

Broaching Multicultural Considerations during the Initial Clinical Interview

Connie T. Jones

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Laura E. Welfare, Chair  
Gerard F. Lawson  
Penny L. Burge  
Nancy E. Bodenhorn

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## ABSTRACT

Counseling professionals are committed to providing multiculturally competent services to the clients they serve. When clients first enter counseling, the therapeutic relationship typically begins by the counselor conducting an initial clinical interview. This initial clinical interview is a critical time to demonstrate cultural competence. Currently, there is no literature that has explored how counselors who work with the substance use population incorporate multicultural considerations during the initial clinical interview. The purpose of this study was to explore whether licensed professional counselors (LPCs) broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders (SUDs). The exploration of this phenomenon occurred through the use of a qualitative methodology. Semi-structured interviews were conducted with nine LPCs in Virginia. The LPCs shared their lived experiences conducting initial clinical interviews with members of the SUDs population. Four themes and a subtheme emerged related to how LPCs perceive the relevance of identifying multicultural factors in their work with the SUDs population: everyone has culture and it is all encompassing, culture is needed to understand clients (subtheme), multicultural factors impact substance use behavior and patterns, cultural identities emerge during the initial clinical interview, and multiculturalism was an important component in counselor preparation. Three themes emerged related to how LPCs describe the term and concept of broaching: no familiarity with the “broaching” term, broaching defined as initiating a topic, and some degree of understanding of the broaching concept. Five themes emerged related to whether and how LPCs introduce or broach multicultural considerations during the initial clinical interview: broaching

approach varies, client introduces multicultural factors, appropriate timing, willingness to be open, and boundaries surrounding broaching. The themes that emerge from this data will help to fill gaps in the literature concerning how counselors broach multicultural considerations, particularly with the SUDs population. Implications for counselors and counselor education are discussed. The limitations of the study and recommendations for future research are provided.

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## TABLE OF CONTENTS

	<b>Page #</b>
<b>ABSTRACT</b>	ii
<b>ACKNOWLEDGMENTS</b>	iv
<b>TABLE OF CONTENTS</b>	v
<b>LIST OF FIGURES</b>	viii
<b>LIST OF TABLES</b>	ix
<b>CHAPTER 1 INTRODUCTION</b>	1
Context of Multiculturalism in Counseling	1
Statement of the Problem	6
Purpose of the Study and Research Questions	12
Definitions	13
Overview of the Method	15
Limitations	15
Summary of Document Organization	16
<b>CHAPTER 2 REVIEW OF THE LITERATURE</b>	17
Multiculturalism in Counseling	17
Theoretical Frameworks	19
Dimensions of Person Identity Model	19
RESPECTFUL Model	20
Broaching	21
Substance Use Disorder Population and Diversity	26
Multiculturalism and Assessment	27
Review of Relevant Literature	29
Multiculturalism in Substance Use Disorder Treatment	29
Multicultural Considerations in Clinical Interviews	45
Broaching as a Multicultural Counseling Approach	49
Multicultural Competency in Substance Use Disorder Treatment	64
Summary	69

<b>CHAPTER 3</b>	<b>METHODS</b>	<b>72</b>
Purpose of Research		72
Rationale for Research Design		72
Ethical Considerations		74
Confidentiality		75
Informed Consent		75
Research Methods		77
Role of the Researcher		77
Participants		79
Data Collection		81
Data Analysis		87
Credibility and Rigor		89
Summary		91
<b>CHAPTER 4</b>	<b>FINDINGS</b>	<b>93</b>
Participants		94
Data Analysis		95
Findings		97
Research Question One		97
Research Question Two		105
Research Question Three		108
Summary		115
<b>CHAPTER 5</b>	<b>DISCUSSION</b>	<b>118</b>
Summary of Findings		119
Research Question One		119
Research Question Two		123
Research Question Three		125
Discussion and Interpretations		129
Research Question One		130
Research Question Two		132
Research Question Three		133
Conclusions		138

Limitations	141
Implications	142
Implications for Counselors	142
Implications for Counselor Educators	144
Future Research	146
Summary	146
<b>REFERENCES</b>	<b>148</b>
<b>APPENDICES</b>	<b>159</b>
A Participant Informed Consent	159
B Recruitment: Email and Phone Script	164
C Interview Protocol	170
D Follow-Up Interview	173
E Demographic Questionnaire	174
F Theme Formulation	175
G Audit Trail	178
H IRB Approval Letter	185

**LIST OF FIGURES**

<b><u>Figure</u></b>	<b><u>Title</u></b>	<b><u>Page #</u></b>
1	Dimensions of Personal Identity Model	20

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**LIST OF TABLES**

<b>Table</b>	<b>Title</b>	<b>Page #</b>
1	Demographic Summary of Participants	95

## CHAPTER ONE

### INTRODUCTION

Due to the multicultural society in which we live, culture-centered addictions treatment is vital (Arredondo et al., 1996; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014; Sue, Arredondo, & McDavis, 1992). Providing culturally competent services to clients ensures the needs of diverse cultural groups are being met (Arredondo et al., 1996; Sue et al., 1992). The importance and benefits of diversity should be expressed in the beginning of the counselor-client relationship (Day-Vines et al., 2007), which is typically the initial clinical interview (Jones, 2010). Individuals who struggle with addiction represent various cultural subgroups (NIDA, 2005; SAMHSA, 2014); for that reason, it seems necessary to explore sociocultural information during the initial clinical interview in order to be able to fully conceptualize each individual case. This study was designed to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders.

### Context for the Study

#### American Counseling Association and Multicultural Counseling Competencies

The American Counseling Association (ACA) embraces diversity and multiculturalism (ACA, 2014). The ACA Code of Ethics Preamble's second core professional value is, "honoring diversity and embracing a multicultural approach in support of the worth, dignity, potential, and uniqueness of people within their social and cultural contexts" (p. 3). This core professional value conveys it is ethical practice to recognize and support multiculturalism and diversity when working with clients (ACA, 2014; Arredondo & Toporek, 2004). In 1982, Sue et al. produced a

paper that introduced cross-cultural counseling competencies. The competencies included in the document were categorized into three dimensions: beliefs and attitudes, knowledge, and skills. These competencies continue to provide the foundation for multicultural competent practice in counseling (Pope-Davis, Coleman, Liu, & Toporek 2003).

In 1992, Sue et al., issued a "call to the profession" to approach counseling from a multicultural perspective by implementing formalized multicultural counseling competencies. The article provided grounds for including multicultural perspectives in counseling assessment, practice, training, and research, and suggested standards for culturally competent counselors (Pope-Davis et al., 2003; Sue et al., 1992). The Association for Multicultural Counseling and Development (AMCD), a division of ACA, has been a prominent leader in supporting, defining, and operationalizing the multicultural counseling competencies (MCC) (Arredondo et al., 1996; Pope-Davis et al., 2003; Sue et al., 1992). They developed and published 31 MCC, categorized by the three main dimensions of beliefs and attitudes, knowledge, and skills (Sue et al., 1992). Applying the MCC to initial clinical interviews is a feasible starting point to aid in understanding the importance of incorporating multicultural considerations into the counseling process.

### **Dimensions of Personal Identity Model and RESPECTFUL Model**

A prominent premise of the multicultural counseling approach is everyone is multicultural (Arredondo et al., 1996; Sue et al., 1992). The ACA Code of Ethics (2014) supports this premise and explains that counselors should take clients' multiple contexts into consideration when addressing evaluation, assessment, and interpretation. The DPIM and the RESPECTFUL model illustrate the idea that we all are multicultural beings and provide frameworks to aid in assessing an individual's complexity (Arredondo & Glauner, 1992; Arredondo et al., 1996; D'Andrea & Daniels, 2001).

**Dimensions of Person Identity model.** The MCC and the Dimensions of Personal Identity Model (DPIM) are separate paradigms that complement one another (Arredondo, 2006; Arredondo, & Glauner, 1992; Arredondo et al., 1996). The MCC provide the general conceptualization and framework for multicultural practice, which includes assessment, and the DPIM offers a contextual model to understand and integrate human complexity into the counseling process (Arredondo, 2006; Arredondo, & Glauner, 1992; Arredondo et al., 1996). The DPIM is a useful paradigm to aid counselors in recognizing and assessing clients' multiple contexts and multiple identities (Arredondo & Glauner, 1992; Arredondo et al., 1996; Arredondo, 2006). The model consists of fixed and developmental dimensions that make human beings unique (Arredondo & Glauner, 1992; Arredondo, 2006). Not only does the DPIM focus on the fixed dimensions of individuals, it considers how the sociocultural, historical, and political factors affect individuals (Arredondo, 2006; Arredondo et al., 1996).

The model was first introduced in 1992 as a multidimensional model, and it consists of three dimensions: A, B, and C (Arredondo & Glauner, 1992; Arredondo et al., 1996). The A dimensions comprise fixed identities, or biologically determined identities (e.g., age, gender, sexual orientation, and race). B dimensions are "fluid or dynamic features" (e.g., interests, education background, and geographic location). Lastly, the C dimensions introduce contextual and sociopolitical factors, which are often out of an individual's control (e.g., slavery and the Holocaust), and highlight that individuals must be seen in historical context (Arredondo et al., 2005; Arredondo et al., 1996). These dimensions and the interplay of the dimensions, illustrate why it is so vital to conduct an initial clinical interview that infuses multicultural considerations.

**RESPECTFUL model.** Similar to the DPIM, the RESPECTUL model also illustrates the complexity of human beings (Arredondo & Glauner, 1992; Arredondo et al., 1996; D'Andrea & Daniels, 2001). The RESPECTFUL model framework is an acronym that

represents ten domains of cultural identity which comprise the model (D'Andrea & Daniels, 2001). The cultural domains represented in the model were chosen by the developers because they can affect individuals' psychological development and well-being on multiple levels (D'Andrea & Daniels, 2001). The developers of the RESPECTFUL model acknowledge that the domains represented in the model are not an exhaustive list of cultural identities. The ten domains included in the RESPECTFUL model include: Religious and spiritual identity; Ethnic, cultural, and, racial background; Sexual identity; Psychological maturity; Economic class standing and background; Chronological-developmental challenges; Threats to well-being and trauma; Family history, values, and dynamics; Unique physical characteristics; and Location of residence and language differences (D'Andrea & Daniels, 2001). The RESPECTFUL model and DPIM provide a contextual approach to assessment and treatment (Arredondo, & Glauner, 1992; Arredondo et al., 1996; D'Andrea & Daniels, 2001; Smith, 2004).

### **Broaching**

The DPIM and RESPECTFUL model are frameworks that assist in understanding the cultural complexity of human beings. Broaching is a term that was created by counselor educators to capture and describe the counselor's effort to explore the complexity or cultural factors of the client during the counseling process (Day-Vines et al., 2007). It is considered a strategy that can be utilized by counselors to introduce or "bring" the discussion of cultural considerations into the counseling process. It is vital that counselors consider how cultural factors may impact the client's presenting problem (Day-Vines et al., 2007). Oftentimes due to oppression and marginalization experienced by non-dominant groups, clients that identify as a member of a non-dominant group may be hesitant to introduce how cultural factors may be affecting their presenting issue (Day-Vines et al., 2007). Society has created a norm of silence surrounding oppression and marginalization and members of non-dominant groups may remain

silent concerning these issues even in counseling due to the lack of strength of the therapeutic relationship, the questionable safety of the environment, and the learned societal norm of needing to compartmentalize (Day-Vines et al., 2007). The broaching strategy allows for counselors to create a safe environment, free from shame and fear, in which the counselor can provide an opportunity to aid the client in examining how sociocultural factors may be affecting their presenting problem (Day-Vines et al., 2007).

## **Summary**

The MCC provide the overall basis for the context of the study concerning multicultural counseling practice, the DPIM and RESPECTFUL model provide frameworks for understanding the complexity of individuals, and broaching provides a strategy for introducing and discussing multicultural identities in the counseling process. These frameworks illustrate the importance of infusing multicultural considerations in the initial clinical interview. The MCC, DPIM, RESPECTFUL model, and broaching complement one another and leads to cultural competent practice. Cultural competence is a concept difficult for some counselors to conceptualize and define. There is no singular definition for this concept, and for the purposes of this paper I define cultural competence as the counselor's ability to effectively engage in practice with clients from diverse cultural backgrounds, and has the awareness, knowledge, and skills to create conditions that maximize optimal well-being and functioning for the client within the client's multiple contexts (Sue & Sue, 2008; Sue & Torino, 2005). As stated in the definition, cultural competence is about creating situations that promote the most favorable client development (Sue & Sue, 2008; Sue & Torino, 2005). It is the researcher's belief that in order to aid clients in reaching their optimal development, counselors must acknowledge clients' cultural identities, and incorporate those identities and contexts into the counseling process, particularly during the initial clinical interview process.

### **Statement of the Problem**

Substance use is a major public health problem that impacts society on multiple levels (National Institute on Drug Abuse [NIDA], 2005). Every community is affected by substance abuse, and no population or cultural group is immune to its affects (NIDA, 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). In the 2013 results from the National Survey on Drug Use and Health, it was estimated that 20.3 American adults have a substance use disorder (SUD). That 20.3 million equates to nearly 1 in 12 adults were diagnosed with a SUD based on the diagnostic criteria stated in the *Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition*, (DSM-5) (American Psychiatric Association [APA], 2013) (SAMHSA, 2014). Often, addiction requires clinical treatment, and the National Survey on Drug Use and Health (2013) indicated that 22.7 million Americans aged 12 and over needed treatment for an illicit drug or alcohol use problem, but only 2.5 million received treatment at a specialty facility (SAMHSA, 2014).

The substance use disorders (SUDs) and addiction population is diverse because addiction transcends all multicultural identities, including: race, age, gender, sexual orientation, and social class (NIDA, 2005; SAMHSA, 2013). Further, clients with non-dominant cultural identities are more likely to struggle with addiction issues due to poverty, unemployment, environmental factors, acculturation stresses, low educational achievement, self-esteem, and economic marginalization (Cherpitel, 1999; Gottfredson & Koper, 1996; Sharma, 2008; Torres-Rivera, Wilbur, Phan, Maddux, & Roberts-Wilbur, 2004). In the helping professions, professional counselors provide more services to clients with a primary substance use disorder than psychiatrists, psychologists, and social workers (Harwood, Kowalski, & Ameen, 2004; Lee, Craig, Fetherson, & Simpson, 2013). Due to the diversity within the addictions population, it is vital that counselors incorporate multiculturalism to better fit the needs of diverse clientele

(SAMHSA, 2013; Sue, Arredondo, & McDavis, 1992; Trepper, Nelson, McCollum, & McAvoy, 1997).

### **Diversity in Substance Use Disorders Treatment**

The recognition and significance of diversity in SUDs treatment is a contemporary approach (Castro & Garfinkle, 2003; Lee et al., 2013). Many traditional and standard substance use treatment programs are “blind” to culture (Castro & Garfinkle, 2003). This is due in part to the most widely accepted model of addiction, the disease model (Lee et al., 2013). This model asserts that addiction is a genetic and permanent disease that alters the body (Lee et al., 2013). Critics of the disease model introduced multicausal models that conceptualize addiction as more than a disease, and view the individual as a whole person including biology, environment, and sociocultural factors (Lee et al., 2013). In multicausal models, clients begin to use substances for different reasons, including cultural and environmental factors (Torres-Rivera, et al., 2004). The counselor’s focus should be on unearthing sociocultural variables such as: client acceptance of a substance problem, barriers to retention, and treatment outcomes that can impact SUDs treatment (Abbot & Chase, 2008; Jacobson, 2004; Walton, Blow, & Booth, 2001). Due to the current and growing diversity in the United States, counselors would be remiss not to consider a client's cultural background when assessing for SUDs (Abbot & Chase, 2008; Arredondo et al., 1996; Sue et al., 1992).

Castro and Garfinkle (2003) stated that although the significance of acknowledging diversity and delivering multiculturally competent services in SUDs treatment has been noted, there are few models that aid in the conceptualization of how to incorporate cultural variables into treatment, and how to deliver multiculturally competent SUDs treatment. Further, despite the plethora of multiculturally-based counseling literature, there is limited literature concerning how cultural variables influence the delivery of culturally competent and effective SUDs

treatment and treatment outcomes specifically (Castro & Alarcon, 2002; Castro & Garfinkle, 2013; Walton et al., 2001). Even more scant, is literature that addresses culturally competent intake processes, including the initial clinical interview (Alcantara & Gone, 2014; Algeria, Katz, Ishikawa, Diaz-Linhart, Valentine, & Lapatin, 2012; Jones, 2010). Most of the literature concerning cultural variable incorporation into SUDs treatment focuses on gender, ethnicity/race, and sexual orientation (Castro & Garfinkle, 2003; Cochran & Cauce, 2006; Torres-Rivera, et al., 2004; Trepper et al., 1997; Walton et al., 2001).

**Studies concerning gender, race/ethnicity, and sexual orientation.** There is a lack of research studies that examine how clinicians implement and provide culturally competent practice, but there is empirical research that demonstrates the need for multicultural practice in SUDs treatment. Mereish and Bradford (2014) conducted a quantitative study that examined the lifetime substance abuse problems experienced by heterosexual and sexual minority men and women using an intersectionality framework. The researchers explored the intersections of gender, race, and sexual orientation. The authors demonstrated how cultural factors such as sexual orientation, race, and gender can influence substance use patterns, and further, explained that the intersection of cultural factors can affect substance use patterns.

Cochran and Cauce (2006) conducted a study concerning the relationship between substance abuse and sexual orientation. The study focus was to examine (a) if the development of substance abuse problems is different among lesbian, gay, bisexual, and transgender (LGBT) individuals and heterosexual individuals, (b) whether the prevalence of alcohol and other substances are different among LGBT and heterosexual individuals, and (c) whether or not standard treatment programs can meet the needs of LGBT clients. The findings of the study not only demonstrate that there are differences between heterosexual and LGBT individuals' substance use behavior, but there are intragroup differences also. The results of this study do not

provide an explanation for why LGBT individuals use substances, but the results do identify difficulties the individuals may experience such as a stigmatized sexual identity and internalizing negative thoughts towards self.

King and Canada (2004) conducted a quantitative study to examine the predictors of early drop-out in a male and female outpatient addiction treatment program. The researchers hypothesized that factors such as unemployment, lower education, longer treatment history, female gender, African American ethnicity, and patient's referrals from a non-medical source would predict early treatment drop-out. Female gender was one of the significant predictors of drop-out. The researchers found that women who dropped out were more likely than women who remained in treatment to be unemployed, have less education, and have dependent children. It was implied by the researchers that this may indicate that females, when taking into consideration particular socioeconomic factors and roles, might need treatment tailored to meet their unique needs. This finding exposes that females may have different treatment needs than the dominant cultural male gender identity. Being African American is also a predictor of early treatment drop-out. African Americans were five times more likely to drop-out of treatment than Caucasians. This finding was consistent with previous empirical literature. The findings of this study indicate that different cultural groups have unique needs that may need to be addressed in addiction treatment in order to reduce attrition (King & Canada, 2004). Community mental health settings often provide outpatient addiction treatment. Therefore, exploring if the counselors practicing in these settings address the unique needs of the clients is important.

### **Community Mental Health Centers**

Community mental health clinics, are community mental health settings that serve a diverse clientele who vary based on race, ethnicity, gender, age, sexual orientation, socioeconomic status, language, etc. (Delphin & Rowe, 2008; Seligman, 2004). Community

mental health centers (CMHC) were a result of The Community Mental Health Centers Act of 1963 (also known as The Mental Retardation and Community Mental Health Centers Construction Act of 1963), and changed how mental health services were delivered (Cutler, Bevilacqua, & McFarland, 2003; Pollack & Feldman, 2003). Prior to the Act, individuals with mental health needs were housed in long-term institutions to receive care. Most care at public institutions was regimented and impersonal (Murphy & Rigg, 2014). The Act led to the establishment of comprehensive CMHC throughout the United States, and individuals were able to return to their communities and receive treatment from the CMHC (Pollack & Feldman, 2003). CMHC have evolved since the date of establishment and currently provide mental health and substance abuse treatment (Murphy & Rigg, 2014). Professional counselors who work in community mental health agencies with adult addictions frequently work with diverse client populations (Cheung & Snowden, 1990; Delphin & Rowe, 2008; SAMHSA, 2013).

CMHC once had “cultural brokers” who helped to facilitate the cross-cultural relationship between the client and the mental health professional, and to provide cultural information that could produce positive treatment outcomes (Murphy & Rigg, 2014). Today, there is less likelihood a cultural broker will be utilized, and community-based counselors are expected to be multiculturally competent, which includes acknowledging and discovering cultural variables and contexts that influence client assessment and interventions (Arredondo et al., 1996; Constantine, 2000). Culturally competent practice includes service delivery and practice methods built on the knowledge the counselor gained concerning contextual factors that may or may not be affecting clients’ lives, and structuring interventions focused on helping clients function optimally in their contexts (Corwin, 2006). Because the initial clinical interview is the beginning of the therapeutic relationship and the gateway to interventions (Jones, 2010), it seems that the initial clinical interview should include gaining knowledge and broaching the

cultural and contextual variables that may be influencing clients' behaviors (Lightburn & Sessions, 2006; Corwin, 2006).

### **Initial Clinical Interviews**

Initial clinical interviews are the most commonly utilized assessment technique for clinical diagnosis and case formulation (Alcantara & Gone, 2014). They are utilized to determine proper diagnosis, and to determine suitable treatment planning (ACA, 2014). Typically, CMHC rely on unstructured, open-ended initial interviews as the assessment tool for diagnosing DSM disorders (Jones, 2010). The interviews can vary in format and be structured, partially structured, or unstructured (Alcantara & Gone, 2014; Jones, 2010). The initial clinical interview occurs at the start of the counseling relationship, and is the *beginning* of the counseling relationship (Jones, 2010). It is important counselors display multicultural sensitivity and competency during the initial clinical interview because many clients who are racial/ethnic minorities discern whether they will return to counseling based on their experience in the first session (Alcantara & Gone, 2014). Therefore, the use of broaching during the initial clinical interview may be particularly impactful when establishing the counseling relationship (Alcantara & Gore, 2014; Day-Vines et al., 2007).

### **Summary**

Oftentimes, mental health professionals do not assess for nor consider the influence contextual factors may have on a client's behavior and overall well-being (Smith, 2004). In order to approach the process of assessment from a multicultural perspective, it is necessary for counselors to include and acknowledge clients' multiple sociocultural contexts, particularly during case conceptualization (Arredondo & Rice, 2004; Smith, 2004). Due to limited time in the intake session, counselors have a propensity to focus on presenting issues instead of gathering clients' perceptions of their cultural identities (Smith, 2004). When sociocultural factors are not

assessed and context is dismissed, there is a possibility for misdiagnosis, a poor therapeutic relationship, inappropriate interventions, and poor treatment outcomes (Castro & Garfinkle, 2003; Cheung & Snowden, 1990; Constantine, 2002; Delphin & Rowe, 2008; Ridley et al., 1998). Because there are few models that assist counselors in incorporating cultural variables into work with SUDs, broaching may be a useful strategy for LPCs to utilize when conducting the initial clinical interview with clients with SUDs. Broaching can aid in introducing the topic of culture into the initial clinical interview (Day-Vines et al., 2007).

### **Purpose of the Study and Research Questions**

Given the importance of cultural factors and how they can affect clients' presenting problem and substance use patterns (Mereish & Bradford, 2014), it is essential to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. The research questions focused on the participants' perceptions by capturing their personal experiences with working with diverse clientele. The research questions that guided the study are as follows:

1. How do LPCs who conduct initial clinical interviews perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?
2. How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?
3. Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?

## Definition of Terms

Key terms will be defined to clarify the meaning of important concepts relevant to the study.

Licensed Professional Counselor (LPC) – A counselor who has been awarded a state license or equivalent certification by passing the state licensure exam or by endorsement (Remley & Herlihy, 2010; Virginia Board of Counseling).

Substance Use Disorders (SUDs) – A collection of cognitive, behavioral, and psychological symptoms that signifies that a person continues to use substances although they are experiencing problems related to their substance use. An individual invests a significant amount of time obtaining, using, and recovering from the substance (APA, 2013).

Sexual Orientation - An individual's preference of whom they have intimate, emotional, and/or sexual attractions towards (Lee, 2013).

Sexual Minorities– Includes individuals who identify as bisexual, gay, and lesbian (Lee, 2013).

Lesbian (L) – The preferred term for women who identify as gay. Women who are attracted to women (Lee, 2013).

Gay (G) – Individuals who are attracted to individuals of the same gender (Lee, 2013).

Bisexual (B) – Individuals who are attracted to people of both genders (Lee, 2013)

Race – A classification system recognized in the United States (U.S.) to group humans into distinct groups based on cultural and ethnic similarities. Not defined biologically, anthropologically, or genetically (U.S. Census Bureau).

Ethnicity – Individuals who identify with one another based on common ancestry, customs, cultural heritage, origin, or social experience (Merriam-Webster, 2014).

African American or Black – A racial category in the U.S. in which a person has origins in any of the Black racial groups in Africa (Humes, Jones, & Ramirez, 2011).

Latino – An inclusive term for individuals who identify as Latin/Hispanic descent (Torres-Rivera, Wilbur, Phan, Maddux, & Roberts-Wilbur, 2004).

White – A racial category in the U.S. in which a person has origins with any of the original people from Europe, the Middle East, or North Africa (Humes, Jones, & Ramirez, 2011).

Gender – For the purpose of this study gender will refer to which biological sex an individual identifies as, male or female. Theoretically gender refers to the social construct created by society that assigns particular behaviors, tendencies, or roles as masculine or feminine and may not correspond to an individual's biological sex. The biological sex of a person is labeled as male and female. (Lee, 2013; U.S. Census Bureau)

Female – Biological sex of a person; an individual who identifies as a woman (Lee, 2013).

Male – Biological sex of a person, an individual who identifies as a man (Lee, 2013).

Community Mental Health Center (CMHC) – Community-based treatment agencies that provide mental and health and addictions treatment throughout the U.S. (Murphy & Rigg, 2014).

Cultural Competence – The counselor's ability to effectively engage in practice with clients from diverse cultural backgrounds, and has the awareness, knowledge, and skills to create conditions that maximize optimal well-being and functioning for the client within the client's multiple contexts (Sue & Sue, 2008; Sue & Torino, 2005).

Initial Clinical Interview – A common assessment technique that begins every counseling relationship. Sometimes it is thought of as the cornerstone of assessment and may be referred to as the initial interview, clinical interview, or diagnostic interview (Jones, 2010).

Intake – The beginning sessions (1-2 sessions) of the counseling relationship that focus on establishing rapport, preliminary diagnosis, and treatment planning (Algeria et al., 2012).

Broaching - A strategy that can be utilized by counselors to introduce or “bring” the discussion of cultural factors into the counseling process (Day-Vines et al., 2007).

### **Overview of the Method**

The qualitative research study took a phenomenological research approach. The qualitative phenomenological approach was appropriate because the purpose of the study was to understand LPCs’ experiences and perspectives concerning whether and how they broach multicultural considerations during the initial clinical interview with clients who have SUDs, which is the purpose of a descriptive phenomenological study (Rossman & Rallis, 2012). The phenomenological approach allowed the researcher to capture and describe the rich, thick detail of the phenomena being studied in its embedded contexts (Rossman & Rallis, 2012). The experiences and perspectives of the participants’ were captured by 60 minute in-depth interviews. The participants’ were all LPCs currently working in a community mental health setting in the Commonwealth of Virginia. The sample size of the study included 9 LPCs who had more than six months experience conducting initial clinical interviews with clients who have SUDs. The responses from the participants were audio-recorded and transcribed. Field notes, an audit trail, and a demographic survey was also used to collect data. Data analysis was conducted on all sources of data. The constant comparative method was used to develop themes among the data. The results and conclusions were based on the participants’ perspectives and experiences.

### **Limitations**

There are several limitations to the study. One limitation was that in-depth interviews was the primary technique for gathering data. Interviews rely on self-report and there was a risk that the participants responded based on social desirability, versus their truth. Also, the participants’

responses were interpreted by the researcher, so there is a chance that the researcher may have lost participants' meaning due to misinterpretation (Rossman & Rallis, 2012). Because this is a qualitative study there is no external generalizability; the findings only represent the views and experiences of the participants in the study. Also, the participants were purposely selected from community mental health settings in the Commonwealth of Virginia, and may not represent practices at other agencies.

### **Document Organization**

This document is organized into five chapters. Chapter One provides an overview of the study, overview of relevant literature, the context for the study, brief statement of the problem, purpose of the study, research questions, definitions of relevant terms, overview of the methodology, and the limitations of the study. Chapter Two covers the review of the literature concerning the context for the study and the statement of the problem. In this chapter relevant studies have been critiqued concerning race, sexual orientation, and gender and how these factors affect substance use patterns and treatment. The theoretical framework for the study is also discussed in this chapter. The focus of Chapter Three is methodology. This chapter includes the research design, the interview protocol outline, selection process of participants, data collection and analysis procedures, rigor and credibility, and limitations. Chapter Four describes the participants and findings of the study. Chapter Five, is the final chapter of the document. This chapter summarizes the findings, provides the discussion and conclusions of the findings, the limitations, implications for the field, and recommendations for future research are also discussed.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

Counselors strive to provide multiculturally competent services to the clients they serve. The initial clinical interview is the beginning of the therapeutic relationship and the basis of treatment (Jones, 2010), particularly with clients who seek substance use disorder counseling. Although scores of counseling literature address the importance of counselor multicultural competence, scant research exists regarding how to integrate multicultural considerations during the initial clinical interview with clients who have SUDs. Within this literature review, the context for the study and the statement of the problem are addressed. I explicate multiculturalism and the initial clinical interview; explain the frameworks to understand multiculturalism in assessment practices; discuss diversity considerations within substance use disorder populations and in treatment; expound upon broaching; and review relevant research studies concerning diversity in substance use treatment, multicultural considerations in initial clinical assessments, and broaching as a multicultural approach to counseling practice.

#### **Context for the Study**

#### **Multiculturalism in Counseling**

Counselors have taken accountability for developing knowledge, awareness, and skills to provide effective, multiculturally competent services to clients (Arredondo et al., 1996; Sue, Arredondo, & McDavis, 1992). Providing multiculturally competent services includes tailoring treatment to include culturally appropriate intervention strategies to fit each client (Arredondo et al., 1996). The Association for Multicultural Counseling and Development (AMCD) multicultural counseling competencies (MCC) are separated into three domains: (1) Counselor Awareness of Own Cultural Values and Biases; (2) Counselor Awareness of Client's Worldview; and (3) Culturally Appropriate Intervention Strategies. Each domain has three dimensions: (a)

beliefs and attitudes, (b) knowledge, and (c) skills, and the dimensions overlap, each informing the other. *Beliefs and attitudes* refer to: How counselors understand those who are culturally different from themselves; the responsibility they have to recognize and confront their biases and stereotypes; the development of a positive stance towards multiculturalism; and recognition of how stereotypes and biases can affect the counseling relationship. *Knowledge* refers to: How counselors understand their personal worldview; knowledge of cultural groups; and recognition and implications of sociopolitical factors in the counseling relationship. Lastly, *skills* refer to the actual abilities needed to work with those who are of different cultural backgrounds (Pope-Davis, Coleman, Liu, & Toporek, 2003). There are a total of nine competency areas, 34 competency statements, and 119 explanatory statements (Arredondo et al., 1996; Arredondo & Perez, 2006).

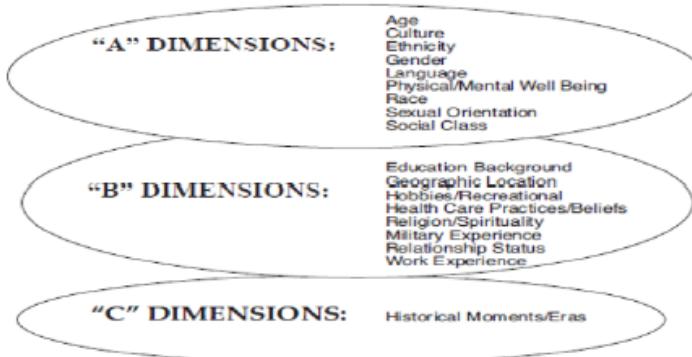
AMCD operationalized the MCC by using personal identities and worldviews (Arredondo et al., 1996; Pope-Davis et al., 2003). The competencies guide culturally competent practice, and as stated earlier, counselors have an ethical duty to provide culturally appropriate services to clients (ACA, 2014). Applying the MCC to clinical assessments is a feasible starting point to aid in understanding the importance of incorporating multicultural considerations into initial assessments/interviews. Although all of the multicultural competencies are important and are guidelines for multiculturally competent practice and education, two are prominent for multicultural assessment. Domain II, Counselor Awareness of Client's Worldview, dimension b.2, expresses how counselors must have knowledge and understanding of how the client's cultural makeup may affect, "personality formulation, vocational choices, manifestation of psychological disorders, help seeking behavior, and the appropriateness or inappropriateness of counseling approaches" (Arredondo et. al., 1996, p. 14). Domain III, Culturally Appropriate Interventions Strategies, is necessary because the initial interview/assessment is the gateway to treatment planning and interventions (Jones, 2010). The multiple contexts and identities of an

individual must be gathered and understood prior to planning and implementing culturally appropriate intervention strategies (Arredondo & Rice, 2004; Constantine, 2000; Smith, 2004). The MCC provide general guidelines for multicultural competent counseling. When counselors practice in a multicultural competent fashion, they operate within the MCC. As stated in the above definition, cultural competence is about creating situations that promote the most favorable client development (Sue & Sue, 2008; Sue & Torino, 2005).

### **Dimensions of Person Identity Model (DPIM) and RESPECTFUL Model**

The DPIM and RESPECTFUL model provide guides to aid counselors in viewing individuals as unique beings, and supports the MCC premise of inclusiveness (Arredondo et al., 1996; D'Andrea & Daniels, 2001; D'Andrea & Heckman, 2008). The MCC, the DPIM, and the RESPECTFUL model are separate paradigms that when used together, can provide a comprehensive framework to conceptualize multicultural initial clinical interviews. The MCC provide general guidelines for multicultural competent counseling, while the DPIM and RESPECTUFL model *operationalizes* the competencies. When used interdependently, there is justification (i.e., multicultural competent practice) and guidelines for multicultural practice, as well as models that illustrate the complexity and uniqueness of individuals.

The DPIM is a useful paradigm to aid counselors in recognizing and assessing clients' multiple contexts and multiple identities (see Figure 1) (Arredondo & Glauner, 1992; Arredondo et al., 1996; Arredondo, 2006). It expresses the complexity of multicultural human beings (Arredondo & Glauner, 1992; Arredondo et al., 1996). The DPIM consists of fixed and developmental dimensions that make human beings unique (Arredondo & Glauner, 1992; Arredondo, 2006). Not only does the DPIM focus on the fixed dimensions of individuals, it considers how the sociocultural, historical, and political factors affect individuals (Arredondo, 2006; Arredondo et al., 1996).

**Figure 1.** Dimensions of Personal Identity Model

*Figure 1.* Visually depicts the three dimensions that make-up individuals' identities. The list of factors given in Dimensions A and B are not exhaustive, but rather possible identities in said dimensions. Reprinted with permission from "Personal Dimensions of Identity Model" by P. Arredondo and T. Glauner, 1992, Boston: Empowerment Workshops.

Individuals are complex beings; when the complexity of a person is not recognized and acknowledged there is a possibility a proper case conceptualization is not made, and thus, the whole person is not treated (Constantine, 2002). Each individual's culture consists of the DPIM's three dimensions and provides counselors with a contextual framework to assess client identities (Arredondo et al., 1996). Recognizing the holism of an individual in the beginning of the counselor-client relationship may aid in the retention of ethnic minorities (Alcantara & Gone, 2014; Arredondo et al., 1996).

The RESPECTUL model is another theoretical model that demonstrates the multidimensionality of human development (D'Andrea & Daniels, 2001; D'Andrea & Heckman, 2008). This counseling model looks at the individuals, client and therapist, involved in the counseling process in a comprehensive manner (D'Andrea & Daniels, 2001). The

RESPECTFUL model of counseling is based on two assumptions: (1) the goal of counseling is to promote clients' development and (2) recognizing and understanding uniqueness of human beings, the multidimensionality of human development, and the need to be intentional about addressing the multiple multicultural factors and identities that affect the counseling process (D'Andrea & Daniels, 2001).

RESPECTFUL is an acronym representing ten different multicultural factors that have an effect on a person's psychological development and sense of person well-being (D'Andrea & Daniels, 2001). The acronym includes: Religious and spiritual identity; Ethnic, cultural, and, racial background; Sexual identity; Psychological maturity; Economic class standing and background; Chronological-developmental challenges; Threats to well-being and trauma; Family history, values, and dynamics; Unique physical characteristics; and Location of residence and language differences (D'Andrea & Daniels, 2001). These factors typically influence how clients perceive themselves, developmental challenges, and the problems clients bring into the counseling process. It is important to note that the developers of the RESPECTFUL model recognize that the list of identities is not exhaustive and there are other possible multicultural factors that may affect a person's development (D'Andrea & Daniels, 2001). The main premise of the RESPECTFUL model is that an individual's psychological needs, attitudes, values, worldviews, and personal identity are affected by how the ten factors of the model interact and intersect with one another (D'Andrea & Daniels, 2001).

### **Broaching**

The term "broaching" was created to explain the counselors' effort to examine cultural factors during the counseling process (Day-Vines et al., 2007). It refers to the introduction of cultural factors during the counseling relationship (Day-Vines et al., 2007). The U.S. is a diverse society and the counseling professional has taken responsibility in developing and implementing

awareness, knowledge, and skills to work with culturally diverse groups (Arredondo et al., 1996; Sue, D. W., & Sue, 2003). It is possible that when counselors are not understanding of their clients' experiences, that cultural conflict and mistrust can occur for the client resulting in underutilization of services and premature departure from counseling (Sue, D. W., & Sue, 2003).

Fifty percent of clients from racially and ethnic minority backgrounds prematurely terminate from counseling compared to thirty percent of White clients (Sue, D. W., & Sue, 2003; Sue, S., 1977). Because counselors have an ethical duty to provide culturally competent services to clients, broaching can be used as a strategy (Day-Vines et al., 2007) to assist in fulfilling this duty (ACA Code of Ethics, 2014; Arredondo et al., 1996). Broaching provides the counselor with a skill to utilize in order to explore how a client's cultural factors may be impacting their presenting problem (Day-Vines et al., 2007). It is a useful strategy as the impact of multicultural considerations on the client's well-being and presenting problem may be unexamined if the counselor does not make a conscious effort to recognize and examine that culture does impact a person's worldview, values, description of problem, and take on counseling (Day-Vines et al., 2007; D'Andrea & Daniels, 2001). Broaching is not a one-time and its done technique, it is a behavior that is consistent and a constant attitude of openness and authentic commitment from the counselor to support multiculturalism and explore how culture affects the client (Day-Vines et al., 2007). Clients may choose not to discuss their cultural make-up with the counselor and may not even be aware of how cultural factors may affect their life and presenting problems, but it is the counselor's duty to provide the space and the option for the client to do so, if he or she chooses to share (Day-Vines et al., 2007). Broaching has been directly linked to the MCC by the developers, Day-Vines et al. (2007), who state that Multicultural Counseling Competence III. C. 7, speaks to the need for counselors to take responsibility for acknowledging and examining

cultural factors that are present in the counseling relationship; this is the broaching process (Day-Vines et al., 2007).

There is a continuum of broaching styles that range from less to complex broaching behaviors (Day-Vines et al., 2007). The five broaching styles include: (1) avoidant, (2) isolating, (3) continuing/incongruent, (4) integrated/congruent, and (5) infusing. It is important to note that in the article the concept of broaching is discussed with a focus surrounding race, but broaching can be applied to any cultural identity (Day-Vines et al., 2007). A counselor operating in the avoidant style would come across as functioning in a race-neutral perspective and would not acknowledge or broach race as being influential to the client's life or presenting problem (Day-Vines et al., 2007). These counselors work from the belief that everyone is human and that racial oppression should not exist; by working in this premise they ignore the realities of the society in which we live. The counselors working within this style can come across as naïve, lacking awareness, resistant, or defensive when working with clients of different cultural backgrounds.

The next broaching style is isolating. This counselor does broach and acknowledge issues of race, but it is done in a simplistic and insincere way (Day-Vines et al., 2007). When a counselor is working from this style, broaching may be seen as a one-time occurrence in which the counselor asks one singular question or makes a singular statement, which is done because of the feeling of obligation to at least attempt to address culture. The broaching behavior is disconnected from the counselor and is seen as a technique to be checked off of a list (Day-Vines et al., 2007). Continuing/incongruent broaching behavior is when the counselor invites the client to discuss the relationship they see between their presenting behavior and culture. Counselors operating from this style are anxious to consider cultural factors that may be affecting the client and the presenting problem, but they do not have the appropriate skills to comprehensively explore the issues of culture in a way that causes the client to feel empowered. They may also

have some parts of being an effective broacher, but they are not able to appropriately translate their appreciation of diversity into effective counseling strategies and interventions (Day-Vines et al., 2007). The fourth broaching behavior, integrated/congruent is when counselors effectively broach culture and have integrated broaching behavior into their professional identity (Day-Vines et al., 2007). The counselors view broaching as much more than a technique, and it has become a consistent, ongoing part of their practice. It is an integrated part of them professionally to consider how culture influences the client. They are not stereotypical in their thought process of clients from different cultural backgrounds (Day-Vines et al., 2007). The final broaching style is infusing. The infusing broaching style is when broaching behavior is a way of being in not only the counselor's professional life, but also in their daily lifestyle (Day-Vines et al., 2007). Counselors who work from the infusing broaching style are committed to social justice and equality that transcends their professional work. Day-Vines et al. (2007) believe that the type of broaching behavior that a counselor works from is dependent on the counselor's level of racial identity. Also the way that clients respond to broaching, will depend upon their level of racial identity functioning (Day-Vines et al., 2007). If a client has a healthy level of racial identity, they may appreciate the counselor's effort of examining the relationship between culture and the presenting problem (Day-Vines et al., 2007). Counselors who function at a low level of racial identity functioning, may cause cultural conflict and mistrust with the client (Day-Vines et al., 2007).

It has been noted through current research that when multicultural factors are broached during the counseling process it increases counselor credibility, enhances client satisfaction, deepens client disclosure, reduces premature termination rates and increases clients' willingness to return for sessions (D. Sue & Sundberg, 1996). Because research has found that acknowledging cultural factors during the counseling process produces these positive treatment

outcomes and broaching is a strategy that can be used to acknowledge cultural factors in the counseling process, it seems like broaching is an effective place to begin to improve treatment outcomes for the substance use disorder population, such as decreasing the premature termination from treatment. For example, African Americans are five times more likely to drop-out of substance use disorder treatment than White Americans (King & Canada, 2004). Even more vital is the counselor showing multicultural sensitivity during the initial clinical interview, because it is the beginning of the relationship and many clients who identify as a racial/ethnic minority decide whether or not they will return to counseling after their first session experience (Alcantara & Gone, 2014; Jones, 2010). Therefore, broaching during the initial clinical interview may be helpful when beginning the counseling relationship and establishing rapport with the client (Alcantara & Gone, 2014). Each initial clinical interview that counselors conduct will contain multicultural factors, so counselors must be intentional in addressing culture (Ivey, Ivey, Zalaquett, 2010).

Ivey et al. (2010) describes five stages of a well-formed interview. The first stage of a well-formed interview is the relationship or initiating of the session which is where rapport, trust building, and structuring is established. The purpose of this stage is to build a working alliance and increase the client's comfort level. Ivey et al. (2010) agree that in order to conduct a successful interview multicultural considerations should be addressed as soon as possible, typically in the initial clinical interview. Being culturally intentional and broaching multicultural considerations is essential to establishing rapport with clients. Relationship building, which includes acknowledging multicultural considerations (Ivey et al., 2010), is vital to substance use disorder counseling (Merta, 2001). The counseling relationship or therapeutic alliance has been found to be central to positive outcomes in all mental health counseling (Merta, 2001; Gelso & Fretz, 1992). In addictions counseling it is very important to establish a strong therapeutic

alliance in the beginning before things such as relapse and withdrawal symptoms begin (Merta, 2001).

### **Statement of the Problem**

LPCs who work with the SUDs population often encounter individuals from very diverse backgrounds (Cheung & Snowden, 1990; Delphin & Rowe, 2008; SAMHSA, 2013). The diversity is compounded even further when the LPC works in a community mental health setting, as community mental health settings typically serve clients that span the spectrum of diversity (Cheung & Snowden, 1990; Delphin & Rowe, 2008; SAMHSA, 2013). It has been found that fifty percent of racially and ethnically minority clients prematurely depart from and do not return to the counseling process (Sue, D.W., & Sue, 2003; Sue, S., 1977), African Americans are five times more likely to drop-out of substance use disorder treatment than White Americans (King & Canada, 2004), and racial and ethnic minority clients determine whether or not they will return to the counseling process after the initial session (Alcantara & Gone, 2014). Particular groups and cultural variables such as, ability, age, gender, race and ethnicity, region of the country, religion, sexual orientation, and socioeconomic status are more at-risk for developing addiction (Merta, 2001). Merta (2001) believes that the more different a client is from the dominant culture (white, middle-class, able-bodied, heterosexual, male, etc.,) the higher the risk for developing an addiction.

Broaching has been identified as a strategy and an ongoing behavior and attitude that can be used by counselors to acknowledge and examine the cultural factors that may be impacting a client's life and presenting problem (Day-Vines et al., 2007). Acknowledging cultural factors during the counseling relationship has been found to increase counselor credibility, enhance client satisfaction, deepen client disclosure, reduce premature termination rates and increase clients' willingness to return for follow-up sessions (D. Sue & Sundberg, 1996). Because of

these findings it is vital to look at the beginning of the counseling relationship, which is typically the initial clinical interview (Jones, 2010) to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders.

### **Multiculturalism and Assessment**

The MCC continue to be impactful in the field of counseling. However, there is limited research concerning assessment and the MCC (Arredondo, Rosen, Rice, Perez, & Tovar-Gamero, 2005). Arredondo et al. (2005) gave directions for future research, which included the need for more scholarly works concerning the MCC, and their efficacy to guide education and training, assessment, research, and practice. The ACA Code of Ethics emphasizes using cultural sensitivity when conducting evaluations and assessments (ACA, 2014). One way to support and recognize multiculturalism is through culturally sensitive assessment procedures (ACA, 2014; Arredondo et al., 1996; Sue et al., 1992). Assessment is a term that carries many different meanings. For the purposes of this study, assessment referred to the initial clinical interview that takes place in the beginning of the counselor-client relationship, and contributes to the case conceptualization and treatment planning for the client (Erford, 2006; Jones, 2010). In order to develop an individualized treatment plan for each client and match clients to appropriate interventions, the assessment should acknowledge clients' multicultural aspects (Alcantara & Gone, 2014; Dadlani, Overtree, & Perry-Jenkins, 2012; Ridley, Hill, & Li, 1998). Although the main goal of assessment is to direct treatment planning, there are several other objectives which include: establishing a working alliance with the client, clearly defining the clinically relevant issues, gathering useful contextual information, and developing hypotheses and/or tentative diagnoses based on the information gathered (Jones, 2010; Smith, 2004; Takushi & Uomoto,

2001). Treatment planning and interventions are based on the initial clinical interview (Jones, 2010; Smith, 2004). The gateway to treatment planning and interventions is the initial interview, and often is referred to as the *clinical interview* or *diagnostic interview* (Jones, 2010). In order to tailor treatment to include multicultural variables and the impact of those variables on clients, such information should be gathered during the clinical interview (Castro & Garfinkle, 2003; Smith, 2004; Takushi & Uomoto, 2001). Further, not only does the initial interview occur at the start of the counseling relationship, it is the *beginning* of the counseling relationship (Jones, 2010).

### **Assessment of Sociocultural Factors in Adult Addictions Population**

There is limited literature concerning the clinical assessment of sociocultural factors in adult addiction populations. The recognition of the need to include contextual factors in the comprehensive evaluation for those seeking substance-use disorder services is relatively new (Castro & Garfinkle, 2003; Lee et al., 2013). Even with the limited literature concerning this concept, it is evident that contextual factors should be considered in any initial assessment, including substance-use disorder assessments (Alacantra & Gone, 2014; Castro & Garfinkle, 2003; Constantine, 2002). For example, Constantine (2002) stated, "Having greater relational or contextual perspectives when assessing and diagnosing clients, for example, may increase the potential for diagnostic validity and, subsequently, effective treatment and intervention" (p. 212). Addiction affects many layers of an individual's life, and in order for treatment to be effective, it must address the whole person (NIDA, 2013). The initial clinical interview seems to be the ideal time to begin to account for these multicultural considerations. For this dissertation research, I explored the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders.

## **Review of Relevant Literature**

The empirical literature concerning multicultural considerations and assessment is scant, and empirical literature concerning multiculturalism and addictions is even scarcer. Arredondo et al. (2005) conducted a ten year content analysis of multicultural focused articles published in the *Journal of Counseling & Development*, and found that only 7% of the articles were centered on multicultural considerations in assessment. Due to the lack of counseling literature concerning a multicultural approach to assessment and addictions, the forthcoming literature I reviewed is from multiple mental health disciplines including counseling, psychiatry, psychology, and social work. The studies reviewed include both quantitative and qualitative methodologies and are related to multiculturalism in assessment and addictions, broaching, practitioners perceived competence when working with addictions; I link the literature to the main concepts of the study.

It is important to note that little is known about how to incorporate multicultural considerations into assessment, and in particular, the initial clinical interview. Even less is known about how to incorporate cultural variables into substance-use disorder assessment and treatment. The findings from the following studies support and justify why broaching multicultural considerations during the initial clinical assessment in substance use disorder counseling is vital for multiculturally competent treatment. I have categorized the literature into four categories: (a) Multiculturalism in SUDs treatment, (b) Multicultural considerations in clinical interviews, (c) Broaching as a multicultural counseling approach, and (d) Perceived competency in SUDs work.

### **Multiculturalism in Substance Use Disorders Treatment**

Although the literature concerning addressing multicultural variables during the initial clinical interview is scarce, there is theoretical and empirical literature concerning cultural variable incorporation into substance use disorder treatment. Castro and Garfinkle's (2003)

theoretical article examined the need to develop culturally competent and effective substance abuse treatment for clients of different races and ethnicities. The authors stated that the common modes of treatment, including outpatient, inpatient, and certain aftercare programs, have mixed outcomes when it comes to applying the treatment to racial/ethnic minority clients. They proposed that these forms of treatment can be more effective if cultural variables related to clients' cultural makeup are incorporated into treatment programs. The exclusion of cultural variables in the treatment process may have negative consequences and outcomes such as relapse and low retention rates (Castro & Garfinkle, 2003; Jacobson, 2004). Client retention is a major concern in substance abuse treatment (Ball, Carroll, Canning-Ball, & Rounsaville, 2006; Jacobson, 2004), and higher retention leads to better treatment outcomes and effectiveness (Ball et al., 2006; Walton et al., 2001).

Although there are few research studies that examine how clinicians implement and provide culturally competent practice, there is empirical research that demonstrates the need for multicultural practice in SUDs treatment. This need is evident in the following research articles, each aimed at addiction work with a specific, multicultural population. A quantitative study conducted by Mereish and Bradford (2013) examined the lifetime substance abuse problems experienced by heterosexual and sexual minority men and women using an intersectionality framework. The cultural intersections included: gender, race, and sexual orientation. The participants in the study were from an urban community health center and ranged from ages 18-72. A nonprobability sample was used that consisted of heterosexual individuals ( $n = 1,091$ ) and sexual minority individuals ( $n = 1,465$ ). In the final sample there were 844 females (33%) and 1,712 males (67%). There were 165 (6.5%) Black, non-Hispanic participants; 183 (7.2%) Hispanic/Latina (o) participants; and 2,208 (86.4%) of the participants were White, non-Hispanic. For the demographic of sexual orientation 1,330 (52%) participants identified as

lesbian/gay; 135 (5.3%) identified as bisexual; and 1,091 (42.7%) identified as heterosexual/straight. Two hundred and eighty-four (11.2%) of the participants had an education level of high school or less and 2,263 (88.8%) had some college or higher. The final demographic concerned the individual or family income; 509 (21.2%) of the participants had an individual or family income less than \$20,000 and 1,897 (57.5%) of the participants had an individual or family income equal to or greater than \$20,000.

The participants completed a brief 25-item questionnaire concerning their demographic information, substance use problems, and experience at the health center. Logistic regression analyses accounted for the interactions between sexual orientation, gender, and race. The methods and the instrumentation used in the study were appropriate and sound. The results found that there is three-way interaction among sexual orientation, race, and gender. The findings illustrate that SUDs disparities are more complex when gender and race were added to the intersecting levels of analysis. There was a wide range in the 95% confidence interval, meaning that the researchers can report with confidence that there is a true effect that lifetime substance use problems were related to the intersections of all three identities. Therefore, support was provided for using an intersectionality approach to work with individuals with particular interactions between sexual orientation, race, and gender. The researchers suggested that the results support that clinicians should have cultural awareness and understand that they must address the needs of sexual minority subgroups. Another finding of the research was that sexual minorities had a significantly greater risk of lifetime substance use problems than heterosexuals (AOR = 1.54). The researchers stated that substance-use programs should apply culturally sensitive approaches for each sexual minority subgroup.

Not only did this research study demonstrate how cultural factors such as sexual orientation, race, and gender can influence substance use patterns; it also illustrated how the

intersection of cultural factors can affect substance use patterns. Limitations of the study include that a convenience sample was used instead of random sampling, which runs a risk for bias in the sample, because the sample is unlikely to represent the population being studied. Due to the use of convenience sampling and because the study included only White, Black and Latino Americas the results cannot be generalized to various racial minority groups within sexual minority communities. Also, the data set was cross-sectional, meaning that relationships between substance use and cultural groups are limited, and there is no way to determine causality. The substance use was self-reported on a dichotomous scale, making it difficult to determine variations of substance use problems. Strengths of the study include that the researchers were able to situate the social categories into structural systems such as privilege and power to explain some of the substance use treatment disparities, it is reliable, and links the findings back to the literature review. The findings of this study the current research study by showing that individuals are complex and their cultural make-up consists of multiple identities that interact and adds multiple layers of context to an individual, all of which may impact substance use. In the initial assessment it is important to assess for the multiple identities of an individual, and the DPIM and RESPECTFUL model can assist in looking at the dimensions of an individuals and how the dimensions interact with one another.

Cochran and Cauce (2006) conducted a quantitative study with a representative sample of LGBT clients receiving public substance abuse treatment in the state of Washington in order to look at the relationship between substance use and sexual orientation. As mentioned previously, the researchers wanted to examine (a) if the development of substance abuse problems is different among lesbian, gay, bisexual, and transgender (LGBT) individuals and heterosexual individuals, (b) whether the prevalence of alcohol and other substances are different among LGBT and heterosexual individuals, and (c) whether or not standard treatment programs can

meet the needs of LGBT clients. The participant criterion included that the participants currently receive publicly funded chemical dependence treatment. The sample consisted of 24,792 participants. The median age of participants was 35 ( $SD = 10.40$ ). The majority of the sample were male 15,571 (62.81%) and 9,221 (37.19%) were female. There were 610 (2.46%) participants who identified as LGBT, 15,705 (63.35%) identified as heterosexual, and data concerning sexual orientation was not available for the remaining percent of participants either for reasons that the participant chose not to disclose ( $n = 1,071$ , 4.32%) or the data was not collected ( $n = 206$ ; 0.83%). The sample consisted of 70.94% Caucasians, 10.50% of Latin Americans, 7.95% as American Indian or Alaskan Natives, 7.51% of African Americans, and 1.83% of Asia Americans. The rest of the participants either selected other or chose not to disclose.

The heterosexual group was used as the comparison group in this study. Cochran and Cauce (2006) used available data from the state of Washington's database that tracks all clients receiving public funds for substance abuse treatment. They utilized sexual orientation information, demographics, and frequency of drug use and drugs of choice, psychiatric services received, and medical services received. The methods used were sound. The data were analyzed by running multiple analyses on the same participants; all analyses were conducted using two-tailed tests of significance. Results of analyses were presented as  $p$  values to determine which tests were significant. The researchers found that their hypothesis that LGBT individuals would have higher rates of substance use and psychopathology at baseline than those who identify as heterosexual was only partially supported, as openly LGBT clients who entered treatment had higher rates of substance use, homelessness, mental health treatment, and domestic violence, they did not have higher rates of current involvement with the criminal justice system. Also, they found that LGBT clients used their primary drug of choice at baseline more frequently than

heterosexual clients ( $M = 9.64$ ,  $t(16, 151)$ ,  $p < .0001$ ); that LGBT clients use more mental health services than heterosexual clients; and LGBT participants identified their drugs of choice as methamphetamine (gay, bisexual, and transgender men) and heroin (lesbian, bisexual, and transgender women), while heterosexual individuals endorsed alcohol as their primary substance.

The researchers (Cochran & Cauce, 2006) listed several implications of this study, but one that is particularly related to the current study is that counselors should inquire about the relationship between sexual identity or gender identity and substance use problems. The findings of the study not only demonstrate that there are differences between heterosexual and LGBT individuals' substance use behavior, but there are intragroup differences also. Although the findings of this study do not provide an explanation for why LGBT individuals use substances, they do illustrate the difficulties that one may experience such as a stigmatized sexual identity and internalizing negative thoughts towards self. A limitation of the study was that the data was collected from a database that allowed the researchers to conduct inferential statistics, but the information in the database was inputted and collected by unknown counselors who may not have been comfortable with asking about sexual orientation. Although, there are limitations, this study was reliable, had a clear purpose, and had logical consistency displayed in the article. The findings lend support for the current research that each client should be viewed as a multicultural, unique individual with multiple identities and subjective meanings of the identities, and that these identities influence substance abuse and substance use. The multiple contexts of LGBT clients must be taken into consideration in substance abuse treatment, and practice and treatment should be tailored to meet needs that are different from heterosexual clients.

A quantitative study conducted by King and Canada (2004) examined the predictors of early drop-out in a male and female outpatient addiction treatment program. It was hypothesized

that factors such as unemployment, lower education, longer treatment history, female gender, African American ethnicity, and patient's referrals would predict early treatment drop-out. To understand retention, the researchers focused on the first month of treatment because the greatest attrition occurs during this month, and it is the most important time for establishing treatment engagement and the therapeutic alliance. The overall sample consisted of 97 participants. The age range of the participants ranged from 20-72 years of age. The years of education ranged from 8-21 years. For ethnicity 51% were Caucasian, 45% African American, and 4% identified as Other. Sixty-four percent were full or part-time employed, 14% were currently employed, and 22% were disabled or retired. Marital status included: 32% married, 40% single, and 28% divorced/separated/widowed. Seventy-one percent of the participants were male and 29% were female. Of the 97 participants 46% reported prior substance abuse treatment experience and 54% reported no prior treatment. Demographics and background data were collected during the initial structured screening interview conducted by the clinician that evaluated the client, and data were verified and entered by a research assistant. Clients were placed into two separate groups: Treatment engaged and non-treatment engaged, depending on if the clients attended five or more sessions or dropped out before attending five sessions. Chi-square analyses were performed for the categorical analyses variables, and *t*-tests were used to compare the means of the continuous variables. A logistic regression analysis was conducted to examine the variance for the factors predicting treatment retention from the *t*-tests and chi-square analyses. The logistic regression exposed that the hypothesized predictors of treatment retention, (i.e., education, gender, ethnicity, primary drug of choice, and referral source) were statistically significant. The likelihood ratio was  $X^2$  (5) = 26.48,  $p < .0001$ . Referral source, education level, and primary drug were significant predictor variables in the univariate analyses, but these factors were not significant when African American ethnicity and female gender were considered.

It was found that female gender and being African American were significant predictors of drop-out. Women who dropped out were more likely than women who remained in treatment to be unemployed, have less education, and have dependent children. The researchers believe that this may indicate that females, when taking into consideration particular socioeconomic factors and roles, have unique needs and that treatment should be tailored to meet these needs. This finding also demonstrates that females may have different treatment needs than the male gender identity. Being a member of the racial group of African American is a predictor of early treatment drop-out. It was found that African Americans were five times more likely to drop-out of treatment than Caucasians. This finding were consistent with previous empirical literature. The researchers speculated that several possible factors may impact the lower retention rate among African Americans including multicultural issues, faults within the intervention and treatment setting, and failure to include cultural variables into treatment (e.g. incorporating the idea of kinship).

The implications of this study are that treatment should be tailored to each individual client, and that there are individuals that belong to particular non-dominant cultural groups such as females and African Americans, who are known to be susceptible to early-drop-out rates. It is especially important for counselors to assess for multicultural variables that may be underlying these susceptible groups early in treatment such as during the initial assessment to determine the best way to engage the individual in treatment. This finding supports the current research study that sociocultural and contextual factors should be accounted for in the initial clinical interview because treatment is based on the initial assessment/interview (Jones, 2010). Without accounting for these variables in the beginning of the therapeutic relationship, how can the counselor form a complete case conceptualization? If the counselor is unaware of the sociocultural and contextual factors that may be impacting the client, they may not be able to tailor treatment effectively to

best fit the needs of the client. Also, because most attrition occurs within the first month, there are not many chances for the counselor to account for multicultural considerations (King and Canada, 2004). There were several limitations to this study, including that the researchers only examined a limited set of factors. Also, they relied on self-reported client variables and had only one definition for the category of “treatment engagement.” Although there were limitations, the study is reliable, the purpose was clear, there was logical consistency, and the findings link back to the literature.

Trepper, Nelson, McCollum, and McAvoy (1997) conducted a study concerning how to improve substance abuse delivery to Hispanic women through increased cultural competencies. It is important to note that the term Hispanic refers to an ethnic group and not a racial group. The ethnic group is comprised of individuals who speak the Spanish language and some similar cultural values (Trepper et al., 1997). This was a qualitative study in which female Hispanic women receiving substance-abuse treatment were interviewed along with therapists to explore ways that substance abuse treatment can improve for Hispanic women receiving treatment. The study filled a gap in the literature concerning the unique characteristics of Hispanic women who abuse substances. The authors believe this was a gap because the literature on women in general who abuse substances were scarce at that time. Most of the literature focused on men who abused substances, which meant that most of the treatment models were male-oriented (Trepper et al., 1997). Because the treatment models are male oriented, they often do not address the needs of women. It has been a major criticism that mental health and substance abuse services lack sensitivity to the needs of women (Trepper et al., 1997). Over the years there has been an interest in understanding of how women perceive drug use (Trepper et al., 1997). The authors make it clear in the article that one should not assume that all Hispanic people have similar cultural and behavioral values, because they are part of the same ethnic group. The therapist must also be

attentive of the individual and cultural differences as well, such as: legal status, socioeconomic status, education level, employment history, acculturation experience, experiences with discrimination and racism, and their own relationship to their culture and family (Trepper et al., 1997).

The researchers chose a qualitative method for this study, because there was little empirical literature concerning this topic and it allowed for the exploration of the needs of Hispanic women using substances and how cultural factors impact treatment. It is important to note that this study was part of a larger study that was being conducted to test the efficacy of couples' therapy for women abusing substances. The sample consisted of eight women who self-identified as Hispanic. Of those eight women, six of them were women who were abusing drugs and enrolled in the treatment program of the researchers and two were local Hispanic women who worked as local therapists with Hispanic women who abused drugs. The six women who were clients had been using illicit drugs for at least 6 months; were between the ages of 18 and 35; were married and/or in a committed relationship; their partners were willing to participate in the assessment and therapy; self-identified as Hispanic; and had completed or were close to completing the therapy phase of the program. The two therapists self-identified as being Hispanic; worked with many Hispanic women who were abusing substances; and did not know the details of the hypotheses of the study. Clients and therapists were included in the study to gain a wide range of treatment experiences.

Intensive interviews were the primary method for gathering data and the analytic induction method was used for the data analysis. The data analysis method was chosen because the aim of the study was to elicit and produce themes from the views of the participants in order to explore what is most helpful in substance abuse treatment. Although an analytic induction was used to analyze the data, an inductive process was also used to enrich the developing themes.

The first person was interviewed using the guided questions and then initial themes and concepts were created. When the second person was interviewed the guiding questions were used and then the researchers went back and related the themes from the first interview. The second person was asked to comment on, add to, change, disagree, and elaborate on the themes. This process continued until all eight participants were interviewed. All the interviews were conducted by two members of the research team. The interviews were audiotaped and transcribed. There were seven phases in the procedures for the study. First there were guiding questions that were created by the research team to generate open and honest feedback concerning the cultural variables being studied. Every guided question was not asked to each participant. The purpose of the questions was to serve as a foundation for the interview and the interviewers would probe for the question until no new data was shared by the participant. Then initial phone interviews were conducted to establish rapport, share the purpose of the study with the participant, and to determine if the client met the criteria for participation. Intensive interviews were then conducted and lasted anywhere from 1 to 2 hours. The interviewer took notes of thematic and behavioral observations during the interviews. After the interviews a preliminary data analysis was conducted in which the interviewer listened to the audiotape to begin developing themes. This process was repeated until all eight interviews were conducted. Lastly the final data analyses were conducted and a refined set of themes were developed.

The researchers identified 11 emerging themes. The themes were only included in the write-up if they were identified by at least five of the eight participants and agreed upon by seven of the eight participants when asked again. Although researchers stated that 11 themes emerged, I was only able to identify 10 and they are as follows: 1) importance of the family, 2) religion and rituals, 3) multiculturalism and acculturation, 4) hierarchy, 5) separation of the sexes, 6) loyalty of the family of origin, 7) problems are addressed by your own family, 8) good of the

social group over the needs of the individuals, 9) structure of therapy, 10) how agencies can be inviting to Hispanic women. The study identified themes that make it evident in therapy there has to be an acknowledgement and understanding of Hispanic culture to work successfully in providing substance abuse treatment to Hispanic women. It was also found that agencies must demonstrate their understanding of the Hispanic culture and work within the cultural world of the Hispanic clients. The findings indicate that Hispanics live in a different familial environment than Anglos and because of the importance of family in the lives of Hispanic women, it is up to the therapists to include the family in the work with the client. The authors state that this means that the therapist has to be willing to apply some family approaches, be flexible, and collaborative in developing strategies that best work for the client. The participants pointed out some ways in which the therapists can be helpful when concerning the family: respect for the family hierarchy, inclusion of extended family members, validation of the efforts of the client to work for the good of their families, and appreciation of the strengths and competencies that exist within Hispanic families. The researchers point out that the therapist has to be careful not to think that there is one example of a Hispanic family and must remember that each family is unique in its experience and the uniqueness must be understood. Categorizing all Hispanic families based on a model of one family is doing a disservice to the clients and is as insensitive as not recognizing that the individuals belong to an ethnic group. Trepper et al., (1997) also identified ways in which the agency can improve to better deliver services to Hispanic women clients who abuse substances. Some of the findings included having Hispanic staff members, and treating the clients according to their cultural expectations.

The findings of this study relate to the current research study as it provides evidence of how different cultural groups have unique needs when it comes to substance use disorder treatment. It makes it clear that cultural differences must be considered when delivering

treatment services. There were limitations to this study such as the small sample size prevents the generalizability of the findings. Also it was not a homogenous sample. Only six of the women were substance using and two were therapists who provide substance abuse treatment. Because the sample was small, it may have made for a more rigorous and trustworthy study if the sample was homogenous. Lastly, the researchers did not disclose their biases and little is known about the role of the researcher which is important in qualitative research. Knowing of any biases and the role of researcher increases rigor and trustworthiness.

Curtis-Boles and Jenkins-Moore (2000) looked at substance abuse in African American women. They recognized that there was limited literature that paid attention to ethnicity that resulted in information that did match up with the experience of women of color. The study they conducted utilized both quantitative and qualitative designs to investigate substance abuse in African American women in cultural and social contexts. The study was based on the fact that literature had been scarce concerning gender and ethnic variations in the substance abuse field (Curtis-Boles & Jenkins-Moore, 2000). Most studies had focused on White male populations (Curtis-Boles & Jenkins-Moore, 2000). Literature began to look at substance abuse in women, but still was scarce when discussing women of color. The study focused on the life experiences of African American women who had never used substances and compared them with African American women with a history of substance abuse. There were four major hypotheses of the study: the African American women with a history of substance abuse compared with the women without a history of substance abuse will (a) report more frequent histories of parental substance abuse and childhood abuse, (b) report less involvement in spiritual practice, (c) demonstrate less consistency in social support throughout their lifetime and have fewer current supports, and (d) report more life stress events, including incidents of racism.

The mixed method design study consisted of a sample of 30 African American women with substance abuse histories and 30 African American women with no substance abuse histories. There were no differences between the remaining demographic characteristics of the study. The participants were between the ages of 24 and 48 years old, with the mean age of 32.3. All of the participants were mothers with dependent children. Also all participants were of low-income status. Seventy-two percent of the participants were unemployed. About 82% of the participants reported their household income to be \$18,000 or less. The mean year of education attainment was 12.3. The participants who identified as substance abusers reported their history of use to average 21 years and were new to recovery with an average of 6 months in treatment. The African American women who were identified as substance abusing were recruited from an outpatient substance abuse treatment program in the San Francisco Bay area. The women received the information concerning the study in their treatment groups. They were informed that their participation in the study was voluntary, would not affect their treatment status, and that they could refuse to participate or withdraw from the study at any time with no penalty. The researchers assured them that their confidentiality would be protected and the responses would not be shared with the treatment facility. After the information was shared with the women at the treatment facility, 85% of the women agreed to be a participant in the study. Once the individuals agreed to participate interviews were scheduled and conducted in a private space at the treatment facility. The participants who identified as nonabusing women were recruited from three sources: health clinics, a support group for African American mothers, and a county department of human services in the San Francisco Bay area. Flyers were used to recruit at these agencies and if an individual was interested they contacted the researchers and received the information about the study. If they met the participant criterion, an interview was scheduled. The women had an option of being interviewed at home or a community meeting room. All the nonabusing women

chose to be interviewed in their homes. These individuals were screened for substance abuse problems by using two subscales of the Addiction Severity Scale (McLellan & Luborsky, 1985). If the women had been in substance abuse treatment or recovery and/or reported legal problems related to substance abuse they were excluded from participating in the nonabusing women group. The interviews for all participants in the study were audiotaped and lasted approximately 2 hours. All participants received a \$20 gift certificate to a local grocery store or department store for participating in the study.

The interviews conducted were structured, life history interviews that was created by the researchers. The interview consisted of 112 questions that covered the topics: demographics, health, substance abuse history and use, spirituality, social support, experiences of trauma, and significant losses and experiences with racism and discrimination. Ninety-four of the items on the interview were forced choice and short answer responses, and remaining items were open-ended questions that allowed for qualitative analysis. The forced choice and short answer questions were quantified. Chi-square analyses and independent t tests were conducted on these items to identify significant differences between groups. The open ended questions were coded and emerging categories were developed.

The researchers found that there was no significant difference between the two groups in reported parental substance abuse and childhood physical or sexual abuse. The Chi-square analyses found that a significantly higher number of nonabusing women (93%) compared with substance abusing women (69%) reported involvement in church at an early age,  $X^2(1, 59) = 5.77, p < .05$ . Also, there was a significant difference of substance abusing women (89%) reported stopping their religious practice versus non-substance abusing women (57%),  $X^2(1, 55) = 6.98, p < .05$ . There were no differences between the groups concerning church membership or frequency of prayer, reading the bible, or spiritual meditation. The qualitative analysis

concerning the topic of spirituality aids in understanding why women stopped their religious practices. Sixty-two percent of the substance abusing women identify substance use as the reason they left the church. They also reported feelings of shame, guilt, and worthlessness during their absence from the church. When Chi-square analyses were conducted to determine the differences in social support between the two groups. Eighty percent of nonabusing women and 57% of substance abusing women identified family members as sources of support and 60% of substance abusing women and 10% of nonabusing women identified professional/institutional supports,  $X^2(1, 56) = 18.6, p < .0001$ . It was also found that 93% of substance using women and 63% of nonabusing women reported being battered; 57% of substance abusing women and 30% of nonabusing women experienced homelessness. A greater number of traumatic events were experienced by the women who were abusing substances versus the women who were not substance abusers,  $t(58) = 2.05, p < .05$ . There were no significant differences between the two groups in reports of racism and discrimination. Approximately 80% of both groups reported direct experiences of racism. These findings add to the lack of literature concerning ethnicity and class in substance abuse with women. It reveals that the experiences of women of color and of a particular socioeconomic status is different from the experiences of most of the research on substance abuse that is based on White males, in areas such as experiences with racism, life stress, spirituality, and trauma. The findings demonstrate that cultural traditions and realities of those African American women living in the inner city and why it is important to understand substance abuse in this particular population. The findings imply that interventions with this population should include aiding this group with connecting to their natural support system and extended kin, involving the children of the women, explore spiritual values and resources, and to receive support in active coping skills. It is vital that the counseling relationship take place in a safe environment in which African American substance using women can share their trauma and

pain and treatment should be at pace that the women do not feel overwhelmed leading to relapse. The implications from this study can be helpful in interventions and treatment for African American women with substance abuse issues. These findings are relatable to the current research study as they illustrate the unique needs for different groups. There are study limitations. The results of the study are not generalizable to all African American women. The sample is small and is representative of only the individuals involved in the study. Because forced choice and short answer questions were used in the study, it restricted the depth and richness of the experiences of the women in the study.

### **Multicultural Considerations in Clinical Interviews**

Multiculturalism and the MCC are concerned with approaching counseling from a multicultural perspective, meeting the needs of diverse clientele, and recognizing how culture impacts each individual, including the counselor (Arredondo et al., 1996; Sue et al., 1992). Because the initial clinical interview is the cornerstone of assessment and guides treatment planning (Jones, 2010), Algeria, Katz, Ishikawa, Diaz-Linhart, Valentine, & Lapatin (2012) conducted a qualitative study to examine how clinicians provide culturally competent care in practice, particularly in the initial clinician-client contact. Algeria et al. described how clinicians utilized sociocultural information and how the utilization impacted the clinical relationship.

Data for the study was collected from eight outpatient clinics that offered mental health and substance abuse treatment with diverse clientele. Clients and clinicians were participants in the three study elements including: videotaping of the intake session, a qualitative interview after the intake session, and sharing socio-demographic and clinical measures. The 47 clinicians participating in the study were obtained by way of a convenience sample. The clinicians consisted of 28% psychiatrists, 26% psychologists, 38% social workers, and the remaining clinicians were nurses or other. The majority of the clinicians (70%) had more than five years of

clinical experience. The majority of the clinicians were female (66%), between the ages 35 - 49 and 34% were male. Fifty-three percent of the clinicians identified as non-Latino White, 36% self-identified as Latino, 9% as non-Latino Black, and 2% as Asian. There were 129 patients, the majority of whom were recruited at the intake session. Sixty percent of the clients were female and 40% were male. The majority of the clients identified as Latino (60%), 39% identified as non-Latino White, and 12% identified as African American or Afro-Caribbean. Of the 129 patients 65% had completed high school and 45% were employed. For personal income, 64% reported a personal income of less than \$15,000 a year. Fifty percent of the patients were on Medicaid.

The qualitative methodology and the use of interviews were sound methodological choices for this study because the researchers were able to gain the perspectives of the clinicians and the clients concerning the intake session. Gaining the perspectives of the actual individuals involved in the intake session allowed the researchers to describe why clinicians collect the sociocultural information and how it impacted the initial session. The interviews were conducted by trained research assistants who were not aware of the study's constructs, goals, or posits.

A thematic analysis of the clinician and client interviews was conducted using NVivo. Thirty out of the 129 cases were chosen based on if culture, race, ethnicity, religion, age, gender, social class, and other social factors were mentioned during the initial session by the clinician or client. Coders met weekly and post-intake interviews were analyzed; multiple coders were used so they were able to member check coded sections. Full transcripts and the intake interviews were reviewed, therefore data sources were triangulated. It was found that clinicians wanted to view clients as individuals, so they asked about many sociocultural factors including: country of origin, cultural background, and experiences with discrimination/racism, ethnicity, family history, immigration history, political factors, region/spirituality, and trauma. Algeria et al.

(2012) identified three ways clinicians utilized the sociocultural factors information in the intake: (a) to create empathy, (b) to individuate clients, and (c) to understand clinical presentation, inform diagnosis, and differentiate between psychopathology and contextual factors that may be influencing behavior. The researchers found also that clinicians may run the risk of making assumptions and stereotyping when interpreting sociocultural factors.

Limitations to the study include factors such as the findings cannot be transferred to a larger population or to private practice settings. Study strengths include multiple perspective data collection (i.e. from the clinician and client), using member checks, and triangulating data sources. The findings of this study emphasized how important it is to focus on sociocultural factors in the intake session because these factors can influence diagnosis and treatment, and improve client engagement and treatment outcomes. Collecting sociocultural factors in the intake session aided clinicians to view the client as a unique individual and to develop empathy for the client. Algeria et al.'s (2012) findings relate to the current study because they support the premise that multicultural considerations should be infused in the initial intake/assessment. Collecting sociocultural factors contributes to individuating clients, developing empathy, and provides a platform for valid case conceptualizations, diagnosis, and treatment planning.

Gallardo (2012) focused also on the initial clinical interview, but with a specific cultural group: Latina/o clients. The focus of this article was to aid clinicians in establishing a therapeutic relationship beginning with the initial interview. This qualitative research study included a group of 27 Latina/o therapists who self-identified as bilingual, bicultural, and highly culturally competent. This subset of 27 participants was taken from a larger mixed methods study of 89 Latina/o therapists. The researcher utilized interviews with the therapists, which were analyzed by a basic content analysis. The results of the study yielded themes indicative of strategies to aid in establishing a therapeutic relationship in the initial session with Latina/o clients. The themes

were: personalismo and respeto, language and psychoeducation, charlar/small talk, and self-disclosure. The themes from this study are helpful in understanding that cultural factors are an important part of establishing a therapeutic relationship in the beginning of the clinician-client interaction. These themes are culturally-based and grounded in multicultural competent practice (Sue et al., 1992). Strengths of this study include that the findings are consistent with existing literature, it provides themes that are effective and multiculturally relevant when conducting an initial interview with individuals who identify as Latina/o, and it included therapists' perspectives.

There are several limitations to this study. The study may not be transferable to other racial/ethnic groups, and does not express to the reader how trustworthiness was achieved. Also, the specific demographics concerning the subset of the 27 participants were not provided. Although themes were included in the article, the descriptions were brief. For example, the description for the theme of *self-disclosure* consisted of one sentence and one quote from a participant. Further, some of the examples were not clearly identified as being a quote from a participant. Overall, the themes were underdeveloped and did not demonstrate deep, qualitative context. The majority of the article consisted of the literature review, while the description of the study received the least attention.

The focus of the study was on the importance of recognizing that multicultural factors are a vital part of establishing a therapeutic relationship during the initial interview with Latina/o clients. This relates to the current research study as I explored whether and how licensed professional counselors (LPCs) broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders, with not just racial and ethnic minority clients, but with each unique individual with whom they begin a therapeutic relationship.

## Broaching as a Multicultural Counseling Approach

Although broaching produces positive outcomes (Day-Vines et al., 2007), there is not a plethora of conceptual and empirical data on broaching. The empirical articles that focus on the coined term “broaching” are scarce, but there are some that actually study the concept of broaching. Zhang and Burkard (2008) conducted a study to obtain clients’ perspectives of the effect of counselor discussion of racial and ethnic differences in counseling. Fifty-one volunteer clients from a Midwestern university counseling center and two Midwestern community mental health agencies made up the study’s sample. All clients were receiving services from counselors who were racially or ethnically different from themselves. At the beginning of the study the sample consisted of sixty-six clients, but only fifty-one clients returned their research packets; making the return rate 77%. The final sample consisted of 31 women (61%) and 20 men (39%). The age range of the 51 participants was from 15 to 42 years with a mean age of 20.08 years ( $SD = 6.26$  years). The racial background of the participants was, 12 (23.52%) African American, 2 (3.93%) Asian Americans, 30 (58.82%) White Americans, 2 (3.93%) Hispanics, 1 (1.96%) Native American, and 4 (7.84%) identified themselves as other (i.e., biracial or multiracial). Also, 27 (53%) participants had no prior counseling experience and 24 (47%) had prior counseling experience.

The researchers utilized the *Counselor Rating Form-Short* (CRF-S; Corrigan & Schmidt, 1983). The CRF-S is a 12-item scale that has three 4-item subscales: Attractiveness, Expertness, and Trustworthiness. The reliability coefficients of the subscales when using the split-half Spearman-Brown formula are as follows: Attractiveness - .91, Expertness - .90, and Trustworthiness - .87. The researchers also used *The Working Alliance Inventory-Short Form* (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is a 12-item instrument that is rated on a 7-point Likert-scale. A positive working alliance between the client and counselor is indicated by

high scores and a poor alliance is indicated by low scores. The WAI-S has internal consistency reliability (.98) and good concurrent and predictive validity. The Cronbach's alpha for this study's sample was .92. A demographic questionnaire was also used to gather demographic information relevant to the study: age, gender, prior counseling experience, and number of counseling sessions. Race and ethnicity was gathered through the use of a question. The final instrument utilized during this study was a discussion concerning racial and ethnic differences. A cross-cultural counseling relationship was defined as a difference between the self-reported client and counselor ethnic or racial identity. The content shared concerning the discussion of racial and ethnic differences was not explored. All of the instruments utilized in this study seem to be sound, appropriate, and reliable measures.

The researchers based this study upon previous literature that stated directly addressing racial and ethnic differences in counseling and being sensitive to racial and ethnic differences in counseling may predict a positive working alliance between racially and ethnically different counseling dyad (Zhang & Burkard, 2008). Former studies found that discussions of racial and ethnic concerns between the counselor and the client significantly and positively affected the therapeutic process (Zhang & Burkard, 2008). Zhang and Burkard (2008) examined whether or not client and counselor discussions of racial and ethnic differences in cross-cultural counseling would affect client ratings of counselor credibility and the working alliance. The researchers hypothesized that an interaction effect would occur and clients of color with whom White counselors discussed racial and ethnic differences in counseling would rate their counselors as credible and their working alliance would be higher than clients of color whose White counselors did not discuss race and ethnicity. It would also be higher than White clients working with counselors of color who discussed or not discussed racial and ethnic differences during the counseling sessions.

Before the researchers began to recruit participants permission was obtained from the university's institutional review board, the university counseling center's research committee, and the research committees of the two local mental health agencies. All participants, including the guardians of the underage participants, signed informed consent forms. The counselors were aware of the cross-cultural study taking place, but they did not know the specific purpose of the study. Clients who were willing to participate signed their names on a list after they read the informed consent. The participants received the research materials after the third session of counseling was completed. First the participants completed the demographic form and then they completed the CRF-S and the WAI-S. The participants were given a \$5.00 gift certificate to a local bookstore if they returned the research materials in a sealed envelope to the receptionists at their particular setting.

The main analyses of the study was conducted by using a 2x2 MANCOVA. Counselor credibility and working alliance ratings were analyzed by using two factors: clients of color and White clients by two factors: discussed racial differences and did not discuss racial differences. It was found that clients of color rated White counselors as significantly more credible if they discussed racial and ethnic differences. Those same clients also rated the working alliance as significantly stronger if racial and ethnic differences were discussed. It was also found if the counselors belonged to racial and ethnic groups of color and the client was White, there was not a significant change in the credibility or working alliance. Another finding of the study was that the client's rating of counselor credibility and the working alliance was significantly related to gender. Men seem to have perceived the working alliance and counselor credibility as more positive than the women in the study. The researchers denote that this is not consistent with previous studies and are unsure why it was different in this study. These findings relate to the

current research as broaching seems to build and improve the working alliance and aids in the clients' perceived credibility of the counselor.

There were several limitations in this study. One limitation is that the study was conducted with a wide age range of clients, ranging from adolescents to adults. Because there are developmental differences between adolescents and adults, their needs concerning discussing racial and ethnic differences may be different. The sample size of this study was small, which affects the generalizability of the findings. Gender was found to be a significant factor in this study, but because of the sample size the researchers were unable to delve deeper into the implication of this finding.

Knox, Burkard, Johnson, Ponterotto, and Suzuki (2003) conducted a consensual qualitative research (CQR) study to explore the experiences of twelve licensed psychologists addressing race in psychotherapy. They explored the experiences of psychologists raising or not raising the topic of race in cross-racial dyads. The researchers' study was based upon prior research studies concerning the impact of race on the therapeutic relationship. Although the previous studies focused on the impact of addressing race and ethnicity in the therapeutic relationship, this study took it a step further by exploring how, when, and why therapists raise discussions of race in the therapeutic relationship. Knox et al., (2003) felt as though a qualitative research method would be best for this study because it allowed them to explore this concept in detail without having to restrict the responses. The researchers also looked at how the therapists interacted with racially different individuals before, during, and after graduate school.

The sample consisted of twelve licensed psychologists. There were 6 men and 6 women. Of the participants five were African Americans and seven were European Americans. The African American therapists ranged in age from 31-53 years and the European American therapists ranged in age from 32-54 years. The African American therapists have been in practice

for 2-27 years and the European American therapists have been in practice for 2-16 years. African American therapists stated that between 10% and 98% of their current adult individuals caseload consisted of clients that were racially different than themselves and the European therapists stated that between 5% and 20% of their current adult individual caseloads consisted of clients racially different from themselves.

Each researcher explored their potential biases and expectations. The researchers were also the interviewers. The measures used in this study included a demographic form and interviews. The demographic form asked for the participants: age; gender; race/ethnicity; years in practice; theoretical orientation; percentage of clients in current adult individual caseload who were racially different from the therapist; the race of the clients; and the three most common diagnostic categories among this caseload. The participants also provided their name, phone number, email address, and convenient times that they could be reached by the researchers to arrange a time to conduct the first interview. The interviews were semi-structured. There was an initial interview and a follow-up interview that occurred approximately two weeks after the initial interview, but before any data analysis began. The follow-up interview allowed for the researcher to ask clarification questions and for both parties to explore further any thoughts or reactions that may have arose from the first interview.

The participants were recruited using the snowball sampling technique. The primary research team knew of 19 colleagues and contacted them to identify as many people as possible that could be potential participants for the study. Once potential participants were identified and the consent and demographic forms were returned, the first interview was scheduled. The participants were randomly assigned to an interviewer, unless the participant was familiar with an interviewer, then they were intentionally assigned to an interviewer. Pilot interviews were conducted by each interviewer with an individual who fit the study criteria. All interviews were

transcribed verbatim and any identifying information was removed. A code number was assigned to each transcript for identification purposes. Participants were given the opportunity to receive a final draft of the results. The data was analyzed with CQR methods (Hill, Thompson, & Williams, 1997). The primary focus was to reach consensus concerning the meaning and categorization of the data. In this method each individual presents their own individual conceptualizations and as a group the final understanding is decided. In the beginning there are often disagreements, but an agreement is eventually reached. The coding began by the primary team developing a list of domains from interview protocol. These beginning codes changed throughout the process as the interviewers went through the transcripts and the analysis process. Cross-analyses were also completed on the 12 cases. The categories were labeled as “general” if they applied to all the cases, “typical” if they applied to at least half of the cases, and “vibrant” if they applied to fewer than half, but at least two cases.

It was found that more African American than European American therapists reported having experiences with those racially different from themselves prior to attending graduate school, which taught them about race and influenced their approach to psychotherapy. European American therapists shared that there was an early naiveté about or denial of racial differences. Both groups of therapists reported having similar graduate school didactic experiences that focused on race. Also, both groups took classes, attended multicultural workshops, interest groups, or received special training in multiculturalism. European American therapists had a variant category that emerged reporting that their didactic class experience did not include or had minimal inclusion of race. Consistent with that finding is that European American therapists also reported receiving little or no supervision or practicum experiences related to race. The researchers stated that this finding may help explain the later finding that European American therapists reported higher discomfort addressing race in the cross-racial

dyad than the African American therapists. The researchers shared that receiving less training and less clinical experience regarding race, may lead the therapists to feel discomfort when addressing the topic of race in the cross-racial dyad. The African American therapists reported having more experiences with those racially different from themselves in their first post-graduate work position than the European American therapists. African American and European American therapists both shared that they typically addressed race with racially different clients if they considered race to be relevant to therapy. It was found that only African American therapists reported raising the issues of race when working with clients of color and the European American therapists did not do so customarily. African American therapists also reported discussing race early in therapy more often than the European American therapists. One of the reasons the African American therapists gave for addressing race early in therapy versus that of their European American counterparts is that they perceived discomfort in their clients. Some of the European American therapists reported that if a client introduces the topic of race they would have the discussion, but some shared that they would not typically discuss race. Although the African American therapists frequently addressed discussing race with clients of color more frequently than European American therapists, both groups reported that the discussions concerning race with the clients had a positive effect on therapy which is reflective of previous research. Both groups of therapists reported very similar patterns of how they addressed race in cross-racial dyads. Mostly all of the participants reported that they addressed race directly, openly, overtly and felt that the discussions led to positive effects such as enhanced trust in the therapeutic relationship. All of the African American therapists and most of the European therapists shared that they felt more skilled and comfortable addressing race in their current careers versus when they first began working. The authors believe this may be due to more experience working with clients, especially racially different clients, which may cause a

greater sense of confidence. More African American therapists felt comfortable addressing race in the cross-racial dyads than the European American therapists. It was reported that most European American therapists and no African American therapists reported discomfort with race based discussions during the cross-racial dyads. The participants admitted to the interviewers that they found the questions to be thought provoking and some expressed some discomfort.

The findings of this study are related to the current research study as it discusses cross-racial dyad therapeutic situations and explores the experiences of 12 psychotherapists when addressing race. The findings of the study support the idea that directly and openly addressing race has positive effects on the therapeutic relationship. Although, the study explored how the psychotherapists addressed race, the current researcher believes that the findings can apply to any multicultural factor, as race is one of many dimensions of multicultural identity (Arredondo & Glauner, 1992; D'Andrea & Daniels, 2001). There were several limitations of this study including that the results cannot be transferred to other groups as it was a qualitative study with a sample size of 12 in which the participants volunteered to participate in the study. Although the sample size was 12 it is consistent with the methodology used. Also the authors stated that some of the participants switched back and forth between a broad definition of multiculturalism and a more narrow focus on race. This could have affected the description of the experiences. The researchers stated that participants seemed more reluctant to discuss negative effects the discussion of race might have. Another limitation is that the interviewers mailed out the interview protocol questions to the participants prior to the interview, so the participants could have had time to formulate socially desirable responses.

Fuertes, Mueller, Chauhan, Walker, and Ladany (2002) conducted a study concerning European American therapists' approach to counseling African American clients. A consensual qualitative research methodology was used and interviews were conducted with nine European

American psychologists. The interviews were based on the European American psychologists' experiences with a current or recent case with an African American client and the first 12 counseling sessions. The first 12 sessions were chosen because the researchers wanted to examine the early events that take place in the counseling relationship. They relied on previous literature which found that the establishment of trust and a working relationship occurs in the first 12 sessions (Gelso & Fretz, 1992) and the events which occur in the initial sessions will greatly impact long-term treatment (Gelso & Hayes, 1998). The researchers chose to examine the relationship between European American therapists and African American clients because there is a lack of empirical evidence concerning this dyad combination in counseling, although this has been identified as a sensitive dyad in counseling (Fuentes et al., 2002).

A qualitative research methodology was used in order to explore this complex phenomenon and provide an in-depth analysis. The researchers chose the CQR method because it provided the research study with rigor by utilizing multiple researchers, consensus on themes and ideas, representativeness of data across cases (Fuentes et al., 2002; Hill et al., 1997). The nine participants volunteered to be a part of the study. There were six women and three men participants. All the participants had doctorate degrees, eight in counseling psychology and one in clinical psychology. Each participant had some experience with African American clients in their post-doctorate work. The average age of the participants was 40 ( $SD = 9$ ). The participants also reported an average of nine years of post-doctorate experience. The sample included three geographical regions of the U.S.: the Northwest, Midwest, and Mid-Atlantic. Of the nine participants four were employed in university counseling centers, three in private practice, and two in mental health agencies. Out of the nine interviews, seven were conducted by phone and two were conducted in person. The participants reported having an average of two courses in multicultural counseling and attended an average of nine workshops in multicultural counseling.

as part of their training. Lastly, the psychologists identified their primary approach to therapy. Two of the participants identified as working from the feminist theory, two worked from psychodynamic perspective, and the final five reported as working from an eclectic-integrative perspective.

All members of the research team participated in the interviewing and in the data analysis. The researchers reported their biases. Some of the researchers believed that the therapists would have a high level of racial identity and be sensitive to issues of racism, bias, and oppression. They also believed that the therapists would be conscious of how they were being perceived by their clients, especially with the issue of race sensitivity and possible racist and/or ignorant views or attitudes. The last shared bias was that the researchers expected the therapists to have the American values such as: individual freedom, self-reliance, competition, and leadership. Not only were these biases expressed, they were discussed in order to increase awareness and minimize the effect of the biases on the data analysis.

The measure used in this study was a semi-structured interview, which was audiotaped. The questions were created by each member of the research team and were then discussed amongst the team. The questions were based upon the three research questions that guided the study. Probes were also generated by the team. The interview protocol was separated into five categories. The researchers used a convenience sample and identified about 30 psychologists through professional contacts and contacted the 30 potential participants by letter or phone. During the phone call and in the letter the description, purpose of the study, and the participation criteria were shared. Participants were assured of anonymity and confidentiality. The participants received the questionnaire before the date of the interview so that they could become familiar with the focus of the interview and recall a specific case. There was one pilot interview conducted and it was done by a conference call by one of the researchers while another

researcher listened, observed, and took notes. Feedback was gathered from the pilot interview participant and changes were made to the interview questionnaire. The interviews were transcribed by a graduate assistant that was not part of the research team. Information that could aid in identifying the participant was removed from the transcript and a number was assigned to the transcript in order to ensure confidentiality and anonymity. The data was analyzed by coding into domains. After the cross-analysis was completed the domains were submitted to auditors who provided written feedback to the research team concerning the core ideas and subcategories. After the feedback was received by the research team it was discussed and consensus was reached.

The researchers found that the participants perceived race as a core component that should be discussed and consistently attended to in counseling sessions in order to establish and maintain a trusting and solid working relationship. The psychologists interviewed for this study reported that they typically address the race difference in the counseling dyad directly and openly within the first two sessions. They also found that discussing race differences was to establish and deepen the client's trust and comfort level. The psychologists reported that they believed race-related issues to be relevant to clients' concerns. Although the participants identified as working from several different theoretical orientations, the researchers found that most of the therapists typically used Rogerian skills to engage the clients and establish a positive relationship. The participants reported that there is sometimes client ambivalence during the counseling dyad that was due to race. This was evident by the clients missing sessions and not committing to the process. The participants reported using culture-specific and sensitive interventions to deepen and strengthen the therapeutic relationship. Some of the culture-specific and sensitive interventions included: utilizing their level of racial identity development to understand the client, being aware of the client's level of racial identity development and

worldview, attending to and being supportive of the client's reports of racism, allowing the client's needs to "warm-up" and commit to counseling, take a collaborative stance with the client, and have an empathetic understanding of the client.

The therapists also reported that supervision and consultation from their supervisors and colleagues aided them in discussing interpersonal/racial issues they were experiencing during sessions. The therapists found that supervision was helpful, calming, reassuring, and supportive. The researchers found that the therapists believed that clients experienced understanding, caring, encouragement in counseling, and that the positive therapeutic relationship is an important part that keeps the African American clients in treatment. The participants described the relationship as trusting, safe, comfortable, and when trust and rapport was established the clients were more motivated to continue working and treatment. All of the therapists reported that the African American clients made gains and progress after the 12 sessions in counseling, such as: reduced anxiety, decreased panic attacks, better interpersonal relations, and decreased drug use.

The findings of this study relate to the current research study as the therapists found addressing the race difference between themselves and the client as vital to establishing trust and rapport with the client. Also it deepened the therapeutic relationship which is vital to the client maintaining treatment. The findings indicate that openly and directly attending to racial difference within the initial sessions creates a safe, engaging, and trustworthy environment, which aids the client in being comfortable and can decrease symptoms such as decreased substance use. There were several limitations of this study. Because it is a qualitative study the results are not generalizable. Although the results are not generalizable, the findings are still quite relevant for audiences looking to gain knowledge concerning the dyadic therapeutic relationship between European American therapists, and African American clients. Also the participants were not randomly selected, but it was a purposeful and convenient sample. The

researchers stated that they limited the scope of inquiry by the questions asked and the boundaries set. Because this was a qualitative study, the researchers had to interpret the data from the interviews, and there is a chance that some information may have been interpreted differently from how the participant meant. The main instrument used to collect data was interviews, because of this there is a chance that the responses of the participants was influenced by social desirability. The interview protocol was accessed by the participants prior to the interview date which could have allowed for the participants to prepare their answers for the interview.

Thompson and Jenal (1994) conducted a study concerning the dyadic interactions between African American clients and European American or African American race-avoidant counselors in one quasi-counseling session. This was a qualitative study that examined one-time interactions between African American female clients and European American or African American female counselors who are race-avoidant in sessions. Race-avoidant was operationalized in this study as counselors whose discussions or statements about race are eliminated in session. The method of the study included selecting videotapes from a previous study conducted by Thompson, Worthington, and Atkinson (1994) in which four counselors, two African Americans and two European Americans conducted one-time quasi-counseling sessions with African American female college students. Six sessions from each of the four counselors were selected and categorized based on the client variables of: (a) age ( $M = 19.8$ ), (b) academic level, (c) the combined total score of the Interpersonal and Educational subscales of the Cultural Mistrust Inventory (Terrell & Terrell, 1981), and (d) ratings of counselor utility. The participants self-identified as Black undergraduate women at a predominately White west coast university. They were asked to participate in a study on the concerns of women on campus. The counselors discussed universal concepts with the participants that were relatable to anyone regardless of

race. If the client introduced race into the session, the counselor was supposed to reflect back to the concern. The sessions lasted about 35-45 minutes in a private room and after the interviews were completed, the participant completed several measures, were debriefed and received \$10.00.

Thompson and Jenal (1994) were responsible for analyzing the data and documenting the findings. Both members of the research team recognized their biases and how their racial identities influenced their experiences, and how they appreciate the experiences of others as well. Thompson identifies as a Black female assistant professor of counseling psychology and Jenal identifies as a White female doctoral student in the same program. They recognized how their worldviews on race and other topics can influence how they look at the data and took measures to avoid overanalyzing the data. One precaution taken was that they shared their perspectives on what they thought would emerge from the data. They also consulted often with colleagues who were well versed in qualitative research.

There were 24 videotapes that were electronically transferred to audiotapes and transcribed by students that were part of the original research team. To increase accuracy a separate team of doctoral and master level students checked the transcripts against the videotapes and audiotapes. The goal of the study was to identify significant patterns in the counselor and client interaction, so the analysis process began by focusing on: process-related factors and content-related factors. Next, two coding procedures were used to analyze the notes from the initial phase. Open coding was used to give names to the observations, then axial coding was used to identify patterns. In the final phase of analysis, three factors contributed to the explanation of the categories: (a) whether and how the clients introduced race and race-related concerns, (b) client racial identity perspectives, and (c) client affiliation or lack of affiliation with the counselor based on race.

The researchers found that the quasi-counseling interactions involving Black female college students and White or Black race-avoidant counselors were influenced by the level of engagement within the dyad. Most of the interactions were based upon: whether or not the client raised the issue of race, the client's racial identity perspective, and the client's affiliation or lack of with the counselor. Some clients who did raise issues of race during the beginning of the session, often stopped discussing this matter if the counselor did not respond. This was interpreted by the researchers as not discussing any further in order to fit the norm and recognizing the cues given off by the counselor. These clients gave into the counselors' racial avoidance attitude and behavior. This was seen in the interracial and non-interracial dyads. Some clients seemed to be eager to share their racial issues with the counselors and when they did they were met with race-neutralizing responses. The researchers stated that this could have been perceived by the clients as resistance or ignorance. The clients' continued to share their racial issues even when being met with this behavior and attitude from the counselors. The researchers identified this as the clients feeling as though racial issues were important for them. Although the clients continued sharing, it was evident that they felt frustrated and exasperated.

In one dyad the client seemed constricted in the interaction. The client did not express her thoughts and emotions, and also set very rigid boundaries. The researchers thought this might be because the client felt as though her White counselor could not understand or empathize with her situation, or that if the client disclosed the counselor might operate from her personal worldview to provide feedback on the situation instead of the worldview of the client. Some of the counselors using this universalistic or race-avoidant approach found that the clients were not responding well to the approach. When the Black female students were working with the Black counselors, sometimes race-related questions were posed which could have been a check-in of assurance that the Black counselor was still connected to the Black community. The researchers

were unsure of what these inquiries meant, but think that it may be connected with identifying if there was an affiliation because they had similar racial qualities. The clients were also seen as trying to form reasonable alliances with their Black counselors.

The findings of this study are related to the current study as it was found that using the universalistic or race-avoidant approach is not productive to the interaction between client and counselor. Although some of the interactions went well, there was evidence that the client may have just adjusted and interacted based on the attitude and behavior of the counselor which conveyed that discussions of race should be avoided. This may have led the students to avoid discussing issues that they felt were relevant to their lives, because the environment was not safe and trusting enough to discuss such matters. The researchers believe that the clients in this study used different strategies to navigate the dyadic interactions and deflect the counselor's race neutralization. The researchers also suggested that if counselors want to create a positive counseling experience for Black clients that understand that their clients are racial beings, race influences their life, and be open to discussing racial issues. A limitation of this study is that the data that the researchers were utilizing came from a previous study, so they were not able to triangulate data such as interviewing the counselors and clients before and after session. Also they were not able to gather data from a larger sample of counselors. Because this is a qualitative study the findings are not generalizable.

### **Multicultural Competency in Substance Use Disorder Treatment**

The studies conducted by Lassiter and Chang (2006) and Chandler, Balkin, and Perepiczka (2011), provide some understanding of how counselors who work with individuals with substance use disorders perceive their multicultural competence and self-efficacy. Lassiter and Chang (2006) conducted a quantitative study that explored the self-perceived multicultural competence of certified substance abuse counselors. They set out to explore three questions: (a)

To what extent do certified substance abuse counselors rate their multicultural competence? (b) Does a difference exist in perceived multicultural competency on the basis of years of experience, education, ethnicity, or level of certification? (c) Does the number of completed classes in multicultural counseling affect counselors' perceived multicultural competence? The sample consisted of 98 certified substance abuse counselors in North Carolina. Of the participants, 61% were female and 39% were male; ages ranged from 21-65; 78 (80%) were Caucasian, 20 (20%) were people of color; 4.1% held a high school diploma, 5.1% received an associate's degree, 23.5, obtained a bachelor's degree, 62.2% received a master's degree, 2.0% earned an education specialist's degree, and 3.1% held a doctoral degree; 75.5% were certified clinical addictions specialists (master's degree and beyond) and 24.5% were certified substance abuse counselors (bachelor's degree); 42.0% of participants reported no formal course work in multicultural counseling, 22.0% reported having completed one course, and 36.0% had completed two or more multicultural courses during their academic programs.

The Multicultural Counseling Knowledge and Awareness Scale (MCKAS) (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002) was the instrument used in the study. It is a self-rating, 7-point Likert format scale used to measure multicultural knowledge and awareness. The researchers stated that the MCKAS has been found to be a valid and reliable instrument to measure multicultural knowledge and awareness. A consent form, survey booklet, demographic page, and the MCKAS were sent to 500 randomly selected certified substance abuse counselors (CSAC) and certified clinical addictions specialists (CCAS). Of the 500 surveys sent out, 100 were returned, and only 98 surveys were able to be used. There was 20% return rate. Follow-up reminders were sent out one month after the first mailing. Means and standard deviations were figured for each subscale of the MCKAS; the higher the scores, the higher the level of self-perceived multicultural competence. A Pearson correlation was run to determine if there was a

relationship between the awareness and knowledge subscales; there was a weak correlation between the subscales ( $r = .25$ ,  $n=98$ ;  $p < .05$ ). A MANOVA was used to analyze the data, using demographic variables as the independent variables and the awareness and knowledge subscales scores as the dependent variables.

Lassiter and Chang found that CSACs rated themselves somewhat competent in the areas of knowledge and awareness. The mean score for the awareness scale ( $M = 5.55$ ,  $SD = 0.70$ ) was slightly higher than for the knowledge subscale ( $M = 5.01$ ,  $SD = 0.82$ ). The results showed that ethnicity ( $F = 7.53$ ,  $p < .01$ ) and education level ( $F = 3.24$ ,  $p = < .05$ ) had a significant influence on perceived multicultural competence, and years of experience and level of certification did not. People of color rated themselves higher on the knowledge subscale than Caucasian participants did, and participants holding a bachelor's degree or below rated themselves lower on the knowledge subscale than those who reported having a master's degree or higher. Also, there was no significance between MCKAS scores and number of multicultural classes completed. The results indicated that CSACs considered themselves slightly more multiculturally competent in the areas of knowledge and awareness than the comparison group, which was a national sample that looked at counselors' in training perceived level of multicultural competence in the areas of knowledge and awareness. The researchers suspected this could be due to the fact that some of the CSACs had already completed their training and were working in the field. The researchers suggested this might mean that experience influences how counselors perceive their levels of multicultural awareness and knowledge competence. Also, the higher the level of education, the higher the participants rated themselves in the subscale of knowledge, but not awareness. Another significant finding of the study was that although the participants reported that nearly half of their clients were members of different ethnic and/or racial groups than their own, and not much time is spent in clinical supervision exploring multicultural issues. Participants were asked

to list ways that clinical supervision could be improved that included: more emphasis on multicultural issues, use group supervision to gain diverse perspectives, and more skill-based training in multicultural issues. A limitation of the study is that the generalizability is limited due to the use of self-report, the low response rate, and the fact that the participants were only from North Carolina. Another limitation is that all people of color were grouped into one category; therefore the intragroup differences were not taken into consideration. Even with the limitations, the study used instrumentation that was sound, conducted a thorough analysis, and the study is reliable. The findings provided a basis of how the participants for the current research study may have presented and responded during the in-depth interview.

Chandler, Balkin, and Perepiczka (2011) examined how licensed counselors perceived their self-efficacy to provide substance abuse counseling. This study does not touch on multicultural competence, but it provides insight into how licensed counselors view their confidence in working with clients with substance use disorders. A demographic questionnaire and the Substance Abuse Treatment Self-Efficacy Scale (SATSES), a reliable 32 question, five-factor scale instrument that scores each item on a 5 point Likert-type scale, (Kranz & O'Hare, 2006) were emailed to 999 professional members of the American Counseling Association (ACA). The participants were randomly selected from the four ACA regions in the United States. All participants held licensure within the U.S., did not have licensure or certifications in the area of substance abuse, were graduates of a counseling program, and were a professional member of ACA. They completed an average of 40.05 continuing education clock hours in the area of substance abuse after their master's program, and the participants reported treating an average of 37.02% of their current clients for substance abuse as the primary diagnosis. The sample size consisted of 102 participants. Multiple regression analysis was used to assess statistical

significance, and then squared semi-partial correlation coefficients were examined to determine the degree of practical significance.

Counselors showed moderately high levels of confidence when treating clients with substance use issues. The researchers posited this could be related to the high number of continuing education hours in the sample, even though continuing education had no predictive relationship to counselor self-efficacy ( $p = .549$ ,  $sr^2 = .004$ ). Also, participants showed moderately high levels of confidence on the subscales (i.e., Assessment and Treatment Planning, Case Management, Individual Counseling, Group Counseling, and Ethics) ( $M = 3.70, 3.78, 3.96, 3.57, 4.16$ ) when treating clients of substance use issues even with having less than one substance abuse course. Participants reported being “moderately highly confident” in their abilities to provide substance abuse services as they relate to assessment and treatment planning, case management, individual counseling, and group counseling. Chandler et al. stated this may be due to learning these skills in counselor preparation programs. The finding relates to the current research study, because if LPCs feel only “moderately confident” in their abilities to conduct the clinical assessment with substance use clients, I needed to structure questions concerning multicultural considerations in SUDs assessment in a way that showed empathy for participants who may feel only “moderately confident” in their abilities. The researchers stated that although LPCs feel confident in their ability to effectively work with clients with substance use disorders that does not mean that the services being delivered are adequate and effective.

The sample was recruited by email, which had an impact on the number of participants recruited; 102 participants responded out of a population of 999. There was an overrepresentation of groups such as private practitioners, females, and Caucasians, which may affect the generalizability of the findings, indicative of random cluster sampling. Although the study had limitations such as generalizability and self-report instrumentation, indicating there

may be social desirability response bias, the study's purpose was clear, there was logical consistency, it was reliable, and provided a helpful view of how LPCs view their self-efficacy in working with clients with substance-use disorders.

### **Summary**

In this literature review, literature relevant to broaching as a multicultural counseling approach, multiculturalism within the substance use population, and the incorporation of multicultural variables into the initial clinical interview was discussed. The MCC (Arredondo et al., 1996; Sue et al., 1992), the DPIM (Arredondo & Glauner, 1992; Arredondo et al., 1996), and the RESPECTFUL model (D'Andrea & Daniels, 2001; D'Andrea & Heckman, 2008) were identified and explained as theoretical bases for the current research study, and several quantitative and qualitative studies related to the tenants of the study were critically reviewed, namely: multiculturalism in SUDs treatment, multicultural considerations in clinical interviews, broaching as a multicultural counseling approach, competency in SUDs work, and the findings were linked to the current research.

Diversity within the addictions population was discussed to provide rationale for incorporating multicultural considerations into SUDs treatment. Further, general assessment information and multicultural considerations within assessment were discussed to provide insight into why the initial clinical interview is a prominent part of practice and how it influences the therapeutic alliance and treatment planning. Finally, broaching was examined as a multicultural approach to addressing and acknowledging multiculturalism during the initial clinical interview with members of the substance use disorders population. By using the MCC, DPIM, and RESPECTFUL model frameworks, I supplied germane guidelines to aid counselors in conceptualizing and approaching assessment from a multicultural perspective. The MCC contributes awareness, knowledge, and skills, and the DPIM and RESPECTFUL model furnishes

a lens through which counselors can view their clients as complex and unique beings. The broaching conceptual model provides a strategy that can be used to aid counselors in introducing and examining multicultural considerations during the initial clinical interview.

The reviewed research studies provide insight into why and how broaching multicultural considerations during the initial clinical interview is vital to culturally competent practice and treatment outcomes; how diverse the SUDs population is and the need for multicultural practice within SUDs treatment; and furnishes an understanding of how counselors who work individuals with SUDs disorders perceive their multicultural competence and self-efficacy. There are few research studies available concerning multiculturalism in SUDs treatment, counselors' multicultural competence level in providing SUDs treatment, and broaching multicultural considerations during the SUDs initial clinical interview.

Due to the scarcity of literature, there are considerable gaps in the literature, such as: how do counselors working with clients with SUDs disorders conduct an initial clinical interview that considers clients' multicultural identities? Do LPCs who work with the SUDs population introduce multicultural factors into the counseling process? Does tailoring SUDS treatment to best fit the cultural needs of the client produce better treatment outcomes? Does conducting an initial clinical interview impact retention and the treatment engagement? How does the multicultural information obtained during initial clinical assessment impact the treatment planning and interventions implemented? Does collecting multicultural information about the client in the initial session aid in case conceptualization? Are counselors currently obtaining multicultural information during the initial session?

Based on the gaps in the literature, the purpose of this study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical

interview with clients who have substance use disorders. I used the MCC, DPIM, RESPECTFUL model, and broaching frameworks to guide the research study. With this research study, I intended to fill a gap in the literature and contribute to multiculturalism in clinical assessment, and particularly multicultural practice in substance use disorder treatment. The findings provide insight into whether and how LPCs broach multicultural considerations during initial clinical interviews with the SUDs population.

## CHAPTER THREE

### METHODOLOGY

The purpose of this study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. The research questions that guided the study and the research design are as follows:

- 1) How do LPCs who conduct initial clinical interviews perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?
- 2) How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?
- 3) Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?

This chapter includes the research design, the interview protocol outline, selection process of participants, data collection, data analysis procedures, and rigor and credibility. First, the chapter will address the rationale for using a qualitative research approach, followed by a discussion of ethical considerations, including: confidentiality, informed consent, and the risks and benefits of the study. Next, the research design will be explicated, followed by the interview guide; data analysis procedures; rigor and credibility, including the role of the researcher; and conclude with limitations of the study.

#### Rationale for a Qualitative Research Design

The purpose of this research study was to explore the experiences and perspectives of LPCs who conduct initial clinical interviews with clients who have substance use disorders in

order to describe whether and how they broach multicultural considerations during the initial clinical interview process. This purpose aligns with the purpose of a descriptive phenomenological study (Creswell, 2013; Patton, 2014; Rossman & Rallis, 2012). Phenomenological studies take an inductive approach to capture rich, thick detail of the phenomena being studied in its embedded contexts (Creswell, 2013; Patton, 2014; Rossman & Rallis, 2012). The qualitative phenomenological approach was appropriate for this study because it aided the researcher in understanding the experiences and perspectives of the participants. After the perspectives of the participants' experiences were captured, the researcher described the subjective experiences and perspectives of actual individuals experiencing the phenomenon.

Phenomenology captures the thoughts, feelings, perceptions, judgments, and detailed descriptions of individuals' lived experiences (Patton, 2014). These experiences and perspectives can be collected by utilizing qualitative methods such as: interviews, discussions, and participants' observations. The goal of phenomenological research is to explore how participants' make sense of an event or phenomenon based on their experience which creates their perspective (Patton, 2014; Rossman & Rallis, 2012). Because phenomenological research is based on interpretations and how the participants make sense of the world, it is vital to consider how an individual's sociocultural contexts influence their perspectives (Fossey, Harvey, McDermott, & Davidson, 2002). The main outcome of phenomenological research is to describe how the event or phenomenon appears to those involved in the situation (Rossman & Rallis, 2012). It is important to note that the researcher interpreted the data collected and described the experiences of the participants, therefore reflexivity and role of the researcher is discussed later in this chapter (Anfara et al., 2002; Patton, 2014; Rossman & Rallis, 2012).

Qualitative research was appropriate for this research study versus quantitative research because the ultimate purpose of the research was to learn about the lived experiences of the LPCs

(Rossman & Rallis, 2012). Qualitative research begins with questions but the researcher does not control and predict the outcome, but rather he or she describes, analyzes, and interprets (Rossman & Rallis, 2012). The researcher's purpose of the study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. Understanding how the participants' see, feel, and experience broaching multicultural considerations during the initial clinical interview is the core of the study and this was best captured through qualitative research methods (Rossman & Rallis, 2012).

### **Ethical Considerations**

Ethical considerations must be a focal point when conducting qualitative research. Qualitative research is rooted in the lived experiences of human participants (Rossman & Rallis, 2012). The participants' are sharing their intimate thoughts, judgments, ideas, perceptions, and descriptions of their lived experiences, therefore it is vital that the researcher respect and care for the participants, while also protecting their rights (Creswell, 2013; Rossman & Rallis, 2012). The researcher has a duty to do no harm to the participants' and have safeguards in place to protect the well-being of the participants of the study, because the topic could invoke particular responses (Creswell, 2013; Rossman & Rallis, 2012). It is important to note that some ethical considerations are general for all qualitative research and some are study-specific (Rossman & Rallis, 2012). Some of the general ethical considerations include: privacy and confidentiality, deception and consent (i.e., informed consent), and trust and betrayal (Rossman & Rallis, 2012).

The Institutional Review Board (IRB) at Virginia Polytechnic Institute and State University also has institutional policies and research protocol that the researcher abided by throughout the study. These policies and research protocol that are in place by the IRB are to

protect the rights and ensure the safety of the participants. The researcher was not only bound by the ethics that guide the decision making in qualitative research and the IRB, but she was also bound by her professions' code of ethics, the American Counseling Association (ACA) Code of Ethics (2014). Section G of the Code of Ethics discusses "Research Responsibilities". One of the considerations discussed in the section is the concept of confidentiality, which is also a crucial part of qualitative research as well.

### **Confidentiality**

Researchers are aware of the participants' identity when conducting qualitative research studies (Rossman & Rallis, 2012). Because phenomenological research studies require participants to share their thoughts, feelings, and descriptions of lived experiences, it is vital that the researcher ensures the safety of the participants' identity is confidential throughout the study (Patton, 2014; Rossman & Rallis, 2012). Several measures were taken to ensure confidentiality including assigning pseudonyms to the participants. First, the participants were given the opportunity to choose their own pseudonym. It should be noted that all participants declined to choose a pseudonym, so all pseudonyms were assigned by the researcher. Second, the interviews were conducted in a location that was confidential, secure, and comfortable for the participants. Third, the collected data was stored in a secured location; locked in a safe box only accessible to the researcher. Fourth, the data will be destroyed once it is analyzed, results disseminated, and the findings are presented at written and oral forums, including the dissertation, conference presentations, and journal articles. These four measures ensure that the participants' identity remain anonymous.

### **Informed Consent**

The participants' engagement in the research study was voluntary. This was verbally shared with the participants and presented in written form via the informed consent. The

informed consent explained the purpose of the study, the intended audience, and what participation in the study entailed. After gaining an understanding of the study the participants were able to voluntarily give their consent, and understood that they could withdraw from the study at any time without any repercussions (see Appendix A for the informed consent) (Rossman & Rallis, 2012). Informed consent ensured that the participants were aware of the details of the study, their voluntary status, confidentiality and privacy. Obtaining the informed consent of the participants is essential when conducting an ethical research study (Rossman & Rallis, 2012). In accordance with Virginia Tech's IRB requirements, the informed consent was submitted and reviewed before the research began. A copy of the informed consent was emailed to the participants prior to the interview to allow them time to read, process, and formulate any questions or concerns about their participation in the research study. Participants were able to ask questions to aid in understanding and clarifying the informed consent before and after signing. A copy of the informed consent was also given to the participants. The researcher shared with the potential participants that there would not be any repercussions or persuasion if they did not wish to consent, as it was his or her choice (Rossman & Rallis, 2012). If the potential participant did not wish to participate in the study, the researcher thanked the potential participant for his or her time and extended the opportunity for the individual to contact the researcher if he or she decided to participate.

The informed consent also covered the risks and benefits of the study. The benefits of the research study seemed to outweigh the risks. A risk of the study was that the discussion of culture, particularly for this study discussing race, gender, sexual orientation, and other multicultural variables may have been a difficult and sensitive topic for the participants. There appeared to be minimal risk for the research study. Benefits of the research study included, participants gaining insight into and reflecting on their clinical practice, participants noticing

their professional development, and participants sharing how they broach multicultural differences and learning from their colleagues on their strategies for broaching. Also, the results of this study contribute to the field of counseling's body of literature concerning broaching multicultural considerations in the initial clinical interview, broaching multicultural considerations in SUDs work, and the incorporation of multiculturalism in SUDs work.

### **Research Methods**

The need to explore the lived experiences of the participants called for a qualitative, descriptive phenomenological research method (Rossman & Rallis, 2012). Working from a phenomenological approach allowed the researcher to capture rich, thick details concerning the participants' experiences. Phenomenological research focuses on describing the "common meaning" of the phenomenon for all of the participants (Creswell, 2013, p. 76). As a phenomenological researcher the aim was to collect and describe what the participants experience and how they experience the phenomenon (Creswell, 2013). For the purposes of this study the lived experiences of the participants were captured by in-depth interviewing.

### **Role of the Researcher**

One of the four philosophical perspectives in phenomenology is that the researcher is to suspend all judgment and preconceived ideas (Creswell, 2013). The researcher should enter into the phenomenological research with all judgments removed and any preconceptions bracketed (Creswell, 2013; Riemen, 2008). Bracketing means that the researcher states his or her assumptions, judgments, and preconceptions concerning the phenomenon being studied (Riemen, 2008). Because the researcher is responsible for interpreting and describing the data it is crucial that the researcher is aware of her personal biases and judgments, and the role of the researcher (Rossman & Rallis, 2012). It is vital that the researcher is aware her judgments so that she can be

fully open to understand the lived experiences of others and not impose her values on the participant or the data (Riemen, 2008).

As the researcher that will be conducting this study it is important that I share about my experiences concerning this phenomenon. I have experience working at in a community mental health setting in the Commonwealth of Virginia. While working in the community mental health setting, I provided clinical services to individuals struggling with substance use disorders, including conducting initial clinical interviews, individual therapeutic sessions, and group counseling sessions. Because of my experience, I have an understanding of varying perspectives that I might encounter concerning the phenomenon. I am aware that the demands of working in community mental health setting can be overwhelming and sometimes one may feel as though they do not have time to explore cultural considerations. I also have experienced mental health providers who make the time to explore the cultural make-up of their client. As a mental health professional who worked with individuals with substance use disorders, there were times when I did broach multicultural considerations during the initial clinical interview and there were times when I did not. Many factors came into play that determined whether or not I broached and many times the decision was not conscious. The demands of the community mental health agency, including documentation or a heavy workload for the day, sometimes made me feel pressed for time, and I focused on what I felt was needed to formulate a diagnosis. There were other times in which my schedule was more flexible and I could allot more time and energy into the sessions, which led me to broach the subject of multicultural considerations. Even if I did not broach in the initial clinical interview, I tried to broach sometime within the therapeutic relationship, but wondered how things would have been different if I would have begun the relationship by broaching?

Based on my experience in the field I am understanding and empathetic to the individuals that I will interview. Although I am empathetic and understanding I truly believe that broaching multicultural considerations during the initial clinical interview is essential for multicultural competent practice. It is important that I mention that currently I am not a LPC and my practice in the field was not under the LPC title. Even though I am not yet a LPC, I am doctoral candidate who is dedicated to the counseling profession. I do not see this as affecting data analysis, but want to share my background and role in the research. Also, I personally and professionally work from the perspective that all human beings are multicultural. I am aware that my personal cultural make-up consists of many social and cultural identities that also intersect and creates multidimensionality. Although I have many other multicultural identities, I identify as a Black American female which are salient multicultural factors that the participants may notice immediately during the interview. Some of the participants may respond based on social desirability (Rossman & Rallis, 2012) due to some my cultural and social identities, such as race, gender, and being a counselor education doctoral student. The experiences of the participants provided me with a rich, thick description of the perspectives of LPCs lived experiences concerning the phenomenon. The purpose of the study was to understand and describe, and not solve or find an answer, so I was open and ready to receive the thoughts, ideas, and feelings of the participants.

## **Participants**

The purpose of the study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders, therefore the participants consisted of LPCs currently working in community mental health settings in the Commonwealth of Virginia who conduct initial clinical interviews

with clients receiving services for substance use disorders. The sample size of the study included nine LPCs, and depended upon data saturation (Creswell, 2013; Patton, 2014). Data saturation is when there is enough data gathered to develop a model and the researcher is not gathering any new data (Creswell, 2013). The participants worked in community mental health settings, which included public (7) and private (2) agencies. Participants were identified by purposeful and snowball sampling (Creswell, 2013; Rossman & Rallis, 2012). Purposeful sampling is when the researcher identifies individuals who can provide rich, thick details of concerning their lived experience as it relates to the study (Patton, 2014). Snowball sampling is a strategy used to conduct purposeful selection of participants (Creswell, 2013; Rossman & Rallis, 2012).

For the intent of this study the participants were currently practicing LPCs, working in a community mental health setting in the Commonwealth of Virginia, and who had been conducting initial clinical interviews with adults with substance use disorders for at least six months. The inclusion criteria made for a well-defined sample and captured the perspectives of individuals who provided rich, thick details of their experience with the phenomenon (Patton, 2014; Rossman & Rallis, 2012). In order to identify potential participants the researcher contacted community mental health centers in Virginia and directly invited individuals who worked at the centers and provided substance use services to participate in the study. The researcher also received names of LPCs who provided substance use services from individuals who participated in the study and other treatment providers who were aware of individuals who may have fit the study's participant selection criteria. The identified potential participants were contacted via email or phone (see Appendix B for recruitment scripts). The potential participants were screened via phone, in-person, or email to determine if they were appropriate for the study. If the individual was an appropriate fit for the study, the researcher shared the data collection process with the participant and established a date, time, and location that worked best for the

participant to conduct the interview. Once the interview date, time, and location was established the researcher met with the participant in order to begin data collection.

## **Data Collection**

**Semi-Structured interviews.** The data was primarily collected through in-depth semi-structured interviews that lasted approximately 60 minutes. In-depth interviews have been described by some as a distinctive feature of qualitative research (Rossman & Rallis, 2012). Semi-structured interviews follow an interview protocol to ensure that the researcher asks certain questions and covers particular topics. The researcher then has the ability to abandon the trajectory of the interview protocol if he or she feels the need to diverge in order to gather data that is relevant to the study (Rossman & Rallis, 2012). Semi-structured interviews provide more flexibility during the interviewing process than solely structured interviews, which do not allow the researcher to diverge from the interview guide (Rossman & Rallis, 2012). A benefit of semi-structured interviewing is that the participant can freely and openly express themselves when sharing their lived experiences, due to the flexibility of the process (Rossman & Rallis, 2012).

The semi-structured interviews conducted for this study were formal and followed an interview protocol. Semi-structure allowed the researcher to stray away from the protocol if she saw fit in order to gather data relevant to the study. All interviews were audio recorded for transcription purposes. The audio recordings were transcribed by a trusted third-party agency. The agency agreed to the confidentiality and privacy policy followed by the study. The researcher reviewed each transcription alongside the audio recording and made necessary edits as needed. Each participant received an electronic version of the final initial transcript and was afforded the opportunity to contact the researcher for any changes or additions they wanted to make. These member checks aided in the credibility of the study and accuracy of the data (Anfara et al., 2002; Rossman & Rallis, 2012). Two pilot interviews were conducted with

counselors familiar with community mental health centers and substance use disorders in order to test the interview design and to determine if the questions and interviewing techniques gathered data that was prevalent to the study (Seidman, 2013). The pilot interviews allowed the researcher to make changes and refine the interview protocol (Seidman, 2013). At the end of each semi-structured interview, the participant was presented with a \$10.00 gift card to Starbucks or Target. The gift cards were given as a “Thank You” for their participation in the research study. Follow-up interviews (see Appendix D for follow-up interview) were conducted via phone for all participants one to three weeks after the initial interview. The follow-up interviews lasted approximately 15 minutes and were also semi-structured. The follow-up interviews allowed the participants the opportunity to provide additional information and reflections that may ensued from the initial interview.

There are several strengths and limitations of interviewing. As previously stated, in-depth interviewing is an advantageous way to collect rich, thick descriptions concerning the lived experiences of those experiencing the phenomenon (Rossman & Rallis, 2012). Interviewing is a very interpersonal experience that requires engagement by both parties, so the interviewer must have interpersonal skills and the participant must be willing to participate (Patton, 2014; Rossman & Rallis, 2012; Seidman, 2013). Also, the researcher is depending on the participant to be truthful about his or her experiences and provide rich responses (Rossman & Rallis, 2012). One of the most essential techniques utilized by the researcher is to be an effective listener (Rossman & Rallis, 2012; Seidman, 2012). The outcome of interviews is that they produce narratives of the participants’ lives (Rossman & Rallis, 2012).

**Interview protocol.** The interview protocol approach was utilized in order to guide the interview and capture the experiences of the participants (Creswell, 2013; Rossman & Rallis, 2012). Using this approach allowed the researcher to generate topics, categories, but also

provided an opportunity to explore ideas that the participant initiated and to go in a direction that the researcher deems appropriate for gathering useful data (Rossman & Rallis, 2012). The interview protocol approach can be described as an outline of topics, categories, and questions to be covered to elicit the participants' responses. Participants can frame their responses however they deem fit (Rossman & Rallis, 2012). By using this approach the researcher posed open-ended questions and the participants had the option to ask for elaboration and clarification from the researcher (Rossman & Rallis, 2012). The hope was that the participants would respond with long narratives that represented their perspectives of the phenomenon; the researcher was just the gatherer of this information (Rossman & Rallis, 2012). The key to this approach is that the participant should talk and share more than the researcher. When using an interview protocol it is important that the purpose of the questions or topics is to help the participant formulate their personal narratives surrounding the phenomenon (Seidman, 2013). The researcher was careful not to manipulate or pose questions in a way that imposed her interests or personal experience on the perspectives of the participants (Seidman, 2013). The questions were posed in a way that was open and non-leading (Seidman, 2013). Also, the researcher asked follow-up questions to aid in gathering thick descriptions and more detail concerning the lived experiences of the participants (Rossman & Rallis, 2012).

The interview protocol for this study followed a typical guided interview process (Rossman & Rallis, 2012). Below is the outline of the interview protocol.

1. Introduction – Researcher will greet the participant and begin to establish rapport with one another. Introductions will take place at this time.
  - (a) Overview and Purpose – The researcher will discuss the purpose of the research study and interview with participant. Also, the researcher will explain how the interview process will be conducted from beginning to end.

- (b) Informed Consent – Researcher will voluntarily gain the consent of the participant to participate in the study. The researcher will allow the participant to read the consent on their own prior to study, and will verbally go over each section of the consent with the participant. Time will be allotted for the participant to pose any questions or concerns for the researcher. There will be sections in the informed consent that cover the purpose of study, confidentiality, rights of the participants, risks and benefits, audio recording and transcription, ownership of the content, and dissemination of results.
2. Body of the Interview – The researcher will have topics, categories, and questions to guide the interview.
- (a) Questions concerning basic background information, in order to build rapport and trust.
  - (b) Questions concerning initial clinical intake process.
  - (c) Questions concerning client populations and cultural identities.
  - (d) Questions concerning culture and substance use disorders work.
  - (e) Questions concerning multicultural considerations during the initial clinical interview.
  - (f) Questions concerning the term and concept of broaching.
  - (g) Any other additional information the participant would like to share, maybe information concerning the participant's training, multiculturalism courses, diversity trainings, and the culture of the organization and addiction unit to determine if the agency support working from a multicultural perspective.
3. Summary and Closure
- (a) Thank the participant for his or her time and openness in sharing.

- (b) The researcher will remind the participant about the follow-up interview that will occur via phone in one to three weeks. Find out if the participant has a particular date and time that works best for the follow-up interview, and if so schedule the follow-up phone call.
- (c) Extend an open invitation to the participant, by letting the participant know that he or she can contact the researcher if anything else comes to mind, or there are any additions and changes to be made to the interview.
- (d) The researcher will share with the participant how the interview will be transcribed and the process concerning how they will be given the opportunity to review their transcribed interview and make additions and changes.
- (e) Lastly the researcher will review with the participant the process that will occur once the member checks are completed concerning developing themes and how the findings will be disseminated.

The interview protocol was developed based on this outline of the interview guide (see Appendix C for interview protocol).

**Demographic questionnaire.** Because phenomenological research studies capture the perspectives, ideas, and feelings concerning the phenomenon being studied it is important to consider the cultural make-up of each participant and how culture influences the worldview and perspectives of the participant (Patton, 2014; Rossman & Rallis, 2012). Gathering demographic information allowed the researcher to have a holistic view of the participant. Also, the research study was concerned with whether and how LPCs broach multicultural considerations with clients; therefore, it was important to gather the participants' cultural background as it may influence the responses. The demographic questionnaire was completed in writing by the participants at the end of the semi-structured interview (see Appendix E for the demographic

questionnaire). The participants had the option of completing the questionnaire based on their level of comfort. Any questions or concerns about the questionnaire were addressed at the end of the semi-structured interview. The demographic questionnaire gathered information such as: gender, race, ethnicity, age, and sexual orientation. All data gathered from the questionnaire and demographic form was analyzed, and represented in the dissemination of results.

**Field notes (Observations).** Field notes are the written form of the researcher's perceptions (Rossman & Rallis, 2012). For the purpose of this study the field notes were for observational purposes only. The observations were about what the researcher saw and heard in the field, how the researcher interpreted the environment, context, and the process (Rossman & Rallis, 2012). Field notes were written as soon as possible after each interview (Rossman & Rallis, 2012). The field notes were handwritten and stored in a secured location, only accessible to the researcher. Field notes served as another form of data for the study, which were also analyzed.

Field notes are produced through observation (Rossman & Rallis, 2012). Careful observation during the interview can provide the researcher with data that can supplement the primary data collection method (Rossman & Rallis, 2012). When combining observation with in-depth interviewing, the researcher looks for and interprets the participants' body language and affect (Rossman & Rallis, 2012). Observation takes the interview experience beyond words and brings the context into play. It provides a holistic view into the lives of the participants (Rossman & Rallis, 2012). Through observation the researcher is able to understand the context, identify patterns that people may not see, and patterns that the participants may not want to talk about (Rossman & Rallis, 2012). When the researcher observes he or she will record events, actions, and interaction in field notes.

## **Data Analysis**

The data analysis process brought purpose and meaning to the data that was collected throughout the study (Anfara et al., 2002; Rossman & Rallis, 2012). The data analysis was based upon a thick description (Rossman & Rallis). Thick descriptions create a detailed picture that assists the researcher in analysis, because there are enough details to support interpretations and others can also see what the researcher is basing his or her interpretation on. A weak description cannot provide the foundation for a strong interpretation, because there are not enough details (Rossman & Rallis, 2012).

The researcher made meaning of the data through interpretation (Anfara et al., 2002; Creswell, 2013, Rossman & Rallis, 2012). In order to conduct qualitative data analysis, the data must be organized (Anfara et al., 2002; Creswell, 2013; Patton, 2014; & Rossman & Rallis, 2012). Qualitative data collection methods, including in-depth interviews typically produce large volumes of data that can be time-consuming to analyze (Patton, 2014; Rossman & Rallis, 2012). There is not a singular right way to conduct the process of data analysis in qualitative research, it is an eclectic process and the process may vary from study to study (Anfara et al., 2002 & Creswell, 2013). The process of data analysis was iterative and sequential (Rossman & Rallis, 2012). The researcher immersed herself in the data, then analyzed the data, and lastly made interpretations of the data in order to make meaning (Patton, 2014; Rossman & Rallis, 2012). The analysis began when the study began, as data analysis is an ongoing and emergent process that relies on inductive and deductive reasoning (Patton, 2014; Rossman & Rallis, 2012). For the research study, the constant comparative analysis method was utilized to analyze the collected data (Anfara et al. 2002; Creswell, 2013).

## Constant Comparative Method

The type of qualitative research study being conducted and the purpose of the study guides which data analysis method to use when analyzing data for a qualitative study (Patton, 2014; Rossman & Rallis, 2012). Because the research is a phenomenological study, the constant comparative method was appropriate. This method entailed that the data would be compared to emerging categories along with the properties of the categories that will emerge from the data (Anfara et al., 2002; Creswell, 2013). The categories produced by comparing the data are theoretical and led to themes (Rossman & Rallis, 2012). If interviews are the primary method for collecting data when working from a phenomenological approach the primary outcome is to develop themes (Rossman & Rallis, 2012). Coding was the primary process in developing the themes.

The constant comparative analysis produced patterns or themes; these patterns were discovered through coding (Anfara et al., 2002). Coding allowed the researcher to interpret and make meaning of the data. The patterns discovered by coding in the research study are represented by themes (Creswell, 2013; Rossman & Rallis, 2012). The codes produced by the process of open coding were placed into categories (Rossman & Rallis, 2012). Coding leads to categories, which connects the data to the conceptual framework (Rossman & Rallis, 2012). Categories aid in providing guidance for data collection because they typically are derived from the conceptual framework as the key constructs that the researcher wants to gain more understanding. The need for understanding the key constructs frames the interview protocol (Rossman & Rallis, 2012). Rossman and Rallis (2012) refer to themes as, "...linkages, patterns, processes, and possible explanations begin to appear within and across categories" (p. 277). Themes are generated from categories and take the analysis to a more integrated and deeper level

(Rossman & Rallis, 2012). Themes aim to embody aspects of the lived experiences of the participants involved in the phenomenon (Rossman & Rallis, 2012).

The process of data analysis was mostly inductive, as the themes are related to the data. Because the researchers' aim was to produce themes, she immersed herself into the data and used the constant comparative method which includes coding and recoding and comparing concepts, which leads to themes (Anfara et al., 2002; Morrow & Smith, 1995). The researcher conducted three levels of coding: 1) open coding; 2) axial coding; and 3) selective coding (Strauss & Corbin, 1998). This coding process is typically seen in the grounded theory approach, but due to its rigorous and logical nature, it was appropriate for this study. The first level of coding, open coding, included line-by-line and paragraph analysis in order to generate initial words, or short phrases to begin conceptualizing the data (Strauss & Corbin, 1998). Axial coding is where category development began. The codes from the first level, open coding were used to develop categories. The final level of coding, selective coding is where the themes were developed (Creswell, 2013; Strauss & Corbin, 1998). During selective coding the categories were refined and connections were made between categories in order to develop themes (see Appendix F for theme development) (Creswell, 2013; Strauss & Corbin, 1998).

### **Credibility and Rigor**

In order for the audience to find the results and finding of a qualitative research study as sufficient, believable, and useful the study must be credible (Rossman & Rallis, 2012). Some of the factors that lead to credibility include, how well the study was conceptualized, whether or not the study was implemented in a comprehensive way, and if the written report was written with rigor (Rossman & Rallis, 2012). There are several ways to demonstrate that the study is credible including: prolonged engagement in the field, use of peer debriefing, triangulation, member checks, and time sampling (Anfara et al., 2002). For the purposes of this study the researcher

used two peer reviewers to each code two interviews independently from the researcher and then each peer reviewer and the researcher debriefed in order to determine if the researcher was being open and non-biased in the coding process (Rossman & Rallis, 2012). Of the two peer reviewers, one was a member of the field and an LPC and the second peer reviewer was from outside the behavioral health field and was in the engineering field. Both peer reviewers have experience with coding and qualitative research. One peer reviewer coded interviews six and seven and the first six follow-up interviews. The other peer reviewer coded interviews one and two. The researcher had the peer reviewers' code different interviews to add to the credibility of the study. At the beginning the researcher wanted to ensure that she was not being biased and asked one peer reviewer to independently code interviews one and two. During the peer debriefing, it was determined that the researcher was interpreting the data in similar ways to the peer reviewer. To make sure that the researcher was consistently being open and unbiased throughout the coding process, the researcher asked a different peer reviewer to analyze interviews six and seven. Again, it was determined that the researcher was interpreting the data similarly to the peer reviewer. Also member checks were used to allow the participants to provide feedback concerning his or her transcribed interview. Each participant was sent their transcribed interview via email from the researcher and had three days to provide feedback to the researcher concerning the interview including whether or not they would like to remove or add anything to the interview. This adds to the accuracy of the collected data (Rossman & Rallis, 2012). Triangulation was also used to add to the credibility of the study (Rossman & Rallis, 2012). Although, in-depth interviews were the primary method of data collection, the multiple data sources such as the audio recordings, transcriptions and field notes, were included in the data analysis. Even though all data sources were analyzed, the themes were derived from the interview transcripts. Also, the researcher received feedback from her dissertation committee

members, who served as external auditors in the process. The committee also served as a community of practice (Rossman & Rallis, 2012).

The trustworthiness of the research study was demonstrated by the researcher portraying the lived experience of the participants as deeply and honestly as possible (Rossman & Rallis, 2012). The researcher reflected on her role in the study and used an audit trail (see Appendix G for audit trail) to document the data collection and analysis process and decisions made throughout the study. The audit trail added to the credibility of the study as the researcher logged activities related to the study indicating the date. The audit trail denotes what the researcher did throughout the study. The audit trail keeps the study transparent and provides documentation of the researcher's logic when conducting the research analysis and the findings. For the purposes of this study the audit trial began from the data collection process throughout the data analysis process (Rossman & Rallis, 2012).

Rigor refers to how rigorously the study was conducted (Rossman & Rallis, 2012). It is about transparency and if others can determine how the researcher conducted the study, and the researcher's logic and reasoning (Rossman & Rallis, 2012). This includes if the decisions made throughout the study are rooted in the conceptual framework and if the research design and decision-making process is transparent (Rossman & Rallis, 2012). The rigor of the study is demonstrated by the use of the audit trail, which provides a log of activity and decisions made by the researcher. Another way to determine the rigor of a study is to know the researcher's stance and role in the research. The researcher has spoken to her role and stance earlier in this document.

### **Summary**

In this chapter, I have discussed the research design, including: the rationale for the researcher's decision to conduct a qualitative study versus a quantitative study, the reasoning for

using the phenomenological qualitative research approach, the selection process of participants, and the use of 60 minute in-depth interviews. Subsequently, the purpose of the study and the research questions were also shared within the chapter. The interview protocol, the data collection process, and data analysis procedures were provided. Credibility and rigor of the study was discussed, demonstrating the trustworthiness and usefulness of the study. This study explored the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. The results of this study have many implications for the counseling profession, the substance use treatment community, and produced directions for future research studies. The main objective of the study was to add to the knowledge base and provide recommendations for those conducting initial clinical interviews with the specific population.

## CHAPTER 4

### FINDINGS

The purpose of this qualitative study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. The study included nine participants. Participation selection was based on the recruitment criteria for the study which consisted of: being a licensed professional counselor practicing counseling in the Commonwealth of Virginia; currently conducting initial clinical interviews with adults who have substance use disorders; and having at least six months of experience conducting initial clinical interviews with the substance use disorders population. Participants were recruited using purposeful and snowball sampling (Creswell, 2013; Patton, 2014; Rossman & Rallis, 2012). All of the participants of the study fit the selection criteria. The following research questions guided the overall study:

- 1) How do LPCs who conduct initial clinical interviews perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?
- 2) How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?
- 3) Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?

The purpose of this chapter is to present the findings of the study. Themes will be used to represent the findings that were discovered through the analysis. The themes are based upon descriptions of the LPCs' experiences and perceptions concerning whether and how multicultural considerations are broached during the initial clinical interview. The semi-structured interviews,

demographic questionnaires, and field notes were analyzed to discover emerging themes and patterns. The chapter is organized into the following sections: participants, analysis, findings, and summary. For the findings, the themes are organized by each research question.

## **Participants**

The demographic questionnaire captured the gender, race/ethnicity, sexual orientation, and age range of the participants. Participants completed the demographic questionnaire at the end of the semi-structured interview. The researcher requested the participants respond to the questions in which they felt comfortable. Data saturation determined the total number of participants in the study (Creswell, 2013; Patton, 2014). The researcher determined that data saturation had been met after the ninth participant, as no new information was being seen or heard in the interviews. Seven females and two males participated in the study. Of the participants, six individuals identified as White, two identified as African American, and one identified as Hispanic. One individual identified as a member of the lesbian, gay, bisexual, and transgender (LGBT) community and eight individuals identified as heterosexual. Participants ranged in age from 21-69 years of age. The range of experience working in the field with the substance use disorders population (pre- and post-licensure) is between 4 to 36 years. The participants were from four regions in the Commonwealth of Virginia: Central Virginia (2), Northern Virginia (2), New River Valley (4), and Shenandoah Valley (1). All of the participants worked in a community mental health setting. Seven of the participants worked in a public community setting and two of the participants worked in a private community setting. Participant demographics can be seen in Table 1.

There was diversity amongst the nine participants which made for rich, thick descriptions. The participants shared about their experiences and perspectives of broaching multicultural considerations with the substance use disorders population, particularly during the

initial clinical interview. The findings of the study are presented in the sections. The findings are presented as themes or patterns that emerged while analyzing the data, using the constant comparative method.

Table 1

*Demographic Summary of Participants (N=9)*

Name	Age Range	Gender	Race	Years of Practice (with or without license)	Sexual Orientation	Virginia Region
Heather	60-69	Female	Black	20	Heterosexual	New River Valley
James	21-29	Male	White	4	Heterosexual	New River Valley
Stella	50-59	Female	White	25	Heterosexual	Central Virginia
Mary	40-49	Female	Black	12	Heterosexual	Central Virginia
Maria	40-49	Female	White	13	Heterosexual	Northern Virginia
Kathleen	40-49	Female	Hispanic	17	Heterosexual	Northern Virginia
Danielle	40-49	Female	White	11	Heterosexual	New River Valley
Brian	50-59	Male	White	36	Homosexual	New River Valley
Rhonda	60-69	Female	White	26	Heterosexual	Shenandoah Valley

**Data Analysis**

Two pilot interviews were conducted prior to the start of data collection. The pilot interviews provided feedback that was incorporated into the interview protocol to ensure that the interviewing techniques gathered the necessary data needed to respond to the research questions (Seidman, 2013). After the participants were screened and selected the in-person interviews were conducted. The interviews ranged in length from 43:00 to 86:00 minutes. After the completion of the interviews, the participants responded to the demographic questionnaire. Then the interviews

were sent to a third-party transcription service. Follow-up interviews occurred one to two weeks after the initial interview. These follow-up interviews took place via phone and audio-recorders were utilized to capture the data. These interviews were also sent to the third-party transcription company. Once the researcher received the transcripts she ensured accuracy by listening to the audio recording while reading through the transcript. The transcripts were then sent to the participants for accuracy and suggested changes.

The researcher immersed herself in the data by listening to the audio recordings of the interviews and by thoroughly reading the transcripts. The analysis began as soon as the first interview was conducted, as it was an ongoing and emergent process (Patton, 2014; Rossman & Rallis, 2012). Once the second initial interview was completed the constant comparative method was utilized (Anfara et al., 2002; Creswell, 2013).

Open codes began the coding process. These codes were descriptive indicators that aided the researcher in beginning to conceptualize the data. Once open coding was completed on all transcripts, the researcher re-read all transcripts and codes in order to conduct axial coding. Axial coding uses the open codes to create abstract categorization. This level is where categories are developed. Finally, selective coding was conducted to begin to develop themes. In this step of the coding process connections are made between categories, which allows for the development of themes. Themes look beyond the experiences of an individual participant, and to all of the participants' experiences within the context of the phenomena being studied (Rossman & Rallis, 2012). As described in Chapter 3, field notes and an audit trail were recorded throughout this process in order to add to credibility and rigor (Anfara et al., 2002; Rossman & Rallis, 2012). Also, peer debriefing, triangulation, and member checks were utilized to aid in credibility (Anfara et al., 2002; Rossman & Rallis, 2012).

## Findings

It is important to note, that in order to not lead the participants to any particular responses the researcher did not provide a definition for culture or cultural identities. The researcher wanted the responses to be based on the participants' definitions of culture and cultural identities. The researcher did gather data concerning how each participant defines cultural identities, including what cultural groups they include in their definition. To aid in reviewing the findings the definitions of broaching, community mental health center, initial clinical interview, licensed professional counselor are listed below and also found in Chapter One of this document:

*Broaching* - A strategy that can be utilized by counselors to introduce or “bring” the discussion of cultural factors into the counseling process (Day-Vines et al., 2007).

*Community Mental Health Center (CMHC)* – Community-based treatment agencies that provide mental health and addictions treatment throughout the U.S. (Murphy & Riggs, 2014).

*Initial Clinical Interview* – A common assessment technique that begins every counseling relationship. Sometimes it is thought of as the cornerstone of assessment and may be referred to as the initial interview, clinical interview, or diagnostic interview (Jones, 2010).

*Licensed Professional Counselor (LPC)* – A counselor who has been awarded a state license or equivalent certification by passing the state licensure exam or by endorsement (Remley & Herlihy, 2010; Virginia Board of Counseling).

**Research Question One: How do LPCs who conduct initial clinical interviews perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?**

Four themes emerged from the data analysis process related to research question one: 1) Everyone has culture and it is all encompassing, 2) Multicultural factors impact substance use behavior and patterns, 3) Cultural identities emerge during the initial clinical interview, and 4)

Multiculturalism was an important component in counselor preparation. Each theme is explained below including excerpts from the participants' interviews.

**Theme 1: Everyone has culture and it is all encompassing.**

The theme everyone has culture and it is all encompassing, emerged as all the participants shared that culture is a part of every individual. They identified that culture includes multicultural factors, such as: family history, gender, sexual orientation, trauma history, racial/ethnic groups, language, geographic location, age, education level, socioeconomic status, and religion/faith. One participant, James, shared that culture is, "...a broad term that encompasses so much about who we are as people and who we identify with ..." Brian had a similar response concerning cultural identities and provided a few specific cultural identities. Brian shared,

Kind of a multifactorial model in that I think you can look at race as one thing, but then you have to look at, okay, the area the person lives or grew up in, the cultural dynamics that then tie into faith and different religions.

The participants' perspective that culture is all encompassing and part of everyone, indicates a high level of perceived relevance. The participants were all aware of the importance of multicultural factors when working with members of the substance use disorders population.

***Subtheme: Understanding culture is needed to understand clients.***

The data analysis found that the participants perceived identifying multicultural factors as necessary to understand clients' lives. Kathleen shared her perspective concerning the importance of culture when understanding a client,

My private outside work that I do, my part-time job, it is a multicultural center so the focus is very multicultural. The expectation is that you're looking at culture and language and how that impacts treatment. The other centers, just thinking back, there's some of

them that do, but I don't think it's a part that's required. I personally feel that it's [culture] important because I think you need to understand where a person's coming from. Their viewpoint or their baseline, so to speak, of why they're where they're at now.

The participants' experiences indicate that multicultural factors help them to understand who their clients are. From the participants it appears that the identification of multicultural factors are essential to understanding the life story of the client; because the factors impact the client's personal experiences, behavior, patterns, and perceptions. The participants shared that multicultural factors influence clients' perceptions and experiences. Kathleen shared how it is important to get a sense of person and their experience when working with the Hispanic population. She shared,

...I do believe that it's important to get a sense of the person, what they've experienced. I work with a lot of the Hispanic population because of the language skill that I have. A lot of time we talk about acculturation issues. The things impacting, in terms of how they got to this country, what supports they have or don't have. Also looking at how in a lot of third world countries, I'm not going to say all of them, but a lot of Hispanic countries, substance abuse is not considered an issue. It's how they interpret their use compared to being here in the USA.

The multicultural factors aid in establishing a connection because the participants shared that culture is who an individual is, where they come from, how they identify themselves, and with whom an individual identifies. Heather provided an example of how the identification of a client's cultural identity aided in establishing a connection with the client. Heather shared,

We had a person that was born in Puerto Rico and he could speak English, broken English pretty good, but he learned to speak and he was very shy about the fact and embarrassed about the fact that he couldn't speak English well. What I did... He would

teach us a word every day. That was his job, to teach us a Spanish word every day, something from the meditation and, "Good morning," and, "Good night," or whatever, "Thank you." Then he felt a part of being here because he was helping us learn something. Because just because he couldn't speak our language. We couldn't speak his language either so we was dumb. He had that task to help him change his thinking about helping somebody that he didn't have anything to give. He had lots to give because we didn't know nothing... but it made his day because I was taking it serious and everybody else was taking it serious so everybody in the house, the clients and everybody.

The overall message was that every client has cultural identities and identifying these identities helps establish a therapeutic connection. The connection is made because learning about cultural identities aid in getting to know the client.

### **Theme 2: Multicultural factors impact substance use behavior and patterns.**

A common pattern that emerged from the data analysis was that multicultural factors impact a client's substance use behavior and patterns. From the interviews it was apparent that the participants' experiences indicated that different multicultural factors, for example, gender, age, geographic location, community, family history, and cultural norms can impact a client's substance use behavior and patterns. Heather shared her experience of how age can impact substance use behavior and patterns,

...the majority of the people [clients] in here are in their early 20s and of late, the cocaine users and the alcoholics are in their 40s and 50s. We got 50 year olds in here. Their drug of choice is alcohol and cocaine. Then these young people, their drug of choice is pills and marijuana...The 20 year olds to the 30 year olds [clients], have used everything; marijuana, pills, alcohol, hallucinogens, cocaine, they've tried them all. The older people, 40 and 50, they've just drink or used cocaine, smoked pot a little, but they don't like it.

They like drinking. It's just the age. I don't know. It's when they came up, especially the 50 year olds, if they're alcoholic that's their drug of choice. They're not using ... They'll tell you in a heartbeat, "I don't use drugs." ... And this one man said, "It's a beverage." They don't look at alcohol as a drug.

Not only do multicultural factors affect substance use behavior and patterns, but they affect how a client perceives substance use and what is considered a substance. Maria shared how substance use is perceived among Muslim families. Maria said,

I've had, for example, in Muslim families as an example are not supposed to drink and of course no illicit drug use and so people who are there's a whole additional shaming factor about using because it's against the rules if you will or against the content of their religion. That's a huge factor I think another layer that's added on there.

A pattern that showed up many times throughout the analysis is how different multicultural cultural factors influence a client's perception of alcohol as a substance and the use of alcohol. This is mentioned in the end of Heather's quote and it is also mentioned by Kathleen. Kathleen shared,

...What you find is a lot of, and again I don't want to be stereotypical, but you find in a lot of Hispanic culture drinking is not considered an abuse. As long as you're functional, you can get to work every day and do what you got to do there's nothing wrong. A lot of times it helps... Getting a sense of how they see their use, being in this country and what their understanding is as opposed to in their home [country] because what I find when I work with a lot of Hispanic families, and individuals, is that they grew up drinking very young and there was almost an acceptance of it or their parents drank. It's very hard for them to see it as something that's a problem. I try to get a sense of their thinking behind use and what it means to them.

Stella also shared a story of a client and their cultural history with alcohol in the statement below:

I'll take this gentleman who did so well in treatment. He was talking about there is no age limit for drinking. That they drink beer because see the water wasn't always clean but beer was clean because the process of, they boil it and everything, they cook it. When they make beer and so instead of drinking water they would drink beer with all their meals. The one from Africa, the Dutch country. I can't remember where he was. It was a Dutch country in Africa and so he actually... We talked about all that, what it was like for him. They would have beer with every meal and you could go and buy he said at age 11 he was going to the bar himself and getting a beer after school.

From the data it was clear that the LPCs believed that multicultural factors can influence substance use behavior, patterns, and perceptions of substance use.

**Theme 3: Cultural identities emerge during the initial clinical interview.**

The participants perceived identifying multicultural factors during the initial clinical intake as important, because the factors almost always emerge during the initial clinical interview. Because they believed that cultural identities/culture is not separate from who an individual is, the cultural identities show up during the initial clinical interview. Most of the participants believed that if they are looking at the client holistically and having the awareness concerning everyone having culture, a portion of their cultural identities will emerge during the first meeting. The questions that gathered most of the data for this theme were 1) Do cultural identities emerge during the initial clinical interview? 2) Do you discuss cultural factors during the initial session? 3) Can you describe a time, when a client's cultural identity shows up during the initial session? Stella responded,

I know that it (cultural identities) always comes up because I'm very interested in what people's life experiences were like, and what life is like for them now and how it impacts them. I've gotten to know people based on their own experience over time so, yes, I would say that that's definitely just a part of everybody that you get to know in terms as you get working with them in-depth.

Mary shared about a specific time in which a client's cultural identity emerged during the initial clinical interview and she also shared about some conversations concerning culture that have occurred during the initial session. Mary said,

The reason why I have this one reaction is because I actually have a client now that I had to get supervision around, because she came in and she had these beautiful diamond and pearl rings, a diamond necklace, and she was just really clear about saying, "I don't even know how I ended up here because I just got a 3,000-square-foot apartment and it's got this many bedrooms and bathroom. I drink this sort of wine." It kept coming up during the interview. I would ask questions, and then it was almost like she was asserting, "This is who I am. Yes, I just told you about all this drug use, but this is really who I am," as if she was struggling with this or trying to keep it in separate compartments. "I'm using drugs with these people, but this is really who I am over here." It comes up like that. Then I've actually had social justice discussions with people talking about oppression and unequal access and food deserts in the middle of the intake as they're talking about "I just got out of jail, 10 years on this drug charge," blah, blah, blah, and then they start talking about, "But there were no opportunities and there was no money." Just to hear their fluency talking about oppression in an intake. They're talking about how their blackness affects the opportunities that they missed and how they wished they would have had mentors. Really, those are just specific examples of how, and then I see it in other ways.

**Theme 4: Multiculturalism was an important component in counselor preparation.**

Almost all of the participants shared that having awareness and identifying cultural identities of the counselor and client was included in their counselor preparation program in some way. Some shared that being aware of multicultural factors was a vital part of their training program, while others shared that it was primarily discussed in the multiculturalism course offered in their program. It was also mentioned that there were specific faculty members in particular programs that stressed the importance of acknowledging and sometimes addressing cultural differences in session. James shared about his counselor preparation program,

I was in a Counselor Education Program. It's a great program. My favorite class from my whole graduate school experience was the cultural diversity class, which was kind of interesting because there was a few of us in that class that said this is the best class we had the whole time. This is the most important thing that we do, is to be aware of and conscious and willing to talk about culture and diversity... I think that class in particular, but even from the very beginning I think there was a focus on culture and understanding that and being willing to talk about it and being self-aware of your own biases, which like I said, talking about myself as seeing myself as a relatively open minded person, I think that took ... It was good in the program to have some soul searching... I don't know that I found a good way to maybe broach those topics when they come... I think the program prepared me to be aware of it and to talk about it. I don't know that it's always been easy to apply it.

When Maria was asked if her masters level program or preparation courses included discussions about bringing up or introducing cultural consideration or cultural differences during the counseling process, she shared,

Yes, absolutely. It was a really important part of my program. I was in the preparation program for my masters. It [discussing cultural differences] was a part of every class literally, yes, even then and that's been a while. Even then we were talking about it. I remember a lot more about the gender issues the male/female the power stuff and power differentials between the genders and things like that, a lot of sexual orientation issues. I don't know that we had a lot of diversity in terms of, I don't remember specifically talking about racial diversity or even religious diversity necessarily. I remember a lot more about sexual orientation and gender issues as part of my program. I know we did talk about cultural identity and also the self of the therapist and how that's relevant...we didn't have a separate class. We talked about it in every class...Yes, it's a core value of the program was talking about those issues.

The degree in which the master level program or preparation courses included discussions about bringing up or introducing cultural consideration or cultural differences during the counseling process varied for the participants who shared that it was part of their program. Some participants had a singular course, while other programs seem to weave multiculturalism into different courses throughout the program.

**Research Question Two: How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?**

Data analysis resulted in three themes concerning how LPCs describe the term and concept of broaching: 1) No familiarity with the “broaching” term, 2) Broaching defined as initiating a topic, and 3) Some degree of understanding of the broaching concept. Each theme will be discussed.

**Theme 1: No familiarity with the “broaching” term.**

Through the data analysis process, it was discovered that the majority of the participants were not familiar with the term broaching as it is used in counselor education. The interview question that gathered data concerning research question two was direct and plainly asked by the researcher as, “Are you familiar with the term broaching”? Most of the participants looked puzzled and responded that they were not familiar with the term as it is used in counselor education. Rhonda responded, “Say that again, broaching probably I’m not familiar with it so tell me again”. Brian responded by saying, “Broaching? No”. Kathleen responded, “Broaching? No. That’s new to me. Is that a new term?” The majority of the participants were not familiar with the term. After the question was asked, the participants asked the researcher to define the term for their understanding.

**Theme 2: Broaching defined as initiating a topic.**

As stated in theme one, most of the participants were not familiar with the term broaching as it is used in counselor education. For the participants that chose to guess what the term meant, they referenced the term as it is defined in the American English dictionary. Most referred to it as initiating a topic that may be uncomfortable. This is close to counselor education’s take on the term, which specifically focuses on introducing and examining cultural variables during the counseling process. Danielle stated, “I know what broaching is, but probably not in this context”. Rhonda shared, “Broaching the subject you mean. Yeah definitely. If you’re saying is that done in our intakes, yes I believe that is”. James responded to the question concerning his familiarity of the term broaching as it is used in counselor education by saying,

I don't have a dictionary handy, but I would say broaching is ... I don't know if I want to use an analogy, wading into something that maybe is, at least in the counseling sense, uncomfortable or not something you would usually be direct in talking to somebody

about. In the counseling world I think we try to be more direct and up front about thoughts and feelings and maybe in your day to day conversations. Certainly a lot of our clients, what they're used to in their day to day conversations.

**Theme 3: Some degree of understanding of the broaching concept.**

Although most of the participants were not familiar with the term broaching as used in counselor education, many had some familiarity with the general definition and some degree of knowledge concerning discussing cultural considerations during the counseling process. When the researcher directly asked the question concerning the participants' familiarity with the concept of broaching, most of the participants shared they were not familiar with the concept. Once the researcher shared the concept with the LPCs, most of the participants confirmed that they were familiar with and utilizing some level of the concept in their practice, but never heard it referred to as broaching. Also, the researcher was able to determine from the interview, before the direct question was asked if they were familiar with and practicing the concept of broaching. Below is James' response concerning if he was familiar with the concept of broaching:

Broaching is putting something out there, name it, say it, acknowledge it, whatever it might be, even if it's uncomfortable. Even if it might cause some tension, because I don't think you're going to be broaching something if it's something that's not carrying a little bit of weight. I think the word "broach" means it's something that does carry a little bit of weight on both sides, the counselor and the client side.

Mary shared that in her multicultural counseling class during her master level counselor preparation discussed bringing up or introducing cultural considerations in the counseling process, which is along the same line as the broaching concept. Mary shared,

I did [discuss bring up cultural consideration in the counseling process] in my counseling class. I did. I really don't remember much other than "do it." You have to do it and at least

point out, "Okay, I just want to point out you're white, I'm black," or this difference.

"How are you feeling about that? Do we need to talk about it?" That's what they are.

Most of the participants were either familiar to some degree with the concept of broaching and some were actually practicing some level of broaching. In some cases broaching was not only used for multicultural considerations, but also for any situation that was uncomfortable and needed to be discussed. It is important to note that using broaching as a strategy to address variables that are not related to culture, is not "broaching" as defined by Day-Vines et al. (2007).

**Research Question Three: Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?**

The data analysis process discovered five themes: 1) Broaching approach varies, 2) Client introduces multicultural factors, 3) Appropriate timing, 4) Willingness to be open, and 5) Boundaries surrounding broaching. Each theme will be discussed and specific excerpts from the interviews will be shared to support the theme.

**Theme 1: Broaching approach varies.**

It was found during the data analysis process that the LPCs' broaching approaches varied. Some took the direct approach, while others took a more indirect approach. The direct approach is when the LPC directly and overtly initiates a conversation concerning any multicultural factor or concern during the counseling process. The indirect approach includes the LPC being less overt in addressing multicultural factors, and relying on external things such as initial clinical interview questions to initiate discussion multicultural factors. It was discovered that many of the participants will switch between the direct and indirect approach depending upon different factors, such as the comfort level of the counselor and/or the counselor's perception of the client's comfort level, if the counselor feels as though the timing is right, and on what cultural

factor is being broached. Heather seemed to rely more heavily on the direct broaching approach as evidenced by the statement below:

... I have this girl that's from down in, far west, Virginia. I know she ain't never been around a black person. When I had my individual with her and we took care of business about what I needed to know about her and what she needed to get from me then I asked her. I said, "So what's it like having a black female to be your therapist and what is it like ...? Have you ever had any black friends?" "No." "What do you think it's going to be like?" so it's out there now. She don't have to step around it and try to figure out how she needs to act around me.

Mary takes a more indirect approach and relies on the assessment to gather cultural information, Sometimes I will say it is intentional. Like sometimes I'll ask about marital status, "Tell me about your family," or something like that, so I'll find out some things that way. Like the part of the intake that I do, we don't have to ask a lot about finances. If the question is more about vocation and education, so I'll say, what's the highest level of education you completed? What do you do all day? How do you spend your day?" I'm trying to get at money, and, sometimes, cultural stuff will come out there because, then, you're here, employed, unemployed, rich poor, all that kind of stuff, how they spend their day. Culture kind of comes out, "Spending a day with my girlfriend," or my boyfriend that type of stuff, but, honestly, our assessment does not give a lot of opportunity for it to come up.

It was discovered that when the participants broach, but their approaches vary. In both styles the LPC is introducing multicultural factors into the intake process, but the approach to broaching is very different. The two excerpts above illustrate the two broaching approaches. Sometimes the LPCs described switching between the two approaches, due to the reasons listed above.

**Theme 2: Client introduces multicultural factors.**

An emerging theme that was evident was that the majority of the participants preferred for the client to introduce multicultural factors during the initial clinical interview process.

Rhonda responded to the question, “When you do discuss cultural factors during the process, what is your intent?” by saying,

Basically I’m not usually the one bringing it (cultural factors) up. It’s usually the client who’s bringing it up... You have to get in there and really see what they want to do. It’s more about what they bring up.

James has experienced clients often bringing multicultural factors into the counseling process concerning his age and he goes along with the conversation if they introduce the topic. James shared,

I've had clients, the first time I met with them, like how are you going to help me, I'm 20 years older, 30 years older than you kind of stuff, so the expectations that come with that can lead to a discussion where I can discuss my background some.

Most of the participants shared that if the client brings up a discussion concerning a multicultural factor that they will engage in the conversation or follow-up with the client.

**Theme 3: Appropriate timing.**

Most of the participants shared that their perception is that the timing has to be right in order to broach, and that it may not be in the first session. Many of the participants shared that broaching must happen in a natural manner. They believed that the first session may not always, be the right time and that the LPC may have to flag things in the first session and weave it into later sessions. Danielle shared that she will overtly broach certain things, but it has to be at the correct time. She shared her perspective below:

"How are you feeling about this first introduction? What's your comfort level? There are some differences between us." If it's man, "Are you feeling okay about the fact that I'm a woman? Are you feeling okay about the fact that I'm white?" I will say these things overtly, but the timing has to be right so that it seems like a natural flow and not being awkward.

Mary shared that sometimes she feels that the initial clinical interview is not the appropriate time to discuss multicultural factors. Mary stated,

I'm less comfortable introducing it [multicultural factors] in the intake because I always feel like I just want to see where they stand. I don't know if I'm very intentional about bringing it up. I just want to be open. I'm trying not to contaminate what they're bringing. I think I err on the side of not bringing it up. If they bring it up, then I'm going to.

Another common pattern was that paperwork can often be a barrier during the first session to discuss multicultural factors. The participants shared the time constraints and detail of paperwork typically becomes the focus of the first session. Some participants shared that the need to complete the paperwork can make broaching seem secondary. Most of the participants believe the initial clinical interview often touches on culture, but the timing may not be right to discuss cultural factors due to the administrative requirements of the initial session. Stella shared that she is not always able to address cultural factors in the initial clinical interview due to paperwork.

Stella said,

I may not always get an opportunity to do it in that session just because the amount of paperwork that we have to do. It's a huge obstacle for making that first session. You try to do your very best, and then I explain to them and I apologize to them, "I'm sorry but, you know, we have to get X, Y, and Z done." I find that clients are receptive to that. They

understand that because they've had to go and apply for other things and know that the process is ... There's red tape everywhere.

**Theme 4: Willingness to be open.**

In order to broach it was found that the participants believed that the LPC must be open to share, open to receive what the client will say without becoming defensive, and willing to leave an open invitation to allow the client to share about multicultural considerations or factors throughout the therapeutic relationship. Stella shared how she tries to be open with her clients and how she assures the client that she will not be offended by their feedback. She shares her experience in the statement below:

Yeah. I think sometimes they're a little hesitant because they don't want to offend you, because they know Americans can get offended very easily. I tell them it's okay that I'm not going to take it personally and it's okay you can freely share how you feel. Once they realize I'm not going to be like, "What do you mean? We're giving you an opportunity here and you're ..." Sounded like someone you know (laughter)... But once the client realizes that I'm not having this visceral reaction, then they're more likely to open up and ... Sure, and the fact that I've invited him to say it.

James shares how he attempts to be open and extends an invitation to the clients in order to establish trust. James said,

... Usually I try to be as open as I can be. If somebody wants to know more about me or understand me or know where I came from or even my perspective on things, if that's important to them I do open the door to talk about it... I maybe sidestep that a little bit at times, but I've certainly invited people to ask about my background, my experiences, and with substance use I think people asking about your background with substance use is often very important as well. I try to be as open as I can be because like I said, trust, and

if they don't think I'm willing to talk about me, that I'm a closed book, like I have something to hide or I'm the more powerful one in the situation, so you don't get to know about me but I get to ask all these intrusive questions about you, I think that you've got to be willing to be open and allow those questions, and most people aren't going to dig too deep...They just want to know if you have something in common, what your level of understanding of where they are or where they come from is and what their experiences, so trust to me is everything.

### **Theme 5: Boundaries surrounding broaching.**

Many of the participants shared about certain multicultural factors that they avoid broaching, for several reasons. Some shared that they do not think about some of the cultural factors when they think about culture as a whole. Others shared that the visible, salient differences such as race and gender should be addressed and the others will come along later.

Maria shared,

The things I'd be looking for in terms of a cultural identity I'm asking about faith organizations, any participation in faith organization, or how much extended families in the area that kind of thing. That's generally what I would think of with cultural identity because I'm thinking mostly of international clients when I think of that. It's not always of course but that is what I think of initially when you ask about it. Then you raised these other issues I was like, oh, right. Yes, I suppose if somebody identified clearly as lesbian or gay, that could be also cultural identity. I honestly don't usually think of it that way.

Heather shared,

See, this is my thing. Race and gender are salient. That's the first things you see, so that's what you need to bring up and whatever comes out of that you can address it. You got too many other things to talk about, and if you are doing your job, those things will come up

and then you can address that culture business as that come up, but if your job is just to address that then you missed a whole lot of information...

Others shared they are reluctant to bring up particular cultural factors due to their comfort level. Danielle shared,

That's interesting, right, because I hadn't really recognized that I've tread much more carefully with that [spiritual/religion]. I think because these other things are obvious when you look at me. If a man comes in and he tells me he's gay, I would also not say, how is it for you because you're gay and I'm heterosexual? I think with the things that are not obvious by looking at me, then unless I'm asked directly, I think it's more about what is overt and what isn't. I potentially see not as much with the sexual orientation, but particularly with religion, because what I practice is not the predominant religion in this area. I potentially see it as something that could be off-putting to a client before they know me

Overall the participants seemed more comfortable broaching visible cultural factors such as race and gender than they did with the cultural factors that are as salient. Although a few of the participants were more comfortable broaching faith/religion because they saw that as an important factor in the lives of the clients with whom they work.

### **Additional Theme from Follow-Up Interviews**

#### **Theme: Heightened Awareness.**

An important theme that was not connected with any of the research questions, but that the researcher found to be of importance, was that most of the participants shared that their awareness was heightened after the initial in-depth interview with the researcher. Heather shared her additional thoughts with the researcher:

...After talking with you it did heighten my awareness, especially at the agency to always acknowledge and be aware of a client's culture, to make sure it happens more time than not...With anybody, whether its males, females, gays, lesbians, whomever it is. It heightened my awareness to make sure that I'm always paying attention to that even though I know I do it.

Mary shared that she incorporated the broaching article in her staff training. Mary shared,

Well, I think the one reflection I have was the importance of bringing up the training issue to my current staff, and for us to continue developing our skills of addressing multi-cultural issues in our work... just having that conversation geared towards the critical aspects of doing intakes and engaging clients because so often we focus just on the administrative parts and the productivity parts, and we lose focus on just what seems to be mundane, clinical issues. It's not like a complicated case, but it's just the every-day foundational practices that set the foundation for good service, the clinical service. This interview brought it up to the forefront for me, to be more attentional with my team about it... I gave that article on broaching last week, and we're going to discuss it in our team meeting this coming Tuesday.

Maria shared, "I think just having the conversation with you probably increased my awareness as far as cultural issues we were talking about. My practice hasn't changed but it has added a dimension". Overall the majority of the participants shared during the follow-up interview that they had an increased sense of awareness after interviewing with the researcher the first time.

### **Summary**

The nine LPCs in the Commonwealth of Virginia shared their perceptions and experiences concerning whether and how multicultural considerations are broached during the initial clinical interview with clients with substance use disorders. The participants

acknowledged that identifying multicultural factors during their work with members of the substance use disorders population is important, due to multiple factors which are represented by the following themes: 1) Everyone has culture and it is all encompassing, 2) Multicultural factors impact substance use behavior and patterns, 3) Cultural identities emerge during the initial clinical interview, and 4) Multiculturalism was an important component in counselor preparation programs.

Secondly, themes emerged concerning the research question, “How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?” Three themes were identified, 1) No familiarity with the “broaching” term, 2) Broaching defined as initiating a topic, and 3) Some degree of understanding of the broaching concept. The majority of the participants were not familiar with the term broaching as it is used in counselor education. When the participants attempted to guess what the term meant, they relied on the broaching definition found in the dictionary. This is not far off from the counselor education, but is missing the culture piece. Although, the participants were not familiar with the broaching term, most all of them spoke about concept to some degree.

Research question three, produced five major themes. Theme One was the broaching approach used by the LPCs varies. Some stated that it depend on several factors whether or not they take the direct or indirect approach and some shared that they have a preference. Theme Two was that the LPCs often waited for the clients to introduce multicultural factors during the process. This was common the majority of the interviews. The participants shared that if the client brings up a topic that is within reason that they will engage in the dialogue. Theme Three was that the LPCs felt that the timing has to be right to broach. Some felt that it has be a natural part of the conversation. Paperwork was an issue that seemed to be a barrier to addressing multicultural factors during the initial clinical interview. Also, some participants felt as though

the initial clinical interview was not the appropriate time to broach, unless the client introduced multicultural factors into the process. Theme Four was the participants believed that there had to be a willingness to be open on the LPCs part. Open to have the discussions and open to personal sharing. And the last theme identified for research question three, was there seemed to be boundaries surrounding which factors the LPCs decided to broach. Some individuals did not broach particular multicultural factors because they were not always thinking of those particular identities, such as sexual orientation. Others felt that the visible cultural factors such as gender and race were easier and more comfortable to broach versus the non-visible factors such as sexual orientation and religion. Themes were developed through the analysis of nine initial interviews and nine follow-up interviews. The findings from the data analysis process were used to develop the discussion, conclusions, and implications for the field in Chapter 5.

## CHAPTER 5

### DISCUSSION

The purpose of this study was to explore the experiences of licensed professional counselors (LPCs) in order to describe whether and how they broach (Day-Vines et al., 2007) multicultural considerations during the initial clinical interview with clients who have substance use disorders. This study was conducted because the substance use disorders population is a diverse group and currently there is no research that has explored whether and how counselors who work with the substance use disorders population incorporate multicultural considerations during the initial clinical interview. The findings indicate that when the LPCs' broach with clients the broaching styles vary. Although the participants were not familiar with the broaching term as used in the counselor education context, it was found that most of the LPCs have some level of familiarity with the broaching concept. Lastly, all of the participants agreed that there is relevance in identifying clients' multicultural factors during the initial clinical interview. A phenomenological qualitative research approach was used for this study in order to capture rich, thick details of the phenomena being studied. The phenomenological approach allows for the researcher to gain an understanding of the experiences and perspectives of individuals who are familiar with the phenomena (Creswell, 2013; Patton, 2014; Rossman & Rallis, 2012). In-depth interviews were conducted with nine LPCs. Of the nine participants, seven were female and two were male. There was racial diversity amongst the participants, but the majority of the participants identified as White. The initial interview was approximately 60 minutes long and occurred face-to-face. The researcher utilized an interview protocol, and because the interviews were semi-structured was able to diverge from the protocol as needed in order to gather data relative to the study (Rossman & Rallis, 2012). Follow-up interviews were conducted via phone 1-3 weeks after each initial interview. All interviews conducted were audio-recorded and

transcribed. The transcriptions were analyzed using the constant comparative method (Anfara et al., 2002; Creswell, 2013). Through a review of the literature and data analysis process, several conclusions and recommendations have been formulated concerning LPCs broaching multicultural factors with the substance use disorders population. A summary of the findings of the study are discussed below in the context of previous literature. Chapter five concludes with limitations of the study, implications for the field, and future research.

### **Summary of Findings and Discussion**

The constant comparative method was used to analyze the data (Anfara et al., 2002; Creswell, 2013). From the analysis themes emerged. The themes are categorized by the three research questions that guided the research study. The research questions included,

- 1) How do LPCs who conduct initial clinical intakes perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?
- 2) How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?
- 3) Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?

A summary of the study's findings are presented below. Discussion and conclusions will follow the summary of findings.

**Research Question One: How do LPCs who conduct initial clinical intakes perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?**

The focus of Research Question One was to gather the LPCs' perspectives and experiences concerning the relevance of identifying multicultural factors to their work with the substance use disorders population. Four themes emerged related to this research question. The

themes included: 1) Everyone has culture and it is all encompassing, 2) Multicultural factors impact substance use behavior and patterns, 3) Cultural identities emerge during the initial clinical interview, and 4) Multiculturalism was an important component in counselor preparation.

**Theme 1: Everyone has culture and it is all encompassing.**

All participants shared that everyone has culture and that culture includes many factors. Some of the multicultural factors identified by the participants include family history, gender, sexual orientation, trauma, racial/ethnic groups, language, geographic location, age, education level, socioeconomic status, and religion/faith. A common factor mentioned by the participants when asked, how they define cultural identities, was that culture is difficult to define because there are many elements of culture. Because the participants perceive culture to be all-encompassing, they believe identifying multicultural factors is relevant to their work with the substance use disorders population as they aid in getting to know the client. This attributed to the subtheme of, culture is needed to understand clients.

***Subtheme: Culture is needed to understand clients.***

The participants did not perceive multicultural identities to be separate from an individual, rather they identified culture to be who a person is, who they identify with, where they come from, and how they identify themselves. Participants shared that these factors are vital in getting to know and understand the client. They believed that identifying these multicultural factors are important in understanding the life story of a client. Several of the participants seemed to indicate that by identifying multicultural factors it helps establish a connection, because they are getting to understand the client. It is important to note that each participant defined culture and cultural identities differently, and for several of the participants some cultural populations were more prominent than others. This influences which factors the participants believe are more

important to identify when getting to know the client. There was variation among the participants as to which factors were perceived as relevant. This variation depended on several factors including the cultural make-up the clients with whom they work. Some participants found that identifying one's faith/religion and geographic/community was more vital than the cultural identities of race and gender, while others believed that the visible cultural factors such as race and gender were more important to identify due to their salience.

**Theme 2: Multicultural factors impact substance use behavior and patterns.**

Participants discussed whether they believe a client's cultural background affects their substance use behavior and patterns. All of the participants agreed that a client's substance use behavior and patterns are influenced and/or affected by multicultural factors. According to the participants, age was a multicultural factor that seemed to contribute to which substance an individual will use and the pattern of use. Also the geographic location and community in which an individual resides seemed to have a large impact on which substances an individual uses and how often an individual uses. The participants discussed that family history seemed to influence what was considered normal substance use behavior and patterns for many of the clients. An interesting finding that emerged from the data was most of the participants experienced a client's multicultural factors to affect the way an individual perceived the idea of substance use and what is perceived as a substance. The majority of participants shared that alcohol is often not perceived to be substance by clients. The participants attributed this to cultural norms that the clients have experienced. Several participants shared that geographic location, community, and family history all influenced the perception associated with alcohol use among clients.

**Theme 3: Cultural identities emerge during the initial clinical interview.**

Participants shared whether cultural identities emerge during the initial clinical interview and if so they provided examples of how cultural identities emerge during that time. Based on

the experiences of the participants, it is common for a client's cultural identities to emerge during the initial session. This was attributed to the idea that culture is not separate from an individual and the different identities of a client's cultural make-up. The participants discussed that the identities may present differently and at different times during the initial process, but it is always there. Several participants explained that it sometimes shows up in the responses to the questions asked during the initial clinical interview. A common example reported by the participants was that culture shows up in the level of personal sharing demonstrated by the client. Several of the participants shared that members of particular racial and ethnic groups, religion and spiritual groups, and geographic location and communities are less likely to be open due to cultural norms concerning the particular cultural identity. For example, one participant shared that Black clients and those individuals from rural areas are less likely to be open and share their personal life, because of a cultural norm that concerning personal life issues stay within the family and/or community. Others shared that some clients are overt and direct in their sharing, and often share how they identify. Some of the participants discussed how clients will directly ask and inquire about the LPCs' age, marital status, parental experience, education level, credentials to be a therapist, race, gender, location in which they live and/or grew up, and religion and faith identification. It was discussed that this inquiry of the therapists' multicultural identity is usually driven by how a client identifies with particular groups and trying to indicate something about their own cultural background through the direct questioning of the LPCs' cultural factors.

**Theme 4: Multiculturalism was an important component in counselor preparation.**

The majority of the participants reported that multiculturalism and the idea of bringing up or introducing cultural considerations in the counseling process was discussed in their counselor education preparation program. This emerged as a theme for Research Question One, because

most of the participants attributed their understanding and view of relevance of culture and identifying cultural identities to their counselor education preparation program. Although most of the participants shared that it was a factor in their preparation programs, the degree of discussion within the programs varied. Some participants shared the multiculturalism factor was mostly discussed within a course specifically concerning multiculturalism, while others shared that it was a vital factor throughout the entire program, including discussions in every course. Several of the participants said they were encouraged and expected to practice bringing up or introducing cultural considerations in the beginning of the counseling process during their practicums and internships.

**Research Question Two: How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?**

The focus of Research Question Two was to gather whether LPCs were familiar with the term and concept of broaching and how they describe broaching. Three themes emerged that related to this research question. The themes included: 1) No familiarity with the “broaching” term, 2) Broaching defined as initiating a topic, and 3) Some degree of understanding of the broaching concept.

**Theme 1: No familiarity with the “broaching” term.**

The majority of the participants shared that they were not familiar with the broaching term within the context of counselor education. When asked directly by the researcher if they had heard of the term either through their counselor education preparation program or their years of practice, most replied no. All of the participants demonstrated a level of curiosity concerning the meaning of the term. This was indicated by asking the researcher to share the meaning of the term after they responded they were not familiar with the term. Some participants chose to guess the meaning of the term, which is connected to Theme Two.

**Theme 2: Defined broaching as initiating a topic.**

As explained in Theme One the majority of the participants were not familiar with the broaching term as it is used in the context of counselor education. Many of the participants attempted to guess what the term means as it is used in the counseling context. When guessing the meaning of broaching, many of the individuals relied on the common American English dictionary definition. The participants reported it is basically initiating a topic and others added another dimension that it is initiating an uncomfortable topic with a client. This is very close to the meaning of broaching as it is used in counselor education, but missing the cultural aspect. In counselor education context it means to introduce multicultural factors during the counseling process (Day-Vines et al., 2007).

**Theme 3: Some degree of understanding of the broaching concept.**

Although most of the participants were not familiar with the term broaching, as it is used in counselor education context, there was some familiarity with the concept of broaching. Even when some of the participants were asked directly if they were familiar with the concept, and responded no, the researcher was able to determine if they broached by the responses shared throughout the interview. Most of the participants agreed that they were familiar with the concept of broaching once the researcher explained the concept. The researcher described broaching as, a strategy or behavior that can be utilized by counselors to introduce or bring the discussion of cultural factors into the counseling process (Day-Vines et al., 2007). Most participants believe they discuss cultural factors with clients, even though they were not familiar with Day-Vines et al.'s (2007) article. Most saw broaching as an integrated part of their counseling practice and not a distinct strategy or behavior. It is important to note that all of the participants had their own perspective on how they utilize broaching. One participant described broaching as bringing up anything difficult in the counseling relationship. Although a natural

extension of the standard American English definition of broaching, bringing up difficult topics, if the topics are not related to culture, it is not “broaching” as defined by Day-Vines et al. (2007).

**Research Question Three: Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?**

The focus of Research Question Three was to gather whether the participants broached multicultural considerations during the initial clinical interviews and if so, how they broach the considerations. Five themes emerged for this research question. The themes included: 1) Broaching approach varies, 2) Client introducing multicultural factors, 3) Appropriate timing, 4) Willingness to be open, and 5) Boundaries surrounding broaching.

**Theme 1: Broaching approach varies.**

There were several participants who shared experiences concerning broaching during the initial clinical interview broached. From the experiences it seems as though the broaching styles vary. Some of the participants shared how they approach discussions concerning multicultural considerations when they do broach and their approach seems to be more overt and direct. When these participants introduced a topic concerning multicultural factors, they would make statements such as, “So what's it like having a black female to be your therapist...?” (Heather). Other participants seemed to take more of an indirect approach and would ask things such as, “How are you feeling about this first introduction?” (Danielle). In both the direct and indirect styles, the LPC examines the multicultural factors during the counseling process, but the indirect approach is not as overt as the direct approach. Through the data analysis process it was also discovered that many participants will shift between the direct and indirect styles depending on several factors, including comfort level of the counselor and/or the counselor's perception of the client's comfort level, if the counselor feels as though the timing is right, and on what cultural

factor is being broached. These factors are connected to the rest of the themes identified for Research Question Three. Several of the participants seemed to be more comfortable broaching multicultural factors that are noticeable, such as gender and race. Others felt more comfortable broaching matters such as faith and religion, as they perceived this to be an important factor in the lives of the clients in which the LPC worked.

**Theme 2: Client introduces multicultural factors.**

The data analysis revealed that seven of the nine participants prefer for the client to introduce multicultural considerations into the counseling relationship. Most of the participants stated that if the client initiates a discussion concerning multicultural considerations they will engage in the conversation. The participants explained that if clients introduce the topic of multicultural considerations they will follow-up with the client by engaging in an immediate dialogue or by weaving the discussion into later sessions. It was discussed by some of the participants that they prefer the clients to initiate the discussion because they do not want to initiate a discussion that is off-putting to the client, while others shared that they believe it is the client's place and responsibility to bring up multicultural considerations, because they should control what they want to discuss during the initial clinical interview. Lastly, several of the participants shared that they are not comfortable initiating the discussion and prefer if the client begins the conversation. It is important to note that some participants shared that their comfort is influenced by where the counseling dyad is in terms of the counseling process. Some shared they feel more comfortable broaching cultural factors after a firm relationship has been established; which is not yet the case during the initial clinical interview.

**Theme 3: Timing has to be appropriate.**

Many of the participants discussed that the timing must be right in order to broach multicultural considerations. Several individuals shared the belief that multicultural discussions

must occur naturally, therefore it may not be appropriate to discuss multicultural considerations during the initial clinical interview. The participants shared that sometimes they flag multicultural considerations in the initial clinical interview, in order to weave them into later session discussions. Some felt that the conversations cannot be forced, because it may offend the client. It was discussed that there has to be a certain level of comfort felt by the LPC and client. Timing often influences which broaching approach a LPC uses. If they perceive the timing to be appropriate several of the LPCs shared they may overtly broach. The majority of the participants discussed that the initial clinical intake paperwork can be a barrier to discussing multicultural considerations during the initial clinical interview. Oftentimes, the completion of the necessary paperwork becomes the focus of the initial session, and broaching is perceived as secondary. Several of the participants perceive the initial clinical interview paperwork as touching on culture in some way, but stated the timing may not be right to discuss cultural factors due to the administrative requirements of the initial session

**Theme 4: Willingness to be open.**

A common factor mentioned by the participants was that the counselor must be willing to be open. Three ways were identified as to how a LPC must be open: open to share, open to receive what the client will say without becoming defensive, and willing to extend an open invitation to allow the client to discuss about multicultural considerations or factors throughout the length of the therapeutic relationship. The idea that the LPC must be open was discussed by all of the participants, in at least one of the three ways mentioned above. Several of the participants reflected that the LPC must be open to personally share about themselves to a certain extent. They discussed that the client must see that the counselor is willing to share about him or herself, because the LPC is asking many personal questions about the client's life. It was expressed that this willingness to share builds trust. Several of the participants noted that it is

important to be open enough to receive what the client may share without becoming defensive. They believe that if the LPC becomes defensive the client will shut down and not share their thoughts and feelings. One participant reflected that some individuals, particularly from different countries of origin than the U.S. do not want to offend the LPC, so if defensiveness is shown, they may shut-down. Most of the participants believe that the client must be offered an open invitation to discuss multicultural considerations. It was discussed that an open invitation sends a message to the client that the LPC is open and comfortable with discussing these multicultural considerations.

**Theme 5: Boundaries surrounding which factors to broach.**

The participants discussed that there are certain multicultural factors that they will discuss, while there are others that they will avoid broaching, due to several different factors. Several participants discussed that some of the cultural factors do not come to mind when they think about culture as a whole. One participant shared that she is more prone to broach religion and faith identity than sexual orientation, because faith and religion is what she immediately thinks of when she considers culture. Others discussed that multicultural considerations such as race and gender should be addressed first as they are visible and salient differences and if the LPC begins with the salient identities, the other multicultural variables will come along in later discussions. Several of the participants noted that they are reluctant to bring up particular cultural factors due to their comfort level with discussing the particular cultural identities. Lastly, which factors to broach was discussed by several participants as being influenced by the cultural identities that seemed to be common to the clients in with whom they worked. Several participants shared that geographic location or community can be an important cultural identity in the lives of the clients with whom they work, because it influences a lot of their behavior. Because of this influence they typically have discussions concerning this multicultural identity.

### **Additional Theme from Follow-Up Interviews**

The purpose of the follow-up interviews was to allow the participants to share any additional thoughts and reflections from the initial interview. These interviews occurred 1-3 weeks after the initial in-depth interview. The follow-up interview was also semi-structured, and there were three questions used to guide the interview. The questions included, 1) Have you had any additional reflections since our previous conversation? 2) Have you noticed anything different while conducting your initial clinical interviews? 3) Any additional thoughts about or talk at the end of the interview, where we discussed how my cultural identities may have impacted what it was like for you to talk with me? Several themes emerged from the data analysis, but the researcher deemed one theme in particular as significant to the study even though it does not fit with the research questions.

#### **Theme: Heightened Awareness**

The majority of the participants shared during the follow-up interviews that their level of cultural awareness increased since the initial interview. Some of the participants shared the interview not only increased their awareness in general, but it made them more aware of additional cultural identities that they were not mindful of previously. Several participants noted that their awareness was heightened to always acknowledge and be aware of a client's culture, no matter who the client appears to be. Some of the participants reflected that the interview motivated them to be culturally aware and the importance of cultural awareness, because there is a lot that they do not know about many different cultures.

#### **Discussion and Interpretations**

Four conceptual models were presented in the literature. The frameworks that anchored this study include: Multicultural Counseling Competencies (MCC) (Arredondo et al., 1996; Sue et al., 1992), Dimensions of Person Identity Model (DPIM) (Arredondo & Glauner, 1992;

Arredondo et al., 1996), RESPECTFUL model (D'Andrea & Daniels, 2001), and broaching (Day-Vines et al., 2007). The MCC, DPIM, RESPECTFUL model, and broaching complement one another and lead to cultural competent practice. The MCC provides the foundation for the context of the study as it the basis for multicultural competent practice in counseling (Pope-Davis et al., 2003). The DPIM and RESPECTFUL model provide frameworks for acknowledging and understanding the complexity of human beings. Both of the models illustrate that all humans are multicultural. Lastly, broaching is a strategy that can be used by LPCs' to introduce and examine race, ethnicity, and culture during the counseling relationship (Day-Vines, et al., 2007). For the discussion the themes and conclusions will be connected to the conceptual models and previous literature.

**Research Question One: How do LPCs who conduct initial clinical intakes perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?**

The four themes that emerged for this research question included: 1) Everyone has culture and it is all encompassing, 2) Multicultural factors impact substance use behavior and patterns, 3) Cultural identities emerge during the initial clinical interview, and 4) Multiculturalism was an important component in counselor preparation. The concept that everyone has culture and it is all encompassing was discussed by all of the participants. This finding is linked to the DPIM and RESPECTFUL model. The DPIM and RESPECTFUL model illustrate that all human beings are multicultural, meaning that individuals' personal identity is made up of multiple cultural identities. The participants discussed many of the dimensions of the DPIM and domains of cultural identity of the RESPECTUFL model (Arredondo & Glauner, 1992; D'Andrea & Daniels, 2001). Many of the participants were able to discuss the importance of identifying multicultural considerations during the initial clinical interview and counseling

process which aligns with the ACA Code of Ethics (2014). ACA Code of Ethics (2014) explains that counselors should take clients' multiple contexts into consideration when addressing evaluation, assessment, and interpretation. It is important to identify the multiple contexts in the assessment and evaluation, as all the participants discussed that multicultural factors impact substance use behavior, patterns, and perceptions, the emergence of this finding became Theme Two. It has been reported that effective treatment and intervention may occur if contextual perspectives are used when assessing clients (Castro & Garfinkle, 2003; Cheung & Snowden, 1990; Constantine, 2002; Delphin & Rowe, 2008). This theme is consistent with the findings of previous studies. Mereish and Bradford (2014) through a quantitative study found sexual orientation, gender and race can all influence substance use patterns, and that the intersection of cultural factors can affect substance use patterns. Also Cochran and Cauce (2006) found that LGBT clients used their primary drug of choice more frequently than heterosexual clients.

Multicultural and effective SUDs treatment may occur when conducting initial clinical interviews from a contextual, multicultural perspective, because all participants discussed how multicultural factors impact substance use behavior, patterns, and perceptions of substance use. (Abbot & Chase, 2008; Alcantara & Gone, 2014; Constantine, 2002; Torres-Rivera et al., 2004). Also, the developers of the RESPECTFUL model suggested that the cultural domains represented in their model affect an individual's psychological development and well-being on several levels (Arredondo & Glauner, 1992; D'Andrea & Daniels, 2001). This is seen in the participants' experiences in which the multicultural factors impact substance use behavior, patterns, and perceptions. The fact that the participants experience clients' cultural identities as emerging during the initial clinical interview is not surprising, as they identified that culture is all encompassing. This is supported by the DPIM and RESPECTUFL model that states that all

human beings are multicultural and that culture is not separate from how a person identifies (Arredondo & Glauner, 1992; D'Andrea & Daniels, 2001).

Theme Four is supported by the fact that the MCC guides multicultural practice in the field of counseling and the ACA Code of Ethics embraces diversity and multiculturalism (2014). The ACA Code of Ethics makes it a core value and ethical practice to recognize and support multiculturalism when working with clients (ACA, 2014; Arredondo & Toporek, 2005). Because of the ethical duty and dedication to work with diverse groups, most counselor education preparation programs, particularly those accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) state that the program area objectives must reflect knowledge of counseling in a multicultural and pluralistic society (CACREP Standards, 2009). CACREP Standards (2009) also state that the counselor education preparation programs must offer a common core curriculum course concerning social and cultural diversity.

**Research Question Two: How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?**

The three themes that emerged for this research question included: 1) No familiarity with the “broaching” term, 2) Broaching defined as initiating a topic, and 3) Some degree of understanding of the broaching concept. It is not surprising that all of the LPCs were not familiar with the term broaching as it is used in counselor education. Most of the previous studies concerning cultural competence do not refer to the action of introducing and examining multicultural factors during the counseling process as broaching. Zhang and Burkard (2008) conducted a study to obtain clients’ perspectives of the effect of counselor initiated discussions of race and ethnic differences and did not once use the term broaching. It appears from other published research and this sample, that the term broaching is not consistently used. The fact that the participants relied on the American English dictionary definition of the term broaching is

plausible, because broaching is a commonly used term in the English language. When not using the term in the context of counselor education and it is used as a verb, broaching is defined as, “to begin a discussion of something difficult” (Cambridge Dictionaries Online, 2015). The definition of the term is closely related to how the term is used in counselor education, but it lacks the emphasis on the discussion of multicultural factors during the counseling process (Day-Vines et al., 2007).

Lastly, it was found that most of the participants had some level of understanding of the broaching concept as it is used in counselor education. This may be attributed to the fact that the counseling profession is dedicated to multiculturalism and embracing diversity and includes these factors in counselor preparation programs (ACA Code of Ethics, 2014; CACREP Standards, 2009). Also, Day-Vines et al. (2007) stated in their article that there was no consistent terminology used in the literature to describe this behavior that counselors were already utilizing. Counselors were discussing cultural factors during the counseling process prior to the coining of the term broaching in 2007 (Day-Vines et al.). Individuals may be familiar with the concept to some degree and not the term because this behavior was common in the counseling practice prior to ever having a consistent term that described the behavior. In addition, most of the participants in this study graduated from their counselor preparation programs prior to 2007.

**Research Question Three: Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?**

The five themes that emerged for this research question included: 1) Broaching approach varies, 2) Client introduces multicultural factors, 3) Appropriate timing, 4) Willingness to be open, and 5) Boundaries surrounding broaching. The theme that the broaching approach varies is consistent with the conceptual framework, continuum of broaching styles (Day-Vines et al.,

2007). The continuum of broaching styles includes: (a) avoidant, (b) isolating, (c) continuing/incongruent, (d) integrated/congruent, and (e) infusing. As stated in the summary of results several of the participants took more of a direct approach when discussing multicultural considerations with the clients, while others took more of an indirect approach. Also, many of the participants shared that they will switch between the two approaches depending on several factors such as, the comfort level of the client and/or counselor, if the counselor feels as though the timing is right, and on what multicultural factor is being broached. Day-Vines et al. (2007) discussed how the racial identity models can influence the counselor's style of broaching behavior. It can influence one's awareness, comfort level, and quality of broaching. In the article only racial identity models were discussed, but looking at identity develop models for different cultural identities may translate to the comfort level, awareness, and quality of broaching that the LPCs have with broaching any cultural identities.

Although, some individuals shared that they took a more indirect approach when broaching because of the perceived level of discomfort of the client, Knox et al. (2003) found that most of the therapists who worked in a cross-racial dyad reported that they addressed race directly, openly, overtly, and found that the discussions contributed to positive outcomes such as, enhanced trust in the therapeutic relationship. This indicates that broaching may ease the perceived discomfort and strengthen the therapeutic relationship. Fuertes et al. (2002) conducted a study of European American therapists' approach to counseling African American clients. They also found that the participants in the study typically address the race difference in the cross-racial dyad directly and openly within the first two sessions. The researchers found that this need to directly, openly, and overly address race in the counseling session, is because the participants perceived race as a core component that aided in establishing and maintaining a trusting and solid working relationship.

The finding that most of the participants preferred for the client to introduce multicultural factors during the initial clinical interview is consistent with some of the previous literature. Knox et al. (2003) found that some of the European American therapists reported if a client introduces the topic of race they would have the discussion, but they typically did not initiate the discussion if the client did not bring it up. Some of the LPCs in the current study shared the same opinions. They shared that they will engage in the conversation and follow-up with the client if the client initiated the process. Some shared that this is because the client should dictate the initial session and decide what they would like to discuss.

The theme willingness to be open relates to the LPC being open to share, open to receive what the client will say without becoming defensive, and willingness to extend an open invitation to allow the client to share about multicultural considerations or factors throughout the length of the therapeutic relationship. The finding that the LPC has to have a willingness to be open is consistent with previous literature. In a study conducted by Thompson and Jenal (1994) concerning the cross-racial dyadic interactions between African American clients and European American or African American race-avoidant counselors in the initial session, the researchers found that some of the clients would stop discussing the issue of race with their counselor if the counselor did not respond. It was also found that some clients were eager to share about their racial issues with the counselors, but they often were met with race-neutralizing responses. Lastly, they found that some of the clients continued to discuss their racial issues even when met with resistance from the counselor, because they felt the issues to be important. Although they continued to share they felt frustrated. These findings are linked to the LPCs' experience of being open and extending an invitation so that the clients are comfortable and that the counselor does not make the client feel that discussing multicultural factors are not welcomed in the counseling process.

Theme Three, is that the LPCs' believe that the timing has to be appropriate in order to discuss multicultural considerations. Several individuals felt that the initial clinical interview session may not be the appropriate time to discuss multicultural factors due to several paperwork requirements and client comfort level. Delaying broaching is a concern, however, because it has been found that broaching overtly, directly, and openly within the first two sessions contributed to establishing and maintaining a trusting and solid therapeutic relationship (Fuertes et al, 2002). Also client attrition is highest after the initial session for racial and ethnic minority clients (Alcantara & Gone, 2014). Smith (2004) shared that it is common that the limited time in intake sessions influences a counselor's propensity to focus solely on the presenting issue instead of gathering clients' perceptions of their cultural identities. The fact administrative responsibilities, such as paperwork becomes the primary focus, making broaching secondary, challenges the MCC, DPIM and RESPECTFUL model, and introducing and examining how multicultural factors are related to the presenting problem.

The last theme, boundaries surrounding which factors to broach, is not linked to any previous studies as most of the previous studies focus specifically on race and ethnicity. Although, it cannot be linked to the literature, there may be a connection between the continuum of broaching styles and comfort level with the different multicultural identities. Also, it is places a perceived level of ranking on the cultural identities, which is contrary to the DPIM and RESPECTFUL model that does not categorize cultural identities by hierachal order. These models illustrate the complexity and stresses the importance of all elements of personal identity. It seems that some individuals will broach using different styles depending on which multicultural identity needs to be discussed. Also, several of the participants shared that when they think about cultural identities some seem more prominent than others, while others shared that they do not think about some of the identities when they think about culture. Some of the

identities immediately come to mind, while others seem not to register as quickly. This is where the DPIM and RESPECTFUL model can come into play, as they have dimensions and domains which can ensure that counselors are aware and acknowledging multiple cultural identities.

### **Additional Theme from Follow-Up Interviews**

#### **Theme: Heightened Awareness**

There was a prominent, additional theme that the researcher felt needed to be mentioned in the findings of the study. The Theme: Heightened Awareness was mentioned by the majority of the participants during the follow-up interviews. The participants shared that the initial interview increased their awareness concerning cultural considerations and reminded them of the importance of discussing multicultural considerations. This indicated to the researcher and connected with Theme Four under research question one, that most of the participants were familiar with and recognized the importance of multiculturalism from their counselor education preparation programs. Several of the participants shared that the initial interview caused them to reflect on their practice and their preparation training. It was also connected to Research Question One, Theme One as some of the participants were reminded the relevance of culture and of specific cultural identities that they commonly do not think of. The heightened awareness is an indicator that the LPCs perceive acknowledging and discussing multicultural considerations as relevant to their practice. It seems as though the constant working in the field can cause LPCs to fall into a certain way of practice that is not based upon their training and until things such as the interview presents the idea of multiculturalism to them again, as a refresher, they are reminded of the relevance. This indicates that LPCs can sometimes lose focus of the importance of multicultural considerations when assessing and conceptualizing clients.

## Conclusions

The participants believe that culture is a part of everyone, but it was found that many of the participants only considered specific multicultural dimensions when working with clients. This was influenced by several factors. Because many of the participants shared that several of the cultural domains are not immediately thought of while in practice, the use of the DPIM and RESPECTFUL Model may aid in ensuring that several of the main cultural domains are acknowledged and assessed for during the initial clinical interview.

It seems as though the LPCs recognize clients as multicultural beings and recognize the relevance in identifying multicultural factors during the counseling process. Many participants believed that identifying these factors aid in getting to know the client and establishing a connection between counselor and client. Although they recognize the importance of identifying multicultural factors, there is variance in when they think they should broach discussions surrounding these factors. It was evident that some participants did not think that the initial clinical interview session was the correct time to have discussions concerning multicultural factors. Most of the participants believed that discussing multicultural considerations in counseling was good practice, but they also had different opinions on how broaching should occur. The previous research has shown that broaching directly, openly, and overtly seems to improve the therapeutic relationship and treatment effectiveness. This makes a case that the direct approaching approach may be more effective than indirect broaching. Also the literature indicates that broaching early on within the counseling relationship, within 1-2 sessions seems to also aid in establishing and maintaining trust and a solid therapeutic relationship (Fuentes et al. 2002). Also, broaching has been found to have many benefits including: enhances counselor credibility, enhances client satisfaction, enhances the depth of client disclosure, and enhances clients' willingness to return for sessions (Sue & Sunberg, 1996). This justifies that broaching

early on in counseling process, in the initial clinical interview, may improve the trust and therapeutic relationship when working with members of the SUDs population.

Paperwork and administrative duties during the first session seems to be a barrier to broaching. This barrier can often make broaching a secondary concern. It also seems as though the participants preferred for the clients to begin the broaching process. Day-Vines et al. (2007) stated that if the counselor does not introduce and examine multicultural factors may be left unexamined. This may be attributed to the power differential in the counseling relationship (Ivey, Ivey, & Zalaquett, 2010). Also it seems as though none of the participants were opposed to having discussions concerning multicultural considerations if the client brought the topic up. The LPC's openness seemed to be a vital part of how a counselor broached. It attributed to the level of sharing a counselor was willing do and the extending of an invitation to be open to have multicultural discussions at any time throughout the process.

The findings suggest that most of the participants were familiar with the concept of broaching due to their counselor education preparation programs. This indicates that counselor education preparation programs are embracing the core principal of multicultural counseling practices. Some level of the concept of broaching was understood by the participants, although they were not familiar with the term of broaching as defined by Day-Vines et al. (2007). This indicates that broaching may be a term that is used in the academic arena of counseling, but is not well-known or being translated into the world of the counselor practitioner. Also, because it is a term that encompasses a skill or behavior that counselors were already practicing and was only coined in 2007, the term may not be universally used in every counselor preparation program. It may empower the LPCs if they knew a term existed for the concept that they are practicing and the concept is an actual skill that aids in multicultural practice.

It was clear that all participants believe that multicultural factors impact substance use behavior, patterns, and perceptions of substance use and that cultural identities emerge during the initial clinical interview. This demonstrates the need for identifying and discussing multicultural considerations during the initial clinical interview when working with the substance use disorders population. LPCs who work with this particular population are attempting to understand the individual and their substance use. If the participants believe that multicultural factors influence clients' behavior, patterns, and perceptions of use and substances this affects conceptualization and treatment planning. Also, if clients' cultural identities emerge during the initial clinical interviews session this means culture is present and influencing the first counseling encounter. The first session is critical to racial and ethnic minority clients returning to counseling and is the first impression of the counseling relationship (Alcantara & Gone, 2014; Jones, 2010). Also all initial clinical interviews contain multicultural factors, so counselors must be intentional in addressing culture (Ivey et al., 2010). Culture is present in the initial clinical interview, and if broaching multicultural considerations has been found to help with trust and establishing and maintaining a therapeutic relationship, broaching multicultural considerations in the first session is highly recommended (Ivey et al., 2010; Merta, 2001).

Overall it appears that the LPCs recognize the value in recognizing and discussing multicultural factors, but that it may not always be practiced in the initial clinical interview session due to paperwork and administrative pressures, level of comfort of the LPC and the LPC's perceived level of the client's culture, perception of what are multicultural factors and waiting for the client to introduce multicultural considerations into the initial clinical interview session. The participants also seem to have different investment levels in addressing multicultural factors, different comfort levels of broaching, and different levels of understanding of how, when, and why they broach with clients. There does not seem to be a sense of

consistency across the sample of broaching and how to broach. Also, there seems to be an understanding of the importance of identifying and discussing multicultural considerations based on training and even experience in the field, but that the realities of being in the field often do not permit for the training to be implemented. This was evident by the additional theme of heightened awareness that emerged from the follow-up interviews. The majority of the participants shared that this study heightened their awareness concerning the importance of viewing all clients as multicultural beings and discussing cultural differences. It was also discussed that the LPC should examine how cultural influences may be related to the client's presenting problem. Some of the participants even shared that the in-depth interview made them reflect on their practice and reminded them of how they were trained in their counselor education preparation programs.

### **Limitations**

There are several limitations that should be considered when interpreting the results of this research study. The first limitation is that in-depth interviewing was the primary data collection method for this study. Using in-depth interviewing as the research method relies on the participants' self-report, which means that the participants decide how much they are willing to share. Also, when relying on interviews there is a risk that the participants responded based on social desirability versus their truth. Because the researcher is in a doctoral level counselor education program and had visible cultural identities that were similar or different from the participants, this may have influenced the individuals to filter their responses in a way that they felt was appropriate for the researcher and the profession of counseling. Another limitation is that the participants' responses were interpreted by the researcher, even though the researcher attempted to take measures to ensure the meaning of the participants was kept, there is a possibility that the researcher may have lost some of the participants' meaning due to

misinterpretation (Rossman & Rallis, 2012). As with any qualitative study there is no external generalizability; the findings represent the experiences and perspectives of the participants in this particular study. Also, the participants were all selected from community health agencies in the Commonwealth of Virginia and may not include phenomena experienced by counselors in other settings or locations.

Another limitation of the research was that even though the researchers clarified to the participants that some of the questions was focused on the initial clinical interview, many referred to and maybe drew from their experiences working with clients throughout the entire counseling process. The researcher asked clarifying questions when it was not clear, but some of the responses may have been based on the experience of the span of the counseling relationship, and not just the initial clinical interview. Also, several of the participants worked with clients who are diagnosed with a mental health disorder and a substance use disorder.

### **Implications**

The implications of the research are discussed below. The implications are based solely on the findings of the current research. The implications are categorized and discussed for counselors who work with the SUDs population and for counselor educators working in counselor education preparation programs.

#### **Implications for Counselors working with SUDs population**

1. Counselors working with the SUDs population should be intentional in identifying and engaging in discussions with clients concerning multicultural considerations during the initial clinical assessment. Not only should counselors identify the client's multicultural factors, but they should initiate discussions concerning the similarities and differences in the counseling dyad. It was found that having these discussions aid in getting to know the client and can helpful in establishing trust and establishing and maintaining a strong

therapeutic relationship (Fuertes et al., 2002; Ivey et al., 2010). Counselors should initiate the discussions surrounding multicultural factors, because the client may not initiate this discussion and therefore the issue may be unexamined (Day-Vines et al., 2007). Also there is a power differential in the room between the counselor and the client and the counselor being the perceived one in power should be the one to initiate the discussion and offer the invitation to have these discussion (Ivey et al., 2010). They should also assess for the multicultural factors and along with the client examine how the multicultural factors may be related to their presenting problem(s). As discussed previously, the data analysis found that the multicultural factors impact substance use behavior, patterns, and perceptions of substance use.

2. Counselors working with the SUDs population need to advocate for a different administrative structure or implement personal changes to their initial clinical intake process in order to allocate more time to assess for and discuss multicultural considerations. This is important because the LPCs felt as though the administrative responsibilities, including the initial paperwork can often be a barrier to broaching. Discussions of multicultural considerations have been linked to establishing trust and a therapeutic relationship in the beginning of the counseling process (Fuertes et al., 2002; Ivey et al., 2010), so being able to have time for this may lead to better case conceptualization and effective treatment (Castro & Garfinkle, 2003; Cheung & Snowden, 1990; Constantine, 2002; Delphin & Rowe, 2008). Also the LPCs shared that a client's cultural identities typically shows up in the initial session, so having flexibility in the first session will allow the counselor to initiate a discussion and extend an open invitation to the client concerning multicultural considerations.

3. It is important that counselors continue to attend trainings and workshops concerning diversity and multiculturalism. Most of the participants shared that their cultural awareness was heightened after the interview and that the interview made them reflect on things they learned in their counselor education preparation programs. This indicates there is a need to be reminded of the importance of multiculturalism in practice, because through everyday practice a counselor may not be mindful to include multiculturalism due to many factors. If counselors are intentional in attending trainings and workshops concerning these matters the idea of multiculturalism will become more of a constant in their practice. Also the agencies in which counselors work could also ensure that they offer trainings or workshops to aid their providers in providing multicultural competent treatment and staying abreast of the latest information concerning multiculturalism and diversity.

### **Implications for Counselor Educators**

1. Educate counselor education students on how the SUD population is diverse, and how multicultural factors influence substance use behavior, patterns, and can influence the perception of substance use and substances. This implication is based on the study's finding in which all the participants discussed that they experience multicultural factors as influencing substance use behavior, patterns, and the way a client perceives substance use and what they identify as a substance. Emphasizing the influence of multicultural factors on substance use, demonstrates and stresses the importance of broaching early on in the counseling process with the SUDs population.
2. Counselor education preparation programs should be purposeful in discussing models such as the DPIM and RESPECTFUL model. Several of the participants stated that they often forget about some of the cultural identities. Discussing conceptual models such as

the DPIM and RESPECTFUL model aids in identifying and remembering the many domains and dimensions of multicultural beings. Also, models like the DPIM also aids in understanding the interaction of multiple cultural identities. The models also illustrate the complexity of human beings and aids in teaching students to look at clients as multidimensional beings that function in multiple contexts.

3. Educate counselor education students on broaching, ensuring that the term broaching is used so there is a level of consistency in understanding and training. The term broaching was coined because there was not consistency in professional literature to describe the counselor's effort of examining cultural factors during the counseling process (Day-Vines et al., 2007). Because this term was coined to aid in consistency in understanding this concept and to explain what counselors were doing, there should be a stronger stance taken to utilize this term. Utilizing this term will help students and future counselors understand that there is term for what they have been taught and that it is an actual skill to aid in multicultural practice (Day-Vines et al., 2007). Counselor education programs should start this pattern so that the counselors graduate with the multicultural counseling skill and the understanding of the benefits of the skill. The benefits of include: enhances counselor credibility, enhances client satisfaction, enhances the depth of client disclosure, enhances clients willingness to return for sessions (Sue & Sunberg, 1996), establishes trust in the therapeutic relationship, and aids in establishing and maintaining a therapeutic relationship (Fuertes et al., 2002; Ivey et al., 2010; Merta, 2001). The counselors in preparation programs will get first-hand experience with the skill. The added supervision in the training programs makes it the perfect time to try approaches, like broaching, which can feel uncomfortable at first. If teaching broaching and its benefits were consistently emphasized, it may increase counselor's cultural competence in practice.

### **Future Research**

Recommendations for future research are based on the findings of the current study and the connection between the findings and the findings of previous research discussed in the literature review. This study used a qualitative method, future research may include quantitative studies, such as a survey that could reach a larger sample of LPCs who work with the SUD population. The survey could look at if LPCs who work with the SUDs population believe that multicultural factors influence substance use behavior and patterns. Also the survey could ask LPCs to identify the multicultural factors they perceive as being most influential in the substance use behavior and patterns. A quantitative survey could also determine if certain multicultural identities of the counselor influences whether or not the counselor broaches or thinks broaching is necessary when working with the SUDs population.

In this study the focus was on whether and how LPCs broach any multicultural identities with the SUDs population. A future study could look at whether and how LPCs broach specific multicultural identities with clients. Also, another qualitative study could look at how LPCs perceive specific identities' influence on a clients' substance use behavior and patterns. Future research may also look at the perceptions and experiences of clients of the SUDs population concerning their cross-cultural interactions with their counselors and look at how the clients perceive the counselors attempt to broach. Future research may also include looking at if conducting an initial clinical interview that focuses on multicultural considerations impact retention and treatment engagement.

### **Summary**

This chapter began with a summary of the findings from Chapter Four. Four themes emerged from the data analysis that seem to relate to Research Question One. The four themes were as follows: 1) Everyone has culture and it is all encompassing, 2) Multicultural factors

impact substance use behavior and patterns, 3) Cultural identities emerge during the initial clinical interview, and 4) Multiculturalism was an important component in counselor preparation. Theme One, also had a subtheme, culture is needed to understand clients. Three themes emerged related to Research Question Two, 1) No familiarity with the “broaching” term, 2) Broaching defined as initiating a topic, and 3) Some degree of understanding of the broaching concept. Research Question Three had five themes which emerged from the data analysis: 1) Broaching approach varies, 2) Client introduces multicultural factors, 3) Appropriate timing, 4) Willingness to be open, and 5) Boundaries surrounding broaching.

The chapter also included a discussion of the findings. The conclusions for each research question followed the discussion of findings. The discussion included linkage between the conceptual models used to frame the study and findings from previous studies. Based on the findings several implications were discussed. The implications were organized based on the implications for the counselors who work with the SUDs population and for Counselor Educators who provide counselor education preparation for future students. Limitations of the study were discussed. The limitations will aid the audience as they interpret the findings of the study. Although, the findings of this study will contribute to the counseling profession by providing insight into whether and how LPCs broach multicultural considerations during the initial clinical interview with the SUDs population, there are many opportunities for future studies. Several recommendations for future research were shared in this chapter.

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## Appendix A

### Participant Informed Consent

#### Virginia Polytechnic Institute and State University

**Informed Consent Form for (Insert Name of Participant):** \_\_\_\_\_

This informed consent is for interviewing those participants in the study concerning, the experiences of Licensed Professional Counselors who conduct initial clinical interviews with clients with substance use disorders, conducted by counselor education doctoral candidate Connie T. Jones. This research study is approved by Virginia Tech Institutional Review Board (IRB), IRB #15-127.

**This Informed Consent Form has three parts:**

1. Information Sheet (to share information about the study with you)
2. Certificate of Consent (for signatures if you choose to participate)
3. Pseudonym Selection Sheet

**\*You will be given a copy of all documents\***

#### **Part I: Information Sheet**

**Purpose of the Research and Participant Requirements**

The researcher is exploring the experiences of Licensed Professional Counselors who conduct initial clinical interviews with substance use disorder clients. You are invited to participate if you are currently a practicing Licensed Professional Counselor; working in community mental health setting in the Commonwealth of Virginia; who has been conducting initial clinical interviews with adults with substance use disorders for at least six months.

**Voluntary Participation**

Your participation in this research is entirely voluntary. The choice that you make will have no bearing on your professional standing, and your choice to participate or not will be kept confidential. You may change your mind later and end participation, without consequence, even if earlier you agreed to participate.

**Type of Research Intervention**

This is a phenomenological, interview-based research study. The interview will last approximately 60 minutes and will be take place in a confidential location convenient for you. One to three weeks after the interview, the researcher will call to follow-up and inquire as to any additional reflections you have had following the interview. The follow-up call may last approximately 15 minutes.

**Procedures**

You are being asked to participate in a research study about your experiences concerning initial clinical interviews with substance use disorder clients. If you accept you will be interviewed by the principal researcher, Connie T. Jones.

If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless

you would like someone else to be there. The information recorded is confidential, and only the principal researcher will have access to the information from your interview. The interviews will be audio recorded. The tape/digital file will be kept in a secure location. Interviews will be transcribed by a professional, secure transcription service and/or the researcher. After audio recordings are transcribed, you will be invited to review the transcript, and make revisions or additions to the transcript if you wish to do so. The tape/digital file will be destroyed within five years from the date of the interview.

### **Duration**

Interviews will take place between February 2015 and April 2015, and will last approximately 60 minutes. One to three weeks after the interview, the researcher will call to follow-up and inquire as to any additional reflections you have had following the interview. The follow-up call may last approximately 15 minutes. You will be invited to read over the transcript of your interview and make revisions, if you wish.

### **Risks**

This research project poses minimal or no risk to participants. Foreseeable risks may include disclosure of personal or confidential information and discomfort discussing feelings pertaining to multiculturalism and initial clinical interview experiences. Please note you have the right to stop the interview at any time, to choose what you disclose, or to opt out of the study at any time during or after the interview.

### **Benefits**

Benefits may include gaining clarity about your experiences with the initial clinical interview and the substance use disorder population.

### **Participant Compensation and Reimbursements**

A \$10.00 gift card will be provided as an incentive to take part in the research.

### **Confidentiality**

The information collected will be kept private and every possible effort will be made to mask your identity. A pseudonym will be assigned to your transcript and only the researcher will know what your pseudonym is. The key linking your identity to your pseudonym will be stored separately.

### **Sharing the Results**

None of the information you share will be attributed to you by name. The knowledge attained from this research will be shared by the way of a summary of the results. Any direct quotes used will include your pseudonym, not your name. The results and knowledge gained from your participation may be used to contribute to the broader knowledge base of the counseling profession via scholarly articles and conference proceedings.

### **Right to Refuse or Withdraw**

You do not have to take part in this research if you do not wish to do so. Choosing to participate or stopping participation in the interview at any time will not be shared with anyone by the interviewer. You will have the opportunity to read the transcript of your interview and review your remarks, and/or modify/remove any portions of the interview.

**Who to Contact**

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact the following:

**Connie T. Jones** 919-791-7904  
Principal Researcher connj84@vt.edu

**Dr. Laura Welfare** 540-819-7551  
Dissertation Chairperson welfare@vt.edu

This research project has been reviewed and approved by the Virginia Tech Institutional Review Board for Research Involving Human Subjects (IRB). The IRB is charged with the task to make sure research participants are protected from harm. If you wish to find out more about the IRB, please go to: <http://www.irb.vt.edu/>.

**If you have questions about your rights in the study, contact:**

Dr. David M. Moore  
Asst. Vice President for Research  
Telephone: (540) 231-4991  
Email: moored@vt.edu

### **Part II: Certificate of Consent**

I have been invited to participate in research concerning the experiences of Licensed Professional Counselors who conduct initial clinical interviews with clients with substance use disorders. I have read the above information, and have had the opportunity to ask any questions about it, and any questions I have been asked have been answered to my satisfaction. I voluntarily consent to be a participant in this study. By signing below, I give my consent to participate in this study, and I attest to the fact that I am 18 years of age or older.

Print Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Researcher Printed Name: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Part III: Pseudonym Selection**

Any research findings reported in conference proceedings, journal articles, and any other mean of dissemination will use a pseudonym to protect your identity. You may choose your own pseudonym, or one will be assigned to you.

**Do you wish to choose your own pseudonym?**

**Please initial in front of either the word “yes” or the word “no.”**

yes       no

**If yes, please write the pseudonym you wish to use here:**

---

Print Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

## Appendix B

### Recruitment: Email

#### 1. Initial Email Contact

Dear <INSERT POTENTIAL PARTICIPANT'S NAME>:

My name is Connie T. Jones, and I am a doctoral candidate at Virginia Tech. I am studying the experiences of Licensed Professional Counselors who conduct initial clinical interviews with substance use disorder clients. I am hopeful you will consider sharing your important perspectives. This research study is approved by Virginia Tech Institutional Review Board (IRB), IRB # <INSERT #>.

Sharing your experience with conducting initial clinical interviews with the substance use disorder population can help to inform other counselors and supervisors. Any responses you give will not be attributed to you, and your identity will be concealed in reports of the data.

You are invited to participate if you are currently a practicing Licensed Professional Counselor; working in community mental health setting in the Commonwealth of Virginia; who has been conducting initial clinical interviews with adults with substance use disorders for at least six months

Interviews will take approximately 60 minutes, and we can meet in a confidential location at a time and place convenient for you. One to three weeks after the interview, the researcher will call to follow-up and inquire as to any additional reflections you have had following the interview. The follow-up call may last approximately 15 minutes.

If you would like to participate, or would like more information, please email me (connj84@vt.edu) or give me a call: 919-791-7904. Also, if you know of anyone else who may meet the criteria, please share this email or reply to this email with names and email addresses. Thank you!

I look forward to hearing from you.

Sincerely,

Connie T. Jones

**2. Follow-Up Email (No response from participant. To be sent seven (7) days after initial contact.)**

Dear <INSERT POTENTIAL PARTICIPANT'S NAME>:

You recently received an email invitation to participate in a research study about the experiences of Licensed Professional Counselors who conduct initial clinical interviews with substance use disorder clients. Your participation is important to me, and I would like your perspective to be included in this research. Please see original email below:

My name is Connie T. Jones, and I am a doctoral candidate at Virginia Tech. I am studying the experiences of Licensed Professional Counselors who conduct initial clinical interviews with substance use disorder clients. I am hopeful you will consider sharing your important perspectives. This research study is approved by Virginia Tech Institutional Review Board (IRB), IRB # <INSERT #>.

Sharing your experience with conducting initial clinical interviews with the substance use disorder population can help to inform other counselors and supervisors. Any responses you give will not be attributed to you, and your identity will be concealed in reports of the data.

You are invited to participate if you are currently a practicing Licensed Professional Counselor; working in community mental health setting in the Commonwealth of Virginia; who has been conducting initial clinical interviews with adults with substance use disorders for at least six months

Interviews will take approximately 60 minutes, and we can meet in a confidential location at a time and place convenient for you. One to three weeks after the interview, the researcher will call to follow-up and inquire as to any additional reflections you have had following the interview. The follow-up call may last approximately 15 minutes.

If you would like to participate, or would like more information, please email me (connj84@vt.edu) or give me a call: 919-791-7904. Also, if you know of anyone else who may meet the criteria, please share this email or reply to this email with names and email addresses. Thank you!

I look forward to hearing from you.

Sincerely,  
Connie T. Jones

**3. Follow-up Email (Response from participant is, “Yes.”)**

Dear <INSERT PARTICIPANT NAME>:

Thank you for your response! I am excited you have agreed to participate in my research study. I want to be sure that you meet the criteria for this study. The criteria is as follows:

1. You are currently a Licensed Professional Counselor practicing counseling in the Commonwealth of Virginia.
2. You currently conduct initial clinical interviews with adults who have substance use disorders.
3. You have at least six months of experience conducting initial clinical interviews with the substance use disorder population.

Please let me know if you do not fit the above criteria.

I want to respect your time and other commitments so I would like to schedule our 60 minute interview as soon as possible. The following are times I am available to meet with you <INSERT THREE (3) DATES/TIMES>. If none of these dates/times work for you, please offer some dates/times you are available.

I am attaching the consent form for this study to this email so you can review it before we meet. We will go over it in person, and if you have any questions about it prior to our meeting, please let me know.

Thank you again for your response, and your willingness to contribute to the counseling profession!

Sincerely,  
Connie T. Jones

**4. Follow-up Email (Response from participant is, “No.”)**

Dear <INSERT PARTICIPANT NAME>:

Thank you for your response. I am disappointed you will not be a participant in my research, but understand you are very busy. If you decide you are able to participate, please do not hesitate to contact me by <INSERT DATE>. Also, if you know of anyone else who may meet the criteria please share this email or reply to this email with names and email addresses.

Thank you for your time.

Sincerely,  
Connie T. Jones

### **Recruitment: Telephone Script**

Hello, my name is Connie Jones, and I am a doctoral candidate at Virginia Tech. I am calling you because I am seeking interview participants for my dissertation study exploring the experiences of Licensed Professional Counselors who conduct initial clinical interviews with substance use disorder clients. Do you have a few minutes to speak with me?

**If yes, continue with script. If no, determine a day/time to connect in the future if the participant is interested.**

I am asking Licensed Professional Counselors to participate in an interview that will last approximately 60 minutes and occur at a confidential place that is convenient time for you. One to three weeks after the interview, the researcher will call to follow-up and inquire as to any additional reflections you have had following the interview. The follow-up call may last approximately 15 minutes. This research study is approved by Virginia Tech Institutional Review Board (IRB), IRB # <INSERT #>. We do not have much research on this topic, so sharing your experience with conducting initial clinical interviews with the substance use disorder population can help to inform other counselors and supervisors. Any responses you give will not be attributed to you, and your identity will be concealed in reports of the data. Is this something you think you would be interested in participating in?

**If yes, continue to screening questions. If no, thank the person for her/his time.**

Would it be okay if I ask you a few questions to ensure you fit the study criteria?

Are you a Licensed Professional Counselor currently working in the Commonwealth of Virginia?

**If yes, continue. If no, thank the person for her/his time. Unfortunately she/he does not fit the study criteria.**

Do you currently conduct initial clinical interviews with adults who have substance use disorders?

**If yes, continue. If no, thank the person for her/his time. Unfortunately she/he does not fit the study criteria.**

Do you have at least six months of experience conducting initial clinical interviews with the substance use disorder population?

**If yes, continue. If no, thank the person for her/his time. Unfortunately she/he does not fit the study criteria.**

**If the person meets all research criteria, continue.**

You meet the criteria for this study. Do you have any questions so far? Would you like to participate?

**If yes, continue. If no, thank the person for her/his time and ask if she/he may know of anyone else who may meet the criteria and please share about this study or share the names and email addresses of the individuals with the researcher .**

As I mentioned, interviews will take approximately 60 minutes, and we can meet in a confidential location at a time and place convenient for you. Can we schedule that time now?

**If yes, schedule interview. If not, set up how (email or phone) and when to make the appointment.**

Do you have an email address? I would like to send you the consent form for your review prior to our meeting. We will go over it when we meet, and I am happy to answer any questions about it prior to our meeting as well.

**If yes, record email address and send consent form. If no, ask for U.S. Postal Service Address and send consent form there.**

Thank you for your time. I'm excited to talk with you in person, and to hear about your experiences. I look forward to seeing you on <INSERT DATE/TIME> at <INSERT PLACE>. My phone number is 919-791-7904, and my email is connj84@vt.edu if you need to contact me for any reason.

## APPENDIX C

### Interview Protocol

Participant Pseudonym: \_\_\_\_\_

Let me begin by thanking you for taking time to talk with me about your experiences of conducting initial clinical interviews with the substance use disorder population. Before I begin the interview, I am required to have you sign a form indicating your consent to participate in this study. Additionally, it provides you with my contact information if you have any questions or comments about the study. (*Give participant the forms. Go through the different sections, answer any questions, and participant will sign the consent form and fill out the pseudonym sheet.*)

### Semi-Structured Interview

#### **Introduction**

As I mentioned to you earlier, this interview is about your experiences when conducting the initial clinical interview with substance use disorder clients. There are no right or wrong answers because your experience is your truth, and I value your experiences. I want to remind you that you have the option not to answer any questions I ask you, and that you are free to disclose or not disclose anything you choose. Do you have any questions before we begin?

#### **Research Questions:**

1. How do LPCs who conduct initial clinical interviews perceive the relevance of identifying multicultural factors to their work with clients with substance use disorders?
2. How do LPCs who conduct initial clinical interviews describe the term and concept of broaching?
3. Whether and how do LPCs who conduct initial clinical interviews introduce or broach multicultural considerations during the initial clinical interview?

#### **Questions and Probes**

1. First, I want to understand your work. How long have you been conducting initial clinical intakes with the substance use disorder population?  
*Probes: Ask about previous work before this position with the substance use population and conducting initial clinical intakes with any population: Do you have experience conducting initial clinical interviews with any other population? How did you begin working with the substance use disorder population? Any influences or passions that led to work with this population?*
2. Describe your typical initial clinical intake process? What information is required in order to complete intake documentation? (RQ1; RQ3)

*Probe: What is your primary objective when conducting the initial clinical intake?*

3. Describe the client populations with whom you work. (RQ1; RQ3)  
*Probe: What are some of the different cultural identities of the clients' with whom you work?*
4. Will you please share with me how you define cultural identities? (RQ1; RQ3)  
*Probe: What groups come to mind?*
5. Does a client's cultural background affect their substance use patterns and behavior?  
Please elaborate on your response. (RQ1; RQ3)  
*Probes: Does addiction look different for different subgroups? Do you believe that a client's culture can influence their substance use? Is there a relationship between substance use and a client's cultural background?*
6. Do clients' cultural identities emerge during the initial clinical interview session? And if so, how? (RQ1; RQ2; RQ3)  
*Probes: Will you please share with me if you discuss cultural factors during the initial clinical interview? Do you consider the cultural identities of the client when you conduct the initial clinical interview?*
7. Can you describe a time when a client's cultural identity emerged during the initial clinical interview?
8. Do you consider your own cultural identity when you first begin working with a new client? (RQ1; RQ2; RQ3)  
*Probe: What influences this decision?*
9. I identify as an African American heterosexual woman and I wonder what it has been like to talk about culture and cultural identities with me?
10. Would you please share with me if your master-level preparation courses and/or program included discussions concerning the idea of bringing up or introducing cultural considerations and/or cultural differences in the counseling process? If so, elaborate. (RQ2; RQ3)  
*Probes: Did you take multiculturalism courses in your masters-level program? And if so, how many? Are you familiar with the term and concept of broaching as it is discussed in counselor education? Did you practice introducing or bringing up the cultural considerations in your internships and practicums? When bringing up cultural factors during the counseling process or the initial clinical interview, what is your intent?*
11. Is there anything else you would like to share?

Thank you for your time. It has been great to talk with you, and to hear about your experiences. I will email you a copy of the transcript of this interview as soon as it is available and I'll call you to follow-up in one to three weeks.

## APPENDIX D

### Follow-Up Interview

*(The follow-up interview is to occur 1-3 weeks after the interview. Can occur via phone, internet, or, in-person)*

- 1) Have you had any additional reflections since our previous conversation?  
*If yes, ask the participant share and elaborate.*
- 2) Have you noticed anything different while conducting your initial clinical intakes?  
*If yes, ask the participant to describe case in which they noticed the difference.  
Also ask about the participant to share what they have noticed.*
- 3) Any additional thoughts about our talk at the end of the interview, where we discussed how my cultural identities may have impacted what it was like for you to talk with me?

## APPENDIX E

Participant Pseudonym: \_\_\_\_\_

### Demographic Questionnaire

Please identity your gender, race, sexual orientation, and age. Only share if you are comfortable doing so. There are no right or wrong responses.

Gender? \_\_\_\_\_

Race/Ethnicity? \_\_\_\_\_

Sexual orientation? \_\_\_\_\_

Which range best describes your age?

21-29     30-39     40-49     50-59     60-69     70 and over

**Thank you for your time!**

## APPENDIX F

### Research Question One

**Theme 1:** Everyone has culture and it is all encompassing.

Categories: Culture consists of many multicultural factors.  
Cultural identity individualizes an individual.

(*relevant open codes*: multicultural factors, family history, gender, gender roles, sexual orientation, trauma, racial/ethnic groups, geographic location, community, age, education level, part of who we are, socio-economic status, language, religion/faith, homelessness, cultural identities is where we come from, how we identify ourselves, who we identify with, culture is all encompassing)

**Subtheme:** Culture is needed to understand clients.

Categories: Multicultural factors promote understanding.  
Multicultural factors aid in establishing connections.

(*relevant open codes*: work holistically, culture needed to understand clients' lives, gathering information about client, importance of life story, strengths/resiliency/support, learning who clients are, establishing relationships/making connections/building rapport, cultural identities is where we come from, how we identify ourselves, who we identify with, culture is all encompassing)

**Theme 2:** Multicultural factors impact substance use behavior and patterns.

Categories: Perception of alcohol  
Geographic location and drug choice  
Age and drug choice  
Cultural Norms  
Multicultural factors impact recovery

(*relevant open codes*: gender and alcohol, multicultural factors, race and alcohol, geographic location and drug choice, family history, age and drug choice/use, geographic location and authority, substance use behavior influenced by type of drug, culture affects trust, culture helps determine what motivates change, cultural differences impact recovery, multicultural factors drives behavior, multicultural factors impact behavior/use/perception of use, multicultural factors shape client behavior, multicultural factors impact recovery, drug of choice and gender, alcohol not viewed as drug, cultural norms influences drug use and patterns)

**Theme 3:** Cultural identities emerge during the initial clinical interview.

Categories: Everyone has culture.  
Cultural identities emerge.

(*relevant open codes*: multicultural identities show, cultural identities show up during initial intake, multicultural factors, gender, racial/ethnic identities, language, religion/faith, geographic location, community, acculturation, international client, refugee, socio-economic status, awareness/not imposing views, cultural identities are how we identify ourselves, consider clients culture)

**Theme 4:** Multiculturalism was an important component in counselor preparation.

Categories: Core value of preparation program  
Discussion of multicultural practice

(*relevant open codes*: core value of preparation program/practice, differing worldviews, assumptions/not to assume, awareness)

### **Research Question 2**

**Theme 1:** No familiarity with the “broaching” term.

Categories: No familiarity with broaching term  
Defined broaching by dictionary definition

(*relevant open codes*: not familiar with broaching term, dialogue, approaching the uncomfortable, initiating the topic)

**Theme 2:** Broaching defined as initiating a topic.

Categories: Open dialogue  
Approaching the uncomfortable  
Acknowledging the uncomfortable

(*relevant open codes*: initiating the topic, dialogue, putting something out there, opening the door for discussion, approaching the uncomfortable, acknowledge the uncomfortable)

**Theme 3:** Some degree of understanding of the broaching concept.

Categories: Familiarity of concept  
Lack of culture included in concept

(*relevant open codes*: not familiar with concept, familiar with concept to a degree, part of what has to happen, acknowledging and understanding there are differences, didn't name culture specifically in broaching concept, putting something out there, acknowledging the uncomfortable, leaving the door open, assess cultural variables)

### **Research Question Three**

**Theme 1:** Broaching approach varies.

Categories: Direct Broaching  
Indirect Broaching

(*relevant open codes*: indirect broaching, direct questioning, utilize records, explicit communication, client initiating broaching, direct/upfront, utilize client background to create talking points, identify commonalities and differences, not always overt, overt vs. indirect depends, ignore issues, immediacy/here and now address culture, broaching when there is a problem, LPC initiate broach, rescue clients, intentionality depends, natural part of conversation)

**Theme 2:** Client introduces multicultural factors.

Categories: Client begins broaching.  
Client led conversation.

(*relevant open codes*: client initiating broaching, client controlling conversation, put client in control, follow-up if client says something, responsibility to listen to client)

**Theme 3:** Appropriate timing.

Categories: Conversation driven.  
Comfort level of both individuals.  
No broaching immediately.

(*relevant open codes*: conversation driven, broaching not priority, natural part of conversation, paperwork as barrier, not broaching immediately/right timing, weave into later sessions, less comfortable broaching during intake, broaching during the initial interview, broaching to help client comfort)

**Theme 4:** Willingness to be open.

Categories: Personal sharing.  
Open invitation.  
Receptive to sharing.

(*relevant open codes*: repetitively, remaining open, willingness to talk, non-defensive, non-judgmental, invitation to client, level of personal sharing, openness, conscious of own culture, acknowledge differences, differing worldviews, allow client to define, identify commonalities and differences, follow-up if client says something, broaching to relate/connect)

**Theme 5:** Boundaries surrounding broaching.

Categories: Boundary setting.  
Comfort level with multicultural factors.

(*relevant open codes*: create boundaries with language, more comfortable broaching certain cultural factors/setting boundaries, level of personal sharing/openness, not easy to broach/uncomfortable, conscious of own culture, perception of diversity, multicultural factors)

## APPENDIX G

### Audit Trail

Date	Activity
01/20/2015	Defended prospectus. Prospectus approved with minor revisions.
01/25/2015	Began working on necessary suggestions and edits in order to submit to IRB.
01/26/2015	Continued working on edits. Made changes to the interview protocol to lessen the number of questions and place in logical order.  Sent changes to dissertation chair. Dissertation chair offered suggestions and changes. I made the changes and the interview protocol I will use for the pilot interviews has been created.
01/26/2015	Communicated with colleague concerning potential individuals to interview for pilot interviews. Colleague connected me with an individual willing to participate in the pilot interview.  Reached out to individual for pilot interview and scheduled a date and time for January 27th from 2:30-3:30. (1st pilot interview scheduled)
01/27/2015	Conducted first pilot interview from 2:30-3:30. The interview occurred face-to-face. Made notes based off of the interview to aid in refining the interview protocol. I will compare the notes from the 1st pilot interview to the second interview.  Scheduled 2 <sup>nd</sup> pilot interview for January 28 <sup>th</sup> .
01/28/2015	Conducted second pilot interview from 7:45pm-9:00pm. The interview occurred via Skype. Made notes based off of the interview to aid in refining the interview protocol. The notes from this pilot interview will be compared with the notes from the first pilot interview.
01/29/2015	(12:30pm) Met with dissertation chair concerning feedback from pilot interviews. Received feedback from dissertation chair. Made necessary adjustments to the interview protocol.
01/31/2015	Worked on edits from pilot interview feedback and from the prospectus defense date.
02/02/2015	Worked on edits and sent an email to dissertation chair with edits and questions. Some of the things questioned and was edited included: Switching the order of research question 2 and 3; edits made on the informed consent; edits made on recruitment material; and edits made on the interview protocol. I questioned leaving “substance use problems” in the purpose statement and defining it or changing it to substance use disorders. My rationale is that the initial clinical interview occurs prior to determining if clients have a SUD, but if it is clearer to the audience to use SUDs, I will change it to make it clearer. Also, I am questioning should I remove “how” from the purpose statement. I am not sure if I am looking at how. Maybe the purpose statement should be, “The purpose of the study is to explore whether LPCs broach multicultural considerations during the initial clinical interview with clients who have substance use problems”
02/03/2015	Received feedback from my chair concerning the edits and questions I sent her yesterday. Started preparing a list of potential agencies and participants to contact once IRB approval is received. Looked online for phone numbers to community mental health settings in Virginia, particularly community service boards; agencies that provide SUDs treatment; and specific individuals who are LPCs and work with the substance use disorder population.
02/04/2015	Incorporated edits. Prepared and submitted paperwork to Virginia Tech IRB.  The researcher decided to use “substance use disorders” instead of “substance use problems” in purpose statement. “SUDs” seems to be clearer for the purposes of the research. Also, I decided to change the purpose statement to “whether and how” versus “whether” as the researcher believes “whether and how” is the basis of the study and if the participants share they broach the researcher will explore how. It seems as though understanding whether or not they broach, that the how part will be inseparable. Also, “whether” language may be a bit too quantitative. The how part will be covered under RQ3

02/05/2015	<p>Virginia Tech IRB requested two minor changes needed on the informed consent. The IRB requested: The IRB requires a revision/response to the following items:</p> <ol style="list-style-type: none"> <li>1. Research Protocol: Please change the response to Question 8.2 to "yes" because this study will have signed consent forms and audio recording, then answer the questions in the table.</li> <li>2. Consent form: Please remove the physical address of the IRB, as the IRB has moved. Dr. Moore/IRB's email and phone number are sufficient contact information.</li> </ol> <p>The researcher made the necessary edits and resubmitted to IRB.</p>
02/06/2015	<p>At 8:18am, I received approval from IRB to begin the research study. "The VT IRB has approved the IRB application referenced in the attached approval letter for the protocol titled "Broaching Multicultural Considerations during the Initial Clinical Interview". Read the approval letter carefully as it contains IRB-related requirements and retain a copy for your records."</p> <p>Began recruiting for the study at 1:00pm. Started with the list of potential participants created a few days earlier. Began calling and emailing individuals. Sent out the recruitment email. Shared recruitment email with colleague that will forward to others who may know of individuals who fit the study's criteria.</p> <p>I was able to schedule two interviews (1, 2) for next week. The first interview will occur 02/11 at 9:00am. The second interview will 02/11 at 5:30pm.</p> <p>After screening the two individuals to determine if they were appropriate for the study, I emailed both participants the IRB Approved Informed Consent form for them to view prior to the interview.</p> <p>Spoke to a colleague that will forward to others who may know of individuals who fit the study's criteria.</p>
02/07/2015	<p>Recruited some more via email. Forwarded recruitment email to colleague who will forward to others who may know of individuals who fit the study's criteria.</p>
02/08/2015	<p>Communicated with two potential candidates the study, but after screening they did not fit the qualifications, because they are not yet LPCs. They were more than willing to help and was receptive to sharing the call for participants with others who may fit the criteria.</p>
02/09/2015	<p>Scheduled two interviews for next week (3,4). After screening the two individuals to determine if they were appropriate for the study, I emailed both participants the IRB Approved Informed Consent form for them to review prior to the interview.</p> <p>Forwarded recruitment email to two colleagues who will forward to others who may know of individuals who fit the study's criteria.</p> <p>Followed up with an individual who agreed to participant, but has not set a date. This individual has been screened and the Informed Consent has been emailed.</p>
02/10/2015	<p>Prepped for the first two interviews tomorrow. Made sure copies of the informed consent and informed consent were made and that the gift cards were packed. Practiced with the audio recorders and practiced to ensure I was conducting the interview in a conversational manner.</p> <p>Also, recruited by email and sent follow-up emails. A colleague shared the call for participants on a listserv that reaches many LPCs. I sent recruitment emails to individuals who are direct supervisors in the SUDs units in community mental health agencies.</p> <p>Forwarded recruitment email to a colleague and a faculty member who will forward to others who may know of individuals who fit the study's criteria.</p> <p>Scheduled interview for next week (5)</p>

02/11/2015	<p>Conducted first initial interview in the New River Valley area. The interview began at 9:00am.</p> <p>Field note was written shortly after the interview.</p> <p>Conducted second initial interview in the New River Valley area. The interview began at 5:30pm.</p> <p>Field note was written shortly after the interview.</p>
02/12/2015	<p>Listened to both of the audio recordings from yesterday's interviews.</p> <p>Scheduled another interview for next week (6?). She is checking to see if she can meet at her office will determine date and time.</p>
02/13/2015	<p>Asked my fellow doctoral colleagues during a supervision meeting, if they were familiar with anyone who may be willing to participate in the study.</p> <p>Sent email to colleague asking her to forward the email to anyone in her agency or that she may know of that fits the criteria of the study.</p> <p>Sent email asking a faculty member to forward the email to anyone she may know of that fits the criteria of the study.</p>
02/14/2015	Traveled to Central Virginia for Monday interviews (3,4).
02/15/2015	<p>Prepped for interviews tomorrow.</p> <p>Purchased more gift cards for the study.</p>
02/16/2015	<p>Conducted interview 3 at 7:30am in Central Virginia.</p> <p>Wrote field note afterwards.</p> <p>Conducted interview 4 at 10:15am (time moved up from 5:30pm due to winter weather warning).</p> <p>Wrote field note shortly afterwards.</p> <p>Sent out first four interview audio-recordings to Rev.com for transcription service.</p> <p>Forgot to give one participant her gift card, so I contacted her to determine how she would like to receive the gift card. She shared via mail, so I will mail it tomorrow.</p> <p>Emailed recruitment material out to individuals in Central Virginia that may fit the criteria. Names were received from those already interviewed, found some from online through searches, and from colleagues.</p>
02/17/2015	<p>Had to reschedule interview 5 due to snow and poor road conditions. Interview moved from Tuesday 1pm to Thursday at 10am.</p> <p>Sent out recruiting email to two potential candidates for the study.</p> <p>I have not heard from the potential participant (6) concerning our meetings this week. I am thinking that this interview is not going to happen.</p> <p>Mailed gift card to participant.</p> <p>Received three transcripts back from Rev.com and began reviewing the transcripts with the audio-recordings.</p>

	Received an email from one of my colleagues with the name and contact information for an individual that may participate in the study.
02/18/2015	<p>Recruiting for study via email and phone.</p> <p>Prepping for 5<sup>th</sup> interview tomorrow at 10:00am.</p> <p>Reviewing transcripts and doing quality check.</p> <p>Received transcript for Interview 1 from Rev. Reviewed transcripts alongside the audio and made any necessary changes.</p>
02/19/2015	<p>Conducted initial interview 5 at 10:00am in Northern VA.</p> <p>Field note written shortly after.</p> <p>Submitted interview 5 for transcription.</p>
02/20/2015	<p>Received transcript 5 from transcription company. Reviewed transcripts alongside the audio and made any necessary changes.</p> <p>Conducted follow-up interview with participant 1 around 2:00pm.</p> <p>Conducted follow-up interview with participant 2 at 4:10pm.</p>
02/22/2015	<p>Scheduled interview for Feb. 26<sup>th</sup>. Sent participant the informed consent and conducted the screening.</p> <p>Began open coding with the initial interview transcripts starting with Interview 1.</p>
02/25/2015	<p>Participant scheduled on 2/22 needed to reschedule interview scheduled tomorrow.</p> <p>Potential participant never responded to email.</p> <p>Received a phone call from a potential participant interested in my study, who received my call for participants from her supervisor. After the screening an interview was scheduled for 03/02 at 10:00am in Northern Virginia.</p>
03/01/2015	<p>Sent informed consent to participant (6) interviewing on 03/02 at 10:00am. Participant sent reply email asking to move the interview to 11:00am.</p>
03/02/2015	<p>Conducted initial interview 6 with participant at 11:00am in Northern VA.</p> <p>Field note written shortly after.</p>
03/03/2015	<p>Emailed participants (3,4) to establish a time to conduct the follow-up interview.</p> <p>Sent interview 6, Follow-up interview 1 and 2 to transcription company.</p>
03/04/2015	<p>Reached out via phone to a supervisor at a Behavioral Health agency concerning recruiting LPCs who work with the substance use population. He shared that it was fine with him and he would ask his LPCs if they would like to participate and then get back with me.</p> <p>Received an email from participant (3) wanting to schedule follow-up interview for Friday at 10:00am.</p> <p>Received an email from participant (4) wanting to schedule follow-up interview for anytime up until 4pm today or 11am tomorrow. I responded that I would call her either before 4pm today or between 9am and 10am tomorrow.</p>
03/05/2015	<p>Conducted follow-up interview with participant (4) at 9:08 am.</p> <p>Per participant's request, I emailed participant (4) the call for participants again, so that she could forward along to those within her agency.</p>

	<p>Email sent to potential participant scheduled on the 2/22 who needed to reschedule. This was the second attempt to reschedule with the participant. I never received a response from her.</p> <p>Follow-up interview 4 sent to transcription company.</p> <p>Received transcript of interview 6, FUI 1 and 2 from transcription company.</p> <p>Received FUI 5 from the transcription company.</p> <p>Reviewed transcripts alongside the audio and made any necessary changes.</p>
03/06/2015	<p>Conducted follow-up interview with participant 3 at 9:10am.</p> <p>A colleague suggested that she knew of several LPCs who may be willing to help with the study. She shared the names of the participants and that she would reach out first and establish the connections. I shared my call for participants with my colleague who said that she would share with the potential participants.</p>
03/09/2015	<p>Emailed participant (6) to schedule a follow-up interview (FUI) time.</p> <p>Reached out to potential participant via email to recruit for study. After screening interview set for 03/16 at 11:45am (7) (New River Valley).</p> <p>Conducted follow-up interview with participant 5 at 7:30pm.</p> <p>Sent out FUI 3 and 5 off for transcription.</p> <p>Received FUI 3 and 5 from transcription company. Reviewed transcripts alongside the audio and made any necessary changes.</p>
03/10/2015	<p>Participant (6) emailed to share that she could participant in her follow up interview via phone today at 12:00pm.</p> <p>Conducted follow-up interview 6 at 12:00pm.</p> <p>FUI 6 was submitted to transcription company.</p> <p>FUI 6 was received from the transcription company. Reviewed transcripts alongside the audio and made any necessary changes.</p> <p>I feel as though I am not having much luck in finding participants. It seems as though I am exhausting my resources. Either I am not hearing back from people, or they do not have time to meet.</p>
03/11/2015	Received an email from a potential participant having an interest in the study.
03/12/2015	<p>Emailed potential participant from yesterday and conducted a screening. Was informed to call his office to schedule an interview.</p> <p>Received an email from a potential participant having an interest in the study.</p>
03/13/2015	<p>Called to schedule interview with potential participant (8). Interview scheduled for 3/17 at 1:15pm (New River Valley). Emailed participant to share date and time and emailed informed consent.</p> <p>Sent an email screening the potential participant whom I received an email from yesterday.</p>
03/16/2015	<p>Conducted initial interview (7) at 11:45am in New River Valley. Field note written shortly after.</p> <p>Received an email from potential participant (9) concerning that she fits the screening requirements and would like to meet 03/18 at noon in her office in Shenandoah Valley.</p>

	Identified one peer reviewer, the other peer reviewer has been identified since the beginning of the prospectus.
03/17/2015	<p>Conducted initial clinical interview (8) at 1:15pm in the New River Valley.</p> <p>Field note written shortly after.</p> <p>Through the coding it is evident that I am not finding any new ideas or concepts, so this influences my decision to say that I am at data saturation. I have enough participants and information for a credible study. Participant 9 will be my last interview.</p>
03/18/2015	<p>Conducted initial clinical interview (9) at 12:00pm in Shenandoah Valley area.</p> <p>Field note written shortly after.</p> <p>Received an email from a potential participant that was not yet scheduled, stating that she would not be able to participate anymore because her schedule will not permit it.</p> <p>Interviews 7, 8, and 9 were submitted to the transcription company.</p>
03/19/2015	<p>Interview 7 and 9 received from the transcription company.</p> <p>Reviewed transcripts alongside the audio and made any necessary changes.</p>
03/21/2015	<p>Debriefed peer reviewer on the purpose and research questions for the study.</p> <p>Interview 8 received from transcription company.</p> <p>Reviewed transcripts alongside the audio and made any necessary changes.</p> <p>Began final quality assurance check of transcripts, to ensure the analyzed data was based upon what was actually shared on the audio.</p>
03/22/2015	<p>After the final quality control, all initial interview transcripts were sent out to the participants.</p> <p>Received an email from participant 8 stating that he made minor edits (mostly spelling and grammatical) but did not feel a need to send it back to me.</p> <p>Sent interviews 1 and 2 to my first peer reviewer. She was given my research questions and purpose. Debriefed about the study earlier this week and yesterday.</p> <p>Finished open coding of initial interviews. Opening coding for initial interviews occurred from 2/22 – 3/22. Categories were emerging along the way.</p>
03/23/2015	<p>Received an email from participant 6 stating that the transcript looks fine.</p> <p>Sent interview 6 and 7 to second peer reviewer. She had been debriefed on the study and research questions prior to receiving the transcripts.</p> <p>Began coding follow-up interviews starting with FUI 1.</p>
03/24/2015	<p>Received the coded transcripts of interviews 6 and 7 from the second peer reviewer. Also debriefed concerning the interviews to ensure I was not being biased and open what was being found through the data analysis process. We seemed to be on the same page and had similar codes throughout the transcript. The only main difference noted was that some of the lines from the second peer reviewer were coded for RQ2 and RQ3. For the peer reviewer these two questions were very similar. The researcher was able to describe the difference in the research question and the peer reviewer was able to understand the difference. But the researcher understands how the questions seem similar.</p> <p>FUI 8 submitted to the transcription company.</p>
03/24/2015	Received an email from participant 3 stating that she added one word into her transcript.

	Conducted follow-up interview 8 at 3:15pm via phone.
03/25/2015	Second peer reviewer also agreed to code and debrief follow-up interviews 1-6. After she coded the interviews she sent them to me and we debriefed. It appeared that we were on the same page and the codes were very similar.  Conducted follow-up interview 7 at 1:30pm via phone.  Conducted follow-up interview 9 at 12:00pm via phone.  FUI 7 and 9 submitted to the transcription company.  FUI 7 received from transcription company.
03/26/2015	FUI 9 and 8 received from transcription company.  Reviewed transcripts alongside the audio recording for accuracy.  Completed open coding for follow-up interviews.
03/24/2015- 04/01/2015	Categories and theme formulation. Codes were sorted based upon research questions. Once the codes were organized by research questions, they were sorted based upon similarities which led to categories. Some of the codes were similar and were categorized more than one time because they seemed to fit with other categories as well. From the categories themes were formed. Some of the themes are closely worded to that of some of the categories. After much analysis of the categories, themes were developed on 4/1. The themes are based mainly on the interview transcripts. Hardly anything was found in the other data sources: (field notes) that contributed to theme formulation.
04/1/2015	I sent my themes along with a list of open codes to my two peer reviewers to gather their feedback.  The second peer reviewer stated that the themes align with what she perceived from the two initial interviews and the follow-up interviews.
04/03/2015	The first peer reviewer responded via phone to the review of the themes. She agreed that the themes seem to be fit what she saw through her brief coding. She had some concern about the wording of the themes. I took notes and incorporated the feedback into how the themes were worded.
04/03/2015 – until defense date	Working on write up of chapters 4 & 5; and making edits to previous chapters and the entire document

## APPENDIX H



Office of Research Compliance  
 Institutional Review Board  
 North End Center, Suite 4120, Virginia Tech  
 300 Turner Street NW  
 Blacksburg, Virginia 24061  
 540/231-4606 Fax 540/231-0959  
 email [irb@vt.edu](mailto:irb@vt.edu)  
 website <http://www.irb.vt.edu>

### MEMORANDUM

**DATE:** February 6, 2015  
**TO:** Laura Everhart Welfare, Connie Telisa Jones  
**FROM:** Virginia Tech Institutional Review Board (FWA00000572, expires April 25, 2018)  
**PROTOCOL TITLE:** Broaching Multicultural Considerations during the Initial Clinical Interview  
**IRB NUMBER:** 15-127

Effective February 5, 2015, the Virginia Tech Institution Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

### PROTOCOL INFORMATION:

Approved As: Expedited, under 45 CFR 46.110 category(ies) 5,6,7  
 Protocol Approval Date: February 5, 2015  
 Protocol Expiration Date: February 4, 2016  
 Continuing Review Due Date\*: January 21, 2016

\*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

### FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

*Invent the Future*

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY  
*An equal opportunity, affirmative action institution*

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

\* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

If this IRB protocol is to cover any other grant proposals, please contact the IRB office ([irbadmin@vt.edu](mailto:irbadmin@vt.edu)) immediately.