AN EXAMINATION OF LEADERS' INTERCULTURAL COMPETENCE AND EMPLOYEES' PERCEIVED ORGANIZATIONAL CULTURE IN SUBSTANCE ABUSE FACILITIES

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AN EXAMINATION OF LEADERS' INTERCULTURAL COMPETENCE AND EMPLOYEES' PERCEIVED ORGANIZATIONAL CULTURE IN SUBSTANCE ABUSE FACILITIES

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Abstract

As we continue to work towards a better understanding of intercultural competence, leaders must identify areas where they can facilitate change in themselves and in the organizations they lead. This quantitative study incorporates the Intercultural Development Inventory (IDI) to measure orientations towards cultural differences of leaders in substance abuse treatment facilities. This study also incorporates the Organizational Culture Inventory (OCI) to measure how the followers' perceive the organizational culture. Data was analyzed using statistical software program (SPSS) and statistical correlations and multivariate analysis of variance were computed. This study is unique in that it breaks new ground in the measurement of the level of intercultural competence of leaders in substance abuse treatment facilities and how their followers' perceive the organizational culture according to the OCI scores.

Results revealed a statistical significance with leaders that scored in the denial orientation of the IDI and their followers that scored the organizational culture as passive/defensive on the OCI. This study points to recommendations for change, from a developmental training perspective and to encourage leaders to become aware of their intercultural competence orientation. Use of the IDI, OCI and interventions to assist in finding ways to increase awareness will strengthen leaders and organizations.

Dedication

First and foremost, I want to thank God for giving me the strength, confidence, and motivation to start this journey.

This dissertation is dedicated to my daughters, Malinda Esmeralda, Natalia Maria, and Olivia Norma for being so patient and understanding during this process. To Rachee for the encouragement and sisterly advice at the exact moments I needed it most. To my dad for teaching me discipline. To both of my moms for keeping their prayers and hope alive. And to my closest friends for being my stress release and source of laughter when needed.

My deepest appreciation goes out to my mentor, Dr. Joanne Barnes, who has always been there for me, leading me through moments of fear, exhaustion, discouragement, and depression. Thank you for listening and for your continuous guidance that led me down a path toward the final steps of accomplishing this goal.

There is no doubt that without everyone's continued support I could not have completed this process.

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Chapter One: Introduction

The United States Census Bureau (2010) reported there were 312.8 million people residing in the United States, which is an increase of 2.25 million people or 0.7% from 2010. The majority of the growth in the population came from increases in those who reported their race(s) as something other than White (U.S. Census Bureau, 2010. Currently, population growth is fastest among minorities as a whole, according to the U.S. Census Bureau, with 50.4% of American children under the age of one belonging to minority groups. The U.S. Department of Labor (2011) reported the highest rate of labor workforce participation was among the Hispanic population at 67.5%. The White population ranked second at 65.1%, Asian at 64.7%, and the Black population was the lowest with 62.2% (U.S. Department of Labor, 2011). This shift in demographics has created an increase of diversity in the workplace for addiction counseling staff and individuals who now require addiction treatment (Campbell & Alexander, 2002). As a result, this change necessitates more now than ever the recruitment of an adequate number of diverse professionals who are sufficiently trained to meet the needs of the treatment and recovery field (Pfefferle & Gibson, 2010). “Diversifying the workforce can correct the current demographic disconnect between a mostly white, female, middle-aged workforce and a primarily male and diverse clientele” (Pfefferle & Gibson, 2010, p. 1).

Andrulis and Sachdev (2009) posited diversity has become critical in everyday business as a result of the Equal Pay Act of 1963 and the Title VII of the Civil Rights Act in 1964. Diversity is evident in businesses' mission statements and human resource practices (Andrulis & Sachdev, 2009). Researchers have continuously documented the impact of organizational climate on important business outcomes (McKay, Avery, & Morris, 2009). McKay, Avery, and Morris (2009) asserted that supportive diversity climates have positive ramifications for organizational performance including: increased creativity, cooperation, problem solving, and enhanced company image. McKay et al. (2009) informed that pro-diversity climate perceptions are associated with lower intentions to turnover, particularly among Black and/or Hispanic personnel.

Problem Statement

Organizations that provide services to diverse populations should be concerned about how followers perceive the climate and culture of the organization. The perceptions of a diverse workforce could influence organizational effectiveness, staff participation, and organizational outcomes (Snipes-Bennett, 2006). Leaders need to be culturally competent to drive a positive, working organizational climate (Capell, Veenstra & Dean, 2007). In this study, behavioral health organizations, specifically substance abuse treatment organizations, were examined. Behavioral health is an over-arching term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders (Finch & Phillips, 2005). Behavioral health leaders are now faced with relating to a more diverse population (Campbell & Alexander, 2002). Munoz, DoBroka, and Mohammad (2009) stated that "there is significant evidence to

document that minorities in this country experience a higher incidence of disability, disease, and death as compared with the mainstream population" (p. 495).

Substance abuse is the problematic use of alcohol or drugs, occurring when an individual's use interferes with basic work, family, or personal obligations (Finch & Phillips, 2005). Substance dependence has been identified as a disease, due to the characteristics of it being chronic, progressive, and deadly (U.S. Department of Health and Human Services, 2011). In 2008, about 40% of admissions to substance abuse and dependence treatment programs were from the minority population (U.S. Department of Health and Human Services, 2011).

Not only is the clientele increasingly diverse, but their clinical needs are complex, necessitating a workforce capable of addressing a range of issues (Pfefferle & Gibson, 2010). Historically, training on cultural competence has focused on awareness, knowledge, and skills for individual counselors in order to work effectively across cultures (Darnell & Kuperminc, 2006). However, it is critical that cultural competencies manifest in the organizational level as well (Darnell & Kuperminc, 2006).

According to Aarons and Sawitzky (2006), studies of human service organizations have shown that organizational culture and climate are important in the quality and outcomes of services provided. Organizational culture is the shared norms and expectations that govern the way that people approach their work and interact with each other (Cooke & Szumal, 2000). Organizational culture influences work attitudes such as job satisfaction and organizational commitment, service quality, and staff turnover (Glisson & James, 2002). Researchers seem to agree that culture may be an

important factor in determining how well individuals fit an organization's context (O'Reilly, Chatman, & Caldwell, 1991).

Organizational culture affects the way in which people behave in an organization, especially in the areas of efficiency, effectiveness, and commitment (Nongo & Ikyanyon, 2012). The problem that this study examined was whether or not a behavioral health leader's intercultural competence level has a relationship to the organizational culture of substance abuse treatment agencies with ethnically diverse clientele.

Research Hypotheses

The research hypotheses for this study were:

Hypothesis 1: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' developmental orientation as measured by the IDI.

Hypothesis 2: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' denial as measured by the IDI.

Hypothesis 3: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' defensiveness as measured by the IDI.

Hypothesis 4: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' reversal as measured by the IDI.

Hypothesis 5: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' minimization as measured by the IDI.

Hypothesis 6: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' acceptance as measured by the IDI.

Hypothesis 7: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' adaptation as measured by the IDI.

A behavioral health professional, as defined by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2011), is a person who is licensed by the state and whose professional activities address a client's behavioral issues. Substance abuse treatment consists of professional assistance in either an inpatient or an outpatient setting. Indiana has 273 behavioral health facilities and 84 of these focus solely on substance abuse. Of those, 15 are located in Indianapolis, Indiana. This study centered on substance abuse treatment facilities located in Indianapolis whose sole focus is substance abuse.

Research has suggested that less than one-half of people with behavioral health problems receive treatment (U.S. Department of Health & Human Services [USDHHS], 2010). Some of the reasons for underutilization are as follows: (a) patients are reluctant to seek services, (b) insurers are reluctant to pay for them, and (c) those in poverty are three times more likely to have serious psychological distress compared to those over twice the poverty level (USDHHS, 2010). Minorities have less access to and less availability of behavioral health services (USDHHS, 2010). According to Stanhope, Solomon, Pernell-Arnold, Sands, & Bourjolly (2005):

> the Surgeon General's report attributed underutilization of behavioral health services by nonwhite people as a result of mistrust that arises from a system that is unable to recognize the needs of nonwhite racial and ethnic people or to collaborate with them to provide culturally appropriate treatment. (p. 226)

The U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (USDHS, 2011) has determined that cultural competence

is a priority issue; therefore, mandates have been developed to ensure that organizations are implementing cultural competence training and evaluations.

Definition of Key Terms

For the purpose of this study, the following operational definitions were used:

Acceptance: An orientation that recognizes and appreciates patterns of cultural difference and commonality in one's own and other cultures (Hammer, 2009).

Adaptation: An orientation that is capable of shifting cultural perspective and changing behavior in culturally appropriate and authentic ways (Hammer, 2009).

Aggressive/Defensive culture: Is the organizational culture in which members are expected to approach tasks in forceful ways to protect their status and security, this construct includes oppositional, power, competitive and perfectionistic (Cooke & Lafferty, 1989).

Behavioral health: Refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders (U.S. Department of Health and Human Services, 2010).

Behavioral health professionals: Refers to mental heath practitioners, psychiatrists, marriage and family counselors, addiction counselors, and social workers (U.S. Department of Health and Human Services, 2010).

Constructive cultures: Is an organizational culture in which members are encouraged to interact with others and approach tasks in ways that will help them to meet their higher-order satisfaction needs, this construct includes achievement, self-actualizing, humanistic-encouraging, and affiliative cultures (Cooke & Lafferty, 1989).

Cultural competence: Refers to the acceptance and respect for difference, continuing self-assessment regarding culture, vigilance toward the dynamics of differences, ongoing expansion of cultural knowledge and resources, and adaptions to services (Cross, Bazron, Dennis, & Isaacs, 1989).

Cultural disengagement: A sense of disconnection or detachment from a primary cultural group (Hammer, 2009).

Defense: An uncritical view toward one's own cultural values and practices and an overly critical view toward other cultural values and practices (Hammer, 2009).

Denial: An orientation that likely recognizes more observable cultural differences but may not notice deeper cultural difference an may avoid or withdraw from cultural differences (Hammer, 2009).

Followers: Those individuals that are full-time staff and have been under the direct supervision of a leader as defined by this study for a minimum of one year.

Intercultural competence: "A set of cognitive, affective, and behavioral skills and characteristics that support effective and appropriate interaction in a variety of cultural contexts" (Bennett, 2004, p. 62).

Intercultural mindset: An individual that makes sense of cultural differences and commonalities based on one's own and other culture's values and practices, uses cultural generalizations to recognize cultural differences, and supports more complex perceptions and experiences of cultural difference and commonality (Hammer, 2009).

Leader: For the purpose of this study, leaders can include full-time managers, supervisors, directors, or executive directors that are responsible for the direct supervision of at least five direct reports and have been in their position a minimum of two years.

Minimization: An orientation that highlights cultural commonality and universal values and principles that may also mask deeper recognition and appreciation of cultural differences (Hammer, 2009).

Monocultural mindset: An individual that makes sense of cultural differences and commonalities based on one's own cultural values and practices, uses broad stereotypes to identify cultural differences, and supports less complex perceptions and experiences of cultural differences and commonality (Hammer, 2009).

Organizational culture: Refers to the shared norms and expectations that govern the way people approach their work and interact with each other (Cooke & Lafferty, 1989).

Passive/Defensive culture: Is the organizational culture in which members believe they must interest with people in defensive ways that will not threaten their own security, this construct includes approval, conventional, dependent, and avoidance (Cooke & Lafferty, 1989).

Polarization: A judgmental orientation that views cultural differences in terms of "us" and "them" (Hammer, 2009).

Reversal: An overly critical orientation towards one's own cultural values and practices and uncritical view toward other cultural values and practices (Hammer, 2009).

Substance abuse treatment facilities: These are organizations that primarily serve those suffering from an addiction to alcohol and/or other drugs.

Delimitations

Due to the large number of potential participants in the study population, the current study focused only on substance abuse treatment facilities that were located within Indianapolis, Indiana. This study only looked at a metropolitan area. The study did not cover private practice addiction counselors, doctor's offices, psychiatrists, or psychologists. The study only assessed the intercultural competence of leaders, as defined above, within the selected substance abuse facilities.

Assumptions Guiding the Study

This study assumed the theoretical framework of Bennett's Developmental Model of Intercultural Sensitivity to be an accurate reflection intended to measure intercultural competence. The researcher assumed that intercultural competence is measurable because the Intercultural Development Inventory is a valid and reliable instrument.

It was assumed all respondents would answer survey questions candidly and to the best of their abilities, as no harm would be imposed if they declined or participated. This study assumed that the sample population was representative of the Indianapolis population of substance abuse treatment facilities. It was also assumed that the substance abuse treatment facilities had an ethnically diverse clientele. It was assumed that leaders had a formal education and training in the field of addictions. According to the Indiana Behavioral Health and Human Services licensing board, an applicant must show verification of meeting education in issues of ethnicity, race, socioeconomic status, and

culture (www.pla.in.gov). Therefore, this study assumed that the leaders had some cultural diversity training or instruction, either through their education or career.

Literature Review

Substance Abuse Treatment Facilities

Substance abuse treatment facilities are those organizations that primarily serve those suffering from an addiction to alcohol and/or other drugs. There are 13,339 facilities in the United States that qualify as substance abuse treatment organizations (USDHHS, 2011). These are private non-profit, private for-profit, local/county or government, state government, and federally owned or operated organizations. These organizations provide substance abuse treatment, mental health treatment, and a mix of substance abuse and mental health treatment. According to USDHHS's (2011) National Survey on Drug Use and Health, 23.5 million people aged 12 or older needed treatment for an illicit drug or alcohol abuse problem in 2009.

According to Rosenberg (2010), one of the most critical issues facing the addiction treatment community in the 21st century is how to meet the needs of an increasingly diverse population. As the demographics continue to rapidly change, substance abuse treatment facilities will be faced with an increase in diverse populations. Dotson and Nuru-Jeter (2012) informed that "the shift in demographic landscape of the health care workforce and consumer's needs requires organizations to embrace an increasingly diverse labor pool if they want to stay current and compete for the best talent" (p. 36). Additionally, "the addictions field is lacking in diversity in leadership ranks" (Rosenberg, 2010, p.125). Top administrators and executives in behavioral health today are "overwhelmingly Whites" (Rosenberg, 2010, p.125). Leaders themselves have

agreed that diversity matters; however, they are unclear on how to address the lack of diversity in management (Dotson & Nuru-Jeter, 2012). The lack of cultural diversity among leaders in behavioral health will lead to an ever-widening gap in the current chasm of racial and ethnic disparities in health care (Rosenberg, 2010).

Intercultural Competence

Intercultural leaders have the ability to understand and interact with others from different ethnic or cultural backgrounds. Deardorff (2006) defined intercultural competence as "the ability to communicate effectively and appropriately in intercultural situations, to shift frames of reference appropriately and adapt behavior to cultural context" (p. 249). According to Pusch (2009), a leader with intercultural competence has some of the following characteristics: (a) cultural empathy, (b) accommodations of cross-cultural situations, (c) communication effectiveness, and (d) language proficiency.

Intercultural competence is not a fixed psychological state but a developmental continuum as reported by Kim (2001). According to Oliver, Church, Lewis, and Desrosiers (2009), today's leaders face an ever-changing environment, which can challenge their insight and knowledge of many different cultures and market demands. Due to this situation, leaders have become aware that they are facing shortages in leadership with intercultural or multicultural expertise, and they have continued to develop and implement a variety of instruments to assess for characteristics and qualities needed to develop intercultural leadership talent (Oliver et al., 2009).

Intercultural Competence Assessments

Instruments are commonly used in intercultural competence assessments (Deardoff, 2006). Instruments can be defined as any measurement device that identifies,

describes, assesses, categorizes, or evaluates the cultural characteristics of individuals, groups, and organizations (Yu, 2012). Some instruments bear the name of inventories, scales, or surveys. These instruments can provide one with feedback on their level of intercultural development or measure one's knowledge and attitude. Some instruments are self-reporting, using a Likert-scale to answer questions and a formula to change answers into quantifiable scores (Yu, 2012). Other instruments use traditional testing formats such as multiple-choice or fill-in-the-blanks. Many instruments are designed for specific audiences such as counselors, nurses, schoolteachers, and expatriate individuals (Yu, 2012).

There are three primary types of instruments to measure intercultural competence. The first type is sensitivity instruments, which assess one's intercultural sensitivity, including qualities such as empathy, flexibility, open-mindedness, interest in other cultures, and respect and tolerance for other cultures. A second type of instrument is awareness tests, which assesses for one's cognition and understanding of cultural knowledge. A final type of instrument used to assess for intercultural competence is cultural profilers, which are instruments that use scenarios or statements to present common issues that all cultures must address (Van de Vijver & Leung, 2009).

Assessment instruments that measure intercultural competence have several benefits and limitations. Van de Vijver and Leung (2009) referred to this as flexibility. In addition, these assessments can determine if changes in trainings are necessary if used as pretest and post-test assessments. Another benefit of cultural assessments is that there is a wide variety to select from based on what skillset, attitude, or personality trait one is attempting to evaluate. Therefore, development plans can be established. Bird (2008)

reported that most of the assessments that are commercially available are highly valid and reliable. Challenges with intercultural competence assessments relate to those in multicultural testing (Van de Vijver & Leung, 2009). These limitations are construct bias, method bias, and item bias.

Currently there are no intercultural competence assessment tools that are specifically used in substance abuse treatment facilities (Fantini, 2009). Many of the commercially available assessments can be employed in private or public health care settings (Fantini, 2009). Since substance abuse treatment facilities are under the umbrella of behavioral health, it is therefore assumed these assessment tools are applicable to substance abuse treatment facilities.

Behavioral Health Leadership and Intercultural Competence

Betancourt, Green, and Carrillo (2002) reported there is a lack of diversity in behavioral health leadership. They stated that minorities make up 28% of the U.S. population but only 3% of medical school faculty, 16% of public health school faculty, and 17% of all city and county health officers. Betancourt et al. (2002) cited that 98% of senior leaders in behavioral health management are Caucasian. Many health care organizations are beginning to look to leadership to help manage a new era of culturally competent, patient-centered care that reduces health and health care disparities (Dotson & Nuru-Jeter, 2012). Dotson and Nuru-Jeter (2012) found that the quality of care being delivered in health care organizations is directly related to how well leadership and management practices are aligned to understanding the organization's health and health care disparities. Richard (2000) suggested that the literature indicates that racially and ethnically diverse organizations outperform homogenous organizations in both quality

and financial outcomes. “Leadership qualities should require knowledge of and the ability to address health disparities in health care organizations that are culturally competent” (Dotson & Nuru-Jeter, 2012, p. 38). D’Aunno (2006) stated that there is a gap between research and practice in the field of substance abuse treatment in regards to the role of organizational and management factors.

Organizational Culture

Organizational culture theory emerges from a combination of organizational psychology, social psychology, and social anthropology (Scott, Mannion, Davies, & Marshall, 2003). The term *organizational culture* first appeared in literature in 1979 by Pettigrew (Hofstede et al., 1990).. There are varying definitions for organizational culture as denoted by Scott et al. (2003) “as a wide range of social phenomena, including an organization’s customary dress, language, behavior, beliefs, values, assumptions, symbols of status and authority, myths, and ceremonies and rituals all of which assist in defining an organization’s character and norms” (p. 925).

Culture as defined by Schein (2010) is a “concept that is constantly reenacted and created by our interactions with others and shaped by our own behavior” (p. 3). In addition, culture is the foundation of the social order that we live in and the rules we abide by (Schien, 2010). Cultures exist in organizations. Organizational cultures differ in strength and stability from highly structured ones to relatively fluid ones (Schein, 2010). The group culture of an organization that is created, embedded, and evolved is ultimately manipulated by leaders. When the culture becomes dysfunctional within an organization, it is the role of the leader to implement programs that can have a positive change on the culture (Schein, 2010).

According to Al-Swidi and Mahmood (2011), organizational culture shapes organizational procedures, provides solutions for many problems that the organization faces, coordinates and directs various organizational activities, and facilitates the organization's achievement of its goals. Al-Swidi and Mahmood argued that there is a clear differentiation between strong and weak organizational culture and their consequences related to organizational performance and employees' behaviors. The Denison Organizational Cultural Model (DOCM) posits four desirable organizational traits grounded in theory and empirical findings (Casida, 2008). The four organizational cultural traits are characteristics of organizational effectiveness, and include adaptability, involvement, consistency, and mission. Casida (2008) informed that effective organizations demonstrate high levels of the four cultural traits. Leaders have the dominant role in deciding work structures within organizations. In addition, they have key roles in developing the organizational culture (Al-Swidi & Mahmood, 2011).

Attitudes and Behavior

Attitudes influence one's beliefs as well as behavior (Liska, 1984). Attitude is a predisposition or a tendency to respond positively or negatively toward a certain idea, concept, person, or situation (Greenwald, 1989). Attitude influences an individual's choice of action and responses to challenges, incentives, and rewards. According to Liska (1984) there are three components of attitudes: affective (emotions or feelings), cognitive (belief or opinions), and conative (inclination for action). Attitudes can be explicit and implicit. Explicit attitudes are those that one is consciously aware of and that clearly influence one's behaviors and beliefs. Implicit attitudes are unconscious, but still have an

effect on one's beliefs and behaviors. People are more likely to act in accordance with their attitudes if they "think before they act" (Ajzen, 1989, p. 50).

Attitudes form as a result of one's experience (Zimbardo & Leippe, 1991). They may emerge due to direct personal experience, or they may result from observation (Greenwald, 1989). According to Zimbardo and Leippe (1991), social roles and social norms can have a strong influence on attitudes. Social roles relate to how people are expected to behave in a particular role or context. Zimbardo and Leippe inform that social norms involve society's rules for what behaviors are considered appropriate. Attitudes can be learned in a variety of ways (Ajzen, 1989). Attitudes are also learned by observing the people around them.

Research Methods and Procedures

This study was intended to test the hypothesis that substance abuse treatment facilities leaders' level of intercultural competence is related to the organizational culture. A quantitative approach using a descriptive design was proposed for this study. The quantitative approach arises from the belief that human phenomena and variables in human behavior can be studied objectively; therefore, this approach was selected for this study. This section presents an overview of the methods used in the study. Areas covered include the population and sample, sampling techniques, data collection, and analysis.

Population and Sample

The population for this research project was leaders in substance abuse treatment facilities located within Indianapolis, Indiana. The targeted population for the study included leaders in administrative positions, executive positions, or director positions, and a sample population of those they lead. This study was based upon a single-stage,

random sampling process. There are approximately 84 substance abuse treatment facilities in Indiana, 15 of which are in the Indianapolis area (USDHHS, 2011). These facilities vary in regards to organizational size and structure, ranging from one leader with seven followers, to 17 leaders with anywhere from one to 25 followers. A minimum of one leader from each organization was sampled. In order for a leader to participate in this study they had to have been in a leadership role for a minimum of two years and have a minimum of five followers, with a minimum of three followers who participated in the study. In order for a follower to participate in the study they had to have been under the direct supervision of their leader for a minimum of one year.

Instruments

The focus of this study was the intercultural competence level of leaders and their followers' perception of the organizational culture. Two instruments were employed for data collection in this research. They included the Organizational Culture Inventory (OCI) and the Intercultural Development Inventory (IDI). The OCI measured how the followers perceived the culture of the organization, which is the dependent variable. The IDI measured the leader's level of intercultural competence, which was the independent variable.

Organizational Culture Inventory

The OCI was developed by Drs. Robert A. Cooke and J. Clayton Lafferty to measure organizational culture. This tool is the most widely used instrument to measure organizational culture (Agbenyia, 2011). This instrument provides organizations with a visual profile of their operating cultures (current culture) in terms of the behaviors that members believe are required to fit in and meet expectations. This instrument has been

evaluated for reliability, consensual, criterion, and constructs validity (Ashkanasy, Broadfoot, & Falkuus, 2000). According to Agbenyia (2011) the OCI has been used effectively with sample sizes as small as 15 to as large as 5,000. The OCI measures four constructive behavioral norms: problem solving and decision-making, teamwork, productivity, and long-term effectiveness. The OCI consists of three self-reported instruments: the inventory with 120 behavioral norms, a 5-point scale culture-performance survey with 12 questions, and a socio-demographic survey. It also measures eight defensive behavioral norms that detract from effective performance. The survey takes approximately 20 minutes to complete and can be self-scored or scored online by the developers.

Intercultural Development Inventory

The IDI was developed by Dr. Mitchell Hammer. The IDI is a statistically reliable, cross-culturally valid measure of intercultural competence adapted from the Developmental Model of Intercultural Sensitivity (DMIS) (Hammer, Bennett, & Wiseman, 2003). The DMIS is a theory-based explanation for the varying degrees of individual and organizational effectiveness one observes in intercultural endeavors (Greenholtz, 2000). It is a model of cognitive development, which requires self-awareness as a pre-requisite for advancing through the developmental stages. The first three stages are ethnocentric, which dictates that one's own culture is experienced as central to reality. The latter three stages are ethnorelative and are based on the realization that one's own culture is merely a representation of one of many equally valid worldviews (Greenholtz, 2000). The ethnorelative stages are characterized by a positive mindset about cultural difference. These stages are indicative of a person who tends to

make more inclusive decisions and actively seek to build a diverse workforce and an inclusive work environment (Hammer et al., 2003). The DMIS posits that cultural competence development moves from the ethnocentric stages to ethnorelative and that the movement is unidirectional.

The IDI assesses one's own orientations toward cultural differences and commonality. The specific orientations measured by the IDI are denial, polarization (defense and reversal), minimization, acceptance, and adaptation (Hammer et al., 2003). It also measures cultural disengagement, which is the disconnection or detachment from a primary cultural group. This instrument is a 50-item, theory-based inventory that can be completed on paper or online.

Data Collection

A letter inviting leaders to participate in the study was sent to all 16 substance abuse facilities in Indianapolis, Indiana, via email to the leaders in administrative positions, executive positions, or director positions of the organization. The email addresses were obtained through the SAMSHA substance abuse treatment facility locator. The letter provided a detailed summary of the requirements for participation (see Appendix A). Once the organization agreed to participate in the study the following steps were followed:

- Once the head of the organization agreed to participate in the study, they were requested to provide a list of the leaders' names and email addresses.
- The leaders as defined for this study were emailed a questionnaire that asked their race/ethnicity, length of time in their role, their professional title, and instructions for completing the IDI survey.

- The leader was then required to forward email addresses for all of their followers to the researcher. Based on this list, the researcher then selected three of these followers to complete the OCI survey.
- The followers of each leader were emailed a questionnaire that asked for their race/ethnicity, gender, length of time in their role, their professional title, if they have had prior cultural competency training, and instructions for completing the OCI survey.
- The survey links remained open for 14 days. After seven days, a follow-up email was sent to remind all of the participants of the completion date.

All data retained during the research process was kept confidential. In order to protect the participants and their organizations, the researcher assigned a number to each facility, and the data is referred to in the study as Facility 1, Facility 2, etc.

Data Analysis and Interpretation

The survey and assessment data was entered into the Statistical Package for the Social Sciences (SPSS) for data analysis. In order to provide a description of the sample from which the data was collected, descriptive information on race/ethnicity, and role in organization was described, as well as the mean, modes, range, and standard deviations for the IDI and OCI scores. Nonparametric statistical procedures were used to test the hypotheses. The Pearson product-moment correlation was used to compare the IDI and OCI scores within the same facilities. To determine any differences in the IDI and OCI scores according to age, gender, race/ethnicity, and role in organization—chi-square, t-tests, and analysis of variance were used to examine for any significant differences among the scores. A test for normality was run. If the data were normally distributed I ran

parametric statistics. If the data were not normally distributed then I ran non-parametric statistics.

Contribution to Organizational Leadership

This research contributed to the body of scholarly work by investigating the relationship between intercultural competence of behavioral health organizations' leaders and the culture within the organization, specifically substance abuse treatment facilities. Intercultural competence as a construct is compelling in that it could help address disparities by improving awareness and the ability to recognize, understand, and work effectively across cultural differences (Capell et al., 2007). Tsai (2011) found that when there is a positive relationship between leadership and subordinates, there would be contributions to team communication, collaboration, and encouragement of subordinates to accomplish the mission and objectives assigned by the organization; this, in turn, enhances job satisfaction (p. 106). Therefore, if an organization can develop culturally competent leaders, it would have a greater chance for a positive organizational culture.

Conclusion

Organizations would be able to utilize the data from this study when hiring and training leaders of substance abuse treatment facilities. This study provided insight into the importance of knowing and understanding how leaders influence the culture of an organization. Another contribution is that it provided awareness of how a leader can develop intercultural adaptability skills. Overall, the outcome of this study increased the leaders' personal awareness and provided knowledge of how leaders are perceived by the members of the organization. The substance abuse professionals are vital in serving the

diverse populations; therefore, it is imperative to enrich their ability to become culturally competent.

Chapter Two: Literature Review

Organizations that provide services to diverse populations should be concerned about how followers perceive the climate and culture of the organization. The perceptions of a diverse workforce could influence organizational effectiveness, staff participation, and organizational outcomes (Snipes-Bennett, 2006). Leaders need to be culturally competent to drive a positive, working organizational climate (Capell et al., 2007). Behavioral health is an over-arching term and refers to a continuum of services for individuals at risk of, or suffering from, mental, behavioral, or addictive disorders (Finch & Phillips, 2005). Behavioral health leaders are now faced with relating to a more diverse population (Campbell & Alexander, 2002).

Substance Abuse Treatment Facilities

Substance abuse treatment facilities are organizations that primarily serve individuals suffering from an addiction to alcohol and/or drugs. Addiction to alcohol and/or other drugs is defined as the repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substances, has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means (American Society of Addiction Medicine, 2011). There are 13,339 facilities in the United States that qualify as substance abuse treatment organizations (USDHHS, 2011). These are private non-profit, private for-profit, local/county or government, state government, and federally owned or operated organizations. These

organizations provide substance abuse treatment, mental health treatment, and a mix of substance abuse and mental health treatment. According to USDHHS's (2011) National Survey on Drug Use and Health, 23.5 million people aged 12 or older needed treatment for an alcohol and/or other drug abuse problem in 2009.

As an organizational field, substance abuse treatment includes a number and range of activities and organizations, including pharmacotherapies and the occupation of substance abuse counselors, the social roles of recovering substance-addicted patients, state substance abuse policy-making agencies, and the entrepreneurial distribution of relapse prevention techniques (Roman, Ducharme, & Knudsen, 2006). Substance abuse treatment is a complex and substantial industry in terms of the size of its internal economy and the extent of the workforce employed (Roman et al., 2006). At the epicenter of this organizational field, the substance abuse treatment center or program serves as the organizational platform for the delivery of substance abuse treatment services and may be the key component of the field (Roman et al., 2006).

According to D'Aunno (2006), substance abuse treatment programs are viewed as open-systems due to their expectations of external groups or external conditions in the environment to influence organizational characteristics, including staffing patterns and client-to-staff ratios. Open-systems model of organizations view organizations as engaging in a series of exchanges with various external groups to obtain vital resources—including funds, staff, clients, licenses, and accreditation (Scott, 1998). Furthermore, open-systems views recognize that organizations operate not only in material environments in which money, authority, power, and politics matter, but also in social and cultural environments that can shape organizational behavior in subtle but powerful

ways (D'Aunno, 2006). Cultural environments emphasize or reinforce shared values in a field and provide role models that organizations and their managers emulate (Scott, 2001). Health care organizations are more value-laden and controversial than most organizations (Scott, 1998). Substance abuse treatment organizations depend heavily on their environment for beliefs and rationales to justify and legitimate their activities (D'Aunno, Vaughn, & McElroy, 1999). These organizations obtain vital resources by conforming to widely-held groups such as professional associations, government agencies, and regulatory bodies (D'Aunno et al., 1999).

Cultural Competence in Substance Abuse Treatment

In today's changing health care environment, organizations are under increasing pressure to ensure quality of care for their patients. It is important for all practitioners and organizations to understand that providing culturally competent services is essential to quality care (American Institutes for Research, 2002). Becoming culturally competent in behavioral health care practice requires that nested or embedded emotions associated with race, culture, gender, and other socio-demographic differences be openly experienced and discussed (Sue & Sue, 2013). These intense feelings often block one's ability to hear the voices of those most oppressed and disempowered (Sue & Sue, 2013).

According to Betancourt et al. (2002), there is a lack of diversity in health care leadership. Minorities make up 28 % of the U.S. population but only 3% of medical school faculty, 16% of public health school faculty, and 17% of all city and county health officers (Betancourt et al., 2002). Furthermore, 98% of senior leaders in health care management are White (Cohen, Gabriel, & Terrill, 2002). Minorities are also underrepresented in the health care workforce (Cohen et al, 2002). The growing diversity

of the population has resulted in substantial challenges for the U.S. health care system (Horwitz, Sonilal & Horwitz, 2011). When health care providers fail to understand sociocultural differences between themselves and their patients, the communication and trust between them may suffer (Betancourt et al., 2002). They may also resort to stereotyping, which can affect their behavior and clinical decision-making. Leadership and the workers need to become culturally competent and exhibit leadership to manage diversity for substantially improving the delivery of care for all (Horwitz et al., 2011).

According to Mulvey, Hubbard, & Hayashi (2003), "individuals seeking treatment for substance abuse addiction rely heavily on the treatment staff (counselors and clinical supervisors) to provide them with quality and effective services" (p. 52). Due to this reliance, patients need to know that the professionals are qualified to treat them. There are few studies that focus on the qualifications and experience of substance abuse treatment professionals.

In order for facilities to be licensed, accredited, or certified as a treatment provider, they must demonstrate compliance with state standards. Facilities are not required to become licensed, accredited, or certified; however, those facilities would not be eligible to receive state or federal funding or third-party reimbursement (USDHHS, 2011). Each state has different requirements for professionals to become licensed addiction counselors. These standards are set by state boards or other designated state authorities. According to Indiana Code 25-23.6-10.5, behavioral health professionals are required to hold a bachelor's degree in addiction counseling or a related field, 40 semester hours (which must include hours in cultural competence), and a minimum of

350 internship hours. In addition, each facility might have additional personnel requirements for individuals working in this capacity.

According to the U.S. Department of Human & Health Services, Office of Minority Health's (2011) final report, the long-standing problem of racial and ethnic heath disparities is well documented and well known. The burden of health disparities continues to disproportionately affect minority populations. The complexity of issues surrounding health disparities makes it difficult to research causal factors (American Institutes for Research, 2002). The American Institutes for Research (2002) also informed that

> causes have been attributed to a variety of factors including socio-economic status, lack of access to quality health services, environmental hazards in homes and neighborhoods, and the scarcity of effective prevention programs tailored to the needs of specific communities, shortages of health professionals in urban areas where minority populations are high, patients' mistrust of the health care system, perceived discrimination, poor communication between the provider and the patient, and lack of cultural sensitivity and cultural competence on the part of the provider and other workers. (p. 14)

Access to services is another area that creates cultural barriers. These barriers include economic, geographic, social, and cultural. The literature on access to services focuses mainly on access to health insurance. The research on health insurance coverage indicates that every major minority group has significantly less access to health care insurance than the Caucasian population (Brown, Ojeda, Wyn, & Levan, 2000). A major

reason for these disparities in access is that minorities have higher rates of poverty (American Institutes for Research, 2002).

Attitudes and Behavior

Attitudes influence one's beliefs as well as behavior (Liska, 1984). Attitude is a predisposition or a tendency to respond positively or negatively toward a certain idea, concept, person, or situation (Greenwald, 1989). Attitude influences an individual's choice of action and responses to challenges, incentives, and rewards. According to Liska (1984), there are three components of attitudes: affective (emotions or feelings), cognitive (belief or opinions), and conative (inclination for action). Attitudes can be explicit and implicit. Explicit attitudes are those that one is consciously aware of and that clearly influence one's behaviors and beliefs. Implicit attitudes are unconscious, but still have an effect on one's beliefs and behaviors.

Attitudes form as a result of one's experience (Zimbardo & Leippe, 1991). They may emerge due to direct personal experience, or they may result from observation (Greenwald, 1989). According to Zimbardo and Leippe (1991), social roles and social norms can have a strong influence on attitudes. Social roles relate to how people are expected to behave in a particular role or context. Zimbardo and Leippe informed that social norms involve society's rules for what behaviors are considered appropriate. Attitudes can be learned in a variety of ways (Ajzen, 1989). Attitudes are also learned by observing the people around them (Ajzen, 1989).

It appears that fostering attitudes that motivate one to learn about others is the place to begin developing intercultural competence. Mendenhall (2001) suggested that inquisitiveness is the critical factor in developing intercultural effectiveness. Gregersen,

Morrison, and Black (1998) noted "that global leaders stated that inquisitiveness is the fuel for increasing their global savvy, enhancing their ability to understand people and maintain integrity, and augmenting their capacity for dealing with uncertainty and managing tension" (p. 23). In order for curiosity to thrive, one must suspend their assumptions and judgments, leaving their minds open to multiple perspectives (Bennett, 2009). According to Bennett (2009), curiosity, suspension of judgment, cognitive flexibility, cultural humility, and tolerance of ambiguity are critical core components of intercultural competence.

There is an emerging consensus about what constitutes intercultural competence, which is most often viewed as "a set of cognitive, affective, and behavioral skills and characteristics that support effective and appropriate interaction in a variety of cultural contexts" (Bennett, 2009, p. 97). There are lengthy lists that describe precisely which knowledge, skills, and attitudes constitute intercultural competence. Deardorff (2006) identified a list of competencies that are a part of intercultural effectiveness. Deardorff further implied that "one begins with attitude and moves toward acquiring the skills and knowledge that produce both internal and external results" (p. 67).

Intercultural Competence

In today's society, there is a multitude of cultures that are intermingling in both the personal and professional realms, and it is important for individuals to understand one's intercultural effectiveness and competency. Intercultural competence is the ability to communicate effectively with others of different cultures. A leader that is interculturally competent has the ability to understand and interact with others from different cultures and/or backgrounds. According to Pusch (2009), an interculturally

competent leader has some of the following characteristics: cultural empathy, accommodations of cross-cultural situations, communication effectiveness, and language competence. Some leaders are born in their own culture; however, according to Pusch (2009), leaders with the ability to be effective in intercultural situations are developed. Pusch posited that a leader must begin with having an open attitude and move toward acquiring the skills and knowledge that produce both internal and external outcomes of increased intercultural competency. Intercultural competency is not a fixed psychological state but a developmental continuum, as reported by Kim (2001). Cultural knowledge does not equal intercultural competence (Bennett, 2009). The gap between knowledge and competence may be a result of one being unaware of their own culture and therefore not fully capable of assessing the cultural position of others (Bennet, 2009).

Intercultural competence is generally viewed as a skillset that enables someone to function effectively in a cross-cultural setting (Ashwill & Oanh, 2009). Intercultural competence can be defined as the overall capacity of an individual to enact behaviors and activities that foster cooperative relationships with culturally or ethnically dissimilar others (Kim, 2009). Intercultural competence is a multifaceted state of being, which includes knowing that there are cultural differences, what they are, and how to apply that knowledge (Bikson, Trevereton, Moini, & Lindstrom, 2003). There is an emerging consensus about what constitutes intercultural competence, which is most often viewed as a set of cognitive, affective, and behavioral skills and characteristics that support effective and appropriate interaction in a variety of cultural contexts (Bennett, 2009, p. 97).

By default, culture forms the mind to be ethnocentric, to think of our own culture as central in the universe and as providing the natural way of doing things (Pusch, 2009). Bennett proposed the developmental model of intercultural sensitivity (DMIS) based on observations of intercultural adaptation (Hammer et al., 2003). The DMIS provides a way of identifying the personal change in individuals as they move from being ethnocentric to ethnorelative (Bennett, 1993). The underlying assumption of the model is that as one's experience of cultural difference becomes more complex and sophisticated, one's potential competence in intercultural relations increases (Hammer et al., 2003). The DMIS has three states of ethnocentrism (denial of difference, defense against difference, and minimization of difference) and three states of ethnorelativism (acceptance of difference, adaptation to difference, and integration of difference). Bennett (1993) defined ethnocentrism as "the assumption that the worldview of one's own culture is central to reality" (p. 30). Ethnocentrism is a root cause for division amongst members of different ethnicities, races, and religious groups. Ethnocentric individuals believe that they are better than other individuals for reasons based solely on their heritage. An ethnocentric view is the cause of prejudice and racism; whereas ethnorelativism is the concept of being open-minded or non-judgmental in intercultural situations.

The first state of ethnocentrism is denial. Denial of cultural difference is the state in which one's own culture is experienced as the only real one (Hammer et al., 2003). Individuals with a denial worldview are generally disinterested in cultural difference when it is brought to their attention. When in the denial state, other cultures tend to be dehumanized; this might be a result of ignorance of, isolation from, or voluntary or involuntary separation from different cultures (Pusch, 2009). Defense against difference,

the second state of ethnocentrism, is when there is a recognition of difference and it is seen as threatening. Individuals in the defense state view their culture as superior and other cultures as inferior (Hammer et al., 2003). The third state is minimization of cultural difference. This worldview understands the similarity of people's biological nature and that individuals are all the same and can understand each other once the cultural differences are accepted (Hammer et al., 2003; Pusch, 2009). As individuals begin to consciously gain interest in learning about other cultures, they will begin to move toward ethnorelativism.

Acceptance of cultural difference is the first state in the ethnorelativism orientation. In this state, cultural differences are recognized, appreciated, and respected (Pusch, 2009). The conscious interest of learning effective ways of interacting across culture continues to move an individual to adaptation. The adaptation worldview allows an individual to skillfully relate and communicate with people from different cultures (Pusch, 2009). Hammer et al. (2003) noted that individuals in the adaptation stage can engage in empathy, which includes affect and behavior. The final state of ethnorelativism is integration of cultural difference. Integration is when an individual is able to identify with more than one culture and has mastered skills of bridging between their own culture and the culture of others (Hammer et al., 2003; Pusch, 2009). The IDI (Hammer et al., 2003) is an instrument that can measure in which state of intercultural sensitivity one might fall.

Behavioral Health Leadership

Leadership is a field of study that has demanded the attention of researchers worldwide (Rosenberg, 2010). From the review of the literature, leadership has been

studied from a quantitative and qualitative context and has focused on small groups, specialty groups, and large organizations (Yeo, 2006). Leadership has been defined in many different ways. Many of the leadership approaches involve some aspect of taking initiative, inspiring commitment, mobilizing action, promoting legitimacy, or exerting influence (Guthey & Jackson, 2011). The Global Leadership and Organizational Behaviour Effectiveness (GLOBE) project defined leadership as "the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of the organizations of which they are members" (House et al., 1999, p. 13).

Leadership and Behavioral Health Leaders

In a health care organization, good leadership is critical to the organization's success (Schyve, 2009). The quality and safety of health care organizations depend on many factors. Some of those factors include: a culture that fosters safety and quality; the planning and provision of services that meet the needs of patients; the availability of resources—human, financial, physical, and information—for providing care; a sufficient number of competent staff and other care providers; and ongoing evaluation and improvement of performance (Schyve, 2009). According to Schyve (2009), only leaders of a health care organization have the resources, influence, and control to provide for these factors. Additionally, clinicians must have leadership expertise in all settings to implement change based upon good clinical decision-making and a patient-centered approach to care (Oliver, 2006).

The addiction treatment profession is a relatively new profession. According to Flood (2013) there are few leaders in the addiction profession that have worked in a variety of positions and levels over the years. As a result, it can be difficult for leadership

to understand everything that goes into a day of treatment, and it can be difficult for people who work in clinical areas to understand the administrative needs (Flood, 2013). According to Durham (2006), there are three leadership qualities necessary to be effective as a leader in the addictions field: humility, service, and creating community. Durham informed that humility leads to integrity, courage, empowerment, and acceptance. The quality of service in a leader implies doing for others, which entails listening, supporting, promoting diversity, and being truly committed to others' success (Durham, 2006). The third leadership quality is creating community. Durham (2006) reported, good leaders create community when they promote equality and freedom among those they lead. Those who experience a sense of community in the workplace attest to feelings of safety, being cared for, respect, high mutual trust, and altruism (Durham, 2006).

Preparation to become a leader is not a one-time event. Therefore, training programs, workshops, and continuing education are needed to effectively and ethically prepare leaders in the field of addiction (Durham, 2006). Addiction treatment is not a field that has an identified school or preferred institute of higher learning. Organizations have begun to create internal training programs that allow for more upward mobility amongst employees, and the National Association of Addiction Treatment Providers (NAATP) has begun to consider reinstituting its American College of Addiction Treatment Administrators (ACATA) credentialing program, which focuses specifically on learning administrative work in the field of addiction (Flood, 2013).

Organizational Leadership

Leadership in an organization is determined by the organization's legitimating principles and cultural norms and by the social structure within which it occurs (Bass & Bass, 2001). Those individuals that represent the organization's philosophy are selected for leadership roles. Bass and Bass (2008) informed that a leader's effectiveness is evaluated by the larger organizational group. Organizational leadership is responsible for leading through the mission, vision, strategy, goals, plans, and tasks (Zaccaro & Klimoski, 2001). The philosophy of the organization is then passed down to lower levels of management, which are then passed down to the members of the organization.

Leaders need to be aware of whether their organization truly reflects the community it serves. Does the organization's workforce mirror the changing faces in the community? Does it deliver the highest quality, most culturally sensitive care to patients? Research and writing on intercultural competence and behavioral health leadership is very limited. Most of the research focuses on health care service delivery and intercultural competence (Anand & Lahiri, 2009). There are many reasons why it is important for behavioral health leaders to develop intercultural competence (Anand & Lahiri, 2009). Patient satisfaction, community support, patients' willingness to seek treatment, and patient outcomes are some examples as to why culturally appropriate care is necessary in health care organizations. These leaders govern those that deliver services to an increasingly diverse U.S. population (American Institutes for Research, 2002).

Executives have expressed concern over the number of competing priorities and the difficulty of adding change initiatives that are neither reimbursable nor mandated (Health Research & Educational Trust, 2011). Those leaders that create a culturally

competent environment for care may well realize increasing market share, create an inclusive work environment that helps recruitment in a highly competitive labor market, and avoid costly state and federal mandates (Health Research & Educational Trust, 2011).

Organizational Culture

Culture and climate as organizational descriptors are on the rise (Schein, 2000). Research has used the terms *culture* and *climate* interchangeably. Schein (2000) defined climate "as a cultural artifact resulting from espoused values and shared tacit assumptions" (p. xxiv). Culture as defined by Schein (2000), is

> a pattern of shared basic assumptions that the group learned as it solved its problems that has worked well enough to be considered valid and is passed on to new members as the correct way to perceive, think, and feel in relation to those problems. (p. xxv)

Organizational culture theory emerges from a combination of organizational psychology, social psychology, and social anthropology (Scott et al., 2003). The term *organizational culture* first appeared in literature in 1979 by Pettigrew. There are varying definitions for organizational culture as denoted by Scott et al. (2003) "as a wide range of social phenomena, including an organization's customary dress, language, behavior, beliefs, values, assumptions, symbols of status and authority, myths, and ceremonies and rituals, all of which assist in defining an organization's character and norms" (p. 925).

As defined by Schein (2010), culture is a "concept that is constantly re-enacted and created by our interactions with others and shaped by our own behavior" (p. 3). In addition, culture can be thought of as the foundation of the social order that we live in

and of the rules we abide by (Schien, 2010). Deal and Kennedy (1984) supported that members learn shared patterns of behavior that are transmitted from one generation to the next. Weick (2001) argued that the primary function of organizations is sense making, where members develop a set of mutually acceptable ideas and beliefs about what is real, what is important, and how to respond. Thus, cultures exist in organizations as well. Organizational cultures differ in strength and stability from highly structured ones to relatively fluid ones (Schein, 2010). The group culture of an organization is ultimately created, embedded, evolved, and ultimately manipulated by leaders. When the culture becomes dysfunctional within an organization is it the role of the leader to implement culture change programs (Schein, 2010). Organizational culture refers to the shared norms and expectations that govern the way people approach their work and interact with each other (Cooke & Lafferty, 2002).

Jung's psychological classification provides a useful fourfold view of widely divergent organizational cultures (Bass & Bass, 2008). These four cultures are: bureaucracies, with sense-thinking managers; matrix organizations, with intuitive thinking managers; organic organizations, with intuitive-feeling leaders; and familiar cultures, with sensing-feeling members (Bass & Bass, 2008). Schein (2010) presented seven dimensions in which organizational culture differs: (a) relation to its environment, (b) nature of human activity, (c) determination of truth and reality, (d) nature of time, (e) human nature, (f) human relationships, and (g) homogeneity or diversity.

Instrumentation

There are numerous instruments that exist that can be used to measure various facets of organizational culture. There is a large amount of research on this topic. Culture

measurement tools adopt either a typological approach, in which the assessment results in one or more types of organizational culture—or a dimensional approach, which describes a culture by its position on a number of continuous variables (Scott et al., 2003). Instruments vary from 13 to 135 items, which will affect the length of time required to complete the questionnaire. The scope of the instrument also varies; some focus on one or more dimensions of organizational culture, others assess a more comprehensive range of dimensions. According to Scott et al. (2003), all of the instruments available to measure organizational culture examine employee perceptions and opinions about their working environment. Ashkanasy et al. (2000) found a lack of agreement about what to measure and concluded that only two instruments, the OCI and the Organizational Culture Profile (O'Reilly et al., 1991) had been evaluated from reliability, consensual, criterion, and construct validity. Neither of these instruments were developed for use in health or mental health settings.

One of the most widely discussed and used instruments is the OCI, which was develop by Cooke and Lafferty in 1983. According to Cooke and Szumal (2000), "the OCI assesses organizational culture per se but not to the degree to which the organization's culture supports diversity and intercultural relations" (p. 148). According to Cooke and Lafferty, the OCI has been used in various ways, including directing, evaluating, and monitoring organizational change; identifying and transferring cultures of high-performing units studying and enhancing system reliability and safety; promoting collaborative relations within and across units; and testing hypotheses on the relationships among culture, outcome, and antecedent variables.

Research demonstrates a link between organizational culture and performance dating back to the Hawthorne studies in the 1920s (Agbenyiga, 2011). Studies have also illustrated the degree to which culture impacts a worker's ability to perform and succeed at the expected organizational level (Glisson, 2007; Glisson & Green, 2006).

Business and health care are two different worlds (Waldman, Smith, & Hood, 2003), and elements of culture salient in one may not apply in the same ways to the other; therefore, industry-specific instruments are necessary to address their unique features (Schiff, 2009). Mental health work is value-laden and value-driven (Hazenfeld, 1992) and models of organizational culture that emerge from corporate dynamics of competition and production fail to capture the subtle nuances of a value-based organizational dynamic (Schiff, 2009). Hazenfeld (1992) informed that mental health organizations' people operate in an environment that specializes in identifying values, attitudes, and beliefs as central to the therapeutic process. Therefore, a relevant and salient measure of organizational culture in mental health settings should ideally include these dynamics.

Scott et al. (2003) concluded that all of the instruments have limitations in terms of their scope, ease of use, or scientific properties, and that the choice of instrument should be determined by how organizational culture is conceptualized by the research team, the purpose of the investigation, intended use of the results, and availability of resources.

Conclusion

This chapter identified the most recent literature regarding substance abuse treatment facilities as well as explaining substance abuse treatment as an organizational field of study. Next, this chapter examined cultural competence in substance abuse

treatment facilities and how attitudes influence one's behaviors. This chapter continued to elaborate on intercultural competence by reviewing seminal and recent literature. Leadership was then discussed in a behavioral health care context and organizational leadership. Finally, this chapter concluded with a review of organizational culture and discussion regarding instrumentation to measure organizational culture.

Chapter Three: Research Method

This chapter on research methods and design began with a review of the research purposes and research hypotheses. It then discussed a general research method by briefly reviewing the rationale for the selected methods. The researcher addressed the specific research designs and procedures for each stage of the field research. This included a description of the selected method, rationale for the sample selection, as well as ethical considerations. Finally, this chapter discussed the quantitative data analysis procedures that were used to evaluate and interpret the data retrieved from the research.

Problem Statement

The problem that this study examined was whether or not a behavioral health leader's intercultural competence level has a relationship to the organizational culture of substance abuse treatment agencies. The research problem represented a gap in the knowledge base regarding the extent to which behavioral health care leaders' intercultural competence will predict the perceptions of the organizational culture. The purpose of the predictive correlational study was to determine the extent to which the independent variable—behavioral health care leaders' intercultural competence—influenced the dependent variable—perception of the organizational culture. Understanding the influence of the independent variable upon the dependent variable, and the interrelationships among the variables, was expected to provide knowledge for improved training and for a healthier organizational culture.

Statement of Hypotheses

The research hypotheses for this study were:

Hypothesis 1: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' developmental orientation as measured by the IDI.

Hypothesis 2: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' denial as measured by the IDI.

Hypothesis 3: There is a relationship between followers' OCI (constructive, pa passive, and aggressive) and leaders' defensiveness as measured by the IDI.

Hypothesis 4: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' reversal as measured by the IDI.

Hypothesis 5: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' minimization as measured by the IDI.

Hypothesis 6: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' acceptance as measured by the IDI.

Hypothesis 7: There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' adaptation as measured by the IDI.

Rationale and Review of Literature for Proposed Methodology

Assessment Instruments

There are several assessment instruments that have been used in evaluating and developing cultural competence. According to Bird (2008), "these assessment instruments are categorized as: cultural difference assessments, intercultural adaptability assessments, and global leadership competency assessments" (p. 66). Practitioners and scholars have developed a variety of assessment and survey instruments to identify

variations in national cultural values (Bird, 2008). Research has identified more than 100 instruments used to assess and measure cultural competence. The primary focus of this research is effective intercultural competence. Therefore, a detailed review of assessment instruments that measure effective intercultural competence was completed. The IDI was judged to be the most appropriate assessment tool to measure intercultural competence of behavioral health leaders. The OCI was determined to be the most appropriate assessment tool to measure the organizational culture in a behavioral health care setting.

Strengths and Limitations of Assessment Instruments

By using cultural assessments, participants will gain valuable insight into the cultural competencies as individuals interact with people from different cultures. Like any assessments, there are strengths and limitations that affect the overall validity of the assessment. One strength of cultural assessments is flexibility. Based on what the researcher is looking to determine, he or she can select an assessment instrument that measures for the specific area of interest. Kim (2001) explained that there has been "various narrowly conceived studies that have generated varied models that are often contradicting another model, or researchers only mention the variables that pertain to their study, ignoring or excluding other factors" (p. 210). This contradiction and oversight could negatively impact cultural assessments because the advantages to cultural assessments can be to help test competing models of intercultural competence. Van de Vijver and Leung (2009) referred to this as flexibility. This strength can also allow one theorist to modify his or her hypothesis. In addition, these assessments can be utilized to determine if changes in trainings are necessary, as they can be used as pretest and post-test assessments. Another strength of cultural assessments is that there is a wide variety to

select from based on what skillset, attitude, or personality trait one is looking to evaluate; therefore, development plans can be established. According to Bird (2008), most of the assessments that are commercially available are highly valid and reliable.

A limitation of assessment instruments is the lack of predictive outcomes. Van de Vijver and Leung (2009) stated, "studies that have tried to predict intercultural adjustments on the basis of global personality traits have not had ample documented success" (p. 407); therefore, more in-depth studies would need to examine this area. Conversely, it may be positive that cultural competencies are not as predictive to the possible future success; therefore, the individuals may continue to grow and develop through education and experiences.

Instruments are limited by the construction of the assessment. As Pusch (2009) explained, "most research about leadership is rooted in a single culture, and much of it is tied to advice on business practices in various countries as contrasted with cultures in the West" (p. 66). Smith, Bond, and Kagitcibasi (2006) referred to this idea as "culture-fair" measures (p. 16). Having prior knowledge and understanding into culture would affect not only how people interact, but also how individuals would perform on an assessment. Displaying ethnocentrism within the construct of the assessment or within the interactions between people will negatively influence the assessment. Bass and Bass (2008) explained, "Most cross-cultural sampling is a matter of convenience and opportunity and research is ethnocentrically biased" (p. 982), so one sampling may not accurately reflect all populations.

Additionally, another limitation includes limited randomization. This type of technique in selection could affect the results because the participants may not have

cultural variability. Van de Vijver and Leung (2009) posited that more work on the conceptualization of intercultural competence is needed to advance the field. Even thought there are different models (black box, hierarchical, and moderation), there are limitations within the conceptual value because different aspects within the model have not been thoroughly evaluated (Van de Vijver & Leung, 2009). Van de Vijver and Leung (2009) explained that there is almost no empirical work where the models have been compared and tested, which affects the validity of the test.

Challenges with intercultural competence assessments are related to those in multicultural testing (Van de Vijver & Leung, 2009). These limitations are referred to as construct bias, method bias, and item bias. Van de Vijver and Leung (2009) define construct bias as "the inadequacy to properly cover the construct in the sample or target culture" (p. 409). An example of construct bias is when the construct attempting to be measured by the test displays significant differences between the original culture for which it was developed and the new culture where it is going to be utilized. The second limitation is method bias, which entails a wide variety of sources. This bias can result from different education levels of those taking the assessment, language can affect the way one interprets the question, and different cultures have different response styles. The last source of bias as reported by Van de Vijver and Leung is item bias. They refer to this type of bias as the differences in the extent to which an item is indicative of its underlying construct. An example of this bias is when one culture scoring lower in one area does not guarantee that a particular culture is lower than another (Van de Vijver & Leung, 2009).

Population and Sample

The population for this research project was leaders in substance abuse treatment facilities located within Indianapolis, Indiana. The targeted population for the study included leaders in administrative positions, executive positions, or director positions. This study was based upon a single-stage random sampling process. There are approximately 84 substance abuse treatment facilities in Indiana, 15 of which are in the Indianapolis area (USDHHS, 2011). These facilities vary in regards to organizational size and structure, ranging from one leader with seven followers, to 17 leaders with anywhere from one to 25 followers. These organizations also vary in demographics of personnel. As these demographics are discussed, it is important to note that this study is not about ethnicity. A minimum of one leader from each organization was sampled. There was no maximum number of leaders that were allowed to participate in the study per organization. In order for a leader to participate in this study they needed to have been in a leadership role for a minimum of two years in their current organization. The leader needed to have a minimum of five followers, with a minimum of three followers who participated in the study. In order for a follower to participate in the study they needed to have been under the direct supervision of their leader for a minimum of one year.

Data Collection and Instrumentation

The Intercultural Development Inventory

The Intercultural Development Inventory (IDI) was developed by Hammer and Bennett (1993) with the purpose of measuring an individual's worldview regarding cultural difference, which is also construed as one's capacity for intercultural competence. Hammer and Bennett developed the IDI based on Bennett's theory of the

developmental model of intercultural sensitivity (DMIS). The DMIS theory identified six stages of intercultural development that are categorized into two dimensions: ethnocentric and ethnorelative. The ethnocentric dimension includes the following stages: development, denial, defense, and minimization. The ethnorelative dimensions are acceptance, adaptation, and integration. According to Bennett (1993), the ethnocentric stages are viewed as different ways of avoiding cultural differences.

The IDI was based on the DMIS and was structured with five scales and ten clusters. The IDI consists of fifty questions, four open-ended questions, and limited demographic information. The purpose of the open-ended questions is to further capture the experience regarding cultural differences of the respondent (Hammer et al., 2003). Once the IDI has been completed, a graphic profile of the respondents' overall position on the intercultural development continuum is provided. Hammer referenced that the IDI is the premier cross-culturally valid and reliable with α .82 - .83 measure of intercultural competence. In addition, the IDI has direct application to global leadership and has been widely utilized with over 1,200 qualified administrators ranging from 30 countries and 12 languages.

IDI and Other Studies

The IDI has been used in several research studies. Leach, Aten, Boyer, Strain, and Bradshaw (2010) noted that the IDI is particularly useful in cultural awareness and cultural competence training. The IDI measure is theoretically based and designed to provide information about an individual's cultural competence by providing an indication of one's sensitivity to or awareness of cultural differences (Leach et al., 2010). Leach et al. (2010) informed that most professionals or therapists have probably been involved

with a multicultural course or engaged in continuing education credits that include cultural components geared toward knowledge. Of particular concern is the lack of workshops designed to evaluate the self, thus Leach et al. recommend facilitating self-awareness and knowledge by incorporating the use of the IDI.

Munoz et al. (2009) incorporated the IDI in a study to develop cultural competence for nursing and the human service professionals. This study concluded that

> it is imperative for professionals in the human services field to be afforded regular opportunities in their professional curricula to increase personal awareness, gain knowledge of intercultural differences, practice intercultural skills, and develop the overall ability to provide culturally competent care. (Munoz et al., 2009, p. 501)

Additionally, Altshuler, Sussman, and Kachur (2003) utilized the IDI to assess intercultural sensitivity among physicians before and after an intercultural training intervention. They concluded that the training increased intercultural sensitivity. Furthermore, this study found the IDI effective in measuring attitudinal changes and behavior intentions.

Organizational Culture Inventory

The OCI was developed by Drs. Robert A. Cooke and J. Clayton Lafferty to measure organizational culture. This tool is the most widely used instrument to measure organizational culture (Agbenyia, 2011). This instrument provides organizations with a visual profile of their operating culture (current culture) in terms of the behaviors that members believe are required to fit in and meet expectations. This instrument has been evaluated for reliability, consensual, criterion, and constructs validity (Ashkanasy et al.,

2000). Cooke and Szumal reported (2000) the OCI has internal consistency of α .67 - .92. According to Agbenyia (2011), the OCI has been used effectively with sample sizes as small as 15 to as large as 5,000. The OCI measures four constructive behavioral norms: problem solving and decision-making, teamwork, productivity, and long-term effectiveness. The OCI consists of three self-reported instruments: the inventory with 120 behavioral norms, a 5-point scale culture-performance survey with 12 questions, and a socio-demographic survey. It also measures eight defensive behavioral norms that detract from effective performance. The survey takes approximately 20 minutes to complete and can be self-scored or scored online by the developers.

OCI and Other Studies

Ray and Sanders (2008) have produced a study using the OCI to measure the culture of the Advocate Health Partners (AHP) in order to improve organizational performance. This study found that the OCI assisted in determining a plan to create an organizational culture change. Ray and Sanders reported that leaders drive positive organizational change by changing their individual behaviors and thus shifting the culture of the entire organization; this finding was derived from the use of the OCI survey. Whitfield and Landeros (2006) also incorporated the OCI in a study to examine the organizational culture. They concluded that the results indicate achievement and affiliative culture styles are important to the effectiveness in diversity of organizations. The results of the OCI indicated that in businesses that were characterized as defensive or passive-defensive cultures, minority sourcing was lower (Whitfield & Landeros, 2006). Conversely, the businesses with constructive cultures for diversity had higher minority representation as reported by Whitfield and Landeros (2006).

IDI and OCI Studies

After examining the current literature there does not appear to be any studies that exist that incorporate or look at the IDI and the OCI together. In addition, there are no studies that exist that incorporate or look at any intercultural assessment tool and an organizational assessment tool. Dr. Hammer confirmed, that to his knowledge, the IDI has not been used in a study along with an organizational assessment tool (personal communication, January 10, 2014). However, there are studies that use each of the assessment tools separately.

Data Analysis

Data Collection

A letter inviting leaders to participate in the study was sent to all 15 substance abuse facilities in Indianapolis, Indiana, via email to the head of the organization. The letter provided a detailed summary of the requirements for participation. Once the organization agreed to participate in the study, the following steps were followed:

- The leaders as defined for this study were emailed a questionnaire that asked their race/ethnicity, gender, length of time in their role, their professional title, identification, if they have completed any prior cultural competency trainings, and instructions on how to complete the IDI survey.
- The leader was also required to forward email addresses of their followers to the researchers.
- The followers of each leader were emailed a questionnaire that asked for their race/ethnicity, length of time in their role, their professional title, length of time

reporting to their current leader, and instructions on how to complete the OCI survey.

- The survey remained open for 14 days. After seven days, a follow-up email was sent to remind all of the participants of the completion date.

All data retained during the research process remained confidential. In order to protect the participants and their organizations, the researcher assigned a number to each facility, and the data were referred to in the study as Facility 1, Facility 2, etc. All of the leaders were assigned a letter and their followers were assigned the leaders' letter along with a number to designate follower A1, etc.

Data Analysis and Interpretation

The survey and assessment data was entered into the Statistical Package for the Social Sciences (SPSS) for data analysis. In order to provide a description of the sample from which the data was collected, descriptive information on race/ethnicity and role in organization was described, as well as the mean, modes, range, and standard deviations for the IDI and OCI scores. Nonparametric statistical procedures were used to test the hypotheses. The Pearson product-moment correlation was used to compare the IDI and OCI scores within the same facilities. To determine any differences in the IDI and OCI scores according to age, gender, race/ethnicity, and role in organization—chi-square, t-tests, and analysis of variance were used to examine for any significant differences among the scores. A test for normality was run. If the data were normally distributed, this writer would run parametric statistics. If the data were not normally distributed, then this author would run non-parametric statistics.

Conclusion

In order to begin to close the gap in the knowledge base regarding the extent to which behavioral health care leaders' intercultural competence will predict the perceptions of the organizational culture, this study analyzed the data collected from the IDI and the OCI. The data was then analyzed using SPSS for statistical data. Indiana Wesleyan University ethical research guidelines were followed throughout. Chapters 4 and 5 reported on the specifics of the research methods and on their analyzed results.

Chapter Four: Results

Introduction

The purpose of this study was to examine whether or not a behavioral health leader's intercultural competence level has a relationship to the organizational culture of substance abuse treatment agencies with ethnically diverse clientele. This chapter reviewed the demographic results of the participants. In addition, this chapter reviewed the data analysis procedure. Finally, this chapter presented the analyses of the research hypotheses.

A letter requesting to participate in this study was sent to the executive director of 16 substance abuse treatment facilities as identified by U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Of those 16 facilities, seven agencies agreed to participate in this study. Of those seven agencies, 18 leaders completed the Intercultural Development Inventory. There were nine male leaders and nine female leaders. There was one leader between the ages of 20–29, eight leaders between the ages of 30–39, four leaders between the ages of 40–49, and five leaders between the ages of 50–59. Four of the leaders identified themselves as African American (22%), and 14 (77.8%) of the leaders identified themselves as Caucasian. Four of the leaders reported working in middle management, 10 reported working in senior management, two leaders reported working at the director level, and two leaders reported they are the owner/CEO. Four of the leaders reported having a bachelor's degree and 14 reported having a graduate degree. Of the 18 leaders, 17 reported having prior cultural

diversity training, and one leader denied any prior cultural diversity training. The overall results of the IDI are displayed in Figure 1.

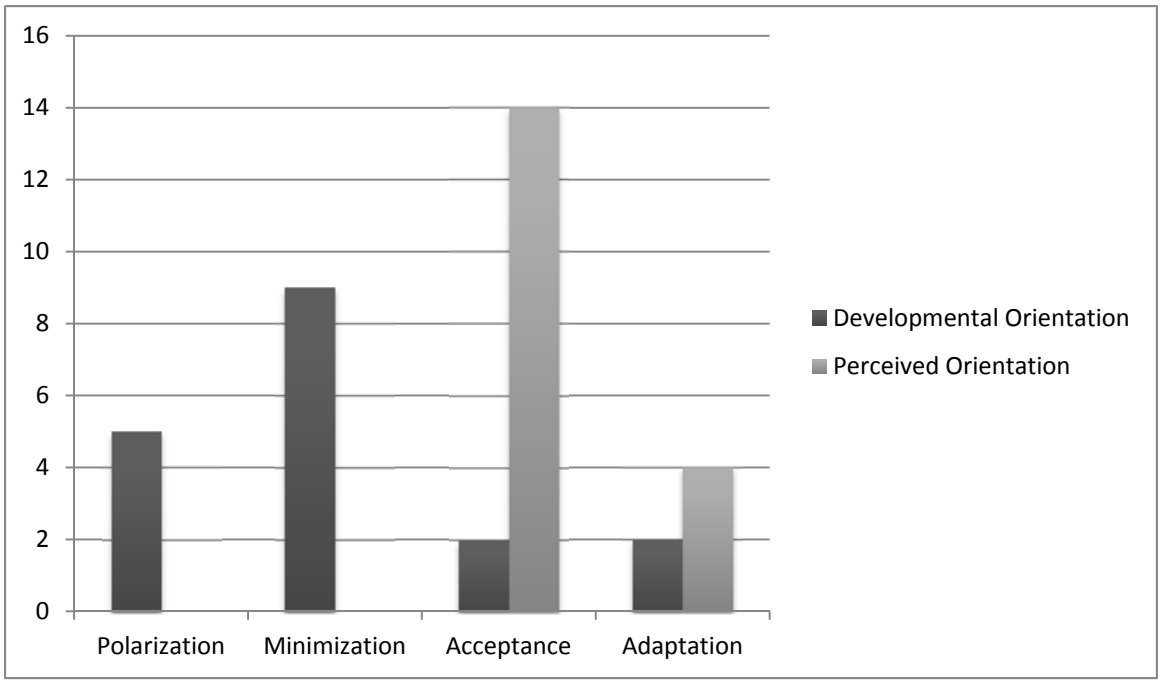

Figure 1. Leaders' overall development and perceived scores.

According to the results of the IDI, most of the participants perceived that they understand and appropriately adapt to cultural differences within acceptance (14) and adaptation (4). However, the majority of the participants are actually in minimization (9) followed by polarization (5) followed by acceptance (2) and adaptation (2).

Each leader presented a list of their followers' email addresses. These followers received an email invitation to participate in this study. A total of 54 followers participated, with a minimum of three followers per leader. Of the 54 followers, there were 23 (42.6%) males and 31 (57.4%) female participants. In addition, 77.8% of the followers were Caucasian and 22.2% were of minority background. Figures 2 and 3 display the breakdown of age and ethnic background of the participants.

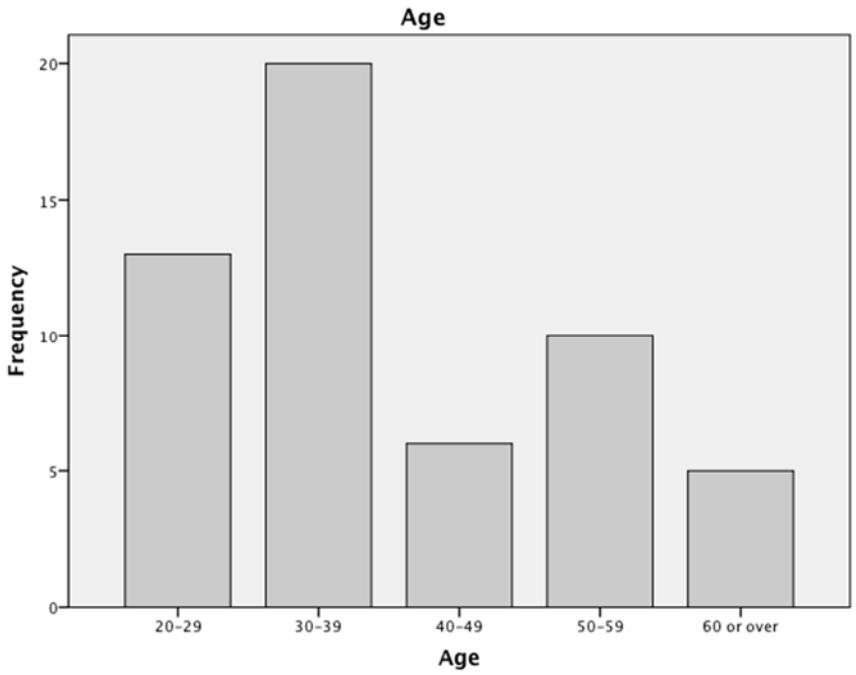

Figure 2. Age demographics of the followers.

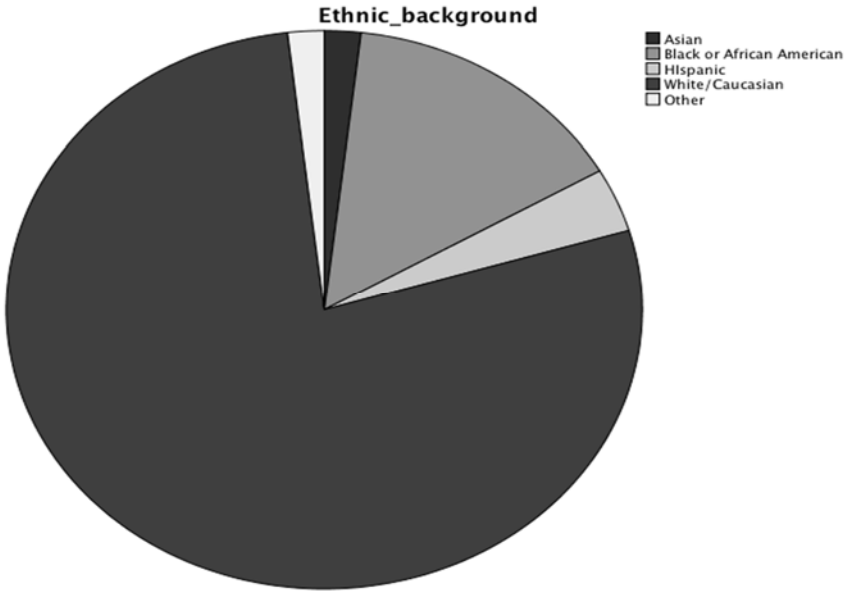

Figure 3. Ethnic background of the followers.

There are 14 followers that reported 2–4 years of service at their current organization, 15 reported 4–6 years, 14 reported 6–10 years, 7 reported 10–15 years, and 4 reported more than 15 years of service at their current organization.

According to the results of the OCI, 63% of the followers perceive that their employers require them to think and/or behave differently than they would otherwise. The mean of each construct of the OCI is displayed in Figure 4. Based on the results of the OCI, the followers perceive their organizations as Constructive overall, followed by Passive/Defensive as they rated Dependent, Perfectionistic, Conventional, and Approval as the second highest domain.

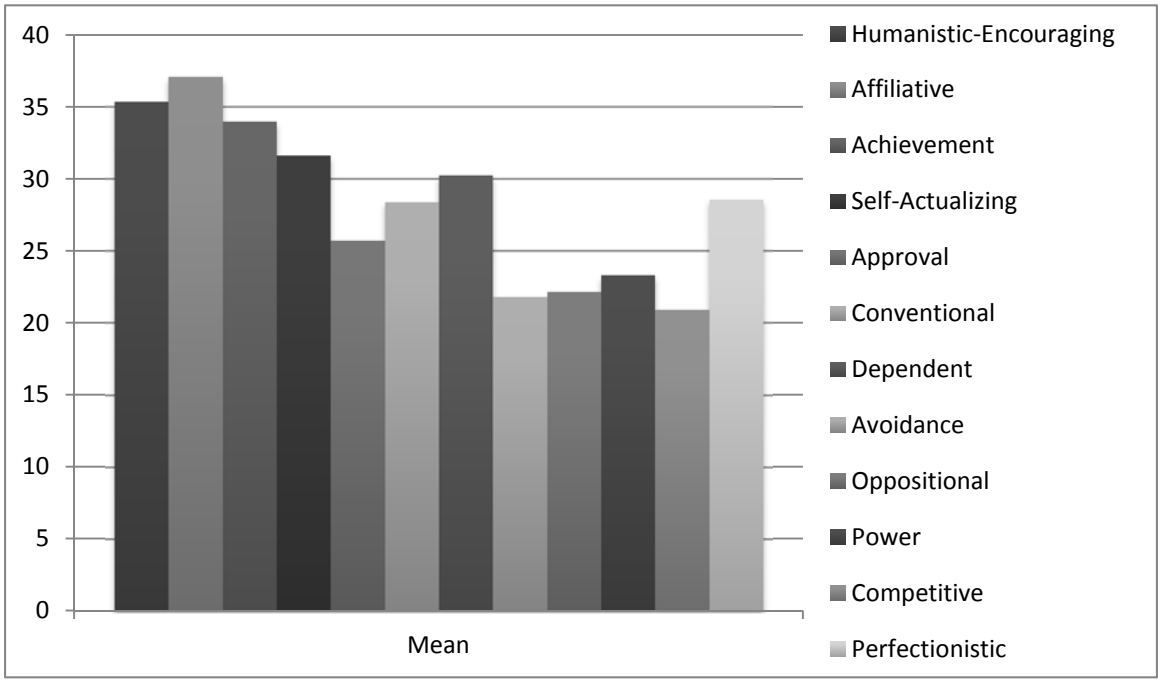

Figure 4. Mean OCI scores.

Data Analysis Procedure

Inferential statistics were used to draw conclusions from the sample tested. The SPSS was used to code and tabulate scores collected from the survey and provide summarized values where applicable, including the mean, central tendency, variance, and

standard deviation. Multiple regression analyses were used to evaluate seven research hypotheses.

Table 1

Summary of Variables and Statistical Tests Used to Evaluate Research Hypotheses 1–7

Hypothesis	Criterion Variable	Predictor Variable	Statistical Test
1	Overall Developmental Orientation	OCI Factors	Multiple Regression
2	IDI Denial	OCI Factors	Multiple Regression
3	IDI Defensive	OCI Factors	Multiple Regression
4	IDI Reversal	OCI Factors	Multiple Regression
5	IDI Minimization	OCI Factors	Multiple Regression
6	IDI Acceptance	OCI Factors	Multiple Regression
7	IDI Adaptation	OCI Factors	Multiple Regression

Note. OCI factors = constructive, passive, and aggressive

Prior to analyzing the seven hypotheses, data cleaning and data screening were undertaken to ensure the variables of interest met appropriate statistical assumptions. Thus, the following analyses were assessed using an analytic strategy in that the variables were first evaluated for univariate and multivariate outliers, normality, linearity, homoscedasticity, and multicollinearity. Subsequently, multiple regression analyses were run to determine if any significant relationships existed between variables of interest.

Analyses of Research Hypotheses 1–7

Research Hypotheses 1-7 were evaluated using multiple regression analyses to determine if any significant relationships existed between followers' organizational culture and leaders' developmental orientation. The criterion variables for research Hypotheses 1–7 were participants' scores on six developmental orientation factors and overall developmental orientation scores as measured by 50 items on the IDI. Specifically, the criterion variable for Hypothesis 1 was participants' overall developmental orientation scores (50 items); the criterion variable for Hypothesis 2 was

leaders' denial scores (7 items); the criterion variable for Hypothesis 3 was leaders' defensive scores (6 items); the criterion variable for Hypothesis 4 was leaders' reversal scores (9 items); the criterion variable for Hypothesis 5 was leaders' minimization scores (9 items); the criterion variable for Hypothesis 6 was leaders' acceptance scores (5 items); and the criterion variable for Hypothesis 7 was leaders' adaptation scores (9 items). Response parameters were measured on a 5-point Likert scale where 1= disagree, 2= disagree somewhat more than agree, 3= disagree some and agree some, 4= agree somewhat more than disagree, and 5= agree. Composite scores were calculated for each of the variables by averaging case scores across the constructs' items and were used as the criterion variables for Hypotheses 1–7. That is, low scores indicate monocultural mindset and high scores indicated intercultural mindset.

The predictor variables for Hypotheses 1–7 were followers' scores on three organizational culture factors. The three organizational culture factors were constructive, passive, and aggressive, and were measured by 120 items on the OCI. Followers' constructive scores were measured by 40 items, passive scores were measured by 40 items, and aggressive scores were measured by 40 items. Response parameters were measured on a 5-point Likert scale where 1= not at all, 2= to a slight extent, 3= to a moderate extent, 4= to a great extent, and 5= to a very great extent. Composite scores were calculated for each of the 12 constructs, and the higher the score, the more constructive the organization.

Data were collected from leaders and three of their followers. For the multiple regression analyses, each of the leader's three followers' organizational culture scores

were combined (averaged) into one score. The combined scores were used as the predictor variables for Hypotheses 1–7.

Data Cleaning

Before the research questions were evaluated, the data were screened for missing data, univariate outliers, and multivariate outliers. Missing data were investigated using frequency counts, and no cases existed. The data were screened for univariate outliers by transforming raw scores to z-scores and comparing z-scores to a critical value of +/- 3.29, *sig.* < .001 (Tabachnick & Fidell, 2007). Z-scores that exceed this critical value are more than three standard deviations away from the mean and thus represent outliers. The distributions were evaluated and no cases with univariate outliers were found.

Multivariate outliers were evaluated using Mahalanobis distance. Mahalanobis distances were computed for each variable and these scores were compared to a critical value from the chi square distribution table. Mahalanobis distance for three predictor variables indicates a critical value of 16.27 and no cases within the distributions were found to exceed this value. Thus, 18 responses from participants were received and 18 were evaluated by Hypotheses 1–7 (n = 18). Descriptive statistics of participants' scores for the criterion and predictor variables are displayed in Table 2.

Table 2

Descriptive Statistics of the Criterion and Predictor Variables Used in Hypotheses 1–7

Variable	Min	Max	Mean	Std. Deviation	Skewness	Kurtosis
Developmental Orientation						
Denial	2.430	5.000	4.325	0.711	-1.237	1.566
Defense	3.170	5.000	4.130	0.704	0.179	-1.758
Reversal	2.890	5.000	4.117	0.655	-0.397	-0.779
Minimization	1.560	4.110	2.833	0.704	0.307	-0.244
Acceptance	2.600	5.000	3.644	0.728	0.483	-0.422
Adaptation	1.670	3.670	2.975	0.516	-0.759	0.837
Overall	72.560	134.630	99.734	18.365	0.308	-0.528
Organizational Culture						
Constructive	25.420	44.420	34.500	4.260	-0.034	1.398
Passive	19.920	32.500	26.528	3.111	-0.373	0.597
Aggressive	16.500	29.580	23.722	3.319	-0.052	0.025

Note. $n = 18$

Test of Normality

Before Hypotheses 1–7 were analyzed, basic parametric assumptions were assessed. That is, for the criterion (developmental orientation, denial, defense, reversal, minimization, acceptance, and adaptation) and predictor variables (constructive, passive, and aggressive), assumptions of normality, linearity, homoscedasticity, and multicollinearity were tested. Linearity and homoscedasticity were evaluated using scatterplots and no violations were observed. To test if the distributions were significantly skewed, the skew coefficients were divided by the skew standard error, resulting in a z-skew coefficient. This technique was recommended by Tabachnick and Fidell (2007). Specifically, z-skew coefficients exceeding the critical range between -3.29 and +3.29 ($sig. < .001$) may indicate non-normality. Thus, based on the evaluation of the z-skew coefficients, no distributions exceeded the critical range. Kurtosis was also evaluated using the same method and no distributions were found to be significantly kurtotic. Since the criterion and predictor variables were not found to be significantly

skewed or kurtotic, the variables were assumed to be normally distributed. Displayed in Table 3 are skewness and kurtosis statistics of the criterion and predictor variables used in Hypotheses 1–7.

Table 3

Skewness and Kurtosis Statistics of the Criterion and Predictor Variables Used in Hypotheses 1–7

Variable	Skewness	Skew Std. Error	z-skew	Kurtosis	Kurtosis Std. Error	z-kurtosis
Developmental Orientation						
Denial	-1.237	0.536	-2.308	1.566	1.038	1.509
Defense	0.179	0.536	0.334	-1.758	1.038	-1.694
Reversal	-0.397	0.536	-0.741	-0.779	1.038	-0.750
Minimization	0.307	0.536	0.573	-0.244	1.038	-0.235
Acceptance	0.483	0.536	0.901	-0.422	1.038	-0.407
Adaptation	-0.759	0.536	-1.416	0.837	1.038	0.806
Overall	0.308	0.536	0.575	-0.528	1.038	-0.509
Organizational Culture						
Constructive	-0.034	0.536	-0.063	1.398	1.038	1.347
Passive	-0.373	0.536	-0.696	0.597	1.038	0.575
Aggressive	-0.052	0.536	-0.097	0.025	1.038	0.024

Note. n = 18

Multicollinearity

The assumption of multicollinearity was tested by calculating correlations between variables and collinearity statistics (Tolerance and Variance Inflation Factor). Results indicated that correlations between predictor variables did not exceed .48 (see Table 4). Tolerance is calculated using the formula $T = 1 - R^2$ and variance inflation factor (VIF) is the inverse of Tolerance (1 divided by T). Commonly used cut-off points for determining the presence of multicollinearity are $T < .10$ and $VIF > 10$. No correlational results between predictor variables violated this assumption; therefore, the presence of multicollinearity was not assumed.

Table 4

Correlation Matrix of Three Predictor Variables

	Pearson Correlation		
Predictor Variable	1	2	3
Constructive (1)	1.000	-0.256	-0.471
Passive (2)		1.000	0.403
Aggressive (3)			1.000

Results of Hypothesis 1

Null Hypothesis 1 ($H1_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' developmental orientation as measured by the IDI.

Alternative Hypothesis 1 ($H1_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' developmental orientation as measured by the IDI.

Using SPSS 22, Hypothesis 1 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' overall IDI developmental orientation scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' overall developmental scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .517$, $R^2 = .267$, $F(3, 14) = 1.699$, $sig. = .213$ (two-tailed). Thus, the null hypothesis for research question 1 was retained. A model summary of the multiple regression analysis is displayed in Table 5.

Table 5

Model Summary Generated from Multiple Regression Analysis of Hypothesis 1

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.517	.267	17.327	1.699	.213

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	34.847	69.534		0.501	.624	
Constructive	-0.364	1.122	-0.084	-0.324	.750	-.086
Passive	2.837	1.481	0.481	1.915	.076	.456
Aggressive	0.092	1.524	0.017	0.061	.953	.016

Note. Criterion variable = leaders' overall IDI developmental orientation

Results of Hypothesis 2

Null Hypothesis 2 ($H2_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' denial as measured by the IDI.

Alternative Hypothesis 2 ($H2_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' denial as measured by the IDI. Hypothesis 2 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI denial scores and followers' OCI scores. Results indicated that a significant relationship did exist between IDI denial scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .695$, $R^2 = .484$, $F(3, 14) = 4.369$, $sig. = .023$ (two-tailed). Thus, the null hypothesis for Research Question 2 was rejected in favor of the alternative hypothesis. Additionally, the coefficient of determination (R^2) statistic indicates that 48.4% of the variance observed in the criterion variable was due to a model containing three of the predictor variables. A model summary of the multiple regression analysis is displayed in Table 6.

Table 6

Model Summary Generated from Multiple Regression Analysis of Hypothesis 2

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.695	.484	0.563	4.369	.023

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	1.743	2.261		0.771	.453	
Constructive	-0.019	0.036	-0.113	-0.515	.614	-.136
Passive	0.168	0.048	0.734	3.484	.004	.681
Aggressive	-0.051	0.049	-0.240	-1.040	.316	-.268

Note. Criterion variable = leaders' IDI denial

The contribution of each predictor variable, when the others were controlled for, was evaluated using the standardized Beta for each coefficient. Specifically, the OCI factor, passive, made the only significantly unique and positive contribution in explaining the criterion variable (Beta = 0.734, *sig.* = .004). The partial correlation coefficient indicates that 68.1% of the variance observed in the criterion variable (IDI denial) was due to participants' OCI passive scores.

Results of Hypothesis 3

Null Hypothesis 3 ($H3_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' defensive as measured by the IDI.

Alternative Hypothesis 3 ($H3_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' defensive as measured by the IDI.

Hypothesis 3 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI defensiveness scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' defensive scores and a model containing three predictor variables (constructive, passive,

and aggressive), $R = .549$, $R^2 = .301$, $F(3, 14) = 2.008$, *sig.* = .159 (two-tailed). Thus, the null hypothesis for Research Question 3 was retained. A model summary of the multiple regression analysis is displayed in Table 7.

Table 7

Model Summary Generated from Multiple Regression Analysis of Hypothesis 3

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.549	.301	0.648	2.008	.159

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	-1.159	2.602		-0.445	.663	
Constructive	0.037	0.042	0.227	0.891	.388	.232
Passive	0.093	0.055	0.410	1.675	.116	.409
Aggressive	0.065	0.057	0.305	1.136	.275	.291

Note. Criterion variable = leaders' IDI defensive

Results of Hypothesis 4

Null Hypothesis 4 ($H4_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' reversal as measured by the IDI.

Alternative Hypothesis 4 ($H4_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' reversal as measured by the IDI.

Hypothesis 4 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI reversal scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' reversal scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .251$, $R^2 = .063$, $F(3, 14) = 0.313$, *sig.* = .816 (two-tailed). Thus, the null hypothesis for Research Question 4 was retained. A model summary of the multiple regression analysis is displayed in Table 8.

Table 8

Model Summary Generated from Multiple Regression Analysis of Hypothesis 4

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.251	.063	0.699	0.313	.816

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	2.450	2.805		0.874	.397	
Constructive	0.002	0.045	0.015	0.052	.959	.014
Passive	0.035	0.060	0.168	0.594	.562	.157
Aggressive	0.027	0.061	0.138	0.443	.665	.118

Note. Criterion variable = leaders' IDI reversal

Results of Hypothesis 5

Null Hypothesis 5 ($H5_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' minimization as measured by the IDI.

Alternative Hypothesis 5 ($H5_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' minimization as measured by the IDI.

Hypothesis 5 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI minimization scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' minimization scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .440$, $R^2 = .194$, $F(3, 14) = 1.120$ *sig.* = .374 (two-tailed). Thus, the null hypothesis for Research Question 5 was retained. A model summary of the multiple regression analysis is displayed in Table 9.

Table 9

Model Summary Generated from Multiple Regression Analysis of Hypothesis 5

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.440	.194	0.697	1.120	.374

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	3.704	2.795		1.325	.206	
Constructive	-0.058	0.045	-0.348	-1.275	.223	-.323
Passive	0.057	0.060	0.250	0.949	.358	.246
Aggressive	-0.016	0.061	-0.077	-0.266	.794	-.071

Note. Criterion variable = leaders' IDI minimization

Results of Hypothesis 6

Null Hypothesis 6 ($H6_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' acceptance as measured by the IDI. *Alternative Hypothesis 6* ($H6_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' acceptance as measured by the IDI.

Hypothesis 6 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI acceptance scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' acceptance scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .521$, $R^2 = .271$, $F(3, 14) = 1.737$, *sig.* = .205 (two-tailed). Thus, the null hypothesis for Research Question 6 was retained. A model summary of the multiple regression analysis is displayed in Table 10.

Table 10

Model Summary Generated from Multiple Regression Analysis of Hypothesis 6

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.521	.271	0.685	1.737	.205

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	5.342	2.747		1.945	.072	
Constructive	-0.025	0.044	-0.149	-0.575	.575	-.152
Passive	0.084	0.059	0.360	1.440	.172	.359
Aggressive	-0.129	0.060	-0.587	-2.142	.050	-.497

Note. Criterion variable = leaders' IDI acceptance

Results of Hypothesis 7

Null Hypothesis 7 ($H7_0$): There is no relationship between followers' OCI (constructive, passive, and aggressive) and leaders' adaptation as measured by the IDI.

Alternative Hypothesis 7 ($H7_A$): There is a relationship between followers' OCI (constructive, passive, and aggressive) and leaders' adaptation as measured by the IDI.

Hypothesis 7 was evaluated using multiple regression analysis to determine if any significant relationships existed between leaders' IDI adaptation scores and followers' OCI scores. Results indicated that a significant relationship did not exist between leaders' adaptation scores and a model containing three predictor variables (constructive, passive, and aggressive), $R = .118$, $R^2 = .035$, $F(3, 14) = 0.172$, *sig.* = .914 (two-tailed). Thus, the null hypothesis for Research Question 7 was retained. A model summary of the multiple regression analysis is displayed in Table 11.

Table 11

Model Summary Generated from Multiple Regression Analysis of Hypothesis 7

Source	*R*	R^2	Standard Error	F	Sig
Omnibus Model	.188	.035	0.559	0.172	.914

	Unstandardized Coefficients		Standardized Coefficients			
	B	Std. Error	Beta	*t*	Sig.	Partial Correlation
(Constant)	1.428	2.242		0.637	.534	
Constructive	0.017	0.036	0.137	0.458	.654	.122
Passive	0.02	0.048	0.12	0.418	.682	.111
Aggressive	0.019	0.049	0.12	0.382	.708	.102

Note. Criterion variable = leaders' IDI adaptation

Conclusion

Organizations that provide services to diverse populations should be concerned about how followers perceive the climate and culture of the organization. Perceptions of a diverse workforce could influence organizational effectiveness, staff participation, and organizational outcomes (Snipes-Bennett, 2006). Many substance abuse treatment facilities have difficulty recruiting, retaining, and successfully treating minority clients. Coupled with the fact that cultural diversity among clients is likely to increase, it is critical that facilities take the steps to increase their cultural awareness (Finn, 1996). Therefore, leaders need to be culturally competent to drive a positive, working organizational climate (Capell et al., 2007).

The sample for this study included seven substance abuse treatment facilities as identified by U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration that are located in Indianapolis, Indiana. These agencies vary in regards to organizational size and structure, ranging from one leader to 17 leaders, and with anywhere from five to 25 followers per leader. This chapter

presented conclusions based on inferential statistics from the sample tested. SPSS was used to code and tabulate scores collected from the survey and provide summarized values. Multiple regression analyses were used to evaluate seven research hypotheses.

A significant relationship does not exist between leaders' overall developmental score and the OCI variables in this study. There is a significant relationship between the denial construct and the OCI variables. A significant relationship does not exist between leaders' defensive score and the OCI variables. In addition, a significant relationship does not exist between the leaders' reversal score and the OCI variables. In regards to the leaders' minimization score a relationship does not exist between the OCI variables. Lastly, a significant relationship does not exist between the leaders' acceptance and adaptation scores and the OCI variables in this research study. The summary of the results are displayed in Table 12.

Table 12

Summary of Results for Hypotheses 1–7

Hypothesis	Criterion Variable	Predictor Variable	Test	Sig.
1	Overall Developmental Orientation	OCI Factors	Multiple Regression	.213
2	IDI Denial	OCI Factors	Multiple Regression	.023*
3	IDI Defensive	OCI Factors	Multiple Regression	.159
4	IDI Reversal	OCI Factors	Multiple Regression	.816
5	IDI Minimization	OCI Factors	Multiple Regression	.374
6	IDI Acceptance	OCI Factors	Multiple Regression	.205
7	IDI Adaptation	OCI Factors	Multiple Regression	.914

Note. OCI factors = constructive, passive, and aggressive *=<.05

The following chapter discussed the summary of this study's findings. In addition, it presented the implications of these findings. A discussion on the limitations of this study was presented. Finally, a discussion on future directions for research was identified.

Chapter Five: Summary, Conclusions, and Recommendations

As the United States becomes a more racially and ethnically diverse country, it is incumbent that the institutions and organizations that represent America and are symbolic of the American ideals reflect varied perspectives, values, and behaviors of their stakeholders. Failure to understand and manage social and cultural differences may have significant consequences for minority groups in particular. Cultural competence has recently emerged in behavior health care organizations as part of a strategy to reduce disparities in access to quality care.

Organizations that provide services to diverse populations should be concerned about how followers perceive the climate and culture of the organization. The perceptions of a diverse workforce could influence organizational effectiveness, staff participation, and organizational outcomes (Snipes-Bennett, 2006). Leaders need to be culturally competent to drive a positive, working organizational climate (Capell et al., 2007). The review of the literature indicated that today's leaders face an ever-changing environment, which can challenge their insight and knowledge of many different cultures and market demands. Due to this situation, leaders have become aware that they are facing shortages in leadership with intercultural or multicultural expertise.

Previous research has found that there are many reasons why it is important for behavioral health leaders to develop intercultural competence (Anand & Lahiri, 2009). Patient satisfaction, community support, patients' willingness to seek treatment, and patient outcomes are some examples as to why culturally appropriate care is necessary in

health care organizations. These leaders govern those that deliver services to an increasingly diverse U.S. population (American Institutes for Research, 2002).

Findings of other studies suggest the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of the organizations of which they are members. Tsai (2011) found that when there is a positive relationship between leadership and subordinates, there are contributions to team communication, collaboration, and encouragement of subordinates to accomplish the mission and objectives assigned by the organization; this, in turn, enhances job satisfaction. Therefore, if an organization can develop culturally competent leaders, it would have a greater chance for a positive organizational culture.

Summary of Findings

Leaders in substance abuse treatment facilities located within Indianapolis, Indiana participated in this study by taking the IDI. These leaders also provided a list of their followers; three followers from each leader were randomly selected to participate in taking the OCI. Data was entered into the SPSS 22 and were then tested using multiple regression analyses to evaluate the research hypotheses. Results of the seven research hypotheses are summarized in Table 13.

Table 13

Summary of Variables and Statistical Tests Used to Evaluate Research Hypotheses 1–7

Hypothesis	Criterion Variable	Predictor Variable	Test	Sig.
1	Overall Developmental Orientation	OCI Factors	Multiple Regression	.213
2	IDI Denial	OCI Factors	Multiple Regression	.023
3	IDI Defensive	OCI Factors	Multiple Regression	.159
4	IDI Reversal	OCI Factors	Multiple Regression	.816
5	IDI Minimization	OCI Factors	Multiple Regression	.374
6	IDI Acceptance	OCI Factors	Multiple Regression	.205
7	IDI Adaptation	OCI Factors	Multiple Regression	.914

Note. OCI factors = constructive, passive, and aggressive

The difference between the perceived orientation and the developmental orientation is referred to as the orientation gap. A gap score of 7 points or higher is considered a meaning difference (Hammer, 2012). In this study, it was also found that the average gap score was 23.47 points, with a range from 3.81-44.91 and 83% of the participants overestimated their orientation.

This study also identified that 77.8% of the followers were Caucasian and 22.2% were of minority background. Therefore, it is recommended for future research to investigate the intercultural competence level of the followers and measure the patients' satisfaction.

Conclusions and Implications

In conclusion, this study found statistical significance with leaders that scored in the denial orientation of the IDI and their followers that scored the organizational culture as passive/defensive on the OCI. Hammer (2012) informed that a denial mindset reflects less capability for understanding appropriately and responding to cultural differences. Individuals with a denial orientation often do not recognize differences in perceptions and behavior as "cultural" (Hammer, 2012). A denial orientation is characteristic of

individuals who have limited experience with other cultural groups and therefore tend to operate with broad stereotypes and generalizations about the cultural "other." In addition, those with a denial orientation may also maintain a distance from other cultural groups and express little interest in learning about the cultural values and practices of diverse communities. When denial is present within an organization, cultural sensitivity often feels "ignored" (Hammer, 2012).

Passive/defensive cultures within an organization reflect norms of approval, conventional, dependent, and avoidance. In organizations with passive/defensive cultures, members feel pressured to think and behave in ways that are inconsistent with the way they believe they should in order to be effective (Hammer, 2012). People are expected to please others (particularly superiors) and avoid interpersonal conflict. Rules, procedures, and orders are more important than personal beliefs, ideas, and judgment. Passive/defensive cultures experience a lot of unresolved conflict, turnover, and organizational members report lower levels of motivation and satisfaction (Hammer, 2012).

Based on the review of research it is suggested that a relationship would likely exist between followers' OCI (constructive, passive, and aggressive) and leaders' developmental orientation as measured by the IDI. In addition, a statistical relationship was not found among the constructive organizational culture and ethnorelative orientation of the leaders. Followers' attitudes toward leaders' intercultural competence was not found among this group. There were only four leaders that identified as African-American; this is an unexpected show of diversity among behavioral health care

leadership, at least in this study in Indianapolis, Indiana. This anomaly may have contributed to the data outcome not showing the expected results.

It seems appropriate that one could make an assumption of research transfer from one sector to another. However, because the human service sector has some unique characteristics, we cannot necessarily generalize research results from corporate organizations in this sector (McCauley & Hughes, 1993).

Recommendations for Further Research

The results of this study present significant practical findings, supporting the need for continuation of research in this area. This may be the first study that has been done, as no other research study like this was found in a review of literature on the subject. As the sector of substance abuse is a specialty under behavioral healthcare, more research can help to support behavioral healthcare organizations. Subsequently, this writer would recommend further research within organizations that have diverse leadership and staff. The anomaly of 22% of the leaders studied being non-Caucasian may have resulted in this study's outcome being different than expected, and further research should be done. However, this study is not about ethnicity. In addition, further research on the patients' perception of the staff that is providing direct service is cultural sensitive while under their care.

There are many ways in which this research supports, expands and contributes to the theories of leadership development. Based on literature it is beneficial to the field of behavioral healthcare that leaders continue to develop their intercultural competence. Klenke (2008) argues that leadership is essential a relational practice. The relationship dimension of leadership is further explored by Stone and Patterson (2006), in their

overview and history of leadership studies' movement toward follower-focused orientations. As a relationally focused endeavor, leadership and leaders must be able to understand and effectively communicate with individuals of their own and different cultural backgrounds (Irving, 2009).

As a result of this study, this writer recommends that behavioral health care organizations should implement strategies to recruit, retain, and promote a diverse staff and leadership that are representative of the demographic characteristics of the service area at all levels of the organization. Building a diverse staff can play an important role in how the organization responds to diverse needs of patients/consumers. Currently, the demographic diversity of behavioral health care professionals is not congruent with the increasingly diverse population they serve. Therefore, efforts to recruit and retain minority professionals are needed in order to reach demographic equity between patients and provider (Weinick, Zuvekas, & Cohen, 2000). This also helps to solidify relationships between academic settings and behavioral health care organizations and can provide community-based experiences focused on cultural diversity and connect younger students with cultural learning experiences.

Another recommendation is that behavioral health care organizations should ensure that staff at all levels and across disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. As shown, the current sample of leaders had minimization and denial orientations, and therefore did not see a need to gain insight regarding awareness of cultural competence. A second measure would be to evaluate if the leaders' attitudes and behaviors effectuate organizational

change regarding hiring more diverse staff, improving policies, marketing, and services to those in need of culturally competent care.

Recommendations for Practice

As a result of this study, it is recommended that leaders in behavioral health care organizations become aware of their intercultural competence orientation. This can be completed by taking the IDI and/or another assessment to obtain a baseline regarding their cultural competence to obtain awareness of their beliefs toward other that are different than their culture. In addition, it is recommended that all members of an organization participate in cultural competence education and training. The education and training for staff and leaders alike need to have different levels in order to maximize the learning objectives. For example, there should be beginner, intermediate, and advanced education and training tracks. Therefore, the learner can take the education and training that they need based on the outcome of their assessment. This intervention would improve the patient-provider relationship when cultural differences exist.

Limitations

Due to the large number of potential participants in the study population, the current study focused only on substance abuse treatment facilities that are located within Indianapolis, Indiana. This study was completed in a metropolitan area; therefore, application of results to population may not accurately reflect the overall population. This study did not include private practice addiction counselors, doctor's offices, psychiatrists, or psychologists. The study only assessed the intercultural competence of leaders within the selected substance abuse facilities. Another limitation that was encountered in this study includes self-reporting bias, as some participants may not answer candidly. In addition, this study included difficulty obtaining

participants that met the inclusion criteria of being a leader in a substance abuse treatment facility within the location of Indianapolis, Indiana. The population employed in this study is highly unique and makes generalizability problematic.

Summary

Diversity is reality. Studies show that new entrants to the workforce and communities increasingly will be people of color, immigrants, and women. Behavioral health care organizations need to recognize the challenge presented by the needs of a growing number of diverse racial and ethnic communities and linguistic groups, each with its own traits and challenges. These organizations need to apply research advances in cultural awareness and understanding in such a way as to ensure improved organizational culture for staff and those served by their organization.

In order for organizations to be successful, its members should ideally find satisfaction and happiness in their roles, particularly at personal achievement and the common good (Cooke & Lafferty, 1989). According to Cooke and Lafferty (1989), organizations with a constructive culture results in "heightened sense of commitment to the organization's mission, values and goals; improved employee morale and retention; greater trust and ethical conduct among employees; and increased teamwork, creativity, productivity and organizational performance. Changing the cultural style will require teamwork and therefore, the leaders will need to encourage communication and getting to know each other (Cooke & Lafferty, 1989).

There are many benefits of building an organization's cultural competence. When cultural competence is developed and implemented as a framework within an organization, cultural competence enables systems, agencies, and groups of professionals

to function effectively to understand the needs of others (Hammer, 2012). In addition, cultural competence contributes to an increase in respect and mutual understanding among those involved; in creativity in problem-solving through new perspectives, ideas and strategies; in trust and cooperation; and promotes inclusion and equality (Hammer, 2012).

Achieving cultural competence is a top-down organizational mandate and it is important to get everyone to support the organization's effort. In conclusion, intercultural competence is teachable, learnable, and achievable if learning interventions are appropriately designed based on the developmental mindset of the learner. Therefore, behavioral health care organizations can incorporate intercultural competence assessments to determine the needs of their leaders and staff and provide them with the necessary education and training in order to develop their knowledge and skills. Since leadership is relational, developing intercultural competence will have a direct effect on how the leader interacts with their followers. Therefore, the leaders influence the organization's culture and in turn the long-term effectiveness of the organization.

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Appendix A: Information Letter

Date

Dear (Insert Facility Name):

This letter is an invitation to consider participating in a study I am conducting as part of my Doctoral degree in the Department of Organizational Leadership at Indiana Wesleyan University under the supervision of Dr. Joanne Barnes. I would like to provide you with more information about this study and what your involvement would entail if you decide to take part.

There has been a growing shift in the demographics of the United States. These changes have a direct impact on the workforce and those seeking substance abuse treatment. Organizations that provide services to diverse populations should be concerned about how followers perceive the climate and culture of the organization. In addition, those leading the organization need to be culturally competent to drive a positive organizational climate. The purpose of this study, therefore, is to examine whether or not a behavioral health leader's intercultural competence level has a relationship to the organizational culture of substance abuse treatment agencies.

This study will focus on measuring the intercultural competence of leaders in the organization. Of those leaders that participate in the study, their direct followers will be required to complete the organizational culture inventory in order to measure the culture organization. It is important to understand if a leader's intercultural competence is a factor in creating a positive or negative organizational culture. Therefore, I would like to include your organization as one of the several organizations to be involved in my study. I believe that because you are an active SAMSHA registered facility, you are best suited to represent substance abuse facilities.

Participation in this study is voluntary. It will involve submitting a list of names and email addresses of all of the leaders in your organization, along with a list of their followers' names and email addresses. The leaders that qualify to participate in the study will be asked to complete an online survey that will take 20 minutes. The followers that are eligible to participate in this study will be asked to complete an online survey that will take 20 minutes. Further, you may decide to withdraw from this study at any time without any negative consequences by advising the researcher. All of the information you provide

is considered confidential. Your name will not appear in any report resulting from this study. There are no known or anticipated risks to you as a participant in this study.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me at (317) 345-6331 or by e-mail at misty.resendez@agsfaculty.indwes.edu. You can also contact my supervisor, Dr. Joanne Barnes at (800) 621-8667 ext. 1138 or e-mail joanne.barnes@indwes.edu.

I hope that the results of my study will be of benefit to those organizations directly involved in the study, other substance abuse treatment facilities not directly involved in the study, as well as the broader research community.

I very much look forward to working with you and thank you in advance for your assistance in this study.

Sincerely,

Misty D. Resendez
Doctoral Student
Indiana Wesleyan University

Dr. Joanne Barnes
Dean of the Graduate School
Associate Professor
Indiana Wesleyan University

Vita

Misty D. Resendez

(317) 345-6331

Indianapolis, IN 46260
mdresendez@gmail.com

Organizational Leadership • Management • Diversity & Inclusion

Collaborative leader with 10+ years experience in leading teams, strategic planning, streamlining people processes, organizational and financial analysis and management, change management and execution. Passionate coach with desire to cultivate, educate, and mentor others to develop their skills and abilities.

Education

Doctorate of Organizational Leadership, Indiana Wesleyan University
Masters of Management, Indiana Wesleyan University
Bachelor of Science in Criminal Justice, Indiana University

Skills

Strategic and Organizational Planning
Budget Administration
Fund and Resource Development
Event Planning and Management
Team Leadership and Collaboration
Volunteer Recruitment, Training, and Management
Program Development, Planning, and Execution
Facilitation, Training, and Consulting
Diversity & Inclusion – Certified Administrator for the Intercultural Development Inventory

Professional Experience

Clinical Manager of Satellite Offices
Fairbanks Hospital June 2007 to Present

- Oversee the planning, implementation and evaluation of 3 sites and 5 programs
- Ensure the programs and services offered contribute to the organization's mission

- Work with the Director of Adult Services to ensure compliance with accreditation and licensing boards
- Provide regular program reports to Director of Adult Services
- Monitor the delivery of the programs and events of the agency to maintain or improve quality
- Recruit, interview and select staff teaching and program staff
- Ensure that all staff receives an orientation and appropriate training is provided
- Supervise teaching and program staff using a performance management process which includes monitoring performance as well as address disciplinary issues
- Promote, reassign and/or release staff as necessary
- Responsible for the clinical supervision of staff
- Keep Director of Adult Services apprised of ongoing program related budget issues
- Manage program budget and resources in a responsible manner
- Represent the agency at community activities to enhance the organization's community profile and share information on programming and foundation events.
- Establish good working relationships and collaborative arrangements with community groups, the media, funders, and other agencies

Administrative Manager/Probation Officer
Marion County Superior Courts Probation Department October 2006 to June 2007
Allen County Superior Court Probation Department May 2004 to October 2006

- Responsible for the supervision of a caseload of 160-180 clients
- Provided training on Latin gangs for the department using Microsoft PowerPoint for my presentations
- Reviewed paperwork including Probation orders and requirements with clients to ensure understanding of the process
- Submitted and prepared Court documents such as minute sheets, petitions and violation notices to revoke probation, travel requests, and affidavits for probable cause
- Ninety percent of caseload spoke only Spanish and used my Spanish skills daily
- Conducted weekly home visits, Worked with Gang Task Force, FBI, and Indianapolis Metropolitan Police Department on home visits and sweeps in the community
- Interpreted for Juvenile Probation Officers as needed

Program Developer
Children's Sanctuary November 2001 to May 2004

- Responsible for the planning, implementation and evaluation of the Independent Living Program
- Ensured the programs and services offered contribute to the organization's mission
- Worked with the Executive Director to ensure compliance with accreditation and licensing boards
- Provided regular program reports to Executive Director
- Monitored the delivery of the programs and events of the agency to maintain or improve quality
- Worked with Executive Director on program related sponsorships, grants and contributions
- Provided Executive Director with program related annual budget request
- Managed program budget and resources in a responsible manner
- Served on specific fundraising event committees as appropriate
- Represented the agency at community activities to enhance the organization's community profile and share information on programming and foundation events
- Established good working relationships and collaborative arrangements with community groups, the media, funders, and other agencies
- Developed and prepared marketing materials for classes, exhibitions and assigned events
- Conducted program related presentations to community organizations when needed

Teaching Experience

PRIme for Life 2008 to Present
Teach 8, 12, and 20 hour courses
English/Spanish

Adjunct Faculty
Indiana Wesleyan University December 2013 to Present
DeVoe School of Business
College of Adult and Professional Studies

Current Professional and Academic Association Memberships

Indiana Counselor's Association on Alcohol and Drug Abuse (ICAADA)
Indiana Coalition Against Domestic Violence (ICDAV)
Society for Human Resource Management (SHRM)
International Leadership Association (ILA)

Current Professional Assignments and Activities

Chair- Cultural Diversity and Inclusion Committee – Fairbanks
Board Member – Prevent Child Abuse Howard County
Board Member – Christamore House

Publications, Papers, Research

Dissertation in progress: An Examination of Substance Abuse Treatment Organizations Leaders' Intercultural Competence and Followers Perception of the Organizational Culture

Antwi, E. Miller, O., Resendez, M., & Walker, N. (2011). Relationship among Wisdom, Stewardship, Followership, and Spirituality in Organizational Leadership. Indiana Wesleyan University, Marion, IN.

Presentations

Resendez, M., & Valencic-Miller, O. Preparing Today's Leaders: From Theory to Praxis. (Poster Presentation) Tobias Leadership Conference, Colorado Springs, CO.

Resendez, M., & Valencic-Miller, O. Preparing Today's Leaders: From Theory to Praxis. Midwest Scholars Conference, Indianapolis, Indiana.

Resendez, M., & Valencic-Miller, O. Preparing Today's Leaders: From Theory to Praxis. International Leadership Association's Annual Conference, Denver, Colorado.

Barnes, J., Resendez, M., & Valencic-Miller. Cultural Intelligence (CQ): Leading with the mind: Being Intelligent and Effective in a Multicultural World. International Leadership Association's Women and Leadership Conference, Pacific Grove, California.