Information*
"I can give you a phone call tomorrow if you want."	"I have an office in LA and in AB— which one is closest for you?"	"Would you like to set up a complimentary phone consult to ask questions before scheduling an appointment?"	"Due to the pandemic (COVID-19), we can consider the option of have counselling session through Telehealth (visual or audio)."
"I like to set up a brief phone call with new clients before booking a session.	"So I am able to offer you a session but before booking you in Lucas I need to have your full personal details please as follows, age, date of birth, address and post code and cell and home number."	"Would you please phone me now or anytime today to talk with me first?"	"Which location is good for you?"
"Please call me this morning after 10:30 AM"	"If you think this is due to underlying emotional difficulties then I could be of help …If this all works, please feel free to email me."	"Please give me a call at your convenience and give me some good times to reach you and the best number to call."	"which office are you interested in"
"Would you like to chat more over the phone? I can offer you a short, free phone consult"	"Let me know what you'd prefer - in person, phone or Zoom…. generally what day and time period is best and we'll go from there."	"The best way to book is to call the clinic"	"Thanks for reaching out? Would zoom or phone sessions work for you?"
"We would be happy to get a bit more information from you in regards to coming in for some counselling."	"I am happy to help, but I am only doing virtual therapy at this point in time…Please let me know if that is	"For further details, you can contact me via phone."	"In order to get started I need you to fill out the attached forms and send them back to me."

	something that you are interested in?"		
"If you would like to speak to me, I can offer you a complementary 20 minute session"	"before we could have our first video session you would have to read and sign some forms (e.g. Consent to Treatment and Additions to Consent to Treatment) as well as providing pertinent information on another form"	"am currently offering telephone counselling sessions B.C.-province-wide, and can offer you a free, no-obligation 15-minute consultation"	"Were you looking for Zoom session or face to face?"
"Would you like to schedule a 30-minute initial consultation first"	"Please let me know if you'd like to be added to the waiting list."	"Thank you for your email. Before we schedule a meeting I usually like to do a free 15 minute phone consultation"	"In order for me to schedule an appointment with you, you will need to contact intake."
	"I can put you on a cancelation list if you'd like. Please let me know."	"I would like to connect with you over the phone for about 15-20 minutes to exchange a brief overview of what to expect and how we can work together to navigate some of the challenges you might be facing."	"Thank you for your email. Can you tell me a little bit more about your difficulty falling asleep?"
	"Do you want me to put you on my waiting list"	"I can offer you a 15 min phone consultation to start with."	
	"We're you looking for an online session or in person…?	"If you would like to book a free 15 minute phone call to see if you think I could be helpful"	
		"offer 15 minutes free phone consultation so we can know each other more before booking the first appointment."	
		"Do you have time today or tomorrow for a phone consultation?"	
		"How about we chat on the phone briefly (no	

		cost) so we can discuss details and you get a chance to see if I'm a good fit for what you're looking for?"	
		"We usually find it best to book the initial visit by phone"	
		"Are you free to chat sometime this week or next briefly to go over some basic information and questions"	
		"Please let me know your availability and we can schedule a time to chat."	