AN EXPLORATION OF FACTORS CONTRIBUTING TO MULTICULTURAL COUNSELING SELF-EFFICACY IN ADDICTION COUNSELORS

by

Joshua D. Smith

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Approved by:

_____
Dr. John R. Culbreth

_____
Dr. Susan Furr

_____
Dr. Pam Lassiter

_____
Dr. Claudia Flowers

ABSTRACT

JOSHUA DAVID SMITH. An exploration of factors contributing to multicultural counseling self-efficacy in addiction counselors. (Under the direction of DR. JOHN R. CULBRETH).

Substance use and addiction is a national healthcare concern affecting millions of families and individuals (National Institute on Drug Abuse [NIDA], 2018; Substance Abuse and Mental Health Services Administration [SAMHSA], 2018). To meet the needs of a growing client base, the addiction profession continues to expand (National Association for Alcoholism and Drug Abuse Counselors [NAADAC], 2018b). Additionally, the increase in ethnic minority or marginalized populations in the United States (United States Census Bureau, 2018) warrants a closer look at the preparedness of addiction counselors to serve a diverse client population. Previous literature has found marginalized or ethnic minority clients are more likely to drop out or not complete treatment compared to Caucasian clients (Cooper et al., 2010; Gonzalez et al., 2011; Guerrero et al., 2013). Despite these concerns, only one found study has examined multicultural counseling competency in addiction counselors (Lassiter & Chang, 2006). A non-experimental, correlational survey design was used to explore relationships between counselor recovery status, training, and counselor demographic variables on multicultural counseling self-efficacy in addiction counselors (N=283) using the Multicultural Counseling Self-Efficacy – Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007). A MIMIC model analysis indicated significant differences based on race, multicultural education, and CACREP program attendance on multicultural counseling self-efficacy. Implications from this study and recommendations for future research are discussed.

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CHAPTER I: INTRODUCTION

Addiction statistics in the United States continue to grow at alarming rates, most notably due to the recent heroin and opioid epidemic. This national healthcare crisis is responsible for claiming hundreds of lives every day (National Institute on Drug Abuse [NIDA], 2018). The 2017 National survey of substance abuse treatment services (N-SSATS) reported 1,356,015 clients enrolled in substance abuse treatment as of March 2017 (Substance Abuse and Mental Health Services Administration [SAMHSA], 2017). In addition, the Treatment Episode Data Set (TEDS), which looks at individuals 12 years or older, reported 1,699,261 client admissions in 2016 (SAMHSA, 2018). These alarming statistics indicate a call to the profession and a need for quality treatment and counseling services for individuals and families experiencing addiction.

To meet the growing public need and increasing client base, the addiction workforce continues to expand. Currently, the profession is estimated at more than 95,000 individuals that consist of counselors, educators, and other health care professionals who work towards prevention, intervention, treatment, recovery support, and education (National Association for Alcoholism and Drug Abuse Counselors [NAADAC], 2018b). With the influx of professionals, paraprofessionals, and counselors it is important to examine the education and training being provided to ensure quality and ethical services are being provided. This has implications for counselor education, supervision, and counselor development and training.

With a growing client population entering addiction treatment, training and education requirements have been designed to prepare professionals entering the field. The 2009 CACREP standards took a step forward in looking to prepare competent

addiction counselors who understand the complex factors of clients entering treatment (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2008). These standards emphasize that counselor education programs address a variety of cultural and developmental factors in addiction treatment. In addition to CACREP, the International Certification and Reciprocity Consortium (IC&RC) and the National Association for Alcoholism and Drug Abuse Counselors (NAADAC) are among agencies that seek to train ethical professionals who are equipped to provide quality addiction prevention, intervention, and treatment services (IC&RC, n.d.; NAADAC, 2018a). However, with the large amount of credentials and certifications for addiction counselors, it is necessary to examine the quality of services being provided. For example, the National Certified Addiction Counselor, Level 1 credential from NAADAC only requires a GED or high school diploma to provide clinical counseling services (NAADAC, 2018a).

The increasing client population and growing addiction workforce requires a more in-depth understanding of variables that impact who addiction counselors are and factors that contribute to client and treatment outcomes. Previous literature has linked client dropout and attrition to minority status (Gonzalez et al., 2011), with Caucasian clients being more likely to complete treatment than African American (Cooper et al., 2010) or Latinx clients (Guerrero et al., 2013). Understanding treatment disparities and client outcomes for diverse populations requires a more systemic approach. Guerrero et al. (2013) conducted a study examining a sample of clients in their first treatment episode that found African American and Latinx clients had higher numbers of individuals not in the labor force. In addition, they found that even after accounting for individual and

service factors, African American and Latinx clients still had lower treatment completion rates compared to White clients. Additionally, Guerrero and Andrews (2011) cited organizational cultural competence as a factor for increasing retention in substance abuse treatment for the African American and Latinx client population.

Other studies have examined the impact of client and counselor racial or ethnic matching on treatment outcomes (Cabral & Smith, 2011; Chang & Yoon, 2011; Ruglass et al., 2014). These studies have produced interesting results, with Ruglass et al. (2014) finding that clients with a racial match with their counselor had lower odds of posttreatment substance use than those with mismatches. Conversely, Cabral and Smith (2011) conducted a meta-analysis of clients in mental health treatment that highlighted while clients prefer a racial match, there were no significant differences in treatment outcomes based on racial or ethnic matching. Chang and Yoon's (2011) qualitative study may further clarify these findings as participants reported difficulty in discussing racial issues such as oppression, cultural practices, and family and community dynamics with a White counselor. However, participants in their study cited that racial differences were minimized if the counselor was accepting and comfortable broaching and discussing race and culture related issues. These findings suggested marginalized clients may have additional treatment needs that are not being met and signals a need for multicultural competency and inclusive treatment interventions to better meet the needs of diverse clients.

The theoretical framework for this study was self-efficacy theory. Self-efficacy theory states that people process, weigh, and integrate diverse sources of information concerning their capability, and regulate their choice behavior and effort expenditure

accordingly (Bandura, 1977). This study utilized self-efficacy theory through a cultural lens to examine multicultural counseling self-efficacy (MCSE) in addiction counselors. MCSE is a concept that utilizes self-efficacy theory in conjunction with multicultural competence to examine perceived ability to counsel diverse clients (Sheu & Lent, 2007). Furthermore, MCSE is designed to measure counselors perceived multicultural knowledge and awareness on skill use when working with racially diverse clients (Sheu & Lent, 2007), linking concepts of self-efficacy with multicultural competence.

Self-efficacy stems from the work of Albert Bandura regarding behavior change, competence, and motivation. Bandura (1977) defined self-efficacy as a phenomenon where people process, weigh, and integrate diverse sources of information concerning their capability and then regulate their behavior and effort accordingly. This was later adapted and refined by Larson and Daniels (1998) to include counseling self-efficacy, which is one's beliefs or judgements about his or her capabilities to effectively counsel a client in the near future.

Self-efficacy in addiction counseling has been examined with mixed results. Chandler et al. (2011) found counselors reported high levels of self-efficacy to provide substance abuse treatment, despite a reported lack of training or education in this area. However, their study did not explore personal experiences with addiction. This indicates a need to further understand the factors impacting self-efficacy in addiction counselors.

Multicultural competency is a core element of the counseling profession (Hays & Erford, 2014; Ratts et al., 2016; Sue et al., 1992). Multiculturalism in counseling involves the integration of cultural identities in the counseling process (Hays & Erford, 2014). With the release of the Multicultural Counseling Competencies (MCC) in 1992 (Sue et

al., 1992), counselor educators began to more readily adapt frameworks and curriculums designed to promote competency in counseling students (Decker et al., 2016). Though there have been conflicting viewpoints and resistance (Patterson, 2004; Vontress & Jackson, 2004; Weinrach & Thomas, 2002), over time the infusion of diversity and multiculturalism has become an integral part of training competent counselors.

The recent revision to the MCC's in 2016 added another element, social justice and action, as part of being a competent counselor (Ratts et al., 2016). In addition to counseling competencies, the American Counseling Association (ACA) supports CACREP's mandate that counselor education programs infuse multiculturalism into their core curriculum (ACA, 2014; CACREP, 2015). Though not all addiction counselors come from CACREP accredited programs or are bound under ACA ethical codes, understanding what factors contribute to multicultural competence in this population is needed. There have been limited studies that examine multicultural competency in relation to addiction counselors (Lassiter & Chang, 2006) and no found studies examining multicultural counseling self-efficacy in addiction counselors. Multicultural counseling self-efficacy involves examining counselors' perceived ability to work with diverse clients and their confidence to incorporate those skills in session (Sheu & Lent, 2007).

Understanding multicultural competency requires examining different cultural constructs. Recovery status is a unique cultural construct in addiction counselors, with prior studies finding a significant portion of addiction counselors identifying as being in recovery (Culbreth, 1999; Knudsen et al., 2006). The definition of recovery status has been previously explored in the literature (Doukas & Cullen, 2009), and traditionally has

been linked to alcoholism. Doukas and Cullen (2009) discuss the use of terms like recovery, recovering, and recovered. Their analysis of these terms stem from a historical perspective regarding different views on addiction. The authors argued for individuals to have agency and ownership of how they identify and which language they choose to express their relationship with substance use and abuse. This perspective was also utilized in this study, as the term "prior history of substance abuse, in recovery, or formerly experienced addiction" was used to classify recovery status.

Prior literature has discussed the role of personal experience in helping professions (Conchar & Repper, 2014; Freed, 2007). White (2000a) discussed the role of "wounded healers", providing a historical account of people in recovery entering the helping professions. The impact of personal experience on professional identity has been influential in the field of addiction treatment and counseling, even being referred to as "experiential credentialing" (White, 2008). The role of personal experience of persons in recovery has been previously identified in the counseling literature as a significant contribution to professional identity (Curtis & Eby, 2010; Hecksher, 2007; White, 2000a; 2000b). The role of recovery status acting as an experience factor or credential warrants further investigation into addiction counselor training, as it may link the client and counselor as sharing a common cultural component.

Addiction counselor training can vary immensely depending on location, credentials, licensure, and education. As mentioned previously, the historical roots of the addiction profession lend itself to a diverse workforce with varying degrees of training and education (NAADAC, 2018b; White, 2000a; 2000b; 2008). NAADAC and IC&RC are among agencies that seek to provide standardized training and credentialing for

addiction professionals (NAADAC, 2018a; IC&RC, n.d.). NAADAC offers credentialing ranging from a level 1 National Certified Addiction Counselor (GED/HS diploma) to a Master Addiction Counselor (graduate degree) (NAADAC, 2018a). Additionally, IC&RC's Alcohol and Drug Counselor (ADC) is the largest credential in the addiction workforce, with an estimated 20,000 professionals worldwide. They also offer credentialing for supervisors, prevention specialists, and peer support specialists (IC&RC, n.d.).

CACREP also provides training and education for addiction counselors (CACREP, 2015). The 2016 CACREP standards seek to prepare addiction counselors to understand the systemic, cultural, and developmental factors of clients entering treatment (CACREP, 2015). These standards reflect the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016), which act to prepare competent counselors entering the workforce. With the diversity in agencies and institutions providing training, credentialing, and licensure, it is imperative to examine how counselor training differs amongst addiction professionals, and how addiction counselor training influences multicultural counseling self-efficacy.

Study Significance

The United States is experiencing an increase in ethnic minority or marginalized populations, with projections estimating that by the year 2045 minority populations will outnumber the Non-Hispanic White majority (United States Census Bureau, 2018). Similarly, the rise in addiction or substance use disorder treatment admissions warrants a closer investigation of the preparedness of addiction counselors to serve a diverse client base. Addiction professionals may enter the workforce with varying levels of personal

experience and training. Understanding how recovery status, training, and counselor demographics impact multicultural counseling self-efficacy may lead to better training, education, and supervision of addiction counselors when working with diverse clients.

This study sought to examine how recovery status, training, and counselor demographics impact multicultural counseling self-efficacy in addiction counselors. Recovery status may impact how a counselor views clients' struggling with addiction positively or negatively. It may be that personal experience provides a deeper level of empathy or understanding for the recovering counselor, or it could restrict the counselor's views on what defines sobriety and recovery, thus limiting the client's autonomy. Additionally, training may play an important role in explaining multicultural counseling self-efficacy in this population. CACREP requires graduates to have completed multicultural course work and demonstrate competency in serving diverse populations (standards 5.A.2.c, e, f, g, and j). Examining how different credentials and licenses' impact multicultural self-efficacy has implications for counselor educators, accrediting bodies, and licensing agencies. Additionally, constructs such as race or ethnicity, sex, age, and years of experience have been linked to multicultural counseling self-efficacy in related populations (Barden & Greene, 2015; Matthews et al., 2018; Sheu & Lent, 2007).

To date, there have been no published studies examining factors that contribute to multicultural counseling self-efficacy in addiction counselors. Previous studies have examined self-efficacy of licensed counselors to provide substance abuse services (Chandler et al., 2011) and multicultural competence in substance abuse counselors (Lassiter & Chang, 2006). This study expands on previous literature by conducting

exploratory analyses regarding how recovery status, training, and counselor demographics explain multicultural counseling self-efficacy in addiction counselors.

Purpose of the Study

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. More specifically, this study aimed to examine differences in multicultural counseling self-efficacy in recovering and non-recovering counselors, among differing levels of training (certified or licensed, education level, CACREP attendance, and multicultural education), and counselor demographics (race, gender, age, and years of experience). In addition, this study examined the amount of variance counselor recovery status, training, and counselor demographics explain in multicultural counseling self-efficacy.

Research Questions

The research questions for this study were:

1. What are addiction counselors' levels of multicultural counseling self-efficacy?
2. Is there a difference between recovering and non-recovering counselors' levels of multicultural counseling self-efficacy?
3. Are there differences in levels of multicultural counseling self-efficacy based on training?
4. Are there differences in levels of multicultural counseling self-efficacy based on counselor demographics?
5. What is the relationship between multicultural counseling self-efficacy, counselor recovery status, training, and counselor demographics?

Limitations

The following limitations were true for this study:

1. The primary method of recruitment for participants was through state licensing and credentialing boards, so participants may have had differing levels of multicultural counseling self-efficacy from other credentialed or licensed professionals in other areas.
2. Due to the nature of social desirability and self-competence, participants may have reported more favorable scores.
3. This is not a random sample. Participants were targeted through a state credentialing board and identified specifically as addiction counselors
4. This was not a true experimental design and was exploratory in nature. As such, causal relationships among variables is not warranted.

Delimitations

The following delimitations were applicable to this study:

1. All data analyzed in this study was a result of participant's self-report.
2. This study was accessible only to participants with email and internet access, who identified as an addiction counselor, and were listed on state credentialing boards.
3. Participants received no incentive for this study
4. This study was not available to current addiction counseling students, unless they already held certification.

Assumptions

The following assumptions were made for this study:

1. Participants responded accurately and truthfully to all study questions
2. Participants were able to comprehend all study instruments on the survey
3. All study instruments are reliable and valid
4. Participants in this study are members of the targeted population

Threats to Internal Validity

The instrument used in this study have previously been found reliable. However, results were subject to participant self-report and the current sample. Cronbach alpha's was utilized to check the reliability of all scales and subscales used in this study. Survey results were anonymous and not connected to participant emails. Even though survey responses were anonymous, social desirability may have posed a threat to internal validity. Additionally, participants of this sample may have responded in a way to represent their group in a favorable light, for either recovering or non-recovering counselors, or certified or licensed counselors.

Threats to External Validity

One of the goals of quantitative analysis is to be able to generalize findings to the larger population. This study targeted a specific population to make up the sample. This study sought to be able to make inferences to related populations (addiction counselors) with similar characteristics. The purposeful sampling technique employed in this study may have limited the external validity of findings.

Operational Definitions

The following sections will further define each construct (multicultural counseling self-efficacy, recovery status, and training) and how it was used in this study.

Multicultural Counseling Self-Efficacy

Self-efficacy has been defined as a process by which people weigh and integrate information about their ability to perform a certain task and then act accordingly (Bandura, 1977). Counseling self-efficacy was later introduced to include one's beliefs or judgements about his or her capabilities to effectively counsel a client in the near future (Larson & Daniels, 1998). Multicultural counseling self-efficacy pulls from these definitions, relating them to multicultural counseling competencies, and has been defined as "the belief that one possesses multicultural attitudes, beliefs, knowledge, and skills and, hence, is able to provide multiculturally competent counseling services to clients" (Constantine & Ladany, 2000). In this study, multicultural counseling self-efficacy will be operationally defined by total and subscale scores on the Multicultural Counseling Self-Efficacy Scale - Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007).

Recovery Status

As previously mentioned, recovery status has been a topic of debate in addiction literature. Doukas and Cullen (2009) discussed the ongoing disagreement about what constitutes or defines recovery. The authors argued that recovery is a question of individual identity, and definitions should encompass that freedom. Whereas recovery has traditionally been associated with alcoholism and 12-step literature, this study seeks to broaden that definition to allow participants to self-identify their recovery status. While this study used the term recovery status to differentiate between participant groups, recovery status was defined as any individual who self-identifies as being in recovery, recovered, ex or former addict, or previously exposed to problematic substance use or

abuse. This definition sought to capture a larger sample of addiction counselors who may have not sought treatment or attended 12-step meetings.

In this study, recovery status was operationally defined by participants self-reporting their recovery status as a yes or no. As mentioned, recovery status encompassed more than traditional 12-step language and was defined as a personal experience (i.e. not having a family member in addiction).

Training

The addiction counseling profession operates under a diverse body of credentialing and accreditation standards, as evidenced by the range of credentials and licensure opportunities provided by NAADAC, IC&RC, CACREP, and other accrediting bodies. As previously mentioned, addiction counselor credentials and training range from certifications requiring a high school diploma or GED, to master's level licensure requiring a graduate degree (NAADAC, 2018a). Due to this diversity in education and credentialing, training was operationally defined by examining credentials, educational level, CACREP attendance, and amount of multicultural training. As different states have different terminology and types of credentials, this study categorized credentials into certification, provisional or associate licensure, and full licensure. Education was operationally defined as the highest level of education completed, ranging from high school diploma or GED to doctorate level degree. Additionally, participants were asked if they graduated from a CACREP accredited program and to list the number of course or trainings completed related to diversity or multiculturalism.

Demographic Variables

As previously mentioned, constructs such as race or ethnicity, gender, age, and years of experience have been linked to multicultural counseling self-efficacy in similar participant populations (Barden & Greene, 2015; Matthews et al., 2018; Sheu & Lent, 2007). In this study, each demographic variable was operationally defined by participant self-report on the demographic questionnaire (see Appendix C). For data analysis purposes, race or ethnicity was categorized by Caucasian and Persons of Color. Gender was categorized as male, female, or other. Age and years of experience was self-reported by each participant and treated as a continuous variable.

Chapter Summary

This chapter provided an introduction and overview of the problem, presented the variables of interest, and discussed the significance and need for this study. Additionally, this chapter identified the purpose of the study, the research questions guiding the study, limitations, delimitations, assumptions, threats to internal and external validity, and operational definitions for each variable.

CHAPTER II: LITERATURE REVIEW

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. This chapter will be divided into five main sections. This first section will review the background of addiction counselors for context on this population. The next section will discuss the theoretical framework for this study and its relation to the current variables of interest. The next section will provide a conceptual and empirical review of the outcome (or dependent) variable in this study, multicultural counseling self-efficacy. The last three sections will examine the empirical literature of the predictor variables (recovery status, training, and counselor demographics), as well as the relationship between each predictor and the dependent variable, multicultural counseling self-efficacy.

Population of Interest

Addiction counselors represent a diverse set of professionals in a variety of treatment domains. Those who identify as addiction counselors may have varying degrees of education, credentials, and professional qualifications. The National Association for Alcoholism and Drug Abuse Counselors (NAADAC) offers different levels of credentials for those with a high school diploma, bachelor's degree, or master's degree (NAADAC, 2018a). In addition, the International Certification and Reciprocity Consortium (IC&RC) offers a wide range of differing credentials for addiction professionals that range from Alcohol and Drug Counselor to Peer Recovery Specialist (IC&RC, n.d.).

The variance in professional qualifications is rooted in the historical development of addiction counseling. White (2000a; 2000b), in one of the only found reviews, traces

this historical development rooted in Native American culture, post-revolutionary war, and temperance movements as the transition of recovered and recovering individuals into new roles and settings as physicians, counselors, managers, and others. The rise in programs such as Alcoholics Anonymous and Narcotics Anonymous further led to what White (2000b) called paraprofessionals. This influx of individuals in recovery as treatment professionals contributes to the wide array of professional qualifications and has been labeled "experiential credentialing" (White, 2008). The present study looks to further explore factors that define addiction counselors and what impact those factors have on multicultural counseling self-efficacy. The diversity in credentials, professional qualifications, and counselor demographics served as the launching point for this study to explore how recovery status and training impact multicultural counseling self-efficacy in this population.

Theoretical Basis: Self-Efficacy Theory

Self-efficacy theory originated out of the early work of Albert Bandura (1977) and posits that people process, weigh, and integrate diverse sources of information concerning their capability and regulate their choice behavior and effort expenditure accordingly. Bandura stated that behavior is influenced by an internal force that seeks to weigh likelihoods for success and failure in a given situation. This process occurs in four major domains: cognitive, motivational, affective, and selection processes. According to Bandura, these processes are influenced by personal accomplishments, vicarious experiences, verbal persuasion, and physiological states.

Self-efficacy theory asserts that people engage in activities they feel capable of handling and avoid threatening situations. Past experiences (positive or negative) serve as

a teacher regarding perceived self-efficacy to perform successfully in a given situation (Bandura, 1994). In addition, the experiences of others can serve as a social model to increase one's own self-efficacy and motivation to act.

The present study sought to examine the influence recovery status, training, and counselor demographics have on multicultural counseling self-efficacy among addiction counselors. Self-efficacy theory asserts that individuals are motivated by a variety of factors, such as personal accomplishment and social modeling (Bandura, 1977; 1994). As such, it was important to examine personal recovery status and training when looking at multicultural counseling self-efficacy. Personal experiences with recovery may fall under personal accomplishments as well as social modeling in Bandura's model and may influence perceived multicultural self-efficacy in this population. However, efficacy expectations regarding recovery may not be attributable to counseling outcomes. Training may also fall under personal accomplishment or social (in this case professional) modeling in this context. As previously mentioned, training differs across addiction counselors due to the diversity of professional credentials and qualifications. Therefore, multicultural counseling self-efficacy may differ based on the training an addiction counselor received.

Multicultural Counseling Self-Efficacy

Multicultural counseling self-efficacy (MCSE) pulls from both the multicultural counseling competencies (Sue et al., 1992) and counseling self-efficacy (Larson & Daniels, 1998) , and has been defined as "the belief that one possesses multicultural attitudes, beliefs, knowledge, and skills and, hence, is able to provide multiculturally competent counseling services to clients" (Constantine & Ladany, 2000). Due to MCSE

being a more recent term in counseling literature, multicultural competency and counseling self-efficacy literature will also be discussed to further define this construct. The following sections will include a review of MCSE, multicultural competency in counseling, and counseling self-efficacy, and how each relates to addiction counselors.

Studies examining MCSE have largely focused on counseling students (Barden & Greene, 2015; Greene et al., 2014; Sheu & Lent, 2007) or school counselors (Camp et al., 2019; Holcomb-McCoy et al., 2008). For counseling students, time in graduate school has been linked to higher scores in multicultural session management, with doctoral students demonstrating higher levels of MCSE compared to master's students (Barden & Greene, 2015). This indicates an experience or training factor related to MCSE. Additional research has shown that MCSE and multicultural competence increases in counseling students as a result of experiential learning activities (Greene et al., 2014).

MCSE has also been linked to knowledge and skills regarding diversity elements in school counselors (Camp et al., 2019). Camp et al. (2019) found that school counselors' knowledge and skills relating to student's experiencing homelessness was a significant predictor of their multicultural self-efficacy to support such students. Additionally, Holcomb-McCoy et al. (2008) proposed that school counselors with higher levels of multicultural self-efficacy are more likely to use additional resources, identify student inequities and achievement barriers, and report higher levels of satisfaction in their work with culturally diverse students.

Other studies examining MCSE have focused on implications for supervision (Constantine, 2001) and identity development (Matthews et al., 2018). For supervisees, higher amounts of multicultural training and receiving multiculturally focused

supervision is associated with increased self-efficacy to work with culturally diverse client populations (Constantine, 2001). Matthews et al. (2018) found that ethnic identity and MCSE were significantly associated with multicultural competence in practicing counselors, with self-efficacy being the strongest predictor for multicultural competency in their sample. This suggests that counselor's belief, or self-efficacy, to work with culturally diverse clients may be a more significant factor than counselor demographics. No published studies were found that examined MCSE in addiction counselors.

Multicultural Counseling Competency

Since the release of the multicultural counseling competencies (Sue et al., 1992), there has been a significant amount of research regarding its impact on training, pedagogy, and client outcomes (Arredondo et al., 2005; Manis, 2012; Worthington et al., 2007). A recent replication study of a national sample of professional counselors found a significant effect of education level on multicultural competence, with those having doctoral degrees perceiving themselves as more multiculturally competent (Barden et al., 2017). Another interesting finding from their study was the significant difference in participant's satisfaction with their cultural knowledge based on their graduation from a CACREP or non-CACREP program, despite no differences between their self-perceived multicultural competence. This may be due to social desirability or experience factors but highlights that training elements may impact multicultural competency in professional counselors.

Other recent studies examining multicultural competency have looked at counseling students or trainees (Collins et al., 2015; Hill et al., 2013; Midgett et al., 2016), supervision (Kissil et al., 2013, 2015), school counselors (Owens et al., 2010), and

client perceptions (Hook et al., 2013). Studies looking at counseling students have focused on training elements and factors that increase multicultural competency (Collins et al., 2015; Hill et al., 2013; Midgett et al., 2016). Collins et al. (2015) found the majority of students in their sample received multicultural training in a single course format, and though participants reported an increase in their awareness and competency, there were also reported barriers and feelings of unpreparedness when it came to clinical situations. Similar to Barden et al.'s (2017) study of professional counselors, student perceptions of their multicultural competence does not appear to differ significantly between CACREP and non-CACREP programs (Hill et al., 2013). Training factors for students appears to be unique, and there has been extensive literature linking experiential learning approaches to fostering multicultural competence in this population (Bemak & Chung, 2011; Decker et al., 2016; Midgett et al., 2016; Murray et al., 2010; Swazo & Celinska, 2014).

Supervision practices have also been linked to multicultural competency (Hays et al., 2007; Kissil et al., 2013, 2015). These studies highlight the importance of culturally responsive supervisors (Hays et al., 2007), and demonstrate the connection between supervisor competence and supervisee self-efficacy (Kissil et al., 2013, 2015). Additionally, other studies have discussed the importance of cultural acceptance (Owens et al., 2010) and cultural humility (Hook et al., 2013) when working with diverse client populations, which are related constructs to multicultural competency.

Studies examining multicultural competency in addiction counselors are limited. In the one published study found specifically examining multicultural competency in this population, counselor ethnicity and educational level were found to be significant

predictors of perceived multicultural competence, though years of experience and level of certification were not (Lassiter & Chang, 2006). These findings have significant implications on the current study, as recovery status was not a measured variable in their research design. Related studies examined organizational competence (Guerrero & Andrews, 2011) and multicultural training (Hayes et al., 2004) in this population. Guerrero and Andrews (2011) found that organizational cultural competence, specifically managers' culturally sensitive beliefs, were linked to reduced wait times and increased retention for Latinx and African American clients in outpatient substance abuse treatment. Additionally, Hayes et al. (2004) examined the impact of a multicultural training on substance abuse counselors stigmatizing attitudes and professional burnout. The training featured group activities, discussion, and presentations centered around issues of cultural diversity, cultural competence in therapy, personal awareness of values and biases, and culturally appropriate intervention strategies. Results indicated a positive effect on reducing stigmatizing attitudes post-treatment. However, follow-up assessments produced inconsistent results. These findings illustrate a need for further research on this population and factors that relate to working effectively with culturally diverse clients.

Other studies have examined multicultural counseling competencies in vocational rehabilitation counselors, with findings that more multicultural education or training was positively associated with perceived multicultural competency (Bellini, 2002, 2003). Lastly, a dissertation study examined cross-cultural competencies in substance abuse counselors (Elamin et al., 2012). Results from this study found no significant differences between counselor demographics and education level on cultural competence, though counselors trained in counseling or social work scored higher than counselors trained in

psychology. There is a limited amount of studies examining multicultural competency in this population, and no studies were found examining multicultural counseling self-efficacy, which warrants a need for the current study.

Counseling Self-Efficacy

Counseling self-efficacy is based on Bandura's (1977, 1994) work, and is defined as one's beliefs or judgements about his or her capabilities to effectively counsel a client in the near future (Larson & Daniels, 1998). Self-efficacy in the counseling literature has been explored extensively (Larson & Daniels, 1998). Recent studies have examined counselor self-efficacy in relation to school counselors (Ooi et al., 2018), supervision and training (Meyer, 2015; Morrison et al., 2018), online learning (Watson, 2012), mindfulness (Bohecker & Doughty-Horn, 2016; Butts & Gutierrez, 2018), and counselor diversity (Haley et al., 2015; Kissil et al., 2013; Li et al., 2018). The literature base becomes much less pronounced, however, when examining counselor self-efficacy in addiction counselors.

To date, there are limited studies that focus on the self-efficacy of addiction counselors, with the majority of studies focusing on client treatment self-efficacy (Kadden & Litt, 2011). While client outcomes and treatment success are of upmost importance, counselor self-efficacy to address client issues is warranted. Chandler et al. (2011) conducted one of the first studies to explore self-efficacy and substance abuse counseling. Their study found that counselors reported high levels of self-efficacy in relation to substance abuse counseling despite limited training in that area. Despite the authors limited findings of significance, their work greatly impacted the current study. Chandler et al. proposed that future researchers explore personal experiences with

substance use in order to better explain self-efficacy in this population. The exclusion of recovery status in their study may have accounted for the limitations in their findings. Older studies have discussed the importance of self-efficacy in substance abuse or addiction counseling, but mainly from a stance of client outcomes rather than counselor competence (Whittinghill et al., 2000). Despite the rationale for understanding counselor self-efficacy, and the development of valid instruments (Murdock et al., 2005), there remains a gap in this area. No found studies examined addiction counselor's multicultural self-efficacy.

Summary

This section provided a conceptual and empirical overview of the literature base regarding MCSE, multicultural counseling competency, and counseling self-efficacy. Limited studies were found that examined MCSE, and no published studies were found that examined MCSE in addiction counselors. Additionally, the literature on multicultural competency and self-efficacy is also limited for this population. This gap in the literature points to a need for research exploring these constructs to better inform training, practice, and supervision of addiction counselors.

Recovery Status

Recovery status refers to the personal identification of the counselor as being, or not being, in recovery. Previous studies have found a significant portion of addiction counselors to identify as being in recovery (Culbreth, 1999; Knudsen et al., 2006). Knudsen et al. (2006) found that 57% of 817 counselors in their sample identified as being in recovery. White's (2000a; 2000b) historical overview of persons in recovery entering the addiction treatment field as paraprofessionals and eventually clinicians and

educators still appears to hold true. Historically, recovery has referred to alcoholism (Doukas & Cullen, 2009), though recent literature suggests a potential broadening of that definition (Doukas & Cullen, 2009; Oser et al., 2011) to be more inclusive.

Recovery status has been an important concept in the addiction counseling literature (Culbreth, 2000; Doukas & Cullen, 2009; Doyle et al., 2008; Greene, 2015; Hecksher, 2007; White 2000a, 2000b). However, despite its importance there are limited current studies that examine recovery status, thus the inclusion of older studies is examined here to provide a more comprehensive overview of the literature. Recovery status has been referred to as an "experiential credential" (White, 2008), whereby the process of personal experience equates to some level of expertness. The term has also been used in conjunction with "wounded healer" to describe individuals who have transcended their own addiction or substance use issues to in turn help others in similar circumstances (White 2000a, 2000b). Conchar and Repper (2014) found in their review of the mental health literature that personal experience was the second most profound theme among professionals regarding their decision to enter the counseling field. The most common was their need to self-heal, which could be looked upon in a similar light.

White (2000a, 2000b) attributed the role of personal experience being a major factor in addiction counseling to the development of the Minnesota Model of Treatment in the 1950's, which sought to credential and employ recovered persons with minimal education requirements (high school education). However, counselors were not the only recovering professionals to shape addiction treatment. In the late 19th and early 20th century doctors and physicians with a history of addiction or recovery began treating individuals with substance use disorders (Freed, 2007). The role of personal experience

as a primary qualification or certification to practice ignited a controversy within the field (Freed, 2007; White 2000b). The vocational calling of someone to help others due to personal experience (rather than education) (White, 2000b) may contribute to recent concerns regarding a lack of graduate level specialization, nationally recognized licensure, and a desire to attract new talent to the field (Duryea & Calleja, 2013).

Recovery status has been examined in the counseling literature previously regarding client outcomes (Culbreth, 2000; Oser et al., 2011), supervision (Culbreth, 1999; Culbreth & Borders, 1998, 1999), personal and professional identity (Curtis & Eby, 2010; Doukas & Cullen, 2009; Hecksher, 2007; Kellogg, 1993; Simons et al., 2017), and education and training (Greene, 2015). Counselor recovery status has been found to have no significant impact on client treatment outcomes (Culbreth, 2000) but may be more beneficial for clients entering treatment as an initial rapport building strategy for recovering counselors (Oser et al., 2011). In relation to supervision, studies have found no significant differences in satisfaction (Culbreth & Borders, 1999), but rather a preference for matching recovery status between supervisor and supervisee (i.e. recovering supervisor and recovering supervisee, or vice versa) (Culbreth, 1999; Culbreth & Borders, 1998, 1999).

Recovery status has also been linked to personal and professional identity in counselors. Counselors who identify as being in recovery have reported higher levels of professional commitment than counselors not in recovery (Curtis & Eby, 2010). In addition, recovering and non-recovering counselors have been found to differ on treatment modalities and interventions used in session (Simons et al., 2017). Hecksher (2007) warned about the downfall of a counselor's recovery identity being at the

forefront of the counseling relationship, resulting in a higher potential for client relapse and personal maintenance. This again has implications regarding the personal experience factor that individuals bring with them as professionals.

In relation to training and education, Greene (2015) conducted a study of recovering and non-recovering masters-level trainees. Trainees in recovery reported entering their program eager to share personal experiences regarding their recovery. Conversely, non-recovering trainees reported entering with feelings of inadequacy and self-doubt. Greene's (2015) findings also illustrated the idea of experiential credentialing, as recovering trainees discussed their personal experience being their primary qualification. These findings have significant implications for counselor education and the present study. Understanding how recovery status impacts current and prospective addiction counselors can better inform teaching and supervision practices. Addiction counselors' needs, skills, and professional identity may differ depending on recovery status.

Recovery Status and Multicultural Counseling Self-Efficacy

There have been no found published studies that specifically examine counselor recovery status and multicultural counseling self-efficacy. However, this section will draw from studies that examined related constructs in this population to examine the need for the current study. As mentioned previously, the only found study to examine multicultural competencies in addiction counselors (Lassiter & Chang, 2006) did not measure recovery status. The limited literature examining counselor recovery status, despite the evidence that a significant portion of addiction counselors identify as being in recovery (Culbreth, 1999; Knudsen et al., 2006) suggests a need for ongoing research.

Despite limited published findings, there have been studies examining related constructs (Dennis et al., 2013; Stöffelmayr et al., 1999). Dennis et al. (2013) examined the influence of counselor recovery status on counselor credibility regarding twelve-step program familiarity. Though credibility is not a function of multicultural competence or self-efficacy, establishing credibility may enhance an addiction counselor's belief that he or she can effectively work with an individual. Additionally, Stöffelmayr et al. (1999) found that counselors in recovery used a wider range of counseling techniques and treatment goals. The authors noted their findings were not supported by prior literature models, but it may suggest that recovery status impacts how counselors approach treatment.

Other studies have examined recovery status and self-efficacy, with implications for supervision (Culbreth & Cooper, 2008), education and training (Green, 2015), research (James & Simons, 2011), client and treatment outcomes (Oser et al., 2011; Simons et al., 2017), and peer support services (Weikel et al., 2017). For supervisors, perceived self-efficacy has been found as the most significant predictor for supervisor development in relation to theory and techniques for both recovering and non-recovering supervisors (Culbreth & Cooper, 2008). Though it should be noted that there was a difference in perceived self-efficacy between recovering (accounted for 54% of the variance) and non-recovering (accounted for 40% of the variance).

In relation to education and training, the only published study found was conducted by Greene (2015) regarding recovering and non-recovering masters level trainees. The findings from that study have been discussed previously, but it should be highlighted that recovering and non-recovering counseling trainees enter their programs

with differing levels of confidence, with non-recovering trainees reporting feelings of inadequacy due to lack of personal recovery experience. While this study did not specifically explore self-efficacy, reports regarding confidence, inadequacy, self-doubt, and skill development were related enough for inclusion in this section. James and Simons (2017) also looked at recovering and non-recovering trainees and self-efficacy. However, their study was focused around research self-efficacy. As it stands, they did not find any significant differences between recovering and non-recovering trainees. These studies highlight a gap that future research should further explore these concepts deeper.

Client and treatment outcomes were discussed in two studies relating to recovery status and self-efficacy (Oser et al., 2011; Simons et al., 2017). Again, these studies did not examine these constructs as the primary variables of interest, but their findings are relevant to the current study. Oser et al. (2011) found in a qualitative study using focus groups that recovering counselors were perceived to have it easier when it comes to building rapport and establishing relationships with clients. This would indicate a potential for lower levels of self-efficacy among non-recovering counselors in the early stages of the client-counselor relationship when it comes to rapport building and therapeutic alliance. In addition, Simons et al. (2017) found that recovering counselors reported higher ratings for group facilitation and using 12-step and faith-based counseling approaches than non-recovering counselors.

These studies point to a gap in the literature and a need for future studies to further explore the relationship between recovery status and counselor self-efficacy. Based on the literature found, counselor recovery status could impact MCSE regarding the counselor's perceived ability to work with a client experiencing addiction related

issues. The current study viewed recovery status as a cultural construct that may be unique to addiction counselors. The studies mentioned above highlight the importance of counselors in recovery shaping the profession and the significant portion of addiction counselors identifying as being in recovery. Counselors in recovery may have unique values, language, or rituals that impact their MCSE as recovery programs (12-step, medication management, etc.) often have group customs, beliefs, or norms shared among members. Recovering counselors may report higher levels of MCSE due to a shared experience of addiction. Conversely, recovery status could negatively impact a counselor's ability to be open and flexible to alternative treatment and recovery options based on their own recovery experiences.

Summary

This section provided a conceptual and empirical review of the literature base regarding recovery status. Additionally, studies examining recovery status and constructs related to MCSE were reviewed. No published studies were found that examined recovery status in relation to MCSE, indicating a need for further research in this area. The role of recovery status in addiction counseling is a unique concept that may impact how counselors work and perceive their clients.

Training

Addiction counselor training can vary immensely depending on location, credentials, licensure, and education. As mentioned previously, the historical roots of the addiction profession lend itself to a diverse workforce with varying degrees of training and education (NAADAC, 2018b; White, 2000a, 2000b, 2008). The National Association for Alcoholism and Drug Abuse Counselors (NAADAC) and the International

Certification and Reciprocity Consortium (IC&RC) are among agencies that seek to provide standardized training and credentialing for addiction professionals (NAADAC, 2018a; IC&RC, n.d.). NAADAC offers credentialing ranging from a level 1 National Certified Addiction Counselor (GED/HS diploma) to a Master Addiction Counselor (graduate degree) (NAADAC, 2018a). Additionally, IC&RC's Alcohol and Drug Counselor (ADC) is the largest credential in the addiction workforce, with an estimated 20,000 professionals worldwide. They also offer credentialing for supervisors, prevention specialists, and peer support specialists (IC&RC, n.d.).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP) also provides training and education for addiction counselors (CACREP, 2015). Though not a credentialing body, the 2009 and 2016 CACREP standards included additional language to prepare addiction counselors to understand the systemic, cultural, and developmental factors of clients entering treatment (CACREP, 2015). These standards reflect the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016), which seeks to prepare competent counselors entering the workforce.

Several studies have examined the training dynamics and recent shift in addiction counselor education and training standards (Hagedorn et al., 2012; Kerwin et al., 2006; Lee, 2014; Miller et al., 2010; Morgen et al., 2012; Stöffelmayr et al., 1999; Toriello & Benshoff, 2003). One of the major themes in the literature regarding addiction counselor training is the lack of consistency and uniformity (Kerwin et al., 2006; Miller et al., 2010; Morgen et al., 2012). Kerwin et al. (2006) conducted an analysis of state requirements for addiction and mental health counselors, with findings that suggest credentialing for substance abuse counselors require less formal education and coursework, but more work

experience and supervision than mental health counselors. Additionally, studies have pointed to a lack of consistent standards and competition amongst credentialing boards, creating problems for addiction professionals (Miller et al., 2010; Morgen et al., 2012). Morgen et al. (2012) alluded to a systemic issue in addiction training that licensed professional counselors (LPC's) cannot or should not do addiction work due to the notion that addiction falls outside of their scope of practice. The authors suggested there needs to be more balance in addiction counselor credentialing, highlighting the tiered system North Carolina uses that allows for greater flexibility.

More recent studies have highlighted the positive trends in addiction counselor training as evidenced by the 2009 CACREP standards (Hagedorn et al., 2012; Lee, 2014). Hagedorn et al. (2012) noted that CACREP was the first accrediting body to establish a formal, national, set of educational standards related to addiction counseling and the first to strongly advocate for inclusion of addiction-related content for all counseling students, regardless of specialty or focus area. Additionally, Lee (2014) conducted a qualitative study of addiction educators and experts in the field. Findings from that study also addressed the importance of the 2009 CACREP standards and the shift in licensing and credentialing requirements as a result. Lee also found themes regarding concerns for addiction counselor training that included financial status of programs to offer addiction as a specialty, lack of addiction training from faculty members, national and state differences in credentialing requirements, and credit-hour constraints of counselor education programs. The findings from these studies suggest future research is needed to further understand how training impacts addiction counselors and their clients. As

credentialing and accrediting bodies seek to professionalize the addiction workforce, research is needed to examine the effectiveness of this training.

Training and Multicultural Counseling Self-Efficacy

Limited studies have examined MCSE and training in the counseling literature base, and none of those studies have focused on addiction counselors. However, MCSE has been linked to graduate school education and training in counseling trainees (Barden & Greene, 2015; Constantine, 2001). Barden and Greene (2015) found that time in graduate school was a significant predictor of multicultural session management (a subscale of the MCSE-RD) and that doctoral students had higher levels of MCSE than master's students. Other studies have examined multicultural, or cross-cultural, competency in relation to counselor training (Barden et al., 2017; Bellini, 2002; Larson & Bradshaw, 2017). Findings from these studies highlight that higher levels of education, such as a doctorate degree (Barden et al., 2017), and training in multiculturalism (Bellini, 2002; Larson & Bradshaw, 2017) are linked to higher levels of perceived multicultural competence.

As mentioned in previous sections, few studies have been found that examine multicultural competence in addiction counselors. In the one published study found, Lassiter and Chang (2006) surveyed a sample of Certified Substance Abuse Counselors (CSAC's). The authors found that participants with a master's degree or higher were more likely to rate themselves as more multiculturally competent regarding multicultural knowledge but not awareness. This suggests that training needs for addiction counselors are sufficiently imparting knowledge but may be lacking in building counselor self-awareness of how multicultural issues influence the counseling relationship.

Additionally, a dissertation was found (Elamin et al., 2012) that examined cross-cultural competency in substance abuse counselors. Results from that study indicated no significant differences based on education level but noted counselors trained in counseling and social work scored higher than counselors trained in psychology.

Studies examining counselor training and self-efficacy have previously focused on students or entry level trainees (Goreczny et al., 2015; Kozina et al., 2010; Mullen et al., 2015; Simmons et al., 2017). These studies all report findings that illustrate student counseling self-efficacy increases as a result of training and educational instruction. One of the larger studies conducted by Mullen et al. (2010) measured counselor self-efficacy at three different intervals of student training. Their results found that self-efficacy increased as a result of training, but more notably they found no relationship between participants' age, gender, ethnicity or program track and reported self-efficacy at any point. However, there appears to be a gap in the literature when examining counselor self-efficacy and training for counselors already in the workforce.

Studies examining addiction counselor training and self-efficacy are limited. Two of the studies previously mentioned were the only found studies mentioning these variables (Chandler et al., 2011; Greene, 2015). Greene (2015) examined differences in recovering and non-recovering counseling trainees during their master's program. The results of this study found that recovering and non-recovering trainees enter their programs with differing levels of self-efficacy, with non-recovering trainees reporting an increase in self-efficacy as a result of the training program. Chandler et al. (2011) conducted a study examining self-efficacy of licensed counselors to provide substance abuse training. Their study found a lack of relationship between counselor self-efficacy

and training, with counselors reporting high levels of self-efficacy to provide substance abuse services despite having little to no training in that area. However, the researchers suggest future studies that may better explain self-efficacy in this population by examining personal experiences with substance abuse.

Based on the literature reviewed in this section, the amount of training a counselor has received could impact their MCSE. As mentioned previously, more training has been linked to higher levels of self-efficacy and increases in multicultural competence in counselors. Therefore, the unique nature of addiction counselor training warrants further exploration of how it facilitates or hinders MCSE. Addiction counselors with different levels of education, credentials, and multicultural training may differ in their reported MCSE.

Summary

This section provided a conceptual and empirical review of the literature base on addiction counselor training. In addition, this section also reviewed literature connecting counselor training to MCSE, and related constructs (multicultural competency and self-efficacy). This section served to highlight the changing dynamics of addiction counselor training, and the need for increased research on addiction counselor's multicultural competency and MCSE. No published studies were found that examined MCSE in addiction counselors, despite recent movements from accrediting and credentialing bodies discussing the importance of diversity elements in addiction training.

Counselor Demographics

This section will be divided into four parts: race, gender, age, and years of experience. Due to the broadness of each demographic variable, the following sections

will highlight the relevant literature between each demographic variable and the outcome variable (multicultural counseling self-efficacy; MCSE). Rationale for inclusion and implications for the current study will be discussed for each variable.

Race and MCSE

Race and multicultural counseling self-efficacy (MCSE) have been examined sparingly in the counseling literature (Barden & Greene, 2015; Matthews et al., 2018; Soheilan & Inman, 2015), with limited findings. Barden and Greene (2015) in a sample of counseling students found that race was not a significant predictor for MCSE. In a study that examined practicing counselors, Matthews et al., (2018) found small positive relationships between ethnic identity and MCSE, but found that MCSE, not ethnic identity, was a stronger predictor for multicultural competence. Additionally, Soheilan and Inman (2015) used clinical case vignettes to examine multicultural competence, empathy, and MCSE when counseling Middle Eastern American clients. Their findings reported no significant group differences between White trainees and trainees of color. Due to the limited amount of available publications on MCSE, multicultural competence and counselor self-efficacy literature will be included in this section to provide more rationale for inclusion in the current study.

Several recent studies have examined the role of race or ethnicity regarding multicultural competency in counselors (Barden et al., 2017; Campbell et al., 2018; Chao & Nath, 2011; Chao et al., 2011; Fietzer et al., 2018; Hill et al., 2013; Lassiter & Chang, 2006). The majority of these studies highlight significant differences in multicultural competency based on race, with counselors of color or non-white counselors reporting generally higher mean scores (Barden et al., 2017; Campbell et al., 2018; Fietzer et al.,

2018; Hill et al., 2013; Lassiter & Chang, 2006). In the one found study that sampled addiction counselors, Lassiter and Chang (2006) found that Persons of Color reported significantly higher multicultural knowledge scores than Caucasian participants. These findings were similar to a study that examined a national sample of professional counselors (Barden et al., 2017). Additionally, Chao and Nath (2011) found that college counselors with higher levels of ethnic identity were more likely to have higher levels of multicultural competency and engage in more multicultural training.

Other studies have examined race and multicultural competency in counseling trainees or students (Campbell et al., 2018; Chao et al., 2011; Fietzer et al., 2018; Hill et al., 2013). Similar to professional counselors, counseling students of color, or non-White students, reported higher levels of multicultural competency than White students (Campbell et al., 2018; Fietzer et al., 2018; Hill et al., 2013). Hill et al.'s study was able to provide deeper insight into how race impacts multicultural competency by reporting group means for each racial or ethnic group, rather than White vs. non-White. The authors found that African American counselor trainees in their sample reported significantly higher scores than Asian American or Caucasian participants. Additionally, they found that Hispanic participants also reported significantly higher scores than Asian American or Caucasian participants. Additionally, Chao et al. (2011) found that training had a moderating effect on multicultural competency between racial and ethnic minorities and White counseling students. Their study highlighted that training significantly enhances multicultural awareness in White trainees, but not racial or ethnic minority trainees.

The previous studies demonstrated that White counselors or trainees report lower levels of multicultural competency that non-White counselors or trainees. Wei et al. (2012) conducted a study examining counseling students concerns regarding counseling racial minority clients. The authors found that White students reported significantly greater concerns for managing cultural differences, offending or hurting clients, biased thoughts and behaviors, and client perceptions than non-White students. To further understand group differences and disparities in multicultural counseling competency, Delsignore et al. (2010) conducted a qualitative study of White mental health practitioners using critical incidents to examine their attitudes towards diversity and multicultural competency. The findings revealed that White practitioners demonstrated awareness of their attitudes, beliefs, and biases, but found limited instances where practitioners were able to recognize the limits of their skills and expertise regarding multicultural competency. This study may better explain the gap in reported multicultural competency between White and non-White counselors and counselor trainees. Their study also lends support to the notion that higher levels of training in multicultural competency for White counselors significantly impacts their multicultural awareness (Chao et al., 2011).

Similar to multicultural counseling competency, recent studies have examined the role of race or ethnicity in counseling self-efficacy (Hu et al., 2015; Kissil et al., 2013; Lam et al., 2013). These studies largely looked at international samples to better understand how race or ethnicity impacts counselor self-efficacy. Hu et al., (2015) examined counseling self-efficacy in a sample of Chinese counselors. Their findings highlighted the role of cultural norms and factors when looking at counseling self-

efficacy, such as being more goal or task-oriented and focusing on more cognitive related components, rather than emotional experiences. In a study that examined acculturation and counseling self-efficacy, Kissil et al., (2013) sampled foreign-born counselors and found that counselor self-efficacy was linked with perceived prejudice and discrimination. Their findings provided a deeper perspective regarding how counselor self-efficacy is impacted by race or ethnicity. It may be that race or ethnicity in itself is not a significant predictor, but rather the experiences associated with racial and ethnic social factors. Lastly, in a study examining counseling student's self-efficacy, Lam et al., (2013) found significant relationships between race and ethnicity. The authors found that Biracial and African American students reported the highest levels of counseling self-efficacy, followed by Latinx, White, and Asian students. The authors also noted that White students in this sample were not the majority in their program, university, or the community. As with multicultural counseling competency, counseling self-efficacy also appears to have a unique relationship with race or ethnicity.

This section provided a review of relevant literature connecting with race or ethnicity with MCSE, multicultural competence, and counseling self-efficacy. The literature points to significant differences in multicultural competency and self-efficacy between different racial and ethnic groups, with most studies examining White counselors and non-White counselors, or counselors of color. The rationale for inclusion in this study is to further understand how race or ethnicity impacts MCSE in addiction counselors and expand upon the literature base in this area.

Gender and MCSE

Gender and MCSE has been previously examined in the counseling literature with mixed results (Barden & Greene, 2015; Sheu & Lent, 2007). During the initial development and validation of the Multicultural Counseling Self-Efficacy – Racial Diversity Form (MCSE-RD), Sheu and Lent (2007) found statistically significant gender differences across all subscales and total scores. In their sample, men reported higher self-efficacy scores than women. However, the authors mentioned that males also reported more contact hours with racially diverse clients and more involvement in multicultural counseling workshops than did females. Conversely, Barden and Greene (2015) found no significant differences based on gender regarding total scores on the MSCE-RD in a sample of counselor trainees. Of note is the differences in sample demographics for each study, with Sheu and Lent (2007) having a majority male sample (53%) compared to Barden and Greene (2015) having 80.7% of their sample as female.

Other studies have examined gender in relation to multicultural counseling competency constructs with similarly mixed findings (Campbell et al., 2018; Chao & Nath, 2011; Chao et al., 2011; Fietzer et al., 2018; Hill et al., 2013; Wei et al., 2012). Several studies found no significant differences based on gender and multicultural competency (Campbell et al., 2018; Chao et al., 2011; Hill et al., 2013; Wei et al., 2012). However, while Chao and Nath (2011) found no significant differences based on gender for multicultural competency scores, they did find that college counselors with higher levels of gender roles reported higher levels of multicultural competency and more engagement in multicultural training. In a study looking at multicultural personality and multicultural counseling competency in counseling students, Fietzer et al., (2018) found

that gender was a significant predictor of sociocultural diversity, though reported demographic variables accounted for a small portion of the explained variance in their model. These studies highlight gender differences may be affected by other variables or a function of the current sample, thus more research is needed with future sample populations.

In addition to MCSE and multicultural competency, other recent studies have examined the role of gender in counseling self-efficacy (Alessi et al., 2016; Lam et al., 2013). Similar to the studies mentioned above, findings have been mixed. Lam et al., (2013) examined counseling self-efficacy in counselor trainees and reported no statistical differences based on gender for total or subscale scores. Additionally, the authors reported that mean scores between males and females were separated by less than one point, suggesting minimal differences. However, Alessi et al., (2016) reported significant gender differences in affirmative counseling self-efficacy for mental health therapists' working with sexual minority individuals. In their study, males reported significantly lower scores than females regarding affirmative attitudes and affirmative counseling self-efficacy.

This section provided an overview of recent literature pertaining to gender and MCSE, multicultural competency, and counseling self-efficacy. The literature has produced mixed findings regarding the impact gender has on these constructs, which may be a function of sampling, instrumentation, or other factors. The rationale for inclusion in this study is that gender is a cultural construct that may produce differences when examining MCSE, and to compare results to previously mentioned findings.

Experience and MCSE

The counseling literature examining experience and MCSE is limited, with mixed findings (Barden & Greene, 2015; Holcomb-McCoy et al., 2008; Matthews et al., 2018; Toomey & Storlie, 2016; Sheu & Lent, 2007). Two studies examining graduate students found that time spent in graduate school was significantly correlated with higher MCSE scores (Barden & Greene, 2015; Sheu & Lent, 2007). More specifically, time spent in graduate school was associated with more multicultural course work, supervision, and direct clinical experience with racially diverse clients (Sheu & Lent, 2007). In the two studies that sampled school counselors, results were mixed, with one finding statistically significant differences based on years of experience (Toomey & Storlie, 2016) and the other reporting no significant differences (Holcomb-McCoy et al., 2008). However, both studies reported that the number of multicultural courses taken was associated with higher MCSE score. Lastly, Matthews et al. (2018) conducted a study of practicing counselors examining multicultural competency, MCSE, and ethnic identity development. Although the authors did not examine years of experience directly, they reported a potential mediating effect between ethnic identity and years of experience on MCSE, as over 50% of their sample had over five years of clinical experience.

Other studies have examined experience in relation to multicultural competency (Owens et al., 2010; Vespia et al., 2010) or working with diverse clients (Alessi et al., 2016; Couture, 2017; Wei et al., 2012). Years of experience was found to be a significant predictor of multicultural competency for school (Owens et al., 2010) and career counselors (Vespia et al., 2010). Two studies examined self-efficacy (Alessi et al., 2016) and preparedness (Couture, 2017) when working with sexual minorities or transgender

individuals. Alessi et al. (2016) found that years of experience positively correlated with higher levels of counseling self-efficacy in applying LGB affirmative knowledge. However, Couture (2017) reported no significant differences regarding years of experience and counselor preparedness to work with transgender individuals. Lastly, Wei et al. (2012) examined graduate students concerns about counseling racial minority clients. The authors found that years of experience was only significantly associated with managing cultural differences (subscale), stating that graduate students with more training reported fewer concerns in managing cultural differences in session.

This section served to provide an overview of relevant literature examining years of experience and MCSE, and related constructs. The results from the studies mentioned above highlight some interesting findings. Though some of the results were mixed, there was a general trend suggesting that time spent in graduate school was positively associated with higher levels of MCSE or multicultural competency when working with diverse populations. Furthermore, multicultural coursework was mentioned several times as a significant predictor. It may be that years of experience and MCSE is moderated by the amount of multicultural training counselors engage in. Inclusion in the current study hopes to add more information to the literature base regarding how years of experience relates to MCSE.

Age and MCSE

Age and MCSE has been minimally explored in the counseling literature. The only found study that reported detailed findings between these two variables was the initial scale development of MCSE-RD (Sheu & Lent, 2007). The authors reported significant relationships between age and two of the instrument's subscales (multicultural

intervention and session management). These findings indicate that older individuals may have more exposure to racially diverse clients and individuals as a product of life experience. The rationale for inclusion in this study was to be able to look at years of experience and age separately, as older individuals may have entered the counseling profession later in life.

Other studies have examined age as it relates to multicultural counseling competency or working with diverse clients (Campbell et al., 2018; Chao et al., 2011; Wei et al., 2012). While these studies reported slight differences, no statistical significance was found between age and multicultural counseling competence (Campbell et al., 2018; Chao et al., 2011) or counseling racial minority clients (Wei et al., 2012). Counselor age has also been examined in relation counseling self-efficacy in recent literature (Lam et al., 2013; McCarthy, 2014). McCarthy (2014) examined counseling self-efficacy in a sample of rehabilitation counselors and found a significant positive association. While Lam et al. (2013) did not find significant associations between age and counseling self-efficacy, they did report several findings that approached significance. The authors reported that the age range 30-39 reported the highest levels of counseling self-efficacy in their sample, compared to 19-22, 23-29, or 40 and above. These results are interesting and suggest there may be some sort of peak effect in relation to age and counseling self-efficacy. Their findings may also explain the lack of significance reported in other studies.

This section provided a brief review of relevant literature pertaining to age and MCSE. Though the literature base is scarce in this area, findings suggest there may be group differences based on age or age categories. Inclusion in this study is to further

examine the influence age may have on MCSE in addiction counselors, as no found published studies have reported these results.

Summary

This section provided a review of relevant literature on the relationship between counselor demographics and MCSE. More specifically, counselor race or ethnicity, gender, years of experience, and age were discussed in relation to MCSE. This section served to highlight the potential differences in counselor demographics and group membership. Results for each variable produced mixed findings. There were no found published studies that examined these variables in relation to MCSE in addiction counselors.

Chapter Summary

This chapter further introduced the population of interest, addiction counselors, and the theoretical basis for this study, self-efficacy theory. Additionally, a conceptual and empirical review of the literature for the dependent (or outcome) variable, MCSE, was discussed. The final three sections examined the literature base of the independent (or predictor) variables, recovery status, training, and counselor demographics and the relationship between each predictor and MCSE. The lack of published studies found that examine these constructs, with no published studies found that examine MCSE in addiction counselors, warrants a need for the current study.

CHAPTER III: METHODOLOGY

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. More specifically, how does counselor recovery status, level of training (credentials, education level, CACREP attendance, and multicultural training) and counselor demographics explain multicultural counseling self-efficacy in addiction counselors. This chapter describes the methodology used in this study. This chapter will include a discussion of study participants, procedures, instrumentation, research design, and data analysis.

Participants

The sample of participants for this study were addiction counselors recruited from a state credentialing board. North Carolina was chosen for this study due to being recognized for its credentialing standards and tiered certification licensure system (Lassiter & Chang, 2006; Miller et al., 2010; Morgen et al., 2012). The North Carolina Professional Practice Board has a long history of advanced credentials and higher training standards for addiction counselors (P. Lassiter, personal communication, June 23rd, 2020). Participants were contacted via email with a request to complete an online survey. Inclusion criteria for this survey included: (a) at least 18 years old, (b) currently practicing as an addiction counselor, and (c) holds a professional license or certification as an addiction counselor.

A total of 8,332 emails were sent out to prospective participants, with 49 of those being returned as invalid, retired professionals, or no longer practicing. These 49 were removed resulting in a final recruitment sample of 8,283. A total of 393 addiction

counselors responded to the survey, resulting in a response of 4.7%. The majority of participants in this study identified as Caucasian (62.6%) and female (71.8%). Participants ranged in age from 22 to 82, with a mean of 48 years and standard deviation of 12. Participants indicated if they worked in a rural (32.3%), urban (37.7%), or suburban (28.5%) setting. Table 1 displays frequencies and percentages of categorical demographic variables.

The majority of participants indicated they held a master's degree (74.3%) and were fully licensed (51.1%). Additionally, about half the sample indicated they did not graduate from a CACREP program (46.3%). Most participants indicated that they had taken two to three multicultural courses (34.4%) and seven or more multicultural trainings (32.8%). Participants ranged in years of experience from one to 45, with a mean of 13.5 and standard deviation of 10.6. The majority of participants in this sample indicated that they were not in recovery from a chemical substance (65.1%).

Table 1: Demographics of Participants

Variable	Number of responses (*N*=393)	Percentage
Gender		
Female	282	71.8%
Male	104	26.5%
Racial Identity		
Caucasian	246	62.6%
African American	104	26.5%
Multiracial	13	3.3%
LatinX	12	3.1%
Native American	4	1%
Asian American	1	0.3%
Other	6	1.5%
Education		
High School	9	2.3%
Associate's	13	3.3%

Bachelor's	39	9.9%
Master's	292	74.3%
Educational Specialist	4	1%
Doctorate	33	8.4%
Credential		
Certification	79	20.1%
Provisional License	107	27.2%
Fully Licensed	201	51.1%
CACREP Graduate		
Yes	177	45%
No	182	46.3%
Multicultural Courses		
0-1	78	19.8%
2-3	135	34.4%
4-5	73	18.6%
6+	57	14.5%
Multicultural Trainings		
0-2	78	19.8%
3-4	64	16.3%
5-6	68	17.3%
7+	129	32.9%
Recovery Status		
In Recovery	129	32.8%
Not in Recovery	256	65.1%

Procedures

University Institutional Review Board approval was sought for this investigation through the University of North Carolina at Charlotte. A purposeful sampling method was used to identify and recruit addiction counselors from a state (NC) credentialing board list. Purposeful sampling was selected due to the entire sample meeting the qualification of being an addiction counselor, with the purpose of the study examining relationships in this population, so shared characteristics are anticipated (Mertens, 2015).

All participants were contacted via email with information about the study, eligibility requirements, and a link to the survey and informed consent.

An online survey was created utilizing SurveyShare for administration and data collection. The link to the online survey was sent out to all prospective participants obtained in the email lists mentioned above. A multiple contact e-mail survey strategy was utilized to maximize response rates as outlined by Dillman et al. (2014). An initial email containing the survey introductory letter (see Appendix A) and participation requests was first sent to all prospective participants. The introductory letter served to address the purpose of the study and eligibility requirements. Following the letter, a link to the survey was provided. Additional waves of emails were utilized with a personalized subject line, once per week for two weeks following the initial request, to capture a robust sample size (Dillman et al., 2014). SurveyShare allowed repeated waves to be sent out to those who have not responded to the survey. Upon clicking on the survey link participants were asked to acknowledge study information and informed consent materials (see Appendix B) prior to proceeding to the survey.

Survey design and implementation utilized techniques outlined by Dillman et al. (2014) to maximize response rates. Dillman et al. (2014) suggested using: a motivational introduction or welcoming screen, a method for limiting access only to people in this sample, a consistent page and question format, minimal color variations or backgrounds, specific instructions, and formats that do not require an answer to each question in order to proceed. The current study included an introductory screen welcoming participants to the survey, with a clear method for proceeding. To limit access to only people in this sample, SurveyShare utilizes a function where participants use their email address for

access to the survey but does not associate those email addresses with participant responses. The web-survey was designed in a question format based on the instrument being used in this study (MCSE-RD, Sheu & Lent, 2007). The formatting remained the same for each item, and instructions for how to best complete the survey were included. Lastly, participants were not required to answer each question in order to complete the survey.

Participation in this study was voluntary and participants could withdraw at any time. Email addresses were not associated with participant responses and no identifying information was collected during this investigation. All collected data was securely stored on a password protected drive. A G*Power analysis was performed to determine a minimum sample size for this study of 158, based on the predictor variables, power of 0.95, anticipated effect size (f^2) of 0.10 and α of .05.

Instrumentation

One instrument was used in this study to address the research questions: the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MSCE-RD, Sheu & Lent, 2007; see Appendix D). A demographics form was also used to gather participant information and verify study eligibility. Recovery status will be measured as a yes or no response on the demographics form. Training will be measured based on participants' responses to education level, credentialing information, CACREP attendance, and multicultural courses and trainings completed.

A demographics form was created to collect information regarding participants' age, race and ethnicity, gender, sex, professional credentials, education, years of experience, work setting, CACREP attendance, multicultural courses and trainings

completed, and recovery status (see Appendix C). Responses were not tracked to participants emails and no identifying information was collected in this study.

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD)

Multicultural counseling self-efficacy was assessed using the Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD, Sheu & Lent, 2007). The MCSE-RD consists of 37 items that measure multicultural counseling self-efficacy across three subdomains: (a) multicultural intervention, (b) multicultural assessment, and (c) multicultural session management (Sheu & Lent, 2007). The MCSE-RD has been found to have good internal reliability, with subscales ranging from .92 to .98 and MCSE-RD total scores producing a Cronbach's alpha of .98 (Sheu & Lent, 2007). Other studies using the MCSE-RD have found similar results and reported reliable psychometric properties (Barden & Greene, 2015; Greene et al., 2014; Matthews et al., 2014). The MCSE-RD was validated on a sample of 181 counseling graduate students who were enrolled in clinical courses, or in later stages of their program, and found to have good discriminant and criterion validity across scales (Sheu & Lent, 2007). The MCSE-RD asks participants to rate their ability to perform different counseling behaviors with clients who are racially different on a 10-point Likert scale ranging from no confidence at all (0) to complete confidence (9) (Sheu & Lent, 2007). Sample questions include asking participants to rate their confidence on "remaining flexible and accepting in resolving cross-cultural strains or impasses" and "conducting a mental status exam in a culturally sensitive way" (Sheu & Lent, 2007, see Appendix D). Total and subscale scores were used in this study.

Research Design

This study utilized a quantitative non-experimental correlational design to explore relationships between the study variables. Specifically, a structural equation model design using a multiple-indicators and multiple-causes (MIMIC) model was utilized to examine the influence of the predictor or explanatory variables (recovery status, training, and counselor demographics) on multicultural counseling self-efficacy (outcome or dependent variable) in addiction counselors. A self-report survey research design was used for data collection purposes.

Research Questions

The following research questions were addressed in this study:

1. What are addiction counselors' levels of multicultural counseling self-efficacy?
2. Is there a difference between recovering and non-recovering counselors' levels of multicultural counseling self-efficacy?
3. Are there differences in levels of multicultural counseling self-efficacy based on training?
4. Are there differences in levels of multicultural counseling self-efficacy based on counselor demographics?
5. What is the influence of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy?

Data Analysis

A MIMIC model was utilized to answer the primary research question: What is the influence of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy? MIMIC models allow for analysis of both causal

and effect indicators simultaneously using regression properties (Kline, 2016). The data was downloaded from SurveyShare and uploaded into SPSS version 26 for screening, cleaning, and preliminary analysis. SPSS Amos Graphics version 26 was utilized to analyze the MIMIC model. Descriptive statistics, frequencies, and correlations were conducted to examine sample characteristics and relationship strength among variables of interest. Table 2 displays how each demographic variable was coded in this study. Age, experience, MCSE total scores, and MCSE subscales were used as string (or continuous) variables.

Table 2: Coding for Categorical Variables

Variable	Code
Gender	
Male	0
Female	1
Racial Identity	
Caucasian	0
Person of Color	1
Education (Ordinal)	
High School	1
Associate's	2
Bachelor's	3
Master's	4
Educational Specialist	5
Doctorate	6
Credential (Dummy coded)	
Certification (full licensure as reference)	1
Provisional (full licensure as reference)	1
CACREP Graduate	
No	0
Yes	1
Multicultural Courses (Ordinal)	
0-1	1
2-3	2
4-5	3
6+	4
Multicultural Trainings (Ordinal)	
0-2	1

3-4	2
5-6	3
7+	4
Recovery Status	
Not in Recovery	0
In Recovery	1

Data Screening

Prior to analysis, the data was screened for missing values, outliers, and multivariate statistical assumptions (Hahs-Vaughn, 2017). Statistical assumptions for primary variables was conducted prior to analysis. For multivariate models, this involved screening for (a) independence, (b) homoscedasticity, (c) normality, (d) linearity, and (e) collinearity (Hahs-Vaughn, 2017). This involved an examination of skewness and kurtosis, scatterplots, box plots, histograms, and residual statistics for all study variables. Upon satisfaction of assumptions, primary variables were used to construct the MIMC model in Amos version 26.

Chapter Summary

This chapter outlined the research methodology for this study. A description of study participants, data collection procedures, and instrumentation was provided. Additionally, the research design and data analysis strategy utilized was discussed. This study recruited a sample of addiction counselors via email to participate in a web-based survey regarding factors contributing to multicultural counseling self-efficacy. A MIMIC model was used for primary data analysis.

CHAPTER IV: RESULTS

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. More specifically, this study sought to examine differences in multicultural counseling self-efficacy in recovering and non-recovering counselors, among differing levels of training (certified or licensed, education level, CACREP attendance, and multicultural training), and counselor demographics (race, gender, age, and years of experience). In addition, this study sought to examine the amount of model variance counselor recovery status, training, and counselor demographics explain in multicultural counseling self-efficacy.

This study was guided by five research questions:

1. What are addiction counselors' levels of multicultural counseling self-efficacy?
2. Is there a difference between recovering and non-recovering counselors' levels of multicultural counseling self-efficacy?
3. Are there differences in levels of multicultural counseling self-efficacy based on training?
4. Are there differences in levels of multicultural counseling self-efficacy based on counselor demographics?
5. What is the influence of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy?

This chapter presents the results of this research study and is divided into five sections. The first section describes the instrument reliability estimates for total and subscale scores. The second section covers the process of data screening and assumption

testing. Third, descriptive statistics for instrument variables are discussed. Fourth, correlations for all study variables are provided. Last, results from the MIMIC model analysis are provided. A summary of findings and model results are provided at the conclusion of this chapter.

Instrument Reliability

The Multicultural Counseling Self-Efficacy Scale--Racial Diversity Form (MCSE-RD, Sheu & Lent, 2007) was the only instrument used in this study. The MCSE-RD has been previously found to have good internal reliability for total and subscale scores (Sheu & Lent, 2007). To assess for instrument reliability in this study, Cronbach's alpha (α) was calculated for total and subscale scores. Table 3 displays the Cronbach's alpha for this study. Reliability estimates ranged from .912 to .965, consistent with findings from previous studies (Barden & Greene, 2015; Greene et al., 2014; Matthews et al., 2014; Sheu & Lent, 2007).

Table 3: Reliability Estimates for MCSE-RD

Instrument Scale	Number of Items	Cronbach's α
MCSE-RD Total	37	.965
Multicultural Intervention - Subscale	24	.962
Multicultural Assessment - Subscale	6	.918
Multicultural Session Management - Subscale	7	.912

Data Screening

All data was downloaded from SurveyShare and uploaded into the Statistical Package for Social Sciences (SPSS) version 26 for screening. Data was screened for missing values, outliers, and multivariate statistical assumptions (Hahs-Vaughn, 2017). These assumptions included normality, homoscedasticity, linearity, independence, and

collinearity. The following sections will discuss the processes utilized for data screening and assumption testing.

Missing Values

A missing values analysis (MVA) was conducted to examine patterns and percentages of missing data for scale items. A total of 134 item responses were missing from the original data set (N=393). No item exceeded 3% in missing data. Results from the Little's Missing Completely at Random (MCAR) test was nonsignificant (χ^2=1806.23, *df*=1741, *p*=.14), indicating the data was missing completely at random. Next, based on the results of the MVA, multiple imputations were utilized to replace missing values. The imputed data set was saved and "imputation 5" was used for primary data analysis. Since demographic variables were used as primary variables in this study, all cases with missing demographic information were removed from the final analysis, resulting in a final sample size of 286. Table 4 displays the adjusted demographic values of the final sample, after the removal of extreme outliers. The majority of the sample identified as female, Caucasian, and held a master's degree.

Table 4: Demographics of Participants

Variable	Number of responses (*N*=283)	Percentage
Gender		
Female	213	75.3%
Male	70	24.7%
Racial Identity		
Caucasian	181	64%
African American	81	28.6%
Multiracial	8	2.8%
LatinX	8	2.8%
Native American	4	1.4%
Asian American	1	0.4%
Education		
High School	5	1.8%

Associate's	10	3.5%
Bachelor's	25	8.8%
Master's	225	79.5%
Educational Specialist	2	0.7%
Doctorate	16	5.7%
Credential		
Certification	50	17.7%
Provisional License	86	30.4%
Fully Licensed	147	51.9%
CACREP Graduate		
Yes	148	52.3%
No	135	47.7%
Multicultural Courses		
0-1	63	22.3%
2-3	115	40.6%
4-5	57	20.1%
6+	48	17%
Multicultural Trainings		
0-2	62	21.9%
3-4	56	19.8%
5-6	63	22.3%
7+	102	36%
Recovery Status		
In Recovery	84	29.7%
Not in Recovery	199	70.3%

Outliers

The data was screened for univariate and multivariate outliers by examining box plots for each study variable and Mahalonobis Distance. One univariate extreme outlier for continuous variables was found and removed from the final data set. Next, Mahalonobis Distance and chi-square distribution testing was conducted to examine multivariate outliers. Two cases were identified as being multivariate outliers (chi-square distribution $p<.001$). These cases were removed from the data set, resulting in a final sample size of 283.

Statistical Assumptions

All assumptions tests were conducted in SPSS version 26. For multivariate models, this involved screening for (a) independence, (b) homoscedasticity, (c) normality, (d) linearity, and (e) collinearity (Hahs-Vaughn, 2017). To assess the independence of observations residual plots of predicted values were examined. Studentized residuals and unstandardized predicted values were graphed for the dependent variables (MCSE total and subscale scores) and each predictor variable. The majority of scores fell randomly between positive and negative two, satisfying the assumption of independence (Hahs-Vaughn, 2017). Homoscedasticity was also assessed by examining residual plots to determine that scores fell randomly (or constant) across independent variables. No patterns were observed, thus satisfying the assumption of homoscedasticity. Additionally, Box's *M* test was nonsignificant for each independent variable.

To assess for normality, normal probability plots, frequency distributions, and skewness and kurtosis statistics were consulted. The probability, or Q-Q plots, revealed the majority of data points fell along a straight diagonal line for each variable. Ordinal variables had a slight deviation from this line. Additionally, skewness and kurtosis statistics were examined for each variable. No skewness values were found exceeding positive or negative 1.08 and no kurtosis values exceeded positive or negative 1.56, indicating the assumption of normality was met (Hahs-Vaughn, 2017).

Next, assumptions of linearity and noncollinearity were examined. Linearity was analyzed by referring to the residual plots used for independence and homogeneity testing. A scatter plot matrix was also conducted to examine linearity of the dependent

variables (MCSE total and subscale scores). The majority of scores fell along a straight diagonal line across all dependent variables, satisfying the assumption of linearity. Tolerance statistics and variance inflation factor (VIF) scores were examined to screen for noncollinearity. Tolerance statistics ranged from .464-.949 and no VIF statistic exceeded 2.16, satisfying the assumption of noncollinearity (Hahs-Vaughn, 2017). Next, descriptive statistics and bivariate correlations were analyzed for all study variables.

Descriptive Statistics

This section highlights the descriptive statistics of the final sample size used for the primary analysis (*N*=283). Descriptive statistics (see Table 5) were used to address the first research question for this study: what are addiction counselors' level of multicultural counseling self-efficacy? Multicultural counseling self-efficacy (MCSE) was assessed using the Multicultural Counseling Self-Efficacy Scale--Racial Diversity Form (MCSE-RD, Sheu & Lent, 2007). The MCSE-RD consists of 37 items that measure multicultural counseling self-efficacy across three subdomains: (a) multicultural intervention, (b) multicultural assessment, and (c) multicultural session management. The MCSE-RD asks participants to rate their ability to perform different counseling behaviors with clients who are racially different on a 10-point Likert scale ranging from no confidence at all (0) to complete confidence (9). Participants in this study, on average, reported high levels of MCSE (*M*=7.26, *SD*=1.02), with 64% of the sample having scores over 7.

Subscale scores were analyzed to further understand addiction counselors' MCSE. Multicultural intervention is a subscale on the MCSE-RD consisting of 24 items and examines how confident the counselor is using interventions in a culturally sensitive and

appropriate manner, and how to intervene when cultural constrains may be present. Sample questions ask participants to rate their confidence on "assessing the meaningfulness of culture or race in the client's life" and "managing your own anxiety due to cross-cultural impasses that may arise during session." Overall participants rated their confidence in performing multicultural interventions in session favorably (*M*=7.47, *SD*=.98).

Additionally, multicultural assessment and multicultural session management subscales were assessed. The multicultural assessment subscale consists of six items that measure how confident counselors are at using assessment tools in a culturally sensitive way. Participant scores on this subscale had a greater range and were lower than any other scale (*M*=5.63, *SD*=2.07), indicating a good amount of variance in this sample's confidence regarding multicultural assessment. Finally, the multicultural session management subscale consists of seven items that measures how confident the counselor is regarding evaluation of counseling sessions, empowering clients to take an active role in session, and preparing clients for termination. Overall, participants reported their confidence to conduct these tasks higher than either of the other scales (*M*=7.95, *SD*=.89), indicating counselors in this sample are confident in their ability to manage sessions effectively. This could be due to the nature of the questions reflecting general counseling skills that may be more applicable cross-culturally.

Table 5: Descriptive Statistics for Scale Variables

Variable	*M*	*SD*	Range	Minimum	Maximum
MCSE-RD	7.26	1.02	5.35	3.65	9
Multicultural Intervention	7.47	.98	5.76	3.25	9
Multicultural Assessment	5.63	2.07	9	0	9
Multicultural Session Management	7.95	.89	4.14	4.86	9

Correlations

To examine bivariate correlations between predictor and outcome variables, a Pearson product coefficient was conducted. Several significant correlations emerged between study variables. Among the predictor variables, gender was positively associated with age (r=.201, p<.01), years of experience (r=.136, p<.05), and recovery status (r=.201, p<.01). The correlations suggest that on average, males were older, had more years of experience, and were more likely to be in recovery than females in this sample. Age, in addition to gender, had significant relationships with years of experience (r=.644, p<.01), recovery status (r=.266, p<.01), CACREP attendance (r=-.120, p<.05), multicultural trainings (r=.150, p<.05), provisional licensure (r=-.135, p<.05), MCSE (r=.145, p<.05), multicultural intervention (r=.140, p<.05), and multicultural assessment (r=.123, p<.05). Notable inferences from these results indicate that older participants were less likely to graduate from a CACREP program or be provisionally licensed but reported higher MCSE scores (total and first two subscales).

Looking at race, Persons of Color had several significant positive relationships with multicultural variables. Persons of Color in this sample were more likely to have taken more multicultural courses (r=.210, p<.01) and report higher MCSE scores across

all scales (r=.245, p<.01; r=.218, p<.01; r=.236, p<.01; r=.193, p<.01). Additionally, Persons of Color were more likely to hold provisional licenses (r=.208, p<.01). Years of experience also had several significant relationships. Participants with more years of experience were likely to have a higher level of education (r=.154, p<.01), have completed more multicultural trainings (r=.314, p<.01), and be fully licensed (r=-.137, p<.05; r=-.197, p<.01). Additionally, participants with more years of experience were likely to report higher scores on MCSE (r=.152, p<.05), multicultural intervention (r=.154, p<.01), and multicultural session management (r=.208, p<.01).

Counselor recovery status had significant correlations with education and credentials. Counselors in recovery were more likely to have lower levels of education (r=-.269, p<.01) and to hold a certification (r=.206, p<.01) instead of a license (r=-.143, p<.05). Additionally, education had significant correlations with CACREP attendance (r=.213, p<.01), certification (r=-.596, p<.01), provisional licensure (r=.156, p<.01), MCSE (r=.133, p<.05), and multicultural assessment (r=.156, p<.01). These correlations suggest that participants who completed a higher level of education were more likely to have graduated from a CACREP program, hold a provisional or full license rather than a certification, and report higher scores on the MCSE and multicultural assessment subscale than those with lower levels of education. Regarding CACREP attendance, participants who reported graduating from a CACREP program reported taking less multicultural courses (r=-.142, p<.05) than non-CACREP graduates. CACREP graduates in this study were also more likely to hold a provisional or full license rather than a certification (r=.123, p<.05; r=-.337, p<.01) and to report higher scores on the multicultural assessment subscale (r=.127, p<.05).

Multicultural education (courses and trainings) produced several significant correlations. Participants with higher reported multicultural courses also reported participating in more multicultural training opportunities (r=.305, p<.01). Somewhat surprising was findings that participants who reported taking more multicultural courses were more likely to hold a certification than a license (r=.140, p<.05), while participants who reported engaging in more multicultural training opportunities were more likely to be certified or fully licensed than hold a provisional license (r=-.154, p<.01). Looking at MCSE and subscale scores, there were positively significant relationships for multicultural courses and training across all scales (p<.01). Regarding credentialing, the only significant relationship found was participants that held a certification were more likely to report lower scores on the multicultural assessment subscale (r=-.127, p<.05). There were no significant correlations between provisional licensure and MCSE scores.

Lastly, the Pearson product correlation coefficient presented significant positive relationships between the outcome variable (MCSE) and instrument variables (subscales). MCSE had strong positive correlations with multicultural intervention (r=.962, p<.01), multicultural assessment (r=.826, p<.01), and multicultural session management (r=.791, p<.01). Additionally, multicultural intervention was positively correlated with multicultural assessment (r=.666, p<.01) and multicultural session management (r=.737, p<.01). Multicultural assessment and multicultural session management were also positively correlated (r=.510, p<.01).

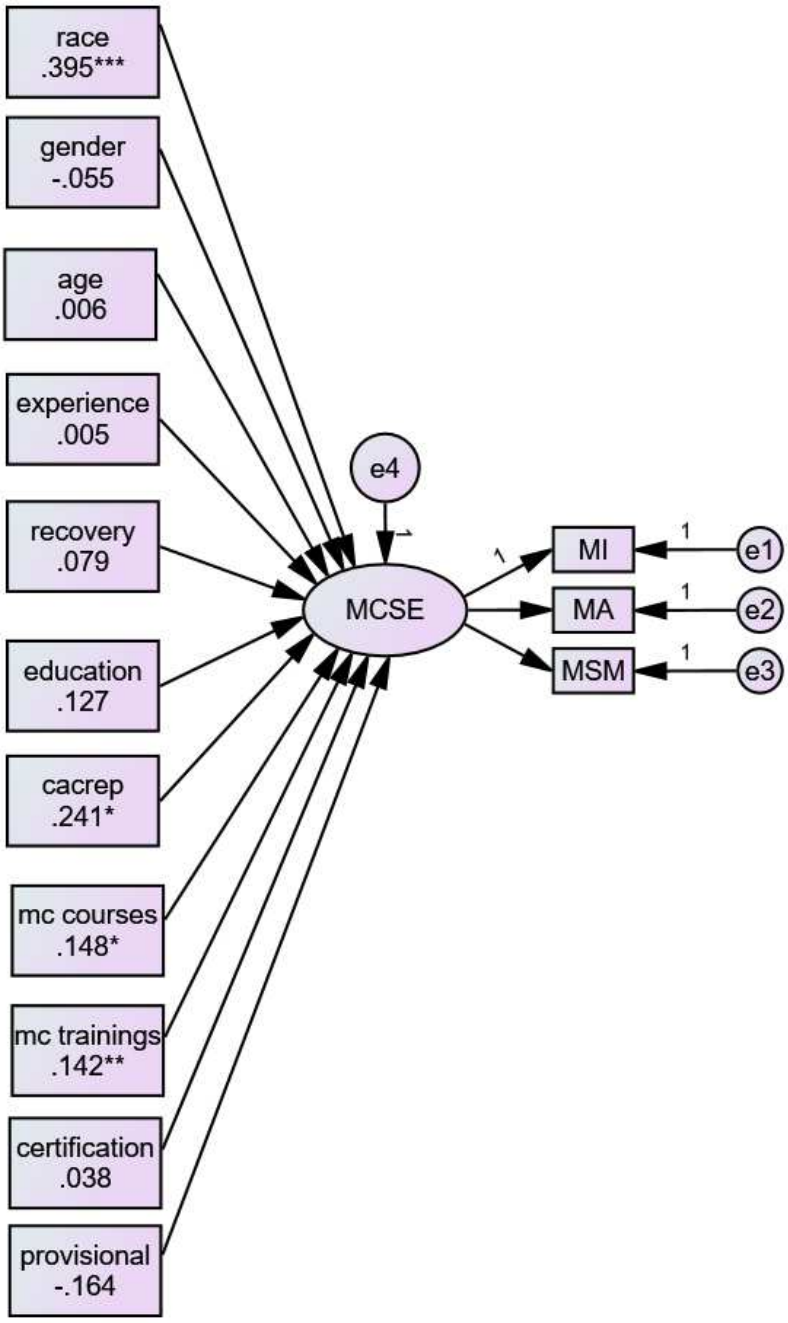
MIMIC Model Analysis

A multiple-indicators multiple-causes (MIMIC) model was conducted to examine research questions two through five, listed above. All data was uploaded into SPSS Amos

Graphics version 26 for analysis. Prior to conducting the MIMIC model, a confirmatory factor analysis (CFA) was conducted to examine the initial measurement model of the dependent variables. MCSE total scores was entered as the latent variable with each subscale (multicultural intervention, multicultural assessment, and multicultural session management) acting as indicators. The model was just identified (df=0), meaning the number of free parameters and known values were equal (Kenny, 2011), but produced good local fit. All regression estimates were positive and statistically significant.

Next, the MIMIC model was built by adding the predictor variables to the CFA model. Figure 1 displays the unstandardized conceptual model tested for this study (note that the actual model tested allowed for covariances between all predictor variables). The model fit indices indicated an acceptable fit: (χ2=39.957, df =22, p=.012, GFI=.981; RMSEA= .053 [90%CI, .025 to .080], CFI=.982; SRMR=.0232). An examination of the standardized residual covariances found no values exceeding two, indicating good local fit. Error variances for subscales were as follows: multicultural intervention (.088, p<.05), multicultural assessment (2.20, p<.001), and multicultural session management (.32, p<.001). Table 9 displays the regression weights for each path tested and their significance level. Four of the paths were statistically significant: race, coded Persons of Color (.395, p<.001), CACREP attendance (.241, p<.05), number of multicultural courses (.148, p<.05), and number of multicultural trainings (.142, p<.01).

Figure 1: MIMIC Model



Note: *p<.05, **p<.01, ***p<.001

To examine the second research question, path coefficients were examined. Based on the model findings, there were no significant differences between counselors in recovery and counselors not in recovery in this sample regarding their MCSE (.079, p=.540). However, counselors in recovery reported slightly higher mean scores for all scales except multicultural assessment (see Table 6).

Table 6: Descriptive Statistics based on Recovery Status

	Not in Recovery (N=199)		In Recovery (N=84)	
Scale	Mean	*SD*	Mean	*SD*
MCSE Total	7.25	1.05	7.28	.95
Multicultural Intervention	7.46	1.01	7.50	.92
Multicultural Assessment	5.64	2.08	5.60	2.05
Multicultural Session Management	7.94	.94	7.97	.77

Next, training variables (education, credentials, CACREP attendance, and multicultural courses and trainings) were examined to see if there were any differences in MCSE. Table 7 displays means and standard deviations for training variables. There were no significant differences based on education (.127, p=.143), though participants with a doctorate degree did report slightly higher mean scores across all scales except for multicultural assessment. There were also no significant differences in MCSE based on credentials: certification (.038, p=.843) and provisional (-.164, p=.205). However, fully licensed participants reported higher mean scores across all scales except for multicultural assessment. There was a significant difference between participants who graduated from a CACREP program and those that did not (.241, p<.05), with CACREP graduates having a higher total MCSE. Lastly, there were significant differences regarding the number of multicultural courses (.148, p<.05) and trainings completed

(.142, $p<.01$) on MCSE total scores. Participants in this sample who reported taking six or more multicultural courses or seven or more multicultural trainings had significantly higher MCSE total scores than those with lesser amounts of multicultural courses or trainings.

Table 7: Descriptive Statistics based on Training

		MCSE Total		Multicultural Intervention		Multicultural Assessment		Multicultural Session Management	
Variable	*N*	Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*
Education									
High School	5	6.75	.79	7.06	.50	4.8	2.64	7.37	.92
Associate's	10	7.40	.88	7.67	.77	5.57	2.0	8.03	.64
Bachelor's	25	6.94	1.14	7.27	1.09	4.49	2.75	7.89	.88
Master's	225	7.26	1.0	7.45	.97	5.71	1.92	7.95	.90
Specialist	2	7.42	.29	7.42	.24	6.83	.47	7.92	1.12
Doctorate	16	7.78	1.16	8.02	1.06	6.45	2.39	8.10	1.02
Credentials									
Certification	50	7.13	1.05	7.44	.95	5.06	2.49	7.83	.90
Provisional	86	7.20	1.05	7.36	1.02	5.77	1.90	7.86	1.02
Licensed	147	7.34	1.0	7.54	.97	5.73	1.98	8.03	.81
CACREP									
No	135	7.15	1.07	7.38	1.03	5.35	2.23	7.91	.87
Yes	148	7.36	.97	7.55	.93	5.88	1.88	7.98	.91
MC Courses									
0-1 courses	63	6.99	1.05	7.27	1.06	4.97	1.93	7.72	.96
2-3 courses	115	7.17	1.02	7.38	.98	5.54	2.01	7.86	.88
4-5 courses	57	7.28	1.03	7.46	.96	5.72	2.22	7.98	.92
6+ courses	48	7.82	.78	7.96	.75	6.58	1.87	8.39	.63
MC Trainings									
0-2 Trainings	62	6.87	1.18	7.12	1.19	4.91	2.10	7.67	1.02
3-4 Trainings	56	7.18	1.07	7.35	1.04	5.76	2.01	7.80	1.0
5-6 Trainings	63	7.17	.98	7.37	.90	5.53	2.04	7.90	.79
7+ Trainings	102	7.60	.81	7.81	.74	6.04	2.01	8.23	.73

To address the third research question path coefficients for age, gender, race, and years of experience were analyzed. Table 8 displays means and standard deviations for categorical demographic variables. There were no significant differences in MCSE score based on age (.006, p=.365), gender (-.055, p=.666), or years of experience (.005, p=.494). However, mean scores for this sample indicated that older individuals, males, and participants with more years of experience tended to rate their confidence higher than younger participants, females, and those with lesser amounts of clinical experience. Race was the only demographic variable that was statistically significant (.395, p<.001) regarding MCSE total scores, with Persons of Color scoring higher than Caucasian participants.

Table 8: Descriptive Statistics based on Demographics

		MCSE Total		Multicultural Intervention		Multicultural Assessment		Multicultural Session Management	
Variable	*N*	Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*
Gender									
Female	213	7.25	.99	7.47	.94	5.57	2.08	7.94	.90
Male	70	7.29	1.13	7.47	1.12	5.78	2.03	7.96	.87
Race									
Caucasian	181	7.07	1.0	7.31	.96	5.26	1.96	7.82	.87
Persons of Color	102	7.56	.99	7.76	.95	6.28	2.10	8.18	.90

Finally, the overall model variance was analyzed to address research question five. Overall, the model accounted for 18.6% of the variance in MCSE, which was statistically different from zero ($F_{(11,282)}$=5.523, p<.001). In this model, four of the 11 paths were statistically significant: race (.395, p<.001), CACREP attendance (.241, p<.05), number of multicultural courses (.148, p<.05), and number of multicultural

trainings (.152, $p<.01$). These results indicate that Persons of Color, CACREP program graduates, and addiction counselors with more multicultural education are more confident (have higher self-efficacy) in their ability to work effectively with racially diverse clients.

Table 9: Regression Weights for Model Variables

Path	Unstandardized	Standardized
MCSE ← Race	.395***	.203
MCSE ← Gender	-.055	-.025
MCSE ← Age	.006	.071
MCSE ← Experience	.005	.055
MCSE ← Recovery Status	.079	.039
MCSE ← Education	.127	.107
MCSE ← CACREP Attendance	.241*	.129
MCSE ← Multicultural Courses	.148*	.158
MCSE ← Multicultural Trainings	.142**	.178
MCSE ← Certification	.038	.015
MCSE ← Provisional	-.164	-.081

Note: *$p<.05$, **$p<.01$, ***$p<.001$

Chapter Summary

This chapter outlined the data screening techniques, instrument reliability, descriptive statistics, bivariate correlations, and primary analysis used in this study. The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. Data screening and instrument reliability techniques found the methodology chosen for this study to be appropriate in answering the research questions outlined above.

An examination of the bivariate correlations in this study revealed several relationships among predictor variables. Next, variables were entered into the MIMIC model for the primary analysis. Findings indicated that race, CACREP attendance, and multicultural education (courses and trainings) were significant predictors of MCSE in

this sample. However, age, gender, years of experience, recovery status, and credentials remained non-significant predictors.

A further examination of the MIMIC model analysis revealed that Persons of Color reported more confidence in their ability to effectively counsel racially diverse clients than Caucasian participants. Additionally, there were significant differences between those that graduated from a CACREP accredited program and those that did not. CACREP graduates in this sample were more likely to report higher levels regarding their confidence to effectively counsel racially diverse clients than non-CACREP graduates. Lastly, multicultural education had significantly positive relationship with MCSE. Participants who reported taking more multicultural courses or engaging in more multicultural trainings were more confident in their abilities to effectively counsel racially diverse clients. These findings indicate that CACREP program attendance and multicultural education could increase MCSE in addiction counselors.

CHAPTER V: DISCUSSION

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. This chapter will provide a discussion of the results from this study. This chapter will also address the limitations of this study, implications of the findings, and recommendation for future research. Lastly, concluding remarks from this research study are presented.

Discussion of Results

This section will be divided into five sections that correspond with the research questions for this study. Each section will discuss the results of each research question and the findings as they pertain to this study. The first section will highlight MCSE in addiction counselors compared to similar samples. Next, the results of recovery status, training variables, and counselor demographics will be discussed. Lastly, a summary of results from the overall model will be discussed.

MCSE and Addiction Counselors

This research study was the first known study to examine multicultural counseling self-efficacy in addiction counselors. The first research question for this study wanted to examine this sample's total and subscale MCSE scores to provide a reference point for similar samples (mental health counselors, school counselors, rehabilitation counselors, etc.). Findings from this study indicate that addiction counselors have moderately high MCSE total scores (M=7.26) compared to counseling students (M=6.18, M=6.56, M=5.39) (Barden & Greene, 2015; Greene et al., 2014; Sheu & Lent, 2007). These results are not surprising as the majority of participants in this sample held a master's degree and

over half were fully licensed. Matthews et al. (2018) examined MCSE in practicing counselors, reporting that their sample had "strong self-efficacy" but did not report specific mean scores on the MCSE-RD. Other studies examined MCSE in school counselors, but used other instruments, so comparisons are cautioned (Camp et al., 2019; Holcomb-McCoy et al., 2008).

Overall, addiction counselors in this sample reported generally high MCSE scores compared to other counseling samples. An examination of subscale scores found addiction counselors in this sample reported higher scores than counseling students on all three subscales (Sheu & Lent, 2007). These findings indicate that participants in this study are more confident in their abilities to effectively counsel racially diverse clients than comparable samples. Participants in this sample reported the most self-efficacy regarding multicultural session management (M=7.95). However, participants reported much lower confidence regarding their ability to use multicultural assessments effectively (M=5.63, SD=2.07). The standard deviation for this scale suggests there may be external factors that contribute to scores. Addiction counselors work in a variety of settings (medication management, outpatient, residential, detox services, etc.), which may impact what assessment tools and strategies they use on a regular basis. Additionally, participants were asked about assessing for culture-bound syndromes and using standardized assessments such as interest inventories, personality indicators, etc. These are assessments that many addiction counselors may not use or be familiar with. The deviation in scores may be a reflection of participants that have prior counseling experience in different settings with exposure to different assessment tools.

Recovery Status

Recovery status, historically, has been an integral part of the addiction counseling profession (Culbreth, 2000; Doukas & Cullen, 2009; Doyle et al., 2008; Greene, 2015; Hecksher, 2007; White 2000a, 2000b). Prior studies have found that a substantial portion of their sample were made up of counselors in recovery (Culbreth, 1999; Knudsen et al., 2006). The results from this study revealed the majority of the sample to not be in recovery. These findings indicate a potential shift in the addiction counseling profession. Recently, there have been calls for the addiction counseling profession to become a more graduate level specialization (Duryea & Calleja, 2013). Historically, the addiction profession was characterized by persons in recovery entering the workforce as part of an "experiential credential" to provide counseling and treatment services (White 2000a, 2000b, 2008). Findings from this study seem to indicate that more people are entering the profession that do not identify as being in recovery, which may be a result of expanding recruitment strategies and a response to the recent opioid epidemic and increased funding for addiction programs.

This study sought to examine if there were differences in MCSE based on counselor recovery status. Recovery status was viewed as a cultural construct in this study, thus the rationale for inclusion was to examine if group differences existed. Findings revealed no significant differences between counselors in recovery and counselors not in recovery. Though counselors in recovery reported slightly higher total scores and higher scores on two of the three subscales, differences were marginal and insignificant. Though no found studies have examined MCSE in this population, other studies have found that counselors in recovery report higher levels of professional

commitment (Curtis & Eby, 2010) and utilize different treatment modalities and interventions than non-recovering counselors (Simons et al., 2017). Additionally, other studies have found that non-recovering counselors report lower levels of self-efficacy and perceive their recovering peers to have an advantage when it comes to rapport building with clients (Greene, 2015; Oser et al., 2011). Despite these findings, recovery status had no significant impact on participants' confidence in their ability to effectively counsel racially diverse clients. These results may reflect a shift in the addiction counseling profession. First, those entering the profession may be less likely to be in recovery; only 30% of the current sample identified as being in recovery, compared to almost 60% reported in prior studies (Culbreth, 1999; Knudsen et al., 2006). Second, those that are in recovery may be seeking higher levels of education or training compared to previous studies, as the addiction counseling profession continues to increase training and credentialing standards, with more recent emphasis on graduate level training.

Counselor Training

Training for addiction counselors is diverse, with several credentialing bodies seeking to prepare competent professionals (NADAAC, 2018a, IC&RC, n.d). Credentialing for addiction counselors and professionals range from requiring a high school diploma to a master's degree. Recently, there has been a call to the profession to increase graduate level training for addiction counselors (Duryea & Calleja, 2013), as several studies have discussed the lack of consistency and uniformity in addiction counselor training (Kerwin et al., 2006; Miller et al., 2010; Morgen et al., 2012). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) responded to the growing need for graduate level specialization by including specific

addiction related language in their 2009 and 2016 standards (CACREP, 2008, 2015), becoming the first accrediting body to advocate for the inclusion of addiction related content for all counseling students (Hagedorn et al., 2012).

This study recruited a sample of addiction counselors from North Carolina due to being recognized for its credentialing standards and tiered certification licensure system (Lassiter & Chang, 2006; Miller et al., 2010; Morgen et al., 2012). Training in this study was operationalized by examining participants education level, credentials, CACREP attendance, and multicultural education. The following sections will highlight results for each training variable.

Education. Due to the diversity in the addiction workforce, with professionals consisting of those with a high school diploma through doctorate level training (NAADAC, 2018a), educational level was examined in this study to see if group differences existed. The majority of the participants in this study held a master's degree (74%), which was higher than several previous studies that sampled addiction counselors (Culbreth, 1999; Culbreth & Cooper, 2008; Lassiter & Chang, 2006; Toriello & Benshoff, 2003). This increase in addiction counselors holding a master's degree may signify a shift in the profession, as funding for addiction programs increase and more billing compensation requires licensure, more professionals are seeking advanced training and education.

This study sought to examine if education level explained any variance in multicultural counseling self-efficacy in this population. There were no significant differences based on education level, though participants with a doctorate degree did report higher mean scores across all scales except multicultural assessment. These results

are similar to a study that examined cross-cultural counseling competencies in substance abuse counselors (Elamin et al., 2012). However, education level has previously been found to be a significant predictor in this population regarding multicultural competency (Lassiter & Chang, 2006). Barden et al. (2017) also found education level to be significantly correlated with multicultural competency in a sample of professional counselors. Additionally, Barden and Greene (2015) found that time spent in graduate school had a significant positive impact on multicultural session management, a subscale of the MCSE-RD. Despite these findings, no statistical significance was found in this study regarding educational level and MCSE.

These findings may be due to such a large portion of the sample holding a master's degree, thus limiting the variability across participants' scores. Recent literature has signaled a call to the profession to increase graduate-level specialization for addiction counselors (Duryea & Calleja, 2013). In the current study, over 80% of participants held a graduate degree. The rise in graduate education for addiction counselors may be the result of increased education and credentialing standards, in addition to third-party insurance and managed care companies beginning to require addiction counselors be licensed for reimbursement.

Credentials. As previously mentioned, addiction counselors vary regarding their professional credentials. Credentialing may range from certification through full licensure, with most licenses requiring a master's degree or higher. Due to the variety in addiction counselor credentials, inclusion in this study was warranted to examine potential group differences. Previous studies have mentioned a lack of consistency and uniformity regarding addiction counselor training and credentialing (Kerwin et al., 2006;

Miller et al., 2010; Morgen et al., 2012). North Carolina was chosen for this sample as prior literature has pointed out the tiered system allows for greater flexibility and provides an example of effective credentialing policy (Miller et al., 2010; Morgen et al., 2012).

Credentials in this study were defined as holding a certification, provisional license, or being fully licensed. Approximately half of the current sample indicated they were fully licensed. There were no statistically significant differences in MCSE based on counselor credentials. However, fully licensed participants reported higher mean scores than certified or provisionally licensed participants. These findings seem to support the results of Lassiter and Chang (2006) who found certification level did not have a statistical influence on multicultural competence in addiction counselors. These findings may be the result of increased uniformity and credentialing standards across all levels of counselor credentials, especially since this sample came from a state that has been previously acknowledged for its effective approach to certification and licensure.

CACREP. The 2009 and 2016 CACREP standards sought to include addiction related training for all counselors (CACREP, 2008, 2015). Several studies have pointed to positive trends in addiction counselor training as a result of these standards (Hagedorn et al., 2012; Lee, 2014). This study sought to examine if there were any group differences between participants who graduated from a CACREP accredited program and those that did not. The CACREP standards for addiction training seek to prepare counselors to understand the systemic, developmental, and cultural factors of clients entering treatment (CACREP, 2015). These factors may impact the training addiction counselors receive and influence their self-efficacy to counsel diverse populations.

The results of this study found a significant difference between participants who graduated from a CACREP accredited program and those that did not. Those who graduated from a CACREP program reported higher levels of confidence in their ability to counsel racially diverse clients. This study supports recent claims regarding a positive trend in addiction counseling as a result of the CACREP standards inclusion of addiction related content (Hagedorn et al., 2012). Findings from this study indicate training in a CACREP accredited program significantly increases MCSE. These results contradict other studies that examined cultural constructs and found no differences between participants who graduated from a CACREP program and those that did not (Barden et al., 2017; Couture, 2017; Hill et al., 2013). These findings suggest that addiction counselors who graduate from a CACREP program have higher self-efficacy to counsel diverse populations than non-CACREP program graduates. Based on the results of studies mentioned above, these findings suggest there may be unique differences in addiction counselor training between CACREP and non-CACREP programs. Furthermore, while not all programs are CACREP accredited, these findings support claims for graduate level training for addiction counselors (Duryea & Calleja, 2013) to better meet the needs of a diverse client population.

Additionally, CACREP significance in this study may be linked to more programs infusing multicultural content across the counseling curriculum, instead of using a single course format. Infusing this content into specialty areas may lead to more exposure regarding client diversity and cultural factors that impact treatment. The results of this study support prior claims of CACREP's positive influence on addiction counseling education standards.

Multicultural Education. The last training variable in this study was examined by assessing differences in MCSE based on participants' amounts of multicultural coursework and multicultural trainings. Recent studies have found multicultural training, specifically experiential learning opportunities, to significantly impact perceived multicultural competence in counselors (Greene et al., 2014; Midgett et al., 2016). Rationale for inclusion in this study was to further add to the growing literature base regarding how multicultural education and training impacts counselors' perceptions of themselves to provide culturally appropriate services.

This study found that multicultural courses and trainings both significantly influenced participant MCSE. Higher levels of multicultural education (more courses and trainings) positively impacted participants' confidence in their ability to effectively counsel racially diverse clients. These findings are consistent with other studies that examined multicultural education and MCSE in counselors (Barden & Greene, 2015; Greene et al., 2014; Holcomb-McCoy et al., 2008; Sheu & Lent, 2007). The results of this study also support findings from several studies that examined the influence of multicultural education on multicultural counseling competency (Chao & Nath, 2011; Chao et al., 2011; Fietzer et al., 2018; Toomey & Storlie, 2016). However, the findings from this study contradict the only known study examining multicultural coursework and multicultural competency in addiction counselors (Lassiter & Chang, 2006). In their study, Lassiter and Chang found that the number of multicultural courses taken had no significant impact on multicultural competency among substance abuse counselors. These results may be related to the increase in training standards since 2006, primarily in the release of the 2009 and 2016 CACREP standards. Additionally, participants in this study

reported engaging in more multicultural trainings than participants in Lassiter and Chang's study. These findings may be the result of a positive shift in the counseling and addiction counseling profession as multicultural competency and social justice becomes more of an emphasis for counselors.

Additionally, the inclusion of addiction related content and the emphasis of multicultural infusion in counselor education may have positively impacted the findings in the current study. Exposure to multicultural content in the addiction curriculum may have positively influenced addiction counselors' beliefs in their ability to effectively counsel diverse clients by reducing cultural stereotypes or assumptions. Previously, non-stereotypical attitudes towards substance use has been linked to positive outlooks and treatment optimism in counseling students (Chasek et al., 2012). The results of this study may be interpreted as addiction counselors' perceptions of their MCSE positively impact their ability to work with racially diverse clients.

Counselor Demographics

The fourth research question in this study examined if there were differences in addiction counselors' MCSE based on demographic factors. This section will highlight findings from the demographic variables analyzed in this study. Counselor race, gender, years of experience, and age were entered into the MIMIC model to examine the amount of variance each explains in MCSE.

Race. Counselor race in this study was categorized by Caucasian and Persons of Color. Race and MCSE has produced conflicted findings in recent literature, with certain studies finding no significant differences between groups (Barden & Greene, 2015; Soheilan & Inman, 2015) and another finding evidence of small, positive relationships

existing between ethnic identity and MCSE (Matthews et al., 2018). The current study found that Persons of Color reported significantly higher levels of MCSE than Caucasian participants. These results indicate that Persons of Color are more confident in their ability to effectively counsel racially diverse clients than Caucasian participants.

These findings support similar studies that have examined race and multicultural competency in counselors (Barden et al., 2017; Campbell et al., 2018; Fietzer et al., 2018; Hill et al., 2013). The majority of these studies found that counselors of color, or non-White counselors, reported significantly higher levels of multicultural competency than White or Caucasian counselors. In the only found study to examine race and multicultural competency in addiction counselors, Lassiter and Chang (2006) found that Persons of Color reported significantly higher scores on the knowledge subscale than Caucasian participants. Similarly, studies that sampled counseling students or trainees reported comparable findings (Campbell et al., 2018; Fietzer et al., 2018; Hill et al., 2013).

These results indicate that non-majority counselors perceive themselves as better prepared to counsel a diverse client population than Caucasian counselors. It may be that Caucasian counselors feel unprepared to address cultural issues in session, or that non-majority counselors are more confident in their abilities due to lived experiences. Additionally, Persons of Color in this study reported taking more multicultural courses and trainings than Caucasian participants. The differences in MCSE may be attributed more to amounts of training than differences based on race. Another conclusion is that Persons of Color may seek out or actively engage in more multicultural education than Caucasian counselors.

Gender. Gender in this study was categorized as male or female. Previous studies that examined gender and MCSE in counseling samples produced mixed findings (Barden & Greene, 2015; Sheu & Lent, 2007). Sheu and Lent (2007) found that males scored significantly higher than females across all subscales during the initial validation of the MCSE-RD. However, Barden and Greene (2015) found no significant differences between male and female counseling trainees. The current study found no significant differences based on gender in addiction counselors, though males tended to report higher mean scores. Several other studies that examined multicultural competency in counselors also reported non-significant group differences based on gender (Campbell et al., 2018; Chao et al., 2011; Hill et al., 2013; Wei et al., 2012).

Studies that have found significant differences based on gender when examining cultural constructs appear to have been the result of moderating factors (Fietzer et al., 2018; Sheu & Lent, 2007). Sheu and Lent (2007) found that males in their study reported more contact with racially diverse clients and more multicultural training than females. Fietzer et al. (2018) found gender to be a significant predictor of sociocultural diversity but reported that participant demographics accounted for a small portion of explained variance. Based on the results of these studies and the findings from the current study, gender differences may be the result of extraneous variables, such as more training or exposure to diverse client populations, rather than group differences. In this study, there were no significant correlations between gender and multicultural education or CACREP program attendance, which may account for the lack of significant group differences in MCSE.

Experience. On average, participants in this study reported over 10 years of clinical experience as an addiction counselor. Years of experience in this sample was positively correlated with higher levels of education and multicultural training. Additionally, participants with more years of experience were more likely to be fully licensed. However, there were no significant differences based on years of experience and MCSE in this sample. These results align mostly with Holcomb-McCoy et al. (2008) who found experience to be non-significant with MCSE in a sample of school counselors. Conversely, other studies have found years of experience to be a significant predictor of MCSE (Barden & Greene, 2015; Toomey & Storlie, 2016; Sheu & Lent, 2007) and multicultural competency (Owens et al., 2010; Vespia et al., 2010) in samples of school counselors or counselor trainees. The findings from these studies suggest that other variables, such as a time spent in graduate school (Barden & Greene, 2015; Sheu & Lent, 2007) or multicultural education (Holcomb-McCoy et al., 2008; Toomey & Storlie, 2016), which may be viewed as byproducts of years of experience, might be better indicators of MCSE.

Age. The only found study to examine age and MCSE was the initial scale development of the MCSE-RD (Sheu & Lent, 2007). In their study, age was significantly associated with higher scores on the multicultural intervention and multicultural session management subscales. The current study sought to examine if age was a significant predictor of MCSE in addiction counselors. Results revealed no significant differences in MCSE based on age, though older participants did report higher mean scores. These differences in results may be due to several factors. The participants in this study were primarily master's level practicing counselors with over 10 years of clinical experience

on average, compared to counseling students (Sheu & Lent, 2007). Other studies that examined age and other multicultural competency constructs found that older individuals tended to report higher scores, but the results were nonsignificant (Campbell et al., 2018; Chao et al., 2011).

Summary

The purpose of this study was to explore the impact of counselor recovery status, training, and counselor demographics on multicultural counseling self-efficacy in addiction counselors. This section highlighted the findings from this study and their significance to the profession. Overall, four of the variables in this study were statistically significant in explaining MCSE in addiction counselors: race, CACREP program attendance, multicultural courses, and multicultural education. The variables in this study accounted for 18.6% of the variance in MCSE, which was statistically significant. These results indicate that Persons of Color, CACREP program graduates, and addiction counselors with more multicultural education are more confident (have higher self-efficacy) in their ability to work effectively with racially diverse clients.

Contributions of the Study

This is the first study to examine multicultural counseling self-efficacy in addiction counselors. This study adds to a growing literature base regarding factors that impact counselors when working with diverse client populations. Previously, only one found study examined multicultural competency in addiction counselors, indicating a need to better understand how this population serves clients and how educators and supervisors can enhance addiction counselors in this domain. The results from this study indicate how training, multicultural education, and counselor demographics impact how

confident addiction counselors are in their ability to effectively counsel racially diverse clients.

Additionally, this study provided additional insight into how CACREP accreditation and training standards are impacting addiction counselors. Recent studies have discussed the positive trends in addiction counselor training as a result of the CACREP standards (Hagedorn et al., 2012; Lee, 2014), but no found studies have examined group differences in this population regarding cultural self-efficacy or competency. This study found that addiction counselors who graduated from a CACREP accredited program had significantly higher confidence in their ability to effectively counsel racially diverse clients than those who did not. Counselor self-efficacy in this study cannot be attributed to client outcomes, but findings indicate that addiction counselors feel more prepared and better suited to address cultural differences and be culturally responsive in session, in part, as a result of graduating from a CACREP program. CACREP program graduates in this study reported taking less multicultural courses than non-CACREP participants, which indicates the quality of multicultural education or the infusion of diversity across the counseling curriculum may be a significant factor in increasing MCSE in this population.

Other significant findings from this study highlight group differences between Caucasian participants and Persons of Color. Persons of Color reported significantly higher confidence in their ability to effectively counsel racially diverse clients. These findings support a larger trend in counseling literature (Barden et al., 2017; Campbell et al., 2018; Fietzer et al., 2018; Hill et al., 2013) that have found similar results. These trends indicate that Caucasian counselors may require more training or multiculturally

focused supervision to increase their confidence and ability to work effectively with racially diverse clients. In summary, the results of this study provided empirical support of factors that contribute to MCSE in addiction counselors and serves to add to the overall literature base seeking to understand diversity and counselor perceptions of their abilities to work effectively with diverse populations.

Limitations of the Study

There are limitations to the findings presented in this study. First, this study was not an experimental design, thus causation is not warranted. The self-report format of this study also presents limitations, as social desirability is likely. Participants may have responded in a way to portray themselves or their group membership in a more favorable way. Another limitation of the current study involves generalizability. The current sample was recruited from the North Carolina addiction professional credentialing board due to the national recognition of it's tiered licensing system. However, these results may not represent a national sample of addiction counselors, so generalizability is cautioned.

Several limitations were identified as a result of counselor demographics. Due to the nature of the study's design and analysis strategies, participants with missing demographic information had to be excluded from the final analysis. The removal of these cases may have impacted the practical and statistical findings in this study. Second, the lack of racial or ethnic diversity in this study led to group differences being analyzed by comparing Caucasian participants with Persons of Color. This did not allow for reliable examinations of potential differences amongst multiple racial or ethnic groups. Additionally, the definitions for multicultural trainings and courses may have caused confusion in participant reporting. The survey did not specify graduate level multicultural

courses, which may have led to a lack of differentiation between multicultural coursework and multicultural trainings. Lastly, a higher response rate and larger sample may have produced different findings.

Implications of Findings

This study expands the existing literature base that examines cultural constructs and addiction counselors. The present study examined counselor training, recovery status, and demographic variables to better understand how these factors impact MCSE in this population. The results of this study have implications for counselor educators, addiction counselors and supervisors, and credentialing and accrediting bodies.

Counselor educators seek to prepare counseling trainees to effectively work with diverse clients with a variety of presenting concerns. Addiction courses can vary depending on programmatic variables and may be taught by core faculty members or adjunct faculty with a specialization in addiction counseling. However, several programs do not have an addiction counseling specialty tract, and often can be taught by instructors with a lack of addiction counseling expertise (Lee, 2014). Professional development may be necessary for counselor educators to effectively teach addiction courses that best prepare future counselors to work with a diverse client population.

Findings from this study indicate that multicultural education had a significant impact on MCSE. Counselor educators should consider how they incorporate diversity and infuse multiculturalism across the curriculum for addiction counselor trainees. Counseling trainees' efficacy and competency to work with diverse populations has previously been linked to training experiences (Collins et al., 2015; Larson & Bradshaw, 2017). Counselor educators teaching addiction courses may seek to utilize experiential

learning opportunities to enhance trainees' efficacy to work with diverse clients experiencing addiction. Previous experiential pedagogy has found service-learning projects and experiential film (films selected intentionally that connect to specific multicultural counseling competencies) to be effective in enhancing MCSE and group self-efficacy in counselor trainees (Greene et al., 2014; Midgett et al., 2016). Addiction counselor educators should consider utilizing community service-learning projects to illustrate how addiction impacts groups differently. Additionally, educators can utilize case studies and videos that highlight diverse elements and how group membership impacts a client's resiliency or risk factors for addictive behaviors. Lastly, findings from this study advocate that addiction courses should be taught through a multicultural lens to infuse content across the curriculum. Using a multicultural lens, educators can discuss the disparity in treatment outcomes for diverse populations and how counselors can better serve these clients by using the examples mentioned above.

Race was also found to be a significant predictor of MCSE in this study. Given that Caucasian participants reported lower confidence in their ability to work effectively with racially different clients, educators should consider identity development and ways to enhance efficacy in Caucasian trainees. Infusing multicultural education across the counseling curriculum increases exposure for trainees and may enhance their efficacy to work effectively with diverse client populations. Multicultural training has been found to significantly impact multicultural awareness for Caucasian trainees, with higher levels of training reducing group differences between Caucasian and racial minority trainees (Chao et al., 2011).

This study also has implications for practicing addiction counselors and supervisors. Results of this study revealed multicultural trainings to be a significant predictor of MCSE. Addiction counselors should continue to seek out training opportunities that emphasize diversity and multiculturalism to enhance their abilities to work effectively with diverse clients. Addiction counselors as advocates should look to increase the quality of training being provided in this area. Collaborating with other professionals and counselor educators to discuss current training policy and experiences working in the field could better prepare addiction counselors to work with diverse clients. Additionally, supervisors can help enhance MCSE in addiction counselors by broaching diversity elements in supervision. Supervisees that perceive their supervisors to be multiculturally competent report higher clinical self-efficacy in their own abilities (Kissil et al., 2013). Supervisors operating from a multicultural lens in supervision may enhance their supervisees' confidence in working with diverse clients.

Lastly, the results from this study have implications for credentialing and accrediting bodies. Findings from this study indicate that CACREP graduates have significantly higher confidence in their ability to work effectively with racially diverse clients. Previous studies have pointed out problems in addiction counselor training due to a lack of consistent national standards and state requirements (Kerwin et al., 2006; Miller et al., 2010). The release of the 2009 and 2016 CACREP standards sought to provide a standardized method in training counselors to work effectively with people impacted by addiction (Hagedorn et al., 2012). Formalized training standards that emphasize client diversity and provide consistency in education standards may increase MCSE in addiction counselors. Some states that require less coursework and formal education for

credentialing purposes (Kerwin et al., 2006) may need to re-evaluate their curriculum and credentialing standards to better prepare counselors for working with diverse client populations.

Recommendations for Future Research

The empirical results of this study add to a growing literature base that examines cultural constructs in counselors. The findings from this study regarding training, recovery status, and counselor demographic variables provide several recommendations for future research. First, future studies should examine MCSE by recruiting a national sample of addiction counselors, as this study only sampled addiction counselors in North Carolina. Obtaining a national sample may improve the generalizability of future findings. Additionally, future research may incorporate social desirability instruments to assess for bias in participant self-report.

This study found significant differences based on multicultural education and CACREP program attendance. Future studies should further explore how multicultural education and training is conducted in addiction counselor education and work settings. Future research may benefit by a qualitative approach to provide more depth regarding what it is about multicultural education and CACREP program attendance that impacts their MCSE. A qualitative approach could highlight themes and specific instances that served to enhance MCSE in addiction counselors. This information could serve to better inform curriculum development and credentialing standards nationally. Future studies should further examine the differences between CACREP and other accrediting bodies regarding curriculum, instruction, and standards that promote cultural development in addiction counselors.

Another recommendation for future research is to examine additional constructs that may help explain MCSE in this population. The model in the current study accounted for less than 20% of the variance in MCSE, leaving over 80% unaccounted for. Future studies should explore additional factors that impact MCSE. Additionally, this was not an experimental study. Future research could use specific elements of multicultural pedagogy in an experimental design to examine causal differences in MCSE. In conclusion, future research in this area could serve to advance the training of addiction counselors to better meet the needs of a diverse client population.

Concluding Remarks

The continued rise of clients entering treatment for substance use disorders (SAMHSA, 2018), in addition to a growing diverse population (United States Census Bureau, 2018), means addiction counselors need to be prepared to serve clients from a variety of different backgrounds. Previous studies have linked treatment dropout and completion rates to client minority status (Cooper et al., 2010; Gonzalez et al., 2011; Guerrero et al., 2013), health disparities, and organizational cultural competence (Guerrero & Andrews, 2011). In addition, other studies have examined the impact of client and counselor racial matching on treatment outcomes (Cabral & Smith, 2011; Chang & Yoon, 2011; Ruglass et al., 2014). The results of these studies indicate that marginalized clients may have different treatment needs and preferences to be successful in treatment. Furthermore, these studies highlight a need for a workforce prepared to effectively meet the needs of diverse clients.

Only one found study has examined multicultural competence in addiction counselors (Lassiter & Chang, 2006), and no studies have been found that examined

multicultural counseling self-efficacy in addiction counselors. This research study contributes to the literature in this area and provides insight regarding factors that contribute to addiction counselors' self-efficacy to effectively counsel racially diverse clients. The findings from this study highlight the importance of counselor training and multicultural education and indicate a need for more consistent training standards for addiction counselors. These results serve to inform counselor educators, addiction counselors and supervisors, and credentialing bodies. Additionally, the results of this study highlight the need for continued research with this population to better prepare addiction counselors to meet the needs of a diverse client population.

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APPENDIX A

Introductory Letter

Greetings,

My name is Joshua Smith and I am a counselor education and supervision doctoral student at the University of North Carolina at Charlotte. I am inviting you to participate in an online survey for a research study on addiction counselors.

About the study:

The study is anonymous and takes about 10-15 minutes to complete. Participation in this survey is voluntary and you have the right to withdraw at any time. Results will be used to better inform teaching, training, and supervision practices for addiction counselors.

Eligibility:

I am recruiting addiction counselors who:

1. Are 18 years of age or older
2. Hold a professional license or certification as an addiction counselor
3. Are currently practicing as an addiction counselor or currently working with substance abuse clients

To participate in this study please follow the link below. The link will take you to the consent form and survey.

Thank you for your time and participation!

Warmly,
Josh Smith NCC, LPCA, LCASA
Doctoral Student, University of North Carolina at Charlotte

APPENDIX B

Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001

Consent to Participate in a Research Study

Title of the Project: An Exploration of Factors Contributing to Multicultural Counseling Self-Efficacy in Addiction Counselors
Principal Investigator: Joshua D. Smith, NCC, LPCA, LCASA
Faculty Advisor: John R. Culbreth, PhD, LPCS, LCAS, CCS

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to give you key information to help you decide whether or not to participate.

- The purpose of this study is to examine multicultural counseling self-efficacy in addiction counselors.
- You must be age 18 or older to participate in this study, hold a professional license or certification as an addiction counselor, and currently practicing or working with substance abuse clients.
- You will be asked to participate in an online survey responding to questions on a Likert scale.
- It will take you about 10-15 minutes to complete the survey.
- We do not believe that you will experience any risk from participating in this study.
- You will not benefit personally by participating in this study. What we learn about addiction counselors will have implications for training, supervision, and education.

Your privacy will be protected and confidentiality will be maintained to the extent possible. Your responses will be treated as confidential and will not be linked to your identity. You are being asked to provide your email address. We need your email address in order to verify you are the person responding. However, your email address will not be associated with any of your response or linked back to you in any way once proceeding to the survey.

Survey responses and email addresses will be stored separately with access to this information controlled and limited only to people who have approval to have access. We might use the survey data for future research studies, and we might share the non-identifiable survey data with other researchers for future research studies without additional consent from you.

After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again. The data we share will NOT include information that could identify you.

Participation is voluntary. You may choose not to take part in the study. You may start participating and change your mind and stop participation at any time.

If you have questions concerning the study, contact the principal investigator, Josh Smith, by email at jsmit643@uncc.edu. If you have further questions or concerns about your rights as a participant in this study, contact the Office of Research Compliance at (704) 687-1871 or uncc-irb@uncc.edu.

You may print a copy of this form. If you are 18 years of age or older, have read and understand the information provided and freely consent to participate in the study, you may proceed to the survey [Please select Continue to Survey below]

APPENDIX C

General Demographics Questionnaire

Directions: Please complete sections **A-N** in the following demographics questionnaire (***all responses are anonymous***)

A. What is your sex/gender?

- ☐ Female
- ☐ Male
- ☐ Other/Do not wish to specify: _____

B. What is your age? _____

C. Please indicate the setting in which you work:

- ☐ Urban
- ☐ Rural
- ☐ Suburban

D. How many years of clinical experience do you have? _____

E. Do you identify as being in recovery, having a prior history of substance abuse, or formerly experiencing addiction from a chemical substance?

- ☐ Yes
- ☐ **No**

F. Approximately what percentage of your caseload is comprised of clients with addiction issues?
_____

G. Please indicate your highest level of education completed:

- ☐ High School
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Educational specialist
- ☐ Doctorate degree

H. If you hold a master's degree or higher, did you graduate from a CACREP program?

- ☐ Yes
- ☐ **No**
- ☐ Not applicable

I. Please select all professional addiction licenses or certifications you hold:

- ☐ Certified Substance Abuse Counselor
- ☐ Licensed Clinical Addiction Specialist Associate
- ☐ Licensed Clinical Addiction Specialist
- ☐ Other: _____

J. Please list the number of courses completed in diversity or multicultural counseling issues: _____

K. Please list the number of workshops or trainings in diversity of multicultural issues: _____

L. Please indicate your sexual identity:

- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Queer/Questioning
- ☐ Other: (please specify) _____

M. What is your race/ethnicity:

- ☐ African-American
- ☐ Asian-American
- ☐ Caucasian (Non-Hispanic)
- ☐ Latina/Latino
- ☐ Middle Eastern
- ☐ Multiracial
- ☐ Native-American
- ☐ Pacific/Islander
- ☐ Other: (please specify) _____

N. Please indicate your religious/spiritual affiliation:

- ☐ No religion
- ☐ Buddhist
- ☐ Catholic
- ☐ Judaism
- ☐ Mormon
- ☐ Muslim
- ☐ Protestant/Other Christian
- ☐ Other non-Christian: _____

Please provide any general comments you have regarding this overall research investigation:

Thank you for your participation!

APPENDIX D

Multicultural Counseling Self-Efficacy Scale – Racial Diversity Form (MCSE-RD)

Instructions: The following questionnaire consists of items asking about your perceived ability to perform different counselor behaviors in individual counseling with clients who are racially different from you. Using the 0-9 scale, please indicate how much confidence you have in your ability to do each of these activities at the present time, rather than how you might perform in the future. Please circle the number that best reflects your response to each item.

		No Confidence at all				**Some Confidence**					**Complete Confidence**
		0	1	2	3	4	5	6	7	8	9
1.	Remain flexible and accepting in resolving cross-cultural strains or impasses	0	1	2	3	4	5	6	7	8	9
2.	Manage your own racially or culturally based countertransference toward the client (e.g., over-identification with the client because of his or her race)	0	1	2	3	4	5	6	7	8	9
3.	Help the client to clarify how cultural factors (e.g., racism, acculturation, racial identity) may relate to her or his maladaptive beliefs and conflicted feelings	0	1	2	3	4	5	6	7	8	9
4.	Admit and accept responsibility when you, as the counselor, have initiated the cross-cultural impasse	0	1	2	3	4	5	6	7	8	9
5.	Encourage the client to express his or her negative feelings resulting from cross-cultural misunderstandings or impasses	0	1	2	3	4	5	6	7	8	9
6.	Assess the salience and meaningfulness of culture/race in the client's life	0	1	2	3	4	5	6	7	8	9
7.	Resolve misunderstanding with the client that stems from differences in culturally based style of communication (e.g., acquiescence versus confrontation)	0	1	2	3	4	5	6	7	8	9

8. Help the client to identify how cultural factors (e.g., racism, acculturation, racial identity) may relate to his or her maladaptive relational patterns	0	1	2	3	4	5	6	7	8	9
9. Take into account multicultural constructs (e.g., acculturation, racial identity) when conceptualizing the client's presenting problem	0	1	2	3	4	5	6	7	8	9
10. Manage your own anxiety due to cross-cultural impasses that arise in the session	0	1	2	3	4	5	6	7	8	9
11. Respond in a therapeutic way when the client challenges your multicultural counseling competency	0	1	2	3	4	5	6	7	8	9
12. Assess relevant cultural factors (e.g., the client's acculturation level, racial identity, cultural values and beliefs)	0	1	2	3	4	5	6	7	8	9
13. Help the client to set counseling goals that take into account expectations from her or his family	0	1	2	3	4	5	6	7	8	9
14. Openly discuss cultural differences and similarities between yourself and the client	0	1	2	3	4	5	6	7	8	9
15. Address issues of cultural mistrust in ways that can improve the therapeutic relationship	0	1	2	3	4	5	6	7	8	9
16. Help the client to develop culturally appropriate ways to deal with systems (e.g., school, community) that affect him or her	0	1	2	3	4	5	6	7	8	9
17. Help the client to develop new and more adaptive behaviors that are consistent with his or her cultural background	0	1	2	3	4	5	6	7	8	9
18. Repair cross-cultural impasses that arise due to problems in the use or timing of particular skills (e.g., introduce the topic of race	0	1	2	3	4	5	6	7	8	9

	into therapy when the client is not ready to discuss)										
19.	Help the client to utilize family/community resources to reach her or his goals	0	1	2	3	4	5	6	7	8	9
20.	Deal with power-related disparities (i.e., counselor power versus client powerlessness) with a client who has experienced racism or discrimination	0	1	2	3	4	5	6	7	8	9
21.	Take into account cultural explanations of the client's presenting issues in case conceptualization	0	1	2	3	4	5	6	7	8	9
22.	Where appropriate, help the client to explore racism or discrimination in relation to his or her presenting issues	0	1	2	3	4	5	6	7	8	9
23.	Take into account the impact that family may have on the client in case conceptualization	0	1	2	3	4	5	6	7	8	9
24.	Deliver treatment to a client who prefers a different counseling style (i.e., directive versus non-directive)	0	1	2	3	4	5	6	7	8	9
25.	Treat culture bound syndromes for racially diverse clients (e.g., brain fag, neurasthenia, nervios, ghost sickness)	0	1	2	3	4	5	6	7	8	9
26.	Assess culture bound syndromes for racially (e.g., brain fag, neurasthenia, nervios, ghost sickness)	0	1	2	3	4	5	6	7	8	9
27.	Interpret standardized tests (e.g., MMPI-2, Strong Interest Inventory) in ways sensitive to cultural differences	0	1	2	3	4	5	6	7	8	9
28.	Select culturally appropriate assessment tools according to the client's cultural background	0	1	2	3	4	5	6	7	8	9
29.	Use non-standardized methods or procedures (e.g., card sort, guided fantasy) to assess the client's concerns in a culturally sensitive way	0	1	2	3	4	5	6	7	8	9

30. Conduct a mental status examination in a culturally sensitive way	0	1	2	3	4	5	6	7	8	9
31. Encourage the client to take an active role in counseling	0	1	2	3	4	5	6	7	8	9
32. Evaluate counseling progress in an ongoing fashion	0	1	2	3	4	5	6	7	8	9
33. Respond effectively to the client's feelings related to termination (e.g., sadness, feeling of loss, pride, relief)	0	1	2	3	4	5	6	7	8	9
34. Keep sessions on track and focused with a client who is not familiar with the counseling process	0	1	2	3	4	5	6	7	8	9
35. Assess the client's readiness for termination	0	1	2	3	4	5	6	7	8	9
36. Help the client to articulate what she or he has learned from counseling during the termination process	0	1	2	3	4	5	6	7	8	9
37. Identify and integrate the client's culturally specific way of saying good-bye in the termination process	0	1	2	3	4	5	6	7	8	9

Sheu, H-B., & Lent, R. W. (2007). Development and initial validation of the Multicultural Counseling Self-Efficacy Scale--Racial Diversity Form. *Psychotherapy, 44*(1), 30–45. doi:10.1037/0033-3204.44.1.30