SUBSTANCE USE COUNSELLORS’ UNDERSTANDING AND INCORPORATION OF ETHNOCULTURAL DIVERSITY FACTORS: AN INTERPRETIVE DESCRIPTION

by

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Abstract

The objective of this study was to explore how counsellors understand and incorporate ethno-cultural (EC) diversity factors in alcohol and drug (A&D) counselling, in order to glean practical information that may contribute to culturally competent and safe practices. Qualitative interviews within an Interpretive Description (Thorne, 2008) approach were conducted with 23 A&D counsellors, 4 of whom reported serving as both counsellors and supervisors. As per design, additional information rich sources were sought that included interviews with 4 participants identifying as other professionals affiliated with A&D services (program managers, directors and consultants). All participants were affiliated with the Lower Mainland, British Columbia, health authorities. Interviews were analyzed using Miles and Hubermans’ (1994) framework. Counsellors demonstrated varying levels of awareness and positions towards EC differences with conversations ranging from overemphasis on similarities to consideration of EC factors as an ethical and integral part of practice. Participants’ view of “addiction” also seemed to inform how they spoke about the relevance of EC factors in therapy. An integrated approach to A&D care revealed multiple levels of analysis and consideration of clients’ socio-cultural contexts. The addiction as a disease model, however, constructed A&D problems as universal and EC factors as secondary. The A&D organizational context included a discussion of strengths and barriers to provision of services to diverse clients. Perspectives that constructed EC differences as secondary seemed to be accompanied with limited self-reflection and examples of application into practice. On the other hand, reflexive practices embedded within social justice elements pointed to counsellors articulating specific examples of integrating EC factors in therapy. Relevant ethical dimensions as well as implications for practice, theory and research were identified.
Preface

This research was approved by the University of British Columbia’s Behavioural Research Ethics Board (Certificate #H10-00717).
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Dedication

I dedicate this project to my two daughters. Leila, your gleaming eyes and smiles bring an enormous sense of happiness since your coming to this world. Sophia, your brief existence on this planet has helped me appreciate what is most important in life; I will remember you forever, my little angel.
Chapter One: Introduction

The provision of alcohol and drug (A&D) treatment has been studied from multiple perspectives in established research. Room and colleagues (2003) summarize the following three major strands: (i) research on treatment modalities and outcome studies investigating the relative effectiveness of specific models of treatment; (ii) research on the process and dynamics of the treatment itself, such as providers’ specific intentions and approaches, the client’s or the recipient’s experiences of the treatment, and the overall process of the therapeutic encounter, and lastly (iii) health services research, the most recent trend that focuses on the influences, interactions and operations of varied elements of alcohol and drug service systems and organizations, including specific issues such as client loads, recording system, follow-ups, funding and other system-related practices.

While the above perspectives cannot be seen in isolation and are mutually influencing, my doctoral research interests arise out of the second trend mentioned above (i.e., research on the process and dimensions of the therapeutic encounter) which has a strong foundation in the field of counselling psychology. The field of psychotherapy research has traditionally explored the diverse aspects of the therapeutic process and outcome, treatment approaches, and the specific contributions of the clients’ or the therapists’ process (Wolff, 2007). The current research is particularly focused on the unique and specific contributions of counsellors in the ways that they understand and incorporate ethno-cultural (EC) factors in therapy as they provide A&D related services for their diverse clients presenting at mainstream A&D settings.

In the sections that follow, I elaborate on the following: setting the context, the research problem, the rationale for conducting this research, assumptions and the relevant definitions.
Setting the Context

Canada is a nation rich in cultural diversity, with over 18% of its population born outside of the country (Statistics Canada, 2001). It is estimated that since 2001, Canada has been receiving approximately 262,236 immigrants per year (Citizenship and Immigration Canada, CIC, 2006). In addition, since 1981, Canada has experienced a three-fold increase in people who identify themselves as ethnic, “a person other than Aboriginal who is non-Caucasian in race or non-white in colour” (Nouroozifar, & Zangeneh, 2006, p. 291). What makes this ethno-cultural make up of Canada even more varied is the diversity in cultural and religious practices, patterns of settlement and immigration, categories of entry (e.g., skilled worker, refugee status, family sponsorship), and the socio-political histories and contexts prior to settlement in Canada (Citizenship and Immigration, CIC).

The Canadian Heritage’s report on population health and well-being of Canada’s ethnocultural minorities has noted disparities in social and health as well as economic outcomes for the above group as compared to the general Canadian born population (Beiser, 2005; Oxman-Martinez & Hanley, 2005). While the etiologies of documented disparities are not well understood, MacLachlan (2006) identifies the following risk factors: pre-migration context (e.g., forced migration, lack of preparation, and traumatic events); cultural factors (culture shock, language, and communication barriers); family factors (e.g., absence of family, shifts in family dynamics, and intergenerational conflict); psychological factors (e.g., loss and grief, status inconsistency); societal factors (e.g., loss of social network, marginality, and unemployment); and biological factors (e.g., chronic illness, and acute travel effects).

It is important to understand the social construction of differences arising from ‘race,’ culture and ethnicity within the Canadian context. While contested throughout Canadian
history, the notion of cultural diversity within the public discourse has been equated with the term “ethnic,” referring to the growth of a non-white population, other than aboriginal people. Historically, cultural diversity referred to those groups who were other than French and British. The Canadian government favored immigrants from Britain, the US and other European countries, with this trend continuing until the end of the Second World War. However, the 1960s saw an emergence of visible minorities, and changes in immigration policies reinforced by the need for skilled labor (Li, 1999; 2000).

The term biculturalism then gave rise to the term Mosaic, referring to the multicultural make-up of Canada. This period also marked the potential reduction of racial and national barriers to allow non-white groups to enter Canada. Multiculturalism as a policy, when announced in 1971, generally referred to everyone being seen as culturally equal, and focused primarily on cultural preservation. However, this official federal policy of multiculturalism was criticized for not making any institutional and legislative changes to promote social equality and participation, criticisms that still persist (Li, 2000).

Henry, Tator, Mattis and Reese (2000) state that, while historically Canada is viewed by many Canadians as a nation free of racial prejudice, racism has continued to affect non-white groups in the form of unequal social value and opportunities for participation. The authors bring attention to the notion of “democratic racism,” giving rise to the continuation of racism in Canada. It is defined as an “ideology in which two conflicting sets of values are made congruent to each other. Commitments to democratic principles such as justice, equality and fairness conflict and co-exist with attitudes and behaviors that include negative feelings about minority groups, differential treatment and discrimination against them” (p. 23). In fact, disparities in the areas of health, economic and labor market access have been noted for visible
minorities in Canada, with visible minorities facing reduced social mobility in the Canadian context (Beiser, 2005; Li, 2000; Oxman-Martinez & Hanley, 2005).

**Research Problem**

An increasingly diverse Canadian context requires that healthcare providers pay attention to the mental health and addiction needs of its ethno-cultural groups. There is a plethora of Canadian literature on substance abuse prevalence, utilization and treatment for certain identified groups such as youth, seniors and individuals with co-occurring mental health disorders and substance use problems (Adlaf, Begin & Sawka, 2005), but little research focused on prevalence, rates, severity or substance use-related service utilization of Canadian ethno-cultural minorities.

Available research points to higher drop out rates and underutilization of mainstream mental health services for Canada’s Aboriginal population (Aboriginal Healing Foundation, 2000, Kirmayer et al., 2001; SalT Shan Institute, 2002) despite the estimated higher rates of mortality and injury due to alcohol abuse (British Columbia Provincial Health Officer, 2002). Smye and Browne (2002) assert that within the Canadian context “aboriginal perspectives and knowledge remain largely absent from the dominant discourse around mental health care—an absence that arises from persistent sociopolitical marginalization” (p. 43). However, the existing literature within the Canadian context highlights innovative culturally safe A&D interventions for Aboriginal population in the area of mental health and addiction that incorporate traditional healing and spiritual practices into the mainstream services. For example, in terms of program planning and delivery, attention is paid to the context of colonization with a focus on reconnecting clients to their spiritual and cultural practices (e.g., the use of sweat lodges and adaptation of Alcoholic Anonymous (AA) models to include
relational and community based values) (Dell et al., 2011). Instead of a disease or pathology perspective, a holistic approach is promoted that considers the physical, spiritual, emotional and social contexts (e.g., use of medicine wheel). Additionally, the incorporation of traditional healing practices is perceived to contribute to clients’ recovery and their sense of connection to self and Aboriginal identity (Brady, 1995; Gone, 2011; McCormick, 1998; Nygaard, 2012; Salt Shan Report, 2002; Tempier, 2011). Furthermore, significant factors in terms of helping in relapse prevention and maintenance of long term recovery from problematic substance abuse have been linked to counsellors connecting clients to support networks within their respective communities as well as incorporating the various socio-political contextual factors in treatment planning and after care (van der Woerd et al., 2010). While the above represent some important examples of integrating specific cultural practices within the mainstream services, the gaps still remain as to how EC diversity factors are addressed at mainstream A&D contexts for Canada’s other minority groups.

The Lower Mainland region of British Columbia presents a combination of rich history of addiction treatment on the one hand, and a disorganized and fragmented array of services on the other hand. For example, while the Vancouver Coastal Health Authority has been continuously working on increasing access and coordination of services in the community, gaps in knowledge still remain related to whether the current services comprehensively address the needs of its diverse population (Marsh & Fair, 2005).

For the last 30 years, researchers have consistently voiced concerns regarding the underutilization of mental health services by minority clients, their premature dropout from therapy (Cheung & Snowden, 1990; Echemendia & Nunez, 2004; Griner & Smith, 2006; McCabe, 2002), the differential quality of care and access to treatment (Snowdon & Yamada,
2005) and the inadequacy of traditional counselling approaches to meet the unique needs of
diverse clients (Collins & Arthur, 2007; Hall, 2003; Parham & Whitten, 2003; Ponterotto,
2002). Researchers in the field of psychotherapy and counselling argue that “the single most
important reason both for the underutilization of mental health services by ethnic minority
clients and for the high dropout rates is the inability of psychotherapists and counselors to
provide culturally sensitive/responsive therapy for the ethnic minority client (Gelso and Fretz,
2001, p. 153). Therefore, researching the counsellors’ understanding and incorporation of EC
factors in alcohol and drug (A&D) counselling is one way to explore the ways that their
attitudes, values and expectations affect their treatment choices and the process of therapy as a
whole. This is particularly important because research (mainly from the US) points to the
following: higher drop out rates at outpatient substance use treatment settings (Jacobson,
Robinson & Bluthenthal, 2007; McKay et al., 2002; Passos & Camacho, 2000; Rychtarik, et
al., 2000; Wickizer et al., 1994); lower rates of substance use treatment completion (Schmidt,
Greenfield, & Mulia, 2006; Tonigan, 2003); and lower access rates specifically by minority
clients (Schmidt, Ye, Greenfield, & Bond, 2007; Wells, Klap, Koike, & Sherbourne, 2001; Wu
& Ringwalt, 2005).

A small body of Canadian research has found that immigrant groups in general are less
likely to use mental health services than those born in Canada (Chen, Kazanjian, & Wong,
2008; Tiwari & Wang, 2008). However, it remains unexplored as to whether such pronounced
under-utilization indicates the following: protective factors leading to better mental health
outcomes (Chen, et al., 2008); untreated mental health problems (Tiwari & Wang, 2008) or
access and barriers to effective mental health care; including professionals lacking
competencies in working with clients from diverse EC realities (Snowdon & Yamada, 2005).
A major area in counselling psychology that can shed light on the direct influence of counsellors and their understanding of clients’ data within the context of therapy is counsellors’ understanding and incorporation of clients’ diverse data comes from research on clinicians’ conceptualization skills. While there is substantial research on general case conceptualization skills and processes (e.g., Falvey, 2001; Falvey, Bray & Hebert, 2005; Prieto & Scheel, 2002; Strohmer & Leierer, 2000) as well as multicultural case conceptualization (e.g., Constantine, 2001; Constantine Kindaichi, Arorash, Donnelly & Jung, 2002; Maxie, Arnold, & Stephenson, 2006), scarce information exists on how A&D counsellors understand and incorporate clients’ EC diversity factors.

**Research Rationale**

My current research explored how A&D counsellors understood and incorporated their clients’ EC factors in therapy. The reasons I became interested in this aspect were two fold. First of all, there is an increasing demand for evidence-based practice that places importance on accountability, and informed treatment planning linking clinician’s overall understanding of clients’ data to effective choice of interventions (Falvey, Bray & Hebert, 2005). Secondly, when counsellors not only understand but also incorporate clients’ presenting data throughout the process of therapy, it can help with the following important therapeutic domains:

- The integration and differentiation of biological, cultural, psychological and social information in the etiology of clients’ presenting concerns (Ladany, Marotta, & Muse-Burke, 2001),
- The organization and interpretation of complex details presented in clients’ files given the time constraints (Meier, 2003),
- The understanding and evaluation of clients’ unique processes and functioning (Meier, 2003) as well as development of alternative hypothesis (Falvey, Bray & Hebert, 2005),
- Counsellors’ openness and commitment to invite clients to explore issues of diversity within the therapeutic milieu, thus creating a safe space to talk about differences (Day-Vines et al., 2007),
- The consideration and integration of how socio-political factors such as racism,
oppression and discrimination may influence the clients’ presenting concerns, thus helping clients feel empowered and heard (Day-Vines et al., 2007)

- The selection of appropriate assessment instruments and interventions (Ladany, Marotta, & Muse-Burke, 2001; Meier, 2003), and
- The overall provision of effective treatment (Ladany, Marotta & Muse-Burke, 2001; Falvey, Bray & Hebert, 2005).

I also believe that counsellors are well positioned in the mental health and addictions system to provide ethical, culturally safe and competent care for their EC clients. In the field of mental health, counselling psychology has been a leader in promoting research, training and education in diversity, multicultural and social justice practice (Arrendondo et al., 1996; Arredondo & Perez, 2003; Arredondo & Toporek, 2004; Pieterse, Evans, Risner-Butner, Collins & Mason, 2009; Ponterotto, 1997; Vera & Speight, 2003). Despite the field’s persistent calls for ethical and culturally competent care, research suggests that the needs of EC clients continue to be poorly assessed by counsellors (Constantine, 2001; Roysircar, 2005). Concerns have also been raised regarding counsellors’ difficulties with client-centered case conceptualization and associated interventions (Roysircar). However, counsellors with previous multicultural training have been found to be better able to incorporate and conceptualize minority client’s diversity and cultural factors (Constantine). Additionally, counsellors who are open to talk about differences arising from ‘race,’ culture and other diversity factors have been found to contribute to their clients’ depth of self disclosure, satisfaction, and engagement in therapy (Sue and Sundberg; 1996; Thompson, Worthingon, & Atkinson, 1994; Zhang & Burkard, 2008; Zhang & McCoy, 2009).

**Purpose of the Study**

The intention of this research was to advance knowledge of how A&D counsellors understand and incorporate clients’ EC factors in counselling. The goal was to explore counsellors’ perspectives on the relevance and application of EC differences in relation to
themselves, their clients and the therapeutic context. The hope was to identify mechanisms that may contribute to effective, culturally competent and safe treatment and interventions for clients from diverse EC communities. By interviewing A&D counsellors situated within mainstream outpatient services, this research also strived to illuminate the organization and delivery of services for EC minorities that would be of interest to service providers, policy makers and relevant health authorities.

This research utilized qualitative interviews embedded within Interpretive Description as an approach to inquiry (Thorne, 2008), to glean discipline-specific, clinical information to inform the work of A&D counsellors in their work with EC clients. I situate this research within overlapping multicultural, social-justice and cultural safety conceptual frameworks (elaborated in my literature review) that honor intersectional approaches to understanding substance use counselling practice with diverse EC groups. Farrell (2009) aptly captures my theoretical stance towards this current research in the following:

If establishing a therapeutic framework that is culturally inclusive is of paramount importance to the profession, a stronger emphasis ought to be placed on the exploration of the counsellor in relation to self, others and environments…it is imperative, then that counselors assume the responsibility to actively address oppressive, discriminatory and ism-based practices, beliefs, attitudes, and values within the process of therapy… [and how] social locations and social identities (e.g., oppressor or oppressed, and race/ethnicity, class, sexual orientation, gender, and age) of therapist and clients contribute substantially to how the therapeutic journey unfolds (p. 46-47).

Research Question

The main research question was: “How do counsellors understand and incorporate EC diversity factors in A&D counselling?”

Assumptions

The assumptions embedded in this research generally, and in my research question more specifically, are: 1) substance use counsellors working within mainstream services are
key players in terms of how A&D services are delivered, and thus they are appropriate individuals to comment and share their perspectives, experiences and process of working with EC clients presenting A&D problems; 2) studying counsellors’ understanding and incorporation of EC factors as a process will inform how A&D counsellors go about treatment planning and choosing appropriate interventions when working with the above population; and lastly 3) by accessing the professionals working directly with EC clients, I will be able to learn more about a population group whose unique needs and challenges with substance use have not been adequately researched.

**Terminology**

When analyzing concepts such as culture, ‘race,’ and ethnicity, one of the challenges is to provide appropriate terminology in a way that the terms themselves are not fixed, problematic and racist. As the language and the social political context evolve, so do the terms and their meanings (Henry et al., 2000). It must be acknowledged that even the terms that I will be referring to are limited in describing the complexity of inherent contexts and that they are not neutral. In fact, I believe the usage of the terms by a researcher is very much influenced by his or her own experiences, social location and theoretical framework as will be elaborated in researcher reflexivity.

I also acknowledge that the social science and healthcare literature is filled with debates and ambiguities about concepts such as ethnicity and ‘race,’ their inclusion/exclusion, meaningfulness and relevance to research. In addition, I believe that no one particular position or term will adequately capture the complexity of these concepts but that each will have its own consequences for various groups. In addition, scholars such as Thomas (2005) emphasize that the above social concepts are dynamic, fluid and constantly influenced by historical and socio-
political contexts. Additionally, Moodley and Palmer (2006) assert that “developing a precise and finite definition of these terms may not be possible or desirable, given their complex history, their present reflexivity, and their potential for change in the future. However, for both psychotherapists and their clients, these social constructions are essential elements within which the identity of the client is negotiated and the inter-subjective relationship is constructed” (p. 11). The relevant terms for the present study are as follows, with the recognition that there are no universally accepted definitions in the literature:

**Culture:** Culture refers to “the totality of the ideas, beliefs, values, knowledge, and way of life of a group of people who share a certain historical, religious, racial, linguistic, ethnic, or social background. Manifestations of culture include art, laws, institutions, and customs. Culture is transmitted and reinforced, and it changes over time. Culture may refer to a lifestyle of a group of people who tacitly acknowledge their differences from others in terms of beliefs, values, world views, and attitudes about what is right, good, and important.” (Henry et al., 2000, p. 407). Lynam and Young (2000) view culture “as a dynamic process informed by a template or worldview held by individuals that shapes the ways in which meanings are assigned, priorities established and ideas articulated” (p. 11). Culture is not seen as neutral but rather as socially mediated, embedded within socio-political and historical processes, as well as power relations and social inequalities (Anderson & Reimer-Kirkham, 1999). The notion of culture cannot be “abstracted from social, political and economic factors” (Johnson et al., 2004, p. 255), thus requiring a broader understanding with intersection of other diversity factors (e.g., age, gender, education, sexual orientation) (Arthur & Collins, 2005; 2010)

**Dominant/majority group:** “The group of people in a given society that is largest in number or that successfully shapes or controls other groups through social, economic, cultural, political, and religious power. In Canada, the term generally refers to white, Anglo-Saxon, Protestant males” (Henry et al., 2000, p. 407).

**Ethno-cultural group:** A social classification where “a particular group of people define themselves as a distinctive category on the basis of an identification that is felt” (Fleras & Elliot, 1992, p. 315) and “maintained by a shared heritage, culture, language, or religion” (Henry et al., 2000, p. 408).

**Essentialism:** “The practice of reducing the complex identity of a particular group to a series of simplified characteristics and denying individual quality. Also, the simplistic reduction of an idea or process” (Henry et al., 2000, p. 408).

**Mainstream:** “In the context of antiracism, the dominant culture and the political, social, educational, cultural, and economic institutions through which its power is
maintained” (Henry et al., 2000, p. 409).

**People of color:** “A group of persons who because of their physical characteristics are subjected to differential treatment. Their minority status is the result of a lack of access to power, privilege, and prestige in relation to the majority group.” Additionally, these diverse communities based on the color of their skin may experience varied discriminatory barriers compared to individuals in the dominant group (Henry et al., 2000, p. 409).

**Privilege:** Privilege refers to a system of benefits, rights, advantages and access that are unearned, and are often taken for granted by members of the dominant groups in a society (Frankenberg, 1993).

**Race:** “Race is a socially constructed category used to classify humankind according to common ancestry in reliance on differentiation by such physical characteristics as color of skin, hair texture, stature, and facial characteristics” (Henry et al., 2000, p. 409). Race is thus used within apostrophes (i.e., ‘race’) in this study to highlight its social construction, while recognizing the impact it has on the lives of people of color.

**Racialization:** Racialization is a process that “assumes that ‘race’ is the primary, natural and neutral means of categorization, and that the groups are distinct also in behavioural characteristics, which result from their ‘race’” (Ahmad, 1994, p. 18). Miles (1989) further elaborates how the notion of “race” is then reproduced and applied giving rise to a process whereby “social significance is attached to certain biological (usually phonotypical) human features, on the basis of which those people possessing those characteristics are designated as a distinct collectivity” (p. 74).

**Skin color:** “Skin color carries with it more than the signification of color: it also includes a set of meanings attached to the cultural traits of those who are a certain color” (Henry et al., 2000, p. 410).

**Chapter Organization**

Chapter 1 of this study provides the context, research question, purpose of the study and its assumptions. Chapter 2 outlines a review of the literature and my theoretical scaffolding, an element specified by Interpretive Description (Thorne, 2008) design. Chapter 3 details the qualitative approach to inquiry, study design and data analysis procedure as well as researcher’s reflexivity. Chapter 4 includes the findings, while Chapter 5 details the discussion, limitations, delimitations, and implications for practice, training and research.
Chapter Two: Literature Review

I have approached the literature review component consistent with Thorne’s (2008) recommendations for Interpretive Description as an approach to inquiry. In terms of orienting oneself to the literature, Thorne talks about “scaffolding the study” through two critical and engaged processes. The first step is conducting a literature review about the “state of science” while the second step is establishing a “theoretical forestructure.”

Scaffolding in the form of literature review refers to “the grounding of the study within the existing knowledge,” while “offering a critical reflection” on what is available in relation to the topic (Thorne, 2008, p. 61). This process locates knowledge that other researchers have generated about the topic of interest, or when scholars have adopted a certain position, and explored the insights as well as challenges. For this study, given the dearth of a direct body of knowledge, the closest literature to my area of interest included an overview of current trends in A&D related problems. The focus was on documented health disparities for various EC groups, followed by a brief critique on using ‘race’ and ethnicity as variables in health research. While data is lacking on the specific contributions of A&D counsellors in meeting the needs of clients from diverse EC realities, I explored issues of access and quality of care that have been documented in the extant healthcare research. I have briefly reviewed conceptualizations of addiction in the literature, since this is considered to help recognize how counsellors understand the intersection of A&D and EC factors. To further explicate counsellors’ understanding and incorporation of EC factors, I have reviewed the concept of conceptualization skills in general, and multicultural conceptualizations in particular.

The second process of scaffolding a study according to Thorne (2008) is establishing a theoretical forestructure. It must be noted that the emphasis is not on formal theory building,
but rather on the researcher’s explicit identification of the ideas and structures that inform and influence the pursued research inquiry. The researcher, using oneself as an instrument within the qualitative tradition, clarifies one’s position within the ideas that influence the nature and the outcome of the pursued inquiry. This also means locating oneself within one’s clinical discipline to “discern its scope and boundaries, its angle of vision on problems of concern, and its philosophical underpinning in relation to what constitutes knowledge” (p. 67). Given that Interpretive Description emphasizes generation of research question and findings that have clinical utility within one’s discipline, grounding of the researcher in his or her applied discipline becomes important. As such, I have included perspectives and conceptual frameworks that have influenced my process of inquiry. I have thus grounded the study’s theoretical forestructure in social justice, cultural safety and ethical practice, all central to my approach to counselling psychology. Lastly, I have conceptualized the interviews within a cross-cultural relational process by utilizing Ensink’s (2004) suggested framework when the interview focuses on topics such as ‘race,’ culture and ethnicity. It must be noted that this study’s theoretical forestructure is not considered to be prescriptive in terms of structuring the study, but rather a means for me as a researcher to make the influences explicit and transparent from the outset.

Current Trends in Alcohol and Drug Use

The 2004 Canadian Addiction Survey (Adlaf et al., 2005) showed that an estimated 13.6% of the total 13,909 interviewed were high-risk drinkers, experiencing serious social and health-related problems. Of those individuals who had consumed drinks in the past year, 17% presented with high risk drinking patterns (specifically male, under the age of 25) as determined by the World Health Organization's Alcohol Use Disorders Identification Test.
(AUDIT). In addition, approximately 80% of the total Canadians surveyed (age 15 and above) were found to consume drinks in moderation and without potential harm. As for Cannabis, one in 20 Canadians reported a cannabis-related concern in the form of not being able to control use. One percent reported experiencing interpersonal, social, health and legal problems. Of those who had used Cannabis in the past year, approximately 34.1% reported failing to control their use and 32% identified a strong desire to use. As for illicit drugs, the life prevalence rates are as follows: 11.4% reported having used hallucinogens, 10.6% cocaine, 6.4% amphetamines, 4.1% ecstasy and lastly, 1% or lower had used inhalants, heroin, steroids and injection drugs.

In the survey data mentioned above, there is no breakdown per ethnicity. This is because collecting such information is not a routine practice in the Canadian context (Varcoe, Browne, Wong, & Smye, 2009) as will be explored shortly. The only exception in reporting has been on British Columbia’s First Nations who are estimated to exhibit the highest rate of mortality and injury due to alcohol problems. This group has also been found to express a general sense of dissatisfaction with mainstream health services. The lack of culturally appropriate models is considered to be one of the major barriers to access and utilization of care for this diverse population embedded within the context of social, economic, cultural and political inequities (British Columbia Provincial Health Officer, 2002).

In the existing literature, the only focus in health research has been to compare immigrants with non-immigrants, i.e., the Canadian born population, without unpacking the diversity and heterogeneity that exist in both groups. For example, currently there exists one Canadian health survey (i.e., the Canadian Community Health Survey: Statistics Canada, 2009) that has attempted to explore depression and alcohol dependence in immigrant groups (not
identifying their place of origin or ethnicity) as compared to those of the Canadian born population (referred generally to those born in Canada, without attention to gender, culture, ethnicity, 2nd generation immigrant status or place of origin).

Ali (2002) utilized data from this Canadian Community Health Survey including 131,000 respondents aged 12 and above, for the 2000-2001 period. Based on age and sex prevalence rates as well length of residence, immigrants were found to specifically have lower rates of depression and alcohol dependence as compared to the Canadian born population. However, immigrants who had been settled in Canada for a longer time seemed to exhibit similar rates of depression as those born in Canada. The research showed that despite adjusting for demographic factors and socio-economic status, lower rates for the above two mental health problems were still observed for the immigrant groups. In addition, it is not indicated whether immigrant groups may be more reluctant than the general population to identify substance use and its associated problems nor the acculturation process is accounted for.

Although little is known about A&D trends in Canada’s diverse EC groups, the indicators from the US are as follows: adopting the classification system routinely utilized in the US, the 2010 National Drug Use and Health Survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) found that Latinos, Blacks and Whites report similar abuse and dependence rates for illicit drugs and alcohol; 9.7%, 8.2%, and 8.9% respectively. For Asians and American Indians, the rates were estimated to be approximately 4% and 16% respectively (SAMHSA, 2011). Other researchers argue that the rates of A&D related problems vary by ethnicity and ‘race,’ such that Blacks and Latinos are found to exhibit higher mortality rates from substance overdose than Whites (Galea, Ahern & Vlahof et al., 2003). Additionally, Latinos are found to exhibit higher alcohol related severity than Blacks.
and Whites (Schmidt, Greenfield, & Bond, 2007). For patients accessing emergency departments for illicit drug use, Blacks have been found to be overrepresented in terms of visits (SAMHSA, 2008). Latino men, Black men and women are also found to have a longer career of heavy drinking (Caetano & Kaskutas, 1996), and are considered to be more susceptible to developing new addiction problems (Caetano & Clark, 1998).

Thus, my reasons for including current trends for A&D related problems are because A&D problems are not only a major public health concern but that they are also accompanied by socio-cultural, political, economic, familial and clinical implications. Counsellors, as one of the primary providers, play a central role in terms of identifying, preventing and addressing A&D problems, and thus are accountable to recognize the severity and complexity associated with the use of substances for diverse clients. The limited available research suggests that disparities exist for EC groups in terms of access, quality of care, and treatments, thus putting the responsibility on the counsellors to educate themselves about how they may influence the above.

Using ‘Race,’ and Ethnicity in Health Research

One of the major critiques for the inclusion of ‘race’ and ethnicity variables in health services research is that researchers do not provide a definition for the above terms. Oftentimes, the terms ‘race,’ culture, nationality and ethnicity are conflated, leading to stereotypes and generalizations (Reid & Kampfe, 2000). In addition, researchers in their analysis of variables such as ‘race,’ utilize biological or genetic definitions of ‘race’ without attention to the social construction of the term (Moscou, 2008).

Most of the literature documenting disparities come from the US, where aggregating individuals into “global racial and ethno-cultural categories such as Black, White, Hispanic,
Asian and Native Americans ignores the diversity within groups and the distinctions in the drinking and drug use patterns” (Straussner, 2001, p. 9). Oftentimes, the focus in the available health research data is on three major groupings, i.e., Whites, Latinos, and Blacks, without attention to other population groups that may also exhibit A&D problems or differential rates of treatment. Others have argued that a focus on ethnicity and ‘race’ alone overlooks socio-cultural contexts (LeFauve, Lowman, Litten III, & Mattson, 2003) and the extent the inequities and barriers to healthcare access are shaped by systemic, institutional and structural factors (Varcoe, et al., 2009).

In contrast to the US, there is a dearth of literature documenting health disparities within Canada’s ethnic minority groups. Varcoe, Browne, Wong, and Smye (2009), in their article on “harms and benefits of collecting ethnicity data in a clinical context,” effectively capture the debate and ethical concerns raised within a Canadian context. The authors argue that, in Canada, collection of data on patients’ ethnicity is not a routine practice and the failure to collect ethnicity data has led to much debate around the meaningfulness of collecting such data (Varcoe, et al), and concerns around stereotyping and discrimination (Huff & Kline, 2007).

Varcoe et al. (2009), in their interviews with policy leaders and decision makers, found more support for collecting ethnicity data as compared to the community leaders and the patients that were also interviewed. The former groups identified the benefits of exploring healthcare utilization patterns for various EC groups. The rationale was that such data would help identify barriers to access and help the healthcare system to become more equitable so that services become more tailored to the specific needs of its diverse users. The latter group expressed a lesser degree of support but nevertheless perceived that collecting ethnicity data
may lead to better action on the part of the decision makers, and could reduce systemic racism and health disparities. However, the patients and the community leaders mainly emphasized the harms associated with the ethnicity data collection such as concerns regarding the use of ethnicity data to reinforce stereotypes resulting in poor quality of care.

Contrary to the notion of the Canadian health care system as being egalitarian and equitable, the patients and community leaders had an implicit awareness of social inequities and racism in the system. Visible minority and Aboriginal patients expressed feelings of anxiety, anger and fear when asked what they thought of routine inquires about their ethnicity and some were not sure as to the difference this question would make in the provision of care (Varcoe, et al., 2009).

The attempts to collect ethnicity information have been endorsed by scholars who assert that there is a real need to identify and alleviate health disparities in diverse EC groups and to promote “the provision of culturally and linguistically appropriate healthcare.” In addition, these efforts aim to provide “quality healthcare for all population groups by contributing to better information databases” (New Zealand Ministry of Health, 2004; Sheth et al., 1997; Smedley et al., 2002 as cited in Varcoe, et al., p. 1660).

Available research in the area of access to mental health care indicate that EC clients experience unequal access to services and that their distinct needs (e.g., language difficulties, acculturation stress, experiences of racism and discrimination due to minority status) go unnoticed by service providers and the healthcare systems (Snowden & Yamada, 2005). In fact, data is lacking on treatment access, quality of care, treatment retention and completion for Canada’s diverse groups. I believe such information is important because counsellors are directly involved in the care of clients with A&D problems, making it an imperative that we
know the extent that counsellors are competently and effectively responding to the diverse treatment needs of their EC clients. Some of the challenges in assessing the health research literature in the area of access and quality of care are that different benchmarks and indicators are used in defining the above. For example, access to care can include variables such as patients’ needs for treatment, ease of entry to treatment, expected time and delays in receiving care and financial means to pay for treatment. The quality of care indicators are generally focused on treatment completion rates, treatment retention, satisfaction and engagement with treatment programs without any focus on how counsellors and their skills may directly be influencing any of the above in the process.

Marsh and Fair (2005), while reviewing services provided by the Vancouver Coastal Health Authorities argue that despite efforts to increase access, the system continues to lag behind in terms of provision of services to diverse populations in Canada. The authors point to the lack of specialist services and capacity within the health authorities to serve the multitude of substance related problems. For example, in British Columbia, despite the rise in the illicit use of methamphetamine and cannabis (Adlaf et al., 2005), no intensive or targeted treatment programs are available. Long-term care in the form of coordinated recovery-oriented programs are also lacking within the mental health and addictions services. In their review, Marsh and Fair do not mention gaps in services for marginalized groups such as Canada’s diverse EC groups.

Clients’ self reports on access to specialist programs such as A&D treatment in the US suggest lower access to treatment by EC minorities than White clients (McAuliffe, Woodworth, Zhang, & Dunn, 2002). Additionally, poorer quality of care in terms of unmet needs for treatment of A&D problems for Hispanics and Blacks have been noted as compared to their
White counterparts. Hispanic clients reported delays in receiving services and an overall lower satisfaction in services (Wells et al., 2001). The only study that directly explored A&D counsellors’ involvement was utilizing the data base from Project Match, one of the largest clinical trials in assessing treatment efficacy for individuals with alcohol-dependent problems (Tonigan, 2003). In this study, clients from three major groups (i.e., Whites, Blacks and Hispanics) directly commented on therapeutic alliance with their counsellors and the resulting treatment satisfaction. This study found no mean ethnicity related differences in the area of therapeutic bond and clients and counsellors’ agreement on therapy goals. However, White clients were found to indicate significantly higher satisfaction rates than the other two groups.

**Conceptualization of Substance Use Problems**

Reid and Kampfe (2000) argue that irrespective of clients’ EC backgrounds, negative stereotypic images are often associated with individuals with substance use problems. Such misconceptions not only give rise to stigma and discrimination but also inadvertently influence treatment models and practitioners’ relationship with clients. For example, there is a preponderance of beliefs, even among counsellors, that clients with A&D problems are difficult to work with as they lack motivation and display denial and increased resistance; making the process of therapy a challenge.

Research has found that a wide range of healthcare providers, such as medical doctors (Karam-Hage, Nerenberg, Brower, 2001; Miller, Sheppard, Colenda, & Magen, 2001); nurses (Carroll, 1995; 1996; Howard & Chung, 2000); rehabilitation counselors (Dunston-McLee, 2001); social workers (Stein, 2003), hold negative perceptions of clients who present with substance use problems. Stereotypical labels such as the “addict,” “drug user,” or “alcoholic,” are common in the field, and thus the conceptualizations of addiction within the individual
often ignore the socio-cultural factors that co-construct the problems of substance use (Graham, Young, Valach, & Wood, 2008).

Alexander and Schweighofe (1988), in their classic article on “Defining Addiction,” assert that the term addiction is ambiguous and outdated containing too many meanings. For centuries the term was used to mean “given over,” or “devoted to something” in both a positive and or negative way (p. 151). However, after the Temperance movement in 19th century, the term became more restrictive and moralistic, referring to illness and a defect in character. Moral models thus included references to “alcoholics,” or “addicts” as characterologically weak and deviant as well as socially unacceptable, having lost personal choice and personal control (Brickman, Rabinowitz et al., 1982; Miller & Kurtz, 1992). Such stance has often been linked to the model of abstinence, which continues to persist in a variety of institutions, including modern day residential treatment programs and seen as popular and effective.

The socio-political context of the 20th century, influenced by enforcement agencies, government control and public health concerns, moved the term “addiction” towards a more medical paradigm, with a focus on health promotion, but behavior dysfunction nonetheless. What followed with the disease model was a decrease in public stigmatization, and increase in public awareness (Alexander and Schweighofe; 1988; Jellinek, 1960; Moyers and Miller, 1993). This medicalization movement was also in line with Alcoholic Anonymous (AA), a self-help grass-roots movement where addiction took on a disease perspective, still recognizing total abstinence as mandatory (Alcoholics Anonymous, 1976; White, 1998). Within the AA movement, the so-called “addict” was considered to be in need of spiritual re-awakening due to their powerlessness over the disease.

It must be acknowledged that numerous models of addiction exist in the literature; each
is unique depending on the evidence, discipline (e.g., epidemiology, genetics, psychology and sociology) or the zeitgeist during which they were created. While a review of models tapping into the processes and mechanism leading up to addiction is beyond the scope of this research, it is important to note that conceptualization of “addiction” is inherently complex and socio-politically constructed; contributing to considerable philosophical debate in the literature. As an example, the etiological models of pathological alcohol use have been driven by theories such as positive and negative affect regulation (use of substances to regulate emotional states) to pharmacological vulnerability (individual differences to acute or chronic effects of alcohol use) or deviance proneness (alcohol use as part of a deviant pattern attributed to early experiences and deficient socialization) (Sher, Grekin, & Williams, 2005).

White and Kurtz (2006) state that A&D “problems and their resolution have been defined in religious terms (sin and redemption), spiritual terms (hunger for meaning and personal transformation), criminal terms (amorality/immorality and reformation), medical/disease terms (sickness and recovery), psychological terms (flawed thinking/coping and maturation), and socio-cultural terms (historical trauma/oppression and liberation/cultural renewal)” (p. 6). Each model is thought to have its own implications, dictating intervention choices, ownership and the location of the problem as well as what settings or whom are best suited for resolution of A&D problems.

Historically, counsellors have utilized treatment approaches to substance use that have been developed for European American men (McHenry & Brooks, 2009; Reid and Kampfe, 2000). De La Rosa and colleagues (1999) assert that there is a need for culturally competent approaches to treating diverse clients with substance use problems, and that it is important and ethical to incorporate contextual factors such as minority status, effects of acculturative stress
and discrimination into A&D conceptualization. I briefly mention the general conceptualization of addiction because research scholars have emphasized that in addition to its socio-political constructions, substance use is a culturally mediated behavior. The multitude of contexts strongly determine who has access to substances, how and what type of substances are tolerated, encouraged/discouraged and or completely forbidden. In addition, societal pressures and policies determine who can use substances based on their gender, social location, or other diverse variables (Vega & Gil, 2009). Additionally, when substances are “culturally conceptualized as “illegal,” negative consequences are reflected in legal, familial, social and economic sequelae and affect the availability of quality of treatment and on the recovery process” (Straussner, 2001, p.11).

**Therapists’ Skills at Conceptualization**

The clinical process of counsellors that involves figuring out the complexity of clients’ presenting information is referred to as conceptualization skills. This process involves consideration of the following elements: presenting *symptoms* (e.g., client’s withdrawal symptoms); *functioning* (e.g., missing work); *domains* (e.g., client’s cognitive, interpersonal, emotional, behavioral, and environmental problems); *strengths* (e.g., social support), and *time* (e.g., short or long term outcomes of therapy). Such consideration is thought to help counsellors to understand the relationship between factors contributing to the presenting problem, thus affecting clients’ overall functioning in multiple domains. In addition, it helps in developing the necessary steps to follow in order to achieve the desired therapy goals and outcomes (Meier, 2003).

Conceptualization skills have been studied using quantitative designs investigating how clinicians engage in clinical judgment and problem-solving when provided with a clients’ case
presenting with mental health concerns (Falvey, 2001; Falvey, Bray, & Hebert, 2005). Others have looked at the ways that clinicians utilize debiasing strategies when making diagnostic decisions (Hill & Ridley, 2001) and how clinicians inquire, select and synthesize clinical information (Falvey, 2001). Some researchers have examined clinicians’ cognitive complexity, i.e., their ability to integrate complex and multidimensional information (Spengler & Strohmer, 1994). Additionally, other researchers have studied clinicians’ integrative complexity comprising of two main components, differentiation skills referring to “the ability [of a counsellor] to offer alternative interpretations or perspectives regarding a given phenomenon,” and integration skills referring “to the ability [of a counsellor] to develop complex connections among the differentiated interpretations or components (Ladany, Marotta, & Muse-Burke, 2001, p. 205).

In the last 50 years, much research has been conducted in the field of cognitive psychology to explicate the cognitive factors that influence clinicians’ conceptualization and its impact on treatment planning tasks (Benbenishty & Treistman, 1998; Falvey, 2001; Falvey, Bray & Hebert, 2005; Garb, 1998; Prieto & Scheel, 2002; Strohmer & Leierer, 2000; Yennie, 1997). In particular, the area of social cognition attends to how individuals make sense of social situations (of others and the self), and the ways that they process social information (i.e., encode, store and retrieve) (Haverkamp & Tashiro, 2007). Clinicians may also engage in confirmatory bias, actively paying attention to selected information that confirm their initial judgments, thus influencing the sources of information sought Haverkamp & Tashiro, 2007). After impressions are formed, therapists may seek cues consistent with the initial impression, disregarding contradictory information (Haverkamp, 1994; Haverkamp & Tashiro, 2007).

Particularly, research has paid attention to professional counsellors’ cognitive schemas
Schemas are defined as organized cognitive structures that help process information, and are comprised of individuals’ fundamental beliefs and assumptions, influenced by their experiences and learning history (Beck, 2005; Beck & Weishaar, 2000). Schemas are stored in memory as “generalizations [of] specific experiences and prototypes of specific cases” that automatically help in screening, encoding, processing and making meaning of the incoming information or stimuli (Reinecke & Freeman, 2006, p. 231). Thus, when an individual is faced with a new situation, his or her pre-existing beliefs and experiences will determine how he or she will respond to new experiences, fill in the gaps and direct his or her subsequent search for new information (Haverkamp & Tashiro, 2007).

Overall, research has consistently shown that clinicians’ use of cognitive schemas influence how and what information they elicit from their clients. Similarly, the operation of cognitive schemas has been linked to additional activities and processes in which clinicians engage. Examples include: how clinicians value the collected information, develop hypothesis, make inferences, assess their clients’ needs and develop treatment plans (Falvey, Bray & Hebert, 2005; Haverkamp & Tashiro, 2007; Prieto & Scheel, 2002). For a professional counsellor, cognitive schemas are shaped not only by their personal beliefs and experiences, but also their professional experiences. For example, schemas could arise from the counsellors’ preferred theoretical orientation, their use of formalized diagnostic/ assessment tools such as the DSM-IV-TR criteria, or their previous and on-going clinical experiences (Falvey, Bray & Hebert, 2005). However, clinicians have been found to have difficulties in explicitly communicating the impact and presence of such schemas on their clinical decisions (Garb, 1998). Falvey, Bray and Hebert (2005) posit the idea that clinicians are particularly vulnerable
to using cognitive short cuts due to their limited time and heavy caseloads.

As a whole, cognitive schemas are often accompanied by cognitive reasoning process that may contribute to potential bias or errors in judgment. When the client’s presenting information is contradictory, complex or ambiguous, counsellors may have to engage in making inferences. Haverkamp (1994, p. 156) defines inference as “the ability to go beyond the information given and to reason beyond the obvious facts of a situation.” Inferences operate automatically without the person being consciously aware of this process (Haverkamp & Tashiro, 2007). The further the clinician has to move away from the immediate information, the higher the likelihood for bias and inferential errors occurring from reliance on cognitive schemas (Haverkamp). Research points to a commonly occurring error in judgment referred to as the fundamental attribution error, defined as the tendency to “underestimate situational influences and overestimate dispositional influences on other’s behavior” (Myers & Smith, 2007, p. 324). For example, a substance use counsellor when confronted with an ethno-cultural client’s reluctance to express his or her emotions, may assume that the client is defensive or suppressing his or her emotions through the use of substances. The counsellor may not realize that that expression of affect may not be a culturally appropriate behavior for this client. Similarly, the counsellor may underestimate that the client may not trust a therapist from a different culture in disclosing his or her intimate feelings during an initial therapeutic encounter.

Researchers such as Falvey (2001), Falvey, Bray and Hebert (2005) and Haverkamp (1994) have provided several strategies to reduce errors in case conceptualization and their overall information processing. Examples include: generating alternative explanations and treatment plans (critically analyzing one’s generated hunches and generating counterarguments,
creating alternate impressions; using structured intake interviews for gathering information (Haverkamp) and increased attention to contextual factors affecting client’s functioning. Thus, counsellors have been urged to consider and integrate contextual and diversity factors (e.g., socialization, gender roles, discrimination) in their conceptualization skills (Haverkamp).

When it comes to seeking help, Anand and Cochrane (2005) posit that EC minority clients display varied and culturally specific conceptualization of mental health problems. The culturally conceptualization of mental health is thought to influence important aspects of help seeking, such as the type of services sought, the meaning and significance assigned to a particular mental health concern, and responses towards the available mainstream mental health treatments and professionals (Anand & Cochrane, 2005).

Researchers argue that when there is a conflict between the values of EC groups and the mainstream health practices, misunderstanding with service providers can occur over the meaning of a health-related problem and its appropriate treatment, thus undermining the effectiveness of care (Oxman-Martinez & Hanley, 2005). Additionally, tensions could arise between the cultural expectations of the mainstream health care system; for example practitioners may emphasize individual responsibility, and the clients from diverse EC communities may conceptualize health as a collective responsibility (Robinson & Gilmartin, 2002). For some groups, these health-related encounters are further complicated by factors such as language barriers, lack of information about resources, stigma, interactions with professionals lacking cultural competency and lack of specialized treatment models (Amaro, Arévalo, Gonzalez, Szapocznik, & Iguchi, 2006). Further to the above, what limits EC clients’ access to services is the failure of traditional counselling approaches to adequately address their unique needs. Moreover, Sue and Sue (2003) maintain that discrimination and racism within
the mental health system are considered to be linked to clients’ premature drop out and underutilization of services.

**Multicultural Conceptualization**

Before reviewing counsellors’ multicultural conceptualization skills, it is important to understand the model that has influenced the development of such conceptualization and the rationale as to why it is imperative for counsellors to have these competencies when working with EC groups. One of the models of multicultural counselling in the discipline is Sue and Sue’s (2003) tripartite model of multicultural competency focusing on three areas of counsellors’ competencies. These are: (i) *awareness* (i.e., being aware of, and examining one’s assumptions, values and biases as well as one’s cultural frame of reference, and their impact on one’s clinical practice), (ii) *knowledge* (i.e., understanding and increasing knowledge about diverse groups, attending to contextual factors affecting client’s functioning; knowledge of socio-political and institutional systems that create barriers and marginalize groups; and increasing knowledge of approaches and interventions that are diversity and culturally-based), and finally (iii) *skills* (i.e., ability to engage in culturally-appropriate interventions and assessment tools with diverse clients, seeking relevant diversity and multicultural training, and examining the scope and limitations of one’s own helping styles) (Arredondo et al., 1996; Pieterse et al., 2009; Sue, 2001; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008). The model is expected to both focus on the process as well as the content of acquiring multicultural competencies. It requires counsellors to balance their cultural knowledge without stereotyping and generalizations. Additionally, it encourages counsellors to push themselves out of their comfort zone and to generate multiple hypotheses without relying on their learned assumptions and schemas (Sue, Arredondo & McDavis).
Constantine (2001) defines multicultural case conceptualization (MCC) as follows: The counsellor is able to: “a) be aware of and can integrate the impact of various cultural factors on clients’ presenting issues and b) able to articulate appropriate treatment plan for working with clients based on this knowledge” (p. 357). MCC is based on Sue and Sue’s model of multicultural counselling competencies focusing on the three aforementioned critical areas, i.e., awareness, knowledge and skills (Sue, 2001; Sue, Arredondo & McDavis, 1992; Sue & Sue, 2008). MCC also incorporates Pedersen (1991)’s definition of multicultural counselling that where the notion of culture includes diversity variables such as sexual orientation, gender, socio-economic status, disability and age (Neufeldt et al, 2006).

From the perspective of MCC, clinicians’ conceptualization skills include identification of cultural and diversity variables, as well as development and implementation of non-culturally biased treatment plans. Further skills constitute clinicians’ assessment of their own cultural characteristics and competencies (limitations and scope) (Neufeldt et al. 2006). For MCC, integrative complexity in conceptualization skills requires the therapist to both differentiate (i.e., offering alternative interpretations regarding the etiology) and integrate information such as placing the client’s problems in a cultural context (Constantine, 2001; Worthington, Soth-McNett, & Moreno, 2007).

Research by Neville and colleagues (1996) on MCC shows a significant correlation between counsellors’ MCC and prior multicultural training. When clients are assigned to counsellors with prior multicultural sensitivity training, research has found that clients are more likely to return for more sessions as compared to clients of counsellors without multicultural training (Wade & Bernstein, 1991). Furthermore, coursework in multicultural counselling has been linked to an increase in counsellor’s own awareness of ‘race,’ and cultural identity,
particularly for White counsellors (Parker, Moore, & Neimeyer, 1998).

Thompson and Jenal (1994) have noted that when assigned to counsellors who avoid making direct references to issues of ‘race,’ or culture, clients from diverse EC backgrounds express difficulties in openly communicating their concerns with their respective counsellors. In contrast, clients’ MCC ratings of their counsellors’ multicultural knowledge and competence have been positively correlated with clients’ satisfaction with counselling (Constantine, 2001; Constantine, Kindaichi, Arorash, Donnelly, & Jung, 2002). Counsellors who come from EC minority backgrounds have also been rated as more multiculturally competent by clients than their White American counterparts (Constantine).

Counsellors who show flexibility in their theoretical orientation (eclectic or integrative) have been found to exhibit a higher level of MCC than those counsellors with a sole Cognitive Behavioral Therapy or psychodynamic orientation. Counsellors who perceive themselves as being more aware of cultural issues have been found to frequently differentiate and integrate such data in their conceptualizations (Constantine, 2001), also referred to as “Cultural empathy” (Ridley & Lingle, 1996).

General empathy as postulated by Rogers (1957) focuses on gleaning the emotional and conceptual perspective of the other, by entering the individuals’ frame of reference. The therapist then communicates this understanding back to the client while seeking a connection and assuming similarity in understanding (Chung & Bemak, 2002). The centrality of empathy in the counselling relationship has been discussed for decades in terms of providing unconditional positive regard and establishing trust (Dyche & Zayas, 2001; Rogers, 1957). Chung and Bemak (2002), however, argue that empathy as a concept has not been taken up in cross-cultural relationships, in terms of exploring the complexity of how culture influences the
therapeutic relationship. Culture, as defined by those that advocate of cultural empathy, involves various factors such as demographic (gender, age), ethnographic (ethnicity and nationality), education, and socioeconomic status. Cultural empathy requires the therapist to respond according to the clients’ unique cultural contexts, not excluding any variables. Furthermore, counsellors who embody cultural empathy remain open to differences and similarities as well as potential conflicts that may arise between the client and the therapist. It is thought to help counsellors accept complexity and ambiguity rather than over simplification of context (Pedersen, 2009).

While outcome research on the link between cultural empathy and the psychotherapy process is lacking, the association between cultural empathy and multicultural counselling competencies has been established (Burkard & Knox, 2002; Constantine, 2001; Constantine & Gainor, 2001). Sue and Sundberg (1996) also found that when cultural factors are recognized during the counselling process, clients reported more satisfaction with therapy and perceived their counsellors as credible. Additionally, clients displayed a depth of disclosure, and expressed their willingness to return for further counselling sessions.

Limitations of existing research on counsellors’ conceptualization skills and MCC include the use of analogue designs, case vignettes and pseudo-clients/actors that are not easily applicable to clinical settings. In addition, survey designs and questionnaires are utilized which may favor respondents who are more interested in this topic (Constantine, 2001). Quantitative research in the area of multicultural counselling competencies, including MCC, has generally focused on developing instruments to assess the professionals’ multicultural competency while basing it on the tripartite model of Sue and Sue (2003) as described above. These instruments mainly involve self-report measures by the professionals themselves without accessing
information from clients (Holocomb-McCoy & Myers, 1999; Ponterrotto, Gretchen, Utsey, Rieger, & Austin, 2002).

Examples of scales include: The Cross-Cultural Counseling Inventory-Revised (LaFromboise, Coleman, & Hernandez, 1991), the Multicultural Counseling Awareness Scale-Form B (Ponterotto et al., 1996), the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), and the Multicultural Awareness-Knowledge-Skills Survey (D'Andrea, Daniels, & Heck, 1991) (please refer to reviews by Ponterotto, Rieger, Barrett, & Sparks, 1994; Pope-Davis & Dings, 1995 on instrumentation and evaluation). Additional instruments in the form of rating scales are utilized by those involved in the training of professionals such as the faculty and supervisors, mainly observational in nature (LaFromboise, Coleman, & Hernandez, 1991; Pope-Davis, Liu, Nevitt, & Toporek, 2000). While MCC incorporates the dimension of skills, research has not yet identified a unique MCC set of skills that may contribute to EC clients’ increased self-disclosure, trust, and satisfaction in counselling (Worthington, Soth-McNett & Moreno, 2007). The instruments, particularly the self-reported measures completed by counsellors themselves have been criticized to have problems with social desirability as well as by counsellors’ actual MCC abilities and actions (Constantine & Ladany, 2000; Worthington, Mobley, Franks, & Tan, 2000). Thus, their content has been criticized to tap more into perceived competence as compared to actual competence (Pope-Davis & Dings, 1995), requiring researchers to involve clients as part of assessing whether their assigned counsellors exhibit multicultural competencies.

Research has not yet established whether counsellors’ MCC skills specifically contribute to improved counselling outcomes for clients from diverse cultures (Worthington, Soth-McNett & Moreno, 2007). Furthermore, there is a paucity of qualitative research that
looks at clinicians’ process of understanding and incorporation of EC diversity factors on the part of the counsellors. To date, research has not explored substance use counsellors’ multicultural counselling awareness, knowledge or skills and how counsellors may integrate these domains into their counselling, thus making the current research inquiry even more compelling.

I believe that, given the dearth of knowledge in my area of interest, my research question is best suited to a qualitative inquiry. Pope and Mays (1995) assert that qualitative approaches can be particularly amenable to exploring topics in health research that have had limited investigation. Instead of seeking concrete answers, qualitative research can help explore the “how,” and “why,” underlying certain phenomenon. Since, my research question explores how A&D counsellors understand and incorporate EC factors, I believe that a qualitative inquiry can be helpful in “giv[ing] emphasis to the meanings, experiences and views of the participants” while highlighting the “professionals beliefs” in relation to my topic of inquiry (Pope & Mays, p. 43). Additionally, qualitative approaches are best suited to explore complex topics (such as EC diversity factors) by providing a holistic perspective (Black, 1994). Further rationale for conducting a qualitative inquiry will be explored in the next chapter.

**Theoretical Forestructure**

As part of my literature review, I briefly describe some of the conceptual frameworks that informed this inquiry as part of Thorne’s (2008) recommendations to outline one’s theoretical forestructure and its respective influences on the nature of knowledge created. I approached the inquiry from a social justice and ethical perspective with a focus on how it is imperative for counsellors to provide culturally safe and competent practice. I also outline practice guidelines that have influenced my training as a counselling psychologist as well as the
frameworks that I utilized as a researcher of color, investigating issues of EC differences. These perspectives are made explicit as part of scaffolding the study and the choice of qualitative design where researcher is an important instrument influencing research outcomes (Thorne).

**Social justice perspective.** Pedersen (1991) defines multicultural counselling psychology as broadly encompassing the following:

> “ethnographic variables such as ethnicity, nationality, religion and language; demographic variables such as age, gender and place of residence; status variables such as social, educational and economic; and affiliations including both formal affiliations to family or organizations and informal affiliations to ideas and a lifestyle” (p. 229).

The above definition which has been widely used in counselling psychology literature has been critiqued for overlooking power differentials, sources of oppression, and systemic barriers that give rise to marginality for minority groups. Additionally, socio-political contexts influencing the nature of counselling have not been adequately addressed (Enns & Sinacore, 2005; Goodman, et al., 2004; Vera & Speight, 2003). The above definition has also influenced the conceptualization of the tripartite model of counsellors’ competencies by Sue and Sue (2003) as well as multicultural conceptualization of clients’ presenting problems as elaborated earlier. While the tripartite model was possibly among the first models in the field of counselling psychology to articulate the central role that cultural variables carry in the counselling domain, its focus has been limited to the counsellor and the one-on-one counselling context, giving insufficient attention to societal concerns such as discrimination, social oppression and systemic inequalities that marginalize various groups (Enns & Sinacore, 2005; Vera & Speight, 2003). Thus, some scholars in the discipline have called for an expansion of counsellors’ role beyond the tripartite model of multicultural competency to incorporate a social justice lens in their practice. In particular, feminist scholars have been at the forefront of
the social justice movement, advocating for elimination of sexism, racism and homophobia that disenfranchise women, people of color, and the LGBTQ groups (Vera & Speight).

According to Goodman et al (2004), social justice within the counselling psychology field refers to “the scholarship and professional action designed to change societal values, structures, policies, and practices, such that disadvantaged or marginalized groups gain increased access to these tools of self determination” (p. 795). I have chosen social justice as a framework for scaffolding this study because it calls for social responsibility and action on the part of the discipline and the professional. This framework also attends to socio-political contexts that affect clinicians’ practice and give rise and maintain power differentials and marginality, thereby limiting access to equitable resources and quality care (Pieterse et al., 2009). I believe the expansion of counsellors’ roles and the definition of multicultural counselling are pertinent for this inquiry. Specifically my research inquiry was not only focused on examining the counsellors’ understanding and incorporation of EC factors within the immediate context of their clinical encounter but also how these factors were socially constructed within the broader socio-political contexts and systems influencing counsellors’ practice. It must also be acknowledged that the social justice framework additionally influenced how I approached different terminologies in the field, as well as the overall analysis of counsellors’ conceptualizations of EC differences during the interviews.

*Cultural safety.* Another concept that influenced this study’s theoretical forestructure is “cultural safety,” which emerged out of social justice framework in the allied health profession of nursing. The term cultural safety was coined by Ramsden (1993), a Maori nurse practitioner to advocate for addressing health disparities in the Maori people of New Zealand. Ramsden argued that health disparities for the above group were due to their marginalized social status,
and reinforced by the predominance of Eurocentric health practices, policies, structures and health system delivery (Gray & McPherson, 2005). Integral to the concept of cultural safety have been issues of minority status, historical and political forces (e.g., colonization), power dynamics, as well as dominant health discourses and structures that influence the lives of minorities and disregard their traditional and cultural health belief systems (Smye & Browne, 2002).

The conceptual framework of cultural safety gives precedence to practices that promote safety, aimed at honoring and respecting the unique cultural identities of different groups. It requires the health practitioners/providers be aware of the power differential that exists between them and the recipient of care. It calls for actions that are aimed at eliminating cultural risk, defined as “actions that diminish, demean or disempower the cultural identity and well being of an individual” (Papps, 2005, p. 25). What stands out uniquely about this perspective is that the determination of safety goes beyond the professional’s awareness, knowledge and skills, to safe practices and services being decided by the recipient of care, or the person in the receiving end of service (Gray & McPherson, 2005).

Cultural safety has been applied to the Canadian context by scholars such as Reimer-Kirkham and colleagues (1999) and Smye and Brown (2002) in relation to the health and mental health concerns of Canada’s aboriginal communities. Canadian researchers Lynam and Young (2000) have also made a case for the creation of culturally safe research environments by those involved in inter-cultural research. According to the authors’ cultural safety framework, research is considered to be a joint construction of the researcher and the participant, both of whose behaviors are socially and culturally mediated. Lynam and Young invite researchers to recognize the power relationships that get created in researchers’
interactions with their participants. The above assertion was therefore integral to my current research endeavor and has been elaborated further in the researcher’s reflexivity section in the next chapter.

In this study, the perspective of cultural safety and social justice helped me stay alert to the dominant conversations on health and wellbeing, as well as the conceptualization of addiction expressed by interview participants. Reimer-Kirkham and Brown (2006) assert that social justice framework needs to attend to “practice environments, institutional structures, and healthcare policy [that] create, or mitigate, the climate necessary for equitable administration and delivery of healthcare services” (p. 324). The authors also recommend examining discourses where some groups are left at the margins, constructed as the “Other,” while certain other groups are perceived as the norm in relation to the dominant healthcare practice. The above discourse is thought to contribute to differential treatment and health inequities. Therefore, the theoretical forestructure of this study encompassing the above elements of social justice influenced me to stay alert to the contextual factors and multiple perspectives, including learning about the organizational context of A&D services shaping counsellors’ responses.

**Professional ethics and practice guidelines.** Cultural safety proponents align the practice of safety with professional ethical standards and guidelines stating that this concept should guide any competent healthcare professional’s practice (Papps & Ramsden, 1996). Similarly, since 1970s, the discipline of counselling psychology has been a pioneer in advocating for multicultural counselling and encouraging practitioners, researchers and policy makers to make culturally competent care an imperative (Ridley & Kleiner, 2003). The discipline has established guidelines so that professionals work effectively across diverse cultures (American Psychological Association, APA, 2003), aligning multicultural practice
with ethical practice.

The practice guidelines have emerged due to the recognition that both clients and their counsellors are inherently embedded within the dynamic social, political and historical contexts. Together with the professional codes of ethics, the guidelines aim at promoting the need for equitable services for diverse groups of clients, with professionals encouraged to be aware of ways that they may be creating harm and barriers to access.

As such, I perceived the “Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists” (APA, 2003) as relevant to my theoretical scaffolding. I utilized these guidelines because they not only focus on the individual counsellor but have also been advocated organizations, policy makers and institutions in response to increased diversity in client population accessing counselling services. They are as follows:

1. Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

2. Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals.

3. As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

4. Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and psychological research among
persons from ethnic, linguistic, and racial minority backgrounds.

5. Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices.

6. Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices (APA, 2003, p. 382-392).

It must be noted that the above guidelines are for psychologists with doctoral training and not for counsellors with Master’s level training, as were the case for the participants of this study. Nevertheless, I mention these guidelines because they have shaped my journey as a psychologist in training and undoubtedly influenced my interest in the topic and how I approach cross-cultural encounters. In this study, I have referred to relevant Canadian professional codes of ethics for counsellors working with diversity. I also perceived the ethics code as critical elements in understanding how counsellors approached various issues such as safety, harm, informed consent and competent practice with diverse clients, as elaborated shortly.

The Canadian Counselling and Psychotherapy Association (CCPA) (2007) code of ethics for instance states that counsellors need to maintain professional responsibility in counselling relationships, through openness to diversity and awareness and knowledge of their own competence. Additionally, the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, CPA, 2000) highlights major principles that involve respect for the rights and dignity of clients, responsible caring, integrity in relationships (e.g., demonstrating values such as openness and straightforwardness), and finally responsibility to society. The above principles are also in line with concepts of social justice and multicultural counselling as
elaborated earlier.

The most relevant aspect of the above mentioned ethics codes to this study, i.e., counsellors’ understanding and incorporation of their clients EC factors, is the ethical decision-making process that requires the clinicians to consider how their personal biases, values, and decisions affect their clients. The above process also encourages clinicians to evaluate the risks and benefits of each course of action they undertake in their clinical practice, thus being cognizant of their limits of competence (CPA, 2000; CCPA, 2007).

Competence is referred to as an ethical principle informing the practice of a particular profession. It is generally thought to constitute “requisite knowledge, skills and values for effective performance” in a given context and practice domain (Falender & Shafranske, 2007). This is consistent with the Canadian Psychological Association professional ethics code (CPA, 2000), which emphasizes that counsellors need to practice within the boundaries of their competence. Related to the above is the notion of meta-competence emerging through self-awareness and reflection (Falender & Shafranske, 2007). Meta-competence focuses on the professionals’ conscious and purposeful use and communication of one’s knowledge, values, clinical reasoning as well as reflection (Epstein & Hundert, 2007).

The ethics codes prioritize responsible caring, which is about recognizing, valuing and respecting the abilities of individuals, groups and communities to make decisions for themselves (CPA, 2000). However, they do not specifically outline the impact of societal values, policies or structures that may disenfranchise certain minority groups’ self-determination (Papps, 2005) or consequently the professional culture and values that may limit responsible caring on the part of the practitioner (Ramsden, 1993). In fact, a rare mention of the impact of Euro-American belief systems on the profession of counselling comes from a
provincial code of ethics, i.e., the British Columbia Association for Registered Counsellors (BCACC). This code places responsibility on the professionals to be aware of their professional socialization and not to assume universality of their values and belief systems (BCACC, 2011).

The field of counselling psychology has put forth calls to infuse ethics into every aspect of a counsellor’s education, training and practice. Pack-Brown, Thomas, and Seymour (2008) argue that ethics, multicultural counselling, and social justice go hand in hand, in that a professional counsellor’s ethical considerations, decision making, choice of actions, and contemplation of appropriate professional conduct are socio-culturally mediated. Thus, in line with the concept of culturally safety, the above scholars assert that it is a counsellor’s ethical responsibility to address societal policies, practices and structures including their professional culture that may perpetuate injustice, cultural biases and marginalize clients.

**Approaching the social dimensions of interviews.** Because qualitative interviews involve social interactions, the skills of the researcher become integral to the research process. Given that the main research question required counsellors to talk about their understanding of EC factors, I was aware of the complexities of interviewing participants on this topic, particularly the power dynamics inherent in cross-cultural relationships (Marshall & Batten, 2004) as will be elaborated upon in the researcher reflexivity section. This assumption of complexity was based on my own personal experience in Canada as a person of color and the relative reluctance on the part of individuals from different groups to explicitly talk about issues such as racism, culture and ethnicity. Thus, I was conscious that this study explicitly asked the participants to engage in such conversations. Green and Thorgood (2004) additionally state that the language inherent in interviews (both verbal and nonverbal) is central in qualitative interviews as it provides critical data. Researchers are required to be aware of
how conversations during the interview interaction can be influential in co-constructing what is explored and interpreted during the research process.

Ensink (2004) gives precedence to the quality of conversations that occur within the interactional dynamics of the interview between the researcher and the participant. Research interviews are compared to social conversation in which “content is influenced by emotional and relational factors” with properties that are highly contextualized, contradictory, and unanticipated (p. 156). Interviews are considered to be “framed activities” operating by how participants engage in answering the research questions, and how they remark about their views with respect to a particular topic.

Ensink (2004) recommends approaching interviews as framed activities, particularly when the researcher is analyzing how individuals relate to, and or talk about topics such as ethnicity, national identity and ‘race.’ Ensink believes that the “interviewer and respondent present themselves to each other not as autonomous persons in their own right, but as belonging to, representative of, or related to several social categories” (p. 162). The categorization is manifested, therefore, in the ways that respondents talk about themselves, the others (including the researcher) and the world in general. Interviews as interactional frames are perceived as the arena where the respondents “categorize self and others,” and “display their identification with or distance from others in society” [italics added]. This is thought to occur both at a cognitive as well as social level within the interview contexts (Ensink, p. 157).

Four frames (non-linear but rather process-oriented and circular in nature) are considered while highlighting the intrinsic social interactive element of the interviews. The first one is the basic “interview frame” that serves as the foundational interactional frame. It is in this frame that both the interviewer and the participant orient themselves to each other, in the roles they
embody and as the patterns of questions and answers emerge. The second frame constitutes “the social research frame,” with the aim of providing data for the research project at hand, in order to answer the guiding research question. Interviews therefore, will occur over a series of occasions with different participants, with the same social research frame in mind; with the role of the researcher and the respondent clearly delineated in each encounter. The third frame, “mutual relations frame” goes beyond the roles of the research agenda to a “being together of two persons.” This refers to how the researcher and the participant relate to each other and inevitably engage in some sort of “social accommodation related to each other’s age, sex, ethnicity, pronunciation, appearance and so on” (Ensink, 2004, p. 160). It is also here that the researcher can identify participants’ “footing,” i.e., when they interact, they may take up certain positioning with respect to the topic, their own comments and the researcher. These footings thus influence both the researcher and the participants’ perceptions of the interview situation.

The fourth frame, “topic-related frame cognitive frame” refers to how both the researcher and the participant organize their knowledge and meaning making about the numerous topics or themes that arise during the interview process. This is seen as an attempt by both parties to effectively communicate with each other their knowledge, feelings and perceptions in order to establish a “common ground” and reduce misunderstandings. All frames thus interact with each other to ultimately highlight participants’ positioning, “footing” and social categorization with respect to the main research focus (Ensink). It is the third and fourth frame that I particularly paid attention to in analyzing conversations around EC diversity occurring with the social dimensions of the interview.

Summary

The above chapter provided scaffolding for the study by covering the current state of
knowledge through the literature review as well as the theoretical forestructure influencing the inquiry. The literature review included a look at the current trends in A&D problems in Canada as well as the documented disparities in health and wellbeing of clients from diverse EC backgrounds. A brief critique of the use of concepts such as ‘race,’ and ethnicity was also provided. Since this study focused on exploring how counsellors understand and incorporate EC factors in A&D counselling, the literature review focused on conceptualization of addiction in general, as well as counsellors’ skills at conceptualizing clients’ presenting concerns, including research on multicultural conceptualization. The theoretical underpinnings of this study consisted of exploring the concepts, frameworks and ideas that shaped the lenses through which I operated, including the disciplinary influences. These included: a social justice framework, professional guidelines and codes of ethics, as well as a framework to help address the social dimensions of interviews.
Chapter Three: Approach to Inquiry

This current research was conducted within a qualitative paradigm using the Interpretive Description (Thorne, 2008), as an approach to inquiry. It utilized interviews to explore the following research question: How do counsellors understand and incorporate EC diversity factors in A&D counselling?

Methodology is defined as “the strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes” (Crotty, 1998 p. 3). In this study, under methodology, I include an overview of my qualitative research paradigm (including my philosophical and epistemological stance), my approach to inquiry, researcher reflexivity, data collection, sampling procedures, analysis and the concepts of rigor and trustworthiness. Specifically, I highlight the relevance of Interpretive Description as a qualitative approach to answer the current research question.

Qualitative Paradigm

Qualitative research approaches are rooted in diverse epistemological traditions each emphasizing a different set of assumptions and philosophy of science. Below, I describe my reasons for engaging in qualitative research and situating myself within a social constructivist paradigm under the larger umbrella of Constructivism-Interpretivism (Ponterotto, 2005) paradigm as elaborated below.

A qualitative approach was pursued here because it places central attention on the “lived experience” of participants and illuminates multiple perspectives rooted in socio-cultural contexts and everyday life processes (Ponterotto, 2005; Smith & O’Flynn, 2000). I also believe that a qualitative paradigm was best suited because it invited inductive ways of knowing embedded within particular contexts (Polkinghorne, 2005). The social constructivist aspect of
my chosen paradigm fits my research objective of valuing multiple realities in addition to the social encounter between the researcher and those who were the focus of inquiry. However, I go further than individual constructions (Ponterotto, 2005, Creswell, 2007) to employ a social constructivist stance, emphasizing that the co-construction of meaning is rooted within the everyday historical and sociocultural contexts, thus highlighting the inherent complexity and embedded nature of subjective experiences. I believe that a social constructivist stance helps me challenge the understanding of individuals as “fixed,” and have a broader conception of participants’ meaning making, in line with O’Conners’s (2001) arguments that people “use multiple and sometimes contradictory discourses or story line, to make sense of their personal experiences” (p. 141).

When practicing from the interpretive tradition, the researcher is required to make explicit his or her ontological position, i.e., “ways of understanding the basic nature of persons, their core being” (McLeod, 2001, p. 29). By adopting an interpretive stance, I was able to pay attention to the ways that participants’ conversations were embedded within the larger cultural and historical contexts while exploring the different ways that meaning was constructed on the topic of EC diversity factors. The interpretive paradigm also asks the researcher to indicate his or her epistemological position referring “to the ways in which people gain knowledge about the world and come to regard some beliefs as true and others as false” (McLeod, p. 29), thus in this research, I also engaged in examining the values and limitations inherent in the creation of knowledge through the action of reflexivity.

Thus, my social constructivist and interpretive positioning enabled me to attend to multiple contexts, generate alternative perspectives and stay open to biases and assumptions. I also believe that the above paradigm is amenable to research projects such as mine that focus
on complex factors (e.g., gender, sexual orientation, ethnicity, culture) and social processes that gave rise to power differentials, and contribute to inequities and marginality due to one’s positioning in the society (Ladson-Billings & Donner, 2005).

As an emerging scientist-practitioner, I also situate myself within the pragmatic tradition of qualitative inquiry that places emphasis on utility and practical implications of research (Creswell, 2007). This tradition has been quite popular in counselling psychology due to the field’s interest in researching phenomenon of clinical interest and applicability that will inform the profession (Ponterroto, 2005). The major aspect of my current research relates to the tradition of pragmatism in the ways that it examines “the consequences of actions based upon particular conceptions” (Cherryholmes, 1992, p. 13) and by providing information that has practical significance. Instead of valuing one inquiry over another, the tradition of pragmatism focuses on “what works” to gather the essential information through research (Patton, 1990). Together, Interpretive Description (Thorne, 2008) and the pragmatist paradigm (e.g., Cherryholmes) allowed me to not only explore a research question that originated from clinical experience but to also consider how the findings of this study might be used in practice.

**Interpretive Description**

Interpretive Description, a qualitative approach to inquiry, has emerged from applied health research. Developed by Thorne (2008), it attempts to promote knowledge generation that directly benefits clinical practice. Thorne asserts that in the current environment of evidence-based practice and knowledge translation, it is becoming increasingly important for health researchers to pursue innovative and flexible means of inquiry. As such, the aim of Interpretive Description as an approach to knowledge is the following: to help the researcher to translate the generated knowledge into the clinical context, to explicate the complexity of clinical issues
arising in the field, and to promote the development of appropriate and effective interventions and assessment tools that will benefit the health users.

Interpretive Description is described more as a framework than a method, with Thorne (2008) emphasizing that it is founded on the notion of a research design that from the outset identifies a practical aim for generation of knowledge. As an approach, it is therefore considered to be “designed to fit the kinds of complex experiential questions that they [nurses] and other applied health researchers might be inclined to ask” (Thorne, Kirkham, & O’Flynn-Magee, 2004, p. 2). The field of counselling psychology has recently been drawn to Interpretive Description due to its specific emphasis on generation of knowledge that informs clinical practice. Some examples include: understanding the ethics experience of eating disorder therapists with a personal history of eating disorder (Williams, 2011); exploring elite athletes’ experience of identity changes during a career ending injury (Muscat, 2010); exploring the Iraqi immigrants’ experience of the North American media coverage of the Iraq war (Rostam & Haverkamp, 2009); and understanding the counsellors’ experience of the ethical dimensions of social justice advocacy (Johnson, 2007). Thorne (2008) asserts that Interpretive Description calls for the generation of informed action as part of the social mandate for scientist practitioners and as such, this way of thinking fits well with my own aforementioned theoretical positioning on ethics, social justice and cultural safety.

Thorne (2008) states that our immersion in the professional field provides the fertile ground for us to ask pertinent research questions and seek answers that will not only improve the health outcomes of those we serve, but also expand the foundational knowledge of our professional discipline. Therefore, the focus is on how the research data illuminates some of the clinical problems we encounter as professionals in the field. Thus, my current area of research
strongly arises from my prior engagement as an A&D counsellor in the field providing treatment to diverse client groups. As for biases and assumptions that I bring as a researcher, please refer to the reflexivity section at the end of this chapter.

While Interpretive Description is embedded within a constructivist paradigm (Thorne, 2008), I am applying it from a social constructivist stance, acknowledging the shared and highly contextualized construction of meaning by the participant and the researcher. Interpretive Description, therefore, argues that there are multiple realities and ways of knowing and as such a researcher can use various sources of data (e.g., journaling, document analysis, field observations) to better understand this research context (Thorne, 2008; Thorne, Reimer-Kirkham, & O’Flynn-Magee, 2004).

As with any approaches to inquiry, there are limitations to Interpretive Description. As also noted by Hunt (2009), some of the challenges I experienced in study were as follows: (a) encountering ambiguity regarding the degree of interpretation and level of abstraction needed during analysis, (b) balancing the demand for generating practical knowledge while being careful not to decontextualize or become prescriptive, and (c) engaging in a lesser known approach with limited guidelines and or resources in terms of the choice of analytic decisions and activities. In order to overcome the above challenges, I tried to engage in continued self-reflexivity, debriefing with my researcher supervisor to provide sufficient level of interpretation so that findings are elaborated and enhanced and practical implications are gleaned. In addition, I aligned my chosen analytic framework (Miles & Huberman, 1994) with the aforementioned aspects of interpretive description as suggested by Thorne (2008), strengthening the defensibility of the research design. Furthermore, to avoid being prescriptive in terms of generating practical findings, I focused on elaboration of the multiple contexts, contradictions
and nuances inherent in participants’ complex construction of EC factors and their relevance to practice.

**Research Design**

From a design point of view, Interpretive Description is emergent (i.e., no pre-determined categories), iterative and contextually based, in addition to encouraging a constant comparative process within case and across cases aimed at illuminating discipline-specific clinical knowledge (Thorne, 2008) as will be illustrated in the data analysis section. The above fits my choice of pursuing a qualitative design aimed at elucidating the processes and socio-cultural contexts that may underlie A&D counsellors’ understanding and incorporation of clients’ EC diversity factors in therapy.

Primarily, the design of an Interpretive Description investigation requires the researcher to “build up a body of knowledge,” and “organize [it] around a disciplinary conceptual frame”(Thorne, 2008, p. 33); this consists of the literature review and the theoretical scaffolding, or the perspectives the researcher brings to the study. Thus, it goes beyond surveying current knowledge to the researcher making his or her assumptions and theoretical lens explicit in the process. The challenge that I faced as a researcher in building a body of knowledge is the paucity of research and disciplinary knowledge particular to substance use counselling with EC clients in Canada. Thus, it is my hope that this current research will contribute to address this limitation. In the sections that follow, I specifically outline the procedures that I employed with regards to participant selection and recruitment, data collection, and data analysis. I also outline researcher’s reflexivity, ethical reflections and the criteria to ensure trustworthiness.
**Participant selection and recruitment.** A qualitative inquiry such as interpretive
description utilizes purposive sampling by providing the opportunity to gather rich and in-depth
information. Thorne (2008) states that purposive sampling is pursued when “the settings and
specific individuals within them are recruited by virtue of some angle of the experience that
they might help us better understand” the research question (p. 90). Additionally, Patton (1990)
states that the “logic and power of purposeful sampling lies in selecting information-rich cases
for study in depth. Information-rich cases are those from which one can learn a great deal about
issues of central importance to the purpose of the research, thus the term purposeful sampling”
(p. 169).

Therefore, given that my focus was on gleaning knowledge that may help inform clinical
practice, I chose participants (A&D counsellors) who I believed would be able to provide the
necessary information to answer my research question. I also hoped that through purposive
sampling, my participant sample would provide rich information as well as multiple
perspectives that could be compared and contrasted (Patton, 1990; Polkinghorne, 2005).
Interpretive Description’s design is flexible and dynamic and thus encourages the adaptation of
the inquiry process as more information is gathered and new themes and patterns are
discovered. In order to explicate the complexity of clinical contexts in which A&D counsellors
are embedded, Interpretive Description additionally invites inclusion of multiple sources of
data within its emergent design.

Sandelowski (1995) recommends that a sample size of 15 can be sufficient to provide a
comprehensive understanding of the phenomenon under study. However, Interpretive
Description recommends keeping the sample size emergent as data is gathered and is
simultaneously analyzed. As previously mentioned, it encourages using multiple sources of
data to answer the research question. Initially, the plan was to conduct qualitative interviews with an approximate sample of 10-15 counsellors who worked at mainstream substance use treatment centers and identified as A&D counsellors. However, to obtain a diversity of perspectives, other variations were sought, consistent with Thorne’s (2008) suggestions to enhance heterogeneity in sample. The variables of interest included paying attention to diversity in age, gender, professional discipline (counselling, clinical and social work), years of experience, treatment setting type (inpatient and out patient) as well as groups of counsellors who may work within culturally specific community settings, albeit still affiliated with and funded by the health authorizes. The research committee recommended that additional participants who were NOT A&D counsellors (other professionals) might be sought if during data analysis these sources were identified to help answer the research question. Thus, as I engaged in interviews and simultaneous data analysis, certain patterns emerged. That is, the preliminary data analysis pointed to some counsellors consistently referring to their work context, and the role of their supervisors and managers in how EC factors were understood and incorporated at the agency level.

In consultation with my research supervisor, it was decided that “other professionals” affiliated with mainstream A&D services (e.g., substance use treatment program directors, supervisors, consultants and managers) would be sampled and sought. This decision in design was based on the premise that interviewing other professionals would help further contextualize A&D counsellors’ work with their diverse clients and was thus consistent with Interpretive Description inquiry. Once the need for these perspectives was identified, recruitment occurred; relevant flyers and letters were sent to mental health and addiction services and agencies in Lower Mainland British Columbia as well as their respective health authorities. It was also
anticipated that if participants recommended certain individuals (who were affiliated with A&D services) for participation in this study (through word of mouth), every measure would be taken to not disclose the identity of those who have referred potential participants. As such research recruitment letters (Appendix A for counsellors and Appendix B for other professionals) were sent directly to the agencies participants recommended, and interested individuals were asked to contact the co-investigator directly.

The inclusion criteria for participants included the following counsellors:

1) Who professionally identified as A&D or substance use counsellors
2) Provided counselling (for at least 2 years) at an A&D agency affiliated with Lower Mainland, British Columbia Health Authorities.
3) Provided, and or are currently providing care to clients from diverse EC backgrounds.
4) Worked at agencies that provide a spectrum of A&D treatment (i.e., harm reduction, detox, abstinence-based programs etc).
5) Completed their Masters degree in psychology (counselling and/or clinical) and/or social work.
6) Communicated and spoke in English.

Other professionals affiliated with A&D services (e.g., substance use treatment program directors, supervisors, consultants and managers) were sought as new patterns in the data emerged. Inclusion criteria for this population were those professionals who:

1) Were working (other than as a counsellor) for an A&D treatment center/agency, affiliated with the Lower Mainland, British Columbia Health Authorities,
2) Were part of an agency that provides A&D services to clients from a diverse EC backgrounds,
3) Were part of an agency that provides a spectrum of A&D services (i.e., harm reduction, detox, abstinence-based programs etc),

4) Communicated and spoke in English.

Recruitment of participants occurred by distributing research advertisement posters to various counselling agencies, including outpatient and inpatient substance abuse treatment centers (hospital and community-based) and general counselling services (community-based) in the Lower Mainland region. I included other agencies in addition to substance abuse treatment centers because mental health counsellors often refer clients to more specialized services when it comes to substance abuse problems, thus having direct contacts with substance use counsellors in the field. Furthermore, I also emailed my research advertisement to mental health and addiction networks in the province and the relevant professional associations.

Please note that this study excluded counsellors who only worked at 12-step programs. While 12-step is a widely recognized recovery based program, offered at many treatment settings as a support group, its main function at mainstream services is to provide peer-support. Thus, it is not necessarily viewed as a formal psychological treatment offered by those trained in counselling psychology and or social work. The exclusion criteria outlined below included individuals:

1) Who did not specifically provide A&D counselling,

2) Provided A&D counselling solely as part of their private practice,

3) Whose work was affiliated with a privately-funded A&D agency/clinic/institution, and

4) Who worked at agencies/clinics that only incorporated a 12-step abstinence based recovery model for substance use treatment.

Exclusion criteria for other professionals affiliated with A&D services were those:
1) Who professionally identified as A&D counsellor only

2) Whose agency was affiliated with a privately-funded A&D agency/clinic/institution, and


**Participant characteristics.** The sample in this study was composed of 27 participants (including counsellors and non-counsellors) whose ages ranged from 28 to 65 years. While a demographic form was used to gather more specific information about the participants, it was proposed as optional with participants’ declining all or any parts. In describing the sample characteristics, participants’ own terms and descriptions are utilized.

Fifteen females and 12 males residing in different cities in the Lower Mainland, British Columbia agreed to participate. Nineteen out of 27 participants identified as A&D counsellors (Participant numbers: 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 14, 15, 19, 20, 21, 22, 23, 25, and 26). Four participants (numbers 1, 5, 16, and 17) described their dual role in the agency, i.e., while they worked as counsellors, certain portion of their work duties also included supervision of counsellors on the team selected based on interest and years of experience, and not necessarily based on specific training as supervisors, or consultants. Counsellor participants, including those with dual counsellor/program leadership roles, were interviewed twice, for 1-1.5 hours each, with the exception of participant 19 who was unable to attend a second interview due to family related concerns, unanticipated prior to the initial interview.

Four participants (numbers: 13, 18, 24, and 27) described themselves as professionals not engaged in direct counselling and participated in one 1-1.5 hour interview. They described their specific work responsibilities as Consultant to A&D residential treatment; Executive
Director; Program Management for Addictions; and Program Director respectively. However, participant 18 had shifted recently from an A&D counselling role to a full time administrative role in the agency and volunteered to be interviewed twice to speak of his A&D counselling experience.

The participants overall represented a variety of EC backgrounds. Please note that the participants themselves chose the categories for EC membership. Participants identified themselves using a single or combination of the terms such as: Punjabi, South Asian, Chinese, Canadian of South Asian descent, Canadian, Australian, Latin American, South Asian Punjabi, Indian, Indo-Canadian, Swedish, Celtic-Druid, English-Welsh, Greek-Cretin, Italian, Caucasian, Irish, Spanish-Canadian, Mennonite-Dutch, Cornish-British, British, Romanian, Scottish, French and English. Five participants described themselves as a person of color and/or as being a visible minority; further many of these participants reported being hired specifically to provide counselling in a language other than English (Punjabi, Hindi, and Chinese). Of the 27 participants, 7 reported being first generation immigrants to Canada with several stating English as their second or third language. The majority of counsellors in this study reported being born and raised in Canada, with four participants describing themselves as being second-generation immigrants, belonging to visible minority groups.

Participants who engaged in direct counselling described their job title as Counsellor, Addictions Specialist, Addictions Counsellor, Clinical Counsellor, Outreach Counsellor, A&D Counsellor, Stopping the Family Violence Counsellor and Family Addictions Counsellor. Years of work experience in the field of A&D counselling ranged from 2 to 40 years, albeit those with higher numbers of years in the field also reported having worked in a combination of settings such as private practice, general counselling and A&D counselling. Participants
identified their clinical orientation on the form as consisting of a range of approaches. Examples of the mentioned theoretical orientations were: Adlerian, bio-psychosocial-spiritual orientation, cognitive behavioral therapy, mindfulness, empowerment, client centered, feminist, Buddhist, motivational interviewing, narrative therapy and other approaches.

In terms of education, participants had multidisciplinary backgrounds. Of those who identified as counsellors, 7 had completed their Master of Arts (MA) degree in Counselling Psychology and another 5 indicated having Masters of Education in Counselling Psychology. Another 3 counsellors had completed their Masters in Social Work. One participant came with a PhD in clinical psychology from another country, however was not able to get it recognized, and was working as a clinical counsellor. One participant stated having finished his Masters in Humanistic psychology. Another stated having received his masters in counselling without specifying MA/MEd degrees. In this group, there was only one counsellor without graduate level training who reported being interested in this study due to his experience of being selected by the designated health authority to work within his community (for the purpose of confidentiality, the specific EC community he worked with is not identified here). He stated having received a counselling certificate. Prior to conducting interviews, I consulted my researcher supervisor and it was decided that given his background and the objective of purposive sampling, he should be included in the study.

Those professionals with the dual role of counselling and supervision/management also came with a variety of educational backgrounds: 1 with Masters of Education in Counselling Psychology, 2 with Masters in Social Work, and 1 with Masters of Arts in Counselling Psychology. In terms of other professionals not affiliated with counselling directly; all had graduate level training ranging in disciplines such as: 1 Masters in distributed learning in
combination with child and adolescent psychology; 1 MEd. in counselling psychology, 1 Masters in social work, and 1 with Masters in public health.

In terms of participants’ affiliation or registration with professional association and licensing bodies for all participants; 6 counsellors stated being registered with British Columbia Association for Clinical Counsellors (BCACC) as registered clinical counsellors, 5 with BC College of Social Workers (3 counsellors, 1 with dual role of counsellor and supervisor/manager) and 3 with the Canadian Counselling and Psychotherapy Association (2 counsellors and 1 with dual role of counselling and supervisor/manager). Two participants who had recently immigrants also reported keeping their professional associations membership with their home country. Eight participants stated no current membership. Two participants who were not directly involved in counselling (i.e., other professionals) held membership in different associations such as licensure as a public health administrator.

As for the types of work setting for all participants (counsellors and non-counsellors), 8 participants worked in residential treatment settings that included both co-ed residential setting and all women’s program. Nineteen participants worked in outpatient settings. Within the outpatient settings, the majority provided A&D counselling to diverse groups. However, a few identified also being involved (mainly on part time basis) in working with specific population groups such as Punjabi and Chinese speaking groups, the elderly, youth and the homeless. None of the outpatient settings focused on abstinence models but rather on helping clients recover from problematic use, based on harm reduction models. The settings ranged from providing detox, stabilization, intensive treatment and transition back to the community. The settings served mainly adult population, with both individual and group formats, the latter being more common in the A&D settings. Please refer to Table 1 below.
Table 1: Participant Characteristics

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Range (28-65 years old)</td>
</tr>
<tr>
<td>Gender</td>
<td>12 males, 15 females</td>
</tr>
<tr>
<td>Ethno-cultural background</td>
<td>20 out of 27 participants identified as being Caucasian and or having European heritage such as: Canadian, Australian, Swedish, Celtic-Druid, English-Welsh, Greek-Cretin, Italian, Irish, Spanish-Canadian, Mennonite-Dutch, Cornish-British, British, Romanian, Scottish, French and English. 7 out of 27 participants identified as being Indo-Canadian, Chinese-Canadian, Punjabi Canadian, Latin American, with 5 of these participants also identifying as a person of color, and or visible minority.</td>
</tr>
<tr>
<td>Education</td>
<td>For those identifying as counsellors only 7 with Masters of Arts degree in Counselling Psychology, 5 with Masters of Education degree in Counselling Psychology, 3 with Masters in Social Work, 1 with PhD in Psychology, 1 with Diploma in Counselling, 1 with Masters in Humanistic Psychology, 1 with Masters in Counselling (specification in terms of MA/MEd degree not provided). For those counsellors identifying as having dual roles 1 with Masters of Education in Counselling Psychology, 2 with Masters in Social Work, and 1 with Masters of Arts in Counselling Psychology. For other professionals/Non-counsellors 1 Masters in distributed learning in combination with child and adolescent psychology; 1 MEd. in counselling psychology, 1 Masters in social work, and 1 with Masters in public health.</td>
</tr>
<tr>
<td>Years of work</td>
<td>Range (2-40 years)</td>
</tr>
<tr>
<td>Settings</td>
<td>8 inpatient/residential, 19 outpatient Range of services provided within group or individual contexts including: detox, stabilization, intensive treatment, transition to community, gender specific counselling, culturally specific services, and outreach.</td>
</tr>
</tbody>
</table>

**Interviews.** This qualitative study utilized individual interviews (open-ended) with each participant. Once the participants directly contacted me via phone and or email as per the
contact information provided in the recruitment flyer/letter, I briefly screened potential participants on the phone to make sure they met the inclusion criteria. Once the screening requirement was met, I discussed the volunteer nature of the interview, informed consent, confidentiality (verbally) and the overall purpose of research. Until the individual interview was arranged (taking approximately several days to a week), the participants had the opportunity to consider their participation in the research, and were told they were free to cancel their pre-arranged appointments. All participants requested that I come to their work setting to conduct the interviews and that is where all the interviews took place. Given that all counsellors were interviewed twice, the purpose of the second interview (taking place approximately 1 week after the completion of the first interview) included a range of activities such as: to ensure that all questions in the interview guide were addressed, to ask for clarification of responses from the first interviews, to provide counsellors with a brief summary of preliminary themes, and to allow counsellors an additional opportunity to reflect and elaborate on the questions that they had answered.

All face-to-face interviews began by a brief introduction by the interviewer about the purpose of the study, followed by reading and signing of the informed consent form. All participants were provided with a signed copy of the form. This form (Appendix C for counsellors and Appendix D for other professionals) explained the purpose of the study, the nature of interview, confidentiality, the potential risks and benefits to the participants, and their right to withdraw from the study at any time. This was followed by a series of open-ended questions as described below (see Appendix E for counsellors and Appendix F for other professionals) and finally the completion of a demographic questionnaire (Appendix G) at the end of the interview. While the demographic questionnaire was presented as optional, all
participants offered to complete it. Given that this was a qualitative design, process consent (Seidman, 2012) was negotiated throughout the interview. Debriefing occurred at the end of each interview and a list of cross-cultural resources (Appendix H) was made available in case participants highlighted their desire to know more about resources in the community for their diverse clients.

All interviews were audio-recorded and transcribed verbatim by two research assistants who had had prior experience of transcribing qualitative interviews. Both assistants agreed to the study’s confidentiality requirements and password protected each data source when working on them. One of the assistants had extensive experience of managing health research data, and thus helped organize data files on Atlas ti.

Data analysis occurred simultaneously with data collection as the interviews progressed. The open-ended format of the interviews was used to allow the participants to freely reflect, recall, and respond and for individual variation to emerge (Hoepfl, 1997). Kvale (1996) states that interviews can be an effective and important means to elicit specific, rich and coherent description of participants’ experiences.

Van-Manen (1990) refers to the researcher engaging in the art of an interpretive interview, where he or she stays open to the question and the meaning of the phenomenon, orients him or her self to the “substance of the thing being questioned,” and “begin[s] to care about the subject and the research question” (p. 98). The participant is viewed as the co-investigator throughout the research process, and that such positioning is conducive to the constructivist philosophy of this research. As mentioned in my theoretical forestructure, I utilized the frames suggested by Ensink (2004) to process the social dimensions of interviews.

The main research question that guided the interviews was:
I utilized the following list of sub-questions to illuminate the above research question. Please refer to interview guide in Appendix E for specific probes used.

1) When you meet a client for the first time, I am interested in learning about how you go about getting to know them, and what they need from counselling?

2) I am curious about how you go about getting to know clients from a variety of ethno-cultural communities, and what they need from counselling?

3) How do you figure out what approach is effective and important when providing A&D counselling to ethno-culturally diverse clients?

4) What influences your A&D counselling with ethno-cultural clients?

5) What has it been like for you to participate in this research?

After each interview, I recorded personal reflections (the process involved journaling my own reactions, feelings and thoughts about the research process) and pertinent information about the context of interviews. This helped me stay cognizant of ways that my own assumptions and expectations might be imposed on the participants. Similarly, I hoped this activity would enable me to be more aware of my reactions to instances of when I reacted to comments made by the participants, and whether I was leading them to say particular things during the interaction. This process was flexible with no predetermined guidelines, thus helping me stay open to the process.

**Data analysis.** Interpretive Description employs an inductive process of data analysis that aims at capturing the context and does not recommend a set of prescriptive rules or steps for analysis (Thorne, 2008). Interpretive Description calls for the use of a solid analytic framework found in the literature, and as such, does not provide a model or step-by-step
approach for data analysis. Interpretive Description’s suggestions are based more on a set of conceptual guidelines that will inform the researcher to navigate the multi-faceted path underlying the qualitative data, requiring creativity and flexibility. Thus, it supports “defensible design variations according to the specific features of context, situation and intent” as long as the integrity and coherence of the data is maintained (Thorne, 2009, p. 27).

In this study, I utilized the analytic framework suggested by Miles and Huberman (1994) to help guide the data analysis, because it is considered practical and iterative as per Thorne’s (2008) recommendations, allowing me to describe and synthesize a large amount of data. Thorne states that Interpretive Description (2008) consists of three essential phases: 1) description, 2) analysis and 3) interpretation. I used Miles and Hubermans’ suggested series of activities or steps to implement each of the above three phases and these include data reduction, identifying patterns and themes, and drawing conclusion, as elaborated shortly. I perceived Miles and Hubermans’ approach to be a good fit with Interpretive Description’s emphasis on approaching data in a cyclical, non-linear and concurrent manner. Please note that while I recognized the above phases as overlapping, and that I engaged in them simultaneously for the most part, for the purpose of clarity, I describe them separately to outline my research process.

**Description.** According to Thorne (2008), the description phase requires the researcher to react to the “initial pieces” of data. Miles and Hubermans’ (1994) recommend that the researcher reflect on what is occurring in the participants’ accounts as he or she chooses certain words or key phrases to sort and organize his or her observations into a manageable form. This active process is referred to as *data reduction*; however, the word reduction by no means indicates a reductionist or simplistic approach to inquiry (Miles & Huberman). The attempt in this phase of the project was to reduce data overload and focus the data by the means of
summarizing, paraphrasing and selecting segments of each interview (within case) that I perceived as relevant to the research objective as elaborated below. Given the large amount of data, I utilized ATLAS.ti5 software to help with organization and data access, employing its organizational capabilities rather than its analytic functions. In addition, ATLAS.ti5 was used to create an audit trail of the activities associated with this phase.

To engage in the description phase, I carefully selected codes that I believed not only illuminated the participants’ perspectives, but also were directly linked to the research question. Miles and Huberman (1994) define codes as “tags or labels for assigning units of meaning to the descriptive or inferential information compiled during a study” and have different levels of analysis that lie on a continuum, from descriptive to inferential, and general to specific (p. 56). The codes I generated helped me organize the information in a systematic way enabling me to describe and link themes later during the analysis and interpretation phase. There was no prior coding system; instead, based on my immersion in the data, codes were created, revised, and re-entered as they emerged during the multiple readings of the interview transcripts.

While I anticipated that the interviews with counsellors and non-counsellors would illuminate somewhat different aspects of the research question, in the initial descriptive phase I approached all transcripts with similar questions in mind. In this phase, I strived to learn about how participants in general constructed the term “Ethno-Cultural,” and was thus drawn to words and phrases used to describe and define the above in relation to A&D counselling with diverse clients. Further, I utilized the non-counsellors’ transcripts with the intention of illuminating the organizational dynamics and or contexts that may help me further understand counsellors’ perspective and attitudes towards relevance of EC factors in A&D counselling with diverse clients. My objectives in this phase were not to create a list of definition for the
term EC, but to describe and code participants’ understandings (i.e., beliefs, interpretations, preferences approaches, and meaning making process) as they talked about clients’ EC differences in the context of A&D service delivery.

I engaged in multiple readings of transcripts and absorbed as much information as possible in order to get an intimate understanding of the data. Thorne and colleagues (2007) assert that the researcher should attend to “synthesizing, theorizing and recontextualizing rather than simply sorting or coding” (p. 175), thus pointing out how the description phase should be pursued in a cyclical fashion with the next phases, i.e., analysis and interpretation as described shortly. Furthermore, Interpretive Description during this phase requires the researcher to take a holistic perspective towards the data and code globally, i.e., code for themes and ideas. Miles and Huberman (1994) also suggest “pattern coding,” a process that “tie together different pieces of data into a recognizable cluster, often to show that those data are instances of a general concept” (p. 72).

**Analysis.** The analysis phase in Interpretive Description involves moving “from pieces to patterns” (Thorne, 2008, p. 142) by attending to the inter-relationships among the coded data. In addition, the “objective is rarely at the fine-tuned level of words and expressions but far more often in the realm of themes and ideas” (Thorne, 2008, p. 145). Please note that in writing about this phase, I recognize that the activities I engaged in were intimately connected with the next one, i.e., the interpretive phase. I pursued the following overlapping activities proposed by Miles and Huberman (1994) during the analysis phase: looking for themes and emerging patterns. The procedure of pattern coding/global coding conducted during the descriptive phase helped me identify larger concepts and develop themes. In literature, a theme is often defined as an “element (motif, formula or device) which occurs frequently in the text” without being
rule-bound (Van Manen, 1990, p. 78), thus helping the researcher to make sense of the data. In looking for themes, my focus was not on repetition or frequency of certain ideas, as Thorne (2008) cautions, but rather on the relationship among ideas to develop new insights while keeping the larger context of conversations in mind.

I continued to evaluate the generated themes for similarities and differences. I examined why certain themes fit better in terms of answering the research question and others did not, i.e., looking for central and peripheral themes. The process of writing memos and drawing informal networks/maps as part of journaling helped me recognize how various codes related to themes. I concentrated on gathering diverse patterns in the data, moving from the specific to the broader context of participants’ accounts (Miles & Huberman, 2004). I then moved to creating categories of themes that provided an opportunity for me to think differently and look for commonalities and differences within and across cases. In terms of within case analysis, I treated each individual account as a whole case and immersed myself in each interview as an attempt to distinguish information relevant to each participant. For example, within case analysis allowed me to capture the contradictions inherent in how participants positioned themselves in relation to EC factors. I thus compared and reconnected significant statements to each other within the same interview, An example is when a participant stated that she is color blind and treats everyone the same, and later in the same interview she identified how important cultural contexts are to her understanding of A&D problems and while working with recent immigrants.

Additionally, within case analysis helped me to understand the nuances inherent in individual’s interviews focusing on the intersection of EC factors and their relevance in A&D context. Such within case analysis particularly emerged around conceptualization of addiction.
as disease, for instance when a counsellor stated that culture did not matter in addiction
counselling and later he stated validating the clients cultural worldviews as part of relationship
building. The within case analysis, therefore helped me have a holistic approach to interviews
and attend to embedded conflicting perspectives within each case, while describing the
influence of the various contexts (e.g., organizational dynamics) with respect to the relevance
of EC factors as experienced by each individual respondent in relation to self, clients, his or her
unique understanding of counselling relationship and organizational culture, as further
elaborated in the findings chapter.

The key question I kept asking throughout this phase was “what is the significance of the
highlighted themes to my research question and to each other as a whole, within and across
participants?” Such reflexive questioning helped me stay open-minded and generate alternative
ways to make sense of data. The action of within case and across case comparisons therefore
enable me to critically reflect on identified themes and stay cognizant of instances when my
analysis would run the risk of becoming reductionist.

Miles and Huberman (1994) also recommend that researcher be reflective, such as
paying attention to the underlying meaning of what participants are saying and how they are
reacting to the interviewer. As per Miles and Huberman’s suggestions, I additionally engaged
in triangulation and debriefed with my research supervisor to gain new angles of vision. The
above activities fit with Thorne’s (2008) assertions that during the analysis phase, one has to be
mindful of information pieces that stick to his or her “antennae,” unconsciously influencing
one’s expectations and initial impressions (p. 142), thus contributing to premature closure.
Such awareness is also thought to help the researcher stay open not only to prototypical cases
but also contrasting and contradictory accounts.
During this phase and continuing until the write up of the findings chapter, I revisited the data by reading and re-reading of transcripts, memos, generated themes and journal entries to get a sense of the whole interviews. Based on my theoretical scaffolding of attending to the social and interactional dynamics of the interviews (Ensink, 2004), I analyzed my observations of some participants’ sense of discomfort, resistance and or guardedness when the topic of research evolved into conversations about culture, ‘race,’ ethnicity and color (please refer to section on researcher reflexivity). In consultation with my research supervisor and committee members, I decided to look for themes and patterns that delved into the immediate context of interviews with participants.

Interpretation. While, I recognize that interpretation is embedded within the analysis phase, for the purpose of clarity, I have described it separately. This phase involved my learning about the “associations, relationships, and patterns within the phenomenon that [had] been described” (Thorne, 2008, p. 50). Interpretation as a phase is considered to “addresses processual questions of meanings and contexts,” with the researcher asking him or herself the questions such as “how does it all mean?” and “What is to be made of it all?” (Wolcott, 1994, p. 12). In this final phase, the specific processes proposed by Miles and Hubermans’ (1994) included drawing conclusions, while also being alert to not rigidly hold on to one’s generated conclusions.

During interpretation phase, I strived to maintain an open and questioning mind by looking at alternative and competing themes, while generating alternative conceptualizations of the relationships among thematic categories (Miles & Huberman, 1994). One of the central tasks at this stage, according to Thorne (2008) is recontextualization, i.e., requiring the researcher to question the implications of findings, and to generate findings that could help
inform clinical practice. To that end, I asked, “How does this relate to practice? What could be useful to an A&D counsellor?”

Thorne (2008) suggests distinguishing between the tasks of explanation and interpretation within the context of conceptualizing the findings. Explanation, which was not a goal in the current work, is considered to be “the understanding of causal antecedents,” while interpretation is considered to be about “delineating the context [that] may help us understand why something occurred” (Roth, 1991, as cited in Thorne, 2008, p. 202). In order to interpret the multiple constructions of participants’ accounts, I referred back to Interpretive Description’s philosophy, which asserts that the “social, structural, cultural, and historical context of human experience [be] recognized as powerfully influential upon what we know, experience, and think” (Garrick, 1999 as cited in Thorne, 2008, p. 202). The above prompted me to interpret how multiple contexts played out in individual experiences, and thus how knowledge was being constructed as a whole and within the relational dynamics of the interviews, as per Ensink’s (2004) interview frames outlined in Chapter 2.

As I studied the themes focusing on the immediate context of the interviews, I interpreted and conceptualized the interview context as a whole as a cross-cultural encounter between participants and me as a female research of color. The aim of the above conceptualization was to further illuminate how participants negotiated differences with me and what I could learn about their overall understanding of differences in relation to themselves, clients and A&D practice. Furthermore, I utilized the theoretical forestructure and literature review as guides to help me contextualize the findings within the established research. However, I consciously challenged myself to continuously assess the dialectical relationship of the data, re-examining, reflecting and synthesizing the findings to further elucidate the research
Throughout the process of data analysis, I maintained a reflexive and iterative questioning approach. Srivastava and Hopwood (2009) challenge the notion that patterns, themes and categories simply emerge from the data. Instead, they argue that it is the researchers’ choices, assumptions, theoretical lenses and subjective positioning that drive what aspects of data get selected, analyzed and interpreted. Thus, as I described, analyzed, constructed and interpreted each participant’s account, I attended to aspects of the data that were surprising, contradictory, confusing and challenging. For example, when counsellors engaged asserted in not seeing color, culture and or ‘race,’ while at the same time making stereotypical comments about clients from minority groups, or comparing some of their values around health to Eurocentric norms. I discussed my interpretations with my research supervisor regularly, in addition to individual consultations with my other research committee members. I engaged in writing and re-writing in order to provide an in-depth understanding of the participants’ perspectives, both implicit and explicit. This process of re-writing continued until I believed I had found a coherent and comprehensive picture of the data at hand, one that provided an answer to the question of “How do counsellors understand and incorporate EC diversity factors in A&D counselling?” The picture that emerged is presented in the findings chapter.

**Reflexivity.** Reflexivity is considered a defining feature of qualitative approaches (Banister, Burman, Parker, Taylor, & Tindall, 1994), given that, the researcher uses him or herself as the instrument for collecting information (Rew, Bechtel and Sapp, 1993). Finlay (2003) sums up the situatedness of reflexivity within an interpretive tradition by stating that “our presuppositions and prejudices are both our closeness and openness to the world,” and that
“[a]ny understanding we gain (e.g., from research) will inevitably inform us simultaneously about the object of the study and about our own preoccupation, expectations and cultural traditions” (p. 107).

I acknowledge that this study is influenced by my personal and 2 years of professional experience of working as an A&D counsellor with clients of diverse EC backgrounds, seeking residential treatment for their substance abuse problems. As a practitioner and a person identifying as a person of color and an ethnic minority, I found certain aspects of the delivered programs Euro-centric, often times lacking the consideration of diverse factors contributing to clients’ A&D related behaviors. Through my work with mandated minority clients at a residential treatment center, I became aware of the limitations of the provided mainstream services. Often my impressions were that the group intervention models were not adequately tailored to meet diverse clients’ needs. Several components of the psycho-educational workshops, interventions, written assignments, and residential guidelines presented challenges in terms of their effectiveness and relevance to diverse clients (particularly for those with limited English). This was an experience that motivated me to pursue my doctoral degree in counselling psychology and to conduct the current research.

During this research, I challenged myself not to impose the above perspective onto the experiences of my participants. At each step, I strived to be open to surprises and contradictions, and considered them more as essential pieces of information rather than disappointment that they did not fit my perceptions. Situating myself within a constructivist framework and reflexive journaling helped me stay open to the process, and deconstruct my values, assumptions and worldviews. I believe that such inward critical gaze came with its own challenges and gifts.
I strived towards situating myself within the research process by keeping a journal and brief memos, which were utilized as additional sources of information during analysis of findings. Reinhartz (1997, as cited in Guba and Lincoln, 2005) speaks about the many selves that we bring in to the research process and their inherent interplay with one another. These include our “research-based selves, brought selves (the selves that historically, socially and personally create our standpoints), and situationally created selves (p. 210). It is also emphasized that any researcher working from a constructivist framework should “interrogate” these selves and reconcile the contradictions and paradoxes that come with such process. As such, I believe that treating interviews as a cross-cultural encounter helped me further analyze how the concept of differences arising from EC factors were co-constructed with me as a female researcher of color in the immediate context of interviewing.

I was often shocked to hear some of the counsellors’ comments about my being from a different EC background, particularly those making racialized comments and exhibiting color-blind attitudes. Initially, I was hesitant to bring such responses and reactions towards into findings and discussion of this study. Yet, my committee’s feedback was that these co-constructions of differences within the interviews were an important analytical and interpretive lens to bring into the study. I experienced it as an enormously challenging task to comment on the relational aspects of the interviews with regards to my differences as a female researcher of color, and thus sought multiple sources of literature where qualitative researchers had just done that, making their rationale explicit.

Additionally, it was hard to name these processes as they were unfolding in the interviews and during the multiple readings of the text during analysis and interpretation. I found myself feeling scared for fear of causing judgment, “rocking the boat,” or challenging
my participants’ assertions on issues such as ‘race,’ color ethnicity and culture. I was afraid that if I critically analyzed participants’ responses, I would not be giving respect to their viewpoints.

Prior to the interviews, I assumed that participants would reflect entirely on their work with clients coming from diverse EC realities. The concept of researcher as having more power as compared to the participant raised questions for me when I experienced a reversal of power in some of the interviews. I did not anticipate that my skin tone, accent and gender would be talked about, or the possibility that I would feel vulnerable as a researcher (as was the case with one participant whose behaviors I perceived to be filled with racialized and sexualized encounters).

As more interviews were gathered and analyzed, I became aware of the ways that I was positioned as an ‘outsider,’ or ‘the Other’ by some of the White participants, and as the ‘insider’ or ‘you are one of us’ by some of the participants who identified as “brown,” “person of color” or “an immigrant to Canada.” On reflection and through consultation, I began to treat the above instances as an important source of data to be analyzed for themes. Overall, it must be noted that, as a researcher, bringing myself into data analysis has been a difficult task, one that is based on my subjective lenses of how participants perceived me and responded to me in relation to the topic of differences.

As I analyzed the transcripts further, I became conscious of a parallel process happening for me in relation to some of the counsellors reactions in the form of resistance to recognize and acknowledge differences or to engage in conversations about this topic thereby insisting that “we are all the same.” Additionally, a few counsellors, while critiquing their work contexts, highlighted the lack of critical dialogues in their work place due to political correctness. As I immersed myself further in critical conversations and readings on ‘race’ and
culture in the Canadian context, I realized that the overall Canadian social context and the
conversations on multiculturalism had also influenced how I was relating to difficult dialogues
on the topic of differences. I had to confront my own ignorance, fear and socialization process
as I was writing on this topic and on several occasions I felt I had no language to express it
articulately. Additionally, to avoid a reductionist lens, I had to constantly situate the
conversations of counsellors within the larger social milieu, the training philosophies, the
context of A&D culture, and the larger socio-political conversations on multiculturalism.

My engagement with research was additionally influenced by my internship training at
the University of California at Berkeley, which happened concurrent of early stages of analysis.
I chose this site for training due to its commitment to multicultural and social justice training,
thus providing me with a platform to openly engage in critical dialogues. Furthermore, one of
my training mandates was to serve underrepresented and underprivileged student bodies on
campus. It was also the first place where I felt a sense of pride working as a therapist of color
on campus. Openly identifying myself as a person of color and finding solidarity with other
minority therapists in a highly multicultural setting enabled me to gain my voice and receive
direct mentorship from supervisors who were also persons of color. While empowering, I also
found the process of exploring, naming and marking my identity as a person of color
emotionally challenging; in a new country with its own historically and politically derived
social construction of ‘race,’ color and culture. In the meanwhile I struggled with balancing the
intersection of my own identities as a female Afghan refugee, Canadian citizen, alien in the
United States, person of color, a researcher, and an academic. The daily supervision sessions
and professional development seminars enabled me find a language where I could not only
process but reconcile the various dimensions of my own being. I mention this internship
experience in my reflexivity because it was a bridge for me to comfortably and confidently engage with the nuances of the topic that I had chosen to investigate.

In sum, reflexivity as a process kept me alert to question my own expectations for these participants in the area of multicultural competencies. I strived to recognize and acknowledge each counsellors’ developmental level, while paying attention to their explicit and implicit attitudes and positions towards differences, related to my research question. I was nevertheless struck by many counsellors’ genuine commitment to be helpful towards their clients, constantly seeking connection in therapy. Managing the complexity of their responses and the inherent contradictions were often difficult to reconcile, as I felt a need to “get it right.” Debriefing with my research committee was essential in helping me negotiate the contradictions and avoid seeking solutions.

**Ethical considerations.** In this section, I briefly outline ethical considerations not only with respect to data collection, but also with regards to the presentation and dissemination of findings. While I believe that this research involved minimal risk, the following harms/risks were anticipated. Given the nature of qualitative interviews, participants may not have been able to foresee what they might disclose, or how they might feel during and after the interview. Therefore, process consent was negotiated throughout the interview to alert participants about the voluntary nature of this research and their rights to withdraw at any time during the process.

During the process of data collection, confidentiality was communicated with respect to the interview information by indicating to participants that digitally recorded audio taped interviews as well as their transcribed reports (i.e., electronic files and their copies) would be password protected on computer. In fact, all paper documents (written transcription of interviews, journaling, contact information, memos, and notes) were kept in a locked filing
cabinet accessible only to my research supervisor, and myself and will continue to be protected, until shredded after five years. I also strived to maintain confidentiality in terms of describing participants’ demographic information as well as how I presented the findings as elaborated below.

Given that my research asked about counsellors’ work with clients of diverse EC backgrounds, participants were encouraged and reminded to not disclose any identifying client information or any other third party information. To maintain confidentiality of the participants themselves, I used participant numbers, and erased any identifying personal or third party information in all reports. Since this research asked participants to talk about their understanding, skills and overall clinical process with respect to provision of A&D counselling to EC clients, it was anticipated beforehand that some professionals might feel discomfort in stating their experiences, or embarrassment if they could not explicitly comment on their counselling process with the above client groups.

In addition, given the topic of this research focused on EC issues, it was anticipated that the participants might feel discomfort, become aware of, or sensitized to their own EC heritage, or that of the interviewer, i.e., who identifies and presents as a person of color, and an ethnic minority immigrant. To reduce discomfort and encourage counsellors to speak openly about the topic, I negotiated process consent and re-iterated the voluntary nature of the interview. In anticipation for counsellors asking me about relevant multicultural resources in the community, I created a list of mental health agencies so that participants themselves or their clients may benefit from (Appendix H). This was again offered as an optional resource at the end of the interviews. I also provided participants with the opportunity to debrief at the end of the interviews.
In terms of presentation and interpretation of findings, there were several ethical dilemmas that I encountered. While I continued to engage in self-reflexivity, one of the questions that kept resurfacing was how to balance and respect participants’ perspectives, while simultaneously critiquing some of the stereotypical and racialized constructions as part of employing a social justice theoretical forestructure. I was therefore pushed to interrogate my approach to inquiry while bearing responsibility to meet the rigor and trustworthiness of the data. While it seemed relatively comfortable to avoid highlighting the racialized and gendered discourses, I felt that it was unethical for me to silence not only my own voice as a female researcher of color, but also of those participants who felt marginalized and racialized by their colleagues and respective work settings. I strived to utilize the above as an analytic framework in understanding how participants constructed EC differences. In particular, I contextualized each participant’s responses as embedded within various socio-political contexts instead of seeing problematic discourses as individual characteristics or personal failings. Related to the above, with respect to communication of findings, my hope was to shift the focus away from the individual and draw attention to constructions of EC differences that I believe as being situated within wider socio-cultural contexts (e.g., dominant discourse of addiction as a disease) that in turn reinforce, reproduce and maintain participants’ views and attitudes. Additionally, ongoing attention to ensuring that participants could not be identified in description of the findings further respected individual participants and protected their confidentiality.

Overall, I believe that this research provided the following potential benefits: an opportunity for participants to specifically share their understanding and incorporation of EC diversity factors that clients presented within A&D counselling context. It was assumed that
this might help counsellors become aware of their own knowledge, resources and skills in the above field. Because the focus of this research was to gather information that would inform and enhance clinical practice, I anticipated that participants might feel that their input was valued and sought after in the area of culturally-competent A&D treatment and services.

**Trustworthiness of data.** Thorne (2008) argues that firstly, all qualitative research has to establish that it has epistemological integrity. This integrity refers to researchers adopting a “defensible line of reasoning from the assumptions made about the nature of the knowledge and through the methodological rules by which decisions about the research process are explained” (p. 223-224). In this study, I have attempted to remain as transparent as possible throughout the following: outlining the current state of knowledge, my assumptions, and theoretical and disciplinary influences. Secondly, Thorne (2008) suggests that the researcher makes his or her “analytic logic” explicit. By utilizing a solid analytic framework such as Miles and Huberman’s (1994), I have made the flow of activities apparent from description to interpretation.

For building credibility and trustworthy indicators within the Interpretive Description methodology, Thorne (2008) recommends using Leininger (1994)’s evaluative criteria: (1) **credibility**, (2) **meaning in context**, (3) **recurrent patterning**, (4) **saturation**, (5) and **confirmability**.

In qualitative research, **credibility** is defined as the “value” or “believability” of the findings that have been established by the researcher through “prolonged observations, engagements, or participation with informants or the situation” under study (Lenninger, 1994, p. 105). To ensure credibility during the interviews, I engaged in clarification of responses, elucidating contradictions, rephrasing, and so on to get a sense of participants’ objectives in communicating their thoughts and feelings. I listened to each participant’s interviews on
multiple occasions and reflected continuously on how to best capture the perspectives relevant to my research question.

According to Leininger (1994) meaning-in-context requires that the researcher take into consideration the “contextualization of ideas and experiences within a total situation, context or environment” (p. 106). As such this process refers to attending to the lived experiences of participants, i.e., the local, emic or insiders’ perspectives, while the researcher iteratively checks his or her meaning making process and perspectives throughout the research. To ensure that the above criteria was met, I immersed myself in the data and approached it holistically, i.e., I attended to the embedded socio-cultural contexts and ethical issues that may inform how participants expressed and shared their views and perspectives to the researcher. Similarly, iterative questioning during the emerging data analysis helped me pay attention to the nuances of utterances that I believed to be contextually situated. In addition, I attempted to make my theoretical forestructure, philosophy of science explicit and the specific design decisions explicit. Interpretive Description (Thorne, 2008) also recommends contextual awareness, by encouraging the researcher to be aware that he or she is bound by his or her disciplinary, and socio-historical contexts when approaching the study. In this study, I have explicitly acknowledged that my understandings, assumptions and interpretations are social constructions, and that they are only one lens to generation of knowledge.

The above process of “meaning in context” according to Leniniger (1994) is also associated with Thorne’s (2008) assertions about “interpretive authority,” where the researchers’ assertions go beyond their “bias,” and “reactivity,” to reveal knowledge and claims that are grounded in established research. I believe that while I have made my reflexive process and reactions explicit; I used them to help me stay open and seek multiple perspectives. For
example, even though the relational aspects of some interviews brought certain reactions, I was able to not only engage in reflexive journaling but also utilize Ensink (2004) frames for processing the social dimensions of interviews on a complex topic such as EC factors.

Another indicator of trustworthiness in qualitative research is when *recurrent patterning* Leininger (1994) occurs during the analysis. This refers to “repeated instances, sequence of events, experiences or lifeways that tend to be patterned and recur overtime in designated ways and in different or similar contexts.” (p. 106). In this research, the within case and across case analysis helped me attend to relationships between themes and ways that certain patterns emerged and re-emerged. This “patterning,” according to Leininger, then leads to the next indicator of trustworthiness, i.e., *saturation*, referred to as “redundancies, and duplication of similar ideas, meanings, experiences,” and when “the researcher finds no further explanations, interpretation or description” ((p. 106). The way I approached the concept of saturation and recurrent patterning during analysis was when I perceived that the same themes kept re-occurring regularly and no new information related to my research question was emerging even though I aimed to explore multiple perspectives. However, it must be acknowledged that this process was influenced by the limitations of my interpretive lenses and analytic framework.

Leininger (1994) refers to *confirmability*, another trustworthiness indicator, as “obtaining direct and often repeated affirmations of what the researcher has heard, seen or experienced with respect to the phenomena under study” (p. 105). To ensure that this aspect was attended to, I engaged in the process of triangulation in the form of using multiple data source, such as interviews with diverse informants, reflexive writing and memos to enhance my understanding of the research context. Debriefing with my research committee and peer reviewing also helped explore aspects of the inquiry that were implicit to me as a researcher.
Peer reviewing occurred by my seeking discussion opportunities with my doctoral student peers as well as the research assistant who had helped in the data organization. While I engaged with my research committee during all phases of my research, I also consulted and debriefed (with regards to my questions and analysis) with peers who had direct experience of working in the field of A&D counselling.

Thorne (2008) suggests some further strategies that can enhance trustworthiness, such as keeping an audit or paper trail. The above exercise in this study took the shape of preparing reports, memos, notes and informal visual maps that specifically documented the various stages of data collection, the analytic decisions, choices and definition of codes and themes inherent in the interpretations. This practice thus helped me make the process transparent in terms of how data was gathered and analyzed.

Thorne (2008) states that knowledge produced through Interpretive Description should be clear in terms of its “disciplinary relevance,” and “pragmatic obligation.” (p. 227) I believe that this study’s design, analysis, and interpretation of findings were motivated and grounded in my understanding of my practice discipline, i.e., counselling psychology. Additionally, the pragmatic obligation in this study meant that I was aware of generating knowledge that would have a practical dimension to the field of A&D recovery. Furthermore, Thorne recommends that the researcher outlines his or her “moral defensibility,” referred to making conclusions about “why the knowledge that we are extracting from people is necessary and what will be the purpose in having such knowledge once we obtain it.” (p. 226). My understanding is that in this research, I have made my rationale clear for the need for this research from the statement of the problem to the literature review and the theoretical forestructure to data analysis.
Chapter Four: Findings

The main research question guiding this study is “How do alcohol and drug (A&D) counsellors understand and incorporate ethno-cultural (EC) diversity factors in their counselling?” Counsellors’ responses with respect to the research question were complex in nature. Throughout the analysis, I found that I needed to present the findings in ways that I had not anticipated. For example, while I learned about counsellors’ descriptions of how relevant EC factors were in therapy, it also became important to consider counsellors’ overall approaches (beliefs, interpretations, preferences and meaning making process) and their embeddedness within the wider socio-cultural contexts. I perceived that without attention to the above, I could not adequately capture the dimensions of research question that dealt with counsellors’ understanding of EC diversity factors, in relation to themselves, clients and A&D work.

Similarly, during early stages of analysis, I had not anticipated the parallels between participants’ views of “addiction” and how they spoke of including EC diversity in their work. I interpreted that participants’ overall construction of EC differences informed how they perceived diverse clients’ needs in A&D therapy. In addition, I perceived the presence of certain models of recovery that seemed to organize counsellor’s perception of the relevance and inclusion of EC issues in A&D practice.

Four major categories were developed to describe the range of responses, organized by their underlying themes and subthemes. These are: i) positions on ethno-cultural differences; ii) the organizational context of A&D service delivery; iii) models of recovery, and iv) translating ethno-cultural diversity into practice.

This chapter begins by describing how counsellors made sense of differences in relation
to themselves, therapy and clients from different EC realities. In this category, I also conceptualized the interviews as a cross-cultural terrain, where participants’ overall positioning towards EC diversity was reflected not only in the ways they spoke about the topic, but also how they related with me as a researcher who identifies as a visible minority and a person of color. This category covers several themes: “Moments of tension and comfort;” “Color-blind attitudes: Capturing contradictions;” “Construction of Canada as open-minded and superior;” “Critical and systemic perspectives: Deconstructing power;” and lastly “Allies to marginalized groups.”

The non-counsellors’ (those who were not directly involved in counselling, i.e., managers, consultants, and directors) interviews were considered, in combination with counsellors’ interviews, in the category of findings aimed at highlighting the organizational context of A&D service delivery. This category, called “The organizational context of A&D service delivery,” includes information about participants’ perspectives on the overall context of how A&D services are delivered with respect to serving clients from diverse EC communities. These findings also focus on the inherent limitations and strengths of the system as perceived by the counsellors and the upper level decision makers in A&D agencies, i.e., other professionals. Thus, it covers the following themes: “Political correctness;” “A disorganized system: Diversity is not prioritized;” and “Systems’ strengths.”

The third category of findings includes participants’ overall frameworks towards recovery, also coined as “Models of recovery.” It explores two conflicting paradigms elucidating the relevance of EC factors in A&D therapy: “The disease model of recovery,” and the “Integrated model of recovery.”

The findings chapter ends with the last category of findings, labelled as “Translating
Ethno-Cultural Diversity into Practice.” Since the purpose of this research and the Interpretive Description was to gather practical knowledge, attention is particularly paid to those findings that were perceived as information rich in the area of clinical application as they pertain to the research topic. It was hoped that this research project would provide a useful direction for understanding of how EC diversity was linked to multi-culturally competent A&D practice. The themes “Ways of being: Reflecting on identities,” and “Cross-cultural relationship building attempts” describe this last category.

**Positions on Ethno-Cultural Differences**

This section begins with the analysis of how the term EC diversity was described and or defined within the context of the interviews in order to capture the ways that counsellors constructed the topic in relation to themselves, clients and A&D practice. Thus, the primary focus is on the ways that counsellors attended to EC differences occurring within the clinical contexts. Nevertheless, attention is also paid to intersecting social identities such as gender, class, and religion as they arose within the context of the interviews. In describing the various categories that I created in relation to participants’ positioning with respect to EC differences, I would like to acknowledge that I did not approach these categories as distinct entities, but rather as unique patterns of responding that were highly complex. In addition, I conceptualized the individual participants’ constructions as being situated in dominant social and cultural contexts that operate and inform how diversity and mental health and addiction are understood.

As some participants spoke of differences, I noted certain tensions and anxieties, not only with respect to the topic but also in relation to me as a female researcher of color. Therefore, throughout this category, I approach the analysis simultaneously from two interacting lenses. As I provide both description and interpretation of themes inherent in the
interviews, I utilize analytical reflexivity when participants’ positions with respect to differences seem to run parallel in their conversations with me as someone different from themselves.

My reasons to approach the analysis of interviews as a cross-cultural terrain are based on Ensink’s (2004) conceptualization of the interviews as “framed activities,” particularly when the interview topic centers on aspects such as ethnicity, ‘race,’ or national identity as elaborated in chapter 3. From this perspective, social and relational dimensions of the interviews are highlighted where some respondents are perceived to engage in contradictory and unanticipated activities when encountering intergroup relations: such as: 1) participants build identities for themselves and others (including the researcher), and may present themselves as belonging to various social categories, either implicitly, explicitly or both; 2) participants may orient themselves to the researcher by showing their identification with and or distance from the researcher; 3) while participants may be aware of their roles in research, they may still monitor themselves and engage in some form of social accommodating related to diversity factors such as age, gender, ethnicity, and appearance, and so on, and lastly, 4) participants and the researcher will engage in mutual relations, where interviews will go beyond the roles of the research agenda to a relational connection, or “being together of two persons.” (p. 160)

The concept of “ethno-cultural” seemed to convey various meanings to counsellors. The narratives of individual participants were filled with contradictory conceptualizations pointing to a considerable level of complexity, ambiguity and fluidity; both within and across most of the participants’ interviews. The terms ethnicity, culture, ‘race,’ color, and ethno-cultural were often conflated and used interchangeably throughout the interviews by some participants.

As counsellors spoke about the term “ethno-cultural” and the concept of differences,
certain definitions were noted that ranged in their scope and emphasis. A multitude of domains, linked to identity and group membership were emphasized. These various domains included: individuals’ place of birth; ‘race;’ nationality; individual’s degree of identification, loyalty, and or connection with one’s place of origin; visible differences such as the color of skin; language differences (accent, verbal and nonverbal expressions, English language fluency); religious practices (and the extent of adherence to these practices); belief systems; norms for behavior; orientation to time; gender expectations; rituals; customs; attitudes; lifestyle; DNA and or genetic makeup.

Despite the fact that a majority of participants spoke of the fluidity of the term EC, some of the participants’ conceptualization seemed to be relatively static and categorical and more focused on clients rather than themselves. However, another group of participants explicitly acknowledged the socio-political construction of the terms that served those in power and marginalized those with less dominant social locations. It must also be acknowledged that, in the course of the interviews, participants referred to few, some, or all of the above domains as they talked about their work with clients from diverse EC realities.

During the interviews, counsellors used various phrases that contributed to my analysis of their understanding and subjective positioning with regards to working with individuals from different EC communities. These included: “ethno-cultural means _______ to me,” “the way I see it [EC differences],” “clients’ world view,” “cultural identity,” “in my mind’s eye, this is how I see differences,” “why this [the research topic] matters to me,” “why is this [the research topic] important or relevant” “I familiarize myself with client’s culture,” “I evaluate my own cultural identity,” “I am a White male or female,” “I am a person of color,” “I am an immigrant,” “I am color-blind,” “we are all the same,” “I don’t see race and culture,” “culture
doesn’t matter when you are dealing with addictions,” “there is nothing multicultural about it [referring to A&D interventions.]” “culturally appropriate makes me cringe” and so on. Some of these reflections helped me better delve into the counsellors’ overall understanding of and social construction of the research topic. Counsellors’ modes of thinking through these concepts ranged from being implicit, to explicit, to being selective, self-reflective and self-critical.

Some counsellors’ argued that culture as a concept was broad and diffused, and could include various other “cultures” such as the “gang culture,” “LGBTQ culture,” “immigrant culture,” and “peer-group culture,” with shared practices and beliefs giving rise to a collective sense of identity.

I don’t use a very restricted use of the word cultural diversity…I can find in my descriptions to talk about a culture of entitlement or a culture of adversity or a culture refugeeism…it caused me to think more on what is this word we call culture and how we defined it over the years. (Participant 4)

There were also other conceptualizations that integrated the term ethno-cultural within the larger socio-political and contextual influences. Furthermore, EC factors were connected to construction of various social locations giving rise to certain privileges and power or lack thereof. Attention was paid to within group differences as well as other intersecting diversity variables such as gender, education, age, disability, socio-economic status, sexual orientation, etc. For example, the following two male counsellors refer to the power that being white carries within the context of therapy:

So an individual is multicultural, they’re intercepting various um positions right. So multi is because each of us is multi-faceted-coming from different orientations and belonging, having membership in different groups. [While referring to being a white, middle class male, he states]…I am pretty um blind to prejudice…I walk somewhere and I just assume everything is fine. (Participant 9)

I probably would um say that culture is defined by our sets of beliefs and values. Um
and those make up our particular culture. I mean obviously I come from a heterosexual North American white perspective… [while continuing to talk about the power and privilege of these categories] (Participant 18)

Some participants’ conceptualizations remained static throughout the conversations mainly linking the term “ethno-cultural” to religion or birthplace and filled with contradictions. For example, one participant stated that EC differences became salient when dealing with visible differences (e.g., color of skin, and accent), however later in the interview, this participant switched the term to include various other dimensions such as a person’s place of birth, beliefs, life style and practices. A further example is that some counsellors generally asserted that individuals’ group memberships should be seen on a continuum and labels or categorization should be avoided. However, their conversations revealed contradictions marked by tendencies to engage in the use of ‘either or’ and mutually exclusive dichotomies. For example, one counsellor talked about how she asks questions with respect to one of her clients’ orientation towards Islam:

…sort of like how Muslim are you? Like are you kind of Westernized? Or are you fairly traditional? (Participant 11)

Another salient finding was the concept of “mattering” where some counsellors engaged in evaluating and or assessing the degree of importance attributed to EC differences within the context of A&D counselling. The terms “culture doesn’t matter,” “culture doesn’t fit” repeated themselves in several interviews. Some participants seemed to argue that culture and ‘race’ did not matter if a therapist had a positive relationship during therapy, was warm, empathic and trusting. Based on some of the participants’ reports, culture seemed to be interpreted to “not matter with addiction counselling” because “addiction” was perceived as a separate/unitary phenomenon deserving its own unique status, as explored under models of recovery. In addition, the concept of mattering will be revisited in more depth throughout the
In contrast to the counsellors who acknowledged the power and privilege that their being male and white carried, the following two counsellors’ comments showed a different conceptualization where privilege and power seemed unmarked and unnamed. In addition, the following participants’ positions at times conflated culture with color, and seemed to discount the challenges that people of color carry as evident in the ways they simplified the word “color.”

It doesn’t matter what religion or belief or what country you’re from, when a white guy is down, a black guy all around just as well to help him, or a red guy, a white, when we shed ourselves of all the outward shows that discriminate us against each other the visible minority stuff, we’re all very alike, we will go to the help, genuine humane caring people, no matter what your culture. (Participant 4)

Because it’s very simple, very clear. So people can have whatever personal political, cultural view they want, but it really comes down to just simple rules. Whether you like brown people or white people, or pink people or yellow people, or you feel more safe with a man or a woman, or this or that, you have to deal with all of them. (Participant 8)

As mentioned earlier, in the next sections, I use analytical reflexivity as a female researcher of color to elucidate participants’ positions with respect to my differences. At the outset of the study, conceptualizing the interviews as a cross-cultural terrain was unanticipated as I assumed that the action of journaling would be sufficient to capture my feelings, thoughts and reactions about the research process including the relationship between the respondents and me, as a female researcher of color. I was surprised, however, when a number of transcripts revealed specific dialogues filled with social categorizations based on the color of my skin, ethnicity, accent, language and gender. As more interviews were gathered and analyzed, I became aware of the ways that I was positioned as an ‘outsider,’ or ‘the Other’ by some of the participants, and as the ‘insider’ or ‘you are one of us’ by some of the participants who identified as “brown,” “person of color” “social justice advocates” and as “an immigrant to
Canada.” I believe these conversations seemed to bring another layer of exploring counsellors’ positions towards differences, which I hoped would shed light on the research question.

The following themes, “Color-blind attitudes: Capturing contradictions,” “Construction of Canada as open-minded and superior,” “Critical and systemic perspectives: Deconstructing power,” and “Allies to marginalized communities,” attempt to further explicate the counsellors’ unique construction of the term “differences” and their various positioning. Before delving into describing the different positions, I use the theme “Moments of tension and comfort” to briefly explore my impressions of how participants responded and or felt as they talked about “differences.” Some attention will also be paid to the negotiation of the tensions with me as a female researcher of color.

**Moments of tension and comfort.** Various moments of tension were observed on the part of some participants as they talked about the research topic, particularly when the topic of differences spontaneously arose. Sometimes, a sense of frustration and hesitance were noted. Phrases such as “I see us more as similar than dissimilar,” “I view everyone basically as the same when they come,” “we all have some similar concerns,” “there’s more similarities we have as humans than differences,” that seemed to capture some participants’ reactions as they engaged with the topic. Some expressed concerns about stereotyping, “I don’t want to make anyone feel uncomfortable or feel like there’s a judgment or a stereotype,” or taking away attention from other diversity factors if the focus shifted on the topic of EC diversity. There was a sense that some participants wanted to include a range of diversity elements in their conceptualizations in addition to differences arising from EC diversity factors.

For a certain number of participants, however, the terms “ethno-cultural” and ‘race’ seemed to be imbued with more discomfort, followed by a tendency to simplify, or overlook
differences, e.g., “‘race,’ culture or color do not matter.” For example, when I asked participants “how do you get to know a client who may come from a different EC background than yours?” occasionally, I could sense nervous laughter or a look of surprise when I posed the question. A few of the immediate responses were “Wow,” “I don’t do anything differently,” “I treat everyone the same,” “my questioning is fit for all races.” There were occasions when inquiring about clients’ EC differences seemed problematic or an aspect that needed caution or even avoidance.

I won’t ask them where they’re from. [Participant nervously laughs] Just because of that’s my awareness. Like I don’t want to make anyone feel uncomfortable or feel like there’s a judgment or a stereotype. (Participant 12)

Moments of tension were further revealed as another participant, for example, talked about the expectations put by the society on counsellors to be “multi-culturally informed.” He asserted that such expectations brought feelings of fear as he thought of the topic.

For me it’s probably the biggest fear is that I honestly be really rigidly authentic is, we all have that fear I think that we’re going to make a major faux pas… in a therapy session it seems somehow way bigger, you know, it’s like the society extracts a slightly higher standard from us, because after all we’re trained in, you know, I mean the ethno-culturalism and multi-culturalism and diversity…(Participant 4)

While several of the participants openly talked about the subject matter, there appeared some need on the part of a few counsellors to censor themselves while speaking. Additionally, I noted feelings of frustration for some as to how to make sense of, or reconcile cross-cultural differences. For example, an interesting observation emerged where a number of counsellors identified and openly named their own bias in working with particular EC groups. However, it appeared that once they could label their “bias,” they could give themselves permission to engage in making evaluative and stereotypical comments about particular groups as illustrated.

A female participant who identified as having European heritage distanced herself from
her comment by laughing and saying that her name is “Mary,” a pseudonym she gave herself in that moment (Please note that none of the participants names are used here in this interview, and every one is given a number). The reason I am highlighting the pseudonym here is that the participant deliberately chooses this name to distance herself from her comment about Sikh men, saying “It is not me, It is Mary who is saying this,” as she giggles. However, she also expresses that she is shocked to hear herself making “racist comments” in front of me. She states that my questions are making her “angry” as she listens to herself. She states being aware of how her own gender and background are operating as she evaluates her male Sikh clients. She then goes on to justify her comments and the sense of discomfort by stating that her clinical observation is “factual” as follows:

I – this sounds racist, but it’s a factual point of view. I’ve noticed with a lot of Sikh, my name is “Mary” saying this [she giggles as she chooses a pseudonym to distance herself]… I said, how does the family take this? ‘Well, the elders don’t mind because we’re making money.’ Um, and even when I – I’m conscious of what I’m saying to you, that shocked me, because it shocked me from a British or Canadian or a woman’s point of view…Like your questions are making me really ‘raa’ [shaking her fist, as she expresses her anger], go in the middle and think about it. (Participant 20)

The above excerpt is an example of how several of the counsellors vacillated between tension and self-evaluation. The counsellor above openly reveals her meaning making processes and criticizes her self for making a comment that was unconscious to her. She then self reflects from the intersection of gender and ethnicity but nevertheless tries to justify her comment by labeling it as a “fact.” Below, I will use the interview excerpt from another participant to elucidate how he attempted to reduce tension arising from the research topic. The participant suggests that he does not understand the significance of my question because he is a “Middle class white guy.” As he makes this statement, he further elaborates on the power and privilege that his own categorization of himself gives him and how he can have the power to
stay invisible and evade examining himself, his own EC background or other dominant social identities. Then, he immediately realizes that I may perceive his statement as if he is trying to avoid talking about differences, so he clarifies.

Respondent: Well I’m not sure if it – I’m not even sure if I can understand your question being, you know, a middle class white guy. Um I’m not sure if I can understand it well enough to use it. So I try not to avoid it, it’s not that I’m avoiding it –

Interviewer: Oh, okay.

Respondent: So I would – I don’t want to get – um I don’t want to let you or your participants –

Interviewer: Okay.

Respondent: – or me off the hook.

Interviewer: Oh yeah, okay I appreciate that. Yeah no, that makes sense.

Respondent: – by saying I can’t make sense of it, yeah.

Interviewer: Yeah, that’s kind of affirming, because that’s what I want to know as well, is the – getting specific about this so that I can understand it better…(Participant 9)

He states that he is open to examine his own blind spots. Then, at some point the conversation centers on the word probe (in the context of requiring participants to clarify or expand their comments to the questions). I immediately realize that the word may have an interrogating aspect to it, so I try to bring it up, as highlighted below. What stands out is that the participant here engages with me in a relaxed manner and talks about how he is relating to me as a researcher and a person, an aspect similar to what Ensink (2004) calls as a “being together of two persons” (p. 160).

Interviewer: …are my questions coming across as a – as I guess, what would I say, as respectful and as –

Respondent: I – it has nothing to do with the words, it has everything to do with how you are. So yeah, I don’t feel probed.

Interviewer: Right.

Respondent: And I think it’s – it’s a worthwhile conversation I felt, you know, I felt it’s um I’m interested in the topic as well –

Interviewer: Yes, right.

Respondent: So I think we are um conversing, we are turning together. (Participant 9)

My aim, in the above section was to capture the interactional dynamics of the interview
when the focus of participants was on differences arising from me as a researcher of color.

From an analysis perspective, I believe that participants’ reactions towards me can additionally illustrate the general attitude or emerging positions held by participants towards differences, which in turn could be related to how they may negotiate differences with their clients.

**Color-blind attitudes: Capturing contradictions.** While exploring this theme, I label it color-blind attitude, as this is a term that one of the counsellors used to describe her own position on the topic of EC differences; and one that also emerged as counsellors positioned themselves in relation to differences. Overall, this theme examines how counsellors connected their sense of self, social identities and social location in relation to differences and their A&D practice. Within this theme of findings, participants identified themselves as having European heritage, such as Irish, British, Greek, and Canadian.

While there was a general consensus that establishing similarities was an important part of building a sense of connection with clients, a few participants seemed to go as far as constructing and or interpreting difference as secondary in their work. Despite assertions of everyone being the same, some participants’ conversations revealed stereotyping and hyper visibility of the following groups: South Asian and Aboriginal clients, and recent immigrants with limited English language fluency. Please note that at times for some participants, the above groups were generally constructed as homogenous. Color-blind attitudes in the context of this interview refer to the following: construction of one’s background as neutral; assuming that culture and ‘race’ resides in clients, not in counsellors themselves, “e.g., my background is boring;” and the therapeutic approach as being applicable to everyone, “fit for all races” not requiring any adaptation as follows:

…you know, like with all the cultures, I tend to be pretty color-blind and pretty, you know, I just try to treat everybody the same. (Participant 11)
As the above participant declares her position of being color-blind, she then contradicts her statement by stating that she is open to consider clients’ cultural backgrounds, by eliciting help from her Chinese-speaking colleagues when working with clients with limited English language skills. She reports being curious about the cultural dynamics of her clients’ lives.

…it behoves me to-to be aware of the cultural differences that are going to be coming into my office and coming in to see me… yes, we all have some similar concerns. But then there’s, you know, certain aspects within other cultures that I, you know, that I may not have necessarily seen or experienced or witnessed, growing up in my little, small part of town, right? (Participant 11)

On another occasion, when talking about one of her Aboriginal clients, the same participant states being aware of their traumatic past, albeit she does not elaborate on how she would integrate it into her sessions. She continues to revert back to her dominant position of “everyone being the same,” by stating that her approaches are “fit” and universal. Another participant states that inquiring about differences is not of particular significance to his A&D work. Analysis reveals that he generally discounts the importance of context (history, trauma, culture, color, substance of abuse and other diversity factors) as illustrated below:

I don't look at people in terms of race or color or culture…Um, knowing where they were born, knowing whether they were psychotic or not, knowing how many years they got on heroin and all that stuff, that’s fine. But that doesn’t really tell me anything about the client… That to me isn’t knowledge, that’s just information. Um and it’s not even – in most cases it's not even important, (Participant 8).

In the following paragraphs, I specifically use the above participant’s interview excerpt (Participant 8, older male, identifying as “Caucasian”) to highlight how his color-blind attitude was operating within the social dimension of the interview with me as a female researcher of color. I also use this segment to capture contradictions in what the participant said he believed versus how he interacted with me. Using analytical reflexivity, I use the interactional elements of the interview to reveal his position towards differences. Analysis revealed that this
participant’s own social identities remained invisible and unacknowledged, to him, throughout the interview. He stated that he did not see any differences and that he did not like to label:

So when a person walks in the door I haven’t labelled them inside. And I don’t get concerned about any of those things unless I notice things different. And um well for instance, a person’s skin color doesn’t bother me. But it may bother them. (Participant 8)

The above question raises several contradictions; firstly he says he does not notice color, but then he immediately says that he may notice things being different; such as a person’s ‘color.’ He further remarks that a person’s color may bother them, that it may be a problem for them individually. He also clearly states his position of staying away from labeling others when he makes contact with them. However, during our introduction to each other outside of his office, he asks me if I cook good curries, as part of making small talk. This conversation is not recorded, as we were climbing the stairs before conducting the interview.

Analytical reflexivity alerts me to his position where his comments indicate both racialization and sexualisation, in the form of perceiving me as a woman (of color) who knows how to prepare curries. I uncomfortably correct him that curry is not part of the Afghan cuisine and that “No, I don’t cook curries,” making no further comments as we reach his office upstairs. As the interview unfolds, I experience an inequality in our power relations. There are several moments when I feel uncomfortable and vulnerable. What contributed to my completing both of the interviews was my observation and assumption that his conversations were directly relevant to the research topic on differences. In addition, I later become aware of my implicit belief that as a therapist, this person would not create an unsafe situation for me. I assume that it must be part of his training to be sensitive, non-judging and caring. In the first interview, he has already labelled me as an “Indian” woman who cooks curries and then as the interview proceeds, he demonstrates his “technique” of how he works with his clients-albeit on
me as the object. At first, I am not aware of what he is doing except feeling that something does not feel quite right. I perceive his interaction and gaze as intensely aggressive as he insists that I look him in the eye.

Respondent: Which is what I try to do all the time anyway. That’s what I’m doing right now. So you want to know what I’m like –

Interviewer: Absolutely –

[I do not anticipate what would follow; start feeling nervous and very uncomfortable, start looking down trying to avoid his gaze on me]

Respondent: – it’s happening right now. Do you feel it?
Interviewer: Absolutely –
Respondent: What do you feel?
Interviewer: How do I feel? (I am at a loss as to how to respond)
Respondent: When you’re dealing with me right now, how do you feel?
Interviewer: I feel –
Respondent: Look at me,
Interviewer: I am looking at you.
Respondent: How do you feel right now?
Interviewer: Um, I think –
Respondent: No, I didn’t ask you how you thought. How do you feel right now?
This is how I deal with clients.

He then asks me if I trust him, and looking for words I tell him that I trust myself, that I am not afraid. I try to find safety in my role as the interviewer/researcher and keep going back to the interview guide in front of me. Following is example of another encounter during the second interview as I wrap up. He refers to me as “cute” and “gal” and reveals that he may not have participated in the research if he didn’t like how I “presented” myself. The transcript also reveals that he has been aware of his own responding towards me, as he starts to evaluate himself, “hope it is not insulting you too much,” with respect to our social interaction. Contrary to the comment I made earlier that participants remained unaware of their power and social location, this participants’ self awareness also points to his potentially deliberate or conscious attempts to engage in encounters that are racialized and or sexualized.
Respondent: I had fun with you. I enjoy you. I wouldn’t have bothered to get into this rigmarole if I didn’t enjoy the way you presented yourself. I said, I’m going to have fun with this gal. It’s going to be fun. And I’ve had fun. Okay? Do I care about research? Not particularly. Not that kind of research. But that’s okay. I don't have to like everything I do. I can still have fun, and I’m having fun. So. Hope it's not insulting you too much.

Interviewer: No. You’re not. [I don’t know how else to respond to this, while all the more feeling unsettled and I mumble] It's just, uh, it's getting to know you, right? It's getting to understand and be able to say, okay, this is how I understand. This is how I –

Respondent: It’s important to realize the bias of universities. When they talk research, they presume all research has to be rational. It doesn’t. (Participant 8)

He later realizes that he has incorrectly chosen the food category that corresponds to my appearance, so he decides to bring up “Baklava” (a dessert associated with the Middle East region as a whole) now assuming that I must be “Middle Eastern” if not an “Indian” woman who cooks curries. As I am constantly reminded of my ‘race’ and gender, we finally wrap up and he talks about himself in the context of the research and deserving a Baklava treat for participating (Please note that no participants received any treats or remuneration throughout this research).

Respondent: A lot of times it sounded like, what the hell is this guy talking about [as he evaluates himself]?

Interviewer: No, it's a different approach. It’s a very different, I guess, as compared to anything I’ve heard so far. It's uh –

Respondent: It’s not even worth a couple of baklava, because of ethics, uh?

Interviewer: Yes.

Respondent: Well when you find out from the ethics committee that you didn't con me, then I expect you to deliver two pieces of baklava to the front desk! You owe me big time! Because I’m the one piece of your research that at least isn’t totally boring.

Interviewer: Right. You bet.

While contextualizing the above interaction within the research question, analysis reveals intersection of gender and ‘race’ and the respective situated vulnerabilities, to highlight the above counsellor’s position with respect to differences. From an analytical lens and related
to the research question, the encounters above also raise concerns with respect to issues of safety and ethics, and how vulnerable his clients (e.g., women in general and women of color specifically) may potentially feel in interactions with him during therapy.

**Construction of Canada as open-minded and superior.** A few of the white counsellors, while talking about their clients’ EC differences constructed the Canadian society as accepting and with equal opportunities for every one. Canadian society was used interchangeably with “Caucasian society,” at times with the implication that both are superior or more civilized than other cultures. Such comparison of “us” versus “them” often pointed to stereotypical evaluation of non-white groups. Additionally, Euro-and North American norms were used as the standard to evaluate clients from different EC communities, with examples provided below. Please note that this perspective will be revisited in the section under “Translating EC differences into practice” which explores how Eurocentric values and beliefs seemed to operate within the culture of A&D counselling itself.

Eurocentrism as a position towards differences operated when “Western practices,” or “Caucasian Society” was perceived as neutral, better, and or with culture residing or being visible with “Others.” For example, one of the counsellors who identified herself as Caucasian shares her notion of other EC communities as being more exotic and fascinating. Her conversation reveals that she does not take into account the power that her position carries in the society as she labels her background “boring” and “mundane.”

…my background is umm you know, everyone – it’s not really that boring, but I found that the most exciting aspect of it was when people came together for a pot-luck and you get – you got to eat as much lime jello as you wanted you know, growing up. You know my family largely came from the Prairies and it was really boring so I found anything else you know, different customs, different ways of interpreting fascinating…I’ll say that, because I’m not sure we have much of culture, but anyway… I consider the - my background to be so boring, so utterly stultifyingly mundane. (Participant 19)
Another way that counsellors made sense of differences and potential conflicts in values was to engage in comparing other groups against Euro-North American norms. However, such comparisons generally resulted in stereotypical comments. For example, the same counsellor quoted above engages in comparing “East Indian” women to “Caucasian” women, with the former being seen as weak or oppressed and the latter as more empowered. Her meaning making is marked by the use of categorization and generalizations of both groups, discounting complexity of gender as well as individual differences within groups. In addition, her comments reveal that she is comfortable to use the term “East Indian” to group the women, but states hating to use “Caucasian” as a term to describe the other woman. She also describes that “Caucasian” does not have as much “ethnic influences” as compared to “East Indian,” further pointing to the stance of neutrality for those who are white, or of European origin.

Respondent: I’ll hear the same things, no matter what the culture in many instances, you know. Although I’ll hear a different approach sometimes uh um by a woman in a East Indian household, sometimes the different approach, as compared to a woman in a Caucasian or what you call it, um I hate to use that word but, you know that doesn’t have ethnic influences. Like the woman who has been privy to uh having a lot of um self-empowerment and uh um a pretty clear idea of what she’ll put up with and what she won’t, might be considering separation and a husband then is really – um has a real serious alcohol dependency and threatening their finances, you know their livelihood. Whereas the other one might not be there at all.

Interviewer: Um-hum.

Respondent: Might be just putting up with the whole lot and might be trying to find a different way to-to – or bluntly denying it, or it might be finding it – trying to find a different way to influence things. It’s quite different than the one that the first woman would consider.

(Participant 19)

As previously mentioned, the majority of the interview participants asked me where I was from, and I was happy to share with them that I was born in Afghanistan but settled in Canada as an immigrant. During one of the interviews with one of the counsellors talking about
his work with clients from various EC communities, the conversation topic suddenly shifts to my home country. His positioning is revealed, as he perceives the “Caucasian society” as far more superior to Afghanistan and India, the latter countries construed as less civilized. In addition, the participant assumes that I agree with his positioning, as evident in his comment “You know about this.” His comments reveal the ways he conceptualize the intersection of culture, ‘race,’ and gender in relation to “Caucasian society:”

**Respondent:** Yah. But within the past two or three years, there’s been a couple of instances of husbands killing their wives in the Indo-Canadian community for perceived transgressions. Beating goes on in the Caucasian society but it doesn’t seem to go to that; and the thing is about that is that the men seem to think that that’s acceptable.

**Interviewer** Hmm, hmm

**Respondent** They somehow, in their mind, go back to India, to the rural village well ultimately ends up with. You know about this [italics added]. Clearly a woman who’s raped in Afghanistan, she’s the one who’s punished; the perpetrator, and it’s roughly the same thing here [referring to other EC communities], I have to beat her up or kill her because if I don’t; she’s at fault, I went out and slept with her, that’s her fault because she went there, it, it’s, yes, they’re personally responsible, but there is a cultural piece there that exist in that society, which doesn’t exist in the Caucasian society. (Participant 10)

**Critical and systemic perspectives: Deconstructing power.** A number of participants, when talking about EC diversity, appeared to take a critical perspective towards the Canadian system and its various institutions. They acknowledged the presence of a racially stratified Canada granting diverse groups different social location and power. Such positioning emerged for those participants who identified themselves as ethnic minorities, people of color, 1\textsuperscript{st} and 2\textsuperscript{nd} generation immigrants, as well as those who identified their social location as “white,” with the latter group openly acknowledging the position of privilege granted by their group membership. Within critical perspectives, conversations also centered on the intersection of class, education, gender and ‘race,’ operating within counsellors, clients and the system at large. Creating safety when working with marginalized communities was also prioritized. One
of the participants, for example, stated that our initial meeting had encouraged him to reflect further about the research topic:

I traffic in identities that carry a lot of weight in this, in our cultural context in Canada in terms of being white, being male, being middle class, those are three of the most powerful categories, right?... a lot of people have had negative experiences of power related to people who look and talk like me, right? …So I think I just try to be really careful and respectful around that and realize the impact. (Participant 7)

Within this perspective, counsellors stated that if they were not aware of their own social identities, they would not be able to honour their clients’ multiple realities. This aspect will be further elaborated under the section labeled as “Ways of being: Reflecting on identities.” A small group of counsellors who identified themselves as ethnic minorities and were specifically hired by the health authorities to work within specific communities seemed to also not shy away from engaging in dialogues about clients’ experiences of racism or difficulties adjusting in Canada. They stated being aware of not imposing their own values on their communities and consistently being cognizant of within group differences.

I need to know from them where they are in terms of culture wise. I think if people wanted to work with different ethnic communities, whether you are from mainstream or from another ethnic community you have to be familiar with that community, comfortable with that community. (Participant 6)

Another participant states that he is more aware of within group differences in his own community as compared to his white colleagues, some of whom he perceives to engage in essentialist thinking, such as “We [South Asians] are all the same,” as illustrated below.

And my white colleagues, they were trying to categorize it … and here’s the difference, is asking the question I think, versus assuming, okay he’s a South Asian male so he’s a patriarchal- he comes from a patriarchal family where he may not treat his wife that well. And like those are pretty sweeping stereotypes, very scary. (Participant 16)

Data analysis raised some questions for me as a researcher of color as to the extent that my social location seemed to have sensitized some of the white counsellors to specifically highlight
issues of privilege and institutionalized racism. However, further analysis revealed a degree of sophistication in these counsellors’ deconstruction of power that seemed to go beyond the mere social desirability of pleasing a minority researcher. I perceived that none of the transcripts of the participants who held critical perspectives revealed any instances of social categorization and racialization.

**Allies to marginalized groups.** Some of the participants who identified themselves as visible minorities, immigrants (1st and or 2nd generation) and as persons of color seemed to position themselves as allies in relation to other minorities. Such positioning was articulated as a result of having shared experiences of marginalization, discrimination and or institutionalized racism due to belonging to less dominant social categories in Canada. In addition, such positioning became evident in the ways these participants positioned themselves in relation to me as a researcher of color.

Analysis further indicated that despite these counsellors perceiving similarity in terms of certain experiences (e.g., immigration, and acculturation), they did not impose the lens of homogeneity as was distinguished earlier. In fact, these participants kept reiterating their attempts to embrace differences and the need to join with clients to overcome systemic barriers. For example, one of the counsellors hired to deliver language specific counselling for clients identifying as South Asian, states that he has to work on Sundays because his clients have to do double shifts to make ends meet. Additionally, he states that there is no support from his clients’ employers for clients to leave work and seek help during a 9:00 to 5:00 work schedule. This participant further states that he has to go beyond one on one counselling to connect his clients to various resources and sometimes act as a translator. In the following quote, he states that sometimes counsellors in the field may forget the history of clients’ prior to their arriving
to Canada, i.e., not taking into account the complex context of immigration. He reiterates that he has to do a lot of advocacy and awareness-raising to inform his colleagues:

A lot of people working in mainstream counselling, we tend to forget that sometimes, like where we – where the client’s coming from…. You tell everybody, you know, I’m going to Canada. And everybody’s like, oh, you’re going to Canada, you’re so lucky, this and that…. They go “we never drank in India. But when we came to Canada that’s when we started drinking”...(Participant 15)

The term “allies” is used here with the assumption to explore how participants viewed their own, their clients’ and my social identities as elements that helped us “bind” together in making sense of the dominant culture in Canada. Participants in this group not only talked about their own struggles but at times also assumed that I “knew” the shared lived experiences (e.g., racism, discrimination, difficulties getting one’s credentials recognized, communicating in their second language, difficulties experienced during settlement process, cultural dislocation, and missing one’s native home etc.). However, to capture their unique perspectives, I attempted to go into each conversation as “not knowing” and asking them to elaborate. One participant, for instance, while sharing that she was initially sceptical of me as an “outsider” coming to interview her mentions the following:

Well I was very happy to be with you and like even motivated. This morning I said that last week or Monday, we have Hajera with us. No I mean like um I’m glad, well I felt like a yeah relaxed in your presence yeah, you were very kind, very nice too. Yes, oh yes, very – there’s is nothing – I remember at the beginning what you sent us and I said oh my goodness…what does she want… (Participant 14)

Another counsellor who also manages a language specific A&D program talks about the ease that my being a researcher of color brings about and that he does not feel “exoticized,” as sometimes he feels could happen with a white researcher.

Respondent: Um you know it’s almost like in research, you – we’ve maybe talked about this at the last time we met, around um there is this desire um from researchers which may traditionally have been more um probably male and white researchers more so than anyone else.
Interviewer: Um-hum.
Respondent: Um but when they want to do research on ethnic communities, if they
do it themselves they can come off a little bit umm what’s the word,
what’s the like anthropological like, where you know, we’re studying
this very exotic people…

Summary. This category of findings was based on two interacting lenses: i) the overall
positioning of the counsellors as they talked about intergroup relations arising from EC
differences in the context of A&D therapy, and ii) the social dimensions of the interviews as a
cross-cultural encounter between the participants and me as the female researcher of color.
Additionally, this category aimed to capture the dynamics of power relations (i.e., intersection
of culture, gender, ‘race’ and color) inherent in counsellors’ modes of thinking that at times
seemed to go unexamined and at other times brought to the foreground. Attention was paid to
moments of tension and comfort as participants approached the topic. The emergent positions
focused on color-blind attitudes marked by denial of differences, Eurocentrism, and seeing the
“Caucasian society” as the norm and healthy way of life. Analysis also revealed the multiple
layers of how counsellors’ identified and or distanced themselves from clients coming from
different EC realities and me as the female researcher of color.

The Organizational Context of A&D Service Delivery

To explore how A&D counsellors understand and incorporate EC diversity in their
practice, it was important to pay attention to the inherent socio-cultural dynamics of the
organizational contexts. Information about the participants’ types of services and work settings
has been mentioned in the previous chapter. This section of findings will utilize the interviews
of those participants who were engaged in counselling, counselling plus supervising (i.e.,
participants with dual roles of clinical work and management) as well as those identified as
non-counsellors’ (i.e., consultants, program directors or managers).

The reasons to go beyond the reports of A&D counsellors’ related to their work settings
and to interview “non-counsellors/other professionals” in A&D settings included the following. First, the attempt was to understand how counsellors and administrative and supervising professionals at A&D services collectively managed and responded to clients who came from diverse EC backgrounds. Second, the perspectives of non-counsellors’ were important as they directly talked about how organizational context and program structures influenced the multicultural clients’ pathways to services and access to A&D practitioners. Third, the hope was to learn about the specific engagement of organizational context in terms of finding out about ways that agencies provided access to training and supervision in the area of multiculturally competent practice. It is assumed that the position of non-counsellors as decision makers in their agencies influenced and or shaped the delivery of services to diverse clients. Last, the aim was to get a brief overview of where A&D services in the Lower Mainland were heading with respect to the A&D service provision for clients of diverse EC realities. The themes for this section are: i) Political Correctness; ii) A Disorganized System: Diversity Is Not Prioritized; and iii) System Strengths.

**Political correctness.** Some counsellors and non-counsellors indicated that political correctness permeated the organizational context of A&D treatment centers. Political correctness was perceived to encompass a sense of discomfort to acknowledge differences, and fear of offending others if conversations centered on aspects such as ‘race,’ colour, culture and ethnicity. This theme was attributed to an “artificial” attitude by the system where intersection of diversities and their power relations were not acknowledged or left unexplored. Political correctness was also assumed to encourage the status quo and a tendency to treat everyone the same. For example, the following consultant to one of the A&D agencies states how the culture of A&D delivery assumes that there is a “generic person” and a “generic way” to provide A&D
I feel like the substance use field is kind of operated as if, as if they were designing a system of care for a generic person and then there were these little extra things on the outside as opposed to fundamentally seeing that there is no generic, that there is everybody is diverse. (Participant 13)

In addition, respondents talked about an attitude marked by a sense of “pretence” that “everything is okay” and that disparities at personal and systemic levels with respect to A&D service delivery do not occur. Moreover, participants seemed to hint that when and if team members spoke of how to accommodate cultural differences or the linguistic needs of clients, the agency would find it too challenging or cumbersome to appropriately address. For example, the following counsellor during our second interview reflects on how the above attitude discourages openness at work settings and problematizes differences.

It’s almost like political correctness has gone so far that it’s not okay to acknowledge difference. It’s like people are so afraid of saying the wrong thing, but it’s just glossed over and not talked about at all, … It’s like it’s the message is that there should be no biases and you shouldn’t notice difference or comment when you see it, and it’s artificial and I think it stands in the way of really being able to talk and understand differences, like it’s not okay to question it (Participant 2).

Other counsellors mentioned that political correctness at their work settings sometimes hindered critical awareness and examination of bias for therapists (i.e., professional reflexivity which will be elaborated later in the section “Ways of being: Reflecting on identities”). Another counsellor stated that “joyful inquiry or curiosity” was stunted due to the existence of political correctness. He further asserts that such phenomenon has contributed to a “washing away” or “diluting” of differences instead of allowing service providers to embrace them.

I wouldn’t want to say we’re all going to dress the same and behave the same way towards our families and our elders and our children and our spouses and so on, I wouldn’t want to have a whole-world culture. But political correctness has required us to be, I think, sometimes almost reverse discriminating or overly sensitive about not offending someone who comes from a different culture than ours. And I think sometimes that’s held us back... (Participant 4)
A number of participants, while expressing their frustration, linked political correctness to “lip service to multiculturalism” in the larger Canadian health care context. These participants stated that recognition of diversity, including EC diversity was often reduced to a few lines in A&D treatment program documents with no attention to how such mandate could be effectively realized. A clinical supervisor, for example, commented on the lack of responsibility on the part of the system to put into place adequate structure, funding and training to translate diversity into practice. His apparent distrust of the health authorities is expressed as follows:

[Name of the Health Authority] is trying to put together a guideline for residential treatment...and in one section in there is kind of this cultural inclusiveness or something like this... that statement’s ridiculous, it’s just too huge, it’s impossible, it’s never going to be even modestly met. Um we’re not, you know, most of the staff here aren’t trained... it’s stays at the level of lip service and actually doing it is a very different reality...Well what are you going to actually do differently? Are you going to actually provide funding or -whether it really is as good and there’s so much that I’ve seen of that kind of hypocrisy. Or is it a political gesture? (Participant 5)

**Disorganized system: Diversity is not prioritized.** All of the non-counsellors and some of the counsellors implied that the A&D system was relatively disorganized in terms of delivery and coordination of care for clients from different EC realities. In particular, they spoke of access challenges within the system for clients. Lack of funding and resources to serve clients with diverse socio-cultural backgrounds and linguistic needs were the primary concerns brought to the forefront. Several participants pointed out that the Mental Health and Addition services in the Lower Mainland lacked a systematic and “methodical” approach towards implementing a thorough needs-assessment of diverse communities. The health authorities were also perceived to be highly influenced by a medical model in terms of the delivery of services, being more open to fund acute or crisis aspects of A&D. In addition, the delivery of
A&D services was perceived to be based on Eurocentric models of health as would be illustrated in this section.

It’s more sort of emphasis on the expertise and you know, I know better than you do what’s good for you, and more relying on medication. (Participant 2)

The lack of integration of mental health and addiction services was also pointed out, where A&D problems were perceived to be seen in isolation from other co-occurring mental health concerns. One participant referred to the disorganization of the system as a “a badly arranged marriage.” Another participant, stated that while there have been some movement on the part of certain health authorities to amalgamate Mental Health and Addictions, the decisions are generally made by policy makers without consultation with service providers and program managers and or supervisors.

We’re really in that part of the consolidation, and we were given no other explanations and nothing at all. Like I said, it was really no explanation, besides the fact and understanding that this is a directive from the Provincial Health Services Authorities and the fact that this is Mental Health and Addiction Services (Participant 27).

Data analysis pointed to an ongoing debate and feelings of powerlessness to move the system to a direction that is multiculturally responsive. For example, the following respondents (counsellor, and non-counsellors respectively) state their scepticism and feelings of being overwhelmed with respect to what structure their programs should strive towards. In addition, their interviews reveal questioning on their part, while reflecting on their lack of self-efficacy to enact changes within the system.

No program can be all things to all people, right? So whatever it is, it’s not going fit across the board. So, you know, do you water it down in order to have appeal to the broadest base? Or do you narrow it knowing that it’s going to exclude some? …there’s constantly pressure to you know, take more work with everyone and uh you know, meet the needs of everyone at the same time and it’s not possible so, you know, where do you draw the lines and who gets to decide that actually? (Participant 2)

It’s um the theory is, yeah, we want to be inclusive. But the product of this, man, this is
a lot of work! I’m limited in how much extra help I can do. And then how do I balance that? It’s a real challenge to not do lip service is what - and that really bothers me. If I’m going to do this, I want to do it well. I don’t want to just say, oh yes, you know we’ve got the picture of the totem pole on the front door, so that means we’re culturally diverse right? That’s to me at best hypocritical. (Participant 5)

One of the program directors emphasized having to “learn on the fly,” and lacking the capacity and resources (both staffing and or monetary) to respond to the emerging needs of diverse EC communities. Dilemmas and doubts were expressed by program directors and or managers as how to best shift the system to a place where services were accessible and culturally appropriate to a wide variety of client population and do the job competently.

… But you have to ask yourself the question at some point. Do you not need it [culturally specific program] because its, there, that those clients you’d be serving with that language capacity don’t have that issue, or is it because you don’t have that capacity so you never see those people right? I think it’s probably the latter. And really, the idea of being providing culturally competent care, being culturally aware, is important, I think, in every, it’s my bias in every aspect of health care…there is a very limited budget for education, very limited…so I think you get into an issue of there’s finite resource, there’s lots of valid competition for those resources. (Participant 24)

One of the lead counsellors, who, in addition to providing counselling also helps with management, captures the contradictions inherent within her own conceptualization of the problem. She finds herself critical of her own meaning making of the current state of the field in terms of not adequately providing services to diverse groups.

Our program can’t be everything to everybody. Like you know, and then, having said that, I go, why not? Like, why can’t we? Because it’s only us that put those limits on, right? (Participant 17)

As mentioned earlier, a few of the counsellors spoke of the structure of their programs and the organizational culture being Euro-American centered, designed to serve white clients. While referring to the program manuals, the following participant who also identifies as white highlights the lack of appropriate educational materials for Canada’s diverse demographics:

How culturally appropriate are some of those topics or some of the notions of self
…they are pretty Western… I’m assuming that the rest of the team at least acknowledges that and I mean it’s um American too. (Participant 2)

From conversations with counsellors and non-counsellors, it became apparent that there was a lack of cultural diversity on the teams, i.e., the majority of service providers were described as white. Often, this was also linked to having fewer opportunities to engage in diversity dialogues. Some exceptions were however noted, i.e., a few counsellors pointed to having diverse and multicultural work environments. One of the program directors who identified herself as “brown” referred to both a lack of diversity in clients in her program as well as on her team:

She [referring to a minority client] also noticed that I’m the only… “brown” here (laughter)…But this girl definitely came in to ask me: How I came here, and how I got this job. She actually point blank asked me. “How, did you get this, they’re all white, how did you get this job?” (Participant 27)

Some of the supervisors and managers, while speaking of the lack of diversity on their teams, blamed the hiring policies of the health authorities. For example, the following supervisors pointed out that the system discourages them from hiring bilingual or multilingual counsellors without a Master’s degree, thus reducing the pool of “qualified” applicants to a small number who are generally white.

…because even just one of the criteria for getting a job here is a Master’s degree. So how much does that narrow the - kind of narrow the field. (Participant 5)

There is a pool out there of people with compassion and understanding, life histories and diversity who may not afford or may not have the grades to be accepted in university, but who have the compassion and practical skills required. (Participant 18)

Please note that one of the counsellors I interviewed did not have a Master’s degree (the only exception in this study) but worked within a language specific program raising a similar concern as the above. Thus, he stated that his program manager had worked around some of the requirements to make room for him to receive training and supervision on the job.
Data analysis pointed to the salience of discrimination and racialized encounters in the conversations of some of the service providers (including counsellors and non-counsellors) who identified themselves as part of a visible minority group or persons of color. They highlighted how constructs of ‘race,’ and color of skin influenced their interactions and the type of work they were assigned. For example, the following counsellor speaks of how generalization and categorization operates within his organization. He talks about being expected to take on any one either resembling or looking to be South Asian despite language and cultural differences. He also points to the assumptions made by his supervisors that he will be more effective because he “looks” like some of the clients labeled as Indian.

I don’t speak their language and they [decision makers at his work setting] will still give it to me [referring to case management of clients who are grouped as South Asian by the agency]. They said, you look like that person, right…but like at least you look like you’re from India, he’s from India, and where you are from, not far apart, but - and their assumption was that he [the client] will be able to develop a relationship with you [talking about himself] because we look alike, right? (Participant 6)

For these counsellors and non-counsellors, their own minority status, experience of racism and discrimination seemed to sensitize them to their work with clients of diverse EC backgrounds. They stated being more cognizant of institutional racism encountered by minority clients. Another participant with a dual role of counsellor and program manager indicated being assigned the position of an expert on South Asian culture because he identifies as a member of this community. Analysis also points to certain expectations for these providers to know everything about what it means to be a South Asian, despite the fact that this label covers multiple countries, histories, cultures, ethnic groups, religions, languages, and practices. The participant below further stated that such categorization puts the burden of responsibility on him to make sure that he would not convey a particular image or stereotype of a South Asian client to his colleagues.
They’ll ask some questions about um the South Asian culture, and I’m always careful because I don’t want them to then, if I tell them one thing they’re going to assume that’s going to happen with every client. (Participant 16)

The above participant further pointed out that oftentimes the mainstream services evade the responsibility to create capacity within their system to better serve clients of diverse EC backgrounds. He also stated that clients would be transferred to minority counsellor’s care if he/she appeared to fit a certain “racial or ethnic category.” As a result, he stated being overwhelmed by referrals and having difficulties accommodating clients’ needs.

I sometimes wonder why we are getting this referral like - I think it’s gotten to a point where mainstream services are so overwhelmed, that if someone’s of a different ethnicity they refer them here. (Participant 16)

**Systems’ strengths.** Data analysis uncovered that, despite challenges, some of the counsellors and almost all of the non-counsellors were constantly reflecting and questioning themselves as to how to effectively contribute to culturally responsive A&D care. A number of managers stated that their agencies were in the process of, or had already created, small initiatives to serve the diverse communities in their surrounding neighbourhoods, thus acknowledging that the health authorities were moving towards more culturally-informed A&D care. However, the effective realization of the initiatives seemed to largely depend on the particular skills and resources of supervisors, managers, and the director of the programs as identified below.

A couple of non-counsellors remarked about their agencies’ specific initiatives to provide outreach and prevention to various communities that may not otherwise have access to services. These included attempts to provide education sessions to seniors, the homeless and the youth. Additionally, they described providing “Education Series on A&D” in multiple languages to diverse immigrant communities. These sessions seemed to be often led by counsellors with connections to various communities. Additionally, there seemed to be support and openness to
adapt the content of the workshops to adequately reflect their clients’ diverse cultural
worldviews and practices. If agencies did not have staff on their teams to speak particular
languages, interpreter services were generally offered through the health authorities.

We modified those to incorporate a slightly different way of presenting the information and
more time to discuss, hum, certain interpersonal issues, because we found… that the way
we were offering [name of the program] wasn’t really working for them. (Participant 24)

Another program director revealed his collaborative efforts with his diverse team members
when he stated being open to their opinion and knowledge, and working to build credibility and
trust. Additionally, he did not appear to be afraid to highlight his own blind spots and
limitations. He also assessed the communities’ needs by engaging his counsellors to do
outreach and advocacy.

My two counsellors that I work with, have certainly been able to teach me um some of the
more culturally important elements. Certainly that’s a, um a lot of what we try to do with
regards to program development is to really work with our um, viable Chinese counsellors
to meet culturally appropriate programs…You kind of work through the back door a little
bit… (Participant 18)

Other unique initiatives by one of the agencies were to incorporate trauma informed,
evidence-based, gender specific A&D treatment. The following participant, for example,
highlights the flexibility of her program, while also emphasizing the need to be informed by
clients’ past histories, risk factors and socio-cultural contexts:

I think the majority of women that come through here had some traumatic experience, or-or
really - um, health crisis, you know - um, cancer or something that has been traumatic for
them. So I think from a trauma informed perspective, every woman can relate um, to the
program. (Participant 17)

Another salient finding during analysis was that all of the non-counsellors (managers,
directors, consultants and supervisors) seemed very self aware, openly examining their own
resistance, power and privilege when working with diversity. These respondents seemed to
constantly ask questions as to what was working and not working within their teams as well as
how their own decision making could be improved. They often stated needing to get feedback from their team members to improve service delivery.

And so we’ve been saying, with our community developer…how do we get to the other populations in this community? How do we bring them in the door? Or how do we go meet them? (Participant 1)

I’m in a position of power, and I can just take whatever I want. It’s - is it a symbol of my um patriarchal-approach or is it a symbol of my inclusiveness and the responsiveness and - or both? I wanna know what my blind spots are, I wanna kind of keep expanding what I understand and what I can respond to... (Participant 5)

One of the managers talked about how the “anti-oppressive framework” offered during her training inspired her to approach issues of diversity. She described this framework as one that recognizes institutional oppression and approaches problems from a strength-and community-based perspective. She stated that this lens informed the ways she coached her staff and how she approached the topic of differences. She openly criticized the composition of her team in terms of lacking cultural diversity, while also questioning the Euro-centric, “dominant” culture of the profession and her own prejudice.

I’ve certainly come up against clinicians struggling with… kind of relative ethnocentrism and where there’s a need to support and coach, uh, clinicians to be perhaps more aware and sensitive to issues of diversity…We were talking about “anti oppressive practice” and recognizing the you know, taking a step back, looking at things more from a holistic diversity lens…knowing what questions to ask to better understand, and maybe having some insights into how we may, how the dominant culture may be different or how the dominant culture may make it difficult for us to work together. (Participant 24)

While not all counsellors commented on the structure and diversity of their teams, some specifically talked about being fortunate to be part of a diverse work setting and how such environment facilitated their learning. Some highlighted that their agencies arranged multicultural counselling training workshops, as well as provided access to interpreters if and when needed. An additional strength described by some participants was having access to
“cultural advocates” or “cultural advisors” through their work setting. They mentioned that these support/consultation-based services generally consisted of individuals hired by the health authorities with close ties to specific cultural communities, advocating for clients’ needs and access to services. Thus, the team of counsellors providing A&D care could consult and locate relevant sources for their clients after completion of treatment (at both residential and non-residential settings). Sometimes, counsellors reported partnering with the cultural consultants to do outreach in the communities. For example, the following two counsellors spoke about the value of being part of a culturally diverse team.

But now my co-worker who speaks Mandarin will be working with the parents and then we can come to each other and talk like after. (Participant 12)

Our team was like very middle-class and very white when I started and I felt really uncomfortable, and um but since then, because we’ve expanded the team and thankfully a lot of the new people that we’ve brought on are more diverse…like if I’m working with a First Nation’s person, then consulting with like our Aboriginal Services Coordinator and getting her perspective and of what she thinks might be helpful for this person, or how should I approach this person, or what might be getting in the way of me communicating with this person… (Participant 7)

**Summary.** By utilizing the interviews’ of both counsellors’ and non-counsellors’ (managers, directors, consultants, supervisors), I was able to explore the organizational context of A&D service delivery. This theme provided further information as to the contextual influences on counsellors’ understanding and incorporation of EC factors. Participants spoke of political correctness pervading the organizational context of A&D services, where talking about differences was met with caution and avoidance. In addition, participants reiterated that the discussion of differences, power and privilege remained unacknowledged and unexamined in their work settings. Participants also highlighted several barriers (e.g., lack of diversity on the team, lack of funding and resources from the health authorities to train staff) to creating culturally appropriate and effective services. Despite the challenges, several system strengths
were mentioned (e.g., diversity on the team, access to cultural consultants, use of interpreters).

**Models of Recovery**

Analysis revealed that how participants spoke of relevance of EC diversity factors in relation to self, clients and therapy also informed how they viewed “addiction.” Dominant models emerged that seemed to serve as organizing principles or frameworks influencing how participants talked about their clinical approaches and decisions while providing A&D services to clients of diverse EC realities.

Overall, participants appeared to emphasize either all or some of the factors such as biological, spiritual, psychological, social and cultural. A challenge experienced in this section was how to best convey counsellors’ perspectives on A&D care of diverse clients, because some participants’ accounts seemed contradictory and ambiguous in the ways that they spoke of the significance of EC factors in their work. Thorne (2008) argues that a lot of new researchers “find themselves wanting to argue that they can’t possibly break up what is a “whole” experience into the component parts, and therefore resist attempts to articulate structural groupings” (p. 178). Therefore, it was deemed important to resolve the above dilemma as I strived to best capture the dominant patterns that were surfacing within the interviews, despite their ambiguity.

Two prominent but divergent paradigms emerged during the analysis: addiction-as-a-disease and a more integrative and culturally informed model, as elaborated below. Analysis indicated that the models often determined not only the comfort level of some counsellors, but also their reported degree of motivation towards integration of EC factors in A&D treatment. I also observed a considerable level of debate on the part of some participants within the disease model as to whether attention to EC diversity is helpful or not, or whether including EC issues
is meaningful in A&D treatment.

However, before exploring the models of recovery, this section aims to clarify the terms “addict,” or “addiction” which regularly surfaced during the interviews. The rationale for highlighting the participants’ use of terms such as “addict,” is because I sometimes perceived a parallel between participants’ conceptualization of A&D problems and their construction of EC differences. Please note that the participants themselves used the term “addict,” and “addiction.” While participants highlighted their discomfort with the use of above terms, they consistently used them throughout the interviews. This seemed to reflect the notion that construction of “addiction” is inherently embedded within the wider historical and socio-cultural contexts. Another rationale for bringing up the terms is that construction of “addiction,” appeared to influence the way that counsellors understood the spectrum of A&D problems that their clients experienced which I believed was important in understanding how much significance they attributed to the intersection of EC factors in A&D treatment.

The majority of participants shared their struggle with the above terms by emphasizing their narrow and stigma-laden focus. However, due to their consistent usage, it suggested that the terms “addict,” and “addiction” had inevitably become part of the therapeutic discourse:

That’s where, you know, it can - the slippery slope starts with - especially in addiction because there is a huge stereotype out there about the addicts. (Participant 3)

We drive people underground, we drive people to secrecy [while speaking of the stigma around A&D problems]. (Participant 17)

Certain participants also struggled with the specific name of their agency that would often include the word “Addiction.” They stated that this further called into attention the associated negative reactions and the socio-cultural stigma surrounding seeking help for A&D problems.
We changed the name because most seniors will reject if they know that I do addictions…Cause right there from the bat – from where? Addictions oh no, no, no. [she laughs and pauses] so then that kills all my opportunities, right? So then I uh we changed our names so the center…so when I introduce myself– you know, I’m a counsellor – sometimes I’m a health worker, right? (Participant 21)

**Addiction-as-disease: Capturing contradictions.** The analysis elucidated that a disease model of recovery continues to prevail in the ways that counsellors provide care and construe A&D problems. The components of the disease model as highlighted by some participants’ descriptions were: 1) “addiction” was viewed as a disease, sickness, and or biological issue; 2) clients were sometimes perceived as unhealthy and needing to be treated; 3) some counsellors seemed to take on an expert role; 4) symptoms such as withdrawal, cravings and triggers received more attention, i.e., treating the addiction, not the whole person; 5) “addiction” was seen as a unitary phenomenon, being the same for every one; 6) “addiction” seemed to be in charge, not the client him or herself; 7) the socio-cultural contexts (e.g., history of trauma, cultural dislocation and cultural practices) were not deemed as well suited to A&D counselling but rather to “general” counselling; 8) description of recovery from substances seemed more prescribed; and lastly 9) the crisis aspects seemed to become a dominant focus.

Two participants deemed my research focus on EC issues as constituting “higher order,” “deeper,” “bigger questions in life,” or “sophisticated concepts.” They stated that my interest in EC issues could be worthy of attention when clients have recovered from their A&D problems, or would be more suited to a “general” mental health counselling. Such distinction and labeling (as elaborated in the quote below) seemed to confirm the segregation and or compartmentalization of EC factors from clients’ A&D problems. Analysis pointed to an ongoing debate on the part of some of the counsellors as to when EC factors should or should not be included, or where these factors fit or did not fit within the clinical context of substance abuse counselling. Thus, for some participants, “addiction work” and integration of cultural
factors seemed mutually exclusive. Please note that the notion of fit will be revisited later in the section entitled “Cross-Cultural Relationship Building Attempts.”

I think, a real difficulty though with your researching with addictions is that addiction is, is so primal that, that it’s actually hard to get through, to begin to engage with these more sophisticated concepts…Because people are just … uh … I guess so rooted in it [referring to addiction]…engaging with sophisticated concepts such as religion or culture, uh, does not fit. (Participant 10)

Based on my observation, a disease model sometimes seemed to accompany an expert stance and a universal approach to treatment. These elements often accompanied conceptualizations of clients’ A&D problems as separate from historical and socio-cultural contexts. For example, a few counsellors stated that they did not integrate trauma history into their A&D counselling even if the counsellors were aware of a clients’ traumatic past, alluding to the notion that trauma was secondary in treatment of A&D problems.

I don’t want to work with trauma and I know how that um can – how substance misuse can either begin as a result of coping with that or um be perpetuated anyway as a result of that. (Participant 19)

I just deal with where the client is right at that moment, and that’s where I make the bonding. Knowing that gee, they had a trauma when they were 13, well that’s nice to know, but all that does is put me in my head and that doesn’t really help the client in terms of healing. It just sort of makes me feel like, gee I’ve got a lot of information, I could diagnose them now. (Participant 8)

In understanding of clients A&D problems, the expert stance sometimes contributed to counsellors deciding whether EC factors fit or did not fit for clients, as the following counsellor asserts:

...we’re looking at the first stage of addiction recovery is, you know, culture at this point really doesn’t matter, because it’s very simple. I’ll give you an example. A person’s having a heart attack, a person’s caught in a house in a fire, a person’s being robbed. Does a police officer, firefighter have to say, hey, what’s your religious background before I pull you out of that fire? You see what I’m saying? It doesn’t matter. When the person’s in addiction and if it’s a crisis situation –culture doesn’t – really doesn’t matter at that point… So addictions counselling is not like um fee for service or private counselling where people come in and I want to explore my deeper issues on why I
became addicted... (Participant 25)

Within case analysis of the above participant’s interview highlights the contradictory stances on the intersection of EC diversity and the model of addiction:

It’s important to learn about different worldviews. Even when I meet someone from different cultures, I’ll ask, where are you from? And uh, and that’s why during my lunch break I actually, you know, read a lot of stuff about different cultures. I’ve read books on Islam, I’ve read books on Buddhism, Jesus, you know, Greek Mythology, you know, so much stuff. Because you meet people and right away you’re able to validate a piece of them. Even if you don’t know a lot, the person’s like, you know what? The person, you know, knows at least something. They took an interest in my culture. And if the culture is important to the person, it’s strengthens that connection, that relationship. (Participant 25)

The above quotation points to the counsellor’s attempts to include culture as part of the relationship building, however, his comments as identified earlier in terms of “culture does not matter in addictions” point to the complexity of how EC factors are understood when a disease approach is endorsed. Additionally, I perceived that a restricted notion of culture was being utilized in the above quote, i.e., culture equated to religious background. Such within case contradictions on significance of EC factors also pointed to multiple constructions of the above terms for the same counsellor.

The ongoing analysis of interviews further pointed to counsellors’ providing contradictory views on “addiction” with respect to the integration of EC diversity factors during therapy. Such contradictions made it difficult to clearly gauge the counsellors’ perspectives and A&D practice with respect to the topic of research. For example, the participant quoted below asserts two contradictory perspectives, where initially “addiction” is considered to be the same for clients irrespective of their socio-cultural contexts, i.e., “addiction is addiction is addiction.” However, he later reiterates the notion that individuals’ recovery may differ as illustrated below.
What I notice is their difficulties are the same as the Indo-Canadian guy or a native guy, ultimately; addiction is addiction is addiction. (Participant 10)

Later he contradicts himself by saying:

…with addiction and recovery it’s important to remember that everybody has their own path into addiction, and…If you talk about emic, everybody does recovery, cleans up differently. It might look the same on the outside; oh yah they counselled, they went to recovery house, they went to A.A… (Participant 10)

One of the counsellors, who provided general A&D counselling as well as culturally specific counselling for his community, highlighted his preference for the use of a medical model or seeing “addiction as a medical illness.” He also raised the question of relevancy of EC factors during treatment. For this participant, engaging with a medical model was perceived to help reduce the stigma and shame surrounding help seeking. He also stated that his clients perceived him as an expert, and thus he was happy to provide them with necessary health-related information. Additionally, this counsellor reiterated that such an approach met some of his clients’ urgent needs to get specific medical information about the negative consequences of their A&D problems. For example:

…defining it as a disease um that’s common with my approach…And that works with a lot of them…I don’t do anything extra than I will do with a white person. Because he’s not bringing in those kind of issues which are interfering to dealing with his addiction. He won’t bring any culture into it, anything he would just [bring] straightforward addiction. And I won’t bring cultural issues…So if it’s going smoothly why would bring culture in it? (Participant 6)

Sometimes within the disease model, I perceived the endorsement of a relatively rigid, or “rule” bound notion of recovery, irrespective of clients’ unique stages of change or readiness as well as socio-cultural and historical contexts. In addition, there were occasions when a confrontational style of relating to clients’ A&D problems seemed to run parallel to the expert position, in that a few counsellors appeared to adopt a moralistic or character-based perspective. Both the expert and confrontational style often seemed to impose an Eurocentric
model of health, focusing on the individual rather than the myriad of socio-cultural contexts underlying A&D concerns. For example, some participants viewed clients as “trapped” in their A&D, needing to be freed or released. A certain language seemed to also pervade these interviews such as “deconstructing” or “breaking down” the numerous defenses of the “addicted” clients who were generally seen to be in denial or immersed in “lies.” For instance:

I define their therapy for them. Or healing, whichever… I said, most of you are on the paths you are because you’ve learned how to lie a lot...You don't know how to be truthful to yourself, so you don’t know the truth… I’d take my breaks and meditate, answers would come even though I hadn’t asked the questions… My approach is to take people on an airplane, open up the airplane, give them a parachute and shove them out the door... (Participant 8)

The prevailing view of the substance-abusing client as being defensive or embodying a “sick role” seemed to exist for some of these participants. Such construction of clients’ A&D problems seemed to also allude to a narrow understanding of EC factors, with ethnicity and culture as being fixed. For instance, a counsellor referring to the stages of adult development alluded to her clients as having skipped certain developmental milestones due to their A&D problems. There is an assumption of a Eurocentric standard that is not being met by her clients. Additionally, this counsellor perceives that the theories of development cut across all EC groups. While she identifies that the use of the word “pathology” is old fashioned, she nevertheless continues to use this word to describe her clients as unhealthy:

If a child gets stuck at particular stages, you’re still going to see that in the adult unless they’ve done things to you know, they’re physically grown up – but they’re still acting from this place…like anyone from any culture, different cultures that are substance misusing, for instance with um heroine, uh they’re going to nod off after injecting, you know – nod off in a certain period of time. It doesn’t matter what culture they’re coming from, there are going to be patterns, you know. (Participant 19)

**Integrated model of recovery.** What I term as the “integrated framework” captures counsellors’ perspectives that centered on the following understanding of A&D problems: 1) diversity factors were perceived as an integral part of conceptualization, treatment planning and
interventions; 2) multiple influences and pathways combining psychological, biological as well as socio-cultural factors were considered when explaining clients’ A&D problems; 3) the expert role was given to the clients, instead of counsellors, with clients perceived as decision makers; 4) approaches included multiple interpretations of clients’ problems; 5) interventions were evaluated in terms of their safety and cultural appropriateness with respect to clients, with an overarching attention to ethics; 6) counsellors engaged in critical analysis of the system and dominant models of therapy so as to not impose ethno-centric attitude on clients; and lastly 7) alternative or traditional approaches to healing were considered as an important part of recovery. For example, the following participant’s quotation describes how models can be guides, but that they are not “truths,” or an objective reality, just one of the ways of knowing:

Different models around substance use and other counselling models can be helpful, but uh they’re not necessarily truth per se. They’re just means to an end, or a vehicle… we can’t get so wrapped up in the way that we do things that we think that that’s the end. (Participant 7)

Within this perspective, there seemed to be an awareness and sense of comfort towards understanding and inclusion of differences in treatment approaches. The way that such awareness was reported in terms of application into practice will be further elaborated in the section “Translating Ethno-Cultural Diversity into Practice.” This particular section is focused on specific perspectives around recovery from A&D problems. An integrated perspective consisted of a Bio-Psycho-Social-Spiritual (BPSS) framework as illustrated by the quote below.

So there’s a high dual diagnosis of anxiety, depression and of um disordered eating. So we incorporate disordered eating into the program as much as possible… we also encourage the clients to do – to set goals…and the goals are in the different areas of – there’s a physical goal, emotional, social, spiritual. (Participant 3)

Analysis revealed that adoption of an integrated model of recovery accompanied openness to ethno-cultural differences from a systemic and critical perspective, where clients’
A&D behaviours were considered to be influenced by an accumulation of historical, psychological, biological, and socio-cultural influences. An integrated approach also included critical analysis of factors such as the history of colonization, immigration, acculturative stress, dislocation and discrimination affecting minority clients’ lives and access to A&D services.

Some of the counsellors asserted that much of the recovery from A&D tend to be focused on identity work, a sense of belonging and the context, as will be further highlighted in the next category of findings “Ways of Being: Reflecting on Identities.” There was recognition that clients’ intersecting social identities not only informed their decision making towards help seeking but also access to resources and services. Some of the counsellors shared that the rupture in certain identities due to oppressive systemic influences were intricately linked to clients’ seeking out substances to cope with alienation. For example, the following counsellor reiterates his approach to A&D work and diversity being influenced by the intersectional approaches (i.e., understanding how culture, gender, religion, ‘race’ intersects with substance abuse)

And again, like we talked earlier about intersectionality right …So I mean if I have a South Asian female in here doing counselling, so it won’t just be her experiences as a South Asian, it will be her experiences as a female. Uh so if she comes in with an addiction issue, which I’ve had clients like that, um we may talk about well some of those other and how does her family look at the issue…(Participant 16)

An integrated framework additionally consisted of dialogues on concepts such as ethics, safety and social justice. These were deemed to include a heightened awareness of advocacy and deconstruction of power within therapy, i.e., “depositioning” oneself as an expert and challenging the hierarchy, as elaborated in the quote below:

I think depositioning ourselves as experts and really putting people’s lived experience, being alongside them as experts, repositioning them as experts you know that creates relationship and it creates a different kind of conversation with people… I think that people, you know, have the right to safety. They have the right to be free from, like
harassment and discrimination. Mostly though acknowledging the power that we do carry, you know and being accountable for that. (Participant 7)

The concept of whether “culture fits or not” (as discussed in the disease model) was perceived differently within an integrated framework. For example, the following counsellor argues that the medical paradigm does not fit for him, as he does not believe that the client “needs to be fixed.” He further states the need to reduce blame on the part of the client:

I think for me - again having a broader context so it’s not that um crack cocaine has this magical ability to alter a person’s whole chemistry and turn them into a so-called addict, right? That’s like a paradigm that doesn’t fit for me… behaviours and so-called symptoms always have a cultural and a social context. It’s not just an individual’s pathology… I ran into narrative therapy during my Masters Degree and that really fit for me in terms of my values, my own, social justice, around, um, contextualizing problems, putting problems in their social and political context. (Participant 7)

Some of the participants adopting an integrated model asserted that inclusion of EC diversity factors contributed to ethical practice. Such practice meant accountability on the part of the counsellor to not only attend to systemic barriers, but also evaluate his or her own competence and limits of practice in an effort to reduce harm. Furthermore, they did not perceive themselves as neutral and openly talked about their own assumptions and values:

I think it’s unethical because, for example, in [stating the name of the country she immigrated from] if I sat with a client and did not talk about the political system, I’m not doing that client justice, I’m totally ignoring their reality. Um that that’s a factor in their mental health. So what I’m also doing is then I’m enabling, I’m part of the system I’m sort of – I would feel like I was oppressing them, because I’m not providing a space. And it’s the same here and I you know, I have – you know I do have disagreements about, with my colleagues, about around this issue but I think that if it’s not – we’re not transparent and if it doesn’t come up. Then that person doesn’t get to heal or see it in a cathartic way. They see the problem as themselves. (Participant 3)

Contrary to the concept of EC diversity as secondary or inconvenient during A&D therapy, the integrated perspective remained open as to how to integrate clients’ diverse healing practices. Treatment often included going beyond the symptoms and using a strength based/empowerment perspective so that clients could effectively overcome their substance use
problems. In fact, the following quotation from a participant who has a dual role as a supervisor and therapist neatly summarizes the debate on the intersection of EC diversity and A&D treatment:

Is there somebody we can call that’s outside the hospital that could support you? Traditional healer, an elder, uh someone from your synagogue… those are questions we can ask…making space for that healing to happen… healing becomes complimentary. It doesn’t come instead of, and it’s not seen as alternative. (Participant 1)

Another participant emphasized the need to be aware of the evidence-based practices in the field, such as providing trauma-informed or integrated-trauma A&D services. She stressed that such a lens helped contextualize clients’ past histories of vulnerabilities (e.g., experiences of colonization and dispossession for an Aboriginal client). She also stated that, based on her research and clinical experience over the years, she is aware of the co-occurrence of trauma and A&D problems. However, she also clearly articulated that the task was not to categorize every client as “traumatized” but rather to be aware of the trauma as a risk factor and create a sense of safety for clients. She stated that integrated treatment was “less fragmenting” where addiction was not treated as a monolithic entity or disease, needed to be addressed in isolation, or fixed at the cost of discounting important socio-cultural variables.

I really think we’re moving in the right direction by being more aware. It’s a huge mind shift – um, for some philosophies to really look at things from a trauma informed perspective, and um, for example, twelve step model has been very [inaudible] – you’re an addict and you have an addiction issue and you need to deal with that and the rest of the stuff can wait until you’ve gotten yourself clean and sober…with the old addiction treatment um, it’s like so much of a woman’s behaviour was identified as being as a result of her addiction. And it may not be as a result of her addiction at all. And um, I find that um, it was quick to be labelled – that this was – oh you’re in post-acute withdrawal, or you know, it’s your old addict self and so like there’s no room for this woman’s past experiences. (Participant 17)

Summary. This category of findings focused on dominant models of recovery with analysis pointing that participants’ view of addiction seemed to inform how they spoke about the relevance of EC differences in therapy. Some counsellors treated “addiction as a disease,”
paying more attention to the crisis aspects of A&D and reduction of symptoms, thus adopting an expert stance. The construction of addiction as a disease further pointed to A&D problems being conceptualized to affect everyone the same way, irrespective of socio-cultural contexts and other diversity elements. Additionally, the above often highlighted the adoption of Eurocentric norms, a generalized approach to A&D care with the underlying notion that A&D problems resided within the individual. In contrast to the “disease model of addiction,” a different perspective on A&D problems consisted of an “integrated model of recovery.” This model emphasized that addiction can not be seen in isolation from the myriad of historical, social and cultural contexts, thus going beyond the biological symptoms and or the crisis aspects of A&D. An integrated approach also seemed to position clients as experts, took a strength-based perspective, and seemed to include openness towards incorporating clients’ traditional healing approaches. In addition, such approach took into account the intersection of ‘race,’ culture, trauma, gender and ethnicity as important influences in shaping clients’ A&D related problems. Lastly, an integrated model also consisted of discussions of ethics, safety and social justice, thus addressing power, systemic oppression and privilege.

**Translating Ethno-Cultural Diversity into Practice**

This section of findings pertains to identification of how counsellors talked about applying their knowledge and awareness of EC diversity into A&D practice. This level of analysis is well suited to the practical dimension of Interpretive Description. As a framework, Interpretive Description aims to identify information that will enhance clinical work and inform practice. With such focus in mind, analysis of the data revealed varying degrees of reflection and motivation on the part of the counsellors with respect to the inclusion of EC factors. The above also seemed to inform and organize the participants’ attitudes towards integration of EC
knowledge into practice. In order to elicit the above information, I used various probes such as: “How do you translate your knowledge of diversity into action?” “Can you give me a glimpse of what happens during your session when working with client(s) with from diverse EC backgrounds?” “Based on what you have told me, can you give me an example of how you would work and or approach clients with differing EC backgrounds?” etc. In this section, I would also like to briefly comment on some of the observations that emerged as I analyzed how participants talked about applying their EC knowledge into practice.

During the interviews, I also observed that some counsellors had difficulties to describe or articulate how they would implement their knowledge of EC factors into therapy. These observations during analysis pointed to the presence of a tacit knowledge about EC factors that required reflection on the part of some of counsellors in order to talk about their experience and make the switch from implicit to explicit. Certain participants often coined their process as “instantaneous,” or “automatic,” making analysis relatively challenging. For example the following counsellor states:

Well, I mean, I understand that in the sense that uh – it’s hard to talk about what I do. It’s just so organic. (Participant 11)

I’m trying to figure out how it developed. I don’t know that it was conscious. Um, simply realizing – from that, but realizing that when people are relaxed, comfortable in my company, the sessions are going to work… it's unconscious. (Participant 20)

I found that participants who had difficulty providing examples of application as per interview question, required a lot more probes such as: “please give me an example of an intervention that you may engage in,” “if you could describe your process of therapy, then it may help me understand what you are referring to,” “if you could teach another counsellor about this, how would you describe what you do?” and so on, in an attempt to help make the implicit more explicit. Counsellors who spoke in generalities also required me to go back to
transcripts on multiple occasions and ask myself the following reflexive questions: “What is going on here?” “Are there unique themes that may capture this implicit process and explain the counsellor’s reports of application of their knowledge and awareness of EC diversity?”

Upon further analysis, several pointers emerged. I learned that the counsellors’ reports of application of EC diversity in A&D treatment seemed to be intricately linked to the category of findings discussed earlier (emerging positions, the organizational context and recovery models). I perceived that how counsellors thought and felt about the topic of differences and the extent of weight they attributed to EC factors (i.e., whether they perceived it was important/needed to be included) seemed to influence their reports of how EC factors were included in therapy. For instance, the already mentioned disease model of recovery focused on a generalized and or universal approach. I also observed limited reflexivity by counsellors on their own identities, biases as well as the need to modify or question the effectiveness of their interventions. I utilize the following two quotations to illustrate the above point where a counsellor reports of her preference towards a generalized approach.

That’s kind of going back to what I was saying about being color-blind. I don’t make the assumption that they’re one way or the other. That is, you know, my questioning is fit for all races and cultures because the questions will inform. (Participant 11)

Later, the same participant quoted above openly shares her objection of how the field is currently emphasizing the need for culturally appropriate care. She states that she prefers not to engage in the use of labels because she considers everyone the same and she expresses her genuine concerns around stereotyping her clients. Her objection seems to not take into account that EC diversity factors may be important for her clients and that they may want to identify with certain labels, social locations and their respective influences on their A&D concerns.

I don't necessarily – yes, it’s in the back of my mind, but culturally appropriate, I just, I kind of cringe a little bit. You know, because that to me sounds like a label and putting
people in a box. (Participant 11)

A different participant in response to my question of whether he modifies his approach when working with diverse clients emphasizes the following:

There’s an obstacle and they’re using mood-altering substances or any other self-harming behaviour to make themselves feel better. That's a universal process. There is nothing multi-cultural about it at all, there’s no specific intervention technique. I could get someone from any background and say the same thing and just translate it and they will all say, you know, that’s how I feel, right? (Participant 25)

Additionally, some interviews revealed limited examples of how differences were incorporated during therapy. On some occasions, certain comments in terms of modification of approaches were noted, however they seemed confined to differences that were easily noticeable, such as language barriers, i.e., working with clients presenting with apparent English language difficulties.

And I spend a lot more time speaking slower, checking if they understand. Finding ways to get around abstract concepts…Um, if I notice the person is anxious for instance, and if the person has communication difficulties, I will ask him right away, would you like to relax better? If they say yes, then I’ll give them an exercise right then and there we’ll do to lower their anxiety. (Participant 8)

At times, there was a sense that some counsellors may have perceived my questions on EC issues in general and questions on applications specifically as an evaluation of their cultural competencies/skills or lack thereof, thus feeling nervous or resistant to provide some examples. A few attributed their difficulties in responding to my questions due to having limited opportunities at work to discuss EC diversity with colleagues. My interviews therefore seemed to have required some participants to engage in vocalizing about a topic that I perceived that they either had limited experience with, or had limited exposure to diverse client population at work. For some other counsellors, their heavy client workload seemed to contribute to fewer instances of engagement and supervision on the topic. The analysis highlighted that
counsellors’ lack of on-site training and exposure limited the ability of counsellors to report on how they put their tacit knowledge into practice. For example, one participant shared that majority of her clients are male, while also reflecting on the lack of contact with diverse clients:

I’m just trying to think of how many women, Asian women that I’m aware of have come for counselling or Indian, you know, women. I mean certainly First Nations women yes, absolutely, but not from India or whatever, so that limits my experience from that standpoint, you know. (Participant 19)

There was also an implicit assumption on the part of some participants that, even if they could not describe the work they did with clients of diverse EC realities, somehow they implicitly knew they were being effective with clients. I also learned that on certain occasions, my questions with respect to “how do you do it?” i.e., the practice part, was experienced by some counsellors as if I was pressuring them to intellectualize or provide a structure for something that they “felt,” or “sensed.” Here is an example:

I don't do that intellectually because when she brings it up, I get a sense right away if this is important and then I act immediately. (Participant 8)

During the interviews, I continued to explain that my aim was to understand participants’ perspective, experience and practice with clients coming from diverse EC communities. I also acknowledged the limitations of interviewing in the form of a verbal exchange to get at their tacit/experiential process, which they coined as constituting a feeling/sense. I had to clarify on multiple occasions what this “sense” was, and how it manifested itself in therapy. Participants’ description of the term “intuitive” referred to a process that seemed instant, immediate and evolving with experience. When counsellors reflected on application of their knowledge of EC diversity, they commented going beyond reasoning/thinking to a “way of being” that was subconscious and effortless.

… I guess after years of doing that I’m - I use my intuition a lot… I see with all my eyes right, and then I have a feeling…using all of your senses, not just the language…
so I guess listening is like this is how I – it’s like almost you use your – all of your senses. (Participant 21)

… it’s kind of sense-set, so if part of it’s visual connection, part of it’s you know, body posture, part of it is if they’re making contact with you (Participant 9).

I utilized the categories labeled above and their underlying themes to not only capture the complexity of the process as a whole but also help illuminate the aspects of cross-cultural work that participants described as tacit. Additionally, these themes include accounts where some participants seemed to articulate their knowledge with/without the use of probes, and made the switch from implicit to explicit as the interviews progressed.

**Ways of being: Reflecting on identities.** This theme covers analysis of interviews where participants talked about how their own social identities shaped their cross-cultural encounters. I perceived that these counsellors also reflected on personal and professional stances that helped them in their A&D work with diverse clients. Transcripts revealed that most participants often alluded to their own sense of self, and intent to “embody” who they are when they worked with clients from diverse EC communities. Embodying referred to a way of being that was intuitive and natural, consistent with the process that some therapists deemed as tacit. Counsellors’ descriptions of self generally concentrated around the notions of curiosity and of “being a learner,” marked by a sense of alertness and attentiveness.

I’m open. You know. With my power open, like you know, my antennas you know, I’m learning. (Participant 21)

When it came to working with differences, these counsellors reported embodying comfort and openness. One counsellor, for example stated that if, as a therapist, he was okay with different aspects of his own identity, then he would make it okay for his clients to feel comfortable with their differences. Such role modeling seemed to move the process to a deeper level helping counsellors explore differences without tension or fear of offending.
So if there’s not acknowledgement of that and creating space for that - it’s like if you assume everyone’s the same, then there’s not - it doesn’t create safety for somebody to come forward and explain how they’re not the same without feeling like it’s something that’s going to be wrong or there’s going to be judgement attached. (Participant 2)

Some counsellors further indicated that exploration of identities occurred through the action of reflexivity, i.e., self-examination as elaborated below. Reflexive moments occurred when counsellors adopted a critical look at their own social identities, values, and assumptions.

And just when I think I’ve eliminated all of my assumptions, I discover another one. (Participant 7)

For me there’s a very clear distinction about being more fully who you are. And I have to be able to embody that myself. Or, you know, what credibility do I have? Right? So that’s kind of really critical. (Participant 1)

The action of reflexivity was further marked by counsellors staying attuned to their own processes (e.g., reactions, values and attitudes), with some counsellors going beyond own biases to reflect on power and privilege as well as historical and socio-cultural influences linked to their providing A&D care to diverse clients.

**Identity as a cultural being.** Analysis of interviews pointed to the notion of one’s identity being culturally bound. Participants embodied their own cultures and acknowledged being aware of when their clients saw them as different than themselves.

They [clients] are comfortable with telling you, my culture is this, and this is what my culture does… it's like they almost notice I’m not of their culture, right, so they want to let me know. (Participant 12)

Some study participants’ ways of being appeared to be informed by their diverse personal experiences. Examples of influences included: training in graduate school, growing up in diverse neighbourhoods, being immersed in what they coined as bi-racial relationships, traveling overseas, experiencing immigration (as 1st or 2nd generation), and or belonging to a minority group. For example, one of the counsellors talked about how her social group
membership as being white conferred a sense of privilege and power that other minorities could not experience.

…if you’re in a position of privilege you don’t necessarily know that you are. It’s being on the receiving end of discrimination is where you can appreciate more that it is discriminatory. (Participant 2)

Another participant with the dual role of supervisor and counsellor reflected on the intersection of his professional identity (graduate school training), sexual orientation, and ‘race’ and their respective impact on his practice.

I find that because of my work that um post–modernism and constructivism um that I’ve challenged those narratives and I’ve challenged – gotten to know where um where that stuff has come from. And that’s I think very – that work that I did with regards to um my discourse analysis um really helped me understand the cultural perspectives of language, and helped me to understand how powerful stereotypes were and, you know, discriminating you know, um and disrespectful story and disrespectful joking and all that has culture too linked in and a lot of it is patriarchal and heterosexual and White, you know. (Participant 18)

Another participant stated that his “bi-cultural” identity was shaped by his experiences as a second-generation immigrant and a person of color living in Canada. He stated using the above experiences to explore his minority clients’ multiple identities and the barriers they may face in the system as a result of their social location.

And that piece even around developing that identity, how that comes about, you know, informs the way I kind of do the work. You know ‘cause I’m curious as to how people have become the way they are, you know…coming from a small town, being a person of color I think early on yeah I – you know being the only person of color usually in my elementary school…wanting to fit in and pushing the parts of me that it didn’t fit in necessarily. Well you can’t change your skin color, but those other pieces, you know, really not wanting to be or even acknowledge those. (Participant 16)

**Identity as a gendered being.** Analysis also pointed to several instances when some counsellors talked about the intersection of culture and gender and how these social categories influenced their work with clients. These participants remarked on their sense of self as gendered beings and its influence on clients of the same or opposite gender. For instance, some
counsellors who identified as white stated needing to constantly challenge their own gender expectations, which were rooted within a Eurocentric paradigm. A few of the male counsellors spoke of their privileged position as “white male” and being cautious to stay away from establishing a patriarchal relationship with their clients. They also spoke of how power can emerge within the therapeutic context and being mindful and alert to constantly work towards equality. Analysis elucidated that these participants also remained aware of their own “taken for granted” ways, and the fact that various categories of privilege made discrimination and institutional racism less visible to them.

And of course, like being white and being male, of course I also internalized a lot of like, a lot of racism that I’ve had to work through at the same time, so I’m not saying that I’m perfect, so to speak, in terms of uh, you know it's taken work to deconstruct some belief systems that were ingrained as well…trying to change the history of racism and colonization that some of my ancestors have taken part in, just by virtue of my-my actions and the choices that I make in life. (Participant 7)

Furthermore, two male therapists stated that being married to women of color had influenced the construction of their identities and worldviews. They commented on personal experiences that had opened their eyes to racism, sexism and privilege as illustrated below:

I have begun to see things a little differently… And that may be because I’m the majority, I don’t know – but I um – and I wasn’t even aware of differences that, for instance, my wife experienced but I never experienced. (Participant 9)

Female therapists who identified as white and middle class reported that such social categories granted them positions of power and influenced their clients and process of therapy. For example the following participant shares that it is sometimes challenging for her older minority male clients to disclose their personal information to a white young woman:

Yah, then there is even more of that kind of odd imbalance, you know. Young woman, in a, white woman in a position of authority prying into issues that are actually really very closely guarded in, in that community, right?…I took that course where I got quite a grounding, hum … in the cultural perspective, or in the gender and the anti-oppression…awareness building, on, on privilege and class and things that, you know,
things you don’t always learn about in every day life, so, so, so that, that hum; and they’re very feminist right? (Participant 23)

**Fostering a culture of safety through advocacy.** The overlapping elements of social justice and reflexivity for some study participants included inquiring about one’s role and identity in relation to diversity. This entailed striving towards enacting change and raising awareness within micro (oneself, and the one on one therapy context), meso (in group therapy context, and work meetings) and macro (to change program structure/content and or to engage in outreach) levels. Please note that not all counsellors’ advocacy efforts in this group covered all levels. It seemed that the underlying framework for advocacy was to reduce harm, and safely create a dialogue around difficult topics such as institutional racism, sexism and homophobia and their impact on clients. These counsellors seemed to strive to find strategies to address clients’ needs, especially those from marginalized groups. Most perceived this to be an ethical imperative to respond in competent and responsible manner.

Most of the participants whom I perceived as able to reflect about their tacit knowledge also spoke spontaneously of their advocacy attempts/actions at the micro-level; pointed to comfort and openness to admit to one’s limits. In fact, the section on cultural and gender identity, described above, seemed to cover counsellors’ micro-level advocacy work, taking the form of challenging their interpretations and admitting that their knowledge and skills were culturally bound. At a micro-level, the counsellor below talks about the impact of his personal choices and decisions on his work.

Part of my process is just needing to be really careful with that and respectful about that and at times leveraging that power to advocate for the client…It almost becomes like, yeah, a force, a very positive force to actually talk about issues that other people may be afraid to talk about…trying to change the history of racism and colonization that some of my ancestors have taken part in, just by virtue of my-my actions and the choices that I make in life (Participant 7).
At the meso-level, participants’ advocacy attempts went beyond the individual to the level of groups. Groups seemed to be comprised of clients seeking A&D in a group context, or colleagues gathered in a team meeting at participants’ respective agencies. Below, two participants’ advocacy attempts within the varied group settings are highlighted.

For example someone says something about another group that sounds, you know, that is a generalization, and use that as a learning teaching moment. So the group is process plus psycho-ed, so you could jump in and I would try and take that as a teaching moment. …because then all the negative stereotypes that are out there would be dealt with…or clients get to see this person outside of their stereotype. (Participant 3)

Another participant explains how, in both group therapy and his team meetings, he addresses the needs of his disenfranchised clients:

When I’m doing like a group therapy session, and somebody says something racist, then I might reinforce that this needs to be a safe place for everybody…Where if I’m working, you know, if with a colleague and they say something that is you know, unintentionally transphobic for instance, then you know that might lead to a whole conversation of, oh I’m just curious about where you’re coming from with that…having a conversation about it and trying to reinforce the need for it to be a safe place for everybody and a respectful place for everybody so, just kind of trying to foster that culture on a team. I think that that creates change - like you can create cultural change within counselling by - in the way that you speak with and about people. (Participant 7)

At a macro-level, some participants talked about their advocacy efforts being geared towards bringing change at the programmatic level as an attempt to evaluate interventions and contents of A&D treatment set by the agency. Therefore, safety and the “fit of program structure” with their diverse clients seemed to form the core of their advocacy at this level. It was apparent that these participants identified and challenged the Eurocentric approaches to A&D work. For example, the following two counsellors engaged in critical analysis of the topics in their manualized treatment programs that are highly structured. In particular, they highlighted one of their program’s psycho-education sessions as being geared towards assertiveness, a relatively Eurocentric concept. They also seemed to be torn and not knowing
how to balance program goals and their own understanding. They nevertheless appeared unsure about the effectiveness of the topic:

> We’re coming from a quite a Eurocentric place in our approach. We’re teaching about the use the assertiveness formula, which can be controversial. Um so a few of us [talking about her colleagues] have been aware of how that has backfired in the past and how we’ve had women come in here - um say we had an East Indian women who’s come in and this is not an approach that is supported by their culture or either by their peers, and actually leads to an abusive situation when they try to use this...And you know I worry sometimes that that’s not always um safe for someone (Participant 3).

> My biggest worry is how to ensure that what we’re teaching isn’t going to be harmful for people in taking what we teach and trying to put into practice in their lives when they go home… just the things that we choose to teach I think are very reflective of a Western viewpoint. (Participant 2)

Another element of advocacy that stood out at the macro-level was outreach activities, built into counsellors’ jobs by a selected number of agencies to reach out to marginalized groups. The targeted groups seemed to comprise those who would have limited access to A&D treatment services (e.g., the elderly, homeless, individuals with long term disabilities, and immigrant groups with limited English language proficiency). The reduced access by the above groups was perceived to be linked to the lack of culturally appropriate treatments, stigma to seek help for A&D problems and, finally, foreignness of counselling as a context. Participants who identified their training in social work stood out in particular. However, there were also a few of the participants with counselling psychology training who performed outreach duties. Analysis revealed the presence of a unique set of skills: advocating for housing, medical help, home visits, dealing with the authorities such as the child protection agencies or the police, and building partnerships with relevant services in the community.

Below, one of the participants speaks of her outreach activities (i.e., home visit) with a senior who comes from a different EC background than hers. She highlights how her work differs from one-on-one A&D therapy context. She highlights the need to build trust over time
with some of her clients who are in immediate need for help but not motivated to see her.

So I’ve got to look for ways of engaging that person and where we…so most of the times I’m not working in addictions directly… I have to go out with my eyes open um for I go all the way from housing to their budget, to looking for the psychiatric part of it say, you know, some symptoms that I need to do a referral or bring somebody in, um medical, you know…What’s happening with the medications, I’m aware of some of them particular benzodiazepine, so I look for that. I look for – I question whether there’s um misuse of the medications, how the management of those medications is happening?  (Participant 21)

Cross-cultural relationship building attempts. All counsellors interviewed (irrespective of their positions on EC differences or models of recovery) talked about the centrality of the therapeutic relationship in their counselling. Descriptions such as “joining together,” “therapeutic alliance,” “rapport building,” “engagement,” and “building relationship” were provided as participants talked about the dynamics of the therapist-client encounters. The underlying perception by the majority of the counsellors was that they were generally successful in establishing positive therapeutic bond, with the process seen as intuitive, tacit and evolving. Some participants rarely spoke of experiencing difficulties in connecting with clients; pointing to an implicit belief that it may also be easy for clients to connect with the counsellors. In contrast to the above, a number of participants talked about actively checking in, or getting feedback from their clients with respect to their attempts at relationship building. These participants did not see themselves as immune from relational struggles, and therefore stated the need to reflect on their own reactions and processes as a way to stay present in the relationship.

Analysis of interviews highlighted that most of the counsellors had a tendency to make general comments about the counselling relationship overall and, in particular, about individual therapy contexts. It must be noted that the majority of counsellors interviewed actually engaged in group therapy, which required simultaneous and multiple relationship building attempts with
a large number and diversity of clients. In fact, only three counsellors spoke of the relationship
dynamics in group therapy. For example, the following counsellor speaking of the “fit” states
that she has to be mindful of how her approach to A&D therapy applies to every one in the
group, acknowledging her limits within a group context.

I hope – it’s like I don’t really have any answers other than to try to not forget about it, like to keep the awareness there and to acknowledge that things may fit more or less well…So and so it is going to fit for them but what about the other 4 that maybe it doesn’t fit for? (Participant 2-Part 2)

Success in relationship building was generally attributed to the quality of counsellors’
interpersonal skills. The skills mentioned included the ability to show empathy, warmth and
respect for clients. It appeared that some counsellors presumed that clients came equipped with
prior knowledge about the role of the therapist or the A&D counselling context. For example,
despite the following counsellor’s assertion that she does not carry culture as evident in her
comment, “I’m not sure we [her assumption of being white and from the West] have much of a
culture,” her transcript reveals her unique cultural expectations as illustrated in the quote
below. This occurs as she reflects on her counselling relationship and relative frustration when
a minority client attends an individual therapy context, but accompanied by his “uninvited”
family members. One of the ways she tries to make meaning of this encounter is to compare it
to the expected or dominant norm for counselling. Her preferences for expression of feelings
and individual growth (away from the influence of family) are revealed as follows. The
conversation also reveals the distance she perceives between her expectations for personal
growth and those of her clients from different EC realities.

I’m struggling with the conceptually understanding of that. That they don’t understand about their leaving a person alone to develop on their own… I’m just aware of how judgmental a family member might be…We’re grappling with sometimes things that haven’t been identified, let alone articulated, ‘cause they are not used to putting words to their experience. And then often not used to even identifying feelings…But uh um
sometimes with uh some minority clients, there really is nothing in the culture or has been nothing in their culture growing up, as I say, the world is changing, but has been nothing in their culture to encourage such uh – that kind of exploration [referring to talking about feelings with a therapist]. (Participant 19)

A notable observation was that some of the counsellors talked in generalities about relationship building as compared to another group of counsellors who emphasized the notion of “multicultural” relationships. Multicultural and cross-cultural relationship, as an interchangeable category, referred to a relationship composed of the therapist and his or her client(s) embodying differing EC backgrounds, social identities and worldviews. Counsellors who spoke directly of the complexities of multicultural relationships generally remarked on counselling as a profession reflecting Eurocentric values, challenging the dominant discourse on construction of self, health and recovery. They also referenced to the power of language in talk therapy and the need to be aware of the complexity of cross-cultural communication:

We often don’t get a second chance to make a first impression…I remember when I was learning some of this stuff, there’s no such thing as values free –counselling. It’s not – as we espouse it… (Participant 4)

A few counsellors who worked within their own EC communities also raised questions about the commonly perceived image of the therapist as aloof, objective, non-directive and neutral. These counsellors stated needing to be flexible and open in terms of providing direction and guidance when clients asked for that stance. However, they stated being careful about advice giving and generally situating it within the context of their client’s socio-cultural realities. These participants stated that clients from their own communities expected to learn about their therapists’ cultural background in addition to their immigration experiences. These participants further indicated using their personal experiences as teaching moments to help build alliance and talk about resources, with self-disclosure targeted towards benefiting the client.
So coming to Canada is a process of adaptation. Adjustment to the new system, to the new lifestyle, new economic, all the issues that we face when we come…the openness that we, and the sensitivity that we give to our clients, like looking at them, more like here I am, yes, to help you and to work with you…I understand why you are getting into these…but sometimes even sharing, I am here, I am an immigrant and we experience different issues (Participant 15).

In the following section, I aim to elaborate on three major subthemes that emerged as therapists spoke of their attempts at relationship building in cross-cultural contexts. These themes were important in elaborating how counsellors understood EC factors and spoke of their importance in being applied to the therapy context. These subthemes are: i) Incorporating EC factors through worldview exploration, ii) Trust building, and iii) Making Space: Client as the decision maker.

**Incorporating EC factors through worldview exploration.** This subtheme developed when participants talked about therapeutic relationships as a ground for cultural learning and worldview exploration. There seemed to be an awareness regarding acculturative stress and the societal expectations put on clients from different EC communities to adapt to the dominant culture and its norms. Participants with such awareness stated the importance of being careful not to repeat the same hegemonic practices within the counselling context:

For example we’ve got clients who come in who might have a different concept of mental health that is not a medical model…I say, you know, what do you understand about [name of the agency]? How do you - do you know how we work with addiction…And then I give them the opportunity to talk about that to me. And then I inform them that they will get a chance to work within their own belief system within the group. But this is the approach that we follow. So it’s more like, um make it so that they’re aware that they have informed consent because they know that the approach that we’re using which is pretty Western, and pretty Eurocentric, frankly. (Participant 3)

Worldview as a theme referred to explanatory internal/subjective frameworks that individuals use to orient themselves to the world and make sense of their social realities. Some participants reported that the notion of worldview was complex, shaping one’s identity,
perception, feelings, as well as actions. One participant referred to worldview as a filter influencing how one evaluated and approached different courses of action. The theme of worldview was deemed fluid, but culture-bound, i.e., socio-cultural contexts shaped their construction. Within the context of A&D counselling, worldview as a comprehensive term was considered to consist of reasons, meanings and explanations for why substances were used, and what it meant to seek help for and or recover from A&D problems.

Understanding that, first of all, understanding that there might be differences in how people experience the world, understand things and practice them. (Participant 5)

Counsellors commented on the relationship between worldview and positive therapeutic relationship, in that worldview exploration enhanced collaborative work and goal setting. When working with differences, many counsellors talked about being aware of not stereotyping or racializing their clients. They remarked that while having familiarity with certain EC communities and their specific practices was important, they did not want to “pigeonhole” their clients or match their unique characteristics to what they had read in textbooks. Most stated not being agenda-driven but, rather, allowing their clients to tell them who they were, where they belonged and the extent they identified with their ethno-cultural communities, for example:

I do is ask them about you know, where did you learn about your culture? How does that happen? How is your culture different? How is it similar? Like start to take a look at where would I find knowledge if I wanted to know more? (Participant 1)

The outcome of worldview exploration for counsellors seemed to consist of the ability to fully immerse oneself in the other person’s perspective without imposing one’s own values and assumptions. Worldview exploration also uncovered the repeated notion of “fit,” i.e., looking for a “fit” seemed to contribute to establishing common ground and a shared understanding of clients’ A&D problems. For some counsellors, the process of assessing “the fit” came through eliciting feedback from their clients during therapy. Additionally,
participants questioned whether their attempts were matched with clients’ preferences and expectations for therapy. The following participant alludes to what happens when the therapist’s and the client’s worldviews are the same or different depending on one’s group membership. He also comments on actively adjusting, and monitoring the process to reach a suitable fit in terms of understanding the clients’ goals in therapy.

I’m looking for um a sense of identity and a sense of belonging and a sense of therapeutic alliance. I don’t try to avoid the dissimilarity, but I’m going to have a harder time building an alliance with dissimilarity than I will with similarity. (Participant 9)

Another participant states that understanding the clients’ perspective could be facilitated when a counsellor is open to shift out of one’s culturally bound worldview. She remarks that immersion in experiential learning is necessary for the change to follow. Below she narrates her own experience of coming to Canada and her need to acculturate herself so that she could be an effective therapist with clients identifying as Aboriginal.

When I came here I had no idea about Canadian culture. I had no clue. I didn’t even know about residential schools…I had no idea, and I did a course, that’s it’s just more than just receiving information, and so I did one course and to acculturalize [acculturate] myself, which was okay, but I still didn’t really get it…But then the second phase of that was actually you yourself did ten weeks of a healing circle with an Aboriginal person…And it was only then that I got it…It’s just that it was the experiential learning piece that helped me understand, not being given a whole bunch of information.. Um because it just you know, because the information I’m going to interpret according to my worldview anyway, but unless I’m shifted out of that into something totally different, um I’m not going really understand. (Participant 3)

Counsellors spoke that understanding the clients’ worldview became particularly vital in the context of A&D counselling, where a majority of clients were required/mandated to seek help. Counsellors’ perceived that the external coercion not only affected their clients’ motivation and readiness for treatment, but also their engagement in relationship building. Establishing safety and trust were reported to be an important goal to help clients engage in therapy (please refer to the next section on trust building). Moreover, the analysis revealed that
counsellors were balancing not only the interpersonal dynamics of their cross-cultural relationship (how client and therapist related to each other) but also their clients’ intrapersonal factors (motivation and readiness) and external socio-cultural realities.

**Trust building.** This subtheme was identified to be a critical element in all cross-cultural relationships; particularly with clients who had previous negative experiences with the system, were mandated, had a history of trauma as well as those unfamiliar with the context of therapy. Some participants described that establishment of trust helped clients to take gentle risks (within the safety of the relationship) to self disclose. These participants additionally felt that trust contributed to a sense of confidence in the therapist by their clients.

Contrary to the notion of counsellors being seen as neutral, participants’ accounts related to the above subtheme consisted of critical evaluation of one’s skills and identity. The quality of a trusting relationship appeared to include an attitude of openness towards, and acceptance of, differences. Trust was perceived to take both time and patience. Some counsellors spoke of how some of their clients came with a sense of mistrust towards care providers, and toward A&D services in general, shaped by their previous negative experiences in the system. As such, these counsellors spoke of prioritizing trust and creating a safe space, contributing to feelings of empowerment and clients’ active decision-making stance.

It’s a process, so at the beginning sometimes it looks like I’m doing nothing, but I’m building trust. Because mostly people that either they have seen too many – too many workers and they don’t want – everybody’s trying to push them and get them to do something that they don’t want to do. Quit, go up to the doctor, change your medication, all the workers that come from the system, right? So the last thing that they want is another worker to come and tell them something else that they need to do. So my role is to find out what is it that they want to do…. (Participant 21)

Trust building meant embodying a “beginner’s mind,” as a way to understand the lived experience of clients from varied EC communities. Some counsellors shared that the notion of
“Beginner’s mind” came from mindfulness based practices and Buddhist principles and comprised holding a non-assuming stance towards clients. It also referred to counsellor’s openness to stay curious and learn about clients’ lives, without seeking rigid answers as the quote below illustrates:

It is about being non-judgemental and not telling them what they should be doing or what expectations are, but really going where their goals are and how you can help them best… you don’t have any agendas of where they should be in terms of their substance abuse treatments. (Participant 15)

Making space: Client as the decision maker. Within the context of cross-cultural relationships, some participants spoke of creating space/making space for clients’ worldviews to be integrated in therapy goals. These participants reported being intentional in creating a space within the relationship to encourage client autonomy, informing clients about options and choices so that decision making could be further facilitated. The creation of this safe space by some counsellors’ was generally accompanied by efforts to present clients with different “possibilities.” These counsellors seemed to admit their own limits in helping, i.e., a client may choose an option that does not suit their lives and they may relapse. The question for these counsellors was how to best support their clients as they examined different choices so that they could get back on track with recovery.

Cause I always ask is this - are we - what we’re talking about is it relevant to you? I mean is it - is there value in what we’re talking about? Are we hitting the points? Am I getting what you are here…So um it’s imperative for me to again, not just offer them the authority but be um close enough but far enough away. (Participant 9)

One of the practical elements for some counsellors for “making space” was to de-position themselves as experts (as already explored in category of findings on models of recovery), and thus embodying flexibility. One of the counsellors states that even despite working within an individual context of therapy, she welcomes family members when her
clients request their inclusion in their recovery.

She’s telling me about what she thinks her culture is and what she thinks her religion is, and kind of telling me where she feels trapped, or where she feels stuck and would like me to uh, kind of help her in that... she is preparing me too, because then she wants to invite her father or family members in. (Participant 12).

When clients were invited into the position of decision maker, counsellors also appeared to experience challenges within their own work setting, which often consisted of a highly structured treatment plan and with treatment aspects not necessarily suited for diverse clients. The accounts of participants with regards to this subtheme consisted of their engagement in difficult dialogues with colleagues as to how best accommodate the unique needs of clients that conflicted with the expectations of the system.

…if I’m going to take into consideration and allow that person to talk about the impact of say residential schooling or any form of oppression they’ve experienced, that’s also going to impact then the aftercare planning. So some of my colleagues would say, well that’s got nothing to do with addiction, you know. Would they, you know, they need to go into a twelve-step group and this is what I’m going to recommend. Whereas if I’m aware that that client feels a twelve step groups were designed for Western males…then I’m not going to recommend that. I’m going to support them in pursuing a different type of women’s group. (Participant 3)

**Summary.** This category of findings focused on elucidating how counsellors’ translated their knowledge and awareness of diversity into A&D practice. While counsellors’ talked about the above process as unconscious, I tried to capture some of these automatic process by the examples that counsellors provided in the form of self reflexivity and relationship building, explored by themes such as “Ways of being: Reflecting on identities,” and “Cross-cultural relationship building attempts.” Perception of a general and universal approach and color-blind attitudes were often accompanied by lack of examples of application during the interviews with counsellors reporting that they treated every client the same, irrespective of their multiple contexts.

My best understanding of data pointed that counsellors who engaged in critical self-
reflection and saw their practice and knowledge as socio-cultural-bound seemed to attend to the intersection of A&D problems with diversity factors such as ‘race,’ gender, culture and trauma. These counsellors also questioned the Eurocentric assumption of counselling as a context and the role of client and therapists. They reported being engaged in advocating for safety and raising awareness about systemic barriers at multiple levels. Counsellors who emphasized the multicultural aspects of counselling relationship also seemed to strive towards exploration of worldviews, trust building and creating a safe space, with clients viewed as active decision makers.

**Summary of Findings**

In this study, I found that counsellors assigned varied degrees of importance to the relevance and integration of EC differences within the context of A&D therapy. I analyzed counsellors’ construction of differences not only by how they spoke of their A&D work with clients of diverse EC realities, but also in how they negotiated differences within the social dynamics of the interviews, with me as a female researcher of color. I perceived the positions of counsellors ranged from resistance towards differences, stereotyping and color-blind attitudes to acknowledging differences within the wider context of socio-cultural influences, thus highlighting how assumptions with regards to culture, ‘race,’ and ethnicity may be interwoven into A&D therapy context.

The position of counsellors was also marked by varying levels of self-reflection on the significance of EC factors, in relation to themselves, clients, one’s practice and the overall context of A&D service delivery. The analysis uncovered a parallel between counsellors’ views of “addiction” and how they reflected on inclusion of EC diversity in their work. Two dominant models of recovery emerged that seemed to inform counsellors’ perspectives on how to
integrate EC factors in A&D context. The “addiction as a disease” model focused on a
generalized approach to A&D treatment by locating “addiction” within the individual and
constructing EC factors as secondary, irrespective of the wider socio-cultural contexts.
Additionally, the above approach was sometimes linked to an expert stance, reliance on
Eurocentric models of health, as well as lack of reflection on power and privilege. In contrast,
the integrated model of recovery considered EC factors as a central and ethical part of A&D
practice, taking into account clients’ multiple worldviews, as well as the influences of
historical, socio-cultural and political contexts. Counsellors adopting an integrated framework
also engaged in reflection on one’s biases and values, with some going further to critically
reflect on power relations, the systemic barriers as well as ethics and social justice elements
linked to the provision of A&D care.

Analysis of interviews from counsellors and non-counsellors shed light on the
organizational factors linked to counsellors’ A&D practice with clients from diverse EC
communities. It appeared that overall, the system discouraged discussion of differences, with
participants pointing out that issues of power and privilege often remained unexamined and
unmarked at work. The delivery of culturally competent care was also constructed to be
fragmented reflecting “lip service to multiculturalism,” a lack of diversity in teams as well as
the client population. The above was in turn perceived to limit clients’ access to services and
counsellors’ exposure to work with diversity or opportunities to engage in critical dialogues. A
few system strengths were noted in the form of hiring of minority therapists, cultural
consultants and provision of culturally specific programs.

In terms of how counsellors spoke of incorporating their knowledge of EC factors in
direct practice, analysis pointed to difficulties on the part of some counsellors to articulate such
information. Some counsellors labeled their process of working with diversity as unconscious or tacit, contributing to difficulties to provide specific examples. However, by utilizing themes of relationship building and ways of being, I looked for examples of how counsellors engaged with the question of how they incorporated diversity into practice. Analysis revealed that emphasis on similarities, perception of addiction as a universal phenomenon and color-blind attitudes often accompanied counsellors’ minimization of differences and thus lack of examples of application. However, those that perceived EC factors as central to their work, and constructed their identities and practice as culture-bound talked openly about how they attended to diversity factors such as ‘race,’ gender, culture and trauma, thus questioning the limits of their interventions. Furthermore, those with social justice and ethical orientation reported advocating for safety at multiple levels and raising awareness about systemic barriers faced by clients from diverse EC backgrounds.
Chapter Five: Discussion

This chapter focuses on the interpretations of findings by elaborating the complexities inherent in how participants constructed differences as a means to answer the research question. In addition, I explicate how the meanings derived from the findings are related to what is known in the field. Four categories of findings were identified that will be further discussed in this chapter. In the first category, I looked at the overall positioning of participants’ in relation to EC differences, including participants’ construction of differences within the social dimensions of the interviews with me as the female researcher of color. In the second category, I focused on participants’ construction of A&D problems, i.e., meaning making process of what clients’ A&D problems were, and how to approach them within the context of caring for clients from diverse EC realities. In the third category, I focused on participants’ reports of how diversity matters were negotiated within the A&D organizational context. In the fourth and last category of findings, I concentrated on participants’ reports of how they translated their knowledge and awareness of EC diversity into A&D practice.

My intentions in this chapter are to explore the social construction of differences that I perceived as contextually situated, diverse and complex, and marked by contradictions. Please note that in this project I discuss how counsellors described and presented their views with respect to the relevance and application of EC factors in A&D settings. Thus, I discuss some of the questions and implications that the participants’ respective positioning on EC diversity raised vis-à-vis practice, and the overall field of counselling psychology. In much the same way as Moghaddam, Erneling, Montero, and Lee (2007), I conceptualized each counsellor’s position as “arbitrary and culturally bound rather than objective and culture free” (p. 191). Furthermore, I interpreted each participant’s reports as “not a product of individual
characteristics, but [one that] arises out of the collective characteristics, and is collectively maintained” (Moghaddam et al., p. 191). I approached the ways that participants presented their understanding of clients’ differences as a reflection of a microcosm that is embedded within the wider socio-political influences, shaping the clinical encounter. Browne (2007) asserts that, while at times invisible, power differentials arising from multiple social locations of healthcare providers greatly influence health care interactions.

The following domains organize this chapter. Within the first domain I discuss the patterns of positioning that emerged with respect to understanding of ‘race,’ color and EC issues, as well as counsellors’ reports of the application of EC differences in therapy, consideration of professional ethics, and the relational dynamics of the interviews as they pertain to participants’ construction of differences. In the second domain I discuss the organizational influences as they relate to provision of A&D care for clients from diverse EC realities. The last domain contains discussion of recommendations for practice, future research, study limitations, delimitations and conclusions.

**Positions on Ethno-Cultural Factors: Relevance to Practice**

Varied positions with respect to relevance of EC factors in A&D treatment emerged ranging from overemphasis on similarities and seeing difference as secondary to consideration of differences as an ethical and central part of therapy. In elaborating these positions, I would like to acknowledge the nuanced and complex nature of participants’ construction within and across cases ranging from narrow to broader understanding of EC factors. Moreover, during the interpretive process, I treated the range of responses not as discrete entities related to participants’ individual characteristics, but rather as patterns of constructions filled with inconsistencies that sometimes appeared unconscious and implicit while at other times
deliberate and explicit. It must be noted that based on my social constructivist philosophy, I perceived participants’ constructions as not operating in isolation but rather as embedded within the larger socio-cultural contexts that reproduce and maintain beliefs and practices. The examples of contexts that I have considered in interpreting participants’ varied responses are as follows: participants’ personal and professional values, past experiences and relationships in working with diverse clients, understanding of their own social location and identities, construction of multiculturalism within the Canadian context, the socio-historical construction of addiction as a disease, agency expectations and norms, experiences of marginalization, and the dominant healthcare contexts shaping clinician-client interactions.

Additionally during the interpretation, I perceived a considerable level of ambiguity when the term culture, ‘race,’ and ethnicity were conflated and used interchangeably by participants during the interviews. Below I discuss the positions where EC factors were considered as central in counsellors’ A&D work, however, I also highlight the nuances where I perceived narrow to broader understanding of the centrality of EC factors. Having contradictory narratives by participants is consistent with a social constructivist paradigm requiring the researcher to consider the multiplicity of experiences (Creswell, 2007, Ponterotto, 2005) as well as the complexity of accounts (O’Conner, 2001), linked to the larger socio-cultural trends. Bloomberg and Volpe (2008) further recommend that a researcher needs to make explicit to the reader what patterns of findings are “clear and strongly supported by the data, or when patterns are merely suggestive” (p. 131). I have thus strived towards providing interpretations that are supported by the data as much as possible.

This domain is organized by the following sections: 1) Ethno-cultural factors as central in A&D counselling, and 2) Ethno-cultural factors as secondary in A&D counselling. The aims
in the above sections are to discuss the findings where counsellors spoke of their views on the relevance of EC factors in relation to A&D contexts, themselves as well as their clients. I believed that these perspectives were pertinent to understand the research question because they appeared to influence participants’ reports of how they might translate their awareness and knowledge of EC factors in clinical practice. However, it remains unclear as to the extent that diversity is recognized by counsellors within the actual practice context. In this discussion, therefore, I focus on the ways that counsellors presented their views on EC differences and the implications that their constructions may have in relation to A&D practice with clients from diverse backgrounds.

Thus, in my discussion of findings, in addition to participants’ conceptual understandings of culture, ‘race,’ and ethnicity, I also explicate their reports of how they may apply such understandings. To clarify, conceptual understanding in this context refers to when participants’ accounts focused on talking about EC factors in generalities, using constructs such as culture and ethnicity without making links to their application in practice. The applied understanding, according to Waldram (2000), requires that counsellors go past a general understanding towards critical analysis of and the consequences of these fluid constructs, in a practical setting. An example is how participants constructed the meaning of differences within therapeutic encounters and in relation to their clients and A&D interventions. While the conceptual and applied understanding are intricately linked, the latter was important, not only how counsellors talked about gaining information on EC differences, but also their “know how to” make sense of, and speak of their application into practice.

Ethno-cultural factors as central in A&D counselling. In this section, I discuss those findings where I perceived that EC factors were constructed as a central part of the particular
participants’ views of A&D treatment, with counsellors reporting the inclusion of EC factors above as an integral part of their personal and professional growth.

The findings revealed conceptualizations where participants’ understanding of EC issues seemed to refer to shared similarities and group related phenomenon (e.g., ethnic heritage, beliefs and practices) giving rise to meaning, and varied interactional patterns. These systems of meanings were considered to stem from cultural differences, which in turn provided the context for actions and differing worldviews. The above conceptualizations are consistent with Markus’s (2008) and Triandis’s (1996) definitions where culture is viewed to consist of symbols, meanings and interactional patterns that are deeply rooted as unexamined assumptions through generations. The centrality of culture is also consistent with the notion of “emic” where culture is not seen as an external factor but rather as an integral context continually shaping behavior (Helfrich, 1999). Additionally, the underlying assumption in emic conceptualizations is that the significance of culture has to be understood from the perspective of the individual within his or her culture.

In this study, some participants saw clients’ A&D problems, differences in communication and help seeking patterns as a function of clients’ cultural customs and worldviews informed by existing norms, values and expectations as also argued by Durrant and Thakker (2003) and Vega and Gil (2009). I perceived that the above might have encouraged participants to remain cognizant of possible conflicts between the worldviews of clients and their own, on concepts such as health and recovery. The available research claims that competent care ensues when counsellors attempt to empathically understand the worldview of particular EC groups in terms of problem definition and help seeking (Arredondo & Arciniega, 2001; Sue et al., 2008; Pieterse et al., 2009; Sue & Sue, 2003; 2008). However in this study,
according to my understanding, there were occasions when cultural differences were narrowly defined, perceived as fixed and applied as the only lens to interpret clients’ varied practices and interactions. I also further interpreted that the above was sometimes accompanied with application of stereotypes. Related, Browne (2007), in her analysis of nurses’ interactions with First Nations women, found that nurses generally constructed First Nations women as passive and reticent. Additionally, the nurses interpreted communication differences as cultural issues without considering the influences of wider socio-political dynamics within the nurse and patient dyad as well as the larger healthcare context.

In fact, one of the cautions raised is that counsellors may run the risk of perceiving cultures as pure or neutral entities (Sinacore-Guinn, 1995), instead of dynamic systems of meaning, embedded within socio-political and historical processes and power relations (Anderson & Reimer-Kirkham, 1999; Johnson et al., 2004). When client-providers’ interactions are interpreted based on the limited definitions of culture as sometimes appeared in this study, Browne (2007) states that it draws attention away from power differentials and health inequities that are embedded within the health care system. In this study, I perceived that when participants seemed unfamiliar with their clients’ specific socio-cultural contexts, they sometimes engaged in making generalizations, with differences as residing within ethnicity or clients’ cultural beliefs and practices. Thus, for some participants, narrow definitions of culture appeared to omit discussion of systemic structures and power relations inherent in clients’ presenting A&D concerns or the counselling context. Additionally, counsellors often focused on clients’ differences rather than themselves. Weaver (2008) argues that by focusing solely on clients’ differences, the role of counsellors and the systemic influences can be overlooked in understanding the dynamics of care and would in turn undermine cultural safety.
Some of the observed nuances within and across interviews were when EC differences and clients’ worldviews were constructed as a dynamic process, influencing clients’ meaning making and everyday decisions, consistent with definitions offered by Lynam and Young (2000) and Sinacore-Guinn (1995). According to my interpretation, the major factor that seemed to help was the participant self-reflection on their biases and the exploration of worldviews, where counsellors reported that they actively engaged in the action of perspective taking. In my view, two separate processes appeared to operate, aimed at negotiating similarities and differences within the therapeutic relationship. The first process seemed to necessitate the counsellors to immerse themselves in how their clients construed their worlds and their A&D problems. The second process appeared to involve counsellors’ engaging in reflexivity and examining the varied influences on their worldviews. I interpreted that participants seemed to conceptualize self-reflection as contributing to an enhanced counsellor-client relationship by increasing collaborative goal setting and providing a shared understanding of clients’ concerns. Please note that the practice of self-reflection will receive further attention in the following section.

In this study, I additionally perceived that a more dynamic conceptualization of cultural differences seemed to go beyond empathic understanding of clients’ worldview. Participants’ communication of empathy appeared to integrate cultural contexts consistent with what research refers to as cultural empathy (Pedersen, 2009; Pedersen & Pope, 2010; Ridley & Lingle, 1996; Suthakaran, 2011). As a social perspective, cultural empathy involves counsellors’ commitment to include cultural factors and their impact on counsellor-client relationship, and to discuss systemic influences and power relations (Pedersen & Pope), which implicitly surfaced in this study.
Flexibility in perspective taking was reported to be a salient factor in terms of helping counsellors to negotiate and consider multiple conceptualizations in their clinical decisions. The above is related to research on counsellors’ cognitive flexibility, i.e., ability to consider complex and multidimensional information (Spengler & Strohmer, 1994) and differentiation skills i.e., consideration of alternative interpretations regarding clients’ presenting problems (Ladany, Marotta, & Muse-Burke, 2001). Research further links counsellors’ flexibility and alternative conceptualizations to counsellors’ exhibiting multicultural competency (awareness, knowledge and skills) (Constantine, 2001).

*Reflexive practices: Social Justice Advocacy.* A salient element that seemed to point to a broader understanding of EC factors in this study was the presence of critical self-reflection on the part of some participants, embedded within elements of ethics and social justice as elaborated below. I label counsellors’ critical reflection as reflexive practice, consistent with Taylor and White (2000)’s distinction between reflective and reflexive. Self-reflection includes observation, interpretation and evaluation of one’s thoughts, feelings, actions, and their consequences on the clinical encounter (Jennings, Sovereign, Bottorff, Mussell & Vye, 2005). However, reflexivity according to Taylor and White adds a critical dimension requiring the professional to interrogate his or her taken for granted assumptions. In this study, some participants shared their being aware of multiple identities and their respective influences on client and counsellor relationship, including analysis of power inherent in the counselling context, and critical perspectives towards the A&D service delivery. The above level of awareness also seemed accompanied by counsellors’ reports of integrating clients’ diverse socio-cultural contexts in treatment planning such as: attention to history of trauma, the experience of colonization for Aboriginal clients, context of immigration and refugee status,
acculturation process, experiences of systemic barriers such as racism, discrimination, and evaluation of multiple other vulnerabilities such as co-occurring mental health issues.

During the process that I engaged in as the interpreter of the data, it became apparent that development of an advocacy identity was central to reflexive practice. The components were: being a critical thinker, seeing oneself as non-neutral, “depositioning” oneself as an expert (encouraging equal power sharing during therapy), confronting oppression within self and others, and being ethically mandated to provide safety. The above seemed linked to the concept of cultural safety where counsellors regarded themselves as bearer of one’s culture. Cultural safety requires examination of the historical and current injustices that may be socially ingrained and affect the service providers’ relationship with their clients (Ramsden, 1993). In this study, counsellors who seemed to engage in reflexive practice also adopted a critical analysis of the program materials, and manualized treatment programs and the extent that various structural components were culturally appropriate and safe.

The social justice components found in this study were also reported in Johnson’s (2007) unpublished Master’s research findings about how Canadian counsellors’ adoption of values such as solidarity with clients, critical consciousness and non-neutrality helped them to take action and challenge the status quo in their work settings. Such positioning further finds support in research that calls for an expansion of roles beyond the immediate context of practice (Reimer-Kirkham & Browne, 2006; Smith, Reynolds & Rovnak, 2009) and where social justice is seen as a prerequisite to competent and ethical practice, not as a separate role (Vera & Speight, 2003).

The above social justice values seemed to be also embedded within an ethical discernment process, aligned with professional codes of ethics (Keith-Spiegel & Koocher,
1985; Kitchener, 1984). For example, some participants critically evaluated the concept of change and growth when working with diverse clients. This is related to the term beneficence in terms of ethics, linked to providers contributing to the wellbeing and health of the client and promoting positive growth (Kitchener). While the above was seen as a major therapy task, those participants with social justice and ethical orientations seemed to examine culturally bound models of health or well being. Creation of the therapeutic alliance was conceptualized to occur when counsellors “depositioned” themselves as the experts, linked to the concept of equal power sharing (Johnson, 2007; Vera & Speight, 2003). Related to the above was the notion of fidelity (Kitchener, 1984), focusing on clients’ autonomy as being a decision maker in the therapy process, also situated in the acts of open communication (informed consent). Furthermore, the above approaches were marked by counsellors’ open discussion of limits of competence, and the need to seek continuous consultation and supervision. Kitchener supports the above by stating that counsellors are ethically mandated to work towards positive growth to increase competence.

In this study, I also perceived that some participants constructed the concept of color as a sense of pride and empowerment for clients rather than inconvenience or a taboo, related to what Frankenberg (1993) calls “race cognizant assertions” (p. 14). These participants also reflected on the sense of privilege that came with certain social categories, such as being white, heterosexual, male and middle class. Abrams and Todd (2011) refer to the above awareness as color consciousness. It is defined as a level of awareness for white individuals involving the following: understanding of oneself as white, awareness of structural inequality, ability to reflect on white privilege, and having a closer engagement with the issues of racism, through advocacy and anti-racist behaviors. The above level of awareness is also linked to counsellors’
engagement with social justice (Goodman, et al., 2004; Pieterse et al., 2009) and multiculturally competent practice (Arthur & Collins, 2010; Sue & Sue, 2003; 2008), where counsellors remain open about their own prejudice, racism and stereotyping tendencies within the dynamics of cross-cultural relationship.

Findings also uncovered that reflexive practice by some participants focused on challenging the traditional aspects of counselling, the dominant healthcare practices, as well as the expectations for clients to assimilate into the mainstream culture. The above was consistent with Heppner’s (2006) arguments where the Eurocentric tradition of counselling psychology has been described as an impediment to embracing differences. The specific social justice elements revealed by participants’ accounts were structural awareness in the form of attention to inequality as well as individual and institutional racism producing differential treatment for clients from less dominant groups. Participants’ subjective understanding of justice and fairness went beyond the immediate aspect of the counselling context towards a critical analysis of the organizational culture, highlighting that the system generally lacked appropriate structure and policy to ensure that access is enhanced and barriers are reduced for clients of diverse EC communities. Reimer-Kirkham and Browne (2003) further support the above by emphasizing the need for service providers to attend to the organizational climate, practice environments as well as decisions around delivery of services that are often socio-politically constructed.

I also perceived that critical self-reflection by some study participants was accompanied by the need to unpack how commitment to cultural competence and multiculturalism had been reduced to “lip service,” and “tokenism” within the A&D treatments. Similarly, some participants reflected that cultural competence has to shift from focusing on “text-book” descriptions of ethnic groups that emphasize specific characteristics disregarding within group
differences and contributing to stereotypes. I believe that the above is consistent with the critiques of cultural competency (Ramsden, 1993) that highlights how health providers’ understanding of cultural competency is often divorced from recognizing racism and more focused on professionals’ own perception of skills and awareness.

I additionally observed a sense of frustration on the part of some counsellors, as reflected on the lack of commitment by their agencies to attend to diversity in teams, program content, policy and procedures; this issue will be revisited in the section on Organizational Influences on the Care of Diverse Clients. I believe it is important to understand some of the participants’ notion of lip service to diversity within the wider discourse of multiculturalism in Canada. Canada has been constructed as a tolerant nation embracing diversity throughout its history. This was also apparent in some of the participants’ constructions where Canadian society was perceived to be more tolerant, less aggressive and more open minded as compared to other nations. While I will discuss this further in the next section, it is important to note that such construction is thought to contribute to a climate that makes discussion of racism a taboo and reinforces political correctness (Christensen, 2003; Henry, et al., 2000). While lacking a precise definition and empirical research, political correctness as a phenomenon is considered to create a climate of resistance to open discussions (Henry, et al), despite its claim to foster tolerance and to condone unfair treatment. As a set of values, political correctness is also considered to limit dissent and critical investigation of beliefs and complex cultural practices (Poole, 1998). Henry and colleagues (2000) support the above by suggesting that taking a critical perspective towards multiculturalism conflicts with the notion of Canada as a nation founded on equality.
The construction of color and ‘race,’ as irrelevant within the context of A&D counselling in this study is also consistent with Dua, Razack and Warners’ (2005) assertion that the construction of Canada as founded on equality strengthens the assumption that skin color is irrelevant to one’s status, and therefore reinforces the denial of Canada’s racialized history, laws and practices in its current institutions (Dua, Razack & Warner, 2005). In fact, a few participants indicated that it is often difficult for counsellors to openly acknowledge the existence of racial prejudice and discrimination at work, further pointing to lack of open dialogues about topics such as ‘race,’ class, gender and color in work settings. I interpreted that the presence of political correctness may have also contributed to the feelings of resistance on the part of some participants, as discussed shortly.

**Ethno-cultural factors as secondary in A&D counselling.** In this section I discuss those patterns of responding by participants where EC factors were constructed as secondary to A&D practice. My best understanding during the interpretation was that the discussion of differences was sometimes marked by a sense of resistance, and color-blind attitudes. I would also like to draw attention to a particular perception of addiction that seemed to be embedded within the dominant discourse of addiction as a disease. I got the sense that addiction was constructed as a universal phenomenon being the same for everyone irrespective of socio-cultural contexts due to its status as a disease. Thus, the construction of addiction as a monolithic entity, qualitatively distinct phenomenon separate from other mental health concerns tended to promote a generalized approach to treatment of A&D problems, with EC contexts as “less fitting.” This section is divided into 2 segments, focusing on the following: 1) Universality of addiction: The prevailing disease concept, and 2) The discourse of color-blindness.
Universality of addiction: The prevailing disease concept. In elaborating the positions that seemed to point to the notion of A&D problems as being universal, one key observation was the feelings of resistance when some participants appeared guarded in terms of talking about differences. One of the contradictions noted was that a few participants asserted that they do not see “race,” and color in their relationships with others. However, when asked to provide examples of their work with diverse clients, some attended to observable differences such as language fluency, accents, and outer appearances. Similarly, despite some counsellors’ emphasis of seeing everyone as the same, a sense of frustration was noted, particularly when clients from certain EC communities were construed as difficult (e.g., not being able to engage or attend therapy without family members or having difficulties expressing feelings). This is supported by research where the notion of “different” has been equated to difficult (Reimer-Kirkham, 1998), or deficit (Dumas & Rollock, 1999).

For instance, ethnicity and culture were at times constructed as the cause of the A&D problems, thus linked to application of stereotypes (e.g., describing men from certain groups as more aggressive than Caucasian men). This particularly occurred when the frame of reference was derived from the dominant culture, perceived as more superior consistent with assertions by Sue (2004) and Heppner (2006). Another observation was that feelings of resistance were accompanied by limited self-examination of one’s values and biases or reflection on ethical mandates of one’s practice to consider EC differences in therapy. The above raises a question as to the degree that counsellors might pay attention to clients’ differences and integrate their socio-cultural contexts in actual therapy setting.

A salient feature was assertions of one’s clinical approaches being universal and appropriate for every client despite differences in socio-cultural contexts. When modification of
approaches was talked about, they seemed narrow in focus, for example, talking about clients with limited English fluency (e.g., requiring changes in communication pace and style). In this study, the construction of EC factors as external to the context of A&D counselling is also consistent with etic conceptualizations referred to as culture-general approaches (Berry, 1999; Bezanson & James, 2007; Helfrich, 1995; Pedersen, 1991; Ponterotto, 2005; Sinnacore-Guinn, 1995). The notion of etic assumes that it is more constructive to “focus on universal processes” rather than differences arising from diverse group membership (Bezanson, & James, p. 160). While the intent of etic approaches is not to endorse Western-based practices across different groups (Fukuyma, 1990), adopting a generalized notion of addiction in this study seemed to do just that, i.e., generalizing information across groups. There was an assumption by some participants that everyone experienced A&D related problems and recovery the same way, had similar needs in therapy as well as similar patterns of behavior and coping mechanisms. This appeared to be associated with limited examination of the applicability of interventions for diverse clients. I further argue that counsellors may run the risk of missing important information in their clinical decisions when they prioritize similarities. Additionally, some clients may feel discouraged to disclose information that would highlight their differences to their assigned counsellors. The above is further supported by Helfrich’s (1999) arguments that the “etic approach demands a descriptive system which is equally valid for all cultures” (i.e., based on European standards), assuming that standards of comparisons are the same across cultures (p. 132).

My interpretation was that when universality of addiction was perceived, it hindered effective exploration of the complexity and continuum of A&D problems in clients, and most significantly, the contextual influences accompanying the unique patterns of A&D use. A
question arising from the findings was how construction of addiction as a disease may impact clients’ safety and the way treatment is approached and delivered to diverse clients. In this study, whenever addiction as a disease perspective was taken as a dominant lens, there appeared to be a relative sense of compartmentalization/segregation of social contexts from clients’ current substance use problems. For some participants, the focus on EC issues during therapy was perceived as irrelevant and distracting from clients’ treatment goals and therapy tasks and emphasis was put on crisis aspects of treatment, i.e., the early stages of recovery and symptoms, i.e., acute model of recovery.

My interpretative lens further suggested that the persistence of the disease model also hindered seeing clients as “whole” person embedded in multiple contexts, separate from their symptoms. Such narrower understanding of A&D problems seemed to not only reproduce the deeply rooted stereotype of an “addict,” but also of the minority client, where sometimes the examples focused on South Asian male or Aboriginal clients. Such construction seemed to promote a dismissal of clients’ strengths and resources arising from their communities.

Values were generally assigned as to whether culture “mattered” or not in A&D therapy. For example, one of the participants perceived culture as a problem by stating that one of his clients had been banished from his EC community as a result of his or her A&D problems and thus it would best if he did not bring up issues to do with his culture or community. I perceived that socio-cultural considerations were treated more as a technique or an “add on,” rather than an integrated part of the counselling; consistent with etic conceptualization of culture as an external factor, located “outside” of the individual (Helfrich, 1999). The term ‘culture’ in this context was often seen as static, conflated with ethnicity and
‘race,’ and thus not embedded within socio-political and historical processes (Anderson & Reimer-Kirkham, 1999; Johnson et al., 2004).

I further argue that the participants’ assertions with respect to EC issues as “not mattering in A&D counselling” may be possibly a result of socialization that has become an internalized value system based on the cultural assumptions prevalent in the field. Roach (1999) asserts that counsellors’ practice and socialization into a profession can be influenced by rigid attitudes and the policies and norms within their institutions. Relatedly, seeing EC factors as secondary could be linked to research that point to counsellors’ difficulties to exhibit differentiation skills (i.e., offering alternative interpretations or perspectives regarding clients’ A&D problem) (Ladany, Marotta & Muse-Burke, 2001) leading to simplification of clients’ identities, and discounting of important socio-cultural contexts influencing A&D problems.

Despite some participants’ assertions of culture as being secondary, some additional nuances I observed included participants’ openness to accommodate conversations on EC factors. For example, some participants commented that if a client brought up information about their culture or ethnicity, they remained open and inquisitive to accommodate such conversations. However, it appeared that clients were delegated the responsibility for bringing up differences rather than counsellors themselves. I argue that it is the counsellors’ responsibility to create an inviting space for conversations on differences to emerge. This aspect will be further discussed under “Broaching” behaviors. I also observed that despite construction of addiction as a universal phenomenon, some counsellors spoke of being curious about contextual factors such as history of trauma or racism. However, I perceived that the above was viewed as part of clients’ individual presenting problems rather than reflecting on systemic or institutional dynamics.
I also noticed the presence of self-reflection when some counsellors described encountering clients whose values and practices conflicted with their own, however, little elaboration was noted as to how to overcome these conflicts. Arthur and Januszkowski (2001), in their study of Canadian counsellors’ multicultural competency skills, noted that some of their participants struggled with how to manage their awareness of cultural differences effectively. This occurred when counsellors experienced discrepancies between their own values and those of their clients. Consequently, they reported that due to being unsure about how to resolve cultural conflicts, their sessions did not go as well as they had expected. In this study there were mixed reports, in that some spoke of their confidence in overcoming cultural conflicts, while others highlighted the need to constantly monitor and stay reflexive about one’s biases, assumption, power and privilege.

Related to the above, I observed that sometimes empathy and a positive relationship were deemed as sufficient in addressing diverse clients’ needs. I perceived the above construction seemed to be accompanied by limited discussion of effectiveness of one’s interventions and how clinicians’ own social locations affected practice, thus lacking critical reflection on practice. Three counselors cited research by Miller and Duncan (2000) and Hubble, Duncan, and Miller (1999) which focus on interpersonal therapy dynamics and therapists’ activities, also referred to as common factors (e.g., warmth and empathy). This body of research argues that the counselling relationship has more positive outcomes for clients as compared to specific techniques and interventions. Consistent with Laungani’s (1999) assertions, I argue that the above stance can sometimes assume that counsellors may be immune from harming clients, potentially creating unsafe situations.
The above is additionally consistent with Sprenkle and Blow’s (2004) arguments that, other than emphasizing therapists’ interpersonal qualities, common factors provide little direction for counsellors in terms of how to assist clients, and may contribute to the loss of informing one self about appropriate interventions. Another observation in this study was that a positive relationship was typically defined from the perspective of the counsellor. This can become problematic because counsellors may end up considering certain factors as crucial for the alliance that may have little or no relevance to their clients, as also highlighted by Bedi (2006) and Bedi, Davis and Williams (2005). Emphasis on common factors is also assumed to lead to difficulties in terms of distinguishing competent counsellors from less competent ones (Wampold, 2001).

Another related observation was the predominance of conversations on client-centered therapy as sufficient in working with differences. The client-centered approach was conceptualized as therapists holding unconditional positive regard, warmth, and a collaborative attitude, consistent with Rogers (1957) work. One of the major tenets of client-centered approach is the recognition that clients, when informed, have the ability to effectively manage and solve their problems with the notion of expertise as being shared (Black, 2005). In this study, however, I noticed that perception of addiction as a disease was linked to counsellors’ seeing themselves as experts in rescuing clients. Black (2005) further argues that a client-centered approach may not be possible if the therapist does not become aware of his or her own biases and values or power as the authority figure (Black, 2005).

The discourse of color-blind attitudes. Within conceptualizations that constructed EC factors as secondary and endorsed a generalized approach to dealing with A&D problems, one notable observation was that majority of counsellors identified their EC heritage as European
and as cultureless/neutral. Such positioning seemed consistent with research on color-blind attitudes (Burkard, & Knox, 2004; Frankenberg, 1993; Henry et al., 2000; Neville & Lilly, 2000), containing a lack of reflection on the salience of racism and discrimination in the society, and in the lives of clients or counsellors themselves. Such discourse is further based on the assumption one can overcome economically and politically constructed social categories and thus one’s social positions do not matter (Applebaum, 2005).

The reason I highlight white participants’ responses in this project is based on conceptualization of the term “whiteness” in literature (Frankenberg, 1993; Sue; 2004). This concept refers to “a set of locations that are historically, socio-politically and culturally produced” (Frankenberg, p.14). When one names “whiteness,” the power and privilege no longer remains unnamed or unexamined and thus brings attention to the ways that racism may shape individuals’ identities (Frankenberg), including study participants. For example, one participant associated the concept of “ethnic” as referring to people whose ancestry is other than European or white (e.g., an Indian women’s life decisions were perceived to have more “ethnic influences” as compared to a Caucasian woman, with the latter construed as cultureless and independent). This is consistent with Christensen’s (2003) arguments that it is common to eliminate discussion of culture, history and practices when referring to individuals with European backgrounds.

In this study, as I use the terms, white or non-white and person of color, also recognize that my own conceptualization may run the risk of objectifying and homogenizing groups of people who carry varied set of positions. Reimer-Kirkham, Smye and colleagues (2002) argue that researchers can engage in essentializing when they create distinct categories during sampling. Groups that are considered to be dissimilar may have more shared similarities than
presumed. For example, Satezwich (2007) further cautions us that one has to remain aware of how membership in white category in itself has been contested throughout history, and is constantly re-negotiated socio-politically in terms of which groups can claim this social identity. My intention in this study with regards to drawing attention to the concept of whiteness is to explore how and whether participants examined the influences of structural issues, their social positions and identities on clients and the clinical encounter.

In this study, when participants with European heritage constructed their identities as cultureless/neutral, it seemed to contribute to a sense of “invisibility” and unmarked power and privilege. With the intention of showing inclusiveness, some participants made comments such as “brown people or white people, or pink people or yellow people” as being the same; reducing the concept of “color” as less meaningful and the systemic dimensions as less noteworthy. This was similar to Frankenberg’s (1993) research of how ‘race’ shaped white women’s lives. She found that participants utilized strategies in the form of euphemisms to avoid naming power, e.g., describing non-white groups as “colorful,” or stating that they didn’t care if someone was “Black, brown, yellow or green” (p. 149).

In this study, color-blind attitudes seemed to reduce the opportunity to recognize and talk about differences. Emphasizing similarities seemed to distance individuals from acknowledging power referred to as “power evasion” by Frankenberg (1993). Such distancing is further linked to dismissal of systemic oppression, unconsciously perpetuating racism (Abrams & Todd, 2011; Applebaum, 2005). In fact, there was an assumption by participants who asserted not seeing ‘race,’ culture and color that an individual is a good person if he or she minimized ‘race.’ Power evasion thus emerged when some participants assumed that they did not carry any internalized racism.
The research on White Racial Identity Development has touched on the issue of resistance when culture and ‘race’ are considered as irrelevant in understanding others (Helms, 1990; Ladany, Inman, Hofheinz & Constantine, 1997). In this study, construction of EC factors as secondary and adoption of generalized approach to A&D problems matched some of Helms’ (1995; 1996) racial identity development statuses as follows: Some study participants appeared to endorse the status quo with little reflection on power relations, a position described by Helms as Contact status. This status indicates unawareness of institutional and cultural racism with culture and ‘race’ deemed as irrelevant for understanding others. While some study participants gave attention to issue of racism, they conceptualized it as part of the individual’s presenting concerns, matching Helms’ Disintegration status. This status indicates awareness of racism but also ambivalence about one’s own group membership. Additionally, some participants conceptualized Euro-Canadian standards as superior and more egalitarian, consistent with Helm’s Re-integration status; involving idealization of one’s own social group and its values and attitudes, while denigrating others’ thus maintaining racism.

The interpretive process also revealed certain racialized conversations within some of the interviews. For example, one participant explained in a simplistic manner that “Caucasian” women were more empowered to let go of a husband who had substance abuse issues than a South Asian woman used to putting up with problems, discounting the complexity of gender. This preceded a comparison of norms to the “Canadian” or “Caucasian” norms, with the latter seen as more liberating and less oppressive. Such explanations were also noted in Johnson et al. (2004) study of Canadian nurses who perceived Asian women as more passive as compared to white women. The nurses engaged in stereotypical description of clients’ practices, blaming the culture for potential conflicts, thus discounting the role of the socio-political contexts.
Furthermore, in this study, the participants’ tendency to engage in “us” versus “them” discourse is referred to as “Othering” (Johnson et al., 2004). This practice is thought to occur when individuals position themselves in relation to those that are different from themselves (based on their diverse identities and group membership) or the mainstream society, assuming that other groups lack certain qualities present in Caucasian or white people (Johnson et al.). The above can be particularly problematic as it can contribute to discrimination and exclusion of clients from diverse EC realities, as also asserted by Fine (1994) who maintained that “othering” can further reproduce and reinforce positions of domination or subordination, with those with less power being excluded.

This “us” versus “them” comparisons are also similar to the notions of Eurocentrism as revealed in this study. The Eurocentric tradition of counselling and its limitations have been acknowledged where counsellors have a tendency to give Western practices and worldviews the primary status (Hall, 2003; Ponterotto, 2002). I believe that the above can block alternative worldviews on the part of participants as occurred in perception of addiction as a disease. I further argue that endorsement of Eurocentric models could make counsellors susceptible to imposing their own belief systems or adopting culture-deficit models. Additionally, there may be an expectation that clients need to “adapt” or assimilate rather than professionals embracing differences (Constantine, Juby & Liang, 2007; and Sue & Torino, 2005).

**Application of ethno-cultural factors.** The findings suggested that some participants’ awareness of application of EC factors into A&D care was rudimentary and fragmented. I perceived that a number of counsellors appeared to have difficulties articulating specific examples of what they would do (i.e., practical implications) with their knowledge and awareness of diversity. Often, they stated that the process was tacit and intuitive and thus
difficult to describe. I noticed that an “addiction as a disease” perspective, as a dominant lens, seemed associated with to the exclusion of socio-cultural contexts from clients’ A&D problems and thus lack of examples of applications. During the interpretation phase, my best understanding of a generalized approach to treatment of A&D and construction of EC factors as secondary were sometimes associated with a lack of discussion on inclusion of EC factors in therapy. However, when EC factors were constructed as central, participants’ account seemed to include specific examples of integration of EC factors into A&D therapy as elaborated.

One area of research that can shed light on explaining how counsellors put their knowledge into practice is the counsellor development process (Etringer, & Hillerbrand, 1995; Hillerband & Claiborn, 1990; Milne et al., 2001). Central to the above are the following processes: declarative, procedural and reflective (DPR) (Bennett-Levy, 2006). DPR is considered to develop and change over time as counsellors gain experience and training. The declarative system focuses on therapists’ “knowing that,” or knowledge of factual information. The above was evident when study participants talked about accumulating knowledge about different EC groups, or other diversity factors such as gender, sexual orientation and family roles. Bennet-Levy (2006) states that counsellors may acquire declarative knowledge but fail to translate it into the clinical context, i.e., have difficulties to engage in skills that are procedural (i.e., practical).

Procedural knowledge is also referred to as “know how to,” and when to apply interventions; contributing to practical implications, gained through experiential learning and or supervision. I interpreted that some study participants’ understandings were marked more by declarative knowledge than procedural knowledge (in the area of working with clients of diverse EC backgrounds), particularly when they appeared to have difficulties describing how
they put their conceptual understanding of EC factors into practice. Milne and colleagues (2001) further support this in their research on therapists’ skill development model from novice to expert trajectory. A novice level is marked by therapists strictly adhering to learned rules, attitudes, thus overlooking contextual or socio-cultural variables, as was evident in this study’s perception of addiction a disease.

One of the salient findings in this study was the varied level of reflection exhibited by participants. Bennett-Levy (2006) claims that what sets expert therapists apart is not the procedural and declarative knowledge, but the reflective system. As a meta-cognitive task, self-awareness or reflection includes observation, interpretation and evaluation of one’s thoughts, feelings, actions, and their consequences on the clinical encounter. It is seen as an attribute of skilled or expert therapist (Jennings, Sovereign, Bottorff, Mussell & Vye, 2005), playing a pivotal role in the development of the professional. It contributes to counsellors’ engaging in intentional, active and purposeful ways of changing and developing as a person (Robitschek, 1999), adding to the expansion of knowledge and clinical practice (Bennett-Levy) as well as multiculturally competent practice (Collins, Arthur & Wong-Wylie, 2010). Self-reflection is also consistent with counsellors’ qualities to be able to conceptualize clients’ presenting problems holistically, link different tasks of therapy, and handle ambiguities with more flexibility (Lovell, 2002, Milne et al., 2001, Wampold, 2001). However, it must be noted the above description of self-assessment lacked critical reflexivity on counsellors’ own social location and the issues of power and privilege, as aforementioned. In this study, I perceived that reflexive practice and attention to social justice elements helped counsellors to talk openly about differences and describe how they put their knowledge into practice.
When participants’ self-reflection lacked critical analysis, I perceived it to be sometimes associated with construction of EC factors as narrow and fixed, color-blind attitudes and perception of addiction as a disease. Kloss and Lisman (2003) argue that when clinicians adhere to one-dimensional frameworks without incorporating multiple levels of analysis, their respective clinical decisions may become counter-therapeutic. Relatedly, Moyers and Miller (1993) found that therapists constructing a disease model showed less flexibility in setting treatment goals or entertaining multiple perspectives. I perceived that the presence of reflexive practice was linked the following: counsellors’ seeking consultation and professional development opportunities; acknowledging one’s limits of practice and staying cognizant of ethical issues in practice (e.g., how to reduce harm and enhance clients’ safety). In fact, development of critical self-reflective skills is also consistent with professional ethics codes where counsellors are mandated to examine aspects such as the impact of their values and the social context of their learning on clients, themselves and the counselling dynamics (e.g., CPA, 2000).

An alternative explanation for the limited self-reflection and difficulties in articulating knowledge into practice could be linked to my being a female researcher of color as discussed shortly. Arredondo, Tovar-Blank, and Parham (2008) have attributed counsellors’ fears or resistance in terms of working with diversity to a number of factors such as: anxiety about one’s own lack of competence or a lack of self-awareness to examine issues of power and privilege (due to professional status or cultural heritage). Resistance is also linked to counsellors restricting their conceptualization of the etiology of clients’ distress to intrapsychic factors rather a combination of personal and contextual vulnerabilities.
I perceived that an integrated framework to A&D problems considered multiple approaches to treatment, with counsellors stating the need to be flexible to meet clients’ needs. Clients’ clinical presentations of problems were perceived as heterogeneous, with attention to bio-psycho-social-spiritual aspects. The focus went beyond symptom management to a holistic view of the client as well as the context of recovery and relapse. Research finds support for approaches that focus on the reciprocal interaction of biological, socio-cultural and psychological factors in explaining the aetiology, course and the recovery process from A&D (Bevacqua & Hoffman, 2010, Griffiths, 2005; Kissin, 1977; Thombs & Osborn, 2001; Toriello & Leierer, 2005). Such contextualization is consistent with contemporary approaches towards A&D treatment where the prevalent theme is diversity of orientations and perspectives. It is emphasized that in order to address the complexity of substance related problems, service providers need to adopt a wide range of options and analysis (Durrant & Thakker, 2003).

Related to the above is the aforementioned research on counsellors’ cognitive complexity and flexibility (Lovell, 2002; McAuliffe, 2006; Wampold, 2001), and integrative skills (Ladany, Marotta, & Muse-Burke, 2001) contributing to better clinical decisions (Constantine, 2001).

One of the highlighted points for therapists talking about application of EC factors included addressing shame and stigma associated with A&D use and the need for establishing trust and a safe space through a collaborative approach. The notion of trust in diverse counsellor-client dyads has received significant attention in research. For example, clients from less dominant groups have been found to have more difficulties trusting and disclosing information to therapists that may have more dominant social locations (Chang & Yoon, 2011) contributing to potential premature termination or lower utilization rates (Alegria et al., 2008; Fuertes, Mueller, Chauhan, Walker & Ladany, 2002). I believe that the issue of trust is
particularly important for clients who have had previous experiences of marginalization and discrimination due to structural oppression and imposition of Eurocentric models of health. Creating an open and trusting environment are also particularly important when working with issues of shame and stigma accompanied with the use of substances.

Compared to confrontational styles that sometimes seemed to be embedded within the disease perspectives of A&D problems, an integrated approach to A&D recovery appeared to often utilize principles of motivational interviewing as described by Rollnick and Allison (2004). This included emphasizing clients’ own intrinsic motivation for A&D behavior change, instead of counsellors imposing their notion of recovery. Additionally, clients were given a central role as decision makers, with counsellors providing gentle feedback to explore discrepancies between clients’ actions and their identified treatment goals. Some counsellors also spoke of attending to clients’ readiness and expectations for therapy, consistent with DiClemente and Prochaska (1998) stages of change model. Client’s ambivalence and relapse were thus conceptualized as a normal aspect of the recovery, rather than clients’ defenses or failure to engage. Motivational interviewing has consistently found support in A&D research as it increases clients’ agency by providing a supportive environment that honors readiness and context (Miller & Rollnick, 1991; 2002; Rollnick, Allison, 2004; Soderlund, Madson et al., 2011). It has additionally been advocated to be effective with minority clients, specifically due to concerns around premature drop out, and lower utilization rates (Anez, Silva et al., 2008; Bernal, 2006).

In my view, the counsellors’ position towards differences seemed to particularly influence their reports of how often they allowed conversations on issues of ‘race,’ culture and ethnicity to emerge in therapy. Such behavior is marked by openness to invite clients to explore
issues of diversity and is referred to as “Broaching” by Day-Vines et al., (2007). It is defined “as the counselor’s ability to consider how sociopolitical factors such as race influence the client’s counselling concerns” (Day-Vines et al., 2007, p. 401). Thus, the ways that participants talked about raising issues of differences within therapy is consistent with Day-Vines and colleagues’ research on broaching styles. For example, an avoidant style seemed similar to comments in this study where differences were minimized and socio-cultural factors constructed as secondary. Another style called isolating became apparent in this study when several participants acknowledged that they would talk about differences, however simultaneously expressed their anxiety and the need to be extra cautious so as not be perceived as offensive or discriminatory. According to Day-Vines and colleagues, this style becomes apparent when a counsellor brings up socio-cultural factors, but only sparingly thus leaving it at a simplistic level. It could take the shape of a single statement or a question “e.g., where are you from or what culture you identify with?” without the counsellor incorporating it into the treatment process. In this study, the isolating style seemed to indicate that the clients’ socio-cultural experiences remained disjointed from the treatment process and the exploration of EC factors occurred in a stereotypic fashion.

In this study, when attention was paid to counsellors’ own social location and power and centrality of socio-cultural contexts, the above seemed consistent with an integrated/congruent style as per Day Vines et al (2007). This is when discussion of EC factors was not perceived as a technique but rather as an integrated skill into one’s practice and professional identity. Related to the above was another broaching behavior called the infusing style, where counsellors adopted an ethical dimension (i.e., concept of safety, accountability and harm) thus challenging the traditional counselling context, advocating and seeking relevant
supervision. Examination of personal biases, privilege and power dynamics also accompanied this style.

The rationale for use of broaching behaviors is to open the counselling context for socio-cultural and political topics to enter and be openly explored. As already discussed, in this study construction of EC factors as secondary seemed to delegate the responsibility of discussing EC factors to clients. Day Vines and colleagues (2007) argue that when counsellors take the responsibility to “broach,” it creates a safe and empowering space for clients to explore the socio-cultural meanings attached to their presenting concerns. Further research has found that clients of color particularly perceive their counsellors as more credible when their counsellors actively broach socio-political factors in client’ lives (Zhang & Burkard, 2008). Similarly, clients’ satisfaction, depth of self-disclosure and eagerness to return to counselling have been associated with counsellors who bring up issues of ‘race,’ ethnicity and culture within the context of counsellor-client relationship (Sue and Sundberg; 1996; Thompson, Worthingon, & Atkinson, 1994; Zhang & Burkard, 2008; Zhang & McCoy, 2009).

**Consideration of professional ethics.** While my research question did not directly examine ethical issues pertaining to diversity practice, construction of A&D problems as a disease, color-blind attitudes as well as social justice dimensions led me to reflect on several ethical dimensions. Professional ethics and social justice, as included in this study’s theoretical forestructure, mandate the consideration of ethics in understanding how counsellors approach EC diversity factors in practice. Pack-Brown, Thomas and Seymour (2008) argue that it is the counsellors’ responsibility to reflect on socio-culturally mediated aspects of their practice that may perpetuate bias and marginalize clients. In order to elaborate on these, I utilize the applicable Canadian counsellors’ codes of ethics.
The Canadian Counselling and Psychotherapy Association (CCPA, 2007), the British Columbia Association for Registered Counsellors (BCACC, 2011) and the Canadian Psychological Association’s professional ethics code (CPA, 2000) require that counsellors demonstrate openness towards differences arising from age, ethnicity, culture, gender, disability, religion, sexual orientation and socioeconomic status. They emphasize that counsellors remain cognizant of differences in values regarding privacy, decision-making, role of families and communities across individuals. Counsellors are further obligated to acquire the relevant knowledge of the socio-cultural systems that the clients are situated in (CPA); considered to help counsellors to avoid discriminating or condoning clients’ differences (CCPA). Additionally, counsellors are required to exercise caution when engaging in assessment and evaluation of clients’ presenting concerns, thus recognizing that mechanisms for interpretation of such information may be limited in terms of representation and application to diverse groups (CCPA; CPA). The BCACC code further adds that many values inherent in the profession of counselling reflect Euro-American belief systems, placing responsibility on the counsellors to be aware and not assume universality.

While I cannot comment on whether counsellors demonstrate such openness and reflexivity in their direct therapy with clients, certain perspectives revealed during the interviews led me to conclude a lack of openness towards consideration of EC issues in some counsellors’ A&D practice. My interpretation is that there are risks and harm associated when clients’ differences are ignored or deemed as unnecessary in terms of inclusion in therapy. All participants spoke of the importance of relationship in therapy. However, an area that I perceived to undermine rapport building was the presence of color-blind attitudes. This
occurred when participants remained unaware of the salience of ‘race’ and overlooked clients’ multiple identities.

Connected to the above is the research on racial micro-aggression (Sue et al., 2007) referring to subtle, “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (p. 271). This form of communication is also similar to what Trepagnier (2006) refers to as silent racism that goes unmarked and unnamed. One aspect of micro-aggression, which I perceived to occur in some of the conversations, is called micro-invalidation, pointing to instances when the importance of differences in therapy was constructed as unimportant. Another component, called micro-insult also occurred when participants engaged in making stereotypical comments about clients from different EC realities. In fact, this type of communication also surfaced in relation to me as a female researcher of color as elaborated.

An additional element that pointed to ethical dimensions was construction of addiction as a disease as a monolithic/universal entity being the same for everyone irrespective of differences. I perceived that when such conceptualization centered on the individual and the notion of similarity, it seemed to discount socio-cultural factors influencing A&D, as also argued by Graham, Young, Valach, and Wood (2008) and Moodley (2000). Reimer-Kirkham and Browne (2006) further postulate that when an individualistic conceptualization of health is assumed, the social conditions that constrain access to resources and quality of services do not get addressed or become part of a social mandate to enact change in practice and polices.

In addition to decontextualization of A&D problems, I perceived that the construction of addiction as a disease seemed to run parallel with counsellors adopting less flexible
approaches, and lacking alternative conceptualizations. Griffiths (2005) states “any framework for the conceptualization of addiction must allow for the bottom-up development,” in that “it must be flexible, accountable, integrative and reflexive” (p. 191). I believe that treating everyone the same as evident in this study’s findings, may contribute to fitting clients into the available services, rather than adapting the programs to better fit their needs. Thus, the above raises ethical concerns in that clients may end up feeling disempowered, with their experiences of the system being minimized. Furthermore, some participants’ construction of EC differences as more suited in mental health counselling than A&D context not only reinforces the above, but also makes discussion of diversity difficult to enter into A&D practice.

Discounting of differences by some participants further raised practice-related questions in terms of how effective counsellors may be in their interventions with clients from different EC realities. Counsellors’ resistance to incorporate EC issues conflict with professional guidelines that mandate professionals to make their services culturally responsive (BCACC, 2011; CCPA, 2007; CPA, 2000). Safety is further threatened when counsellors do not take into account power differentials as well as the individual and institutional racism as already discussed (Ramsden, 1993; Smye & Browne, 2002; Sue & Sue, 2000).

Approach to differences: The relational interview dynamics. One area of knowledge that pointed to the participants’ responses to differences was my experiences during the interviews as a female researcher of color. This helped to look at the “processual questions of meanings and contexts” (Wolcott, 1994, p. 12) by conceptualizing participants’ responses as a socially organized relational experience. Such perspective appeared critical because the research topic seemed to be directly co-constructed in the immediate interview context. The interactions illustrated participants’ everyday relationship when it came to negotiating
researcher’s differences; as per Ensink (2004)’s “mutual relations frame” of “being together of two persons” (p. 160). Here, I discuss the social construction of knowledge mediated by participants’ understanding of what social categories (such as ethnicity, culture and ‘race’) represented for them in relation to me as a female researcher of color.

In this study, I attended to the power relations in social interactions, which occasionally pointed to mostly implicit, but sometimes explicit, constructions of me as the “other.” In contradiction to the position of not seeing ‘race,’ color or culture, the interview process revealed that some study participants made remarks about my background and appearance, at times in a stereotypical fashion. For example one of the counsellors engaged in “us” versus “them” comparisons by stating that Afghanistan and India were more savage as societies, and the males from these societies were more aggressive than the Caucasian or Canadian men. There was also an assumption that I agreed with his racialized statement, such as the participant asserting that “I know about this.”

Phoenix (1994) explored the complexities of interviewing participants on topics such as gender, sexism, social class, and racism. She found that whenever the topic of ‘race’ emerged during the interviews, it was generally perceived as controversial and thought provoking, consistent with this study’s findings. She argues that when difficult feelings arise within the interviews, research inquiry provides an important lens to the data, e.g., when participants react to the topic and the differences of the interviewer, such as the resistant position and the stereotypical comments by participants. Qualitative interviews are therefore, expected to evoke participants’ accounts rather than being a mere absorption of interviewees’ accounts.

Consideration of the powerful dynamics of participant-researcher interaction is thus another interpretive element to be attended to. This does not mean that participants are to be
made vulnerable and unsafe, but rather to have the interview process remain open, to give rise to participants’ expressing their views and feelings with as little censorship as possible. It refers to attending to instances when the interviewer is surprised and challenged by the interviewees, thus providing an additional analytical lens (Phoenix, 1994).

As previously discussed, resistance to differences emerged as participants’ interactions were marked by tensions with respect to my focus on EC diversity. As a black identified researcher, Phoenix (1994) found that the topic of ‘race’ sometimes shifted the balance of the power from the interviewer to the interviewee. Marshall and Batten (2004) further assert that power dynamics are inevitably present in any kind of cross-cultural relationship, thus cautioning researchers to pay attention to this important element. While I attended to the power I held as a researcher in relation to the participants, I also experienced a reversal of power on certain occasions. For instance, an older male counsellor identifying as “Caucasian” consistently made racialized comments based on my appearance and gendered comments such as “I must cook good curries,” “cute,” and liking my “presentation;” thus creating a context of relative vulnerability and lack of power for me as a researcher. In fact, I noticed that the above counsellor seemed conscious of his behavior towards me as evident in his comment “I hope I didn’t insult you too much.” However, when asked about his work with clients from different EC backgrounds, he constructed his approach as safe, non-discriminatory and non-racist.

Applebaum (2005) refers to the above as privilege and power that generally go unmarked, particularly when individuals do not perceive themselves as racist even when creating racialized encounters (consciously or unconsciously). The above observations also brought to my attention the intersection of gender, ‘race,’ and age where I became aware of my own situated vulnerability due to these social locations. These situated vulnerabilities further
highlighted the need to understand participants’ responses as being embedded within the wider set of social relations and socio-political influences on construction of differences.

Davison (2004) contends that researchers need to acknowledge the vulnerability that they may experience when doing qualitative research. Therefore, activities such as seeking supervision and keeping a research journal are thought to help in debriefing and managing conflicting emotions that may arise in the field, influencing interpretation. I strived to engage in both of these activities, but also wanted to draw attention to the analysis of power relations during the interviews. Additionally, I interpreted that the construction of differences with me as a female researcher of color may run parallel to the experiences of clients from less dominant groups, raising concerns around safety and counsellors’ competency in working with diversity.

In this study, there were a few counsellors who identified themselves as individuals of color or visible minorities. They spoke of their own racialized encounters within the system while expressing their solidarity with clients of color. In fact, within the relational dynamics of the interview, they constructed me as an “insider,” as someone familiar with the context of immigration, discrimination and systemic racism. Two participants shared their feelings of initial hesitation prior to meeting me, with one being concerned about issues of trust, and the other one expressing concern about being “exoticized,” as he stated that it could occur with researchers of European heritage. These concerns are consistent with Marshall and Batten (2003)’s emphasis on needing to pay attention to cultural differences inherent in the research process with minority and or marginalized participants who may have had prior experiences of being misunderstood by Euro-American researchers.

It must be noted that I did not assume that I extracted more information or some degree of “truth” because of the shared sense of similarity in terms of being a person of color with
minority participants. In fact, Merriam, Johnson-Bailey and colleagues (2001) argue that in the past, it has been assumed that if the researcher is perceived as similar in culture to those of the participants, the following is thought to unfold: easier access to participants’ experiences, valid findings, “more truthful, authentic understanding of the culture,” and shared understanding of the participants’ experiences and meaning making (p. 411). However, I believe that the construction of researcher as an insider or outsider in relation to the participants is marked with blurred boundaries and complexities. Assuming authenticity simplifies the nature and dynamic of the relationship between the researcher and the researched. In addition, it does not take into account other power relations that may arise due to the intersection of multiple diversity factors.

In this study, I do not emphasize an “objective reality” but rather understand the existence of multiple truths that are socio-culturally situated. I believe that the similarity in my skin color or my immigration status, as pointed out by some participants, did not necessarily give me access to further information or open discussions of ‘race,’ ethnicity or culture. For instance, only a few of the counsellors who identified as people of color openly talked about issues of ‘race,’ and color and their potential impact on client-counsellor relationship.

During my interactions, I was fully aware of the power-based dynamics that my being a researcher carried in relation to the participants. I was also at times alert when some of the male participants, particularly those older than me, talked over me or interrupted the conversations. Additionally, I was reminded by one of the participants that she was afraid that I may not understand her English because my language skills were better than hers due to settling in Canada for longer and at a younger age. In attempts to get these counsellors’ unique
perspectives, I tried to enter a position of curiosity encouraging participants to elaborate while opening space for further conversations.

**Summary.** The first domain of this discussion focused on counsellors’ positioning towards differences, marked by varied construction of EC factors and their relevance to A&D counselling context. The interpretative process revealed that while some counsellors talked about their awareness of EC factors, they had difficulties in reporting how they incorporated their awareness into practice. This seemed to overlap with construction of addiction as a disease, EC factors as secondary and color-blind attitudes. The disease perspective was accompanied by assumption of A&D as a universal phenomenon, being the same for every one, separate from other mental health concerns. EC factors were further perceived to be more suited in general mental health counselling than A&D field. However, constructions of EC factors as central and reflexive practices marked by social justice dimensions seemed to specifically include counsellors’ descriptions of how they prioritized and accommodated differences. Related to the above, an integrated approach to A&D recovery seemed to include multiple influences and pathways with socio-cultural contexts perceived as an integral part of A&D recovery process. The above domain further covered ethical dimensions and ended with a discussion of how counsellors made sense of me as a female researcher of color. I perceived that the relational interview dynamics helped me examine the unique ways that differences between the researcher and participants were negotiated to produce research on a topic that also dealt with differences.

**Organizational Influences on the Care of Diverse Clients**

This domain focuses on interviews with counsellors and non-counsellors (i.e., managers, directors, supervisors and consultants) highlighting that A&D organizational context
could be an influential factor in explaining counsellors’ respective positions towards differences. Based on the findings, some counsellors’ attitudes towards inclusion of EC factors seemed to be influenced by the following: their teams’ degree of commitment to diversity, program structure, administrative policies and the role of leadership in promoting and providing relevant training. Further elements included: openness of the work environment to dialogues about differences, resource availability, team diversity and agency expectations as well as policies to promote culturally competent services. The above is consistent with Aaron and Sawitzkys’ (2006) arguments that quality of mental health services and treatment effectiveness can be influenced by organizational culture such as norms, expectations and practices, strongly shaping how staff should behave, make decisions, and perceive innovations.

It must be acknowledged that not all counsellors adopted a systemic perspective as they talked about the intersection of diversity and their practice environments. That is, construction of EC factors as less fitting into A&D context tended to contain cursory remarks about the system, with study participants constructing work settings as egalitarian and non-discriminatory. The presence of reflexive practices, on the other hand, included critical analysis of A&D services and construction of socio-cultural contexts as integral to the process of counselling. In addition, all of the non-counsellors interviewed appeared to openly examine their organizational context and the relative strengths and limitations related to the topic. It is also noteworthy that all of the non-counsellors seemed to openly engage in self-reflection, a positive indication that these individuals in the positions of authority and or leadership were demonstrating diversity affirmative attitudes. Thus, in my view, the organizational structure and processes as reported by some study participants served as an important mechanism in influencing pathways to A&D access and services for clients of diverse realities. Based on
some participants’ reflections, it appeared that A&D agencies exposed counsellors to a small number of clients from diverse EC realities. These participants attributed the lack of diversity and low rates of access to stigma around help seeking, and unfamiliarity with services.

Counsellors embodying critical reflection, however, highlighted their organizations’ “lip service to multiculturalism” and lack of initiative to reduce barriers. They also acknowledged that minority clients may have had negative experiences with the dominant models of A&D services, and that the services were only accessible to English speakers. The reduced exposure to diverse clients raised a question as to the degree that A&D agencies committed themselves to the provision of services to marginalized groups. Based on participants’ reports, I perceived that lower utilization rates or access issues were often explained as clients’ unfamiliarity with the system rather than systemic inequities creating barriers.

The theme of political correctness also seemed to hinder the creation of a safe and inviting space for counsellors to engage in diversity dialogues. I observed that a few of the participants who identified themselves as ethnic minorities reported not challenging racialized conversations at work, further raising a question of how the construct of ‘race,’ color and ethnicity were negotiated in work settings. The concept of “othering” (Johnson et al., 2004) seemed evident in the reports of two participants who identified as “South Asian.” They commented on being delegated the expert position on South Asian culture by white colleagues. Another noted that any one looking “Indian,” based on the color of their skin or other visible appearances, were referred to him despite the fact that South Asia covers a multitude of cultures, religions, languages, and socio-political contexts. Nolte (2007) indicates that it is not
uncommon for ethnic minority therapists to be identified as cultural experts on issues such as racism and cultural sensitivity.

The “othering” of ethnic minority professionals raises a number of interpretive comments. First, it seemed that being delegated the position of cultural expert put pressure on the counsellors to be an accurate representative for diverse groups of clients, as well as to experiences of being stereotyped. In fact, Burman, Gowrisunkur and Sangha (1998) indicate that when counsellors are deliberately matched to clients based on factors such as ethnicity or ‘race,’ it may suggest to them that they are only competent or well suited to work with ethnic minority clients. When such positioning of a therapist, based on one supposed common salient identity status (e.g., ethnic identity status) occurs, it does not allow for exploration of power relations and other identity factors and can lead to simplistic generalizations (Walker, Burman, Gowrisunkur, 2002).

**Disjointed care.** This section describes how A&D services collectively managed and responded to clients from diverse EC realities. A&D services as a whole were constructed as relatively disjointed and disorganized by those adopting a systemic perspective. Participants asserted that, if minority clients made it to A&D services, the program content (e.g., the manualized structure of the treatment) remained Euro-American in focus. This in turn meant that integration of socio-cultural influences on A&D depended largely on the individual counsellors’ awareness, commitment and skills towards diversity. Lack of adequate and relevant resources in the community were also identified, consistent with the literature on minority clients’ reduced access to treatment (Echemendia & Nunez, 2004; Griner & Smith 2006; McCabe, 2002; Snowdon & Yamada, 2005). Marsh and Fair (2005)’s review of addiction services within the Lower Mainland, British Columbia also confirms the above, in
that despite efforts to increase access, the health authorities continue to be slow in providing services to diverse population. The British Columbia Mental Health and Addiction Services (BCMHA, 2012) mentions the phrase ‘multicultural services’ only once in their vision statement, and in reference to making linkages with other multicultural community health programs. While BCMHA highlights making services accessible to all BC residents, it does not identify targeted efforts with specific population groups or marginalized communities that encounter health disparities.

Based on interviews, it also appeared that the delivery of A&D services was highly influenced by a bio-medical and acute model of care. I believe that a practice environment such as the above reinforces the construction of “addiction as a disease,” hindering exploration of the complexity and the continuum of A&D problems, as were noted in this study. As Griffiths (2005) asserts, the conceptualization of A&D problems can have varied social implications for clients, communities, professionals, policy makers and health service delivery. The prevalence of a medical approach can contribute to a discounting of the chronic and relapsing nature of A&D problems (Galanter, Keller, Dermatis & Egelko; 2008) in addition to a lack of long-term, coordinated recovery-oriented approach (Davidson & White, 2007). Furthermore, symptom management can underscore the economic and social links of disparities in health (Lantz, Uchtenstein & Pollack, 2007). I believe that certain participants’ assertions with regards to EC issues “not mattering in A&D counselling” could be linked to the dominant discourse in the field that endorses addiction as a disease, separate from other co-occurring mental health concerns. Research further points to the presence of ongoing schism between mental health and addictions field (Davidson & White, 2007) contributing to fragmentation as well as lack of
integration of co-occurring mental concerns (Barry, & Huskamp, 2011; Burnam & Watkins, 2006).

Generally, the desired changes articulated by participants assuming a systemic perspective seemed to focus on better coordination of services and increasing access to resources for EC clients. This need was consistent with Davidson and White’s (2007) assertion that the system has to shift towards a long-term and recovery oriented philosophy rather than symptom management. Participants alluded to a sense of pressure to solely treat A&D problems and leave other mental health problems such as trauma, anxiety, and depression for referral to “mental health counselling.” Drake, Mueser, Brunette and McHugo (2004), in their review of treatments for people with severe mental illnesses and co-occurring substance abuse, concluded that parallel and or separate treatment approaches are ineffective. Researchers advocate for integrated care, with more involvement from the different levels of system (Barry & Huskamp, 2011; Burnam & Watkins, 2006; Drake et al., 2001).

Related to the above, I perceived that A&D counselling has remained relatively impervious to debates on culturally competent practice. In fact, despite calls for multicultural competency and social justice in the counselling field, their adoption has been slow in the practical context (Moodley, 2007; Worthington, Soth-McNett, & Moreno, 2007). Similarly, scholars assert that, instead of focusing on the professional alone, a systemic adoption of culturally competent practice is needed (Arredondo, Tovar-Blank, & Parham, 2008; Darnell, & Kuperminc, 2006). Research in general points to slow adoption of new practices in A&D organizations (Miller, Sorensen et al., 2006) such as the following: clinicians placing more emphasis and trust on their own experience; the A&D field consisting of staff with varied levels of training and exposure to diversity, and agencies being resistant to adopt new
approaches due to ideological conflicts (Sloboda & Schildhaus 2002). Research has noted a disparity in terms of openness towards change and adoption of new approaches between staff with graduate training and staff without (those hired based on apprenticeship in the field), with the former considered as being more open towards change. However, this distinction was not relevant in this study because everyone with the exception of one participant had graduate level training.

I perceived that conflict with organizational cultural norms, such as with the dominant “addiction as a disease” discourse, seemed to contribute to work cultures that seemed defensive. Aaron and Sawitzky (2006) support the above by stating how a defensive organizational culture enforces the status quo by requiring conformity and reducing independence on the part of the staff. Additionally, such environment can affect motivation to, and attitudes toward adoption of new practices.

Another observation pointed to a sense of insecurity and powerlessness to enact change, expressed by both counsellors and non-counsellors who critically evaluated their work setting and the overall A&D system of care. They felt that their voices were generally not heard or even solicited by the upper level decision makers. Non-counsellors, in particular, seemed concerned as to how to manage the demands for resources or how to go about adapting the programs to better meet the needs of clients. Other examples of concerns included wondering how to hire and fund more bilingual counsellors given their small numbers as well as strict criteria for graduate level training (Master’s degrees). The interviews also pointed to a lack of guidance from those in upper level leadership positions on how to resolve these issues. To cope with such a sense of powerlessness, and reduce dissonance, it seemed that participants
(both counsellors and non-counsellors) made comments such as “we can’t be everything to everybody,” that further contributed to their sense of disempowerment to bring system change.

Research has found that counsellors generally do not receive guidance during their training on organizational change and that their supervisors may not have adequate skills and knowledge to promote advocacy (Trusty & Brown, 2005; Vera & Speight, 2007). Discussion of social justice advocacy in counselling psychology has been an explicit area of training and professional mandate only as of late, i.e., within the past decade (Hipolito-Delgato & Lee, 2007; Toporek & Liu, 2001), therefore it is expected that counsellors who may have been in the field for longer would have not received direct training in this domain. In this study, only a few of the counsellors (2 with counselling psychology training and another 2 with social work backgrounds) talked about being directly exposed to social justice values and concepts through their academic programs. For some other participants, these values were reported to have developed out of their personal interest or professional experiences of working with individuals from marginalized group.

Summary. The A&D organizational context seemed to serve as an important context in explaining counsellors’ positions towards inclusion of diversity in practice. Counsellors’ and non-counsellors’ accounts pointed to various barriers, such as lack of diversity on the teams, lack of resources to provide culturally focused services, and lack of supportive environments to have dialogues around diversity. Examples of system strengths included small initiatives to provide culturally and linguistically appropriate services for diverse communities as well as agencies providing cultural advisors for consultation. Furthermore, a sense of insecurity was expressed in terms of counsellors and non-counsellors’ attempts to bring change and make the services more accessible for clients from diverse EC realities. Additionally, the
A&D counselling services were reported to be disconnected from other mental health services pointing to fragmentation and lack of service coordination.

**Implications for Practice, Theory and Research**

The objective of this section is to provide recommendations based on the findings of this study that will enhance counsellors’ practices towards providing culturally competent and safe service, and to identify important areas for future research.

**Recommendations for practice.** This study’s findings indicate that counsellors’ understanding of EC factors and their relevance to A&D care ranged from narrow to broad. In particular, construction of EC factors as secondary seemed accompanied by minimization of differences and contexts, color-blind attitudes, stereotyping and conceptualization of “addiction as a disease.” Some counsellors identified centrality of EC factors in A&D treatment and reflected on integration of clients’ worldviews and cultural practices, however such construction sometimes pointed to assumption of EC factors as being fixed. However, counsellors exhibiting social justice elements in their constructions pointed to the need for a broader understanding of EC factors with an integrated approach to A&D requiring multiple level of analysis and to power and privilege as well as socio-cultural and political factors influencing clients’ A&D system.

Please note that I cannot comment on whether outcomes are better or worse for the above perspectives in practice settings. However, based on the findings of this study, I argue that clients’ safety can be compromised when diversity and socio-cultural contexts are constructed as secondary to therapy. Additionally, counsellors may run the risk of not seeing themselves, their values, attitudes and the counselling practices as cultural bound. This may in turn be linked to counsellors unintentionally imposing their own value system, as well as
invalidating and disregarding important socio-cultural contexts influencing clients A&D problems and the larger context of service delivery. Attention to the above is particularly important because research further highlights concerns around premature drop out and lower utilization rates for minority clients stemming from A&D systems of care that are not responsive to their needs (Anez, Silva et al., 2008; Bernal, 2006).

According to the findings of this study, I recommend adoption of integrated, and multidimensional approaches, as these were found to be more consistent with both standards of multicultural competence and professional ethics codes. Further, I recommend that counsellor training programs incorporate models and approaches that address socio-cultural and political contexts in the provision of A&D services. In the current study, such perspectives were marked by the following: appreciation of differences, counsellors’ continual self-reflection, power and system analysis, awareness and understanding of diversity, including that diverse clients experienced A&D problems and recovery in different ways based on their social location, resources and salient identity factors.

Certain racialized discourses present in this study suggest that stereotyping and “othering” practices can go unmarked and unnamed by counsellors, and indicate the need for cultivation of critical consciousness among A&D practitioners. As was the case in this study, approaching EC groups’ differences as fixed, and applying Eurocentric standards of care, may potentially expose clients to further marginalization and discrimination. In this study, self-reflection emerged as an important attribute in helping some participants examine how their personal experiences and professional training may have influenced their attitudes towards working with diversity. I recommend that individual counsellors and counsellor training programs implement reflexive practices that encourage critical self-reflection.
Emerging from this study’s findings, I encourage A&D practitioners to engage in reflexive practices, by examining the impact of their own identities and respective social positions on clients and the counselling process and, specifically, to challenge their own assumptions as to the universal applicability of interventions and Eurocentric practice models as the norm. Reflexive practices may involve counsellors to increase their comfort level to address their own assumptions, limits of practice and what they construct as important in A&D counselling for diverse clients. In addition, reflexive practices may encourage counsellors to acknowledge that as practitioners they are embedded in their own value systems, power relations and inequalities of their cultures. In the discipline of counselling psychology, self-assessment has been described as not only instrumental in counsellor development (Bennett-Levy, 2006) but also pivotal in maintaining competence (Belar, Brown et al., 2001; Collins & Arthur, 2005). This is also in line with guidelines for multicultural counselling competencies (APA, 2003; Constantine, 2007; Sue & Sue, 2003), social justice (Enns & Sinacore, 2005; Smye & Browne, 2002) and professional codes of ethics mandating that counsellors self reflect on the following: examine how racism and oppression operate in themselves, in the lives of their clients as well as the system (APA); question the dominant practices of the health care system (BCACC, 2011); and select treatment approaches that are applicable and safe to their clients and their socio-cultural contexts (CCPA, 2007; CPA, 2000).

While this research did not specifically focus on participants’ A&D counselling with Aboriginal population, several of the participants in this study did in fact provide brief examples of their work with Aboriginal clients. Thus, I believe that the recommendations from this research, particularly the notion of reflexive practice, can inform counsellors who are directly working with Canada’s diverse Aboriginal groups. It is crucial for counsellors to
recognize the impact of colonization and its relationship to trauma, racism and A&D problems for Canada’s Aboriginal groups. Constructing EC factors as secondary may not only invalidate Aboriginal clients’ identity but also perpetuate their sense of dislocation and compromise safety.

Counsellors also need to be aware of both their perspectives towards EC differences and their explanatory models of A&D recovery, as these may likely influence their motivation and ability to integrate EC variables into the therapeutic context. To do so, it will be necessary to create opportunities for reflection on power and privilege through didactic and experiential learning, and consideration of how to use power responsibly, given clients’ multiple vulnerabilities. Instead of constructing differences as secondary, and clients A&D concerns as a disease, counsellors are encouraged to embrace differences and foster a strength-based perspective that allows for clients’ empowerment and proactive decision-making.

The findings also suggest caution in pursuing a disease model to A&D recovery, as locating recovery within the individual can decontextualize clients’ A&D problems, thus reducing the complexity of their concerns and perpetuating the shame and stigma that is associated with A&D problems. In response, I recommend a multidimensional approach to A&D, one that balances emic and etic conceptualization of differences, suggests that context and EC factors count, and avoids imposition of Eurocentric models of health. This will require counsellors and their agencies to adopt multiple strategies for addressing clients’ concerns, thus providing clients with options and the space for informed decision-making. Adoption of an integrated approach may reduce the risk that EC differences will be constructed as an “add on,” with opportunities for effective multi-strategy A&D treatment.
Based on findings associated with the organizational context of A&D recovery, counsellors’ reflexive practices on ethics and health policies is another valuable component in provision of culturally safe A&D counselling. Interviews with counsellors who adopted a critical perspective, as well as those participants identifying themselves as non-counsellors, pointed out that professionals need to expand their roles beyond the traditional context of therapy. Specifically, changes to A&D services may require that counsellors and agency administrators engage in social justice advocacy. To do so, the findings pointed to the importance of supportive organizational infrastructure to help counsellors in acquisition and consolidation of skills aimed at working with differences. At the same time, this study indicated that it could be a challenge and a risk for counsellors to engage in advocacy work, particularly in an organizational environment where dialogues on differences are discouraged, through “lip service to multiculturalism” and political correctness. Counsellor training programs are encouraged to include this area in their curriculum, as research shows that professionals do not receive adequate mentorship and guidance in the area social justice advocacy (Trusty & Brown, 2005; Vera & Speight, 2007).

This study additionally pointed to some counsellors’ resistance and anxieties to acknowledge differences or broach the topic of ‘race,’ color and culture within therapy. To address this finding, I recommend the need for creation of safe climates where counsellors can engage in open dialogues, thus enhancing their critical self-reflection skills. Supervisors of A&D counsellors and new trainees are encouraged to assess counsellors’ unique developmental levels with respect to working with diversity as well as their understanding of biased views, stereotypes and prejudices that may unintentionally perpetuate racism. As part of this effort, Falender and Shafranske (2007) argue that it may be beneficial to increase counsellors’
dissonance to experience difficult conversations within a supportive supervision context. The above is considered to help counsellors to take risks and disclose their own blind spots. Such activities would also contribute to earlier recommendations on enhancing counsellor reflexive practices.

Findings of this research additionally suggest that counsellors may benefit from a clear vision for culturally safe practices and social justice that is embedded within A&D services, as this may help enable counsellors to adopt expanded roles in terms of advocacy, networking and awareness raising. Additionally, lack of a coordinated mandate to make diversity a priority within agencies and training environments raises questions as to whether clients are getting the type and quality of services they need. The above may also reinforce marginalization and sense of powerlessness on the part of those counsellors who are engaged in promoting diversity affirmative services. I therefore, recommend that counsellors could benefit from practice environments that provide a coordinated ethical mandate for diversity training. The above can be achieved through professional development initiatives such as experiential learning workshops, participation in open dialogues about diversity, as well as seeking supervision and consultation in the area of culturally competent practice. A&D programs may need to prioritize funding arrangements that support staff education while providing clinicians with allocated time to be flexible in delivery of services. Given some participants reports, A&D organizational contexts were overall criticized for not prioritizing funding to address issues of access and implementation of diverse services. Thus, it will be important to allocate funds to address broader organizational issues that will enhance the provision of culturally safe practices.

Related to the above, the finding indicated that counsellors working within the health authorities’ language-specific services are at risk for marginalization and racialized
experiences, through being stereotyped and designated as the experts to provide culturally relevant care. Leaving the responsibility of care on the shoulders of minority counsellors decontextualizes care and also does not make it an institutional requirement to implement appropriate changes. As highlighted by participants who adopted a critical and systemic perspective, the A&D practice environment must adapt to the needs of its multicultural client population, with resources directly reflecting this diversity in staff and program structure, moving beyond tokenism and “cosmetic” changes in their organizational practices. To achieve multicultural competency in A&D treatment, I encourage agencies to enhance cultural safety for clients by going beyond the skills and competencies of individual practice (i.e., counsellor) to emphasize accountability on the systems and policies influencing counsellors’ practice.

**Implications for theory.** A major theoretical implications for this research is that reflexive practice may serve as an important element in helping counsellors to not only have a deeper understanding of contextual factors linked to A&D problems, but also navigate the complexities of working with clients from diverse realities. Based on the findings of this study, I view this process as developmental, and as one that has the potential to contribute to a critical understanding of multicultural competencies. In addition, I view reflexive practice as a fluid and a relational process that could broaden counsellors’ understanding of multicultural competencies from being static and including a series of checklists focusing on other groups, to critical examination of counsellors’ own social location and the embedded power and privilege in wider social relations. I observed reflexive practice as an attribute of perspectives with social justice and ethical dimensions, and given that social justice is considered as action oriented (Pieterse et al., 2009), reflexive practice is hoped to not only add to process of increasing counsellors’ awareness of racial dynamics and structural oppression but also encouraging skill
building in working with clients from diverse background. The notion of reflexive practice is also consistent with counselling psychology’s move towards social justice frameworks (Vera & Speight, 2003), where reflexivity is not just an expansion of counsellors’ practice but serves as a professional responsibility.

Related to the above, an additional theoretical contribution of this study is infusing reflexive practices within an integrated approach to A&D treatment that is holistic, multidimensional, flexible and strength-based. The above findings extend the contemporary bio-psychosocial approaches to A&D treatment that advocate for multiple strategies and levels of analysis when working with A&D related concerns. (Bevacqua & Hoffman, 2010, Griffiths, 2005; Kissin, 1977; Thombs & Osborn, 2001; Toriello & Leierer, 2005). In sum, this study contributes to integration of reflexive practices in conceptualization, assessment and intervention of A&D problems, while critically analyzing the dominant models of health and service delivery. This is consistent with the major tenets of counselling psychology as a field that honors the developmental, contextual, familial, interpersonal, and social experiences of clients and their complex reciprocal interaction with the healthcare environments (Chwalisz & Obasi, 2008), thus bringing an alternative perspective to the prevailing disease model of recovery in the field of A&D treatment.

**Recommendations for future research.** This study was based on a selected group of counsellors situated within the mainstream A&D counselling services in the Lower Mainland region, British Columbia, Canada. Further research is warranted to examine if similar positions towards EC diversity factors, and similar models of A&D care, are present for A&D counsellors in other regions and privately funded A&D services. While this research indirectly highlighted a range of awareness and skill related to counsellors’ multicultural competencies,
future research could benefit from utilizing some of the established measures of cultural competency to assess A&D counsellors’ unique competencies. Additionally, this research was based on counsellors’ reports of their work with diverse clients. Thus, studies that look at actual video-recorded sessions of counsellors with their clients may be helpful in further elucidating whether these competencies are evident or lacking, thus providing specific opportunities for counsellor training and skill development. Further to that, research could assess the extent that counsellors’ competencies are linked to improved outcomes for clients from diverse EC backgrounds.

Reliance on sources of data such as counsellors, and a small number of non-counsellors’ accounts, to understand the complexity of A&D organizational context and culture of care provided a cursory glimpse. Future research will be helpful in utilizing alternative data sources such as organizational policies, manuals and other relevant program materials to assess how a diversity lens is incorporated into the infrastructure of specific organizations; influencing counsellors’ practice and overall delivery of care. Furthermore, a thorough study of how counsellors understand and incorporate EC issues is incomplete without including other sectors, such as policy makers, service users, community members and administrative staff associated with A&D care. In particular, further research is warranted in accumulating information at the client level with regards to the specifics of services they receive from counsellors, elucidating the extent that they may perceive these services as culturally responsive and safe.

While participants in this study briefly talked about organizational climates that were unsafe to engage in difficult dialogues, future research may be helpful in uncovering specific organizational dynamics that support and hinder diversity-related conversations. This study briefly highlighted the various ways that counsellors modified their interventions to
accommodate differences. However, it will be important to research how counsellors who specifically engage in socio-cultural adaptations/modifications and to what extent the outcomes for their clients differ compared to interventions that do not involve the above. In particular, it will be important to assess what socio-cultural variables may be directly helpful in shaping clients’ A&D recovery so that such knowledge is incorporated into intervention programs. Studies of modifications should be conducted in consultation with clients and multicultural community partnerships to give voice and enhance the study design and future delivery of such interventions.

Limitations

The scope established for this research resulted, necessarily, in a number of limitations that need to be considered alongside the conclusions of the study. The choice to focus on how counsellors understood and spoke of the relevance of EC factors in clinical context made it difficult to address the overall nature of the therapeutic encounter and the extent that diversity is recognized and implemented at actual practice settings. While some participants talked about intersection of diversity factors (age, gender, socioeconomic status, etc.), the central focus of the research question being on clients from different EC backgrounds may have limited some participants to comment on the relationship of other diversity factors to their practice.

Another factor limiting this research is that counsellors represented a wide variety of contexts (in patient and out patient) as well as a range of theoretical orientations and disciplinary training. As such, these relative variations in context, orientation and training precluded exploration of which specific training may have contributed to counsellors’ reports of the relevance of EC factors in A&D therapy. Participants’ work contexts also differed in terms of in patient and out patient setting, and provision of care in the form of individual or
group therapy format thus making it difficult to assess how these contexts contributed to counsellors’ ability to provide culturally safe care.

The scope of this inquiry was delimited in numerous ways as elaborated below, leading to limitations on the findings that should be noted. The interviews were restricted to participants working in the Lower Mainland, British Columbia region, in agencies that were affiliated and funded by the provincial health authorities. Thus, those practicing at private A&D services and or private counselling practice were not included. Another delimitation included the exclusion of counsellors who were hired based on their past history of recovery without any training or certification in A&D counselling.

Additionally, the interview format in the form of counsellors’ individual reports may have been affected by social desirability factors and anxiety around talking about EC differences and specifically to a female researcher of color. Another delimitation was recall factors and self report, in that participants were required to retrospectively share their experiences and process of working with clients from diverse EC communities, with some having difficulties expressing how they translated their knowledge and awareness into practice. The above therefore meant that counsellors generally commented on their previous or anticipated behaviours rather than what may have actually transpired in their clinical sessions with clients of diverse EC realities. I also want to acknowledge, as researcher, that my choice of the research question, design, data collection and analysis is greatly shaped by my own beliefs, socio-cultural positioning and experiences. As such, it is hoped that ongoing reflexive engagement with the research process allowed some of my inherent biases and assumptions to surface, and permitted appropriate attention in the process of analysis and interpretation of findings in this study.
Conclusions

This study provided a rich description of how counsellors understood and incorporated EC diversity factors in A&D counselling. Overall, this study indicated a range of knowledge and skills reported by A&D counsellors with respect to multiculturally competent counselling. More specifically, this study highlighted that the incorporation of EC factors in A&D treatment was inconsistent, in that counsellors varied in their degree of reflection, and intention towards including EC factors in A&D counsellors. The findings further suggested that some counsellors who have some awareness and knowledge around diversity issues do not necessarily link or incorporate the above in their clinical practice. This study also indicated that inclusion of EC factors into the participants’ A&D organizational context was rudimentary and fragmented. The above was linked to factors such as the historical separation of mental health and addiction services; counsellors’ resistance towards differences; lack of critical dialogues around diversity and lack of sufficient funding and resources.

The findings of this study also revealed varying level of awareness (related to EC diversity factors) on the part of the participants in relation to self, clients, one’s practice and the work context. Counsellors’ awareness levels seemed linked to how they understood and approached the intersection of diversity factors and clients’ A&D related problems. A continuum of conversations emerged, ranging from resistance towards differences and color-blind attitudes to acknowledging and embracing of differences. While the counselling relationship was revealed to be an important theme re-occurring through all of the dialogues, the ways that counsellors approached these relationships were marked by the extent they were comfortable with, and the importance they assigned to, differences and contextual influences on A&D related behaviours.
Findings further revealed that the counsellors who engaged in critical self-reflection were able to examine their own biases and seemed open to integration of EC factors. Likewise, reflexive practices seemed to aid counsellors to articulate their attempts at translating their knowledge of diversity into practice. Understandings marked by reflexive practices included examination of biases, privilege and power relations as well as one’s limits of competence. Furthermore, counsellors endorsing integrated approaches considered numerous pathways to recovery from A&D problems, adopting multiple levels of analysis and strategies while evaluating program structure and content, as well as systemic variables such as discrimination, institutional racism affecting access to care. In contrast, issues of power, privilege, socio-cultural context and one’s competency generally remained unexamined for counsellor approaches that lacked reflexive practices. The above lack of reflexive practices seemed associated with perception of addiction as a disease, and approaching A&D problems from a generalized lens. Endorsing a disease model of addiction seemed to indicate the need for A&D counselling to be separate from EC factors and other mental health concerns, due to a belief that the disease aspects needed to be prioritized over any other determinants.

It is hoped that this research will catalyze greater attention to the important of EC factors in A&D counselling, and that the findings contribute to enhanced understanding of how counsellors may approach and integrate EC factors in treatment. While the findings of this study suggested that infusion of EC factors into A&D care is rudimentary and fragmented for some counsellors, the culture-focused, ethical and social justice orientations indicated that culturally competent and safe A&D services are becoming a priority for some within the A&D field. Additionally, the non-counsellors’ accounts about system strengths suggested that despite
barriers and lack of resources, the organizational culture of A&D are working towards diversity affirmative environments to increase access to clients from diverse EC realities.
References


Benbenishty, R., & Treistman, R. (1998). The development and evaluation of a hybrid decision
support system for clinical decision-making: The case of discharge from the military. 


Rehabilitation, 24(4), 409-422.


documents/CodeofEthics_en_new.pdf


Constantine, M. G., & Gainor, K. A. (2001). Emotional intelligence and empathy: Their


therapy: A New Zealand perspective. *Australian Occupational Therapy Journal, 52*(1), 34-42.


Westport, CT: Greenwood Press.


ethnicity. *American Psychologist, 63*(8), 651-670.


Scale. In G. R. Sodowsky & J. C. Impara (Eds.), *Multicultural assessment in counseling and clinical psychology* (pp. 247-282). Lincoln, NE: Buros Institute of Mental Measurements.


misuse, 37(8-10), 1079-1087.


Appendices
Appendix A: Research Recruitment Letter for Counsellors

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Dear Sir/Madam:

I am conducting a doctoral research study entitled “Understanding and Incorporation of Clients’ Diversity Factors in Substance Use Counselling,” as part of my doctoral degree (PhD) requirement in Counselling Psychology at the University of British Columbia, supervised by Dr. Beth Haverkamp. The purpose of this research is to explore how counsellors’ understanding and incorporation of clients’ ethno-cultural diversity factors contribute to effective and culturally competent alcohol and drug (A&D) treatment and services. This research has been approved by UBC’s Behavioral Research Ethics Board (certificate # H10-00717).

Your participation is welcome if you:

• Professionally identify as an A&D or substance use counsellor,
• Have provided counselling (for at least 2 years) at an A&D treatment center/agency affiliated with the Lower Mainland, British Columbia Health Authorities,
• Have provided, and or are currently providing care to ethno-culturally diverse clients,
• Are working at an agency that provides a spectrum of A&D services (i.e., harm reduction, detox, abstinence-based programs, etc),
• Have completed your Masters degree in psychology (counselling and clinical) and or social work,
• Communicate and speak in English.

Your participation would involve:

• Discussing with a female researcher, Hajera Rostam your process of how you understand and incorporate clients’ ethno-cultural diversity factor in substance use counselling.
• 2 confidential, audio-recorded face-to-face interviews (each 1-1.5 hours in length).

Voluntary Participation

Your decision to participate in this is entirely voluntary and if you decide not to participate, it will not affect your current or future relationship with the University of British Columbia. You have the right to refuse to participate, to decline to answer any questions, or to withdraw your consent and terminate your participation in this study at any time without penalty of any kind.
Completely Confidential

The information you will share will be kept anonymous and completely confidential and I will remove any information that could identify you. All documents and audiotapes will be kept in a locked filing cabinet. Although the transcribed interview data are on the computer, they will be password protected.

If you, or someone you know, would like to participate in this study or would like more information about this research, contact Hajera Rostam or the principal investigator Dr. Beth Haverkamp at (604) 822-5354. Once we get your message, we will then call you back to speak to you directly.

Sincerely,

Hajera Rostam, M.A., Doctoral Student
Department of Counselling Psychology
University of British Columbia,
2125 Main Mall, Vancouver, BC, Canada, V6T 1Z4
Appendix B: Research Recruitment Letter for Other Professionals

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Dear Sir/Madam:

I am conducting a doctoral research study entitled “Understanding and Incorporation of Clients’ Diversity Factors in Substance Use Counselling,” as part of my doctoral degree (PhD) requirement in Counselling Psychology at University of British Columbia, supervised by Dr. Beth Haverkamp. The purpose of this research to explore how counsellors associated with alcohol and drug (A&D) treatment services understand and incorporate ethno-cultural diversity factors in their work. To gain a broad perspective, I wish to interview professionals and administrators who play a wide variety of roles in A&D treatment systems.

Your participation is welcome if:

• You are working (other than as a counsellor) for an A&D treatment center/agency, affiliated with the Lower Mainland, British Columbia Health Authorities,
• Your agency provides A&D services to clients from a variety of ethno-cultural communities,
• Your agency provides a spectrum of A&D services (i.e., harm reduction, detox, abstinence-based programs etc),
• You communicate and speak in English.

Your participation would involve:

• Discussing with a female researcher, Hajera Rostam your insights as to how ethno-cultural diversity factors are understood and incorporated in your work and agency.
• A confidential, audio-recorded face-to-face interviews (1-1.5 hours in length),

Voluntary Participation

Your decision to participate in this is entirely voluntary and if you decide not to participate, it will not affect your current or future relationship with the University of British Columbia. You have the right to refuse to participate, to decline to answer any questions, or to withdraw your consent and terminate your participation in this study at any time without penalty of any kind.

Completely Confidential

The information you will share will be kept anonymous and completely confidential and I will
remove any information that could identify you. All documents and audiotapes will be kept in a
locked filing cabinet. Although the transcribed interview data are on the computer, they will be
password protected.

If you, or someone you know, would like to participate in this study or would like more
information about this research, contact Hajera Rostam or the principal investigator Dr. Beth
Haverkamp at (604) 822-5354. Once we get your message, we will then call you back to speak
to you directly.

Sincerely,

Hajera Rostam, M.A., Doctoral Student
Department of Counselling Psychology
2125 Main Mall
University of British Columbia
Vancouver, BC, Canada, V6T 1Z4
Appendix C—Informed Consent for Counsellors

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Understanding and Incorporation of Clients’ Diversity Factors in Substance Use Counselling

Principal Investigator: Beth Haverkamp, Ph.D., Department of Educational and Counselling Psychology and Special Education, (604) 822-5354.

Co-Investigator: Hajera Rostam, M. A., (Doctoral Student), Department of Educational and Counselling Psychology and Special Education, University of British Columbia. This research is being conducted as part of the requirements for Hajera Rostam to complete her doctoral degree (PhD) in Counselling Psychology program at the University of British Columbia, Vancouver, Canada. This research is being supervised by Dr. Beth Haverkamp.

Purpose: The purpose of this research is to explore how counsellors’ understanding and incorporation of clients’ ethno-cultural diversity factors contribute to effective and culturally competent alcohol and drug (A&D) treatment and services.

Study Procedures: If you choose to participate in this study, you will be interviewed twice (1-1.5 hours each) by the co-investigator, Hajera Rostam. During this interview, you will also be asked to provide demographic information. The interviews will be audio-taped, transcribed and later analyzed for patterns, themes, and meanings. A summary of your individual interview and its preliminary themes will be sent to you. The total amount of time that will be required of you to participate in the study is approximately 2-3 hours.

Confidentiality: The records for this research will be kept private, in a locked cabinet by the principal investigator and the co-investigator. Similarly, no information will be included that will disclose the identity of the participants or third parties mentioned during the interview. Pseudonyms will be used to keep track of all the records. Although the transcribed interview data are on the computer, they will be password protected. Respondents will not be identified by name in any reports of the completed study. The data will be destroyed after 5 years, and your identity will be kept confidential.

Potential benefits or risk: There are no direct risks associated with this study. However, since this study asks you to talk about your experience in the area of ethno-cultural diversity, there could be instances when talking about this topic may bring emotional discomfort, or sensitize you to your own ethno-cultural heritage or that of the interviewer’s. Please note that this research is situated within a diversity and multicultural perspective, and that all perspectives
will be valued. If interested, a list of cross-cultural resources will be available to you at the end of the interview. The potential benefit of this study is that it will give you the opportunity to provide us with some insight into your clinical process of how you understand and incorporate ethno-cultural diversity factors in your A&D counselling. This research may further generate clinically significant knowledge that could inform other professionals who provide substance use counselling to the above client groups.

**Voluntary Nature of Study:** Your decision to participate in this is entirely voluntary and if you decide not to participate, it will not affect your current or future relationship with the University of British Columbia. You have the right to refuse to participate, to decline to answer any question, or to withdraw your consent and terminate your participation in this study at any time without penalty of any kind. If you choose to withdraw at any time before the study is complete, all the information you provided will be destroyed.

**Remuneration/Compensation:** There will be no monetary compensation to participants.

**Feedback:** A summary of the study findings will be sent to you when the research is completed upon your request. The study results are anticipated to be available in September 2011.

**Contact for information about the study:** If you have any questions or would like further information about this study, you may contact Hajera Rostam and Dr. Haverkamp at (604) 822-5354.

**Contact for information about the rights of research participant:** If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

**Consent:** Your participation in this study is entirely voluntary. You may refuse to participate, decline to answer any questions, or withdraw from the study at any time without penalty of any kind.

Your signature indicates that you consent to participate in this study. By signing below you also acknowledge that you have read and understood this consent form, and been provided a copy of this consent form.

**I consent/do not consent to participate in this study.**

_____________________________          ________________________          ________________________
Participant’s Signature                  Participant’s Name                  Date
Appendix D–Informed Consent for Other Professionals

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Understanding and Incorporation of Clients’ Diversity Factors in Substance Use Counselling

Principal Investigator: Beth Haverkamp, Ph.D., Department of Educational and Counselling Psychology and Special Education, (604) 822-5354.

Co-Investigator: Hajera Rostam, M. A., (Doctoral Student), Department of Educational and Counselling Psychology and Special Education, University of British Columbia.

This research is being conducted as part of the requirements for Hajera Rostam to complete her doctoral degree (PhD) in Counselling Psychology program at the University of British Columbia, Vancouver, Canada. This research is being supervised by Dr. Beth Haverkamp.

Purpose: The purpose of this research is to explore how counsellors’ understanding and incorporation of clients’ ethno-cultural diversity factors in alcohol and drug (A&D) treatment contribute to effective and culturally competent services. To gain a broad perspective, I wish to also interview professionals and administrators who play a wide variety of roles in A&D treatment systems.

Study Procedures: If you choose to participate in this study, you will be interviewed for 1-1.5 hours by the co-investigator, Hajera Rostam. During this interview, you will also be asked to provide demographic information. The interviews will be audio-taped, transcribed and later analyzed for patterns, themes, and meanings. A summary of your individual interview and its preliminary themes will be sent to you. The total amount of time that will be required of you to participate in the study is approximately 1-1.5 hours.

Confidentiality: The records for this research will be kept private, in a locked cabinet by the principal investigator and the co-investigator. Similarly, no information will be included that will disclose the identity of the participants or third parties mentioned during the interview. Pseudonyms will be used to keep track of all the records. Although the transcribed interview data are on the computer, they will be password protected. Respondents will not be identified by name in any reports of the completed study. The data will be destroyed after 5 years, and your identity will be kept confidential.

Potential benefits or risk: There are no direct risks associated with this study. However, since this study asks you to talk about your experience in the area of ethno-cultural diversity, there
could be instances when talking about this topic may bring emotional discomfort, or sensitize you to your own ethno-cultural heritage or that of the interviewer’s. Please note that this research is situated within a diversity and multicultural perspective, and that all perspectives will be valued. If interested, a list of cross-cultural resources will be available to you at the end of the interview. The potential benefit of this study is that it will give you the opportunity to provide us with some insight into your clinical process of how you understand and incorporate ethno-cultural diversity factors in your A&D counselling. This research may further generate clinically significant knowledge that could inform other professionals who provide substance use counselling to the above client groups.

**Voluntary Nature of Study:** Your decision to participate in this is entirely voluntary and if you decide not to participate, it will not affect your current or future relationship with the University of British Columbia. You have the right to refuse to participate, to decline to answer any question, or to withdraw your consent and terminate your participation in this study at any time without penalty of any kind. If you choose to withdraw at any time before the study is complete, all the information you provided will be destroyed.

**Remuneration/Compensation:** There will be no monetary compensation to participants.

**Feedback:** A summary of the study findings will be sent to you when the research is completed upon your request. The study results are anticipated to be available in September 2011.

**Contact for information about the study:** If you have any questions or would like further information about this study, you may contact Hajera Rostam and Dr. Haverkamp at (604) 822-5354.

**Contact for information about the rights of research participant:** If you have any concerns about your treatment or rights as a research participant, you may contact the Research Subject Information Line in the UBC Office of Research Services at (604) 822-8598.

**Consent:** Your participation in this study is entirely voluntary. You may refuse to participate, decline to answer any questions, or withdraw from the study at any time without penalty of any kind.

Your signature indicates that you consent to participate in this study. By signing below you also acknowledge that you have read and understood this consent form, and been provided a copy of this consent form.

**I consent/do not consent to participate in this study.**

| Participant’s signature | Participant’s Name | Date |
Appendix E—Interview Guide for Counsellors

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Questions for Alcohol and Drug (A&D) Counsellors
I will begin the interview by welcoming the participant followed by a brief introduction to the purpose of the study.

When you meet a client for the first time, I am interested in learning about how you go about getting to know them, and what they need from counselling?

Probe:
• If you need more information about your client(s), what else would you want to know?
• Please comment on the diversity of the client population that you work with.
• What do you find yourself noticing when you work with diverse clients?

I am curious about how you go about getting to know clients from a variety of ethno-cultural communities, and what they need from counselling?

Probes:
• In your experience of A&D counselling, what are some of the typical presenting needs of ethno-culturally diverse clients?

How do you figure out what approach is effective and important when providing A&D counselling to ethno-culturally diverse clients?

Probes:
• What helps?
• What makes it challenging?
• What is surprising?

What influences your A&D counselling with ethno-cultural clients?

Probes:
• What aspects of you as a person influence your A & D counselling with ethno-cultural clients (e.g., gender, culture, ethnicity, sexual orientation, etc)?
• Probe for aspects of counselling style (e.g., model, training) and its potential influence.
• Probe for aspects of work setting, organization and policy and their respective influences.

Upon completion of the first interview, I will administer the demographic questionnaire. I will then debrief with each participant by asking him or her the following:

What has it been like for you to participate in this research?

Finally, I will thank the participants for their participation.
Appendix F–Interview Guide for Other Professionals

Questions for A&D professionals and administrator (NOT counsellors)
I will begin the interview by welcoming the participant followed by a brief introduction to the purpose of the study.

What are some of your general impressions of where the field is going with respect to A&D service provision for clients from a variety of ethno-cultural communities?

Probes:

- How do you see the field engaging with respect to A&D care for the above client groups?
- How do you see your counsellors engaging with respect to A&D care for the above client groups?
- Probe for examples of potential efforts (pertaining to diversity) that they may be aware, and or part of?
- How is ethno-cultural diversity reflected in your work setting, agency, program materials/policies/guidelines etc?

What influences how you provide A&D service to ethno-culturally diverse clients?

Probes:

- What helps?
- What makes it challenging?
- What is surprising?
- What are some of the influences on your counsellors?
- What are some of the influences on your on your agency?

Upon completion of the interview, I will administer the demographic questionnaire. I will then debrief with each participant by asking him or her the following:

What has it been like for you to participate in this research?

Finally, I will thank the participants for their participation.
Appendix G–Demographic Questionnaire

Department of Educational and Counselling Psychology, and Special Education
The University of British Columbia
Faculty of Education
2125 Main Mall
Vancouver BC Canada V6T 1Z4

Please complete the following questionnaire. You are free to decline all or any parts. Thanks for your time and cooperation.

Age: ___________________________________________________________________

Ethno-cultural background: ___________________________________________________________________

Gender: ___________________________________________________________________

Education: ___________________________________________________________________

Professional Title: ___________________________________________________________________

Years of Experience Providing Alcohol and Drug Counselling: ________________

If applicable, what is your theoretical orientation/model for providing services to clients:
_______________________________________________________________________

Please indicate below if you have taken any courses or training in diversity and multicultural practice:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Are you registered and or affiliated with any professional bodies? If yes, please indicate in the space provided:
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

If there is any thing else you would like us to know about your background, please feel free to comment below:
_______________________________________________________________________
_______________________________________________________________________
Appendix H: List of Cross Cultural Resources

List of Cross-Cultural Resources

Improving mental health services for immigrant, refugee, ethno-cultural and racialized groups: Issues and options for service improvement.
Document prepared by: Mental Health Commission of Canada and the Centre for Addiction and Mental Health, November 12, 2009
Website:

Cross Cultural Clinic
Website: http://psychiatry.vch.ca/ccc.htm
Vancouver Coastal Health, Vancouver General Hospital
This clinic comprises of a team of psychiatrists who provide culturally sensitive and language-specific assessment and treatment.
Site 715 West 12th Avenue
Health Centre, Ground Floor
Vancouver, BC V5Z 1M9

City of Vancouver's Four Pillars Drug Strategy
http://vancouver.ca/fourpillars/index.htm
This website contains current information about ways to reduce drug-related harm in Vancouver.

This project was created in partnership between the First Nations Chiefs’ Health Committee and the BC Ministry of Health Planning. The objective was to create a user-friendly health guide reference for First Nations Communities and is part of the provincial government’s commitment to improve the quality of life, education and health care for Aboriginal people.
http://www.healthlinkbc.ca/first_nations_healthguide.pdf

HeretoHelp
http://www.heretohelp.bc.ca/
HeretoHelp is a project of the BC Partners for Mental Health and Addictions Information, funded by BC Mental Health and Addictions.
Fact sheets and other resources regarding mental health and substance use issues are available in several languages (i.e., Arabic, Chinese, English, Persian, French, Korean, Punjabi, Russian, Spanish, Japanese and Vietnamese).

Alone in Canada: 21 ways to make it better
http://www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/alone_in_canada.html
Center for Addiction and Mental Health (CAMH)
It is a self-help guide for single new immigrants and refugees to adjust to their new lives in
Canada. The booklet (free of charge for orders of 50 or under) is available in 18 languages including English, French, Arabic, Chinese, Dari, Farsi, Hindi, Punjabi, Serbian, Tagalog, Tamil, Twi and Urdu.

AMSSA
http://www.amssa.org/
AMSSA is an affiliation of more than 80 multicultural agencies providing immigrant settlement and multicultural services in communities throughout British Columbia. The focus of AMSSA includes promotion of multiculturalism, multicultural health, anti-racism and human rights. AMSSA also provides on-line multicultural resources in several languages. In addition it includes a database of multicultural health publications, guides of multicultural health services/programs and resources, as well as a BC directory of multicultural expertise. Relevant website:
http://www.amssa.org/multiculturalhealthyliving/onlineresources.html

The Multicultural Mental Health Resource Centre (MMHRC)
www.mcgill.ca/mmhrc/listserv
The MMHRC is an information centre, listserv, web-site and a network designed to improve the delivery of mental health services to a culturally diverse population. The MMHRC is a project of the Mental Health Commission of Canada. In addition, the email-list serv aims to promote knowledge exchange in the area of culture and mental health services.

DIVERSEcity Community Resources Society
http://www.dcrs.ca/index.php?page=services&section=services
DIVERSEcity offers counselling, employment, outreach, interpretation and translation Services and various other services. Many of the counselling programs are offered in different languages to serve the needs of linguistically diverse communities.

Relevant Publications: