Examining Cross-Cultural Counseling Competencies of Substance Abuse Counselors in the Commonwealth of Pennsylvania

Abdelhadi Elamin

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EXAMINING CROSS-CULTURAL COUNSELING COMPETENCIES OF
SUBSTANCE ABUSE COUNSELORS IN THE COMMONWEALTH OF
PENNSYLVANIA

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the degree of Doctor of Education

By
Abdelhadi Elamin

August 2012
EXAMINING CROSS-CULTURAL COUNSELING COMPETENCIES OF SUBSTANCE ABUSE COUNSELORS IN THE COMMONWEALTH OF PENNSYLVANIA

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ABSTRACT

EXAMINING CROSS-CULTURAL COUNSELING COMPETENCIES OF SUBSTANCE ABUSE COUNSELORS IN THE COMMONWEALTH OF PENNSYLVANIA

By
Abdelhadi Elamin
August 2012

Dissertation supervised by David Delmonico, PhD

With minority Americans expected to comprise more than 40% of the U.S population by 2035 and 47% by 2050 and substance abuse epidemic with 23.5 million nationwide in need for treatment, there is a growing need for cross-cultural counseling competence among substance abuse counselors. This study examined substance abuse counselors’ level of cross-cultural counseling competence in the Commonwealth of Pennsylvania. The research method used was quantitative in nature. Substance abuse counselors were asked to self-assess their level of competence by completing a questionnaire and modified Cross-Cultural Counseling Inventory Revised (CCCI–R) subscales to determine whether counselor’s gender, level of education, field of study, ethnicity, and number of continuing education make a difference in level of cultural competence. CCCI–R was proven to have acceptable content validity and is
representative of domain of cross-cultural counseling competence. A total of 109 participants completed the questionnaire and CCCI-R.

The result of a one-way ANOVA in the mean scores revealed no significant difference between counselor’s gender, level of education, field of study, ethnicity, and cultural competence. The post hoc data analysis in the field of study indicated those counselors who were trained in Counseling and Social Work scored higher than counselors trained in Psychology. The results of the Pearson Correlation revealed no relationship between the number of continuing education hours and substance abuse counselor’s level of cross-cultural counseling competence. After the testing of hypotheses of this study, the results indicated no significant differences in the mean scores of the independent variables and substance abuse counselor’s level of cross-cultural competence.

The limitations include the fact that caution should be used in generalizing the results due to the low response rate and the results should be interpreted as representative of all substance abuse counselors in Pennsylvania. Another major limitation was substance abuse counselors may have inflated their rating in a desirable way. Thus, it is imperative to use the Social Desirability Index along with the CCCI-R. Further research is needed with a larger number of participants to identify the incongruity of existing practice, curriculum, and methods used in training of the development of cross-cultural counseling competence.
DEDICATION

I dedicate this dissertation to my wife and children Rashed, Israa, and Ehdaa for their patience. I am forever grateful to my brothers and sisters for their endless support with special thanks to my brother Abdelmunim for his confidence and his faith in me to take on this challenge. My gratitude to Almighty Allah (Subhanawthala) for giving me the strength and the determination to accomplish this mission.
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CHAPTER I
INTRODUCTION

Over the last three decades, professional counseling associations have put tremendous effort into addressing cross-cultural and multicultural counseling competencies. This effort has been motivated by the increased numbers of diverse ethnic groups, other socially and culturally diverse populations, and the upsurge of immigrants pursuing counseling for substance abuse issues.

Sue (1998) referred to cultural competency as one of the most discussed issues among scholars and counselors interested in ethnic minorities and diversity. Sue stated that the enthusiasm to establish guidelines was attributed to the increasing number of diverse groups in U.S. society along with the growing recognition that counselors must be cross-culturally competent to work effectively. Abreu, Gim-Chung, and Atkinson (2000) noted that the American Psychological Association (APA) addressed the need for cultural diversity in training for psychologists at The Vail National Conference in 1973. APA defined cultural diversity as a premise of ethical practice and recommended that the issues of cultural diversity need to be addressed in education and training of psychologists. The acknowledgment of the need for cultural diversity prompted the establishment of the Office of Minority Affairs in 1979, the Board of Ethnic Minority Affairs in 1981, and the Division of Ethnic Minority Affairs in 1986. Abreu et al. noted that, as a result, mandates endorsing Multicultural Counseling Training (MCT) have been codified in APA’s Accreditation Handbook, which highlights the need to prepare mental health practitioners to work effectively with diverse populations. Shortly thereafter, the Council for Accreditation of Counseling and Related Educational Programs (CACREP)
mandated that all counseling programs recognized by CACREP need to address cultural diversity in their clinical training (Abreu et al., 2000).

**Demographic Trends in the Commonwealth of Pennsylvania**

In the last decade, the United States has continued to become more culturally diverse due in part to demographic changes. The state of Pennsylvania has experienced similar changes resulting from diverse ethnic groups who fled their native countries for a variety of reasons. Aponte and Wohl (2000) noted the change in census data over the last several decades revealed significant changes in the number and distribution of culturally diverse populations, changes in immigration and migration patterns, and changes in ethnic group population characteristics. Brach and Fraserirector (2000) reported that minority Americans are expected to comprise more than 40% of the U.S. population by 2035, and 47% by 2050. The surge in the minority population comprises a major challenge for the healthcare system and the counseling profession.

The Pennsylvania Office of Mental Health and Substance Abuse Services’ Strategic Plan Committee for Cultural Competence (2002–2004) confirmed the increase in ethnic minority populations between 1980 and 1990 and stated,

The Caucasian population in Pennsylvania showed little growth, increasing by just one percent. However, the ethnic Asian and Pacific Islander populations increased by 114%, Native Americans by 56% and African Americans by four times the rate of the Caucasian population. (p. 4)

This rapid increase in ethnic minorities in Pennsylvania has impacted the delivery of behavioral healthcare services. The Pennsylvania Office of Mental Health and Substance Abuse Services Strategic Plan for Cultural Competence also pointed out that empirical
research conducted in the past 25 years revealed the central impact of culture on behavioral healthcare. The plan indicated that misconstrued cultural aspects in treatment delivery and design contributed to the negative outcome to the recovery of consumers. To mention a few biases, the Strategic Plan for Cultural Competence (2002–2004) noted existing evidence of cultural insensitivity in diagnostic assessment instruments, specific techniques based on Eurocentric values are frequently applied regardless of their cultural appropriateness to the client, treatment procedures are not designed according to cultural distinctions and ethnic groupings, and other patterns of persisting racial and ethnic differences in utilization of services.

Multicultural Counseling Competency in Counselor Education

Little information in the literature comprehensively discusses the intersection of race, ethnicity, gender, and social class in counselor education. Currently, most counselor training programs neglect to teach students counseling skills relevant to race, gender, and ethnicity. Constantine (2002) noted that many counselor educators and counselors frequently have tended to compartmentalize these issues without considering the scope and salience of their potential interaction in counseling. Constantine stated that this phenomenon may be true of counselors whose training programs may have neglected to pay attention to multicultural issues. Ponterotto and Casas (1987) researched multicultural competence in counselor education programs and concluded that the profession as a whole has failed to meet successfully the needs of racial and ethnic minorities. Ponterotto and Casas also noted that other researchers in cross-cultural counseling validated the widespread ineffectiveness of Eurocentric traditional counseling approaches with culturally different and ethnically diverse clients.
Abreu et al. (2000) supported the Ponterotto and Casas (1987) findings and confirmed that the use of treatment approaches designed for the Eurocentric population with individuals from other cultural backgrounds represents failure to acknowledge diversity. Abreu et al. stated that the difficulty in using existing counseling techniques with ethnic minority clients have been attributed to the pathology of the clients rather than to the reliability of the counseling techniques. D’Andrea and Arredondo (2002) stressed the need for multicultural counseling competency among professional counselors and supported the report published by former U.S. Surgeon General David Satcher in 2001, *Mental Health: Culture, Race and Ethnicity*. The report implied that the substance abuse care system in the U.S. is failing to satisfy the psychological needs of ethnic and racial minorities. Campbell and Alexander (2002) evaluated the experience of minority groups in substance abuse treatment and concluded that racial minorities are less likely to seek and complete treatment, receive fewer services, and are unlikely to achieve recovery. These results are attributed to the lack of effective, culturally competent care. Stanhope, Solomon, Pernell-Arnold, Sands, and Bourjolly (2005) evaluated cultural competence among behavioral health professionals. Stanhope et al. noted the lack of cultural competence among mental health professionals and claimed that research has been unsuccessful in verifying the effectiveness of classic Eurocentric interventions for diverse racial, ethnic populations.

**Substance Abuse Among Gay, Lesbian, and Bisexual Population**

Matthews, Selvidge, and Fisher (2005) conducted a study with addictions counselors to determine issues that predict affirmative attitudes and behaviors towards substance abuse among the gay, lesbian, and bisexual (GLB) population. Matthews et al.
noted that despite the difficulty in determining the prevalence of addiction in GLB populations from previous studies, the rates of alcoholism among the lesbian and gay population is 30% higher than in the general population. Matthews et al. stressed the importance of recognizing the unique needs of gay men and lesbians who are at higher risk of abusing alcohol and drugs than their heterosexual counterparts. Furthermore, Matthews et al. asserted that most recent studies revealed the lack of effectiveness of traditional substance abuse treatment programs with GLB populations and the reluctance of GLB populations to using them. Matthews et al. also alluded to previous studies of government-funded treatment facilities in New York City and noted that participants confirmed the lack of information and insufficient training in working with the GLB population.

Bidel, Turner, and Casas (2002) evaluated the type and amount of application materials used to recruit lesbian, gay, bisexual, and/or ethnic minority students into professional psychology training programs. The study revealed the absence of multicultural and diversity issues in psychology programs and raised concerns regarding counseling educators’ and researchers’ cross-cultural level of competency and ability to provide services to gay, lesbian, bisexual and transgender (GLBT) populations. Kocarek and Pelling (2003) stated that despite the progress made in multicultural and cross-cultural counseling competence, training in GLB issues continues to be neglected in the face of a growing GLB population seeking professional help for substance abuse and mental health issues. Bridges, Selvidge, and Matthews (2003) stressed the need for mental health professionals to be aware of issues of lesbian women of color and stated, “Unfortunately, theoretical models that incorporate an understanding of sexual
orientation and the development of sexual identities have not been well integrated into
the research, training, or practice of therapy” (p. 122). Finnegan and McNally (2005)
concluded that substance abuse counselors are often unfamiliar with GLBT cultures and
lack information that would help them understand and become culturally competent in
counseling the GLBT population.

**Substance Abuse Among Immigrants and Refugees**

Immigration to the United States from developing countries has risen in the late
20th century as a result of political and economic instability, civil wars, and genocide.
Such experiences have placed these immigrants and refugees at a higher risk for mental
health issues and substance abuse. The most recent United States census issued by the
Committee for Refugees in 2000 revealed an estimation of 14 million refugees
worldwide, an increase of 600,000 from the preceding year. Miller, Worthington,
Muzurovic, Tipping, and Goldman (2002) conducted a study of Bosnian refugees in the
Chicago area to examine exile-related stressors. The study discussed the emphasis of
previous mental health research on the assessment of psychiatric symptomatology
through the use of symptom checklists and structured clinical interviews. These tools
have limited use when assessing refugees whose life experiences include exile. Miller et
al. asserted that most of these refugees fled situations of extreme violence that inflicted
physical and psychological scars. In addition, traumatic events prior to exile often
produce post-traumatic stress disorder. The migration of these refugees to the U.S. raises
concerns about counselors’ cultural competency and ability to provide appropriate
interventions. Most recently, Leow, Goldstien, and McGlinchy (2007) conducted a
literature review on immigration, acculturation, and substance abuse. Leow et al. noted
that immigrants and refugees are more likely to experience health deterioration due to alcohol and drug abuse.

**Substance Abuse and Ethnic Minorities in the Criminal Justice System**

High unemployment rates and poor socioeconomic status among minorities have contributed to their involvement in drug related criminal activities and incarceration. Williams (2006) noted that between 1980 and 1992 commitments to state prisons have increased by 155%. While violent offenders account for 16%, the remaining 84% were incarcerated for drug related, property, and public order offenses. Williams argued that chemical dependency has been directly correlated to high unemployment and noted that there was strong evidence that link chronic drug use and the propensity to commit crime. Despite the high correlation, treatment for chemically dependent minorities is not readily available to minorities because the assessment of their situations too often made by practitioners who lack proper training.

Primm, Osher, and Gomez (2005) reviewed a report issued by the Substance Abuse and Mental Health Services Administration (SAMHSA). Primm et al. stated that 61% of individuals in the criminal justice system with co-occurring serious mental health and substance use disorders were not perceived to have need of treatment and had not received treatment for either illness. Only 34% had received mental health treatment. The data emphasized the need for competent screening, assessment tools, and mental health/substance abuse treatment programs for inmates in the criminal justice system. Primm et al. pointed to recent reports from the Institute of Medicine and the U.S. Surgeon General (Institute of Medicine, 2002; U.S. Department of Health and Human Services, 2001) emphasizing the difficulty for people of color to access behavioral health services.
in community mental health agencies due to the agencies’ reluctance to serve persons
who have been involved with the criminal justice system in addition to lack of cultural
competencies among the staff of community mental health agencies.

Primm et al. (2005) conducted a research on racial disparities in the criminal
justice system. Primm et al. noted that although in 2000 non-Whites represented a
minority with 25% of the general U.S. population, non-Whites constituted the majority of
incarcerated individuals with 62% in the U.S. prison system and 57% in the jailed
population. The racial breakdown of incarcerated ethnic minorities included: 46%
African American, 16% Hispanic, 1% American Indian, and 1% Asian American. With
regard to substance use among inmates, Primm et al. stated that in 1998, 70% of non-
White jailed inmates had been convicted of a drug offense or had used drugs. Forty
percent of the non-White inmates reported that they used alcohol and 20% used drugs at
the time of their offense. Overall, two-thirds of the non-White inmate population was
involved with drugs prior to incarceration. Williams (2006) conducted research on racial,
cultural, and sociopolitical disparities in mental health and substance abuse. He
concluded that the rate for incarceration in state prisons for drug use arrests has risen
dramatically in the 20th century.

Yet the availability of treatment for chemical dependency is not readily available
to minorities because the assessment of their condition was all too often made by
a practitioner who may lack the training to understand, much less accept all the
elements of their conditions. (p. 68)

Narconon Arrowhead (2007) reported that the 2004 national survey on drug use
and health’s substance abuse statistics estimated that 23.5 million needed treatment for
drug and alcohol addiction. Narconon Arrowhead stated that, The Center for Substance Abuse Treatment (CSAT; 2002) reported 80% of the women offenders in state prison systems have long and intensive histories of substance dependence with 63% women from ethnic minorities. Many of these women have been incarcerated for drug offenses and crimes committed to support their drug and alcohol habits.

In a study on race, ethnicity, mental health services, and cultural competence in the criminal justice system, Primm et al. (2005) stated that in 2003, 6.9 million adults in the U.S. were incarcerated, on probation, or out on parole with 62% being non-White. The authors stated that approximately 15% of prison and jail populations have active symptoms of serious mental health issues with two-thirds likely to have co-occurring substance use disorders. With respect to the racial disparities in the criminal justice system, Primm et al. (2005) noted that ethnic minorities represented a 62% majority of the incarcerated population in prisons and 52% in the jails. These high rates were attributed to the War on Drugs and Three Strikes You’re Out policies implemented in 1980. Furthermore, Primm et al. noted that the different mandatory sentencing guidelines for crack cocaine versus powder cocaine are often viewed as an example of policy reflecting racial bias rather than public safety/public health concerns. Primm et al. noted that although the American Psychiatric Association and the American Association of Community Psychiatrists have provided guidelines and position statements for psychiatric services in jail and prison, the correctional facilities continue to lack appropriate psychiatric and substance abuse services.
Statement of the Problem

In the last decade, the United States has continued to become a culturally diverse society. Substance abuse continues to pose challenges to the counseling profession, particularly to substance abuse treatment providers. D’Andrea, Daniels, and Heck (1991) acknowledged that demographic changes in the United States present many new challenges to counselor-educators and the counseling field. D’Andrea et al. stated,

In conjunction with this awareness is an increasing recognition within the professional ranks that many of the existing psychological and counseling training paradigms simply do not accurately or adequately address the mental health needs of many persons from different cultural backgrounds. (p. 143)

Pope-Davis, Reynolds, Dings, and Nielson (1995) concluded, “graduate programs in psychology have failed to prepare trainees for effective practice with clientele from culturally diverse populations” (p. 323). Sue (1998) stressed the need for cultural competency in psychotherapy and counseling and highlighted the growing recognition that effective counselors must be cross-culturally competent in order to deal with the evolving multicultural and diverse nature of the U.S. society.

According to Keller and Dermatis (1999), most recent statistics estimated that more than 20 million Americans have been diagnosed with alcohol and/or drug dependence. Reid (2000) reported 16% of African Americans are alcoholics and 32% have used illicit drugs. According to the most recent statistics in Pennsylvania, 27% of people admitted to drug and alcohol treatment were African Americans (www.drug-rehabs.org/Pennsylvania-Pittsburgh-drug-rehab-treatment.htm). Scheyett, Kim, and Sangalang (1990-2000) conducted a review of the current literature on providers’ views
and attitudes towards substance abuse and substance abusers. Scheyett et al. noted that substance abuse provokes complicated reactions that consist of stigma and rejection due to lack of awareness and understanding of substance abuse and addiction. Consequently, substance abuse remains undetected and untreated. In addition, the authors noted that substance abuse counselors, just as members of society, are more likely to be unaware of their biases and attitudes, which may result in significant barriers in the counseling process. Constantine, Melinoff, Barakett, Torino, and Warren (2004) stated that even though enormous progress has been made in the area of multicultural counseling competence, various conceptual and operational difficulties continue to exist. For instance, the definition of the term *multicultural* remains broad with little consensus; experts in the multicultural counseling arena have yet to agree on specific variables that ought to be included when defining the term multicultural. For the purpose of this study, the operational definition of multicultural counseling competence is defined as counselors’ attitudes/beliefs, knowledge, and skills in working with individuals from a variety of culturally diverse groups that include race, ethnicity, gender, social class, and sexual orientation (Constantine & Ladany, 2000).

**Purpose of the Study**

The purpose of this study is to assess the substance abuse counselors’ cross-cultural competency (awareness/attitude, knowledge and skills). The Cross-Cultural Counseling Inventory–Revised (CCCI–R) was used to assess the level of cultural competency in relationship to the counselor’s level of education, field of study/specialty, number of trainings received, and counselor’s ethnicity. Considering the fact that substance abuse counselors come from different disciplines, the assessment of their
awareness, knowledge, and skills would provide helpful suggestions for implementing future multicultural education and diversity trainings.

Keller and Dermatis (1999) noted that despite the enormous strides made with regard to the standards for credentialing addiction counselors, current training protocols may vary between states and national counselor organizations because consensus as to a national standards for addiction counseling competencies has not been reached. Keller and Dermatis added that even though the federal initiatives sponsored by SAMHSA have had an impact on counselor training programs, limitations still exist in the formal training curricula: lack of sufficient exposure to empirically tested psychosocial interventions, and lack of training with dual diagnosed and other special populations. Holcomb-McCoy and Myers (1999) stated that American society today is more multicultural and expected to be more diverse in the near future. Holcomb-McCoy and Myers asserted, “Dramatic changes in the ethnic composition of the United States have had a significant impact not only on the counseling process, but also on the dynamics of the counselor/client relationship” (p. 294). By increasing counselors’ awareness, skills, and knowledge of the role of cultural factors (ethnicity, race, gender, age, socioeconomic, sociopolitical, sexual orientation) in personality development, culturally competent substance abuse counselors would be able to incorporate the client’s culture and have better understanding of the presenting problems. The advantages of competent substance abuse counselors would result in achieving a high level of racial and cultural awareness; understanding clients’ worldview, beliefs, cultural values, socioeconomic and sociopolitical experience; and incorporating their effects on case conceptualization and treatment planning. Substance
abuse counselors would be able to use intervention strategies that are sensitive to factors such as cultural traditions and spiritual beliefs.

Center for Substance Abuse Research (CESAR, 2007) alluded to the recent report commissioned by the Substance Abuse and Mental Health Administration. The report noted overwhelming evidence that the behavioral health workforce is ill equipped in skills and numbers to respond adequately to the changing needs of the American populations. Most importantly, the report noted that employers of behavioral health care described recent graduates of professional training programs as unprepared, having to unlearn an array of attitudes and assumptions, and that current professional education has failed to provide substantive training in evidence-based practice.

Eliason (2000) surveyed 242 substance abuse counselors to evaluate their attitudes toward Gay, Lesbians, Bisexuals, and Transgender (GLBT) clients. The study revealed that substance abuse counselors have very little formal education regarding GLBT clients. One of the most alarming findings was that half of the respondents had negative attitudes concerning GLBT clients. Regarding gender-variant clients, Carroll, Gilroy, and Ryan (2002) asserted that professional counselors were neither informed nor skilled to work with transgender and transsexual clients. Kocarek and Pelling (2003) stated that despite the progress that has been made in multicultural counseling with respect to gay, lesbian, and bisexual issues, little progress has been made with regard to counselors’ skill building. Kocarek and Pelling concluded that more investigation is needed to assist counselors to become culturally competent and knowledgeable regarding the GLB population. Sodowsky, Taffe, Gutkin, and Wise (1994) conducted two studies in the development of Multicultural Counseling Inventory (MCI) to assess multicultural
counseling competencies among psychology students and university counselors.

Sodowsky et al. noted that despite the variety of treatment approaches, there is no particular mainstream approach to treat all the forms of human difficulties. In addition, there is no particular approach to counsel the diverse racial ethnic minorities and people of foreign origin in the United States. Sodowsky et al. asserted that diverse populations, refugees, and immigrants were more likely to be challenged by cognitive, emotional, and behavioral problems specific to their respective cultures and socioeconomic status. Sodowsky et al. suggested that the significant construct that brings about the counselors’ cross-cultural counseling competency is measured by the counselors’ levels of awareness of their own ethnicity, race, culture, language, and recognition of the impact of those variables on the counseling process.

Pope-Davis and Ottavi (1994) conducted a national survey with a sample of 220 counselors. Of the 220 participants, 169 were White, 26 African American, 15 Asian American, and 10 Hispanic. The authors examined the association between self-reported multicultural counseling competencies and demographic variables among counselors. The instrument used in the study was the Multicultural Counseling Inventory (MCI) to measure for counselor’s skills, knowledge, awareness, and the relationship with client. Pope-Davis and Ottavi suggested that ethnicity was the only demographic variable associated with differences in the self-report of multicultural counseling competencies and stated that Asian American and Hispanic counselors reported more multicultural counseling knowledge than did White counselors. African American, Asian American, and Hispanic counselors reported more competence in multicultural awareness and relationships with clients than White counselors.
Pope-Davis, Reynolds, Dings, and Ottavi (1994) concluded that the graduate programs in psychology have fallen short in preparing trainees to work with culturally diverse populations despite the additional curricular and recruitment efforts that have been made to integrate a variety of rationales for cross-cultural counseling competencies into curricula and counselor training. The authors reviewed previous research on multicultural competencies and determined that many psychologists have expressed concerns about the scarcity of people of color entering the counseling profession. Stanhope et al. (2005) evaluated cultural competence among behavioral health professionals and concluded that research has frequently failed to establish the effectiveness of interventions for diverse racial, ethnic, and cultural populations.

Refugees are a particularly vulnerable population and at risk for trauma and psychological distress. Tribe (2002) reviewed several studies on immigrants and refugees and reported that the strongest and most influential factors for psychological health problems that immigrants and refugees experience are separation from family, severe traumatic experience prior to exile, and a hostile host community. Tribe asserted that these factors have contributed to alcohol and drug abuse among immigrants and refugees and that behavioral health professionals often overlook these problems.

Thus, the previous information on the lack of cultural counseling competency among substance abuse counselors substantiates the need for behavioral health professionals to acquire cross-cultural competence. The examination of cross-cultural counseling competencies of substance abuse counselors in the Commonwealth of Pennsylvania is vital given the increased number of diverse populations pursuing
counseling for substance abuse due to legal, socioeconomic problems, sociopolitical conflicts, and sexual and gender identity issues.

**Significance of the Study**

Eurocentric practices continue to be the standard methods in counseling regardless of the diversity in the U.S. and the counseling profession’s efforts to embrace multiculturalism and cultural diversity. Brach and Fraser (2000) noted that the minority American populations are expected to increase by 47% by 2035. This demographic change of the U.S. landscape is posing a challenge to the counseling profession. The Office of Substance Abuse (OSAS, 2003) conducted literature reviews for substance abuse professionals and noted that despite the growing need for substance abuse services, traditional treatment approaches have failed to serve the African American population effectively due to the lack of cultural competency among counselors. Such failure is evidenced by the difficulty in recruiting and retaining minority clients in treatment. Keller and Dermatis (1999) argued that substance abuse education and training must improve considerably and noted that addiction education for counselors and other health care professionals is inadequate.

The Pennsylvania Office of Mental Health and Substance Abuse Services (OPMHSAS) *Strategic Plan for Cultural Competence* reported that implementation of cultural competence in the state and local mental health systems rests on a weak foundation. The report noted that there is a tendency to view cultural competency as an activity, such as an appreciation of symbols and festivals rather than a developmental process that must occur on both the corporate and individual levels. Only 22% of states have focused on cultural competency by conducting research and evaluation. Forty
percent of states have completed an assessment of their cultural status or needs. Only 22% of states have included cultural competence criteria in certification standards. Ohio, New York, California, and Massachusetts’ mental health systems have identified performance measures to evaluate and improve the overall level of cultural competence in their systems of care. Based on this information, the OPMHSAS has yet to identify performance measures regarding cultural competence. Pennsylvania Certification Board’s (PCB) Code of Ethical Conduct does not specifically include cultural competence measurement. On the other hand, OPMHSAS requires “6-hour” training on multicultural counseling for certification once every two years. This raises concerns regarding the cultural counseling competence of substance abuse professionals in Pennsylvania. In contrast, the National Association of Social Workers (NASW, 2001) has developed standards for cultural competence, which state that social workers shall advocate for and participate in educational and training programs that help advance cultural competence within the profession.

Historical disparities in both access and service delivery for persons from different ethnic and cultural groups was noted by the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) Strategic Plan for Cultural Competence. The plan emphasized the need for cultural competency and the incorporation of cultural competence into all levels of its system, expanding cultural knowledge, skills, and the adaptation of services to better address the unique needs of a diverse population in order to grant availability and access to services.

In order to provide quality treatment, substance abuse counselors must possess knowledge, awareness of personal attitude, and the skills to work with diverse cultural
issues. Patterson (2004) supported the need for multicultural counseling competencies, and acknowledged the fact that everyone is a multicultural being despite race, ethnicity, gender, age, or sexual preference. According to the Center for Substance Abuse Treatment report published by SAMHSA in 2002, most inmates who have histories with substance abuse are stipulated by probation and parole to pursue counseling. Thus, substance abuse counselors are called upon to acquire cross-cultural counseling competency in order to be able to conceptualize the clients’ presenting issues and problems in the context of their culture and belief systems and develop appropriate treatment intervention.

Constantine et al. (2004) noted that in spite of the progress made by multiculturalism in the field of applied psychology, little consensus about the definition of the term *multicultural* and the specific components of multicultural counseling competence have been accomplished. In addition, criticism has been directed toward the lack of empirical validation for some of the existing models and training interventions in multicultural counseling. The participant scholars claimed that the challenge of being a cross-culturally competent psychologist was related to colleagues’ and institutional resistance and lack of support for multicultural issues.

**Research Questions**

This study intends to measure cross-cultural counseling competencies among substance abuse counselors. The broad question is, are substance abuse counselors competent to counsel culturally diverse populations?
This study intends to assess substance abuse counselors’ level of cross-cultural competency based on counselors’ gender, level of education, field of study, ethnicity, and number of continuing education hours received in cross-cultural competency.

1. Does gender contribute to cross-cultural counseling competency?
2. Does level of education contribute to cross-cultural counseling competency?
3. Does field of study relate to cross-cultural counseling competency?
4. Does the number of continuing education hours on cross-cultural counseling impact cross-cultural counseling competency?
5. Does ethnicity influence substance abuse counselor’s cross-cultural counseling competency?

**Hypotheses**

1. There is a significant difference between male and female substance abuse counselors’ levels of cross-cultural counseling competency as measured by the CCCI–R.
2. There is a significant difference of the mean score on the CCCI–R subscales based on the substance abuse counselor’s level of education as measured by the CCCI–R.
3. There is a significant difference of the mean score on CCCI–R subscales based on substance abuse counselor’s field of study and level of cross-cultural counseling competency as measured by the CCCI–R.
4. There is a statistically significant difference of the mean score on the CCCI–R subscales based on the substance abuse counselor’s ethnicity and level of cross-cultural counseling competency as measured by CCCI–R.
5. There is a positive correlation between the numbers of continuing education hours in cross-cultural counseling a substance abuse counselor has attended and the level of cross-cultural counseling competency as measured by the CCCI–R.

**Definition of Terms**

The following definitions are provided to clarify terms that were used throughout this study and to assist the reader in understanding their context as they relate to this study.

*Cross-culture, multiculturalism and cultural diversity.* For the purpose of this study, these terms are used interchangeably to include aspects of identity stemming from gender, sexual orientation, disability, socioeconomic status, race, ethnicity, age and country of origin.

*Cultural competency.* For the purpose of this study cultural competency refers to the combination of congruent behaviors, knowledge, and understanding of different cultures in addition to the skills and ability of a substance abuse counselor to work effectively with individuals from different ethnic groups, ages, races, sexual orientation, socioeconomic status and country of origin.

*Substance abuse counselors.* For the purpose of this study, substance abuse counselor is defined as any professional including certified addiction counselors, social workers, mental health counselors, psychologists, and psychiatrists who provide direct services to individuals diagnosed with substance abuse or dependence.
Limitations of the Study

The use of the Cross-Cultural Counseling Inventory–Revised (CCCI–R) as the single tool to assess for cross-cultural competency among substance abuse counselors poses concerns regarding the validity of the collected data. The alteration from secondary report to self-report made for this study may affect the construct and criterion-related validity of the CCCI–R since the instrument was mainly developed for supervisors to evaluate their trainees’ multicultural counseling competency levels (Constantine, 2001). Constantine and Ladany (2000) noted that self-report multicultural counseling competence scales have been criticized for measuring anticipated rather than actual behavior or attitude associated with cultural competence. The scales are prone to social desirability, lack uniformity regarding the constructs they actually assess, and, most importantly, their theoretical foundations often do not match the philosophical orientations of many training curricula, making it difficult to obtain accurate assessment of multicultural competence (Constantine & Ladany, 2000).

Constantine (2002) reported the use of the CCCI–R to the exclusion of other methods may inflate the counselors’ perceived level of cross-cultural counseling competence. Moreover, the social desirability of cultural competence could affect the level of objectivity and impact the outcome of the study. With respect to the quantitative nature of this study, Taylor (2000) identified the limitation of quantitative research methods and noted that complete control and objectivity cannot be successfully achieved in behavioral sciences. Furthermore, the data gathering instruments used in quantitative studies do not often answer all of the questions posed by the researchers.
Summary

Chapter 1 provided an introduction and an overview of the challenges facing the counseling profession as well as substance abuse counselors. A brief review of the literature and supportive evidence for this study were provided. Keller and Dermatis (1999) noted that although enormous strides have been made in systemic addictions education and training, addiction counselors as well as other health professionals remain inadequately trained in cultural issues. The review of the literature has indicated that substance abuse counselor training across the spectrum has been inadequate. Previous studies on multicultural training and counselor education programs were discussed substantiating the need for cross-cultural competence for substance abuse counselors. Statistical data on LGBT, geriatric, criminal justice, and Immigrants/Refugees populations in the U.S. and the Commonwealth of Pennsylvania demonstrate the increasing need for cross-cultural counseling competencies among substance abuse counselors in the Commonwealth of Pennsylvania. Information on the CCCI–R was provided. The use of the instrument by the participants to self-report their attitudes, knowledge, and counseling skills level of cultural competency was provided (Stanhope et al., 2005). The research questions, hypotheses, and limitations were stated.
CHAPTER II

REVIEW OF THE LITERATURE

This chapter provides a review of past and current literature on multicultural and cross-cultural counseling competency in the counseling profession. This review reveals the increase of ethnic and culturally diverse populations in the U.S. posing challenges and the emerging need for culturally competent counselors. Assessments of multicultural training in psychology and counseling programs were discussed. Past and current research outcomes on substance abuse treatment are provided. This chapter looks at literature examining disparities in the availability, access, and quality of substance abuse and mental health care services for ethnic minorities; immigrants and refugees; gay, lesbian, bisexual, and transgendered individuals; and geriatric populations. The need for cultural competence of the substance abuse counselors is discussed.

The counseling profession as a whole is becoming increasingly aware of the role of cultural factors such as race, ethnicity, gender, sexual orientation, age, and socioeconomic/sociopolitical status in personality development and functioning. Ponterotto and Casas (1987) pointed out that results of past assessments of multicultural training in counselor education programs have failed to effectively prepare counselors to meet the needs of ethnic and culturally diverse populations. Ponterotto and Casas attributed these findings to multicultural insensitivity in training programs’ curricula, stating,

More specifically, from the perspective of sensitivity, in most traditional training programs the existence of racial and ethnic minorities is totally ignored, or it is
ethnocentrically assumed that the materials taught in the curricula are equally applicable to all groups, including racial and ethnic minorities. (p. 432)

With respect to competency, Ponterotto and Casas noted that most multicultural sensitive programs struggled to define multicultural competence in reference to the curricula. The counseling profession has been inconsistent in the definition of cultural competency. The inconsistency is evidenced by the difference in the standards and requirements for cultural competency between Pennsylvania Certification Board (PCB) Professional Standards and the National Association of Social Workers (NASW) Standards for Cultural Competence (2001). Fuertes, Bartolomeo, and Nicholas (2001) agreed that one of the most important developments of the recent cross-cultural research has been the identification and definition of multicultural counseling competencies. Multicultural competencies have been developed to ensure counselors’ abilities to attend effectively to the role of cultural issues in clients’ lives in the counseling process. Fuertes et al. also noted that multicultural competencies focus on counselors’ attitudes, knowledge, and skills. Attitudes include counselors’ racial and cultural self-awareness including their understanding of racially or culturally based beliefs and attitudes about self and others. Secondly, counselors’ understanding and knowledge of clients’ worldviews, beliefs, cultural values, and sociopolitical experiences enhance case conceptualization. Third, competency includes counselors’ skills and abilities to implement treatment interventions that are sensitive to clients’ cultural issues.

Despite the lack of any previous models, some programs recognized the need to provide their students with knowledge and skills related to racial and ethnic minorities. LaFromboise, Coleman, and Hernandez (1991) shared their research findings and pointed
out that psychologists need to be well prepared and competent in order to effectively serve the increasing number of ethnic minorities in the United States. Mio and Morris (1990) asserted that despite the APA support for the inclusion of cross-cultural training in accredited clinical programs, the implementation for such trainings has been slow due to possible resistance based on the framework of majority culture identity models. LaFromboise et al. (1991) stressed the enormous need for psychologists to be well equipped to serve effectively the growing population of ethnic minorities in United States. Such need inspired LaFromboise et al. to revise the development and factor structure of the CCCI with the intention to assess mental health clinicians’ competencies in the areas of beliefs, attitudes, knowledge, and skills.

**Prevalence of Substance Abuse in the U.S.**

The rising epidemic of substance abuse in the U.S. was discussed in the 2004 national survey on drug use and substance abuse (Narconon Arrowhead, 2007). The statistical findings estimated 23.5 million people nationwide needed treatment for drug and alcohol addiction. The Department of Mental Health, Mental Retardation and Substance Abuse Services (OSAS, 2003) reported 35% of people admitted to treatment for alcohol abuse were African American and 28% of individuals admitted to treatment for cocaine were African American, whereas 19% of people admitted to treatment for marijuana were African American. Although African American males made up to 12% of the general population in 1999, it was noted that Black males represented 23% of all admissions to publicly funded substance abuse treatment facilities. Furthermore, the report noted, more than 40% of the nation’s prison population consisted of Black males with 60% of these males incarcerated for drug-related charges.
The Center for Substance Abuse Treatment (CSAT, 2002) reported that 80% of women offenders in state prison systems have long and intensive histories of substance dependence and abuse. Women of color incarcerated in U.S. prisons have increased seven times more than White women. During the last decade, the number of women of color incarcerated for drug-related offenses has increased by 828% from 1986 to 1991 (p. 4). The increased number of ethnic minorities in the criminal justice system due to substance abuse related crimes has generated a huge volume of referrals for treatment. Primm et al. (2005) conducted research on racial disparities in the criminal justice system. They reported that non-Whites represented a 25% minority in the general U.S. population, yet they comprised a 62% majority in the prison system and were 57% of the jails’ population. The racial breakdown of incarcerated ethnic minorities is 46% African American, 16% Hispanic, 1% American Indian, and 1% Asian American. With regard to substance use among inmates, Primm et al. stated that in 1998, 70% of jail inmates had been convicted of a drug offense or had used drugs. Forty percent of inmates reported using alcohol and 20% used drugs at the time of their offense with an overall two-thirds of the inmate population involved with drugs prior to incarceration.

Williams’ (2006) research on racial, cultural, and sociopolitical disparities in mental health and substance abuse concluded that the rate for incarceration in state prisons for drug use arrests has risen drastically in the 20th century. Williams stated, Yet the availability of treatment for chemical dependency is not readily available to minorities because the assessment of their condition is all too often made by a practitioner who may lack the training to understand, much less accept all the elements of their conditions. (p. 68)
The outcome of the Primm et al. and Williams’ research supports the increasing need for cultural competency of substance abuse counselors.

**Substance Abuse and Multicultural Competency**

Despite the urgent call for professionals in the addiction-counseling field to pursue cultural competency, substance abuse counselors have fallen short in acquiring cultural competency. Campbell and Alexander (2002) reviewed the literature and noted that professionals in the substance abuse field have endorsed the requirement of culturally competent treatment programs as effective policy to address disparities in diverse populations. Nevertheless, Campbell and Alexander stated that minorities are less likely to seek treatment for substance abuse or complete treatment and achieve recovery due the lack of cultural competency among the behavioral health providers. The experience of minorities in substance abuse treatment has provoked serious concerns regarding staff training and development as well as concerns for large-scale empirical investigations to assess the effectiveness of culturally competent treatment versus mainstream modalities. Fuertes et al. (2001) indicated the growing awareness and need among mental health professionals to acquire cross-cultural counseling competency and stated that professionals and scholars in mental health fields have grown increasingly aware of the role of cultural factors such as race, ethnicity, gender, religion, and sexual orientation. Campbell and Alexander (2002) noted that the standard approach to delivering health services does not fit the increasingly racially and ethnically diverse populations in the United States. Campbell and Alexander stated, “Professionals in the field of substance abuse treatment have advocated for culturally competent treatment as an important strategy to address the racial disparities in client services use and clinical outcomes” (p.
Campbell and Alexander conducted a quantitative study on culturally competent practice and ancillary service on Outpatient Substance Abuse Treatment (OSAT). Their findings revealed disparities in culturally competent services.

The first objective of the OSAT was to address the extent to which substance abuse outpatient programs were employing specific tactics interpreted as culturally proficient care, and to what degree these tactics were implemented. Although outpatient substance abuse treatment encourages cultural competency, implementation of the tactics was not documented. The second objective of the study was to assess the correlation between Culturally Competent Treatment Practices (CCTPs) and the utilization of ancillary services in outpatient treatment proven to prolong the length of sobriety, thus increasing the benefit to ethnically diverse groups’ treatment outcome. The results revealed that the utilization of CCTPs with OSAT varies significantly. The potential advantages of racial/ethnic counselor-client matching indicated a widely held practice with 40% among OSAT clients who chose same-race therapist. An average of only 16% of OSAT units staffed with African-Americans explained the presence of African-American clients in treatment. Generally, Leow et al. (2007) stated, “most programs have superficial coverage of cultural variables and are culturally blind to the needs of racial/ethnic minority recipients” (p. 12). In regard to the utilization of CCTPs, the availability of a single-race group therapy was 10%. Although language is regarded as a vital component of cultural competency, the study also revealed that bilingual treatment staff did not comprise more than 11% of treatment centers. Most importantly, the result indicated that 57% of OSAT units offered some sort of cultural competency training, which may not have been more than an in-service offered to staff at the time of
orientation in an attempt to improve culturally competent treatment. Campbell and Alexander (2002) argued that appropriate cultural competency training needs further clarification.

**Training and Development in Multicultural Competence**

The need for further research to promote multicultural competency was supported by Salzman (2000) who conducted a Cross-Cultural Mentorship Project (CCMP) that was designed to increase the multicultural competency of Euro-American graduate counseling students working with Native American students in an urban school district. Salzman indicated the need to prepare Euro-Americans to deal with challenges of multiculturalism and diversity, specifically indicating the need for self-knowledge, awareness of one’s cultural biases, and knowledge of people from different cultures, to acquire the skills needed to develop culturally appropriate interventions in counseling culturally different clients. Most importantly, the promotion of multicultural competency has been supported by ethical guidelines that indicated counselors who lack multicultural counseling competency are more likely to unintentionally harm the clients. Fier and Ramsey (2005) noted that one of the most pressing issues facing counselors is the importance of providing effective, ethical multicultural services. Fier and Ramsey noted that although ACA has incorporated into its code section addressing teaching, training, and supervision, this code is geared primarily toward the content of counselor education programs rather than to instructional processes and counseling techniques. Salzman (2000) stated, “Culturally encapsulated counselors distort their clients’ psychological presentations with their own cultural biases, assumptions, and assessment” (p. 119). Coleman (1998) conducted a study investigating this hypothesis and the perceptions of
general and multicultural counseling competence as distinct constructs. Coleman suggested that the framework created for the current understanding of multicultural counseling competency consists of three domains: awareness, knowledge, and skills. Furthermore, Coleman agreed that the majority of trainings provided in multicultural counseling competency focus on counselors’ awareness and knowledge aspects of competence instead of skills. Whereas Coleman agreed that counselors need to understand their own cultural biases and increase knowledge about other cultures, he asserted that the outcome of the process ought to focus on applying awareness and knowledge in the counseling relationship with the culturally different person. Substance abuse counselors, at the forefront in human services, are more likely to encounter ethnically diverse populations seeking social services to deal with problems encompassing substance abuse, mental health, socioeconomic, and legal issues. Consequently, substance abuse counselors are obligated to acquire clinical cultural competency skills, self-awareness, knowledge, and culturally specific counseling skills in order to fulfill their ethical obligations and to provide quality professional services.

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2002), Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001), and the American Psychological Association Guidelines (APA, 2003) have fundamentally agreed and stressed the need for multicultural education, training, and research. Daniel, Roysircar, Abeles, and Boyd (2004) conducted training at the Competencies Conference in Arizona. The training focused on Individual and Cultural-Diversity (ICD). The training addressed future directions in education and credentialing with emphasis on racism, homophobia, and ageism. Daniel et al. supported the rationale
for addressing diversity competencies with trainees and psychologists due to the present contexts in the United States. Daniel et al. noted several reasons for multicultural competency in trainees and psychologists such as the level of racial/ethnic diversification in the U.S. stemming from the increase in minority populations and decrease in the Caucasian population. Keller and Dermatis (1999) noted that despite the enormous amount of progress made in the development and testing of effective treatment for substance abuse disorders, addiction training curricula remained insufficient, leaving newly substance abuse professionals lacking basic diagnostic addiction treatment skills. LaFromboise et al. (1991) highlighted the need for well-trained psychologists in the United States to serve growing ethnic minorities effectively.

LaFromboise et al. (1991) stated that professional, ethical, cultural, scholarly, and legal knowledge are crucial to the training of cross-cultural competent psychologists. Pope-Davis et al. (1995) asserted that counselor training in multicultural counseling competencies remains inadequate and thus violates the professional and ethical standards of the profession. Pope-Davis et al. reflected on the ethical principles and professional standards of the APA and other professional associations and articulated the need for psychologists to integrate multicultural competencies into their expertise. Pope-Davis et al. concluded that graduate programs in psychology have fallen short in preparing trainees for effective practice with culturally diverse clients. Additionally, Pope-Davis et al. ascertained that the lack of representation of culturally diverse individuals in the psychology profession has motivated some scholars to call attention to the development of programs with more emphasis in multicultural counseling competencies that focus on training, research, and practice. Furthermore, Abreu et al. (2000) reported that existing
traditional counseling program and workshop designs have not fully integrated cross-cultural training into their curricula. Nelson et al. (2001) conducted interviews with therapists at a conference for ethnicity issues in family therapy. Nelson et al. aimed to assess the therapists’ perceptions of ethnicity issues in family therapy and how they reflected on ethnicity training for future family therapists. The participants acknowledged that training programs have failed to integrate issues of diversity. The participants also suggested that student counselors should be required to have a variety of external cultural experiences to increase their factual knowledge about different cultures.

Ancis and Sanchez-Hucles (2000) conducted a preliminary analysis of counseling students’ attitudes toward ethnic minority women. The study revealed that considerable barriers to the implementation of cross-cultural competency training continue to exist. Ancis and Sanchez-Hucles also noted that one of the fundamental obstacles is the fact that cultural competency issues are often offered at the later stages of graduate training with inadequate exposure to foundational elements of multicultural issues rather than at the center of graduate course work.

Abreu et al. (2000) reflected on past, present, and future directions in multicultural counseling training and asserted that statistics indicated those minority populations underutilized counseling services and those who sought psychological services terminated treatment prematurely. Abreu et al. attributed early termination of treatment to the lack of appropriate culturally competent services targeted to ethnic minority populations. The mandates issued by the APA and CACREP recognized the need to address cultural diversity in the clinical psychology and counselor training programs. As a result, the counselor training programs have implemented a variety of
instructional models intended to increase the level of cultural competency among counselors in training. Even though the MCT model was presented by the Multicultural Program Development Pyramid (MPDP) as the most comprehensive model to provide an outstanding measure for training program, Abreu et al. noted that the MCT has yet to be implemented. Instead the training programs continued to presume that traditional psychological treatment approaches designed for Eurocentrics were suitable for ethnic minorities and non-Whites. Given the fact that trainees are encouraged to attend workshops and in-services on diversity, Abreu et al. suggested that the integration of MCT training models in multiculturalism needs to be infused in the program’s curriculum. With respect to future research, the authors recognized the need to further test and enhance the existing measures of MCT competence and evaluate the relationship between MCT and the outcome of treatment processes. In addition, CESAR (2007) reported a critical shortage in substance abuse counselors, particularly those who have been trained to serve youth and the elderly. Furthermore, the report indicated that prevention, intervention, and treatment strategies primarily developed by, tested with, and provided by Caucasians in urban areas are inappropriate to apply to culturally diverse individuals. The outcome of this study may provide useful suggestions that would assist with the development of culturally relevant training for counseling minorities and diverse populations.

Kress, Eriksen, Rayle, and Ford (2005) conducted a study on diagnosis and cultural foundations of human behavior and concluded that in spite of requirements for counselors to receive training in the Diagnostic and Statistical Manual (DSM) and cultural issues, little research addressed the interface of these two important topics in
relation to the outcome of the counseling process. The lack of research on these topics may lead to the false assumption that cultural issues do not interact with the counselors’ use of the DSM.

Constantine et al. (2004) conducted a qualitative study using consensual qualitative research (CQR) methodology to examine the experience and perception of 12 scholars in multicultural counseling. The study intended to identify: (a) the existing definitions of the terms *multiculturalism* and *multicultural counseling competence*, (b) concepts and variables that might expand current multicultural counseling methods, (c) possible variables associated with multicultural counseling competence, (d) processes by which individuals attain high levels of competence in multicultural counseling, and (e) training methods and interventions to attain multicultural counseling competence. Constantine et al. noted that despite the impact of the multicultural counseling movement on the field of applied psychology, most of the participants agreed that a challenge associated with being culturally competent has been related to counselors’ reluctance and the lack of institutional support for multiculturalism. Pope-Davis et al. (1994) conducted an exploratory investigation with 141 doctoral interns at university counseling centers to determine whether educational variables were predictors of multicultural competency. The findings illustrated that the interns who attended more workshops, took more coursework, and received supervision reported greater multicultural knowledge, skills, and awareness than those who attended fewer workshops, took less coursework, and received no supervision.

Kiselica and Maben (1999) reviewed the research literature and evaluated the effectiveness of multicultural education and diversity appreciation training to determine
whether trainings in cross-cultural issues reduced prejudice among counselor trainees. Kiselica and Maben concluded that counselor trainees and professionals who received training in multicultural issues frequently perceived themselves as challenging their biases towards those who are culturally different from them. Most importantly, the study suggested that exposing students to multicultural training across the curriculum over time might be necessary to reduce prejudice. Keller and Dermatis (1999) noted that regardless of the advances made in counselor training, a number of limitations still exist in formal training programs. These limitations contributed to the lack of consensus on national standards for multicultural competence, a lack of adequate exposure to empirically tested psychosocial intervention, and a lack of training with dual diagnosed and special populations.

In 2003, the Office of Substance Abuse Services (OSAS) reviewed the current literature for substance professionals and concluded that despite the increasing need for substance abuse services, Eurocentric treatment modalities have failed to serve African Americans and other ethnic minority populations. For instance, the OSAS indicated that many programs had difficulty engaging and retaining minority populations in treatment due to clients’ mistrust of practitioners. OSAS also noted that other findings suggested that treatment outcomes may vary as a result of differential treatment of minority clients by individual providers, possibly indicating diagnostic bias as well as prejudice on the part of providers. Abreu et al. (2000) asserted the need for more research to examine the relationship between MCT and treatment outcome.

Most importantly, Daniel et al. (2004) noted that clinical counseling and psychology training content has been based on Eurocentric perspectives which are no
longer acceptable as the only source of knowledge given the current demographics in the U.S. In addition, Daniel et al. stated, “the reality of discrimination and prejudice in the lives of many marginalized groups impact their access to institutions such as health care resources” (p. 756). Furthermore, Daniel et al. stated that the understanding of individual and cultural differences as a multidimensional construct of historical and sociopolitical factors needs to be included in analyses and assessments along with ethical and legal implications recognizing existing disparities in racial and ethnic minorities’ access to substance abuse services.

Constantine (2001) used transcribed intake sessions of 52 counselor-client dyads to explore relative variables consisting of counselor-client race/ethnicity, counselor-client racial/ethnic match, prior training in multicultural counseling and finally, self-reported multicultural counseling competence versus observer ratings of trainees’ multicultural counseling competence. When conducting multiple regression analysis using the CCCI–R ratings, results revealed that African-American and Latino-American counselor trainees were rated higher on multicultural competency than White American counselor trainees. The study also asserted that previous multicultural trainings were a positive predictor of observer-rated multicultural counseling competence.

**Multicultural Counseling Competence Instruments**

The search for a reliable instrument for this study led to an assessment of several instruments often used by researchers in multicultural competence: the Cross-Cultural Counseling Inventory (CCCI–R), the Multicultural Counseling Awareness Scale–Form B (MCAS–B), the Multicultural Counseling Inventory (MCI), and the Multicultural Awareness-Knowledge-and Skills Survey (MAKSS). After a thorough assessment of
these instruments, Ponterotto, Rieger, Barrett, and Sparks (1994) concluded that CCCI–R’s internal consistency was adequate with a coefficient alpha of .95 taken from a sample of 86 university students and faculty. The criterion validity was demonstrated by evidence that 80% of the time student counselors agreed that items reflected the competency areas in which they were based (kappa = .58, p > .001). Ponterotto et al. reported that the coefficient alpha of MCAS–B was .92 for the knowledge/skills and .72 for awareness factors. The authors noted that MCAS–B has many limitations and needs to be tested across additional large samples to define the utility and validity of the instrument. Considering the limitations of the CCCI–R and MCAS–B, Ponterotto et al. suggested that, even though these instruments lack the systematic and longitudinal validation data to be incorporated in training, they can be used for research and continuing validation.

Ponterotto et al. (1994), in their review of the CCCI–R, the MCAS–B, the MCI, and the MAKSS, concluded that multicultural instrumentations are in early stage development with respect to empirical validation. In addition, Ponterotto et al. noted little attention has been directed toward the development of psychometrically sound and practical instrumentation for evaluating multicultural counseling training. Constantine (2001) noted that CCCI–R has been a successful instrument for self-report of multicultural counseling competence. Considering the findings of Ponterotto et al. on the assessment of the current instruments designed to assess multicultural counseling competency, this investigator elected to utilize the CCCI–R based on the fact that it has an acceptable internal consistency with moderate evidence for content and criterion validity and construct validity.
Epidemic of Substance Abuse Among Ethnic Minority Populations

In the last two decades, the counseling profession has become increasingly aware of the need to develop cross-cultural competence. Alcohol and drug abuse problems continue to rise among ethnic minority populations. In 2007 the Drug Rehabilitation Organization (www.drug-rehabs.org) reported that the Commonwealth of Pennsylvania presented an opportunistic area for wide scale narcotics shipment and distribution carried out by Hispanics and African Americans. The report indicated that in 2004 more than 106,000 individuals were admitted to treatment for alcoholism, cocaine, heroin, marijuana, and methadone in Pennsylvania. More than 20% of the admissions were African Americans.

The Office of Substance Abuse (2003) reviewed the current literature and noted that even though treatment programs have always served clients from different cultures, many programs have difficulty retaining ethnic minority clients. Failure to retain and successfully treat ethnic minorities is attributed to lack of cultural counseling competency among substance abuse counselors and the practice of Eurocentric treatment modalities. Fuertes et al. (2001) stated that multicultural competencies have been initiated to ensure counselors’ ability to understand the role of cultural factors in clients’ lives and the counseling process. Nardine (2005) conducted research on ethnic and cultural considerations in the treatment of substance abuse clients in mixed-race therapeutic group settings and noted that therapeutic and counseling approaches have been developed with an understanding of addiction as a Caucasian middle-class phenomenon. Most importantly, Nardine assessed counselors’ cultural proficiency as a factor in the success of the therapeutic group process and stated that with the increasing number of ethnic
minority populations, it is important to adjust and modify the theories and techniques of addiction therapy when dealing with minority group members. Furthermore, Nardine emphasized that clinicians who have been working in the addiction field are susceptible to social and political biases and concluded that most counselors remain unfamiliar with and uncertain of the dynamics of ethnicity and race in treatment. In order for counselors to be effective in cross-cultural situations, Nardine indicated that they must acquire knowledge, develop skills, and continually engage in self-evaluation. Culturally competent counselors would possess the ability to perform effective and thorough assessments for minority clients that result in a positive treatment outcome.

D’Andrea and Arredondo (2002) alluded to the 2001 report from the U.S. Surgeon General that identified the failure of the mental and substance abuse healthcare system to meet the needs of ethnic minorities. The report attributed this failure to the fact that the majority of counselors simply have not achieved cross-cultural counseling competency skills needed to work effectively, ethically, and respectfully with culturally and racially diverse clients. In addition, D’Andrea and Arredondo noted that professionals in the counseling field have not been advocating for multiculturalism, but rather resisting the infusion of multicultural training in counseling programs. Stanhope et al. (2005) evaluated cultural competence among behavioral health professionals, and stated, “The existing racial and ethnic disparities in access and utilization demonstrate that the behavioral health system is struggling to serve diverse groups of people” (p. 226). As well, Stanhope et al. stated that these disparities exist in all levels of care, particularly the lack of access to services. Most important is the inaccurate assessment and diagnosis
and a high treatment dropout rate due to the deficiency of culturally appropriate treatment and support.

**Substance Abuse Among Immigrants and Refugees**

In addition to the challenges ethnic minority populations present to the addiction-counseling field, immigrants and refugees, GLBT, and geriatric populations pose added urgency for substance abuse counselors to acquire cultural competency. Immigrants and refugees pose new challenges for the counseling field in general and particularly the substance abuse field. Sue (1998) explored the need for cultural competence in psychotherapy and acknowledged the growing realization that counselors and psychologists need to become cross-culturally competent. Sue noted that with the rise of the multi-ethnic nature in the U.S. society and the increased frequency of interactions Americans have with people from throughout the world, counselors must develop the skills to work effectively with people from diverse cultures and backgrounds. Leow et al. (2007) referred to the U.S. census in 2003 and reported a substantial increase of immigrants, refugees, and asylum seekers to the U.S. in most recent years. The data revealed over a million immigrants arrive in the U.S. per year. An average of 700,000 to 900,000 are legal immigrants. Over 70,000 are refugees and asylum seekers. In addition 300,000 to 500,000 undocumented immigrants arrive every year. Furthermore, and according to 2000 U.S. Census, the data revealed that the number of the foreign born immigrants residing in the U.S. reflect over 100 countries that vary in culture and ethnicity. The authors pointed to the 2004 SAMHSA report that noted even though new immigrants were found to be less likely to engage in substance abuse than U.S.-born populations, those immigrants who have been in the United States for 10 years or more
have exhibited significant increases in substance abuse. Despite the effectiveness of the evidence-based practices at decreasing substance abuse risk and behaviors among the general population, Leow et al. argued that the design of most evidence-based programs are not culturally sensitive to immigrants and refugees. Furthermore, many substance abuse programs are designed for a White middle class, given that theoretical constructs, strategies, and research evaluation have all been influenced by the mainstream American values.

A report issued by the National Child Traumatic Stress Network (NCTSN) and the Refugee Trauma Task Force (2005) funded by the SAMHSA, U.S. Department of Health and Human Services, revealed that refugee children experience a wide range of psychological and social problems. The report linked these problems to exposure to trauma prior to migration and difficulties integrating into the new country and culture. Also it was noted that 50–90% of the refugee children experience posttraumatic stress symptoms, which substantiate the need for trauma-informed treatment and services. A recent survey of refugee programs conducted in nine metropolitan areas in the U.S. confirmed that, of the 78% of the sites that offered mental health care, only 33% of those sites carried out mental health status examinations. The result of the NCTSN report suggested that refugees with mental health issues are not likely to be identified and are therefore unlikely to receive treatment. Most importantly, these findings suggested the need for culturally competent interventions for refugee children and their families in order to facilitate access and engage them in substance abuse and mental health services.
Gay, Lesbian, Bisexual and Transgender (GLBT) Populations

The issue of substance abuse in GLBT populations has emerged as another challenge for substance abuse counselors. Despite the recent focus on cross-cultural competency and diversity within the counseling field, research in counselor training has failed to give significant attention to the GLBT population. Eliason (2000) examined 242 substance abuse counselors’ attitudes towards and knowledge of GLBT clients and the effect on clients’ recovery process. The study concluded that substance abuse counselors received little formal training on GLBT client issues. It also demonstrated that substance abuse counselors exhibit negative attitudes toward the GLBT population and possess very limited knowledge of clients’ needs. More importantly, Eliason pointed out that the GLBT population tends to encounter several obstacles related to the stigma associated with homosexuality: (a) the stress associated with the suppression of the identity to avoid harassment and discrimination, (b) lack of social outlets for support other than bars, and (c) the likelihood of losing family support. Eliason also noted that even though training programs and continuing education forums are increasingly addressing the needs of diverse clients, GLBT clients’ issues are more likely to be ignored for many reasons such as: (a) the trainer’s lack or limited knowledge of GLBT issues, (b) fear of presenting potentially controversial information, (c) the understanding of diversity strictly in terms of racial differences, and (d) discomfort with talking about sexuality.

Despite the recent focus on cross-cultural competency and diversity within the counseling field, research in counselor training has failed to give significant attention to the GLBT population. Carroll et al. (2002) addressed counseling competency among counselors who have not been well informed with objective empirical research and noted
that counselors are ill-prepared to meet the needs of their GLBT clients. Carroll et al. called for counselors to change their attitudes and alter their assumptions by adopting a “trans-affirmative” approach, which would call for counselors to acquire the knowledge and skills to understand transgender issues from political and psychological contexts. Pennsylvania Strategic Plan has stated that gay and lesbian youth are over four times more likely to attempt suicide than their heterosexual counterparts, suggesting serious problems with this population’s assessment and referral to behavioral health care and substance abuse services (The Pennsylvania OMHSAS).

**Geriatric Population and Addiction**

The growing number of elderly individuals and their families who may seek social services as well as counseling for addiction issues indicates new and additional demands for competency. Schwiebert, Myers, and Dice (2000) reported that the population of adults ages 65 and older is increasing drastically and posing ethical challenges to the counseling profession. Schwiebert et al. estimated that by 2030 there would be 70 million Americans over 65, which is double the number in 1997. According to a report issued by Join Together (2008), *Specialized Treatment for Elder Addicts Growing*, experts in the addiction field predict a wave of Baby Boomers who are dealing with addiction issues as they reach the final stages of their middle age. The report indicated that 10% of those who entered treatment for addiction in 2005 were over the age of 50, up from 8% in 2001. By 2020 SAMHSA predicted 4.4 million older people with addiction problems, up from 1.7 million in 2001. Join Together (2005) *Elderly Addicts Face Unique Challenges* stated that although older addicts share as many problems as young addicts, older addicts tend to have different health and emotional
needs that are associated with grief and depression. In another Join Together (1998), _Substance Abuse: Older Adults At Risk_, reported that the Center for Substance Abuse Treatment (CSAT) released research findings and indicated that abuse of alcohol and over-the-counter medications pose serious problems among older Americans. This epidemic affects up to 17% of adults age 60 or older, a rapid-growth segment of American’s population. The new SAMHSA publication series on Treatment Improvement Protocols (TIPs) alerted the health care community to better detect and treat alcohol and medication abuse among older patients.

Rosen, Zlotnik, Curl, and Green (2000) pointed out that the social work profession is facing new challenges in working with older people and their families. These new challenges require social workers to become competent and well prepared in order to provide proper treatment. Furthermore, Rosen et al. stressed the need to prepare researchers, educators, policy-makers, and administrators to endorse optimal well-being and support of elderly individuals. Rosen et al. conducted an extensive review of the literature and called for competent and skilled social workers who are interested in working with aging populations. The review revealed that 62% of social workers were not prepared to work with older people. Rosen et al. conducted a national survey to assess if social workers were competent to provide services to older people and their families. The study addressed levels of competencies required for all social workers to work with an aging population. The participants in the study were practitioners and academics, both with aging and non-aging research and practice interests. The instrument that was utilized in the study consisted of a 65-item survey, which was developed from a comprehensive literature review as well as input from nationally
recognized experts in the field of social work. The general population of social work education faculty was found to have the least amount of special training and education in relation to aging clients and gerontology. These findings suggested that efforts to integrate aging content into basic social work curricula would not be a simple task, since most faculty members have little knowledge, skills, or interest in an aging population.

CESAR (2007) reported 700 practicing psychologists specialize in serving older adults as their principal population of focus. This is only a fraction of the estimated 5,000 to 7,500 geropsychologists needed to meet the current demand. In addition, the Pennsylvania Strategic Plan concluded that physicians are less likely to identify substance abuse and psychological problems among older adults or refer them to behavioral health specialists because they attribute their symptoms to age. In 2005, the Countrywide Older Adult Ad Hoc Committee, Older Adult System of Care, the County of Los Angeles Department of Mental Health Older Adult Services and the Association of Community Human Services Agencies submitted a collaborative report on older Adult Mental Health Services. The report highlighted that persons reaching the age of 65 are living longer suggesting that co-morbidity factors such as deteriorating health and substance abuse problems among older adults would likely to increase. The report also noted that the existing mental health system has been underdeveloped to meet the ongoing mental health needs of the older adult population.

Summary

This chapter addressed current literature and research findings on cultural competency in counseling and stressed its need by social work professionals and substance abuse counselors. In addition, a review of the literature indicated that
Counselor education and psychology training programs have failed to promote cross-cultural counseling competency in their curricula despite growing numbers of ethnic minorities, immigrants and refugees, GLBT individuals, criminal justice clients, and the rising population of elderly in United States. Based on these findings, substance abuse counselors as the forefront for counseling these individuals face tremendous challenges. These challenges consist of difficulties beyond substance abuse such as psychiatric, medical issues, socio-economic, legal, and other issues that call for cultural competency to provide competent services. The data collected in this study is rich and helpful for future training and professional development of substance abuse counselors in Pennsylvania as well as the U.S. In addition, this chapter provided a review of multicultural counseling training and the need for increased multicultural competency in the counseling field which is supported by demographic changes occurring in the U.S., the lack of culturally appropriate counseling intervention, and insufficient addiction training curricula in counselor education programs.
CHAPTER III

METHODOLOGY

This chapter addresses the methodology used to examine the research question: Are substance abuse counselors competent to counsel culturally diverse populations? Hypotheses were stated. The statistical procedures that were utilized to accept or reject the hypotheses were discussed. In addition, this chapter outlines the methods of investigation and the procedures that were used to obtain the data, the target participants, and the statistical methods that were applied to analyze the data.

Research Method

This investigation gathered information from substance abuse counselors through self-assessment, specifically their cross-cultural counseling skills, socio-political awareness, and cultural sensitivity. A demographic questionnaire along with the CCCI–R was used to assess substance abuse counselors’ multicultural counseling competence. The findings of this study provided information that can be generalized to determine the level of cross-cultural counseling competency among substance abuse counselors in Pennsylvania. This investigation examined the differences in the mean scores in cross-cultural competence, as measured by the CCCI–R subscales, of substance abuse counselors of different genders, ethnicities, as well as those with different level of education, and from different professional specialties. In addition, the investigator examined whether there was a correlation between the number of continuing education hours in cross-cultural counseling earned by a substance abuse counselor and level of cross-cultural counseling competence.
Participants

Substance abuse counselors who have been providing direct services to substance abuse populations in the Commonwealth of Pennsylvania were the target population. According to the Pennsylvania Counseling Association (PCA), there are 21,000 professional counselors practicing in Pennsylvania.

The investigator submitted a letter to the Pennsylvania Chemical Abuse Board and the Pennsylvania Department of State requesting mailing lists. Pennsylvania Department of State declined the request. Pennsylvania Chemical Abuse Board provided a mailing list of approximately 1,500 certified substance abuse counselors. From that list letters soliciting voluntary participation in the study were mailed to 450 randomly selected. In addition, letters were sent to directors of substance abuse treatment facilities in the Pittsburgh area, informing them of the research study and requesting permission for voluntary participation of the substance abuse counselors at their agencies.

A total of 133 substance abuse counselors participated in the study by accessing the posted research materials on the Internet in addition to those who completed the research materials that were mailed. Of those, 24 were deemed unqualified for not completing all of the questions in the demographic and CCCI–R forms of the study leaving a total of 111 to be included in the data analysis. The majority (68.5%) of the sample was White (n = 76), 23.4% were African American (n = 26), 6.3% were other ethnic minority groups (n = 7), and 1.8% of the participants did not indicate their ethnic backgrounds (n = 2). There were 45 male and 66 female substance abuse counselors. The identified participants for this study included 49 certified addiction counselors; 12 social workers; 36 licensed professional counselors, marital and family therapists; 13 mental
health counselors; 2 psychologists; and 1 psychiatrist who have been providing direct service to substance abusers. Two of the participants did not indicate their field of study. The 111 participants were between 24 and 72 years of age ($M = 46.08$, $SD = 12.584$). The level of education between the participants varied from Bachelor, Masters and No college training.

To obtain a significant response rate for a mail survey, Creswell (1994) suggested a three-step follow-up procedure: (a) an initial mailing including a letter stating the nature of the study and consent form; (b) two weeks later, a second mailing including the instrument, the survey, and a stamped envelope for returning the completed survey and the CCCI–R; and (c) a reminder postcard to complete and mail back the instrument and the demographic survey for data analysis.

Due to cost associated with mailing, the investigator followed a two-step procedure similar to Creswell’s recommendations. Step one involved mailing a description of this study; the consent form; the demographic survey; and the Cross-Cultural Counseling Inventory Revised (CCCI–R) to each prospective participant. The prospective participants were asked to voluntarily complete the materials and return them by mail using the provided stamped envelope. Prospective participants were also directed to http://www.surveymonkey.com/s/crossculturalcounseling to complete the survey if they preferred to do so electronically. The invitation to participate and the surveys were posted at this site for participants who preferred to use the Internet. In addition, upon permission from program directors, the investigator sought voluntary participation of substance abuse counselors at treatment facilities in the Pittsburgh area. Of 133
completed surveys, 37 were completed via mail, 44 completed at substance abuse facilities in Pittsburgh area, and 52 completed on the Internet.

**Instrumentation**

In 1985 Hernandez and LaFromboise initially developed the CCCI based on the recommendations from the position paper developed by the APA Division (17) Education and Training Committee (Ponterotto et al., 1994). The Education and Training Committee emphasized the need to develop minimal cross-cultural counseling competencies for incorporation into counseling psychology training programs. The CCCI was designed for supervisors to evaluate their trainees’ multicultural counseling competency. After assessing the CCCI’s validity, reliability, and factor structure, LaFromboise et al. (1991) determined that the CCCI was an effective instrument to measure cross-cultural competency, beliefs/attitudes, knowledge, and skills.

The preliminary and initial construct of the CCCI consisted of 22 items measuring cultural awareness, beliefs, knowledge, and flexibility in counseling skills. Overlapping items were extracted. As a result, an 18-item scale was developed. Each item consisted of a statement about the counselor’s interview behavior accompanied by a 5-point continuum for indicating extent of agreement with the item. Thus, the scale range was 18 to 90. The internal consistency reliability of the CCCI was .92 (LaFromboise et al., 1991). LaFromboise et al. stated, “Although internal consistency reliability cannot substitute for evidence of stability, the finding nevertheless demonstrates homogeneity” (p. 381). LaFromboise et al. reported an internal consistency reliability of .88 in a study of 43 African American male counselors classified as either at the encounter or internalization stage of racial identity using subscales of Parham and Helm’s Racial
Identity Scale. The participants were asked to evaluate videotapes of an Anglo-American female counselor playing culturally sensitive and culturally insensitive roles while working with African American clients.

LaFromboise et al. (1991) made minor adjustments to the content and presentation of the CCCI, adding two items to directly assess general understanding of the counseling process. To avoid confusion, the new 20-item revised version of the scale was named the Cross-Cultural Competency Inventory–Revised (CCCI–R).

The CCCI–R consists of 20 items used to measure three general areas including cultural awareness and beliefs, cultural knowledge, and flexibility in counseling skills. The CCCI–R was upgraded to a 6-point scale in order to improve the instrument’s ability to distinguish levels of counseling competence. The revision consisted of a 6-point Likert scale range from 1 (strongly disagree) to 6 (strongly agree). As a result, the scale range of the CCCI–R is from 20 to 120. LaFromboise et al. (1991) asserted that the CCCI–R has proven to be an effective instrument for measuring cross-cultural counseling skills, socio-political awareness, and cultural sensitivity (the three subscales) with internal consistency reliabilities of .95 and inter-item correlation ranging between .18 and .73.

The outcome of the study conducted by LaFromboise et al. (1991) indicated an acceptable factor structure. The CCCI–R is representative of cross-cultural counseling competency. With respect to reliability, the authors asserted, “The 20-item scale yields an internal consistency (coefficient alpha) reliability of .95 with inter-item correlations ranging between .18 and .73” (p. 384). LaFromboise et al. tested the content validity of the instrument to determine whether the items in the CCCI–R sufficiently represented
cross-cultural competencies as defined and reported by the APA, Division 17. Eight
graduate students in a psychology doctorate program were appointed to judge the study.
Four of the appointed students had specific training in cross-cultural counseling. The
judges reviewed the Division 17 report and classified each item in the CCCI–R with a
cross-cultural counseling competency from the position paper. LaFromboise et al.
reported, “The students’ overall agreement rate was 80% with corresponding value for
generalized kappa of .58, \( p < .001 \)” (p. 383). The level of agreement demonstrated that
the CCCI–R is representative of cross-cultural counseling competency and has acceptable
content validity.

LaFromboise et al. (1991) investigated the factor structure of the CCCI–R with 86
students, diverse in age, socioeconomic levels, ethnicity, fields of education, and
trainings. The participants rated a counseling interview with an Anglo-American female
counselor who had been assessed by faculty supervisors to consistently exhibit cross-
cultural competency in counseling interviews. As a prerequisite for participation, all
raters had to have completed at least one counseling course to ensure that they were
familiar with the counseling context. The raters did not receive any training on the use of
the inventory and were informed that the purpose of the study was to gather their
impressions of a specific counselor’s cross-cultural competence. The raters were
encouraged to put themselves in the client’s place while viewing the videotaped section
of the counseling session in order to assess the counselor’s level of effectiveness.
Immediately after viewing the videotaped session, they completed the CCCI–R and discussed
the study. Results indicated that as a group, the raters were in agreement with most
items, rating the counselor above average. As an example, the raters agreed with each
other on item 19, which stated, “Counselor is aware of professional and ethical responsibilities of a counselor ($M = 4.59$)” (p. 384). Disagreement mainly occurred with item 7, “Counselor demonstrates knowledge about the client’s culture ($M = 3.55$)” (p. 384). The results also indicated that the 20-item scale yielded an internal consistency reliability of .95 with inter-item correlations varying between .18 and .73.

With regard to the scoring method, LaFromboise et al. (1991) did not recommend a particular scoring method or set of scores to be produced since the items constituting each factor were identified. Ponterotto et al. (1994) agreed with the total score and stated, “At this time, however, the developers are recommending the scale be scored in a unidimensional (total score only) fashion” (p. 317). LaFromboise et al. affirmed that the CCCI–R, as currently constructed, has the ability to appraise a counselor’s level of cross-cultural counseling competency and suggested that researchers use the CCCI–R as an additional instrument to further determine the effectiveness of various interventions with diverse populations. Ponterotto et al. argued that although the CCCI–R is reliable; further research is needed in that the factor structure of the CCCI–R is still in question. Constantine and Landany (2000) stated that even though the CCCI–R was developed mainly for supervisors to evaluate their trainees’ multicultural counseling competency, it had been successfully adapted for self-report use in previous studies. Despite the fact that the CCCI–R is often used in training settings by evaluators, Stanhope et al. (2005) noted that the CCCI–R might be utilized to assess counselors on an individual basis as well.

Since this study was intended for the substance abuse counselors to self-assess their cross-cultural counseling competencies, the investigator requested special
permission and modified the CCCI–R to a self-report measure. The changes were reviewed and approved by Dr. LaFromboise (personal communication, November 28, 2006). Overall, the CCCI–R appears to have acceptable levels of internal consistency, moderate evidence for content and criterion validity and construct validity. In addition, the brevity of the CCCI–R makes it easy and efficient to complete and score.

**Procedures**

Once permission was granted by Duquesne University’s Internal Review Board (IRB) to conduct the study, a cover letter explaining the nature of the study and a consent form, demographic survey, the CCCI–R, and a stamped self-addressed envelope were mailed to participants. Finally, as a reminder, a letter with the link to www.surveymonkey.com was mailed to all participants, urging them to complete and mail back the demographic survey and CCCI–R or to access the survey on the Internet and complete it. The collected data were analyzed, hypotheses were tested, and conclusions were formulated. The limitations of the study were discussed. Future research recommendations were stated and implications for practice were presented.

**Hypotheses of the Study**

The hypotheses that were tested in this study:

Hypothesis 1: There is a significant difference between male and female substance abuse counselors’ levels of cross-cultural competency as measured by the CCCI–R.

Hypothesis 2: There is a significant difference of the mean score on CCCI–R subscales based on the counselor’s levels of education and cross-cultural counseling competency as measured by the CCCI–R.
Hypothesis 3: There is a significant difference of the mean score on CCCI–R subscales based on the counselor’s field of study, and cross-cultural counseling competency as measured by the CCCI–R.

Hypothesis 4: There is a statistical difference of the mean score on the CCCI–R subscales based on the counselor’s ethnicity and cross-cultural counseling competency as measured by CCCI–R.

Hypothesis 5: There is a correlation between the numbers of continuing education hours in cross-cultural counseling a substance abuse counselor has attended and the levels of cross-cultural counseling competency as measured by the CCCI–R.

Analysis

The investigator applied analysis of variance (one-way ANOVA) to test the first four hypotheses. The investigator analyzed the difference of the mean scores on the CCCI–R subscales based on substance abuse counselor’s gender, level of education, field of study, and ethnicity as they relate to the levels of cross-cultural competency.

Given the fact that there are three dependent variables (cross-cultural counseling skills, socio-political awareness, and cultural sensitivity) in the construct of the CCCI–R that was assessed in this study, analysis of variance (one-way ANOVA) was used to analyze and test the hypotheses. Gay and Airasian (2000) stated, “Simple, or one-way, analysis of variance (ANOVA) is used to determine whether there is difference between two or more means at a selected probability level” (p. 491). In order to assess the participants’ levels of cross-cultural competency, the investigator employed ANOVA for the dependent variable (CCCI–R) in relation to the independent variables: Substance Abuse counselor’s gender, level of education, field of study/specialty, number of
continuing education in cross-cultural counseling, and counselor’s ethnicity. Each hypothesis was assessed using a one-way analysis of variance (ANOVA).

The Pearson $r$ correlation was used to assess whether there was a correlation between the number of continuing education hours on cross-cultural counseling competency and the counselor’s levels of cross-cultural competency. Gay and Airasian (2000) stated,

*Pearson $r$ correlation coefficient is the most appropriate measure when the variables to be correlated are either interval or ratio. Like the mean and the standard deviation, the Pearson $r$ takes in account each and every score in both distributions; it is also the most stable measure of correlation.* (p. 452)

Pearson’s correlation was used to measure possible correlation between the numbers of trainings in the past two years and cross-cultural counseling competency.

To avoid any measurement error that may hinder the finding of statistical significance in the research results, the sample of participants for this study was representative of substance abuse counselors in Pennsylvania. Gay and Airasian (2000) suggested that a number of methodological practices could lead to invalid research results and weaken research generalizations. Thus, a higher statistical power must be attained to avoid Type II error. In case the analysis has little statistical power, the investigator is likely to overlook the desired outcome. In this investigation a prior power analysis has been conducted to determine the appropriate sample size needed to achieve acceptable power to accurately reject the null hypothesis and reduce Type II error. However, the multiple comparisons in this study are more likely to reduce Type II error and increase Type I error when the null hypothesis is true. In order to detect the effects of each
variable on the levels of competencies, alpha = .05 and Power = 0.80 was used in computing the sample size in this study. The result of the power analysis indicated an optimal sample size of $n = 300$.

**Summary**

This chapter provided information on the research methods that were used in this investigation, the participants, the hypotheses of the study, and a brief description of the data analysis. It also reviewed validity and reliability determinations of CCCI–R in previous studies. LaFromboise et al. (1991) affirmed that the CCCI–R has proven to be an effective instrument for measuring cultural competency with an internal consistent reliability of .95, and inter-item correlation ranging between .18 and .73. Even though the CCCI–R is designed for supervisors to evaluate trainees’ cross-cultural competency, it has been effectively adapted for self-report. The methodology for the study was to assess cross-cultural counseling competencies among substance abuse counselors along five variables (gender, level of education, field of study/specialty, number of continuing education hours, and counselor’s ethnicity). In addition, research procedures included gathering and analyzing the data and testing the study’s hypotheses. Because of the multiple statistical tests being performed in this study, other statistical procedures including a one-way ANOVA, Pearson Correlation statistical procedure were discussed.
CHAPTER IV
RESULTS

The purpose of the study was to determine whether significant statistical differences occurred on the subscales of the CCCI–R (Cross-Cultural Counseling, Sociopolitical Awareness and Cultural Sensitivity) by the following substance abuse counselors’ gender, level of education, field of study, ethnicity, and number of continuing education hours in the last two years.

Hypotheses of the Study

The study tested the following hypotheses.

Counselor’s Gender and Level of Cross-Cultural Competence

Hypothesis 1: There is a significant difference between male and female substance abuse counselors’ levels of cross-cultural competency as measured by the CCCI–R.

The investigator examined the mean differences between males and females on cross-cultural counseling skills. The results indicated no difference for either gender: males ($M = 51.37, SD = 7.34$) and females ($M = 50.98, SD = 5.31$). On sociopolitical awareness subscale, male scores were $M = 30.91, SD = 4.69$ and female scores were $M = 30.21, SD = 2.69$. On cultural sensitivity male scores were $M = 18.00, SD = 2.89$ and female scores were $M = 17.27, SD = 2.71$. The CCCI–R total scores for males were $M = 100.28, SD = 13.93$ and females were $M = 98.47, SD = 9.56$.

At the .05 level there was no statistically significant difference in the mean score between male and female substance abuse counselors’ levels of cross-cultural counseling competency as measured by the CCCI–R. Therefore, this hypothesis was rejected.
The results indicated that there was no significant difference in the mean scores between male and female as shown in Table 1. The results of one-way Analysis of Variance (ANOVA) indicating that male and female substance abuse counselors have similar scores with no significant differences on CCCI–R subscales or total score (cross-cultural counseling $F = .750$; Sociopolitical Awareness $F = .329$; Cultural Sensitivity $F = .186$; CCCI–R Total score $F = .423$) (See Table 1).

**Counselor’s Level of Education and Level of Cross-Cultural Competence**

Hypothesis 2: There is a significant difference of the mean score on CCCI–R subscales based on the counselor’s level of education and cross-cultural counseling competency as measured by the CCCI–R.

A one-way ANOVA was computed to measure whether there were significant differences in mean of cross-cultural competence scores (total and subscales on the CCCI–R) among the three levels of education groups presented in this study (BA, MA, and no college). In the cross-cultural counseling subscale, the mean for Bachelors was 50.2, Masters was 51.9, and No College Training was 47.2. The differences between the mean scores in all levels of education indicated no significant differences. Consequently, this hypothesis was rejected (See Table 2).

**Counselor’s Field of Study and Level of Cross-Cultural Competence**

Hypothesis 3: There is a significant difference of the mean score on CCCI–R subscales based on the counselor’s field of study, and cross-cultural counseling competency as measured by the CCCI–R.

A one-way ANOVA was computed to measure the significant difference in the mean scores of substance abuse counselor’s field of study among Counseling, Social
Table 1

*M Differences Between Males and Females on the Subscales and the Total Scores on CCCI–R*

<table>
<thead>
<tr>
<th>CCCI-4 Subscales</th>
<th>Gender</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>df</th>
<th>Sig.</th>
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<tr>
<td>Cross-Cultural Counseling</td>
<td>Male</td>
<td>43</td>
<td>51.37</td>
<td>7.34</td>
<td>1.12</td>
<td></td>
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<td></td>
<td>Female</td>
<td>66</td>
<td>50.98</td>
<td>5.31</td>
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<td>.319</td>
<td>107</td>
<td>.750</td>
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<td></td>
<td></td>
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<td>70.288</td>
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<td></td>
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<td>.299</td>
<td>70.288</td>
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<tr>
<td>Sociopolitical Awareness</td>
<td>Male</td>
<td>43</td>
<td>30.91</td>
<td>4.69</td>
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<td></td>
<td>Female</td>
<td>66</td>
<td>30.21</td>
<td>2.69</td>
<td>.33</td>
<td>.881</td>
<td>60.139</td>
<td>.382</td>
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<td>Cultural Sensitivity</td>
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<td>18.00</td>
<td>2.89</td>
<td>.44</td>
<td>1.332</td>
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<td>.186</td>
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<td></td>
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<td>17.27</td>
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<td>85.732</td>
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<tr>
<td>CCCI–R Total Score</td>
<td>Male</td>
<td>43</td>
<td>100.28</td>
<td>13.93</td>
<td>2.12</td>
<td>.804</td>
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<td>.423</td>
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<td></td>
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*Note.* CCCI–R (Cross-Cultural Counseling Inventory–Revised). *N* (Number of participants), *p* = < .05
Table 2

*A One-Way ANOVA Analysis Measuring the Difference in M Scores and the Level of Education*

<table>
<thead>
<tr>
<th>CCC1–R Subscales</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>f</th>
<th>sig.</th>
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<tr>
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<td>No College Training</td>
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Table 2 (continued)

A One-Way ANOVA Analysis Measuring the Difference in M Scores and the Level of Education

<table>
<thead>
<tr>
<th>CCCI–R Subscales</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>f</th>
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<tr>
<td>Between Groups</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. N = Number of subjects. M = Mean. SD = Standard Deviation. SE = Standard of Error. SS = Sum of Squares. df = Degree of Freedom. f = f ratio. MS = Mean Square. Sig. = 2 tailed.*
Work, and Psychology fields. The results revealed that in Cross-Cultural Counseling subscale, there were no significant differences in the mean scores for counselors ($M = 51.11$) and social work ($M = 52.92$). However, substance abuse counselors who reported training in psychology scored significantly lower ($M = 46.90$). In the Sociopolitical Awareness scale, substance abuse counselors who reported training in counseling and social work were not significantly different ($M = 30.77$ and $M = 30.81$). To the contrary, substance abuse counselors who reported training in psychology scored $M = 27.81$. With regards to Cultural Sensitivity Subscale, substance abuse counselors who were trained in Counseling and Social Work had mean scores of $17.81$, whereas those trained in Psychology had a mean score of $15.27$. The results of ANOVA in field of study between the groups revealed that on cross-cultural counseling subscale ($F = 3.93$), sociopolitical awareness ($F = 3.49$), cultural sensitivity ($F = 4.34$) and CCCI–R Total score between the groups ($F = 4.45$). These findings indicated that there were significant differences in the mean scores between substance abuse counselors who were trained in Counseling, Social Work, and Psychology. Thus, the investigator accepted the hypothesis. (See Table 3).

The results of multiple comparison data analysis on the field of the study (Counseling, Social Work, and Psychology) revealed that there were differences in the Sig. (2 tails) between Counseling, Social Work, and Psychology. Both Counseling and Social Work have no significant differences in Cross-Cultural Counseling subscale with Sig = .553. On the other hand, the Psychology field has Sig. = .099. The comparison between Social Work and Psychology indicated Sig. = .018. On Sociopolitical Awareness, Counseling and Social Work have Sig. = 1.000 whereas psychology has Sig. = .033. The comparison between Social Work and Psychology yield Sig. = .058. In
Table 3

*One-Way ANOVA Measuring the Difference in M Scores of Counselor’s Field of Study*

<table>
<thead>
<tr>
<th>CCC1–R Subscales</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
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<th>sig.</th>
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</table>
Table 3 (continued)

*One-Way ANOVA Measuring the Difference in M Scores of Counselor’s Field of Study*

<table>
<thead>
<tr>
<th>CCCI–R Subscales</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>SE</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>f</th>
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<tbody>
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</tbody>
</table>

|                   |     |      |     |     |     |     |      |     |      |
| Between Groups     | 1098.88| 2  | 549.44| 4.45| .014|     |      |     |      |
| Within Groups      | 13081.46| 106| 123.41|     |     |     |      |     |      |
| Total              | 14180.33| 108|     |     |     |     |      |     |      |

*Note.* N = Number of subjects. M = Mean. SD = Standard Deviation. SE = Standard of Error. SS = Sum of Squares. df = Degree of Freedom. f = f ratio. MS = Mean Square. Sig. = 2 tailed.
Cultural Sensitivity subscale Counseling and Social Work both revealed Sig. = 1.000, yet there was significant difference by the Counseling and Psychology with Sig. = .014 as well as significant difference between Social Work and Psychology with Sig. = .030. The CCCI–R total score yield no significant difference with Sig. = 1.000. There was a significant difference between counseling and Psychology with Sig. = .024. The comparison between Social Work and Psychology yielded Sig. = .013 (See Table 4).

Table 4

*The Field of Study and Subscales of CCCI–R*

<table>
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<tr>
<th>Dependent Variable</th>
<th>Field of Study</th>
<th>Sig.</th>
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<td>Cross-Cultural Counseling</td>
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<td></td>
<td>Social Work Psychology</td>
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<td>Social Work Psychology</td>
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<td>Sociopolitical Awareness</td>
<td>Counseling Social Work</td>
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<td></td>
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<tr>
<td>Cultural Sensitivity</td>
<td>Counseling Social Work</td>
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<td>Social Work Psychology</td>
<td>.014</td>
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<tr>
<td></td>
<td>Social Work Psychology</td>
<td>.030</td>
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<tr>
<td>CCCI–R Total score</td>
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<td>1.000</td>
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<tr>
<td></td>
<td>Social Work Psychology</td>
<td>.024</td>
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<tr>
<td></td>
<td>Social Work Psychology</td>
<td>.013</td>
</tr>
</tbody>
</table>

*Note.* Dependent variables are the subscales of CCCI–R. Sig. = $p < .05$

Counseling and Social Work scored higher on CCCI–R subscales versus Psychology. The difference may be attributed to the trainings they received on cross-cultural or the differences in number of participants who took part in the study. It is important to acknowledge the fact that only 11 from the psychology field versus a total of 92 were from Counseling and Social Work. Another factor that needs to be examined is
whether CCCI–R subscales have specifically measured what they have intended to measure. With $p = .05$, the investigator accepted that there were significant differences of the mean scores on CCCI–R subscales based on the counselor’s field of study and cross-cultural counseling competency. The significant difference in the field of study was found in the comparison between substance abuse counselors who were trained in counseling and social work who scored higher in cross-cultural counseling, sociopolitical awareness and cultural sensitivity, versus those who were trained in psychology.

**Counselor’s Ethnicity and Level of Cross-Cultural Competence**

Hypothesis 4: There is a statistical difference of the mean score on the CCCI–R subscales based on the counselor’s ethnicity and cross-cultural counseling competency as measured by CCCI–R.

Ethnicity was recorded as White, African American, or Other. The differences in the group means were tested using one-way ANOVA. The results on cross-cultural counseling subscale indicated that African American substance abuse counselors scored ($M = 53.65$), Other had a ($M = 53.57$) while their While counterpart scored ($M = 50.05$). With respect to sociopolitical awareness subscale White, African American and Other substance abuse counselors had $M = 30.41, 30.73$, and $30.43$ respectively. The mean scores on cultural sensitivity for substance abuse White was ($M = 17.32$), African American scored ($M =18.27$) and Other scored ($M = 17.57$). The results indicated no significant differences among the groups. Thus, substance abuse counselors from all ethnic backgrounds were equally culturally competent. Consequently, this hypothesis was rejected (See Table 5).
Table 5

One Way ANOVA Measuring M Scores of the Counselor’s Ethnicity and Cross-Cultural Counseling Subscale Between Groups

<table>
<thead>
<tr>
<th>CCCI–R Subscales</th>
<th>Sum of Squares</th>
<th>df.</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cross-Cultural Counseling</td>
<td>295.55</td>
<td>2</td>
<td>147.77</td>
<td>4.12</td>
<td>.019</td>
</tr>
<tr>
<td>Sociopolitical Awareness</td>
<td>2.043</td>
<td>2</td>
<td>1.02</td>
<td>.08</td>
<td>.93</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
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<td>2</td>
<td>8.81</td>
<td>1.13</td>
<td>.327</td>
</tr>
<tr>
<td>CCCI–R Total Score</td>
<td>503.53</td>
<td>2</td>
<td>251.77</td>
<td>1.95</td>
<td>.147</td>
</tr>
</tbody>
</table>

Considering the p value = 0.05, there was no significant difference in the mean square of 147.77, $F = 4.11$ and Sig. = .019 between the groups (White, African American, and Other) in Cross-Cultural Counseling subscale. With respect to the difference between the groups in Sociopolitical Awareness and Cultural Sensitivity, the results indicated that there was no significant difference between the groups (White, African American, and Other) with mean square of 1.02, $F = .077$ and Sig. = .926 for Sociopolitical Awareness and mean square of 8.80, $F = 1.13$ and Sig. = .327 in Cultural Sensitivity. As a result, the hypothesis was rejected.

Counselor’s Continuing Education and Level of Cross-Cultural Competence

Hypothesis 5: There is a correlation between the numbers of continuing education hours in cross-cultural counseling a substance abuse counselor has attended and the level of cross-cultural counseling competency as measured by the CCCI–R.

The Pearson correlation was conducted to determine whether there was correlation between the number of continuing education hours in cross-cultural
counseling and level of competency. The results revealed that in Cross-Cultural Counseling, \( r = .025 \) with \( p \) value = .800; Sociopolitical Awareness, \( r = -.025 \) and \( p \) value = .802; Cultural Sensitivity, \( r = -.020 \) and \( p \) value = .842. CCCI–R total score \( r = .001 \) with \( p \) value = .993. This hypothesis was rejected. The results are reported in Table 6.

Table 6

*Pearson Correlation of the Number of Continuing Education Hours and Level of Competency*

<table>
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<tr>
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<th>( r )</th>
<th>( p ) value</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>Social Political Awareness</td>
<td>-.025</td>
<td>.802</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td>-.020</td>
<td>.842</td>
</tr>
<tr>
<td>CCCI–R Total</td>
<td>.001</td>
<td>.993</td>
</tr>
</tbody>
</table>

*Note.* \( R = \) Pearson Correlation. \( p \) value < 0.05 (2-tailed). Correlation is significant at 0.01 level (2 tailed).

**Summary**

This chapter discussed the outcome of the data analysis for the hypotheses under investigation. The results of one-way ANOVA revealed that there was no significant difference between male and female substance abuse counselors’ levels of cross-cultural counseling competency. Also, after the examination of the level of education the results indicated that there were no significant differences between substance abuse counselors’ cross-cultural counseling and level of education (BA, MA, and No College Training). The hypothesis was rejected.
The result of field of study (Counseling, Social Work, and Psychology) showed some differences in the level of cultural competence between substance abuse counselors who were trained in Counseling, Social Work, and those who were trained in Psychology and the hypothesis was accepted.

With regard to substance abuse counselor’s ethnicity and level of cultural competence, the results indicated that there was no significant difference between African American, White, or Other substance abuse counselors’ level of cultural competence. In that, ethnicity did not influence substance abuse counselor’s cross-cultural counseling competence. Similarly the number of continuing education hours did not impact the substance abuse counselor’s level of cultural competence. Consequently, the investigator rejected the hypothesis.
CHAPTER V

DISCUSSION

The purpose of this study was to examine substance abuse counselors’ levels of cross-cultural counseling competence in the Commonwealth of Pennsylvania. The variables in question included substance abuse counselors’ gender, level of education, field of study, ethnicity, and the number of continuing education hours to determine if these variables contribute to the prediction of substance abuse counselors’ levels of cross-cultural counseling competence. This chapter discusses the implications of the findings for practice and counselor training, the limitations of this study and future research recommendations.

The Implications of the Study

Implications of Gender and Level of Cross-Cultural Competence

Hypothesis 1 stated there is a significant difference between male and female substance abuse counselors’ levels of cross-cultural competency as measured by the CCCI–R. A one-way ANOVA on the mean difference between male and female substance abuse counselors on the Cross-Cultural Counseling Inventory–Revised (CCCI–R) subscales. The results of this study indicated there were no significant differences in the level of cross cultural counseling competence between male and female substance abuse counselors in cross-cultural counseling skills, sociopolitical awareness, or cultural sensitivity. These results were consistent with Pope-Davis et al. (1994) who reported similar findings in an exploratory investigation on multicultural competencies of doctoral interns at university counseling centers. They noted no significant gender differences in multicultural knowledge, skills, and awareness. Although an assumption was made that
gender may play a part in the level of cross-cultural counseling competence, the results indicated otherwise.

Furthermore, although previous research in multicultural counseling competence focused on identifying effective ways to examine self-report of multicultural counseling competence when social desirability factor was controlled, the result revealed little or no evidence of a relationship between counselors’ gender and level cultural counseling competence (Constantine, 2002a). This is a relevant finding for substance abuse clinics where decision to hire or assign counselor based on their gender might be considered since female gender may have been viewed as more sensitive to cultural differences. However, these findings revealed a counselor’s gender does not contribute to the level of cross-cultural counseling competence. No previous studies were conducted regarding the difference between male and female substance abuse counselors to substantiate gender difference as a factor in cross-cultural counseling level of competency. The result implies that the substance abuse counselor’s gender may not play a part in the level of cross-cultural counseling competence. Thus, counselor’s gender may not be considered as a factor in employment in matching diverse clients with counselors.

Previous research asserted that counselors’ personal experiences and beliefs have an impact on the development of cross-cultural competencies (Pope-Davis et al., 1994). In order to determine whether substance abuse counselor’s gender perhaps should be considered as a factor in the level of cross-cultural counseling competence, it is imperative for future research to solicit clients’ perspectives of their counselors’ gender and level of cross-cultural counseling competence (Constantine, 2002a; Fuertes et al., 2001). Counselor education programs may need to improve the existing screening
procedures and tools in place to assess the level of multicultural knowledge and personal awareness for prospective students in graduate psychology and counseling programs and to examine whether there is any difference between male and female level of personal knowledge cultural awareness. Perhaps that would enhance the development of more effective curriculum for multicultural counseling course work and address any possible deficiencies in the existing procedures that may have been overlooked. In addition, further research is needed to assess clients’ perceptions of their counselors ‘gender role in multicultural competence as proposed by Fuertes et al. (2001) who recommended further studies to evaluate substance abuse counselors’ level of competence from clients’ experience. It is also suggested that CCCI–R items may properly be modified and used successfully to assess clients’ perceptions of their counselors’ gender and level multicultural competence taking into account the importance of the therapeutic relationship factors and treatment outcome.

**Implications of Level of Education and Cross-Cultural Competence**

The second hypothesis stated, there is a significant difference of the mean score on CCCI–R subscales based on the counselor’s level of education and cross-cultural counseling competency as measured by the CCCI–R. Analysis of variance (ANOVA) indicated that counselors’ level of education did not make any differences in the mean scores in CCCI–R subscales. Therefore the hypothesis was rejected. Despite the incorporation of multicultural course work in the curriculum to most of the counseling psychology masters programs in the past 20 years. The result from this study does not find any significant improvement in the substance abuse counselors’ level of cross cultural competence in cross cultural counseling, sociopolitical awareness or cultural
sensitivity. Previous research analysis supported the results of this study and indicated the absence of consensus as to what would be an ideal way to prepare and train counselors for multicultural practice with the need for more research to evaluate the effectiveness of training methods (Manese, Wu, & Nepomuceno, 2001). Holcomb-McCoy and Myers (1999) supported the results of this hypothesis and noted that there was no significant difference between professional counselors’ perceptions of their multicultural competence and training whether they were graduates of CACREP accredited or non accredited programs. There was no specific research that primarily focused on examining substance abuse counselors’ levels of multicultural competence based on the field of study to determine whether there would be a difference in cross cultural competence between masters, bachelors, and those who did not receive college training.

The implications for counselor preparation drawn from the result of hypothesis 2 are to examine and enhance the existing multicultural competence in psychology, social work, and counselor education programs by evaluating the quality of the educational variables that include course work, multicultural workshops, and supervision. These variables were found to be effective predictors that may increase counselors’ levels of multicultural competence, sensitivity, and effectiveness to work with culturally diverse clients (Constantine & Gloria, 1999). From a research perspective, qualitative studies are needed to further explore and examine the multicultural competence course work offered in psychology, social work, and counselor education graduate programs. Recent studies reported that trainings in multicultural competence were found inadequate for the counselors’ preparation to work with cross-culturally diverse clients (Holcomb-McCoy & Myers, 1999).
Implications of Field of Study and Level of Cross-Cultural Competence

The analysis of the third hypothesis assessed the differences in mean score on the CCCI–R subscales based on the counselor’s field of the study. A one-way ANOVA revealed no significant difference in the mean of CCCI–R subscales. The results indicated some differences in the mean score in cross cultural counseling subscales among counseling, social work, and psychology fields. The hypothesis was accepted. Those participants from the psychology field of study scored lower in all Cross-Cultural Counseling Competence Inventory–Revised (CCCI–R) subscales when compared to those from the counseling and social work fields. The findings indicated that participants from the psychology field were less competent in cross-cultural counseling, sociopolitical awareness, and cultural sensitivity than their counterparts. Previous studies supported the findings and asserted that graduate psychology programs have failed to prepare their students in training for effective practice with culturally diverse clients (Pope-Davis et al., 1995). Such failure was indicated by the insufficient training opportunities, needed changes in the existing curricular, and the need to increase the recruitment of racially diverse faculty and students (Pope-Davis et al., 1995).

The difference in the level of multicultural counseling competence between psychology and counseling was attributed to the differential exposure to multicultural counseling educational and clinical issues. It is imperative to note that there have not been specific and comparative studies that examined the quality of multicultural counseling training of counselors from psychology, counselor education, and social work programs. Thus, it is still important for psychology programs accredited by the APA to further expand the quality and types of multicultural training in psychology programs.
through the enforcement of its accreditation criteria (Pope-Davis et al., 1995). Although one might assume that counselor education programs accredited by CACREP adhere to multicultural training standards, additional research is needed regarding the contribution of the CACREP multicultural training standards to the development of multicultural counseling competence in professional counseling. The lack of data on the status and adequacy of multicultural training in CACREP implies the need for further for research (Holcomb-McCoy & Myers, 1999).

The Post Hoc test data analysis on the fields of study of counseling, social work, and psychology revealed some differences between the groups. Participants from counseling and social work backgrounds showed some differences in cross-cultural counseling. The difference may have been attributed to the incorporation of multicultural course work in the programs’ curricular in both counseling and social work in comparison to psychology programs. Another factor to be considered to support the similarity between counseling and social work is the exposure and daily contact they have with culturally different clients (Holcomb-McCoy & Myers, 1999). Yet, it is unclear whether the difference on CCCI–R subscales was a result of the participants’ multicultural training they may have received in their fields of study or the lack sufficient data to evaluate the strength and weakness of individual programs (Pope-Davis et al., 1995).

Overall, participants who have graduated from counseling and social work programs scored high on CCCI–R subscales compared to those who graduated from psychology programs. The difference in the scores may have been a result of Other various trainings and educational variables. Previous studies suggested a relationship
between some educational and demographic variable and cross-cultural counseling competencies (Pope-Davis et al., 1994). Other findings credited the difference in the level of multicultural competence to differential exposure to multicultural counseling issues that were related to educational and clinical experiences provided in counseling and social work programs compared to those from psychology graduate programs that fell short to provide trainees with effective skills to work with culturally diverse clientele (Manese et al., 2001).

The result of this study suggested that an evaluation of the curricular of psychology, counselor education, and social work graduate programs. Psychology graduate programs in particular must examine the quality of multicultural counseling curriculum and reinforce the APA accreditation criteria through the integration of multicultural content into course work, practicum, and supervision. It is vital for all graduate programs in psychology, counselor education, and social work to evaluate the quality and content of the course work and training offered to determine which format would more effective for the development of multicultural competence. Furthermore, despite the widespread implementation, multicultural competence is mandated in graduate programs by APA and CACREP, there has been no agreement on the definitions of multiculturalism to facilitate the development of effective multicultural training programs (Constantine et al., 2004). Graduate programs are to consider recruitment of ethnic minority internship staff and faculty. Previous studies indicated training programs that recruit minority internship staff and faculty often serve as role models and mentors which could result in providing the training program with unique perspectives, contributing to multicultural issues, and demonstrating the commitment to multicultural
diversity thus adding a richness to the training experience for the interns and faculty (Pope-Davis et al., 1995).

**Implications of Ethnicity and Cross Cultural Competence**

The analysis of the fourth hypothesis examined the possibility of statistical difference of the mean score on the Counseling Competency Inventory–Revised subscales (CCCI–R) based on the counselor’s ethnicity and cross-cultural counseling competency. The results indicated no difference in the mean score between White counselors and African American and Others in Cross-Cultural Counseling Competency Inventory–Revised subscales. Consequently, the hypothesis was rejected. Nevertheless, a counselor’s ethnicity has been found to be consistent with a counselor’s self-reported ability to work with culturally diverse clients. This finding has been supported by previous studies that indicated counselor’s ethnicity has been recorded as a significant predictor of self-perceived cross-cultural counseling competence. The findings as indicated support the assumption that ethnically diverse counselors have been found to be consistent with predicting higher scores in self-reporting abilities to counsel culturally diverse clients than their counterpart White counselors (Constantine, 2001). This assumption does not clearly support the fact that counselors from ethnic minorities are more culturally competent than others. In previous investigations (Constantine, 2002) indicated both prior cross-cultural training and ethnicity or race has been found to consistently predict counselors’ self-report abilities to counsel culturally diverse clients. Also, there has been no definite link to support the relationship between self-reported and other-ratings of counselors’ multicultural counseling competence. In other studies after controlling for social disability attitude, the results revealed no significant relationship
between self-reported multicultural counseling competence and multicultural-case conceptualization ability (Constantine, 2001).

The implications of the above mentioned finding for clinical practice and training is critical and raises important issues about the construct of CCCI–R. There is a need for future research to confirm the nature of the relationships between self-reported multicultural competence and whether social desirability. Until then, the CCCI–R as well as other measuring instruments that are currently administered to assess for self-report multicultural competence need to be accompanied by a social desirability index to minimize the potential for inflated self-rating. Hence future researchers need to examine the relationships between actual multicultural counseling competence and counselor’s ethnicity (Constantine & Ladany, 2000).

Implications of Continuing Education Hours and Level of Cross-Cultural Competence

The fifth hypothesis investigated the correlation between the number of continuing education hours in cross-cultural counseling a substance abuse counselor has attended in the past two years and the level of cross-cultural counseling competency. The result of Pearson correlation (Sig. 2-tailed) indicated no correlation between the number of continuing education in the past two years the substance abuse has attended and level of cross-cultural counseling competency. The hypothesis was rejected. The results revealed a lack of evidence linking the number of continuing education hours to counselor’s level of competence in cross-cultural counseling, sociopolitical awareness, or cultural sensitivity. Previous investigations examined the contributions of counselor’s previous training in cross-cultural counseling showed no solid evidence to link the
number of continuing educational hours to counselor’s multicultural counseling level of competence but argued higher number of previous cross-cultural training can positively be associated to cultural competence (Constantine, 2001; Manese et al., 2001). Furthermore, the result of data analysis of this hypothesis revealed that the number of educational hours the practicing counselors received made no significant difference in their level of cross-cultural counseling competence. Thus, there is a need to evaluate the quality of the training offered in graduate programs, engage in more cultural relevant practice and recruit diverse professionals to assist in the development effective training models. It is important to consider the involvement of minority staff in supervision. Previous investigation supported the finding and indicated that professional counselors perceived their training to be less than adequate and ineffective (Holcomb-McCoy & Myers, 1999). Although issues regarding quality and amount of training are important, there is an urgent need for psychology, counselor education, and social work graduate programs to evaluate and examine the quality and content of the training and continuing education currently offered in order to determine which formats and contents are effective in the development of cross-cultural counseling competence. Another implication that needs to be considered is to examine the effects of integrating multicultural content into all courses and address multicultural issues in practicum and supervision as another potential untapped resource to increase multicultural competencies. The implication for counseling research is further qualitative investigation is necessary to explore the effects of continuing education hours and training on the level of counselors’ multicultural competence (Holcomb-McCoy & Myers, 1999; Pope-Davis et al., 1995).
Limitations of the Study

The outcome of the data analysis of this study and results of previous investigations revealed that counselor’s gender, level of education; field of study, ethnicity, and number of continuing education hours did not play a significant role on counselor’s level of cross-cultural counseling competence. Further investigations may provide some answers and identify specific factors to be considered in the development of culturally competent counselors. Consequently, one might ask, how and when do counselors acquire multicultural competence? Perhaps, cross-cultural competence develops as a result of cross-cultural experience, counselor’s daily contact with culturally different people or post degree training (Holcomb-McCoy & Myers, 1999).

Several limitations are associated with this study; first, caution should be used in generalizing the results. The results should not be interpreted as representative of all substance abuse counselors in Pennsylvania. The rate response indicates that cross-cultural competence may be viewed as irrelevant to potential participants. In addition, it may also raise issue regarding substance abuse counselors’ personal biases and resistance to acknowledge the importance of cross cultural competence. Furthermore, substance abuse counselors who participated in the study may have misunderstood or have misinterpreted the statements in CCCI-R based on their worldviews. Thus, future researchers may wish to continue exploring this study’s variables in a larger sample of substance abuse counselors, review and discuss the current multicultural instruments in class and implement experimental activities that would provide helpful information to assist in the development of psychometric properties and pragmatic utility for future research.
Second, although the Cross-Cultural Counseling Inventory–Revised (CCCI–R) was developed primarily for supervisors to evaluate the trainees’ multicultural counseling competence and has been effectively adapted for self-report ratings of multicultural counseling competence in previous studies, the CCCI–R has been criticized for its tendency to measure anticipated rather than actual behavior or attitude associated with multicultural competence. Also, the modified version of the CCCI–R is subjective in that the participants may have selected socially desirable responses and may have interpreted the items differently than was intended by the author. Therefore, future investigations examining counselor’s self-report multicultural counseling competency when CCCI–R is administrated must be accompanied with social desirability index to temper the potential for self-inflated ratings thus reducing the possibility for the results to be contaminated by social desirability. Also, it is important to mention that the CCCI-R doesn’t offer a clear cut off score to determine certain score a substance abuse counselor needs to obtain in order to be culturally competent. Additionally, despite the extensive use, the CCCI–R, among other scales of self-report multicultural counseling competence, has been criticized for its conceptual foundations which may not match with the philosophies of various graduate academic training programs, in that there is a need for consistency regarding the constructs used in graduate programs which makes it difficult to assess level of multicultural competence (Constantine & Ladany, 2000).

Third, most of the previous studies have attempted to examine self-report multicultural competence after controlling for social desirability to determine whether there is a difference in counselors’ levels of multicultural counseling competence. The results revealed no significant relationship between self-report and multicultural
counseling competence. Further studies are needed to examine substance abuse
counselor gender in relationship to level of cultural competence by investigating client’s
attitude towards counseling, rating counselor’s general counseling competence,
counselor/client therapeutic relationship, and clients perception of counselor’s gender to
determine whether the counselor’s gender plays a part in a counselor’s level of
competence (Constantine, 2002a; Manese et al., 2001; Pope-Davis et al., 1994).

Fourth, the results of this study indicated there are no differences between
substance abuse counselors’ levels of competence regardless of level of education or field
of study. This in turn implies that there is a discrepancy in the definition of cross-cultural
competence and training implications. For example, whereas CACREP endorses a broad
definition of multiculturalism that includes differences pertaining to gender, age, religion,
and social groups, the Association for Multicultural Counseling and Development
(AMCD) proposes a definition of multiculturalism that relates specifically to ethnic/racial
groups, the quality and contents of multicultural competence curriculum and training.
Such discrepancy in the definition of cross cultural competence results in an
inconsistency in the expectations and training practices of multicultural competence in
order to appropriately prepare counselors to be culturally competent. In light of this
discrepancy, there is a need to clarify and agree to a definition of what multicultural
competence is and whether the true constructs that are used to measure for level of
competence by the existing instruments are appropriate (Constantine & Ladany, 2000;
Holcomb-McCoy & Myers, 1999).

Fifth, in this study, the result of counselor’s ethnicity and level of cross-cultural
counseling competence indicated that there was no difference in the mean score between
White and ethnic minority counselors and their levels of cross-cultural counseling competence. On the contrary, previous studies asserted that the difference of White and ethnic minority counselors is indeed relevant to their self-perceived multicultural competence. The investigator recommends further research to examine the relationship between counselor’s ethnicity and multicultural counseling competence through observational methods that involve actual counseling situations (Constantine, 2001; Constantine & Gloria, 1999). Even though counselors’ levels of cross-cultural counseling competence may have been attributed to the number of graduate course work and training as mentioned in previous studies, a recent study indicated that counselors are acquiring their cultural competence through post-degree work with culturally diverse clients rather than training and graduate course work (Holcomb-McCoy & Myers, 1999). More research is needed to determine the correlation between training and the number of continuing education hours and counselor’s cross-cultural competence.

**Future Research and Recommendations**

In view of the progress made in development of multicultural counseling competence, more research is needed if the counseling profession is committed to provide effective services to a rapidly changing and diverse society. The most recent study conducted on the experiences and perceptions of multicultural counseling scholars shed light on various issues that need to be considered in the recruitment and development of culturally competent counselors. As mentioned, the definition of multiculturalism has been broad and needs to include a wide range of cultural variables such as race, ethnicity, gender, sexual orientation, religion, and social class. Other aspects of multicultural counseling competence about which one must inquire when
examining counselor’s multicultural competence are personality characteristics such as whether or not the counselor is open-minded, committed, and passionate about his or her vision of multiculturalism; whether he or she has knowledge/awareness of cultural issues, possesses the needed skills to make culturally sensitive interventions with the ability to integrate client cultural identities into the counseling process, with commitment to social justice, is self-aware of personal biases and cultural identity, and has diverse life experiences and exposure to different cultures with personal experience in discrimination and forms of oppression. Other challenges that are facing the development of multiculturalism involves the complexity of multicultural constructs, lack of solid multicultural theories that are based research, inadequate instruments to measure multicultural constructs, and most importantly the lack of support and awareness among colleagues and resistance of academic institutions to the integration of multicultural issues throughout the programs’ curricular. Also, multicultural supervision was also noted as an important and critical technique in training for the development of multicultural competent counselor (Constantine et al., 2004).

With respect to Gay, Lesbian, Bisexual, and transgender (GLBT) population, the previous studies (Matthew et al., 2005, Bidel et al., 2002) indicated the lack of effective substance abuse treatment programs and insufficient training and information for working with GLBT population. These findings imply the need for counselor education programs need to recruit GLBT individuals, provide trainings that provide information about GLBT and addiction, provide a safe environment and encourage the trainees to openly discuss their personal worldviews and biases as well as discuss trainees sexual orientation. In addition, programs’ applications materials need to communicate openly
antidiscrimination policies, minority-based financial aids, commitment to diversity training and recruitment. Treatment programs need to create affirming treatment environment for GLBT clients and by hiring openly GLBT staff members who are themselves in recovery, support and finance training that address understanding GLBT cultures, become familiar with the multiple traumas the GLBT clients may be subjected to such as sexual abuse, growing up in substance-abusing families, racial and/or ethnic oppression.

Similarly, immigrants and refugees who migrated to U.S in recent years have posed challenge to the counseling profession. Recent studies (Miller et al., 2002) indicated that the screening and assessments checklists and structured clinical interviews have limited use when assessing refugees who have experiences include exile. Leow et al. (2007) noted that immigrants and refugees’ exhibited increase in substance abuse resulted from the traumas they have experienced that are less likely to identified at initial stages due the infective existing screen tools. In addition, the designs of most evidence-based programs are not culturally sensitive to address immigrants and refugees issues. These findings imply the need graduate in counselor education and psychology programs to incorporate training and course-work in the curriculum that address culturally diverse population, immigration, exile and war trauma issues. Most importantly, more research is needed to reassess the existing screening and diagnostic assessment tools such as DSM system that are proven to be inaccurate in diagnosing culturally diverse population.

The geriatric population has posed another challenge to counseling field as well. Previous researches asserted that substantial number of older adults have been struggling with addiction to alcohol, over-counter medication and illegal substances (Steinhagen and
Considering the rising number of older adults with addiction problems to 4.4 million by 2020 imply the need to educate substance abuse counselors of substance dependence in geriatric population. Counselor Education, Social Workers, Psychology graduate programs need to acknowledge and incorporate geriatric counseling by providing training in assessment skills to recognize symptoms of use abuse of alcohol and other illegal substance. It is equally important to inform trainees of the difficulties older adults experience to address alcohol related issues. Health Care providers need to acquire prevention, interventions skills, and supportive services as well as counseling techniques to explore their patient’s concerns, understand their cultures in order to provide effective treatment. Physicians need to integrate alcohol and drug screening tools in their practices and make referrals at early stages. The implications for treatment providers, are to develop clinically and culturally competent workforce through education and training of counselors, recruit bilingual culturally competent and use older adults in peer-to-peer service roles more extensively. More research on effective prevention, intervention, and recovery support strategies are needed to address this epidemic.

The number of individuals who have been incarcerated in state prisons and county jails has risen in recent years for crimes related to addiction. Primm et al. (2005) indicated 61% of incarcerated individuals were diagnosed with substance abuse dependence and co-occurring disorders were not perceived to have need of treatment due to the lack of competent counselors, screening and assessment tools. Few studies have evaluated substance abuse and mental health treatment services in the criminal justice system for cultural competence. The outcome of focus groups study conducted with ethnic minority individuals who were previously involved with the criminal justice
system indicated that at every point of contact, participants reported inadequate cultural competence not only in health services. This finding implies the need for systemic training under the direction of advisory groups and leadership to include law enforcement, prisons and jail intake and treatment staff, courts, correctional settings and community re-entry. Counselors employed by the criminal justice must undergo various training.

**Conclusion**

In this study, the investigator sought to examine the relationships between substance abuse counselor’s gender, level of education, field of study, ethnicity, number of continuing of education hours the counselor has attended, and cross-cultural counseling competence. The results of the four hypotheses (Gender, level of education, ethnicity and number of continuing education hours) indicated no significant relationships between the variables studied and level of cross-cultural counseling competence. With respect to field of study, the result revealed some difference in the level of cross cultural counseling competence between Counselors and Social Workers and their counterpart Psychologists. According to the above mentioned recommendations and the limitations, future investigators should re-examine specific areas and issues that have been discussed with a larger number of participants in psychology, counseling education, and social work graduate programs and identify the pitfalls of the existing practice, methods, and work to improve the growth and development of multicultural counseling competence. Furthermore, future researchers may wish to embrace diversity and include GLBT, Immigrants and Refugees, Geriatric and Forensic populations in their
research in pursue of an answer to what, how, and when counselors acquire multicultural competence.
REFERENCES


Countrywide Older Adult Ad Hoc Committee, Older Adult System of Care, County of Los Angeles Department of Mental Health Older Adult Services and Association of Community Human Services Agencies. (2005). Collaborative Report on Older Adult Mental Health Services. Los Angeles, CA: Author.


APPENDIX A

PERMISSION FOR USE OF CCCI-R

NetZero Message Center

From: Terese LaFromboise <lafrom@stanford.edu>
To: "a.elamin@netzero.net" <a.elamin@netzero.net>
Cc: lafrom@stanford.edu
Subject: Re: Requesting to order CCCI-R research purpose
Date: Tue, Nov 28, 2006 02:51 PM

Dear Abdelhadi,
You do not need to pay for the CCCI-R. I suggest you read the literature to find the article on psychometric properties in Professional Psychology. I will also forward a summary of a review the scale.
Teresa

At 11:46 AM 11/17/2006, you wrote:

Hi Dr. LaFromboise,

Thanks for allowing me use the CCCI-R. I am not sure where to purchase it and how much. I do need information on the validity, reliability and the scoring for chapter three. I look forward to hear from you. Thank you so much. Abdelhadi

Teresa D. LaFromboise
Associate Professor
School of Education
Stanford University
(650) 723-1202
(650) 725-7412 FAX
lafrom@stanford.edu
www.stanford.edu/~lafrom

http://webmaila.netzero.net/webmail/new/8?block=1&msgLst=00002y00:0015R9DP000... 11/28/2006
Dear Abdeljadi,
These minor modifications are fine. You have my endorsement for doing so. Good luck in your work. Please keep me informed of your results.
Teresa
At 10:12 AM 6/7/2005, you wrote:

Hello Dr. LaFromboise,

I finally managed to work on the CCI-R. Attached is the modified version. I very much stayed with the same questions. Please review and let me know what you think via email a.elamin@netzero.com. Thanks.

Abdeljadi

Teresa D. LaFromboise
Associate Professor
School of Education
Stanford University
(650) 723-1202
(650) 725-7412 FAX
lafrom@stanford.edu
www.stanford.edu/~lafrom

6/13/2005
APPENDIX B

DEMOGRAPHIC SURVEY

Please check the following information as it pertain to you and complete the following attached survey. A return envelope is included for your convenience. Thank you for your participation.

Gender: ____ Male            ____ Female

Age: _____

Level of Education: ____ Pre Bachelor’s Training    ____ Bachelor       ____ Master
                  ____ Post Master    ____ No College Training

Field of Degree:  ____ Counseling
                   ____ Social Work
                   ____ Psychology
                   ____ Other specialty. Specify: ________________________.

Number of continuing education hours on Cross-Cultural/Multicultural Counseling I have had in the past two years: ________

I am: (Please check all that applies)

______ Certified Addiction Counselor (CAC, AAC etc). Specify: ____________________.
______ Licensed Counselor (LPC, LMF, etc.). Specify: ____________________________.
______ Licensed Social Worker
______ Licensed Psychologist
______ Other specialty

The ethnicity group I most identify with is: (Please specify):

______________________________.

Years of experience in the counseling field: ________.

Group(s) I feel comfortable counseling: (Please check all that apply).

______ Ethnic minorities.
______ Gay/Lesbians/ Bisexual/Transgender.
______ Immigrants/Refugees.
______ Forensic (Criminal Justice System population)
______ Geriatrics.
APPENDIX C

CROSS-CULTURAL COUNSELING INVENTORY- REVISED

The purpose of this modified inventory is to measure your knowledge, skills and awareness about the Cross- Cultural Counseling Competence. I am interested in self-report of your cross-cultural counseling competencies, so please make a judgment on the basis of what the statements in this inventory mean to you. In recording your response, please keep the following points in mind:

a) Please circle the appropriate rating under each statement.
b) Please circle only one response for each statement.
c) Make sure you check every scale even though you may feel that you have insufficient data on which to make judgment. Please do not omit any.

Rating Scale: 1 = strongly disagree 4 = slightly agree
2 = disagree 5 = agree
3 = slightly disagree 6 = strongly agree

1. I am aware of my own cultural heritage
2. I value and respect cultural differences
3. I am aware of how my own values might affect my work with the client
4. I am comfortable with differences between the client and me
5. I am willing to suggest referral when cultural differences between me and the client are extensive
6. I understand the importance of the client’s socio-political system and its impact on the counseling process
7. I am well-informed about cultural diversity
8. I have a clear understanding of cross-cultural counseling and the therapy process with client
9. I am aware of institutional barriers, which might affect client’s circumstances
10. I am able to elicit varieties of verbal and non-verbal responses from culturally diverse client.
<table>
<thead>
<tr>
<th>Rating Scale:</th>
<th>1 = strongly disagree</th>
<th>4 = slightly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 = disagree</td>
<td>5 = agree</td>
<td></td>
</tr>
<tr>
<td>3 = slightly disagree</td>
<td>6 = strongly agree</td>
<td></td>
</tr>
</tbody>
</table>

11. I am well aware of the variety of verbal and non-verbal messages that I send to and receive from the client during the counseling process

12. I am able to suggest institutional intervention skills that favor the client

13. I am able to send messages that are appropriate to the communication of the client

14. I attempt to perceive the presenting problem within the context of the client’s cultural experience, values, and/or lifestyle

15. I present my own values and beliefs to the client

16. I am at ease talking with the client regardless of his/her cultural background

17. I am able to recognize the limitations that are determined by the cultural differences between me and the client

18. I appreciate the client’s social status as an ethnic minority.

19. As a counselor, I am aware of the professional and ethical responsibilities towards client

20. I acknowledge and comfortable with cultural differences
APPENDIX D

LETTER TO PARTICIPANTS

Dear Participant:

I am currently working on my doctoral dissertation titled, "Examining Cross-Cultural Counseling Competencies of Substance Abuse Counselors in the Commonwealth of Pennsylvania." This investigation is conducted in partial fulfillment of the requirements for the doctorate degree in the Counselor Education Program at Duquesne University.

This research study will utilize Cross-Cultural Counseling Inventory Revised (CCCI-R) to examine cross-cultural counseling competencies of substance abuse counselors and identify factors that will contribute to enhancing cross-cultural counseling competencies in substance abuse treatment.

There is no risk to you by participating in this research. In order to assure confidentiality all participant responses will be completely anonymous. All information you provide will be combined with the data from other participants and reported in aggregated form. All materials will be destroyed upon completion of the study. Your participation is voluntary with no obligations.

Please take approximately 10 minutes to complete the demographic survey and CCCI-R and mail back to me using the enclosed stamped self-addressed envelope. The survey data collection materials will also be available on www.surveymonkey.com. If you have any questions, please contact me at (412) 310-5639 or e-mail: a.elamin@netzero.net

Thank you for your gracious assistance,

Abdelhadi A. Elamin, Ms Ed, NCC, LPC
Doctoral Candidate
Duquesne University,
Department of Counseling, Psychology and Special Education.
APPENDIX E

CONSENT FORM

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Examining Cross-Cultural Counseling Competencies of Substance Abuse Counselors in the Commonwealth of Pennsylvania

INVESTIGATOR: Abdelhadi A. Elamin
116 Champa Street
Pittsburgh, Pennsylvania, 15235
412-243-0154
412-310-5639

ADVISOR: David Delmonico, Ph.D
Duquesne University
School of Education
Department of Counseling, Psychology and Special Education
412-396-3333

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the Doctor of Education (Ed.D.) degree in Counselor Education and Supervision at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate cross-cultural counseling competencies of substance abuse counselors in the Commonwealth of Pennsylvania. You are asked to complete one questionnaire that takes approximately twenty minutes to complete.

RISKS AND BENEFITS: There are no risks to you. Your participation will assist in future research in cross-cultural counseling competency.

COMPENSATION: There is no compensation to you. However, participation in the project will be of no monetary cost to you.

CONFIDENTIALITY: Your name will never appear on any survey or research instruments. No identifying information will be used in the analysis. All written data collection materials will be locked.
and secured. Electronic data will be stored in a password protected computer and stored in a locked file in the researcher’s office. Your response(s) will only appear in statistical data summaries. All research written and electronic materials will be kept for five years and destroyed thereafter.

**RIGHT TO WITHDRAW:**

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time.

**SUMMARY OF RESULTS:**

A summary of the results of this research will be supplied to you, at no cost, upon a written request.

**VOLUNTARY CONSENT:**

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any questions about my participation in this study, I may call Dr. Paul Richer, chair of the Duquesne University Institutional Review Board (412-396-6326).

By submitting a completed data collection materials, you are consenting to participate in the research project.