A TREATMENT IMPROVEMENT PROTOCOL

Improving Cultural Competence

TIP 59

Substance Abuse and Mental Health Services Administration
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

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Disclaimer

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). TIPs are best practice guidelines for the treatment of substance use disorders. TIPs draw on the experience and knowledge of clinical, research, and administrative experts to evaluate the quality and appropriateness of various forms of treatment. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at http://store.samhsa.gov.

Although each TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that the field of substance abuse treatment is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey front-line information quickly but responsibly. If research supports a particular approach, citations are provided.

Foreword

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities by providing evidence-based and best practice guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people in need of behavioral health services. We are grateful to all who have joined with us to contribute to advances in the behavioral health field.

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Executive Summary

The development of culturally responsive clinical skills is vital to the effectiveness of behavioral health services. According to the U.S. Department of Health and Human Services (HHS), cultural competence "refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (HHS 2003*a*, p. 12). It has also been called "a set of behaviors, attitudes, and policies that . . . enable a system, agency, or group of professionals to work effectively in cross-cultural situations" (Cross et al. 1989, p. 13).

This Treatment Improvement Protocol (TIP) uses Sue's (2001) multidimensional model for developing cultural competence. Adapted to address cultural competence across behavioral health settings, this model serves as a framework for targeting three organizational levels of treatment: individual counselor and staff, clinical and programmatic, and organizational and administrative. The chapters target specific racial, ethnic, and cultural considerations along with the core elements of cultural competence highlighted in the model. These core elements include cultural awareness, general cultural knowledge, cultural knowledge of behavioral health, and cultural skill development. The primary objective of this TIP is to assist readers in understanding the role of culture in the delivery of behavioral health services (both generally and with reference to specific cultural groups). This TIP is organized into six chapters and begins with an introduction to cultural competence. The following subheadings provide a summary of each chapter and an overview of this publication.

Introduction to Cultural Competence

Why is the development of cultural competence and culturally responsive services important in the behavioral health field? Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.

The development of cultural competence can have far-reaching effects not only for clients, but also for providers and communities. Cultural competence improves an organization's sustainability by reinforcing the value of diversity, flexibility, and responsiveness in addressing the current and changing needs of clients, communities, and the healthcare environment. Culturally responsive organizational strategies and clinical services can help mitigate organizational risk and provide cost-effective treatment, in part by matching services to client

needs more appropriately from the outset. So too, culturally responsive organizational policies and procedures support staff engagement in culturally responsive care by establishing access to training, supervision, and congruent policies and procedures that enable staff to respond in a culturally appropriate manner to clients' psychological, linguistic, and physical needs.

What is the process of becoming culturally competent as a counselor or culturally responsive as an organization? Cultural competence is not acquired in a limited timeframe or by learning a set of facts about specific populations; cultures are diverse and continuously evolving. Developing cultural competence is an ongoing process that begins with cultural awareness and a commitment to understanding the role that culture plays in behavioral health services. For counselors, the first step is to understand their own cultures as a basis for understanding others. Next, they must cultivate the willingness and ability to acquire knowledge of their clients' cultures. This involves learning about and respecting client worldviews, beliefs, values, and attitudes toward mental health, help-seeking behavior, substance use, and behavioral health services. Behavioral health counselors should incorporate culturally appropriate knowledge, understanding, and attitudes into their actions (e.g., communication style, verbal messages, treatment policies, services offered), thereby conveying their cultural competence and their organizations' cultural responsiveness during assessment, treatment planning, and the treatment process.

What is culture? Culture is the conceptual system developed by a community or society to structure the way people view the world. It involves a particular set of beliefs, norms, and values that influence ideas about relationships, how people live their lives, and the way people organize their world. Culture is not a definable entity to which people belong or do not belong. Within a nation, race, or community, people belong to multiple cultural groups and negotiate multiple cultural expectations on a daily basis. These expectations, or cultural norms, are the spoken or unspoken rules or standards for a given group that indicate whether a certain social event or behavior is appropriate or inappropriate. The word "culture" is sometimes applied to groups formed on the basis of age, socioeconomic status, disability, sexual orientation, recovery status, common interest, or proximity. Counselors and administrators should understand that each client embraces his or her culture(s) in a unique way and that there is considerable diversity within and across races, ethnicities, and culture heritages. Other cultures and subcultures often exist within larger cultures.

What are race and ethnicity? Race is often referred to as a biological category based on genetic traits like skin color (HHS 2001), but there are no reliable means of identifying race through biological criteria. Despite its limitations, the concept of race is important to discussions of cultural competence. Race—when defined as a social construct to describe people with shared physical characteristics—can have tremendous social significance. The term ethnicity is often used interchangeably with race, although by definition, ethnicity—unlike race—implies a certain sense of belonging. It is generally based on shared values, beliefs, and origins rather than shared physical characteristics. With the exception of its final chapter, which examines drug cultures, this TIP focuses on the major racial and ethnic groups identified by the U. S. Census Bureau within the United States: African and Black Americans, Asian Americans (including Native Hawaiians and other Pacific Islanders), Hispanics and Latinos, Native Americans, and White Americans.

What constitutes cultural identity? Cultural identity, in the simplest terms, involves an affiliation or identification with a particular group or groups. An individual's cultural identity reflects the values, norms, and worldview of the larger culture, but it is defined by more than these factors. Cultural identity includes individual traits and attributes shaped by race, ethnicity, language, life experiences, historical events, acculturation, geographic and other environmental influences, and other forces. Thus, no two individuals will possess exactly the same cultural identity even if they identify with the same cultural group(s). Cultural identities are not static; they develop, evolve, and change across the life cycle.

This TIP explores cultural identity and its influence on assessment, treatment planning, and therapeutic and healing practices. The introduction it provides to the cross-cutting factors of race, ethnicity, and culture will help counselors gain knowledge about the many forces that shape cultures, communities, and the lives of clients, including, but not limited to, families and kinships, gender roles, socioeconomic status, religion, education, immigration, and migration.

What core assumptions serve as the foundation of this TIP? The consensus panel developed several core assumptions upon which to structure the content of this TIP:

- An understanding of race, ethnicity, and culture (including one's own) is necessary to appreciate the diversity of human dynamics and to treat clients effectively.
- Incorporating cultural competence into treatment improves therapeutic decisionmaking and offers alternative ways to define and plan a treatment program firmly directed toward progress and recovery.
- Organizational commitment to supporting culturally responsive treatment services, including adequate allocation of resources, reinforces the importance of sustaining cultural competence in counselors and other clinical staff.
- Advocating culturally responsive practices increases trust within the community, agency, and staff.
- Achieving cultural competence requires the participation of racially and ethnically diverse groups and underserved populations in the development and implementation of treatment approaches and training activities.
- Consideration of culture is important at all levels of operation and in all stages of treatment and recovery.

Core Competencies for Counselors and Other Clinical Staff

Cultural competence has come to mean more than a discrete skill set or knowledge base; cultural competence also requires self-evaluation on the part of the practitioner. Culturally competent counselors are aware of their own culture and values, and they acknowledge their own assumptions and biases about other cultures. Moreover, culturally competent counselors strive to understand how these assumptions affect their ability to provide culturally responsive services to clients from similar or diverse cultures.

Counselors should begin the process of becoming culturally competent by identifying and exploring their cultural heritage and worldview along with their clinical worldview, uncovering how these views shape their perceptions of and during the counseling process. In addition to understanding themselves and how their culture and values can affect the therapeutic process, culturally competent counselors possess a general understanding of

the cultures of the specific clients with whom they work. Counselors should also understand how individual cultural differences affect substance abuse, health beliefs, help-seeking behavior, and perceptions of behavioral health services. Culturally competent counselors:

- Frame issues in culturally relevant ways.
- Allow for complexity of issues based on cultural context.
- Make allowances for variations in the use of personal space.
- Are respectful of culturally specific meanings of touch (e.g., hugging).
- Explore culturally based experiences of power and powerlessness.
- Adjust communication styles to the client's culture.
- Interpret emotional expressions in light of the client's culture.
- Expand roles and practices as needed.

Chapter 2 addresses counselors' core cultural competencies and presents clinical activities, including clinical supervision tools. The key areas explored include cultural awareness and cultural identity development, the cultural lens of counseling, key components of cultural knowledge for behavioral health counselors, and specific counseling skills that support culturally responsive services.

Culturally Responsive Evaluation and Treatment Planning

The role of culture should be considered during initial intakes and interviews, in screening and assessment processes, and in the development of treatment planning. Culturally responsive treatment can only occur when the making of clinical and programmatic decisions includes culturally relevant information and practices and is endorsed and supported by clinical staff, clinical supervisors, and the organization as a whole. Chapter 3 presents culturally responsive evaluation and treatment planning as a series of nine steps.

Step 1: Engage clients. Because the intake meeting is often the first encounter clients have with the behavioral health system, it is vital that they leave the meeting feeling understood and hopeful. Counselors should try to establish rapport with clients before launching into a series of questions.

Step 2: Familiarize clients and family members with the evaluation and treatment process. Often, clients and family members are not familiar with treatment jargon, the treatment program, the facility, or the expectations of treatment; furthermore, not all clients will have had an opportunity to express their own expectations or apprehension. Clinical and other treatment staff must not assume that clients already understand the treatment process. Instead, they need to take sufficient time to talk with clients (and their families, as appropriate) about how treatment works and what to expect from treatment providers.

Step 3: Endorse a collaborative approach in facilitating interviews, conducting assessments, and planning treatment. Counselors should educate clients about their role in interview, assessment, and treatment planning processes. From first contact, they should encourage clients and their families to participate actively by asking questions, voicing specific treatment needs, and being involved in treatment planning. Counselors should allow clients and family members to give feedback on the cultural relevance of the treatment plan.

Step 4: Obtain and integrate culturally relevant information and themes. By exploring culturally relevant themes, counselors will better understand each client and will be better equipped to develop a culturally informed evaluation and treatment plan. Areas

to explore include immigration and migration history, cultural identity, acculturation status, health beliefs, healing practices, and other information culturally relevant to the client.

Step 5: Gather culturally relevant collateral information. Such information is a powerful tool in assessing clients' presenting problems, understanding the influence of cultural factors on clients, and gathering resources to support treatment endeavors. By involving others in the early phases of treatment, providers will likely obtain more external support for each client's engagement in treatment services. Counselors can obtain supplemental information (with client permission) from family members, medical and court records, probation and parole officers, community members, and so on.

Step 6: Select culturally appropriate screening and assessment tools. In selecting evaluation tools, counselors should note the availability of normative data for the populations to which their clients belong, the incidence of test item bias, the role of acculturation in understanding test items, and the adaptation of testing materials to each client's culture and language.

Step 7: Determine readiness and motivation for change. Although few studies focus on the use of motivational interviewing with specific cultural groups, its theories and strategies may be more culturally appropriate for most clients than other approaches. Through reflective listening, motivational interviewing focuses on helping clients explore ambivalence toward change, decisions, and subsequent treatment. It is a nonconfrontational, client-centered approach that reinforces clients as the experts on what will work and supports the key idea that change is a process.

Step 8: Provide culturally responsive case management. Many core competencies for counselors are also relevant to case managers. Like counselors, case managers should possess cultural self-knowledge and a basic knowledge of other cultures. They should possess traits conducive to working well with diverse groups and the ability to apply cultural competence in practical ways. Case management includes the use, as necessary, of interpreters who can communicate well in the specific dialects spoken by each client and who are familiar with behavioral health vocabulary relevant to the specific behavioral health setting in which service provision will occur. Case managers should acquire cultural and community knowledge to assist with the coordination of social, health, and other essential services and to secure culturally relevant services in and outside the treatment facility. Case managers should also keep a list of culturally appropriate referral resources to help meet client needs.

Step 9: Integrate cultural factors into treatment planning. Counselors should be flexible in designing a treatment plan to meet the cultural needs of clients and should integrate traditional healing practices into treatment plans when appropriate, using resources available in the clients' cultural communities. Treatment goals and objectives need to be culturally relevant, and the treatment environment must be conducive to client participation in treatment planning and to the gathering of client feedback on the cultural relevance of the treatment being provided.

Pursuing Organizational Cultural Competence

Organizational cultural competence is a dynamic, ongoing process that begins with awareness and commitment and evolves into culturally responsive organizational policies and procedures. A commitment to improving cultural competence must include resources to help support ongoing fidelity to these policies and procedures along with an ongoing process

of reassessment and adaptation as client and community needs evolve. Chapter 4 presents 20 organizational tasks that support counselors' development of cultural competence and improve organizational development of culturally responsive treatment services.

Beginning with the organization's vision and mission statement, administrators and governing boards need to develop, implement, and support a strategic planning process that demonstrates commitment to cultural competence. Key staff members assigned to oversee the development of culturally responsive services act as liaisons and facilitators in establishing a cultural competence committee and conducting an organizational self-assessment of cultural competence. With the involvement of community members, staff, clients and their families, board members, and other invested individuals, the cultural competence committee supports and oversees organizational self-assessment, using it to identify strengths and specific areas for improvement in cultural responsiveness. Based on the results of the self-assessment, the committee develops and implements a cultural competence plan.

An organizational self-assessment helps the committee prioritize the steps needed to improve culturally responsive services. The plan should address strategies for recruiting, hiring, retaining, and promoting qualified, diverse staff members; the use of interpreters or bilingual staff members; staff training, professional development, and education; fostering community involvement; facilities design and operation; development of culturally appropriate program materials; how to incorporate culturally relevant treatment approaches; and development and implementation of supporting policies and procedures, including reassessment processes. An organization's commitment to and support of culturally responsive services, including congruent policies and procedures, will enable counselors to respond more consistently to clients in a culturally competent manner.

Behavioral Health Treatment for Major Racial and Ethnic Groups

Knowledge of a culture's attitudes toward mental illness, substance use, healing, and help-seeking patterns, practices, and beliefs is essential in understanding clients' presenting problems, developing culturally competent counseling skills, and formulating culturally relevant agency policies and procedures. Treatment providers need to learn and understand how identification with one or more cultural groups influences each client's worldview, beliefs, and traditions surrounding initiation of use, healing, and treatment.

Chapter 5 provides a review of the literature as it pertains to specific racial and ethnic groups identified by the U.S. Census Bureau. After a brief introduction, the chapter explores each major racial and ethnic group's specific patterns of substance use and substance use disorders, help-seeking patterns, beliefs about and traditions involving substance use, beliefs and attitudes about treatment, assessment and treatment considerations (including co-occurring disorders and culturally specific disorders), and theoretical approaches and treatment interventions (including evidence-based and best practices as well as traditional healing practices).

Chapter 5 also offers assistance in providing treatment to African and Black Americans, Asian Americans (including Native Hawaiian and other Pacific Islanders), Latinos, Native Americans, and White Americans. Counselors, clinical supervisors, and administrators are encouraged to use the information in this chapter as a starting point for learning about

the major cultural groups of their clients. Nonetheless, many forces shape how an individual identifies with, is influenced by, or portrays his/her culture, and numerous subcultures can exist within any culture; thus, generalizations about various population groups should be avoided.

Drug Cultures and the Culture of Recovery

This TIP emphasizes the concept that many subcultures exist within and across diverse ethnic and racial populations and cultures. Drug cultures are a formidable example—they can influence the presentation of mental, substance use, and co-occurring disorders while also affecting prevention and treatment strategies and outcomes. Drug cultures differ from the types of cultures discussed in the rest of this TIP, but they do share some common features. For instance, there is not a single drug culture in the United States today, but rather, a number of distinct (although sometimes related) drug cultures that differ according to substances used, geographic location, socioeconomic status, and other factors. Drug cultures focusing on illicit substances may be of greater importance in the lives of people who use substances, but people who use legal substances, such as alcohol, can also participate in a drug culture. For example, people who drink heavily at a bar or fraternity/sorority house can develop their own drug culture that works to encourage new people to use, supports high levels of continued use or binge use, and reinforces denial.

Understanding the role that drug cultures play in clients' lives is particularly important because these cultures, more than any other cultural connections, influence clients' substance use or abuse and the behaviors in which they engage to manage mental disorders. Through drug cultures, people new to using learn to experience "getting high" as a pleasurable activity; they also learn the skills needed to procure and use drugs effectively and to avoid the pitfalls of the drug-using lifestyle (e.g., getting arrested, running out of money to buy drugs). Perhaps most importantly, the person who uses gains acceptance from a group of peers even as mainstream society increasingly discriminates against him or her because of his or her substance use or mental illness. Prejudice from mainstream society may make ties with the drug culture even stronger; he or she may feel as if there is no other place to turn for social and cultural support.

Within a treatment program, an understanding of drug cultures will help providers engage new clients and recognize the social and cultural bonds that might lead them back to substance use or other high-risk behaviors that are contraindicated for individuals who are being treated for psychological symptoms and/or mental illness. However, unlike other types of cultural affiliations, the treatment provider's relationship to the drug culture does not just involve understanding; the provider must actively work to weaken that connection and replace it with other experiences that meet the client's social and cultural needs. In many cases, this involves helping the client connect with a "culture of recovery" to meet those needs over the long course of recovery.

In sum, this TIP was written to help counselors and organizations provide culturally responsive services. Practices and procedures that improve one's cultural competence will likely result in better outcomes for clients in treatment for mental and substance use disorders. Culturally competent counseling can improve counselor credibility, client satisfaction, and client self-disclosure while increasing clients' willingness to continue in treatment.

1 Introduction to Cultural Competence

IN THIS CHAPTER

- Purpose and Objectives of the TIP
- Core Assumptions
- What Is Cultural Competence?
- Why Is Cultural Competence Important?
- How Is Cultural Competence Achieved?
- What Is Culture?
- What Is Race?
- What Is Ethnicity?
- What Is Cultural Identity?
- What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture?
- As You Proceed

Hoshi was born and grew up in Japan. He has been living in the United States for nearly 20 years, going to graduate school and working as a systems analyst, while his family has remained in Japan. Hoshi entered a residential treatment center for alcohol dependence where the treatment program expected every client to notify his or her family members about being in treatment. This had proven to be a positive step for many other clients and their families in this treatment program, where the belief was that contact with family helped clients become honest about their substance abuse, reconnect with possibly estranged relatives, and take responsibility for the decision to seek treatment.

He was reluctant, but staff members persuaded Hoshi to comply with program expectations. He wrote to his family, describing his current life and explaining his need for treatment. It was not until weeks later, after he had been discharged from residential treatment and was participating in the program's continuing care program, that he received a reply. Staff members were shocked to learn that Hoshi's parents had disowned him because he had "shamed" the family by disclosing the details of his life to the program staff, publicly admitting that he had a drinking problem.

As Hoshi's story demonstrates, a well-meaning but culturally inappropriate intervention can be counterproductive to recovery. The program applied a "one size fits all" model without being sensitive to the possibility that such an approach might harm the client. Fortunately, Hoshi eventually reconciled with his family, and the program administration and staff began to develop initiatives to improve their cultural awareness and competence.

Counselors and other behavioral health service providers who are equipped with a general understanding of how culture affects their

own worldviews as well as those of their clients will be able to work more effectively with clients who have substance use and mental disorders. Even when culture is not a conscious consideration in providing interventions and services, it is a dynamic force that often influences client responses to treatment and subsequent outcomes. Although outcome research is limited, culturally responsive behavioral health counseling results in greater counselor credibility, better client satisfaction, more client self-disclosure, and greater willingness among clients to continue with counseling (Goode et al. 2006; Lie et al. 2011; Ponterotto et al. 2000). This Treatment Improvement Protocol (TIP) examines the significance of culture in substance abuse patterns, mental health, treatment-seeking behaviors, assessment and counseling processes, program development, and organizational practices in behavioral health services.

Purpose and Objectives of the TIP

This TIP is intended to help counselors and behavioral health organizations make progress toward cultural competence. Gaining cultural competence, like any important counseling skill, is an ongoing process that is never completed; such skills cannot be taught in any single book or training session. Nevertheless, this TIP provides a framework to help practitioners and administrators integrate cultural factors into their evaluation and treatment of clients with behavioral health disorders. It also seeks to motivate professionals and organizations to examine and broaden their cultural awareness, embrace diversity, and develop a heightened respect for people of all cultural groups. This TIP places significant importance on the role of program management and organizational commitment in the development of cultural competence. Organizational support allows counselors, case managers, and administrators to begin to integrate culturally congruent and responsive services more consistently across the continuum of care—including outreach and early intervention, assessment, treatment planning and intervention, and recovery services.

The key objectives of this TIP are helping readers understand:

- Why it is important for behavioral health organizations and counselors who provide prevention and treatment services to consider culture.
- The role culture plays in the treatment process, both generally and with reference to specific cultural groups.

Intended Audience

The primary audiences for this TIP are prevention professionals, substance abuse counselors, mental health clinicians, and other behavioral health service providers and administrators. Those who work with culturally diverse populations will find it particularly useful, though all behavioral health workers—regardless of their client populations—can benefit from an awareness of the importance of culture in shaping their own perceptions as well as those of their clients. Secondary audiences include educators, researchers, policymakers for treatment and related services, consumers, and other healthcare and social service professionals who work with clients who have behavioral health disorders.

Structure of the TIP

This TIP focuses on the essential ingredients for developing cultural competence as a counselor and for providing culturally responsive services in clinical settings as an organization. Chapter 1 defines cultural competence, presents a rationale for pursuing it, and describes the process of becoming culturally competent and responsive to client needs. The chapter

highlights the consensus panel's core assumptions. It introduces a framework, adapting Sue's (2001) multidimensional model of cultural competence as the guiding model across chapters. The initial chapter ends with a broad overview of the concepts integral to an understanding of race, ethnicity, and culture.

Chapter 2 addresses the development of cultural awareness and describes core competencies for counselors and other clinical staff, beginning with self-knowledge and ending with skill development. It covers behaviors and skills for cultivating cultural competence as well as attitudes conducive to working effectively with diverse client populations.

Chapter 3 provides guidelines for culturally responsive clinical services, including interviewing skills, assessment practices, and treatment planning.

Chapter 4 provides organizational strategies to promote the development and implementation of culturally responsive practices from the top down, beginning with organizational self-assessment of current services and continuing through implementation and oversight of an organizational plan targeting initiatives to improve culturally responsive services.

Chapter 5 provides a general introduction for each major racial and ethnic group, providing specific cultural knowledge related to substance use patterns, beliefs and attitudes toward help-seeking behavior and treatment, and an overview of research- and practice-based treatment approaches and interventions.

Chapter 6 closes the TIP with an exploration of the concept of "drug culture"—the relationship between the drug culture and mainstream culture, the values and rituals of drug cultures, how people "benefit" from participation in drug cultures, and the role of the drug culture in substance abuse treatment.

Terminology

Throughout the TIP, the term *substance abuse* is used to refer to both substance abuse and substance dependence. This term was chosen partly because substance abuse treatment professionals commonly use the term substance abuse to describe any excessive use of addictive substances. In this TIP, the term refers to use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; American Psychiatric Association, 2013).

Throughout the TIP, the term *behavioral health* refers to a state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, psychological distress, suicide, and mental and substance use disorders. This includes a range of problems, from unhealthy stress to diagnosable and treatable diseases like serious mental illness and substance use disorders, which are often chronic in nature but from which people can and do recover. The term is also used in this TIP to describe the service systems encompassing the promotion of emotional health, the prevention of mental and substance use disorders, substance use and related problems, treatments and services for mental and substance use disorders, and recovery support. Behavioral health conditions, taken together, are the leading causes of disability burden in North America; efforts to improve their prevention and treatment will benefit society as a whole. Efforts to reduce the impact of mental and substance use disorders on communities in the United States, such as those described in this TIP, will help achieve nationwide improvements in health.

Core Assumptions

The consensus panel developed assumptions that serve as the fundamental platform of this TIP. Assumptions were derived from clinical and administrative experiences, available empirical evidence, conceptual writings, and program and treatment service models.

Assumption 1: The focus of cultural competence, in practice, has historically been on individual providers. However, counselors will not be able to sustain culturally responsive treatment without the organization's commitment to support and allocate resources to promote these practices. Organizations that value diversity and reflect cultural competence through congruent policies and procedures are more likely to be successful in the ever-changing landscape of communities, treatment services, and individual client needs.

Assumption 2: An understanding of race, ethnicity, and culture (including one's own) is necessary to appreciate the diversity of human dynamics and to treat all clients effectively. Before counselors begin to probe the cultures, races, and ethnicities of their clients and use this information to improve client treatment, the consensus panel recommends first that counselors examine and understand their own cultural histories, racial and ethnic heritages, and cultural values and beliefs. This applies to all practitioners regardless of race, ethnicity, or cultural identity. Beyond that, clinicians should clearly identify the influences of their own cultural experiences on the counseling relationship. In other words, each counselor must understand, embrace, and, if warranted, reexamine and adjust his or her own worldview to practice in a culturally competent manner. So too, all support staff, clinicians, administrators, and policymakers—including those not from the mainstream culture—must become educated and convinced of the importance of cultural competence in the delivery of effective behavioral health services.

Assumption 3: Incorporating cultural competence into treatment improves therapeutic decision-making and offers alternate ways to define and plan a treatment program that is firmly directed toward progress and recovery—as defined by both the counselor and client. Using culturally responsive practices is essential and provides many benefits for organizations, staff, communities, and clients.

Assumption 4: Consideration of culture is important at all levels of operation—individual, programmatic, and organizational—across behavioral health treatment settings. It is also important in all activities and at every treatment phase: outreach, initial contact, screening, assessment, placement, treatment, continuing care and recovery services, research, and education. Because organizations and systems have their own internal cultures, it is vital that treatment facilities, training and educational programs on substance-related and mental disorders and treatment processes, and licensing agencies and accrediting bodies incorporate culturally responsive practices into their curricula, standards, criteria, and requirements.

Assumption 5: Achieving cultural competence in an organization requires the participation of racially and ethnically diverse groups and underserved populations in the development and implementation of culturally responsive practices, program structure and design, treatment strategies and approaches, and staff professional development. Culturally congruent interventions cannot be successfully applied when generated outside a community or without community participation. Clients, potential clients, their families, and their communities should be invited to participate in the development of a cultural competence plan (an

organization's plan to improve cultural competence and to provide culturally responsive services) and, subsequently, the design of culturally relevant treatment services and organizational policies and procedures.

Assumption 6: Public advocacy of culturally responsive practices can increase trust among the community, agency, and staff. The community is thus empowered with a voice in organizational operations. Advocacy can further function as a secondary form of public education and awareness as well as outreach. High collective participation allows treatment to be viewed as of and for the community.

What Is Cultural Competence?

In 1989, Cross et al. provided one of the more universally accepted definitions of cultural competence in clinical practice: "A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable the system, agency, or professionals to work effectively in cross-cultural situations" (p. 13).

Since then, others have interpreted this definition in terms of a particular field or attempted to refine, expand, or elaborate on earlier conceptions of cultural competence. At the root of this concept is the idea that cultural competence is demonstrated through practical means—that is, the ability to provide effective services. Bazron and Scallet (1998) defined culturally responsive services as those that are "responsive to the unique cultural needs of bicultural/bilingual and culturally distinct populations" (p. 2). The Office of Minority Health (OMH 2000) merged several existing definitions to conclude that:

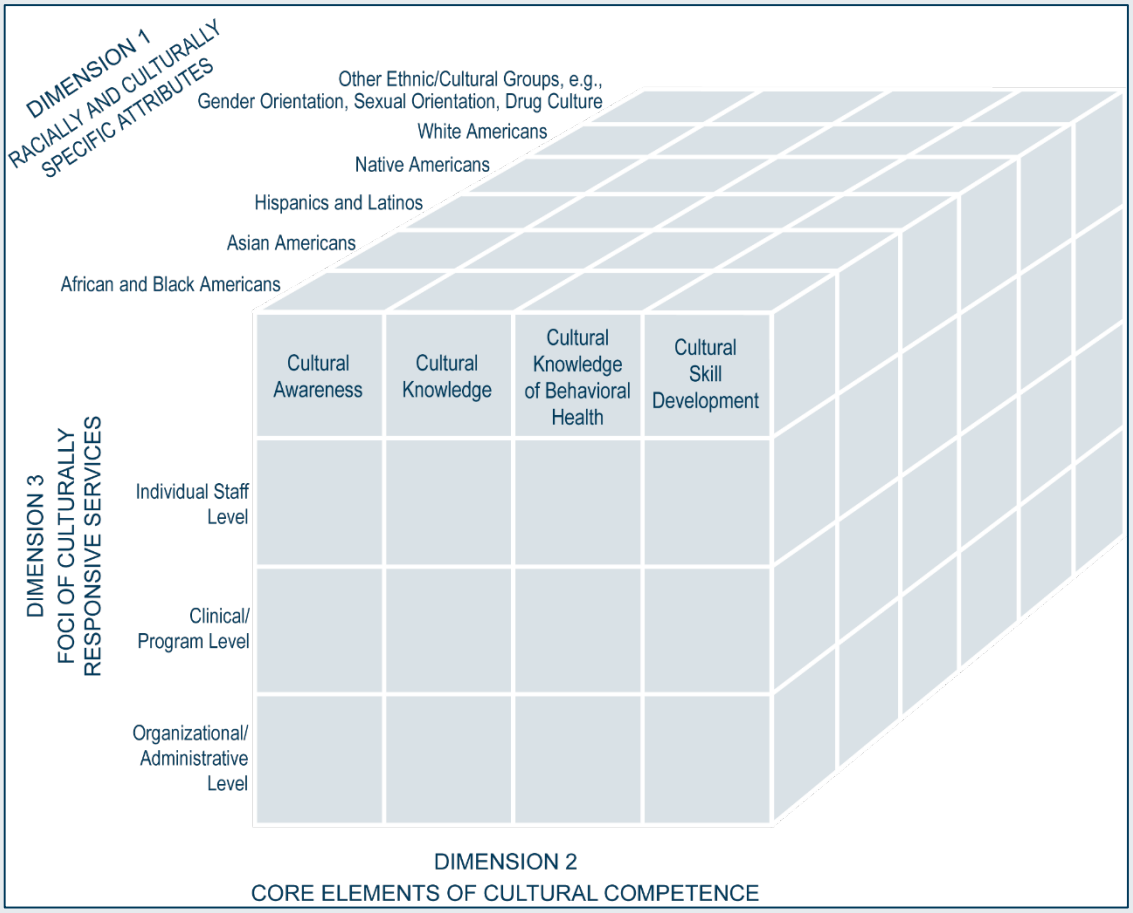
> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (p. 28)

Numerous evolving definitions and models of cultural competence reflect an increasingly complex and multidimensional view of how race, ethnicity, and culture shape individuals—their beliefs, values, behaviors, and ways of being (see Bhui et al. 2007 for a systemic review of cultural competence models in mental health). In this TIP, Sue's (2001) multidimensional model of cultural competence guides its overall organization and the specific content of each chapter. The model was adapted to fit the unique topic areas addressed by this TIP (Exhibit 1-1) and to target essential elements of cultural competence in providing behavioral health services across three main dimensions, as shown in the cube. (Note: Each subsequent chapter displays a version of this cube shaded to emphasize the focus of that chapter.)

Dimension 1: Racially and Culturally Specific Attributes

Exhibit 1-1 and this TIP focus on main population groups as identified by the U.S. Census Bureau (Humes et al. 2011), but this dimension is inclusive of other multiracial and culturally diverse groups and can also include sexual orientation, gender orientation, socioeconomic status, and geographic location. There are often many cultural groups within a given population or ethnic heritage. For simplicity, these groups are not represented on the actual model, and it is assumed that the reader acknowledges the vast inter- and intragroup variations that exist in all population, ethnic,

Exhibit 1-1: Multidimensional Model for Developing Cultural Competence



and cultural groups. Refer to Chapters 5 and 6 to gain further clinical knowledge about specific racial, ethnic, and cultural groups.

Dimension 2: Core Elements of Cultural Competence

This dimension includes cultural awareness, cultural knowledge, and cultural skill development. To provide culturally responsive treatment services, counselors, other clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers need to invest in gaining cultural knowledge of the populations that they serve and obtaining specific cultural knowledge as it relates to help-seeking, treatment, and recovery. This dimension also involves competence in clinical skills that ensure delivery of culturally appropriate treatment interventions. Several chapters capture the ingredients of this dimension. Chapter 1 provides an overview of cultural competence and concepts, Chapter 2 provides an indepth look at the role and effects of the counselor's cultural awareness and identity within the counseling process, Chapter 3 provides an overview of cultural considerations and essential clinical skills in the assessment and treatment planning process, and Chapter 5 specifically addresses the role of culture across specific treatment interventions.

Dimension 3: Foci of Culturally Responsive Services

This dimension targets key levels of treatment services: the individual staff member level, the

clinical and programmatic level, and the organizational and administrative level. Interventions need to occur at each of these levels to endorse and provide culturally responsive treatment services, and such interventions are addressed in the following chapters. Chapter 2 focuses on core counselor competencies; Chapter 3 centers on clinical/program attributes in interviewing, assessment, and treatment planning that promote culturally responsive interventions; and Chapter 4 addresses the elements necessary to improve culturally responsive services within treatment programs and behavioral health organizations.

Why Is Cultural Competence Important?

Foremost, cultural competence provides clients with more opportunities to access services that reflect a cultural perspective on and alternative, culturally congruent approaches to their presenting problems. Culturally responsive services will likely provide a greater sense of safety from the client's perspective, supporting the belief that culture is essential to healing. Even though not all clients identify with or desire to connect with their cultures, culturally responsive services offer clients a chance to explore the impact of culture (including historical and generational events), acculturation, discrimination, and bias, and such services also allow them to examine how these impacts relate to or affect their mental and physical health. Culturally responsive practice recognizes the fundamental importance of language and the right to language accessibility, including translation and interpreter services. For clients, culturally responsive services honor the beliefs that culture is embedded in the clients' language and their implicit and explicit communication styles and that language-accommodating services can have a positive effect on clients' responses to treatment and subsequent engagement in recovery services.

The Affordable Care Act, along with growing recognition of racial and ethnic health disparities and implementation of national initiatives to reduce them (HHS 2011*b*), necessitates enhanced culturally responsive services and cultural competence among providers. Most behavioral health studies have found disparities in access, utilization, and quality in behavioral health services among diverse ethnic and racial groups in the United States (Alegria et al. 2008*b*; Alegria et al. 2011; HHS 2011*b*; Le Cook and Alegria 2011; Satre et al. 2010). The lack of cultural knowledge among providers, culturally responsive environments, and diversity in the workforce contribute to disparities in healthcare. Even limited cultural competence is a significant barrier that can translate to ineffective provider–consumer communication, delays in appropriate treatment and level of care, misdiagnosis, lower rates of consumer compliance with treatment, and poorer outcome (Barr 2008; Carpenter-Song et al. 2011; Dixon et al. 2011). Increasing the cultural competence of the healthcare workforce and across healthcare settings is crucial to increasing behavioral health equity.

Additionally, adopting and integrating culturally responsive policies and practices into

What Are Health Disparities?

A health disparity is a particular type of health difference closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual or gender orientation; geographic location; or other characteristics historically tied to discrimination or exclusion.

Source: U.S. Department of Health and Human Services (HHS) 2011a.

behavioral health services provides many benefits not only for the client, but also for the organization and its staff. Foremost, it increases the likelihood of sustainability. Cultural competence supports the viability of services by bringing to the forefront the value of diversity, flexibility, and responsiveness in organizations and among practitioners. Beyond the necessity of adopting culturally responsive practices to meet funding, state licensing, and/or national accreditation requirements, cultural competence essential in organizational risk management (the process of making and implementing decisions that will optimize therapeutic outcomes and minimize adverse effects upon clients and, ultimately, the organization). For instance, implementing culturally responsive services is likely to increase access to care and improve assessment, treatment planning, and placement. So too, it is likely to enhance effective communication between clients and treatment providers, thus decreasing risks associated with misunderstanding the clients' presenting problems or the needs of clients with regard to appropriate referrals for evaluation or treatment.

Organizational investment in improving cultural competence and increasing culturally responsive services will likely increase use and cost effectiveness because services are more appropriately matched to clients from the beginning. A key principle in culturally responsive practices is engagement of the community, clients, and staff. As organizations establish community involvement in the ongoing implementation of culturally responsive services, the community will be more aware of available treatment services and thus will become more likely to use them as its involvement with and trust for the organization grows. Likewise, clients and staff are more apt to be empowered and invested if they are involved in the ongoing development and delivery of culturally responsive services. Client and staff satisfaction can increase if organizations provide culturally congruent treatment services and clinical supervision.

The Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (OMH 2013) are meant to reduce and eliminate disparities, improve quality of care, and promote health equality by establishing a blueprint for health and the organization of health care (see Appendix C or visit http://www.thinkculturalhealth.hhs.gov).

An organization also benefits from culturally responsive practices through planning for, attracting, and retaining a diverse workforce that reflects the multiracial and multiethnic heritages and cultural groups of its client base and community. Developing culturally responsive organizational policies includes hiring and promotional practices that support staff diversity at all levels of the organization, including board appointments. Increasing diversity does not guarantee culturally responsive practices, but it is more likely that doing so will lead to broader, varied treatment services to meet client and community needs. Organizations are less able to ignore the roles of race, ethnicity, and culture in the delivery of behavioral health services if staff composition at each level of the organization reflects this diversity.

Culturally responsive practice reinforces the counselor's need for self-exploration of cultural identity and awareness and the importance of acquiring knowledge and skills to meet clients' specific cultural needs. Cultural competence requires an understanding of the client's worldview and the interactions between that worldview and the cultural identities of the counselor and the client in the therapeutic process. Culturally responsive practice reminds counselors that a client's worldview shapes his or her perspectives,

beliefs, and behaviors surrounding substance use and dependence, illness and health, seeking help, treatment engagement, counseling expectations, communication, and so on. Cultural competence includes addressing the client individually rather than applying general treatment approaches based on assumptions and biases. It also can counteract a potentially omnipotent stance on the part of counselors that they know what clients need more than the clients themselves do. Cultural competence highlights the need for counselors to take time to build a relationship with each of their clients, to understand their clients, and to assess for and access services that will meet each client's individual needs.

The importance and benefit of cultural competence does not end with changes in organizational policies and procedures, increases in program accessibility and tailored treatment services, or enhancement of staff training. In programs that prioritize and endorse cultural competence at all levels of service, clients, too, will have more exposure to psychoeducational and clinical experiences that explore the roles of race, ethnicity, culture, and diversity in the treatment process. Treatment will help clients address their own biases, which can affect their perspectives and subsequent relationships with other clients, staff members, and individuals outside of the program, including other people in recovery. Culturally responsive services prepare clients not only to embrace their own cultural groups and life experiences, but to acknowledge and respect the experiences, perspectives, and diversity of others.

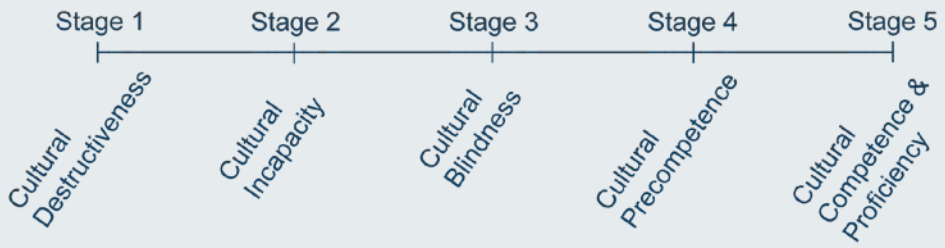
How Is Cultural Competence Achieved?

Cultural groups are diverse and continuously evolving, defying precise definitions. Cultural competence is not acquired merely by learning a given set of facts about specific populations, changing an organization's mission statement, or attending a training on cultural competence. Becoming culturally competent is a developmental process that begins with awareness and commitment and evolves into skill building and culturally responsive behavior within organizations and among providers.

Cultural competence is the ability to recognize the importance of race, ethnicity, and culture in the provision of behavioral health services. Specifically, it is awareness and acknowledgment that people from other cultural groups do not necessarily share the same beliefs and practices or perceive, interpret, or encounter similar experiences in the same way. Thus, cultural competence is more than speaking another language or being able to recognize the basic features of a cultural group. Cultural competence means recognizing that each of us, by virtue of our culture, has at least some ethnocentric views that are provided by that culture and shaped by our individual interpretation of it. Cultural competence is rooted in respect, validation, and openness toward someone whose social and cultural background is different from one's own (Center for Substance Abuse Treatment [CSAT] 1999*b*).

Nonetheless, cultural competence literature highlights how difficult it is to appreciate cultural differences and to address these differences effectively, because many people tend to see things solely from their own culture-bound perspectives. For counselors, specific cognitions, attitudes, and behaviors characterize the path to culturally competent counseling and culturally responsive services. Exhibit 1-2 depicts the continuum of thoughts and behaviors that lead to cultural competence in the provision of treatment. The "stages" are not necessarily linear, and not all people begin with a negative impression of other cultural groups—they may simply fail to recognize differences and diverse ways of being. For

Exhibit 1-2: The Continuum of Cultural Competence



Stage 1: Cultural Destructiveness

Organizational Level: At best, the behavioral health organization negates the relevance of culture in the delivery of behavioral health services. Agencies expect individuals from diverse ethnic and cultural backgrounds to fit into the existing treatment program rather than adapting the program to each client to provide culturally congruent services. Driving this expectation is the attitude that mainstream culture and current services are superior and that other approaches (e.g., Native American traditional healing practices) need not be considered. Organizations can also take a more adversarial role at this level—failing to provide basic services, creating an uncomfortable environment to covertly discourage the use of services, or expecting the individual to leave culture at the door.

Individual Level: Counselors can also operate from this stance, holding a myopic view of "effective" treatment. However, it would likely be difficult to operate at this level as a counselor without organizational endorsement. Counselors can project superiority by stating with authority and conviction in sessions that their approach is the best and expressing directly to clients that they should be grateful to receive these services. At the same time, these counselors filter interactions through a biased lens without engaging in self-reflection or examination of the impact of their prejudice.

Stage 2: Cultural Incapacity

Organizational Level: Due to lack of organizational responsiveness, services and organizational culture may be biased, and clients may view them as oppressive. An agency functioning at cultural incapacity expects clients from diverse backgrounds to conform to services rather than the agency being flexible and adapting services to meet client needs. Treatment of diverse individuals is often paternalistic, limiting their active participation in treatment planning or minimizing the need for culturally congruent treatment services.

Individual Level: Counselors ignore the relevance of culture while using the dominant client population and/or culture as the norm for assessment, treatment planning, and determination of services. At this level, counselors can be aware of the need to approach treatment differently but likely believe that they are powerless over circumstances or the organizational system.

Stage 3: Cultural Blindness

Organizational Level: The core belief that perpetuates cultural blindness is the assumption that all cultural groups are alike and have similar experiences. Taking the position that individuals across cultural groups are more alike than different, organizations can rationalize that "good" treatment services will suffice for all clients regardless of ethnicity, race, religion, sexual orientation, national origin, or class. Consequently, organizations that operate at this level will continue developing and implementing policies and procedures that propagate discrimination.

Individual Level: At this stage, counselors uphold the belief that there are no essential differences among individuals across cultural groups—that everyone experiences discrimination and is subject to the biases of others. Counselors rationalize that approaching all clients as individuals negates the need to focus specifically on cultural competence. For example, some counselors may believe that there is

(Continued on the next page.)

Exhibit 1-2: The Continuum of Cultural Competence (continued)

too much focus on cultural competence and that training in this area has become the "pop culture" in the counseling field, or they may feel that too much time is spent on cultural issues when a good assessment addressing individual issues and needs would suffice.

Stage 4: Cultural Precompetence

Organizational Level: Organizations at this stage begin to develop a basic understanding of and appreciation for the importance of sociocultural factors in the delivery of care. Similar to the preparation stage identified in the stages of change model (Prochaska et al. 1992; Miller and Rollnick 2013), this level involves recognition of the need for more culturally responsive services, further exploration of steps toward creating more appropriate services for culturally diverse populations, and a general commitment characterized by small organizational changes. Despite having incomplete knowledge, agencies at this stage can evolve toward organizational cultural competence with support, planning, and commitment from the governing and advisory boards, community, and administrators.

Individual Level: Counselors acknowledge a need for more training specific to the populations they serve at this level of development. They acknowledge the need to attend more to ethnicity, race, and culture in the provision of services, but they probably lack the information and skills necessary to translate their recognition into behavioral change. Even so, they are open to training, recognize the importance of developing cultural competence, and have taken small steps to improve their clinical knowledge.

Stage 5: Cultural Competence and Proficiency

Organizational Level: Organizations are aware of the importance of integrating services that are congruent with diverse populations. Organizations understand that a commitment to cultural competence begins with strategic planning to conduct an organizational self-assessment and adopt a cultural competence plan. There is a willingness to be more transparent in evaluating current services and practices and in developing policies and practices that meet the diverse needs of the treatment population and the community at large. Proficiency on an organizational level is characterized by an ongoing commitment to workforce development, training, and evaluation; development of culturally specific and congruent services; and continual performance evaluation and improvement.

Individual Level: Recognition of the vital need to adopt culturally responsive practices is present. Counselors acknowledge significant differences across and within races, ethnicities, and cultural groups, and they know that these differences need to be integrated into assessment, treatment planning, and services. At this stage, counselors are committed to an ongoing process of becoming culturally competent.

Sources: Comas-Diaz 2012; Cross et al. 1989; Sue and Constantine 2005.

most people, the process of becoming culturally competent is complex, with movement back and forth along the continuum and with feelings and thoughts from more than one stage sometimes existing concurrently.

What Is Culture?

Culture is defined by a community or society. It structures the way people view the world. It involves the particular set of beliefs, norms, and values concerning the nature of relationships, the way people live their lives, and the way people organize their environments. Culture is a complex and rich concept. Understanding it requires a willingness to examine and grasp its many elements and to comprehend how they come together. Castro (1998) identified the elements generally agreed to constitute a culture as:

- A common heritage and history that is passed from one generation to the next.

- Shared values, beliefs, customs, behaviors, traditions, institutions, arts, folklore, and lifestyle.
- Similar relationship and socialization patterns.
- A common pattern or style of communication or language.
- Geographic location of residence (e.g., country; community; urban, suburban, or rural location).
- Patterns of dress and diet.

Although these criteria cannot be strictly applied to every cultural group, they do sufficiently define cultures so that groups are distinguishable to their members and to others (Castro 1998). Note that these criteria apply more or less equally well to cultural groups based on nationality, ethnicity, region (e.g., Southern, Midwestern), profession, and social interests (Exhibit 1-3 reviews common characteristics of culture).

However, culture is not a definable entity to which people belong or do not belong. Within a nation, race, or community, people belong to multiple cultural groups, each with its own set of cultural norms (i.e., spoken or unspoken rules or standards that indicate whether a certain behavior, attitude, or belief is appropriate or inappropriate).

The word "culture" can be applied to describe the ways of life of groups formed on the bases

Exhibit 1-3: Common Characteristics of Culture

The following list provides examples of common elements that distinguish one culture from another. Not every cultural group will define or endorse every item on this list, but most cultural groups will uphold the most common characteristics, which include:

- Identity development (multiple identities and self-concept).
- Rites of passage (rituals and rites that mark specific developmental milestones).
- Broad role of sex and sexuality.
- Images, symbols, and myths.
- Religion and spirituality.
- View, use, and sources of power and authority.
- Role and use of language (direct or implied).
- Ceremonies, celebrations, and traditions.
- Learning modalities, acquisition of knowledge and skills.
- Patterns of interpersonal interaction (culturally idiosyncratic behaviors).
- Assumptions, prejudices, stereotypes, and expectations of others.
- Reward or status systems (meaning of success, role models, or heroes).
- Migration patterns and geographic location.
- Concepts of sanction and punishment.
- Social groupings (support networks, external relationships, and organizational structures).
- Perspectives on the role and status of children and families.
- Patterns and perspectives on gender roles and relationships.
- Means of establishing trust, credibility, and legitimacy (appropriate protocols).
- Coping behaviors and strategies for mediating conflict or solving problems.
- Sources for acquiring and validating information, attitudes, and beliefs.
- View of the past and future, and the group's or individual's sense of place in society and the world.
- History and other past circumstances that have contributed to a group's current economic, social, and political status within the broader culture as well as the experiences associated with developing certain beliefs, norms, and values.

Sources: American Psychological Association (APA) 1990; Center for Substance Abuse Prevention 1994; Charon 2004; Dogra and Karim 2010.

of age, profession, socioeconomic status, disability, sexual orientation, geographic location, membership in self-help support groups, and so forth. In this TIP, with the exception of the drug culture, the focus is on cultural groups that are shaped by a dynamic interplay among specific factors that shape a person's identity, including race, ethnicity, religion, socioeconomic status, and others.

What Is Race?

Race is often thought to be based on genetic traits (e.g., skin color), but there is no reliable means of identifying race based on genetic information (HHS 2001). Indeed, 85 percent of human genetic diversity is found within any "racial" group (Barbujani et al. 1997). Thus, what we perceive as diverse races (based largely on selective physical characteristics, such as skin color) are much more genetically similar than they are different. Moreover, physical characteristics ascribed to a particular racial group can also appear in people who are not in that group. Asians, for example, often have an epicanthic eye fold, but this characteristic is also shared by the Kung San bushmen, an African nomadic Tribe (HHS 2001).

Although it lacks a genetic basis, the concept of race is important in discussing cultural competence. Race is a social construct that describes people with shared physical characteristics. It can have tremendous social significance in terms of behavioral health services, social opportunities, status, wealth, and so on. The perception that people who share physical characteristics also share beliefs, values, attitudes, and ways of being can have a profound impact on people's lives regardless of whether they identify with the race to which they are ascribed by themselves or others. The major racial groupings designated by the U.S. Census Bureau—African American or Black, White American or Caucasian, Asian American, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander—are limiting in that they are categories developed to describe identifiable populations that exist currently within the United States. The U.S. Census defines Hispanics/Latinos as an ethnic group rather than a racial group (see the "What Is Ethnicity?" section later in this chapter).

Racial labels do not always have clear meaning in other parts of the world; how one's race is defined can change according to one's current environment or society. A person viewed as Black in the United States can possibly be viewed as White in Africa. Racial categories also do not easily account for the complexity of multiracial identities. An estimated 3 percent of United States residents (9 million individuals) indicated in the 2010 Census that they are of more than one race (Humes et al. 2011). The percentage of the total United States population who identify as being of mixed race is expected to grow significantly in coming years, and some estimate that it will rise as high as one in five individuals by 2050 (Lee and Bean 2004).

White Americans constitute the largest racial group in the United States. In the 2010 Census, 72 percent of the United States population consisted of non-Hispanic Whites, a classification that has been used by the Census Bureau and others to refer to non-Hispanic people of European, North African, or Middle Eastern descent (Humes et al. 2011). The U.S. Census Bureau predicts, however, that White Americans will be outnumbered by persons of color sometime between the years 2030 and 2050. The primary reasons for the decreasing proportion of White Americans are immigration patterns and lower birth rates among Whites relative to Americans of other racial backgrounds (Sue and Sue 2003*b*).

Whites are often referred to collectively as Caucasians, although technically, the term

refers to a subgroup of White people from the Caucasus region of Eastern Europe and West Asia. To complicate matters, some Caucasian people—notably some Asian Indians—are typically counted as Asian (U.S. Census Bureau 2001*a*). Many subgroups of White Americans (of European, Middle Eastern, or North African descent) have had very different experiences when immigrating to the United States.

African Americans, or Blacks, are the second largest racial group in the United States, making up about 13 percent of the United States population in 2010 (Humes et al. 2011). Although most African Americans trace their roots to Africans brought to the Americas as slaves centuries ago, an increasing number are new immigrants from Africa and the Caribbean. The terms African American and Black are used synonymously at times in literature and research, but some recent immigrants do not consider themselves to be African Americans, assuming that the designation only applies to people of African descent born in the United States. The racial designation Black, however, encompasses a multitude of cultural and ethnic variations and identities (e.g., African Caribbean, African Bermudian, West African, etc.). The history and experience of African Americans has varied considerably in different parts of the United States, and the experience of Black people in this country varies even more when the culture and history of more recent immigrants is considered. Today, African American culture embodies elements of Caribbean, Latin American, European, and African cultural groups. Noting this diversity, Brisbane (1998) observed that "these cultures are so unique that practices of some African Americans may not be understood by other African Americans…there is no one culture to which all African Americans…belong" (p. 2).

The racial category of Asian is defined by the U.S. Census Bureau (2001*a*) as people "having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam" (p. A-3). In the 2010 census, Asian Americans accounted for 4.8 percent of the total United States population, or 5.6 percent when biracial or multiracial Asians were included (Hoeffel et al. 2012). For those who identified with only one Asian group, 23 percent of Asian Americans were Chinese; 19 percent, Asian Indian; 17 percent, Filipino; 11 percent, Vietnamese; 10 percent, Korean; and 5 percent, Japanese. Asian Americans comprised about 43 ethnic subgroups, speaking more than 100 languages and dialects (HHS 2001). The tremendous cultural differences among these groups make generalizations difficult.

Until recently, Asian Americans were often grouped with Pacific Islanders (collectively called Asians and Pacific Islanders, or APIs) for data collection and analysis. Beginning with the 2000 Census, however, the Federal Government recognized Pacific Islanders as a distinct racial group. As a result, this TIP does not combine Asians with Pacific Islanders. Nonetheless, remnants of the old classification system are evident in research based on the API grouping. Where possible, the TIP uses data solely for Asians; however, in some cases, the only research available is for the combined API grouping.

Native American is a term that describes both American Indians and Alaska Natives. Racially, Native Americans are related to Asian peoples (notably, those from Siberia in Russia), but they are considered a distinct racial category by the U.S. Census Bureau, which further stipulates that people categorized in this fashion have to have a "Tribal affiliation

or community attachment" (U.S. Census Bureau 2001*a*, p. A-3). There are 566 federally recognized American Indian or Alaska Native Tribal entities (U.S. Department of the Interior, Indian Affairs 2013*a*), but there are numerous other Tribes recognized only by States and still others that go unrecognized by any government agency. These Tribes, despite sharing a racial background, represent a widely diverse group of cultures with diverse languages, religions, histories, beliefs, and practices.

What Is Ethnicity?

The term ethnicity is sometimes used interchangeably with "race," although it is important to draw distinctions between the two. According to Yang (2000), ethnicity refers to the social identity and mutual sense of belonging that defines a group of people through common historical or family origins, beliefs, and standards of behavior (i.e., culture). In some cases, ethnicity also refers to identification with a clan or group whose identity can be based on race as well as culture. Some Latinos, for example, self-identify in terms of both their ethnicity (e.g., their Cuban heritage) and their race (e.g., whether they are dark or light skinned).

Because Latinos can belong to a number of races, the Census Bureau defines them as an ethnic group rather than a race. In 2010, Latinos comprised 16 percent of the United States population (Ennis et al. 2011). They are the fastest growing ethnic group in the United States; between 2000 and 2010, the number of Latinos in the country increased 43 percent, a rate nearly four times higher than that for the total population (Ennis et al. 2011). By 2050, Latinos are expected to make up 29 percent of the total population (Passel and Cohn 2008). Nearly 60 percent of Latino Americans were born in the United States, but Latinos also account for more than half of the nation's foreign-born population (Larsen 2004; Ramirez and de la Cruz 2003). Foreign-born Latinos include legal immigrants, some of whom have succeeded in becoming naturalized American citizens, as well as undocumented or illegal immigrants to the United States. Approximately three-quarters (74 percent) of the Nation's unauthorized immigrant population are Hispanics, mostly from Mexico (Passel and Cohn 2008).

> Ethnicity differs from race in that groups of people can share a common racial ancestry yet have very different ethnic identities. Thus, by definition, ethnicity—unlike race—is an explicitly cultural phenomenon. It is based on a shared cultural or family heritage as well as shared values and beliefs rather than shared physical characteristics.

The terms "Hispanic" and "Latino" refer to people whose cultural origins are in Spain or Portugal or the countries of the Western Hemisphere whose culture is significantly influenced by Spanish or Portuguese colonization. Regional and political differences exist among various groups as to whether they prefer one term over the other. The literature currently uses both terms interchangeably, as both terms are widely used and refer generally to the same Latin-heritage population of the United States. That said, a distinction can technically be drawn between Hispanic (literally meaning people from Spain or its former colonies) and Latino (which refers to persons whose origins lie in countries ranging from Mexico to Central and South America and the Caribbean, which were colonized by Spain, and including Portugal and its former colonies as well). For that reason, this TIP uses the more inclusive term Latino, except when research specifically indicates the other. The term Latinas is used to refer specifically to women who are a part of this cultural group.

Within a racial group (e.g., Asian, White, Black, Native American), there are many diverse ethnicities, and these diverse ethnicities often reflect vast differences in cultural histories. The White Anglo-Saxon Protestant peoples of England and Northern Europe have, for example, many differing cultural attributes and a very different history in the United States than the Mediterranean peoples of Southern Europe (e.g., Italians, Greeks).

What Is Cultural Identity?

Cultural identity describes an individual's affiliation or identification with a particular group or groups. Cultural identity arises through the interaction of individuals and culture(s) over the life cycle. Cultural identities are not static; they develop and change across stages of the life cycle. People reevaluate their cultural identities and sometimes resist, rebel, or reformulate them over time. All people, regardless of race or ethnicity, develop a cultural identity (Helms 1995). Cultural identity is not consistent even among people who identify with the same culture. Two Korean immigrants could both identify strongly with Korean culture but embrace or reject different elements of that culture based on their particular life experiences (e.g., being raised in an urban or rural community, belonging to a lower- or upper-class family). Cultural groups may also place different levels of importance on various aspects of cultural identities. In addition, individuals can hold two or more cultural identities simultaneously.

Some of the factors that are likely to vary among members of the same culture include socioeconomic status, geographic location, gender, education level, occupational status, sexuality, and political and religious affiliation. For individuals whose families are highly acculturated, some of these characteristics (e.g., geographic location, occupation, religion) can be more important than ethnic culture in defining their sense of identity. The section that follows provides more detailed information on the most important cross-cutting factors involved in the creation of a person's cultural identity.

What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture?

Language and Communication

Language is a key element of culture, but speaking the same language does not necessarily mean that people share the same cultural beliefs. For example, English is spoken in Australia, Canada, Jamaica, India, Belize, and Nigeria, among other countries. Even within the United States, people from different regions can have diverse cultural identities even though they speak the same language. Conversely, those who share an ethnicity do not automatically share a language. Families who immigrated to this country several generations earlier may identify with their culture of origin but no longer be able to speak its language. English is the most common language in the United States, but 18 percent of the total population report speaking a language other than English at home (Shin and Bruno 2003).

Styles of communication and nonverbal methods of communication are also important aspects of cultural groups. Issues such as the use of direct versus indirect communication, appropriate personal space, social parameters for and displays of physical contact, use of silence, preferred ways of moving, meaning of gestures, degree to which arguments and verbal confrontations are acceptable, degree of formality expected in communication, and amount of eye contact expected are all culturally defined and reflect very basic ethnic and cultural differences (Comas-Diaz 2012;

Franks 2000; Sue 2001). More specifically, the relative importance of nonverbal messages varies greatly from culture to culture; high-context cultural groups place greater importance on nonverbal cues and the context of verbal messages than do low-context cultural groups (Hall 1976). For example, most Asian Americans come from high-context cultural groups in which sensitive messages are encoded carefully to avoid giving offense.

A behavioral health service provider who listens only to the literal meaning of words can miss clients' actual messages. What is left unsaid, or the way in which something is said, can be more important than the words used to convey the message. African Americans have a relatively high-context culture compared with White Americans but a somewhat lower-context culture compared with Asian Americans (Franks 2000). Thus, African Americans typically rely to a greater degree than White Americans on nonverbal cues in communicating. Conversely, White American culture is low context (as are some European cultural groups, such as German and British); communication is expected to be explicit, and formal information is conveyed primarily through the literal content of spoken or written messages.

Geographic Location

Cultural groups form within communities and among people who interact meaningfully with each other. Although one can speak of a national culture, the fact is that any culture is subject to local adaptations. Local norms or community rules can significantly affect a culture. Thus, it is important for providers to be familiar with the local cultural groups they

Advice to Counselors: Cultural Differences in Communication

The following examples provide broad descriptions that do not necessarily fit all cultural groups from a specific racial or ethnic group. Counselors should avoid assuming that a client has a particular expectation or expression of nonverbal and verbal communication based solely on race, ethnicity, or cultural heritage. For example, a counselor could make an assumption during an interview that a Native American client prefers a nondirective counseling style coupled with long periods of silence, whereas the client expects a more direct, active, goal-oriented approach. Counselors should be knowledgeable and remain open to differences in communication patterns that can be present when counseling others from diverse backgrounds. The following are some examples of general differences among cultural groups:

- Individuals from many White/European cultural groups can be uncomfortable with extended silences and can believe them to indicate that nothing is being accomplished (Franks et al. 2000), whereas Native Americans, who often place great emphasis on the value of listening, can find extended silences appropriate for gathering thoughts or showing that they are open to another's words (Coyhis 2000).
- Latinos often value *personalismo* (i.e., warm, genuine communication) in interpersonal relations and value personal rapport in business dealings; they prefer personal relationships to formal ones (Barón 2000; Castro et al. 1999*a*). Many Latinos also initially engage in *plática* (small talk) to evaluate the relationship and often use *plática* prior to disclosing more personal information or addressing serious issues (Comas-Diaz 2012). On the other hand, Asian Americans can be put off by a communication style that is too personal or emotional, and some may lack confidence in a professional whose communication style is too personal (Lee and Mock 2005*a*).
- Some cultural groups are more comfortable with a high degree of verbal confrontation and argument; others stress balance and harmony in relationships and shun confrontation. For some, forceful, direct communication can seem rude or disrespectful. In many Native American and Latino cultural groups, cooperation and agreeableness (simpatía) is valued. Members often avoid disagreement, contradiction, and disharmony within the group (Sue and Sue 2013*a*).

encounter—to not think, for example, in terms of a homogeneous Mexican culture so much as the Mexican culture of Los Angeles, CA, or the Mexican culture of El Paso, TX.

Geographical factors can also have a significant effect on a client's culture. For example, clients coming from a rural area—even if they come from different ethnicities—can have a great deal in common, whereas individuals from the same ethnicity who were raised in different geographic locales can have very different experiences and, consequently, attitudes. For example, although the vast majority of Asian Americans live in urban areas (95 percent in 2002; Reeves and Bennett 2003), a particular Asian American client may have been born in a rural community or come from a culture (e.g., the Hmong) that developed in remote areas; the client may retain cultural values and interests that reflect those origins. Other clients who currently live in cities may still consider a rural locale as their home and regularly return to it. Many Native Americans who live in urban areas or in communities adjacent to reservations, for example, travel regularly back to their home reservations (Cornell and Kalt 2010; Lobo 2003).

In addition to its potential influence upon culture, geography can strongly affect substance use and abuse, mental health and well-being, and access to and use of health services (Baicker et al. 2005). In the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2012 National Survey on Drug Use and Health (NSDUH), past-month illicit drug use rates among individuals ages 12 and older were 9.9 percent in large metropolitan areas, 8.3 percent in nonmetropolitan urbanized areas, 5.9 percent in less urbanized nonmetropolitan areas, and 4.8 percent in rural areas (SAMHSA 2013*d*). In very rural or remote areas, illicit drug use is likely to be even less common than in rural areas (Schoeneberger et al. 2006). Even among members of the same culture, less substance use is observed in those who live in more rural regions. For example, O'Connell and associates (2005) found that alcohol consumption was lower for American Indians living on reservations than for those who were geographically dispersed (and typically living in urban areas). Likewise, individuals born or living in urban areas may be at greater risk for serious mental illness. In one systematic study, higher distribution rates of schizophrenia were found in urban areas, particularly among people who were born in metropolitan areas (McGrath et al. 2004).

Worldview, Values, and Traditions

There are many ways of conceptualizing how culture influences an individual. Culture can be seen as a frame through which one looks at the world, as a repertoire of beliefs and practices that can be used as needed, as a narrative or story explaining who people are and why they do what they do, as a set of institutions defining different aspects of values and traditions, as a series of boundaries that use values and traditions to delineate one group of people from another, and so on. According to Lamont and Small (2008), such schemata recognize that culture shapes what people believe (i.e., their values and worldviews) and what they do to demonstrate their beliefs (i.e., their traditions and practices). Cultural groups define the values, worldviews, and traditions of their members—from food preferences to appropriate leisure activities—including use of alcohol and/or drugs (Bhugra and Becker 2005). Thus, it is impossible to review and summarize the variety of cultural values, traditions, and worldviews found in the United States in this publication. Providers are encouraged to speak with their clients to learn about their worldviews, values, and traditions and to seek training and consultation to gain specific

knowledge about clients' cultural beliefs and practices.

Family and Kinship

Although families are important in all cultural groups, concepts of and attitudes toward family are culturally defined and can vary in a number of ways, including the relative importance of particular family ties, the family's inclusiveness, how hierarchical the family is, and how family roles and behaviors are defined (McGoldrick et al. 2005). In some cultural groups (e.g., White Americans of Western European descent, such as German, English), family is limited to the nuclear family, whereas in other groups (e.g., African Americans; Asian Americans; Native Americans; White Americans of Southern European descent, such as Italian, Greek), the idea of family typically includes many other blood or marital relations (Almeida 2005; Hines and Boyd-Franklin 2005; Marinangeli 2001; McGill and Pearce 2005; McGoldrick et al. 2005). Some cultural groups clearly define roles for different family members and carefully prescribe methods of behaving toward one another based on specific relationships. For example, in Korean culture, wives are expected to defer to their in-laws about many decisions (Kim and Ryu 2005).

Even in cultural groups with carefully defined roles and rules for family members, family dynamics may change as the result of internal or external forces. The process of acculturation, for instance, can significantly affect family roles and dynamics among immigrant families, causing the dissolution of longstanding cultural hierarchies and traditions within the family and resulting in conflict between spouses or different generations of the family (Hernandez 2005; Juang et al. 2012; Lee and Mock 2005*a*). Information on family therapy with major ethnic/racial groups is provided in Chapter 5 of this TIP. Details of the role of family in treatment and the provision of family therapy appear in TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*).

Gender Roles

Gender roles are largely cultural constructs; diverse cultural groups have different understandings of the proper roles, attitudes, and behaviors for men and women. Even within modern American society, there are variations in how cultural groups respond to gender norms. For example, after controlling for income and education, African American women are less accepting than White American women of traditional American gender stereotypes regarding public behavior but more accepting of traditional domestic gender roles (Dugger 1991; Haynes 2000).

Culturally defined gender roles also appear to have a strong effect on substance use and abuse. This can perhaps be seen most clearly in international research indicating that, in societies with more egalitarian relationships between men and women, women typically consume more alcohol and have drinking patterns more closely resembling those of men in the society (Bloomfield et al. 2006). A similar effect can be seen in research conducted in the United States with Latino men and women with varying levels of acculturation to mainstream American society (Markides et al. 2012; Zemore 2005).

The terms for and definitions of gender roles can also vary. For example, in Latino cultural groups, importance is placed on *machismo* (the belief that men must be strong and protect their families), *caballerismo* (men's emotional connectedness), and *marianismo* (the idea that women should be self-sacrificing, endure suffering for the sake of their families, and defer to their husbands) (Arciniega et al. 2008; Torres et al. 2002). These strong gender roles have benefits in Latino culture, such as simplifying and clarifying roles and responsibilities,

but they are also sources of potential problems, such as limiting help-seeking behavior or the identification of difficulties. For example, because of the need to appear in control, a Latino man can have difficulty admitting that his substance use is out of control or that he is experiencing psychological distress (Castro et al. 1999*a*). For Latinas, the difficulties of negotiating traditional gender roles while encountering new values through acculturation can lead to increased substance use/abuse and mental distress (Gil and Vazquez 1996; Gloria and Peregoy 1996; Mora 2002).

Negotiating gender roles in a treatment setting is often difficult; providers should not assume that a client's traditional culture-based gender roles are best for him or her or that mainstream American ideas about gender are most appropriate. The client's degree of acculturation and adherence to traditional values must be taken into consideration and respected. Two TIPs explore the relationship of gender to substance abuse and substance abuse treatment: TIP 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT 2009*c*), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA 2013*a*). TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders,* addresses the relationships among gender, mental illness, and substance use disorders (CSAT 2005*d*).

Socioeconomic Status and Education

Sociologists often discuss social class as an important aspect in defining an individual's cultural background. In this TIP, socioeconomic status (SES) is used as a category similar to class—the difference being that socioeconomic status is a more flexible and less hierarchically defined concept. SES in the United States is related to many factors, including occupational prestige and education, yet it is primarily associated with income level. Thus, SES affects culture in several ways, namely through a person's ability to accumulate material wealth, access opportunities, and

What Causes Health Disparities?

The National Institutes of Health (NIH; 2012, Overview, p. 1) define health disparities as "differences in the incidence, prevalence, morbidity, and burden of diseases and other adverse health conditions that exist among specific population groups." Numerous studies have found longstanding health disparities among racial/ethnic groups in the United States (Smedly et al. 2003), and the Agency for Healthcare Research and Quality (AHRQ) issues yearly reports that provide updates on this topic (AHRQ 2012). An Institute of Medicine report on disparities (Smedly et al. 2003) found multiple causes for these disparities, including historical inequalities that have influenced the healthcare system, persistent racial and ethnic discrimination, and distrust of the healthcare system among certain ethnic and racial groups. However, the most persistent and prominent cause appears to be disparities in SES, which affect insurance coverage and access to quality care (Russell 2011). These economic disparities account for significantly higher death rates, particularly among African Americans compared with non-Hispanic Whites (Arias 2010), as well as greater lack of insurance coverage or worse coverage for people of color (Smedly et al. 2003).

Evidence-based interventions to reduce health disparities are limited (Beach et al. 2006; Carpenter-Song et al. 2011). Current strategies generally focus on reducing risk factors that affect groups who experience a greater burden from poor health (Murray et al. 2006). The Federal Government has recognized the need to address health disparities and has made this issue a priority for agencies that deal with health care (HHS 2011b). As part of this effort, it has created the National Institute on Minority Health and Health Disparities (see http://ncmhd.nih.gov/). More specific information on mental health and substance abuse treatment disparities is provided in Chapter 5 of this TIP.

Social Determinants of Health

Per Healthy People 2020 (http://www.healthypeople.gov), a federal prevention agenda involving a multiagency effort to identify preventable threats to health and set goals for reducing them, "social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." Social determinants include access to educational, economic, and vocational training; job opportunities; transportation; healthcare services; emerging healthcare technologies; availability of community-based resources, basic resources to meet daily living needs, language services, and social support; exposure to crime; social disorder; community and concentrated poverty; and residential segregation.

Source: Office of Disease Prevention and Health Promotion, HHS 2013.

use resources. Discrimination and historical racism have led to lasting inequalities in SES (Weller et al. 2012; Williams and Williams-Morris 2000). SES affects mental health and substance use. From 2005 to 2010, adults 45 through 64 years of age were five times more likely to have depression if they were poor (National Center for Health Statistics 2012). Serious mental illness among adults living in poverty has a prevalence rate of 9.1 percent (SAMHSA 2010). Some research demonstrates higher risk for schizophrenia from lower socioeconomic levels, but other studies draw no definite conclusion (Murali and Oyebode 2010). Most literature suggests that poverty and its consequences, including limited access to resources, increase stress and vulnerability among individuals who may already be predisposed to mental illness. Often, theoretical discussions explaining a significant relationship between mental illness and SES suggest a bidirectional relationship in which stress from poverty leads to mental illness vulnerability and/or mental illness leads to difficulty in maintaining employment and sufficient income.

Studies have had conflicting results as to whether people with high or low SES are more likely to abuse substances (Jones-Webb et al. 1995). In international studies, increases in wealth on a societal level have been associated with increases in alcohol consumption (Bergmark and Kuendig 2008; Kuntsche et al. 2006; Room et al. 2003). However, other factors, such as the availability of social support systems and education, as well as the individual's acculturation level, can also play a role. Karriker-Jaffe and Zemore (2009) found that, in immigrants, a greater level of acculturation was associated with increased heavy drinking for those with above-average SES but not for those with lower SES. Besides lower socioeconomic status, neighborhood poverty (defined as having a high [≥20 percent] proportion of residents living in poverty) was associated with binge drinking and higher rates of substance-related problems, particularly for men (McKinney et al. 2012).

Education is also an important factor related to SES (Exhibit 1-4). Higher levels of education are associated with increased income, although the degree to which education increases income varies among diverse racial/ethnic groups (Crissey 2009). Research in the United States has found that problems with alcohol are often associated with lower SES and lower levels of education (Crum 2003; Mulia et al. 2008). However, other studies have shown that greater frequency of drinking and number of drinks consumed are generally associated with higher levels of education and higher SES (Casswell et al. 2003; van Oers et al. 1999). For example, the 2012 NSDUH showed that adult rates of past-month alcohol use increased with increasing levels of education; among those with

Exhibit 1-4: Education and Culture

Culture has an effect on an individual's attitudes toward education; for instance, a lack of cultural understanding on the part of educational institutions affects student goals and achievements (Sue 2001). A number of factors besides culture also appear to affect educational attainment, including immigration status and longstanding systemic biases. For example, 88 percent of the native-born United States population ages 25 and older had at least a high school degree in 2007, but only 68 percent who were foreign-born were high school graduates (Crissey 2009). Research also highlights large within-group differences in educational attainment. For example, among Asian Americans, who overall have high levels of education, some groups had very low rates—only 16 percent of Vietnamese Americans and 5 percent of other Southeast Asian Americans had a college degree in 2000 (Reeves and Bennett 2003).

Immigration status does not always affect education status in the same way. For non-Latino Whites and Blacks, being born *outside* the United States is associated with a greater likelihood of obtaining at least a bachelor's degree. African immigrants have the highest level of education of any immigrant group, higher than White or Asian immigrants (African Immigrant 2000).

less than a high school education, 36.6 percent were current drinkers, whereas 68.6 percent of college graduates were current drinkers. (SAMHSA 2013*d*). Education can also affect substance use independently of SES. For example, lower education levels seem to relate to heavy drinking independently of socioeconomic status (Kuntsche et al. 2006).

The desperation associated with poverty and a lack of opportunity—as well as the increased exposure to illicit drugs that comes from living in a more impoverished environment—can also increase drug use (Bourgois 2003). Lower SES and the concurrent lack of either money or insurance to pay for treatment are associated with less access to substance abuse treatment and mental health services (Chow et al. 2003). For example, compared with Medicare coverage, private insurance coverage increases the odds twofold that someone who has a substance use disorder will enter treatment (Schmidt and Weisner 2005). Thus, lower SES can have a dramatic effect on recovery.

Immigration and Migration

With the exception of American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders, the United States is a country of immigrants. Recent immigrants, even when they come from diverse ethnic/racial backgrounds, typically share certain experiences and expectations in common. Often, they encounter a difficult process of acculturation (as discussed throughout this chapter). They can also share concerns surrounding the renewal of visas, obtainment of citizenship, or fears of possible deportation depending on their legal status. Immigration itself is stressful for immigrants, though the reasons for migrating and the legal status of the immigrant affect the degree of stress. For documented residents, the process of adaptation tends to be smoother than for those who are undocumented. Undocumented persons may be wary of deportation, are less likely to seek social services, and frequently encounter hostility (Padilla and Salgado de Snyder 1992).

Nonetheless, there are numerous variables that contribute to or influence well-being, quality of life, cultural adaptation, and the development of resilience (e.g., the capacity to mobilize social supports and bicultural integration; Castro and Murray 2010). Research suggests that immigrants may not experience higher rates of mental illness than nonimmigrants (Alegria et al. 2006), yet immigration nearly always includes separation from one's family and culture and can involve a grieving process

The Cultural Orientation Resource Center

The Cultural Orientation Resource Center, funded by the U.S. Department of State's Bureau of Population, Refugees, and Migration, is a useful resource for clinicians to gain information about topics including culture, resettlement experiences, and historical and refugee background information. This site is also quite useful for refugees. It provides refugee orientation materials and guidance in establishing housing, language, transportation, education, and community services, among other pressing refugee concerns.

as a result of these losses as well as other changes, including changes in socioeconomic status, physical environment, social support, and cultural practices.

Immigrants who are refugees from war, famine, oppression, and other dangerous environments are more vulnerable to psychological distress (APA 2010). They are likely to have left behind painful and often life-threatening situations in their countries of origin and can still bear the scars of these experiences. Some refugees come to the United States with high expectations for improved living conditions, only to find significant barriers to their full participation in American society (e.g., language barriers, discrimination, poverty). Experiencing such traumatic conditions can also increase substance use/abuse among some groups of immigrants (see TIP 57, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA 2014]). Behavioral health services must assess the needs of refugee populations, as the clinical issues for these populations may be considerably different than for immigrant groups (Kaczorowski et al. 2011).

For immigrant families, disruption of roles and norms often occurs upon arrival in the United States (for review, see Falicov 2012). Generally, youth adopt American customs, values, and behaviors much more easily and at higher rates than their parents or older members of the extended family. Parental frustration may occur if traditional standards of behavior conflict with mainstream norms acquired by their children. The differences in parents' values and expectations and adolescents' behavior can lead to distress in close-knit immigrant families. This disruption, known as the acculturation gap, can result in increased parent–child conflicts (APA 2012; Falicov 2012; Telzer 2010). For some youth, it may contribute to experimentation with alcohol and/or illicit drugs—increased acculturation is typically associated with increased substance use and substance use disorders.

Overall, "old country" or traditional behavioral norms and expectations for appropriate behavior become increasingly devalued in American majority culture for members of various immigrant groups (Padilla and Salgado de Snyder 1992; Sandhu and Malik 2001). Research shows that family cohesion and adaptability decrease with time spent in the United States, regardless of the amount of involvement in mainstream culture. This suggests that other factors may confound the relationship between family conflict and increased exposure to American culture (Smokowski et al. 2008).

Advice to Counselors and Clinical Supervisors: Initial Interview and Assessment Questions

When working with clients who are recent immigrants or have immigrated to United States during their lifetime, the APA (1990) recommends exploring:

- Number of generations in the United States.
- Number of years in the United States.
- Fluency in English (or literacy).
- Extent (or lack) of family support.
- Community resources.
- Level of education.
- Change in social status due to immigration.
- Extent of personal relationships with people from diverse cultural backgrounds.
- Stress due to migration and acculturation.

Clients who are migrants (e.g., seasonal workers) pose a particular set of challenges for treatment providers because of the difficulties involved in connecting clients to treatment programs and recovery communities. In the United States, migrant workers are considered one of most marginalized and underserved populations (Bail et al. 2012). Migrants face many logistical obstacles to treatment-seeking, such as lack of childcare, insurance, access to regular health care, and transportation (Hovey 2001; Rosenbaum and Shin 2005). Current data are limited but suggest high rates of alcohol use, alcohol use disorders, and binge drinking, often occurring as a response to stress or boredom associated with the migrant lifestyle (Hovey 2001; Worby and Organista 2007). In addition, limited data on migrant mental health reflect mixed findings regarding increased risk for mental illness or psychological distress (Alderete et al. 2000). One factor associated with mental health status is the set of circumstances leading up to the migrant worker's decision to migrate for employment (Grzywacz et al. 2006).

Acculturation and Cultural Identification

Many factors contribute to an individual's cultural identity, and that identity is not a static attribute. There are many forces at work that pressure a person to alter his or her cultural identity to conform to the mainstream culture's concept of a "proper" identity. As a result, people may feel conflicted about their identities—wanting to fit in with the mainstream culture while also wanting to retain the values of their culture of origin. For clients, sorting through these conflicting cultural expectations and forging a comfortable identity can be an important part of the recovery process. Some of the more commonly used terms related to cultural identity are defined in Exhibit 1-5.

All immigrants undergo some acculturation over time, but the rate of change varies from group to group, among individuals, and across

Exhibit 1-5: Cultural Identification and Cultural Change Terminology

Acculturation is the process whereby an individual from one cultural group learns and adopts elements of another cultural group, integrating them into his or her original culture. Although it can refer to any process of cultural integration, it is typically used to describe the ways in which an immigrant or nonmajority individual or group adopts cultural elements from the majority or mainstream culture, as the incentive is typically greater for acculturation to occur in this direction (see Lopez-Class et al. 2011 for a historical review of acculturation concepts).

Assimilation is one outcome of acculturation. It involves the complete adoption of the ways of life of the new cultural group, resulting in the assimilated group losing nearly all of its original or native culture.

Segmented assimilation describes a more complicated process of assimilation whereby an immigrant group does not assimilate entirely with mainstream culture but adopts aspects of other diverse cultural groups that are themselves outside mainstream culture (e.g., involvement in the drug culture; see Chapter 6 of this TIP and Portes et al. 2005).

Biculturalism occurs when an individual acquires the knowledge, skills, and identity of both his or her culture of origin and the mainstream/majority culture and is equally (or nearly equally) capable of social and cultural interaction in both societies.

Enculturation can denote a process whereby an individual adopts the culture that surrounds him or her (similar to acculturation), but the term has more recently been used to describe the process by which individuals come to value their native cultures and begin to learn about and adopt their native cultural lifeways.

Sources: LaFromboise et al. 1993; Paniagua 1998; Portes et al. 2005; Smokowski et al. 2008; Stone et al. 2006.

different periods of history. Earlier theories suggested that immigrants generally assimilated within three generations from the time of immigration and that assimilation was associated with socioeconomic gains. More recent scholarship suggests that this is changing among some cultural groups who may lack the financial or human capital necessary to succeed in mainstream society or who may find that continued involvement in their native or traditional culture has benefits that outweigh those associated with acculturation (Portes et al. 2005; Portes and Rumbaut 2005).

Acculturation typically occurs at varying speeds for different generations, even within the same family. Acculturation can thus be a source of conflict within families, especially when parents and children have different levels of acculturation (Exhibit 1-6) (Castro and Murray 2010; Farver et al. 2002; Hernandez 2005). Others have suggested that acculturation can negatively affect mental health because it erodes traditional family networks and/or because it results in the loss of traditional culture, which otherwise would have a protective function (Escobar and Vega 2000; Sandhu and Malik 2001).

Many studies have found that increased acculturation or factors related to acculturation are associated with increased alcohol and drug use and with higher rates of substance use disorders among White, Asian, and Latino immigrants (Alegria et al. 2006; Grant et al. 2004*a*; Grant et al. 2004*b*; Vega et al. 2004). Place of birth is most strongly associated with higher rates of substance use and disorders thereof. For example, research suggests a rate of substance use disorders about three times higher for Mexican Americans born in the United States than for those born in Mexico (Alegria et al. 2008*a*; Escobar and Vega 2000). Asian adolescents born in the United States present a higher rate of past-month alcohol use than Asian adolescents not born in the United States (8.7 versus 4.7 percent); however, the rate of nonmedical use of prescription drugs is higher among Asian adolescents not born in the United States than among those born in the United States (2.7 versus 1.4 percent; SAMHSA, Center for Behavioral Health Statistics and Quality 2012).

Acculturation can increase substance use/abuse, in part because the process of acculturation is itself stressful (Berry 1998; Vega et al. 2004). Mora (2002) asserts that the stress associated with acculturation has a significant effect on increasing substance use and abuse among Latinas; this can be observed most clearly in the increases in substance use associated with being a second- or third-generation

Exhibit 1-6: Five Levels of Acculturation

Numerous models have been developed to explain the process of acculturation. Choney et al. (1995) proposed a model, applicable to a number of different contexts, that features five levels:

1. A traditional orientation: The individual is entirely oriented toward his or her native culture.
2. A transitional orientation: The individual is more oriented toward traditional culture but has some familiarity with mainstream culture.
3. A bicultural orientation: The individual is equally comfortable with and knowledgeable of both traditional and mainstream culture.
4. An assimilated orientation: The individual is mostly oriented toward mainstream culture but has some familiarity with the traditional/native culture.
5. A marginal orientation: The individual is not comfortable with either culture.

Note: This is not a stage model in which a person naturally moves from one orientation to the next, nor does this model place greater value on one level versus another. The authors emphasize that each level of acculturation has strengths.

Latina from an immigrant family. The stress associated with acculturation could also contribute to rates of mental disorders and co-occurring disorders (CODs), which are higher among more acculturated groups of immigrants (Cherpitel et al. 2007; Escobar and Vega 2000; Grant et al. 2004*a*; Organista et al. 2003; Vega et al. 2009; Ward 2008). In fact, American-born Latinos who have used substances are three times more likely to have CODs than foreign-born Latinos who have used substances (Vega et al. 2009). Research also suggests that acculturation could interact with factors such as culture or stress in increasing mental disorders.

Rates of substance use/abuse in the United States are among the highest in the world (United Nations, Office on Drugs and Crime 2008, 2012), so for many immigrants, adopting mainstream American cultural values and lifestyles can also entail changing attitudes toward substance use. As an example, Marin (1998) found that, compared with Whites, Mexican Americans expected significantly more negative consequences and fewer positive ones from drinking, but Marin also found that the more acculturated the Mexican American participants were, the more closely their expectations resembled those of Whites.

Other factors that can contribute to increased substance use among more acculturated clients include changes in traditional gender roles, exposure to socially and physically challenging inner-city environments (Amaro and Aguiar 1995), and employment outside the home (often a role-transforming change that can contribute to increased risk of alcohol dependence). Although much of the research has focused on the relationship of acculturation to male substance use/abuse patterns, women can be even more affected by acculturation. Multiple studies using international samples have found that the greater the amount of gender equality in a society, the more similar alcohol consumption patterns are for men and women (Bloomfield et al. 2006). Many immigrants to the United States (where gender equality is relatively strong) come from societies with less gender equality and thus with greater prohibitions against alcohol use for women.

Karriker-Jaffe and Zemore (2009) found that higher levels of acculturation are associated with increased alcohol consumption only when combined with above-average SES (and not with lower SES), suggesting that income is another factor to consider when evaluating the effect of acculturation on alcohol use.

There are exceptions to the idea that acculturation increases substance use/abuse. Most notably, immigrants coming from countries with unusually high levels of drinking do not necessarily experience a change in their use, and they may even consume less alcohol and fewer drugs that they did in their native countries. Even among those born in the United States, however, data suggest that greater identification with one's traditional culture has a protective function. For example, in the National Latino and Asian American Study, the largest national survey specifically targeting these population groups to date, greater ethnic identification was associated with significantly lower rates of alcohol use disorders among Asian Americans (Chae et al. 2008), and the use of Spanish with one's family was linked with significantly lower rates of alcohol use disorders in Latinos (Canino et al. 2008).

Less research is available on the relationship of acculturation to substance use and substance use disorders among nonimmigrants, but some data suggest that a lower level of identification with one's native culture is linked with heavier, lengthier substance use among American Indians living on reservations (Herman-Stahl et al. 2003). For some American Indians, more

involvement in Tribal culture and traditional spiritual activities is associated with better posttreatment outcomes for alcohol use disorders (Stone et al. 2006). American Indians who drink heavily but live a traditional lifestyle have better recovery outcomes than those who do not live a traditional lifestyle (Kunitz et al. 1994). Likewise, African Americans may have greater motivation for treatment if they recognize that they have a drug problem and also have a strong Afrocentric identity (Longshore et al. 1998*b*). Strong cultural or racial/ethnic identity can have protective features, whereas acculturation can lead to a loss of cultural identity that increases substance abuse and contributes to poorer recovery outcomes for both Native Americans and African Americans.

Overall, acculturation and cultural identification have tremendous implications for behavioral health services. Research has shown an association between low levels of acculturation and low usage rates of mainstream healthcare services. Individuals can feel conflicted about their identities—wanting to both fit in with the mainstream culture and retain the traditions and beliefs of their cultures of origin. For such clients, sorting through these conflicting cultural expectations and forging a comfortable identity can be an important part of the recovery process. Familiarity with cultural identity formation models and theories of acculturation (including acculturation measurement methods; see Exhibit 1-7) can help behavioral health workers provide services with greater flexibility and sensitivity (see Appendix B for instruments that measure aspects of cultural identity and acculturation).

Heritage and History

A culture's history and heritage explain the culture's development through the actions of members of that culture and also through the actions of others toward the specific culture. Providers should be knowledgeable about the many positive aspects of each culture's history and heritage and resourceful in learning how to integrate these into clinical practice.

Nearly all immigrant groups have experienced some degree of trauma in leaving behind

Exhibit 1-7: Measuring Acculturation

Acculturation is a construct that includes factors relating to behavior, knowledge, values, self-identification, and language use (Zea et al. 2003). One of the biggest problems in analyzing the effects of acculturation is determining how to define and evaluate it. In research literature, acculturation is inconsistently defined and measured. In some large-scale surveys, it is not defined at all, but only implied in other factors, such as length of stay in the United States, English language use, or place of birth. Overall, instruments that assess acculturation do not ask the same questions or address the same factors, thus making it unclear whether acculturation is truly being evaluated (Zane and Mak 2003). More research is warranted on how to conceptualize and evaluate acculturation and cultural identity.

Many acculturation tools focus on specific racial or ethnic groups (for example, see Wallace et al. 2010). Acculturation and cultural identity instruments typically ask questions about language use and preference (e.g., whether English is used at home), media preferences (e.g., preference for foreign language programming), social interactions (e.g., friendships with persons from other ethnicities/cultural groups), cultural knowledge (e.g., knowledge of beliefs, traditions, and ceremonies specific to a cultural or ethnic group), and cultural values (Zea et al. 2003). Others evaluate acculturation simply by asking which culture a person identifies with most. Organista et al. (2003) and Zane and Mak (2003) reviewed measures designed to evaluate acculturation and cultural identity. Appendix B provides a sample of acculturation and cultural identity instruments.

family members, friends, and/or familiar places. Their eagerness to assimilate or remain separate depends greatly on the circumstances of their immigration (Castro and Murray 2010). Additionally, some immigrants are refugees from war, famine, natural disasters, and/or persecution. The depths of suffering that some clients have endured can result in multiple or confusing symptoms. For example, a traumatized Congolese woman could speak of hearing voices, and it could be unclear whether these voices suggest an issue requiring spiritual healing within a cultural framework, a traumatic stress reaction, or a mental disorder involving the onset of auditory hallucinations. Those who have watched close family members die violently can have "survivor guilt" as well as agonizing memories. Amodeo et al. (1997) report that "somatic complaints, including trouble sleeping, loss of appetite, stomach pains, other bodily pains, headaches, fatigue or lack of energy, memory problems, mood swings and social withdrawal have been reported to be among the refugees' most frequent presenting problems" (p. 70). For an overview of the impact of trauma, see TIP 57, *Trauma-Informed Care in Behavioral Health Services* (SAMHSA 2014).

Abueg and Chun (1998) caution, however, that "traumatic experience is not homogenous" (p. 292). Experiences before, during, and after migration and/or encampment vary depending on the country of origin as well as the time and motivation for migration. Within the United States, cultural groups such as African Americans and Native Americans have long histories of traumatic events, which have had lasting effects on the descendants of those who experienced the original trauma. Consequently, past as well as present discrimination and racism are related to a number of negative consequences across diverse populations, including lower SES, health disparities, and fewer employment and educational opportunities (see review in Williams and Williams-Morris 2000).

According to theories of historical trauma, the traumas of the past continue to affect later generations of a group of people. This concept was first developed to explain how the trauma of the Holocaust continued to affect the descendants of survivors (Duran et al. 1998; Sotero 2006). In the United States, it has perhaps been best explored in relation to the traumas endured by Native American peoples during the colonization and expansion of the United States. One can extend this concept to other groups (e.g., African Americans, Cambodians, Rwandans) who suffered traumatic events like slavery or genocide.

Among Native Americans in treatment for substance use and/or mental disorders, historical trauma is an important clinical issue (Brave Heart et al. 2011; Duran et al. 1998; Evans-Campbell 2008). Some research indicates that thinking about historical loss or displaying symptoms associated with historical trauma plays into increases in alcohol use disorders, other substance use, and lower family cohesion (Whitbeck et al. 2004; Wiechelt et al. 2012). Brave Heart (1999) theorizes that historical traumas perpetuate their effects among Native Americans by harming parenting skills and increasing abuse of children, which creates a cyclical pattern—greater levels of mental and substance use disorders in the next generation along with continued poor parenting skills. Specifically, Libby et al. (2008) found that substance use was involved in the intergenerational transmission of trauma. Additional research highlights a relationship between elevated chronic trauma exposure and prevalence of both mental and substance use disorders among large samples of American Indian adults living on reservations (Beals et al. 2005; Manson et al. 2005).

Sotero (2006) reviews research on historical trauma across diverse populations and proposes a similar explanation of how deliberately perpetrated, large-scale traumatic events continue affecting communities years after they occur. She argues that the generation that directly experiences the trauma suffers material (e.g., displacement), psychological (e.g., post-traumatic stress disorder), economic (e.g., loss of sources of income/sustenance), and cultural (e.g., lost knowledge of traditions and beliefs) effects. These lasting sequelae of trauma then affect the next generation, who can suffer in many similar ways, resulting in poorer coping skills or in attempts to self-medicate distress through substance abuse.

Sexuality

Attitudes toward sexuality in general and toward sexual identity or orientation are culturally defined. Each culture determines how to conceptualize specific sexual behaviors, the degree to which they accept same-sex relationships, and the types of sexual behaviors considered acceptable or not (Ahmad and Bhugra 2010). In any cultural group, diverse views and attitudes about appropriate gender norms and behavior can exist. For example, in some Latino cultural groups, homosexual behavior, especially among men, is not seen as an identity but as a curable illness or immoral behavior (Kusnir 2005). In some Latino cultural groups, self-identifying as other than heterosexual may provoke a more negative response than engaging in some homosexual behaviors (de Korin and Petry 2005; Greene 1997; Kusnir 2005).

For individuals from various ethnic/racial groups in United States, having a sexual identity different from the norm can result in increased substance use/abuse, in part because of increased stress. Additionally, alcohol and drug use can be more acceptable within some segments of gay/lesbian/bisexual cultures (Balsam et al. 2004; CSAT 2001; Mays et al. 2002). As a result of a lack of acceptance within both mainstream and diverse ethnic/racial communities, various gay cultures have developed in the United States. For some individuals, gay culture provides an alternative to their culture of origin, but unfortunately, cultural pressures can make the individual feel like he or she has to select which identity is most important (Greene 1997). However, a person can be, for example, both gay and Latino without experiencing any conflicts about claiming both identities at the same time. For more information on substance abuse treatment for persons who identify as gay, lesbian, or bisexual, refer to the CSAT (2001) publication, *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals.*

Heterosexual behaviors are carefully prescribed by a culture. Typically, these prescriptions are determined based on gender; behaviors considered acceptable for men can be considered unacceptable for women and vice versa. In addition, cultures define the role of alcohol or other substances in courtship, sexual behaviors, and relationships (Room 1996). Other factors that can vary across cultural groups include the appropriate age for sexual activity, the rituals and actions surrounding sexual activity, the use of birth control, the level of secrecy or openness related to sexual acts, the role of sex workers, attitudes toward sexual dysfunction, and the level of sexual freedom in choosing partners.

Perspectives on Health, Illness, and Healing

Beliefs, attitudes, and behaviors related to health, illness, and healing vary across racial, ethnic, and cultural groups. Many cultural groups hold views that differ significantly from those of Western medical practice and thus can affect treatment (Sussman 2004). The field of medical anthropology was developed,

in part, to analyze these differences, and much has been written about the range of cultural beliefs concerning health and healing. In general, cultural groups differ in how they define and determine health and illness; who is able to diagnosis and treat an illness; their beliefs about the causes of illness; and their remedies (including the use of Western medicines), treatments, and healing practices for illness (Bhugra and Gupta 2010; Comas-Diaz 2012). In addition, there are complex rules about which members of a community or family can make decisions about health care across cultural groups (Sussman 2004).

In mainstream American society, healthcare professionals are typically viewed as the only ones who have real expertise about health and illness. However, other societies have different views. For instance, among the Subanun people of the Philippines, all members of the community learn about healing and diagnosis; when an individual is sick, the diagnosis of his or her problem is an activity that involves the whole community (Frake 1961). Cultural groups also differ in their understanding of the causes of illness, and many cultural groups recognize a spiritual element in physical illness. The Hmong, for example, believe that illness has a spiritual cause and that healing may require shamans who communicate with spirits to diagnose and treat an illness (Fadiman 1997; Gensheimer 2006).

With respect to mental health, providers should be aware that any mental disorder or symptom is only considered a disorder or problem by comparison with a socially defined norm. For instance, in some societies, someone who hears voices can be considered to have greater access to the spirit world and to be blessed in some way. Furthermore, there are mental disorders that only present in a specific cultural group or locality; these are called cultural concepts of distress. Appendix E describes cultural concepts of distress recognized by the DSM-5. Other specific examples of cultural differences relating to the use of health care and alternative approaches to medical diagnosis and treatment are also presented in Chapter 5.

Religion and Spirituality

Religious traditions or spiritual beliefs are often very important factors for defining an individual's cultural background. In turn, attention to religion and spirituality during the course of treatment is one facet of culturally competent services (Whitley 2012). Christians, Muslims, Jews, and Buddhists (among others) can be members of any racial or ethnic group; in the same vein, people of the same ethnicity who belong to different religions sometimes have less in common than people of the same religion but different ethnicities. In some cases, religious affiliation is an especially important factor in defining a person's culture. For instance, the American Religious Identification Survey reported that 47 percent of the respondents who identified culturally as Jewish were not practicing Jews (Kosmin et al. 2001).

According to the American Religious Identification Survey (Kosmin and Keysar 2009), only 15 percent of Americans identified as not having a religion; of those, less than 2 percent identified as atheist or agnostic. In another survey from the Pew Forum on Religion and Public Life (2008), 1.6 percent of respondents stated that they were atheist; 2.4 percent, agnostic; and 6.3 percent, secular and unaffiliated with a religion. Many religions are practiced in the United States today. This TIP cannot cover them all in detail in. However, this TIP does briefly describe the four most common (by size of self-identified membership) religious traditions.

Advice to Counselors: Spirituality, Religion, Substance Abuse, and Mental Illness

For people in treatment and recovery, it can be especially important to distinguish between spirituality and religion. For example, some clients are willing to think of themselves as spiritual but not necessarily religious. Religion is organized, with each religion having its own set of beliefs and practices designed to organize and further its members' spirituality. Spirituality, on the other hand, is typically conceived of as a personal matter involving an individual's search for meaning; it does not require an affiliation with any religious group (Cook 2004). People can have spiritual experiences or develop their own spirituality outside of the context of an organized religion.

Spirituality often plays an important role in recovery from mental illness and substance abuse, and higher ratings of spirituality (using a variety of scales) have been associated with increased rates of abstinence (Laudet et al. 2006; Zemore and Kaskutas 2004). If substance abuse represents a lack of personal control, discipline, and order, then spirituality and religion can help counter this by providing a sense of purpose, order, self-discipline, humility, serenity, and acceptance. In addition, spirituality can help a person with mental illness gain a sense of meaning or purpose, develop inner strength, and learn acceptance and tolerance. Chappel (1998) maintains that the development of spirituality requires a concerted and consistent effort through such activities as prayer, meditation, discussion with others, reading, and participation in other spiritual activities. Counselors, he says, have an obligation to understand the role that spirituality can play in promoting and supporting recovery. The first step in this process is for counselors to learn about and respect clients' beliefs; understanding the roles of religion and spirituality is one form of cultural competence (Whitley 2012).

Christianity

Christianity, in its various forms, remains the predominant religion in the United States today. According to Kosmin and Keysar (2009), 76 percent of the population in 2008 identified as Christian, with the largest denomination being Catholics (25.1 percent), followed by Baptists (15.8 percent). Christianity encompasses a variety of denominations with different beliefs and attitudes toward issues such as alcohol and/or other substance use. Most mainstream Christian religions support behavioral health treatment, and many churches serve as sites for self-help groups or for Christian recovery programs. Some Christian sects, however, are not as amenable to substance abuse and mental health treatment as others.

Judaism

Judaism is the second most common religion in the United States (1.2 percent of the population as of 2008; Kosmin and Keysar 2009). Most Jews believe that they share a common ancient background. However, the population has dispersed over time and now exists in various geographic regions. The majority of Jews in the United States would be considered White, but Ethiopian Jews (the Beta Israel) and members of other African-Jewish communities would likely be seen as African Americans; the Jewish community from India (Bene Israel), as Asian Americans; and Jews who immigrated to the United States from Latin America, as Latinos. In 2001, approximately 5 percent of people who identified as adherents to Judaism (the religion, as opposed to people who identify as culturally Jewish) were Latinos, and approximately 1 percent were African Americans (Kosmin et al. 2001).

Regarding beliefs about and practices surrounding substance use, there are no prohibitions against alcohol use (or other substance use) in Judaism, but rates of alcohol abuse and dependence are significantly lower for Jews than for other populations (Bainwol and Gressard 1985; Straussner 2001). This could be partially attributable to genetics, yet there is also a definite cultural component (Hasin et al. 2002). Conversely, rates of use and abuse of

other substances are about the same or slightly higher for Jews in the United States compared with other populations (Straussner 2001). Because some Jewish people will feel uncomfortable in 12-Step groups that meet in churches and are largely Christian in composition, mutual-help groups designed specifically for Jewish people have been developed. The largest of these is Jewish Alcoholics, Chemically Dependent Persons and Significant Others (see http://www.jbfcs.org/programs-services/jewish-community-services-2/jacs/ for more information). Other Jewish people in recovery may prefer participating in secular self-help programs (Straussner 2001). Most Jewish people support behavioral health treatment.

Islam

In 2008, roughly 1.3 million people identified as Muslims in the United States, making it the third most common religion (Kosmin and Keysar 2009). Many Americans assume that all Arabs are Muslim, but the majority of Arab Americans are Christian; Muslims can come from any ethnic background (Abudabbeh and Hamid 2001). Islam is the most ethnically diverse religion in America, with a membership that is 15 percent White, 27 percent Black, 34 percent Asian, and 10 percent Latino (Kosmin et al. 2001).

Attitudes of Muslims toward mental illness and seeking formal mental health services are likely to be affected by cultural and religious beliefs about mental health problems, knowledge and familiarity with formal services, perceived societal prejudice, and the use of informal indigenous resources (Aloud 2004). Attitudes toward substance use, abuse, and treatment will likely be shaped by Islam's prohibition of the use of alcohol and other intoxicants. Many Muslim countries have harsh penalties for the use of alcohol and other drugs. For these reasons, Muslims appear to have low rates of substance use disorders. Despite there being no current data regarding levels of alcohol and other substance use among Muslim immigrants in the United States, Cochrane and Bal (1990) found that, in a comparison of Sikh, Hindu, Muslim, and White (probably Christian) men in a British community, Muslims by far drank the least, yet those Muslims who consumed the most alcohol experienced a greater number of alcohol-related problems on average. High levels of alcohol consumption among Muslims who do drink could be related to feelings of guilt and shame about their behavior, thus potentially leading to further abuse and avoidance of seeking substance abuse treatment when problems arise (Abudabbeh and Hamid 2001).

Buddhism

In 2008, about 1.2 million Buddhists were living in the United States (Kosmin and Keysar 2009). In 2001, according to Kosmin et al (2001), the majority of Buddhists were Asian Americans (61 percent), but a significant number of White Americans have embraced the religion (they make up 32 percent of Buddhists in the United States), as have African Americans (4 percent) and Latinos (2 percent). In China and Japan, Buddhism is often combined with other religious traditions, such as Taoism or Shintoism, and some immigrants from those countries combine the beliefs and practices of those religions with Buddhism.

Buddhists believe that the choices made in each life create karma that influences the next life and can affect behavior (McLaughlin and Braun 1998). The Fifth Precept of Buddhism is not to use intoxicating substances, and thus, the expectation for devout believers is that they will not use alcohol or other substances of abuse (Assanangkornchai et al. 2002). In the United States, no specific substance abuse treatment programs specialize in treating

Buddhist clients. Buddhist substance abuse and mental health treatment programs do exist in other countries (e.g., Thailand) and report high outcome rates (70 percent) using culturally specific practices (e.g., herbal saunas) and religious practices (Barrett 1997).

As You Proceed

This chapter has established the foundation and rationale of this TIP; reviewed the core concepts, models, and terminology of cultural competence; and provided an overview of factors that are common among diverse racial, ethnic, and cultural groups. As you proceed, be aware that diversity occurs not only across racially and ethnically diverse groups, but within each group as well—there are cultures within cultures. Clinicians and organizations need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client, as outlined earlier in this chapter in the "What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture?" section. As you read this TIP, remember that many cross-cutting factors influence the counselor–client relationship, the client's presentation and identification of problems, the selection and interpretation of screening and assessment tools, the client's responsiveness to specific clinical services, and the effectiveness of program delivery and organizational structure and planning.

2 Core Competencies for Counselors and Other Clinical Staff

IN THIS CHAPTER

- Core Counselor Competencies
- Self-Assessment for Individual Cultural Competence

Gil, a 40-year-old Mexican American man, lives in an upper middle class neighborhood. He has been married for more than 15 years to his high school sweetheart, a White American woman, and they have two children. Gil owns a fleet of street-sweeping trucks—a business started by his father-in-law that Gil has expanded considerably. Of late, Gil has been spending more time at work. He has also been drinking more than usual and dabbling in illicit drugs. As his drinking has increased, tensions between Gil and his wife have escalated. From Gil's perspective and that of some family members and friends, Gil is just a hard-working guy who deserves to have a beer as a reward for a hard day's work. Many people in his Mexican American community do not consider Gil's low-level daily drinking a problem, especially because he drinks primarily at home.

Recently, Gil had an accident while working on one of his trucks. The treating physician identified alcohol abuse as one of several health problems and referred him to a substance abuse treatment center. Gil attended, but argued all the while that he was not a *borracho* (drunkard) and did not need treatment. He distrusted the counselors, stating that seeking help from professionals for a mental disorder was something that only *gabachos* (Whites) did. Gil was proud of his capacity to "hold his liquor" and felt anger and hostility toward those who encouraged him to reduce his drinking. Gil's feelings and attitudes were valid; they stemmed from and were influenced by the Mexican American culture and community in which he had been raised from infancy. Gil dropped out of treatment. When his wife threatened to divorce him if he did not take immediate action to deal with his drinking problem, he reluctantly

enrolled in an outpatient treatment program. Gil, like all people, is a product of his environment—an environment that has provided him with a rich cultural and spiritual background, a strong male identity, a deep attachment to family and community, a strong work ethic, and a sense of pride in being able to support his family. In many Mexican American cultural groups, illness disrupts family life, work, and the ability to earn a living. Illness has psychological costs as well, including threats to a man's self-identity and sense of manhood (Sobralske 2006). Given this background, Gil would understandably be reluctant to enter treatment, to accept the fact that his drinking was a problem or an illness, and to jeopardize his ability to care for his family and his company. A culturally competent counselor would recognize, legitimize, and validate Gil's reluctance to enter and continue in treatment. In an ideal situation, the treatment counselor would have experience working with people with similar backgrounds and beliefs, and the treatment program would be structured to change Gil's behavior and attitudes in a manner that was in keeping with his culture and community. His initial treatment might have succeeded if the counselor had been culturally competent and the treatment program had been culturally responsive.

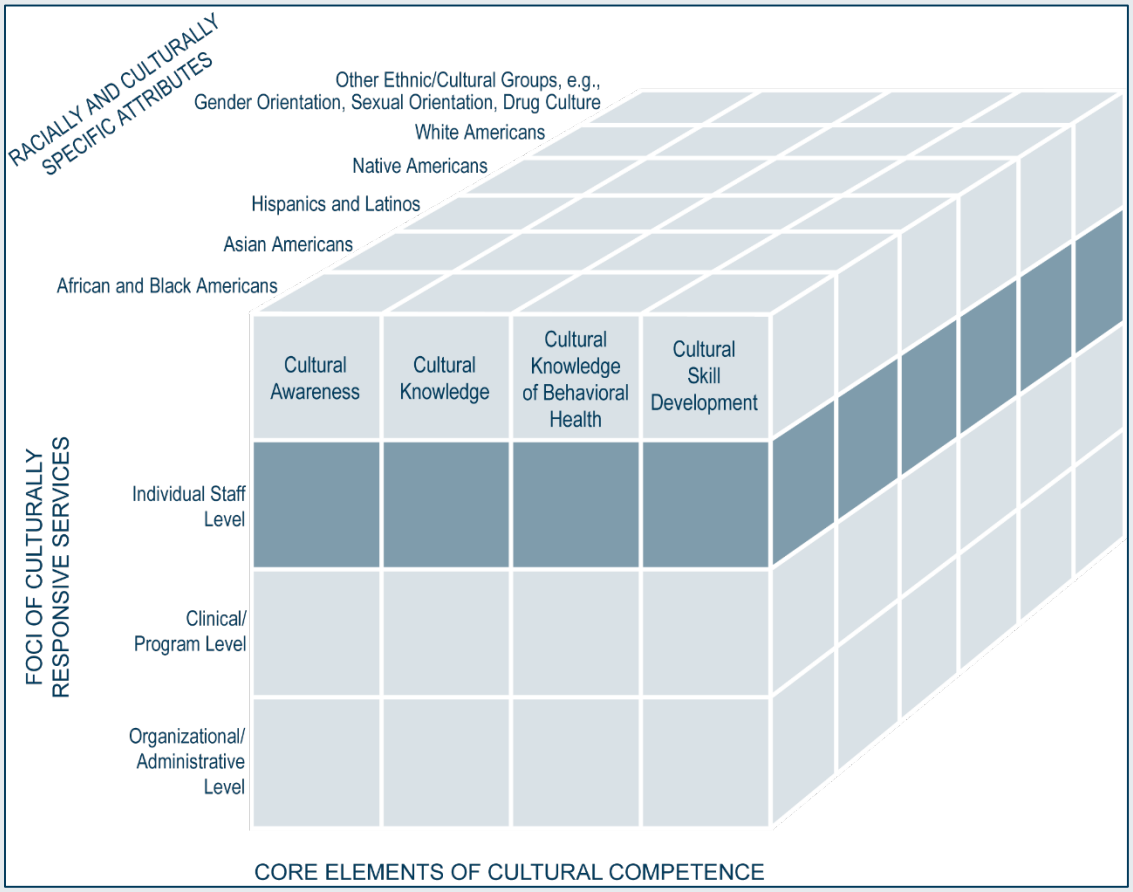
Like Gil, all clients enter treatment carrying beliefs, attitudes, conflicts, and problems shaped by their cultural roots as well as their present-day realities. As with Gil, many clients enter treatment with some reluctance and denial. Research shows that if clients such as Gil are greeted by a culturally competent counselor, they are more likely to respond positively to treatment (Damashek et al. 2012; Griner and Smith 2006; Kopelowicz et al. 2012; Whaley and Davis 2007). The presence of counselors of any race or gender who are culturally competent in responding to the needs and issues of their clients can greatly assist client recovery. Gaining regard, respect, and trust from clients is crucial for successful counseling outcomes (Ackerman and Hilsenroth 2003; Sue and Sue 2003*a*).

Effective therapy is an ongoing process of building relational bridges that engender trust and confidence. Sensitivity to the client's cultural and personal perspectives, genuine empathy, warmth, humility, respect, and acceptance are the tenets of all sound therapy. This chapter expands on these concepts and provides a general overview of the core competencies needed so that counselors may provide effective treatment to diverse racial and ethnic groups. Using Sue's (2001) multidimensional model for developing cultural competence, the content focuses on the counselor's need to engage in and develop cultural awareness; cultural knowledge in general; and culturally specific skills and knowledge of wellness, mental illness, substance use, treatments, and skill development.

Core Counselor Competencies

Since Sue et al. introduced the phrase "multicultural counseling competencies" in 1992, researchers and academics have elaborated on the core skill sets that enable counselors to work with diverse populations (American Psychological Association [APA] 2002; Council of National Psychological Associations for the Advancement of Ethnic Minority Interests 2009; Pack-Brown and Williams 2003; Tseng and Streltzer 2004). Cultural competence has evolved into more than a discrete skill set or knowledge base; it also requires ongoing self-evaluation on the part of the practitioner. Culturally competent counselors are aware of their own cultural groups and of their values, assumptions, and biases regarding other cultural groups. Moreover, culturally competent counselors strive to

Multidimensional Model for Developing Cultural Competence: Individual Staff Level



understand how these factors affect their ability to provide culturally effective services to clients.

Given the complex definition of culture and the fact that racially and ethnically diverse clients represent a growing portion of the client population, the need to update and expand guidelines for cultural competence is increasing. The consensus panel thus adapted existing guidelines from the Association of Multicultural Counseling for culturally responsive behavioral health services; some of their key suggestions for counselors and other clinical staff are outlined in this chapter.

Self-Knowledge

Counselors with a strong belief in evidence-based treatment methods can find it hard to relate to clients who prefer traditional healing methods. Conversely, counselors with strong trust in traditional healers and culturally accepted methods can fail to understand clients who seek scientific explanations of, and solutions to, their substance abuse and mental health problems. To become culturally competent, counselors should begin by exploring their own cultural heritage and identifying how it shapes their perceptions of normality, abnormality, and the counseling process.

Counselors who understand themselves and their own cultural groups and perceptions are better equipped to respect clients with diverse belief systems. In gaining an awareness of their cultures, attitudes, beliefs, and assumptions through self-examination, training, and clinical supervision, counselors should consider the factors described in the following sections.

Cultural awareness

Counselors who are aware of their own cultural backgrounds are more likely to acknowledge and explore how culture affects their client–counselor relationships. Without cultural awareness, counselors may provide counseling that ignores or does not address obvious issues that specifically relate to race, ethnic heritage, and culture. Lack of awareness can discount the importance of how counselors' cultural backgrounds—including beliefs, values, and attitudes—influence their initial and diagnostic impressions of clients. Without cultural awareness, counselors can unwittingly use their own cultural experiences as a template to prejudge and assess client experiences and clinical presentations. They may struggle to see the cultural uniqueness of each client, assuming that they understand the client's life experiences and background better than they really do. With cultural awareness, counselors examine how their own beliefs, experiences, and biases affect their definitions of normal and abnormal behavior. By valuing this awareness, counselors are more likely to take the time to understand the client's cultural groups and their role in the therapeutic process, the client's relationships, and his or her substance-related and other presenting clinical problems. Cultural awareness is the first step toward becoming a culturally competent counselor.

Racial, ethnic, and cultural identities

A key step in attaining cultural competence is for counselors to become aware of their own racial, ethnic, and cultural identities. Although the constructs of these identities are complex and difficult to define briefly, what follows is an overview. Racial identity "refers to a sense of group or collective identity based on one's perception that he or she shares a common heritage with a particular racial group" (Helms 1990, p. 3). Ethnic and cultural identity is "often the frame in which individuals identify consciously or unconsciously with those with whom they feel a common bond because of similar traditions, behaviors, values, and beliefs" (Chavez and Guido-DiBrito 1999, p. 41). Culture includes, but is not limited to, spirituality and religion, rituals and rites of passage, language, dietary habits (e.g., attitudes toward food/food preparation, symbolism of food, religious taboos of food), and leisure activities (Bhugra and Becker 2005).

Aspects of racial, ethnic, and cultural identities are not always apparent and do not always factor into conscious processes for the counselor or client, but these factors still play a role in the therapeutic relationship. Identity development and formation help people make sense of themselves and the world around them. If

Models of Racial Identity

Models of racial identity, often structured in stages, highlight the process that individuals undertake in becoming aware of their sense of self in relation to race and ethnicity within the context of their families, communities, societies, and cultural histories. Influenced by the Civil Rights Movement, earlier racial identity models in the United States focused on White and Black racial identity development (Cross 1995; Helms 1990; Helms and Carter 1991). Since then, models have been created to incorporate other races, ethnicities, and cultures.

Although this chapter highlights two formative racial identity models (see next page), additional resources highlight racial identity models that incorporate other diverse groups, including those individuals who identify as multiracial (e.g., see Wijeyesinghe and Jackson 2012).

positive racial, ethnic, and cultural messages are not available or supported in behavioral health services, counselors and clients can lack affirmative views of their own identities and may internalize negative messages or feel disconnected from their racial and cultural heritages. Counselors from mainstream society are less likely to be actively aware of their own ethnic and cultural identities; in particular, White Americans are not naturally drawn into examining their cultural identities, as they typically experience no dissonance when engaging in cultural activities.

In working to attain cultural competence, counselors must explore their own racial and cultural heritages and identities to gain a deeper understanding of personal development. Many models and theories of racial, ethnic, and cultural development are available; two common processes are presented below. Exhibit 2-1 highlights the racial/cultural identity development (R/CID) model (Sue and Sue 1999*b*) and the White racial identity development (WRID) model (Sue 2001). Although earlier work focused on a linear developmental process using stages, current thought centers on a more flexible process whereby identification status can loop back to an earlier process or move to a later phase.

Using either model, counselors can explore relational and clinical challenges associated with a given phase. Without an understanding of the cultural identity development process, counselors—regardless of race or ethnicity—can unwittingly minimize the importance of racial and ethnic experiences. They may fail to identify cultural needs and secure appropriate treatment services, unconsciously operate from a superior perspective (e.g., judging a specific behavior as ineffectual, a sign of resistance, or a symptom of pathology), internalize a client's reaction (e.g., an African American counselor feeling betrayed or inadequate when a client of the same race requests a White American counselor for therapy during an initial interview), or view a client's behavior through a veil of societal biases or stereotypes. By acknowledging and endorsing the active process of racial and cultural identity development, counselors from diverse groups can normalize their own development processes and increase their awareness of clients' parallel processes of identity development. In counseling, racial, ethnic, and cultural identities can be pivotal to the treatment process in the relationships not only between the counselor and client, but among everyone involved in the delivery of the client's behavioral health and primary care services (e.g., referral sources, family members, medical personnel, administrators). The case study on page 41 uses stages from the two models in Exhibit 2-1 to show the interactive process of racial and cultural identity development in the treatment context.

Cultural and racial identities are not static factors that simply mediate individual identity; they are dynamic, interactive developmental processes that influence one's willingness to acknowledge the effects of race, ethnicity, and culture and to act against racism and disparity across relationships, situations, and environments (for a review of racial and cultural identity development, see Sue and Sue 2013*c*). For counselors and clinical supervisors, it is essential to understand the dynamic nature of cultural identity in all exchanges. Starting with a personal appraisal, clinical staff members can begin to reflect—without judgment—on how their own racial and cultural identities influence their decisions, treatment planning, case presentation, supervision, and interactions with other staff members. Clinicians can map the interactive influences of cultural identity development among clients, the clients' families, staff members, the organization, other agencies, and any other entities involved in the client's treatment. Using mapping (see the

Exhibit 2-1: Stages of Racial and Cultural Identity Development

R/CID Model	WRID Model
Conformity: Has a positive attitude toward and preference for dominant cultural values; places considerable value on characteristics that represent dominant cultural groups; may devalue or hold negative views of own race or other racial/ethnic groups. **Dissonance and Appreciating:** Begins to question identity; recognizes conflicting messages and observations that challenge beliefs/stereotypes of own cultural groups and value of mainstream cultural groups; develops growing sense of one's own cultural heritage and the existence of racism; moves away from seeing dominant cultural groups as all good. **Resistance and Immersion:** Embraces and holds a positive attitude toward and preference for his or her own race and cultural heritage; rejects dominant values of society and culture; focuses on eliminating oppression within own racial/cultural group; likely to possess considerable feelings—including distrust and anger—toward dominant cultural groups and anything that may represent them; places considerable value on characteristics that represent one's own cultural groups without question; develops a growing appreciation for others from racially and culturally diverse groups. **Introspection:** Begins to question the psychological cost of projecting strong feelings toward dominant cultural groups; desires to refocus more energy on personal identity while respecting own cultural groups; realigns perspective to note that not all aspects of dominant cultural groups—one's own racial/cultural group or other diverse groups—are good or bad; may struggle with and experience conflicts of loyalty as perspective broadens. **Integrative Awareness:** Has developed a secure, confident sense of racial/cultural identity; becomes multicultural; maintains pride in racial identity and cultural heritage; commits to supporting and appreciating all oppressed and diverse groups; tends to recognize racism as a societal illness by which all can be victimized.	**Naiveté:** Had an early childhood developmental phase of curiosity or minimal awareness of race; may or may not receive overt or covert messages about other racial/cultural groups; possesses an ethnocentric view of culture. **Conformity:** Has minimal awareness of self as a racial person; believes strongly in the universality of values and norms; perceives White American cultural groups as more highly developed; may justify disparity of treatment; may be unaware of beliefs that reflect this. **Dissonance:** Experiences an opportunity to examine own prejudices and biases; moves toward the realization that dominant society oppresses racially and culturally diverse groups; may feel shame, anger, and depression about the perpetuation of racism by White American cultural groups; and may begin to question previously held beliefs or refortify prior views. **Resistance and Immersion:** Increases awareness of one's own racism and how racism is projected in society (e.g., media and language); likely feels angry about messages concerning other racial and cultural groups and guilty for being part of an oppressive system; may counteract feelings by assuming a paternalistic role (knowing what is best for clients without their involvement) or overidentifying with another racial/cultural group. **Introspection:** Begins to redefine what it means to be a White American and to be a racial and cultural being; recognizes the inability to fully understand the experience of others from diverse racial and cultural backgrounds; may feel disconnected from the White American group. **Integrative Awareness:** Appreciates racial, ethnic, and cultural diversity; is aware of and understands self as a racial and cultural being; is aware of sociopolitical influences of racism; internalizes a nonracist identity. **Commitment to Antiracist Action:** Commits to social action to eliminate oppression and disparity (e.g., voicing objection to racist jokes, taking steps to eradicate racism in institutions and public policies); likely to be pressured to suppress efforts and conform rather than build alliances with people of color.

Sources: Sue 2001; Sue and Sue 1999b.

Case Study for Counselors: Racial and Cultural Identity

The client is a 20-year-old Latino man. His father immigrated to the United States from Mexico as a child, and his mother (of Latino/Middle Eastern descent) grew up near Albuquerque, New Mexico. Throughout the initial phase of mental health treatment, the client presented feelings, attitudes, and behavior consistent with the resistance and immersion stage of the R/CID model. During group counseling in a partial hospitalization program, the client said that he did not think treatment was going to work. He believed that no one in treatment, except other Latino men, really understood him or his life experiences. He thought that his low mood was due, in part, to his recent job loss.

The client's current concerns, symptoms, and diagnosis (bipolar I) were presented and discussed during the treatment team meeting. The client's counselor (a White American man in the dissonance stage of the WRID model) was concerned that the client might leave treatment against medical advice and also stated that this would not be the first time a Latino client had done so. The team recognized that a Latino counselor would likely be useful in this situation (depending on the counselor's cultural competence). However, no Latino counselor was available, so the team decided that the client's current counselor should try to gain support from the client's parents to encourage the client to stay in treatment.

Because the client had signed an appropriate release of information, his counselor was able to contact the parents and arrange a family session. During the family session, the counselor brought up the client's need for a Latino counselor. His parents disagreed, expressing their belief that it was important for their son to learn to relate to the counselor. They said that this was just an excuse their son was using to leave treatment, which had happened before. The parents' reaction exemplified a conformity response, although other information would need to have been gathered to determine their current stage more accurately.

The counselor, client, parents, and organization were operating from different stages of racial and cultural identity development. Considering the lack of a proactive plan to provide appropriate resources—including the hiring of Latino staff or the development of other culturally appropriate resources (e.g., a peer counselor program)—the organization was most likely in the conformity phase of the WRID model. The counselor had some awareness of the client's racial and cultural needs and of the organization's failure to meet them, but he alienated the client despite his good intentions and reinforced mistrust by engaging the client's parents before working directly with the client. Had the counselor taken the time to understand the client's concerns and needs, he would likely have created an opportunity to challenge his own beliefs, learn more about the client's racial and cultural experiences and values, advocate for more appropriate resources for the client within the organization, be more flexible with treatment solutions, and enable the client to have an experience that exceeded his expectations of the treatment provider.

"How To Map Racial and Cultural Identity Development" box on the next page) as preparation for counseling, treatment planning, or clinical supervision, clinicians can gain awareness of the many forces that influence culturally responsive treatment.

Worldview: The cultural lens of counseling

The term "worldview" refers to a set of assumptions that guide how one sees, thinks about, experiences, and interprets the world (Koltko-Rivera 2004). Starting in early childhood, worldview development is facilitated by significant relationships (particularly with parents and family members) and is shaped by the individual's environment and life experiences, influencing values, attitudes, beliefs, and behaviors. In more simplistic terms, each person's worldview is like a pair of glasses with colored lenses—the person takes in all of life's experiences through his or her own uniquely

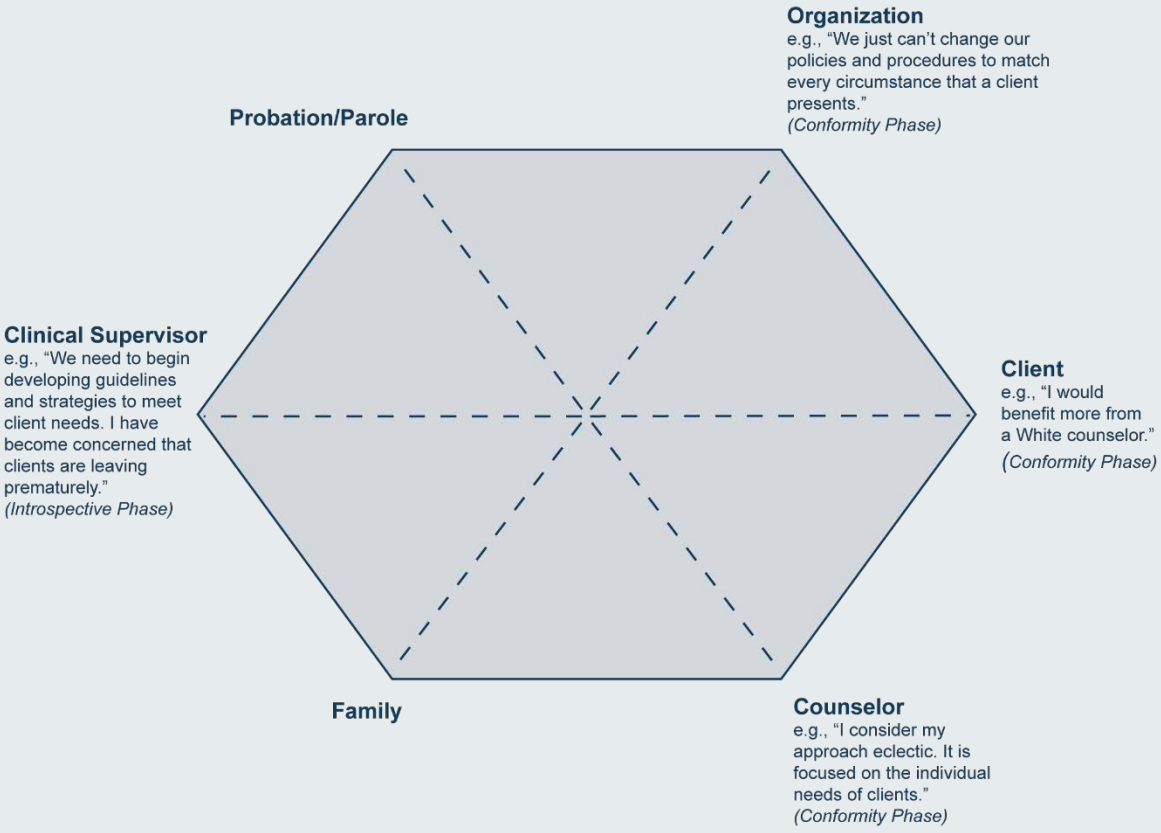
How To Map Racial and Cultural Identity Development

Completing this diagram can give a clearer perspective on past and anticipated dialog among key stakeholders. The diagram can be used as a training tool to teach racial and cultural identity development, to help clinicians and organizations recognize their own development, to explore clinical issues and dialogs that occur when diverse parties are at similar or different developmental stages, and to develop tools and resources to address issues that arise from this developmental process. Using case studies, this diagram can serve as an interactive educational exercise to help counselors, clinical supervisors, and agencies gain awareness of the effects of race, ethnicity, and cultural groups.

Materials needed: Paper and pencils; handouts on the R/CID and WRID models.

Instructions:

- Identify all relevant parties, including client, counselor, family, supervisor, referral source, other staff members, and staff from other agencies (e.g., probation/parole, medical center/office, child and youth services). Include yourself. Place the names at each intersection of the hexagon.
- List the common statements and behaviors (including lack of verbal responses) that you witness regarding the cultural needs of the client and/or the general statements made by each party regarding race, ethnicity, and culture. Write these as one-line abbreviated phrases that represent each person/agency's stance under the appropriate entry on the diagram.
- Using current information, choose the cultural identity development stage that best fits the statements or behaviors (knowing that you may be inaccurate); write it under each name.



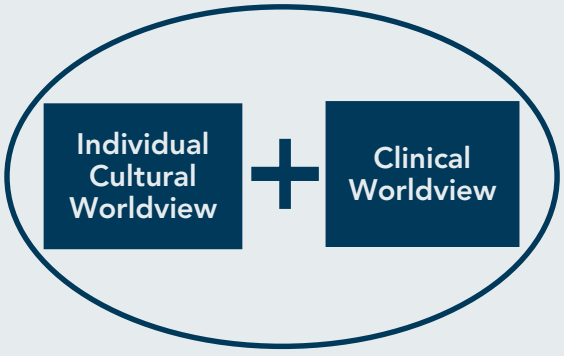
tinted view. Not unlike clients, counselors enter the treatment process with their own cultural worldviews that shape their concept of time; definition of family; organization of priorities and responsibilities; orientation to self, family, and/or community; religious or

spiritual beliefs; ideas about success; and so on (Exhibit 2-2).

However, counselors also contend with another worldview that is often invisible but still powerful—the clinical worldview (Bhugra and Gupta 2010; Tilburt and Geller 2007; Tseng and Streltzer 2004). Influenced by education, clinical training, and work experiences, counselors are introduced into a culture that reflects specific counseling theories, techniques, treatment modalities, and general office practices. This worldview, coupled with their personal cultural worldview, significantly shapes the counselor's beliefs pertaining to the nature of wellness, illness, and healing; interviewing skills and behavior; diagnostic impressions; and prognosis. Moreover, it influences the definition of normal versus abnormal or disordered behavior, the determination of treatment priorities, the means of intervention, and the definitions of successful outcomes and treatment failures.

Foremost, counselors need to remember that worldviews are often unspoken and inconspicuous; therefore, considerable reflection and self-exploration are needed to identify how their own cultural worldviews influence their interactions both inside and outside of counseling. Clinical staff members need to question how their perspectives are perpetuated in and shape client–counselor interactions, treatment decisions, planning, and selected counseling approaches. In sum, culturally responsive practice involves an understanding of multiple perspectives and how these worldviews interact throughout the treatment process—including the views of the counselor, client, family, other clients and staff members, treatment program, organization, and other agencies, as well as the community.

Exhibit 2-2: Counselor Worldview



Stereotypes, prejudices, and history

Cultural competence involves counselors' willingness to explore their own histories of prejudice, cultural stereotyping, and discrimination. Counselors need to be aware of how their own perceptions of self and others have evolved through early childhood influences and other life experiences. For example, how were stereotypes of their own races and ethnic heritages perpetuated in their upbringing? What myths and stereotypes were projected onto other groups? What historical events shaped experiences, opportunities, and perceptions of self and others?

Regardless of their race, cultural group, or ethnic heritage, counselors need to examine how they have directly or indirectly been affected by individual, organizational, and societal stereotypes, prejudice, and discrimination. How have certain attitudes, beliefs, and behaviors functioned as deterrents to obtaining equitable opportunities? In what ways have discrimination and societal biases provided benefits to them as individuals and as counselors? Even though these questions can be uncomfortable, difficult, or painful to explore, awareness is essential regarding how these issues affect one's role as a counselor, status in the organization, and comfort level in exploring clients' life experiences and perceptions during the treatment process. If counselors avoid or minimize the relevance of bias and discrimination in self-exploration, they will likely do the same in the assessment and counseling process.

All counselors should examine their stereotypes, prejudices, and emotional reactions toward others, including individuals from their own races or cultural backgrounds and individuals from other groups. They should examine how these attitudes and biases may be detrimental to clients in treatment for substance-related and mental disorders.

Clients can have behavioral health issues and healthcare concerns associated with discrimination. If counselors are blind to these issues, they can miss vital information that influences client responses to treatment and willingness to follow through with continuing care and ancillary services. For example, a counselor may refer a client to a treatment program without noting the client's history or perceptions of the recommended program or type of program. The client may initially agree to attend the program but not follow through because of past negative experiences and/or the perception within his or her racial/ethnic community that the service does not provide adequate treatment for clients of color.

Trust and power

Counselors need to understand the impact of their role and status within the client–counselor relationship. Client perceptions of counselors' influence, power, and control vary in diverse cultural contexts. In some contexts, counselors can be seen as all-knowing professionals, but in others, they can be viewed as representatives of an unjust system. Counselors need to explore how these dynamics affect the counseling process with clients from diverse backgrounds. Do client perceptions inhibit or facilitate the process? How do they affect the level of trust in the client–counselor relationship? These issues should be identified and addressed early in the counseling process. Clients should have opportunities to talk about and process their perceptions, past experiences, and current needs.

Practicing within limits

A key element of ethical care is practicing within the limits of one's competence. Counselors must engage in self-exploration, critical thinking, and clinical supervision to understand their clinical abilities and limitations

Advice to Counselors and Clinical Supervisors: Using the RESPECT Mnemonic To Reinforce Culturally Responsive Attitudes and Behaviors

- **R**espect—Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communications.
- **E**xplanatory model—Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective?
- **S**ociocultural context—Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.
- **P**ower—Acknowledge the power differential between clients and counselors.
- **E**mpathy—Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.
- **C**oncerns and fears—Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.
- **T**herapeutic alliance/**T**rust—Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors.

Sources: Bigby and American College of Physicians 2003; Campinha-Bacote et al. 2005.

regarding the services that they are able to provide, the populations that they can serve, and the treatment issues that they have sufficient training to address. Cultural competence requires an ability to assess accurately one's clinical and cultural limitations, skills, and expertise. Counselors risk providing services beyond their expertise if they lack awareness and knowledge of the influence of cultural groups on client–counselor relationships, clinical presentation, and the treatment process or if they minimize, ignore, or avoid viewing treatment in a cultural context.

Some counselors may assume that they have cultural competence based on having similar experiences as clients, being from the same race as clients, identifying as a member of the same ethnic heritage or cultural group as clients, or attending training on cultural competence. Other counselors may assume competence based on their current or prior relationships with others from the same race or cultural background as their clients. These experiences can be helpful and filled with many potential learning opportunities, but they do not make an individual eligible or competent to provide multicultural counseling. Likewise, the assumption that a person from the same cultural group, race, or ethnic heritage will intrinsically understand a client from a similar background is operating out of two common myths: the "myth of sameness" (i.e., that people from the same cultural group, race, or ethnicity are alike) and the myth that "familiarity equals competence" (Srivastava 2007). The Association for Multicultural Counseling and Development adopted a set of counselor competencies that was endorsed by the American Counseling Association (ACA) for counselors who work with a multicultural clientele (Exhibit 2-3). Competencies address the attitudes, beliefs, knowledge, and skills associated with the counselor's need for self-knowledge.

Knowledge of Other Cultural Groups

In addition to an understanding of themselves and how their cultural groups and values can affect the therapeutic process, culturally competent counselors work to acquire cultural knowledge and understanding of clients and staff with whom they work. From the outset, counselors need general knowledge and awareness when working with other cultural groups in counseling. For example, they should acknowledge that culture influences communication patterns, values, gender roles and socialization, clinical presentations of distress, counseling expectations, and behavioral norms and expectations in and outside the counseling session (e.g. , touching, greetings, gift-giving, accompaniment in sessions, level of formality between counselor and client). Counselors should filter and interpret client presentation from a broad cultural perspective instead of using only their own cultural groups or previous client experiences as reference points.

Counselors also need to invest the time to know clients and their cultures. Culturally responsive practice involves a commitment to obtaining specific cultural knowledge, not only through ongoing client interactions, but also through the use of outside resources, cultural training seminars and programs, cultural events, professional consultations,

> "Become familiar with the community in which the client lives and the general cultural norms of the individual client. This can be accomplished by visiting with people who know the community well, attending important community celebrations and other events, asking open-ended questions about community concerns and quality of life, and identifying community capacities that affect wellness in the community."
>
> (Perez and Luquis 2008, p. 177)

Exhibit 2-3: ACA Counselor Competencies: Counselors' Awareness of Their Own Cultural Values and Biases

Attitudes and beliefs:

- Culturally skilled counselors have moved from being culturally unaware to being aware and sensitive to their own cultural heritages and to valuing and respecting differences.
- Culturally skilled counselors are aware of how their own cultural backgrounds, experiences, attitudes, values, and biases influence psychological processes.
- Culturally skilled counselors recognize the limits of their multicultural competence and expertise.
- Culturally skilled counselors are comfortable with differences that exist between themselves and their clients in terms of race, ethnicity, culture, and beliefs.

Knowledge:

- Culturally skilled counselors have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions of normality, abnormality, and the process of counseling.
- Culturally skilled counselors possess knowledge and understanding of how oppression, racism, discrimination, and stereotyping affect them personally and in their work. This allows them to acknowledge their own racist attitudes, beliefs, and feelings. Although this standard applies to all groups, for White American counselors, it can mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism.
- Culturally skilled counselors possess knowledge about their social impact on others. They are knowledgeable about communication style differences and how their style may clash with or foster the counseling process with minority clients. They anticipate the impact their style may have on others.

Skills:

- Culturally skilled counselors seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally diverse populations. Being able to recognize the limits of their competencies, they seek consultation, seek further training or education, refer out to more qualified individuals or resources, or engage in a combination of these.
- Culturally skilled counselors are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a nonracist identity.

Source: American Counseling Association Web site (http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf). Adapted with permission.

cultural guides, and clinical supervision. Counselors need to be mindful that they will not know everything about a specific population or initially comprehend how an individual client endorses or engages in specific cultural practices, beliefs, and values. For instance, some clients may not identify with the same cultural beliefs, practices, or experiences as other clients from the same cultural groups. Nevertheless, counselors need to be as knowledgeable as possible and attend to these cultural attributes—beginning with the intake and assessment process and continuing throughout the counseling and treatment relationship. For a review of content areas essential in knowing other cultural groups, refer to the "What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture" section in Chapter 1. These cultural knowledge content areas include:

- Language and communication.
- Geographic location.
- Worldview, values, and traditions.
- Family and kinship.
- Gender roles.
- Socioeconomic status and education.

- Immigration, migration, and acculturation stress.
- Acculturation and cultural identification.
- Heritage and history.
- Sexuality.
- Religion and spirituality.
- Health, illness, and healing.

Counselors should not make assumptions about clients' race, ethnic heritage, or culture based on appearance, accents, behavior, or language. Instead, counselors need to explore with clients their cultural identity, which can involve multiple identities (Lynch and Hanson 2011). Counselors should discuss what cultural identity means to clients and how it influences treatment. For example, a young adult two-spirited (gay) American Indian man may be more concerned with having access to traditional healing practices than to specialized services for gay men. Counselors and clients should collaboratively examine presenting treatment issues and obstacles to engaging in behavioral health treatment and maintaining recovery, and they should discuss how cultural groups and cultural identities can serve as guideposts in treatment planning.

Exhibit 2-4 lists ACA-endorsed counselor competencies for knowledge of the worldviews of clients from diverse cultural groups.

Exhibit 2-4: ACA Counselor Competencies: Awareness of Clients' Worldviews

Attitudes and beliefs:

- Culturally skilled counselors are aware of their negative and positive emotional reactions toward other racial and ethnic groups and recognize that these reactions may prove detrimental to the counseling relationship. They are willing to contrast their own beliefs and attitudes with those of clients from diverse cultures in a nonjudgmental fashion.
- Culturally skilled counselors are aware of the stereotypes and preconceived notions they may hold toward other racial and ethnic minority groups.

Knowledge:

- Culturally skilled counselors possess specific knowledge and information about the particular group(s) with whom they are working. They are aware of the life experiences, cultural heritages, and historical backgrounds of clients from cultures other than their own. This competence is strongly linked to the minority identity development models available in the literature.
- Culturally skilled counselors understand how race, cultural group, ethnicity, and other factors can affect personality formation, vocational choices, manifestation of mental disorders, help-seeking behavior, and the appropriateness or inappropriateness of various counseling approaches.
- Culturally skilled counselors understand and have knowledge of sociopolitical influences upon the lives of racial and ethnic minorities. They understand that factors such as immigration issues, poverty, racism, stereotyping, and powerlessness can affect self-esteem and self-concept in the counseling process.

Skills:

- Culturally skilled counselors familiarize themselves with relevant research and the latest findings regarding mental health and mental disorders that affect various ethnic and racial groups. They actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective counseling behavior.
- Culturally skilled counselors are actively involved with minority individuals outside of the counseling setting (community events, social and political functions, celebrations, friendships, neighborhood groups, etc.); their perspective of minorities is more than an academic/helping exercise.

Source: American Counseling Association Web site (http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf). Adapted with permission.

Cultural Knowledge of Behavioral Health

Counselors should learn how culture interacts with health beliefs, substance use, and other behavioral health issues. They can access literature and training that address cultural contexts and meanings of substance use, behavioral and emotional reactions, help-seeking behavior, and treatment. Chapter 5 gives information on culturally responsive behavioral health services for major ethnic and racial groups. The how-to box below lists ways to improve one's cultural knowledge of health issues by acquiring knowledge in key areas to work successfully with diverse clients:

- Patterns of substance use and treatment-seeking behavior specific to people of diverse racial and cultural backgrounds.
- Beliefs and traditions surrounding substance use, including cultural norms concerning the use of alcohol and drugs.
- Beliefs about treatment, including expectations and attitudes toward health care and counseling.
- Community perceptions of behavioral health treatment.
- Obstacles encountered by specific populations that make it difficult to access treatment, such as geographic distance from treatment services.
- Patterns of co-occurring disorders and conditions specific to people from diverse racial and cultural backgrounds (e.g., culturally specific syndromes, earlier onset of

How To Improve Cultural Knowledge of Health, Illness, and Healing

To promote culturally responsive services, counselors need to acquire cultural knowledge regarding concepts of health, illness, and healing. The following questions highlight many of the culturally related issues that are prevalent in and pertinent to assessment, treatment planning, and case management. This list of considerations can help facilitate discussions in counseling and clinical supervision contexts:

- Does the cultural group in question consider psychological, physical, and spiritual health or well-being as separate entities or as unified aspects of the whole person?
- How are illnesses and healing practices defined and conceptualized?
- What are acceptable behaviors for managing stress?
- How do people who belong to the culture in question typically express emotions and emotional distress?
- What behaviors, practices, or customs do members of this culture consider to be preventive?
- What words do people from this cultural group use to describe a particular problem?
- How do members of the group explain the origins or causes of a particular condition?
- Are there culturally specific conditions or cultural concepts of distress?
- Are there specific biological and physiological variations among members of this population?
- What are the common symptoms that lead to misdiagnosis within this population?
- Where do people from this cultural group typically seek help?
- What traditional healing practices and treatments are endorsed by members of this group?
- Are there biomedical treatments or procedures that would typically be unacceptable?
- Are there specific counseling approaches more congruent with the beliefs of most members?
- What are common health inequities, including social determinants of health, for this population?
- What are acceptable caregiving practices?
- Do members of this group attach honor to caring for family members with specific diseases?
- Are individuals with specific conditions shunned from the community?
- What are the roles of family members in providing health care and in making decisions?
- Is discussing consequences of and prognosis for behaviors, conditions, or diseases acceptable?
- Is it customary for family members to withhold prognosis from the client?

diabetes, higher prevalence of depression and substance dependence).
- Assessment and diagnosis, including culturally appropriate screening and assessment and awareness of common diagnostic biases associated with symptom presentation.
- Individual, family, and group therapy approaches that hold promise in addressing mental and substance-related disorders specific to the racial and cultural backgrounds of diverse clients.
- Culturally appropriate peer support, mutual-help, and other support groups (e.g., the Wellbriety movement, a culturally appropriate 12-Step program for Native American people).
- Traditional healing and complementary methods (e.g., use of spiritual leaders, herbs, and rituals).
- Continuing care and relapse prevention, including attention to clients' cultural environments, treatment needs, and accessibility of care within their communities.
- Treatment engagement/retention patterns.

Skill Development

Becoming culturally competent is an ongoing process—one that requires introspection, awareness, knowledge, and skill development. Counselors need to develop a positive attitude toward learning about multiple cultural groups; in essence, counselors should commit to cultural competence and the process of growth. This commitment is evidenced via investment in ongoing learning and the pursuit of culturally congruent skills. Counselors can demonstrate commitment to cultural competence through the attitudes and corresponding behaviors indicated in Exhibit 2-5.

Beyond the commitment to and development of these fundamental attitudes and behaviors, counselors need to work toward intervention strategies that integrate the skills discussed in the following sections.

Frame issues in culturally relevant ways

Counselors should frame clinical issues with culturally appropriate references. For example, in cultural groups that value the community or family as much as the individual, it is helpful to address substance abuse in light of its consequences to family or the community. The counselor might ask, "How are your family and community affected by your use? How do family and community members feel when they see you high?" For clients who place more value on their independence, it can be more effective to point out how substance dependence undermines their ability to manage their own lives through questions like "How might your use affect your ability to reach your goals?"

Exhibit 2-5: Attitudes and Behaviors of Culturally Competent Counselors

Attitude	Behavior
Respect	• Exploring, acknowledging, and validating the client's worldview • Approaching treatment as a collaborative process • Investing time to understand the client's expectations of treatment • Using consultation, literature, and training to understand culturally specific behaviors that demonstrate respect for the client • Communicating in the client's preferred language
Acceptance	• Maintaining a nonjudgmental attitude toward the client • Considering what is important to the client

(Continued on the next page.)

Exhibit 2-5: Attitudes and Behaviors of Culturally Competent Counselors (continued)

Attitude	Behavior
Sensitivity	• Understanding the client's experiences of racism, stereotyping, and discrimination • Exploring the client's cultural identity and what it means to her/him • Actively involving oneself with individuals from diverse backgrounds outside the counseling setting to foster a perspective that is more than academic or work related • Adopting a broader view of family and, when appropriate, including other family or community members in the treatment process • Tailoring treatment to meet the cultural needs of the client (e.g., providing outside resources for traditional healing)
Commitment to equality	• Proactively addressing racism or bias as it occurs in treatment (e.g., processing derogatory comments made by another client in a group counseling session) • Identifying the specific barriers to treatment engagement and retention among the populations being served • Recognizing that equality of treatment does not translate to equity—that equity is defined as equality in opportunity, access, and outcome (Srivastava 2007) • Endorsing counseling strategies and treatment approaches that match the unmet needs of diverse populations to ensure treatment engagement, retention, and positive outcomes
Openness	• Recognizing the value of traditional healing and help-seeking practices • Developing alliances and relationships with traditional practitioners • Seeking consultation with traditional healers and religious and spiritual leaders when appropriate • Understanding and accepting that persons from diverse cultural groups can use different cognitive styles (e.g., placing more attention on reflecting and processing than on content; being task oriented)
Humility	• Recognizing that the client's trust is earned through consistent and competent behavior rather than the potential status and power that is ascribed to the role of counselor • Acknowledging the limits of one's competencies and expertise and referring clients to a more appropriate counselor or service when necessary • Seeking consultation, clinical supervision, and training to expand cultural knowledge and cultural competence in counseling skills • Seeking to understand oneself as influenced by ethnicity and cultural groups and actively seeking a nonracist identity • Being sensitive to the power differential between client and counselor
Flexibility	• Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client • Accommodating different learning styles in treatment approaches (e.g., the use of role-plays or experiential activities to demonstrate coping skills or alcohol and drug refusal skills) • Using cultural, socioeconomic, environmental, and political contextual factors in conducting evaluations • Integrating cultural practices as treatment strategies (e.g., Alaska Native traditional practices, such as tundra walking and sustenance activities)

Allow for complexity of issues based on cultural context

Counselors must take care with suggesting simple solutions to complex problems. It is often better to acknowledge the intricacies of the client's cultural context and circumstances. For instance, a Native American single mother who upholds traditional values could balk at a suggestion to stop spending time with family members who drink heavily. Here, the counselor might encourage the woman to broaden support within her community by connecting with an elder who supports recovery or by engaging in a women's talking circle. Likewise, a referral for a psychiatric evaluation for major depression may not be an appropriate initial recommendation for a Chinese client who relies on cultural remedies and healing traditions. An alternative approach would be to explore the client's beliefs in healing, develop steps that respect and incorporate the client's help-seeking practices, and coordinate services to secure a culturally responsive intervention (Cardemil et al. 2011; Gallardo et al. 2012; Lynch and Hanson 2011).

Make allowances for variations in the use of personal space

Cultural groups have different expectations and norms of propriety concerning how close people can be while they communicate and how personal communications can be depending on the type of relationship (e.g., peers versus elders). The concept of personal space involves more than the physical distance between people. It also involves cultural expectations regarding posture or stance and the use of space within a given environment. These cultural expectations, although they are subtle, can have an impact on treatment. For example, an Alaska Native may feel more comfortable sitting beside a counselor, whereas a European may prefer to be separated from a counselor by a desk (Sue and Sue 2013*a*). The use of space can also be a nonverbal expression of power. Standing too close to someone can, for example, suggest power over them. Standing too far away or sitting behind a desk can indicate aloofness. Acceptable or expected degrees of closeness between people are culturally specific; counselors should be educated on the general

Advice to Counselors and Clinical Supervisors: Behaviors for Counselors To Avoid

- Addressing clients informally; counselors should not assume familiarity until they grasp cultural expectations and client preferences.
- Failing to monitor and adjust to the client's verbal pacing (e.g., not allowing time for clients to respond to questions).
- Using counseling jargon and treatment language (e.g., "I am going to send you to our primary stabilization program to obtain a biopsychosocial and then, afterwards, to partial").
- Using statements based on stereotypes or other preconceived ideas generated from experiences with other clients from the same culture.
- Using gestures without understanding their meaning and appropriate context within the given culture.
- Ignoring the relevance of cultural identity in the client–counselor relationship.
- Neglecting the client's history (i.e., not understanding the client's individual and cultural background).
- Providing an explanation of how current difficulties can be resolved without including the client in the process to obtain his or her own explanations of the problems and how he or she thinks these problems should be addressed.
- Downplaying the importance of traditional practices and failing to coordinate these services as needed.

Sources: Fontes 2008; Lynch and Hanson 2011; Pack-Brown and Williams 2003; Srivastava 2007.

parameters and expectations of the given population. However, counselors should not predetermine the clients' expectations; instead, they should follow the clients' lead and inquire about their preferences.

Display sensitivity to culturally specific meanings of touch

Some treatment and many support groups have opening or closing traditions that include holding hands or giving hugs. This form of touching can be very uncomfortable to new clients regardless of cultural groups; cultural prescriptions, including religious beliefs, concerning appropriate touching can compound this effect (Comas-Diaz 2012). Many cultural groups use touch to acknowledge or greet someone, to show respect or convey status or power, or to display comfort. As counselors, it is essential to understand cultural norms about touch, which often are guided by gender and age, and the contexts surrounding "appropriate" touch for specific cultural groups (Srivastava 2007). Counselors need to devote time to understanding their clients' norms for and interpretations of touch, to assisting clients in negotiating and upholding their cultural norms, and to helping clients understand the context and cultural norms that are likely to prevail in support and treatment groups.

Explore culturally based experiences of power and powerlessness

Ideas about power and powerlessness are influenced by the client's culture and social class. What constitutes power and powerlessness varies from culture to culture according to the individual's gender, age, occupation, ancestry, religious affiliation, and a host of other factors. For example, power can be defined in terms of one's place within the family, with the oldest member being the most powerful and the youngest being the least powerful. Even the words "power" and "powerlessness" carry cultural meaning. These words can carry negative connotations for clients with histories of discrimination and multiple experiences with racism, for some women, for indigenous peoples with histories of colonization, and for refugees or immigrants who have left oppressive regimes. In this regard, counselors should use these words carefully. For example, a Hmong refugee who experienced trauma in her country of origin could already feel helpless and powerless over the events that occurred; thus, the concept of powerlessness, often used in drug and alcohol treatment programs, can be contraindicated in addressing her substance-related disorder. However, a White American business executive who has authority over others and a history of financial influence may need help acknowledging that he cannot control his substance abuse.

Adjust communication styles to the client's culture

Cultural groups all have different communication styles. Norms for communicating vary in and between cultural groups based on class, gender, geographic origins, religion, subcultures, and other individual variations. Counselors should educate themselves as much as possible regarding the patterns of communicating in the client's cultural, racial, or ethnic population while also being aware of his/her own communication style. For a comprehensive guide in self-assessment and understanding of communication styles, refer to *Culture Matters: The Peace Corps Cross-Cultural Workbook* (Peace Corps Information Collection and Exchange 2012).

The following are general guidelines for ascertaining the client's communication style:

- Understand the client's verbal and nonverbal ways of communicating. Be aware of the possible need to move away from comprehending and interpreting client responses in conventional professional ways

How To Assess Differences in Communication Styles

This exercise can be used by counselors and clinical supervisors as a self-assessment tool and a means of exploring differences in communication styles among counselors, clients, and supervisors. It can also serve as a group exercise to help clients discuss and understand cultural differences in communicating with others. This self-administered tool promotes self-understanding and cultural knowledge. It is not an empirically based instrument, nor is it meant to assess client communication styles or skills formally.

Materials needed: Colored pencils/pens and copies of the exercise.

Instructions:

- First, place an X along the line for each item that best matches your style or pattern of communication overall. Communication patterns can change across situations and environments depending on expectations, stress level, and familiarity, (e.g., attending a staff meeting versus spending time with friends); try to assign the style that best reflects your patterns across situations.
- After reviewing your own patterns, compare differences between you and your client, clinical supervisor, or fellow staff member. For example, select a recent client you treated and place a second X (using a different color pen) on each line to mark your perceived view of this client's communication style. Then examine the differences between you and your client and generate a list of potential misunderstandings that could occur due to these differences. Use clinical supervision to discuss how your own patterns can hinder and/or promote the counseling process.

NONVERBAL PATTERNS

Eye Contact

When talking:
Direct, sustained ⟷ Indirect or not sustained

When listening:
Direct, sustained ⟷ Indirect or not sustained

Vocal Pitch/Tone
High/loud ⟷ Low/soft

More expressive ⟷ Less expressive

Speech Rate
Fast ⟷ Slow

Pauses or Silence
Little use of silence in dialog ⟷ Pauses; uses silence in dialog

Facial Expressions
Frequent expression ⟷ Little expression

Use of Other Gestures
Frequent expression ⟷ Little expression

VERBAL PATTERNS

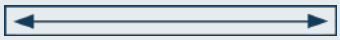
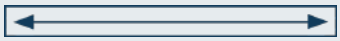
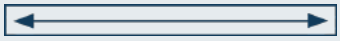
Emotional Expression
Does express and identify feelings in speech ⟷ Does not express or identify feelings in speech

Self-Disclosure
Frequently ⟷ Rarely or little

Formality
Informal ⟷ Formal in addressing others and showing respect

(Continued on the next page.)

How To Assess Differences in Communication Styles (continued)

Directness Verbally explicit		Indirect; subtle; doesn't believe in saying everything
Context Low context; relies more on words to convey meaning		High context: verbal and nonverbal cues convey much of the meaning
Orientation Orientation to self; use of "I" statements		Orientation to others, use of plural and third-person pronouns (e.g., we, he)

Other Things To Consider in Exploring Communication Styles:

- Are there known differences in body language and expression within the given cultural group?
- What are the common, culturally appropriate parameters of touch across situations? For example, a handshake could be appropriate as a means of introduction for one cultural group but not for another.
- How is personal space used in and outside of the office? Are there known cultural patterns in the use of space and proximity of communication?
- What verbal and nonverbal counselor behaviors may affect trust in the counseling process?

Sources: Cormier et al. 2009; Fontes 2008; Srivastava 2007; Sue and Sue 2013a.

(Bland and Kraft 1998). Always be curious about the client's cultural context and be willing to seek clarification and better understanding from the client. It is as important for counselors to access and engage in cultural consultation to acquire more specific knowledge and experience.

- Styles of communication and nonverbal methods of communication are important aspects of cultural groups. Issues such as the appropriate space to have between people; preferred ways of moving, sitting, and standing; the meaning of gestures; and the degree of eye contact expected are all culturally defined and situation specific (Hall 1976). As an example, high-context cultural groups place greater importance on nonverbal cues and message context, whereas low-context cultural groups rely largely on verbal message content. Most Asian Americans come from high-context cultural groups in which sensitive messages are encoded carefully to avoid offending others. A provider who listens only to the content could miss the message. What is not said can possibly be more important than what is said.
- Listen to storytelling carefully, as it can be a way of communicating with the therapist. As in any good therapy, follow the associations and listen for possible metaphors to better understand relational meaning, cognition, and emotion within the context of the conversation.

Interpret emotional expressions in light of the client's culture

Feelings are expressed differently across and within cultural groups and are influenced by the nature of a given event and the individuals involved in the situation. A certain level of emotional expression can be socially appropriate within one culture yet inappropriate in another. In some cultural groups, feelings may not be expressed directly, whereas in other cultural groups, some emotions are readily expressed and others suppressed. For example, expressions of sadness may at first be more readily shared by some clients in counseling settings, whereas others may find it more

comfortable to express anger as their initial response. Counselors must recognize that not all cultures place the same value on verbalizing feelings. In fact, clients from some cultures may not perceive that emotional expression is a worthy course of treatment and healing at all. Thus, counselors should not impose a prescribed approach that measures progress and equates healing with the ability to display emotions. Likewise, counselors should be careful not to attribute meaning based on their own cultural backgrounds or to project their own feelings onto clients' experiences. Instead, counselors need to assist their clients in identifying and labeling feelings within their own cultural contexts.

Expand roles and practices

Counselors need to acquire a mindset that allows for more flexible roles and practices—while still maintaining appropriate professional boundaries—when working with clients. Some clients whose culture places considerable emphasis upon and orientation toward family could look to counselors for advice with unrelated issues pertaining to other family members. Other clients may expect a more prescribed and structured approach in which counselors give specific recommendations and advice in the session. For example, Asian American clients appear to expect and benefit from a more directive and highly structured approach (Fowler et al. 2011; Lee and Mock 2005*a*; Sue 2001; Uba 1994). Still others could expect that counselors be connected to their communities through participation in community events, in working with traditional healers, or in building collaborative relationships with other community agencies. As counselors, it is important to understand the cultural contexts of clients and how this translates to expectations in the client–counselor relationship. The appropriate role usually

Providing good care goes beyond counselors' general knowledge, clinical skills, and approaches; it involves understanding the multicultural context of clients and of themselves as counselors. Cultural competence is an ethical issue requiring counselors to be invested in developing the tools to provide culturally congruent care—care that matches the needs and context of the client. For a review of ethics and ethical dilemmas in a multicultural context, refer to Pack-Brown and Williams (2003).

Results from the counselor's understanding of and sensitivity to the values, cultures, and special needs of the individuals and groups being served (Sue and Sue 2013*d*). Counselors need to adopt an ongoing commitment to developing skills and endorsing practices that assist clients in receiving and experiencing the best possible care. Exhibit 2-6 lists counselor competencies endorsed by ACA for culturally appropriate intervention strategies.

Self-Assessment for Individual Cultural Competence

Several instruments for evaluating an individual's cultural competence have been developed and are available online. One assessment tool that has been widely circulated is Goode's *Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families*. It can be adapted for counselors treating adult clients with behavioral health concerns. This tool and other additional resources are provided in Appendix C. For an interactive Web-based tool on cultural competence awareness, visit the American Speech-Language-Hearing Association Web site (http://www.asha.org).

Exhibit 2-6: ACA Counselor Competencies: Culturally Appropriate Intervention Strategies

Attitudes and beliefs:

- Culturally skilled counselors respect clients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning, and expressions of distress.
- Culturally skilled counselors respect traditional helping practices and intrinsic help-giving networks in minority communities.
- Culturally skilled counselors value bilingualism and do not view another language as an impediment to counseling.

Knowledge:

- Culturally skilled counselors have a clear and explicit knowledge and understanding of the generic characteristics of counseling and therapy (culture bound, class bound, and monolingual) and how they could clash with the cultural values of various minority groups.
- Culturally skilled counselors are aware of institutional barriers that prevent minorities from using behavioral health services.
- Culturally skilled counselors know of the potential biases in assessment instruments and use procedures and interpret findings in keeping with the cultural and linguistic characteristics of clients.
- Culturally skilled counselors have knowledge of minority family structures, hierarchies, values, and beliefs. They are knowledgeable about family and community characteristics and resources.
- Culturally skilled counselors are aware of relevant discriminatory practices at the social and community levels that could be affecting the psychological welfare of the populations being served.

Skills:

- Culturally skilled counselors are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach, recognizing that helping styles and approaches can be culture bound. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and ameliorate its negative impact.
- Culturally skilled counselors are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a problem stems from racism or bias in others (the concept of health paranoia) so that clients do not inappropriately personalize problems.
- Culturally skilled counselors are not averse to seeking consultation with traditional healers, religious and spiritual leaders, and practitioners in the treatment of culturally diverse clients when appropriate.
- Culturally skilled counselors take responsibility for interacting in the languages requested by their clients; if not feasible, they make appropriate referrals. A serious problem arises when the linguistic skills of a counselor do not match the language of the client. When language matching is not possible, counselors should seek a translator with cultural knowledge and appropriate professional background and/or refer to a knowledgeable and competent bilingual counselor.
- Culturally skilled counselors have training and expertise in the use of traditional assessment and testing instruments, understand their technical aspects, and are aware of their cultural limitations. This allows counselors to use test instruments for the welfare of diverse clients.
- Culturally skilled counselors are aware of and work to eliminate biases, prejudices, and discriminatory practices. They are aware of sociopolitical contexts in conducting evaluation and providing interventions and are sensitive to issues of oppression, sexism, elitism, and racism.
- Culturally skilled counselors educate clients about the processes of psychological intervention, explaining such elements as goals, expectations, legal rights, and the counselor's theoretical orientation.

Source: American Counseling Association Web site (http://www.counseling.org/docs/competencies/cross-cultural_competencies_and_objectives.pdf). Adapted with permission.

3 Culturally Responsive Evaluation and Treatment Planning

IN THIS CHAPTER

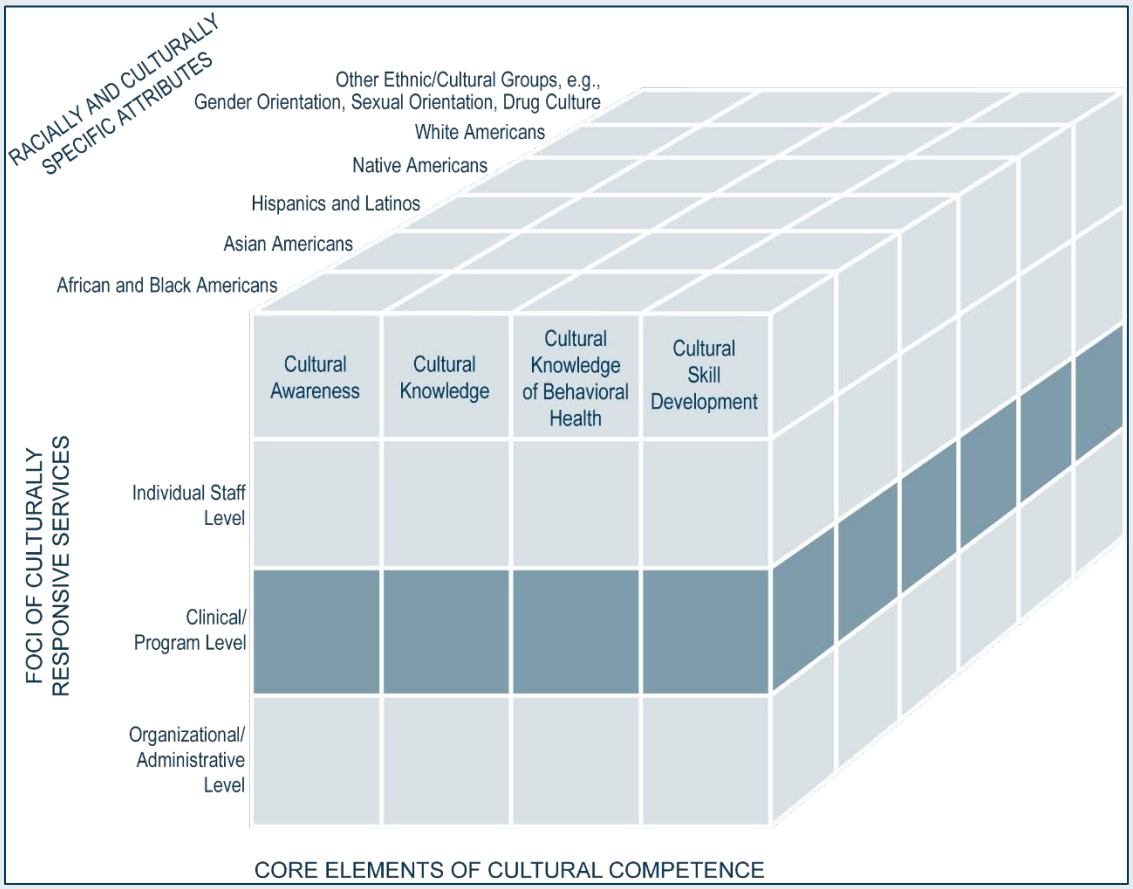
- Step 1: Engage Clients
- Step 2: Familiarize Clients and Their Families With Treatment and Evaluation Processes
- Step 3: Endorse Collaboration in Interviews, Assessments, and Treatment Planning
- Step 4: Integrate Culturally Relevant Information and Themes
- Step 5: Gather Culturally Relevant Collateral Information
- Step 6: Select Culturally Appropriate Screening and Assessment Tools
- Step 7: Determine Readiness and Motivation for Change
- Step 8: Provide Culturally Responsive Case Management
- Step 9: Incorporate Cultural Factors Into Treatment Planning

Zhang Min, a 25-year-old first-generation Chinese woman, was referred to a counselor by her primary care physician because she reported having episodes of depression. The counselor who conducted the intake interview had received training in cultural competence and was mindful of cultural factors in evaluating Zhang Min. The referral noted that Zhang Min was born in Hong Kong, so the therapist expected her to be hesitant to discuss her problems, given the prejudices attached to mental illness and substance abuse in Chinese culture. During the evaluation, however, the therapist was surprised to find that Zhang Min was quite forthcoming. She mentioned missing important deadlines at work and calling in sick at least once a week, and she noted that her coworkers had expressed concern after finding a bottle of wine in her desk. She admitted that she had been drinking heavily, which she linked to work stress and recent discord with her Irish American spouse.

Further inquiry revealed that Zhang Min's parents, both Chinese, went to school in England and sent her to a British school in Hong Kong. She grew up close to the British expatriate community, and her mother was a nurse with the British Army. Zhang Min came to the United States at the age of 8 and grew up in an Irish American neighborhood. She stated that she knew more about Irish culture than about Chinese culture. She felt, with the exception of her physical features, that she was more Irish than Chinese—a view accepted by many of her Irish American friends. Most men she had dated were Irish Americans, and she socialized in groups in which alcohol consumption was not only accepted but expected.

Zhang Min first started to drink in high school with her friends. The counselor realized that what she had learned about Asian

Multidimensional Model for Developing Cultural Competence: Clinical/Program Level



Americans was not necessarily applicable to Zhang Min and that knowledge of Zhang Min's entire history was necessary to appreciate the influence of culture in her life. The counselor thus developed treatment strategies more suitable to Zhang Min's background.

Zhang Min's case demonstrates why thorough evaluation, including assessment of the client's sociocultural background, is essential for treatment planning. To provide culturally responsive evaluation and treatment planning, counselors and programs must understand and incorporate relevant cultural factors into the process while avoiding a stereotypical or "one-size-fits-all" approach to treatment. Cultural responsiveness in planning and evaluation entails being open minded, asking the right questions, selecting appropriate screening and assessment instruments, and choosing effective treatment providers and modalities for each client. Moreover, it involves identifying culturally relevant concerns and issues that should be addressed to improve the client's recovery process.

This chapter offers clinical staff guidance in providing and facilitating culturally responsive interviews, assessments, evaluations, and treatment planning. Using Sue's (2001) multidimensional model for developing cultural competence, this chapter focuses on clinical and programmatic decisions and skills that are

important in evaluation and treatment planning processes. The chapter is organized around nine steps to be incorporated by clinicians, supported in clinical supervision, and endorsed by administrators.

Step 1: Engage Clients

Once clients are in contact with a treatment program, they stand on the far side of a yet-to-be-established therapeutic relationship. It is up to counselors and other staff members to bridge the gap. Handshakes, facial expressions, greetings, and small talk are simple gestures that establish a first impression and begin building the therapeutic relationship. Involving one's whole being in a greeting—thought, body, attitude, and spirit—is most engaging.

Fifty percent of racially and ethnically diverse clients end treatment or counseling after one visit with a mental health practitioner (Sue and Sue 2013*e*). At the outset of treatment, clients can feel scared, vulnerable, and uncertain about whether treatment will really help. The initial meeting is often the first encounter clients have with the treatment system, so it is vital that they leave feeling hopeful and understood. Paniagua (1998) describes how, if a counselor lacks sensitivity and jumps to premature conclusions, the first visit can become the last:

> Pretend that you are a Puerto Rican taxi driver in New York City, and at 3:00 p.m. on a hot summer day you realize that you have your first appointment with the therapist…later, you learned that the therapist made a note that you were probably depressed or psychotic because you dressed carelessly and had dirty nails and hands…would you return for a second appointment? (p. 120)

To engage the client, the counselor should try to establish rapport before launching into a series of questions. Paniagua (1998) suggests that counselors should draw attention to the presenting problem "without giving the impression that too much information is needed to understand the problem" (p. 18). It is also important that the client feel engaged with any interpreter used in the intake process. A common framework used in many healthcare training programs to highlight culturally responsive interview behaviors is the LEARN model (Berlin and Fowkes 1983). The how-to box on the next page presents this model.

Improving Cross-Cultural Communication

Health disparities have multiple causes. One specific influence is cross-cultural communication between the counselor and the client. Weiss (2007) recommends these six steps to improve communication with clients:

1. Slow down.
2. Use plain, nonpsychiatric language.
3. Show or draw pictures.
4. Limit the amount of information provided at one time.
5. Use the "teach-back" method. Ask the client, in a nonthreatening way, to explain or show what he or she has been told.
6. Create a shame-free environment that encourages questions and participation.

Step 2: Familiarize Clients and Their Families With Treatment and Evaluation Processes

Behavioral health treatment facilities maintain their own culture (i.e., the treatment milieu). Counselors, clinical supervisors, and agency administrators can easily become accustomed to this culture and assume that clients are used to it as well. However, clients are typically new to treatment language or jargon, program expectations and schedules, and the intake and treatment process. Unfortunately, clients from diverse racial and ethnic groups can feel more estranged and disconnected from treatment services when staff members fail to educate them and their families about treatment expectations or when the clients are not walked

How To Use the LEARN Mnemonic for Intake Interviews

Listen to each client from his or her cultural perspective. Avoid interrupting or posing questions before the client finishes talking; instead, find creative ways to redirect dialog (or explain session limitations if time is short). Take time to learn the client's perception of his or her problems, concerns about presenting problems and treatment, and preferences for treatment and healing practices.

Explain the overall purpose of the interview and intake process. Walk through the general agenda for the initial session and discuss the reasons for asking about personal information. Remember that the client's needs come before the set agenda for the interview; don't cover every intake question at the expense of taking time (usually brief) to address questions and concerns expressed by the client.

Acknowledge client concerns and discuss the probable differences between you and your clients. Take time to understand each client's explanatory model of illness and health. Recognize, when appropriate, the client's healing beliefs and practices and explore ways to incorporate these into the treatment plan.

Recommend a course of action through collaboration with the client. The client must know the importance of his or her participation in the treatment planning process. With client assistance, client beliefs and traditions can serve as a framework for healing in treatment. However, not all clients have the same expectations of treatment involvement; some see the counselor as the expert, desire a directive approach, and have little desire to participate in developing the treatment plan themselves.

Negotiate a treatment plan that weaves the client's cultural norms and lifeways into treatment goals, objectives, and steps. Once the treatment plan and modality are established and implemented, encourage regular dialog to gain feedback and assess treatment satisfaction. Respecting the client's culture and encouraging communication throughout the process increases client willing to engage in treatment and to adhere to the treatment plan and continuing care recommendations.

Sources: Berlin and Fowkes 1983; Dreachslin et al. 2013; Ring 2008.

through the treatment process, starting with the goals of the initial intake and interview. By taking the time to acclimate clients and their families to the treatment process, counselors and other behavioral health staff members tackle one obstacle that could further impede treatment engagement and retention among racially and ethnically diverse clients.

Step 3: Endorse Collaboration in Interviews, Assessments, and Treatment Planning

Most clients are unfamiliar with the evaluation and treatment planning process and how they can participate in it. Some clients may view the initial interview and evaluation as intrusive if too much information is requested or if the content is a source of family dishonor or shame. Other clients may resist or distrust the process based on a long history of racism and oppression. Still others feel inhibited from actively participating because they view the counselor as the authority or sole expert.

The counselor can help decrease the influence of these issues in the interview process through a collaborative approach that allows time to discuss the expectations of both counselor and client; to explain interview, intake, and treatment planning processes; and to establish ways for the client to seek clarification of his or her assessment results (Mohatt et al. 2008*a*). The counselor can encourage collaboration by emphasizing the importance of clients' input and interpretations. Client feedback is integral in interpreting results and

can identify cultural issues that may affect intake and evaluation (Acevedo-Polakovich et al. 2007). Collaboration should extend to client preferences and desires regarding inclusion of family and community members in evaluation and treatment planning.

Step 4: Integrate Culturally Relevant Information and Themes

By exploring culturally relevant themes, counselors can more fully understand their clients and identify their cultural strengths and challenges. For example, a Korean woman's family may serve as a source of support and provide a sense of identity. At the same time, however, her family could be ashamed of her co-occurring generalized anxiety and substance use disorders and respond to her treatment as a source of further shame because it encourages her to disclose personal matters to people outside the family. The following section provides a brief overview of suggested strength-based topics to incorporate into the intake and evaluation process.

Immigration History

Immigration history can shed light on client support systems and identify possible isolation or alienation. Some immigrants who live in ethnic enclaves have many sources of social support and resources. By contrast, others may be isolated, living apart from family, friends, and the support systems extant in their countries of origin. Culturally competent evaluation should always include questions about the client's country of origin, immigration status, length of time in the United States, and connections to his or her country of origin. Ask American-born clients about their parents' country of origin, the language(s) spoken at home, and affiliation with their parents' culture(s). Questions like these give the counselor important clues about the client's degree of acculturation in early life and at present, cultural identity, ties to culture of origin, potential cultural conflicts, and resources. Specific questions should elicit information about:

- Length of time in the United States, noting when immigration occurred or the number of generations who have resided in the United States.
- Frequency of returns and psychological and personal ties to the country of origin.
- Primary language and level of English proficiency in speaking and writing.
- Psychological reactions to immigration and adjustments made in the process.
- Changes in social status and other areas as a result of coming to this country.
- Major differences in attitudes toward alcohol and drug use from the time of immigration to now.

Advice to Counselors: Conducting Strength-Based Interviews

By nature, initial interviews and evaluations can overemphasize presenting problems and concerns while underplaying client strengths and supports. This list, although not exhaustive, reminds clinicians to acknowledge client strengths and supports from the outset.

Strengths and supports:

- Pride and participation in one's culture
- Social skills, traditions, knowledge, and practical skills specific to the client's culture
- Bilingual or multilingual skills
- Traditional, religious, or spiritual practices, beliefs, and faith
- Generational wisdom
- Extended families and nonblood kinships
- Ability to maintain cultural heritage and practices
- Perseverance in coping with racism and oppression
- Culturally specific ways of coping
- Community involvement and support

Source: Hays 2008.

Cultural Identity and Acculturation

As shown in Zhang Min's case at the beginning of this chapter, cultural identity is a unique feature of each client. Counselors should guard against making assumptions about client identity based on general ethnic and racial identification by evaluating the degree to which an individual identifies with his or her culture(s) of origin. As Castro and colleagues (1999*b*) explain, "for each group, the level of within-group variability can be assessed using a core dimension that ranges from high cultural involvement and acceptance of the traditional culture's values to low or no cultural involvement" (p. 515). For African Americans, for example, this dimension is called "Afrocentricity." Scales for Afrocentricity have been developed in an attempt to provide an indicator of an individual's level of involvement within the traditional or core African-oriented culture (Baldwin and Bell 1985; Cokley and Williams 2005; Klonoff and Landrine 2000). Many other instruments based on models of identity evaluate acculturation and identity. A detailed discussion of the theory behind such models is beyond the scope of this Treatment Improvement Protocol (TIP); however, counselors should have a general understanding of what is being measured when administering such instruments. The "Asking About Culture and Acculturation" advice box at right addresses exploration of culture and acculturation with clients. For more information on instruments that measure acculturation and/or identity, see Appendix B.

Other areas to explore include the cross-cutting factors outlined in Chapter 1, such as socioeconomic status (SES), occupation, education, gender, and other variables that can distinguish an individual from others who share his or her cultural identity. For example, a biracial client could identify with African American culture, White American culture, or both. When a client has two or more racial/ethnic identities, counselors should assess how the client self-identifies and how he or she negotiates the different worlds.

Advice to Counselors: Asking About Culture and Acculturation

A thoughtful exploration of cultural and ethnic identity issues will provide clues for determining cultural, racial, and ethnic identity. There are numerous clues that you may derive from your clients' answers, and they cannot all be covered in this TIP; this is only one set of sample questions (Fontes 2008). Ask these questions tactfully so they do not sound like an interrogation. Try to integrate them naturally into a conversation rather than asking one after another. Not all questions are relevant in all settings. Counselors can adapt wording to suit clients' cultural contexts and styles of communication, because the questions listed here and throughout this chapter are only examples:

- Where were you born?
- Whom do you consider family?
- What was the first language you learned?
- Which other language(s) do you speak?
- What language or languages are spoken in your home?
- What is your religion? How observant are you in practicing that religion?
- What activities do you enjoy when you are not working?
- How do you identify yourself culturally?
- What aspects of being _____ are most important to you? (Use the same term for the identified culture as the client.)
- How would you describe your home and neighborhood?
- Whom do you usually turn to for help when facing a problem?
- What are your goals for this interview?

Membership in a Subculture

Clients often identify initially with broader racial, ethnic, and cultural groups. However, each person has a unique history that warrants an understanding of how culture is practiced and has evolved for the person and his or her

family; accordingly, counselors should avoid generalizations or assumptions. Clients are often part of a culture within a culture. There is not just one Latino, African American, or Native American culture; many variables influence culture and cultural identity (see the "What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture" section in Chapter 1). For example, an African American client from East Carroll Parish, LA, might describe his or her culture quite differently than an African American from downtown Hartford, CT.

Beliefs About Health, Healing, Help-Seeking, and Substance Use

Just as culture shapes an individual's sense of identity, it also shapes attitudes surrounding health practices and substance use. Cultural acceptance of a behavior, for instance, can mask a problem or deter a person from seeking treatment. Counselors should be aware of how the client's culture conceptualizes issues related to health, healing and treatment practices, and the use of substances. For example, in cases where alcohol use is discouraged or frowned upon in the community, the client can experience tremendous shame about drinking. Chapter 5 reviews health-related beliefs and practices that can affect help-seeking behavior across diverse populations.

Trauma and Loss

Some immigrant subcultures have experienced violent upheavals and have a higher incidence of trauma than others. The theme of trauma and loss should therefore be incorporated into general intake questions. Specific issues under this general theme might include:

- Migration, relocation, and emigration history—which considers separation from homeland, family, and friends—and the stressors and loss of social support that can accompany these transitions.
- Clients' personal or familial experiences with American Indian boarding schools.
- Experiences with genocide, persecution, torture, war, and starvation.

Advice to Counselors: Eliciting Client Views on Presenting Problems

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word the following questions using the clients' terminology rather than using the word "problem." These questions help explore how clients view their behavioral health concerns:

- I know that clients and counselors sometimes have different ideas about illness and diseases, so can you tell me more about your idea of your problem?
- Do you consider your use of alcohol and/or drugs a problem?
- How do you label your problem? Do you think it is a serious problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What is going on in your body as a result of this problem?
- How has this problem affected your life?
- What frightens or concerns you most about this problem and its treatment?
- How is your problem viewed in your family? Is it acceptable?
- How is your problem viewed in your community? Is it acceptable? Is it considered a disease?
- Do you know others who have had this problem? How did they treat the problem?
- How does your problem affect your stature in the community?
- What kinds of treatment do you think will help or heal you?
- How have you treated your drug and/or alcohol problem or emotional distress?
- What has been your experience with treatment programs?

Sources: Lynch and Hanson 2011; Tang and Bigby 1996; Taylor 2002.

How To Use a Multicultural Intake Checklist

Some clients do not see their presenting physical, psychological, and/or behavioral difficulties as problems. Instead, they may view their presenting difficulties as the result of stress or another issue, thus defining or labeling the presenting problem as something other than a physical or mental disorder. In such cases, word questions about the following topics using the client's terminology, rather than using the word "problem." Asking questions about the following topics can help you explore how a client may view his or her behavioral health concerns:

- ☐ Immigration history
- ☐ Relocations (current migration patterns)
- ☐ Losses associated with immigration and relocation history
- ☐ English language fluency
- ☐ Bilingual or multilingual fluency
- ☐ Individualistic/collectivistic orientation
- ☐ Racial, ethnic, and cultural identities
- ☐ Tribal affiliation, if appropriate
- ☐ Geographic location
- ☐ Family and extended family concerns (including nonblood kinships)
- ☐ Acculturation level (e.g., traditional, bicultural)
- ☐ Acculturation stress
- ☐ History of discrimination/racism
- ☐ Trauma history
- ☐ Historical trauma
- ☐ Intergenerational family history and concerns
- ☐ Gender roles and expectations
- ☐ Birth order roles and expectations
- ☐ Relationship and dating concerns
- ☐ Sexual and gender orientation
- ☐ Health concerns
- ☐ Traditional healing practices
- ☐ Help-seeking patterns
- ☐ Beliefs about wellness
- ☐ Beliefs about mental illness and mental health treatment
- ☐ Beliefs about substance use, abuse, and dependence
- ☐ Beliefs about substance abuse treatment
- ☐ Family views on substance use and substance abuse treatment
- ☐ Treatment concerns related to cultural differences
- ☐ Cultural approaches to healing or treatment of substance use and mental disorders
- ☐ Education history and concerns
- ☐ Work history and concerns
- ☐ SES and financial concerns
- ☐ Cultural group affiliation
- ☐ Current network of support
- ☐ Community concerns
- ☐ Review of confidentiality parameters and concerns
- ☐ Cultural concepts of distress (DSM-5*)
- ☐ DSM-5 culturally related V-codes

**Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (American Psychiatric Association [APA] 2013).

Sources: Comas-Diaz 2012; Constantine and Sue 2005; Sussman 2004.

Step 5: Gather Culturally Relevant Collateral Information

A client who needs behavioral health treatment services may be unwilling or unable to provide a full personal history from his or her own perspective and may not recall certain events or be aware of how his or her behavior affects his or her well-being and that of others. Collateral information—supplemental information obtained with the client's permission from sources other than the client—can be derived from family members, medical and court records, probation and parole officers,

community members, and others. Collateral information should include culturally relevant information obtained from the family, such as the organizational memberships, beliefs, and practices that shape the client's cultural identity and understanding of the world.

As families can be a vital source of information, counselors are likely to attain more support by engaging families earlier in the treatment process. Although counselor interactions with family members are often limited to a few formal sessions, the families of racially and ethnically diverse clients tend to play a more significant and influential role in clients' participation in treatment. Consequently, special sensitivity to the cultural background of family members providing collateral information is essential. Families, like clients, cannot be easily defined in terms of a generic cultural identity (Congress 2004; Taylor et al. 2012). Even families from the same racial background or ethnic heritage can be quite dissimilar, thus requiring a multidimensional approach in understanding the role of culture in the lives of clients and their families. Using the culturagram tool on the next page in preparation for counseling, treatment planning, or clinical supervision, clinicians can learn about the unique attributes and histories that influence clients' lives in a cultural context.

Step 6: Select Culturally Appropriate Screening and Assessment Tools

Discussions of the complexities of psychological testing, the interpretation of assessment measures, and the appropriateness of screening procedures are outside the scope of this TIP. However, counselors and other clinical service providers should be able to use assessment and screening information in culturally competent ways. This section discusses several instruments and their appropriateness for specific cultural groups. Counselors should continue to explore the availability of mental health and substance abuse screening and assessment tools that have been translated into or adapted for other languages.

Culturally Appropriate Screening Devices

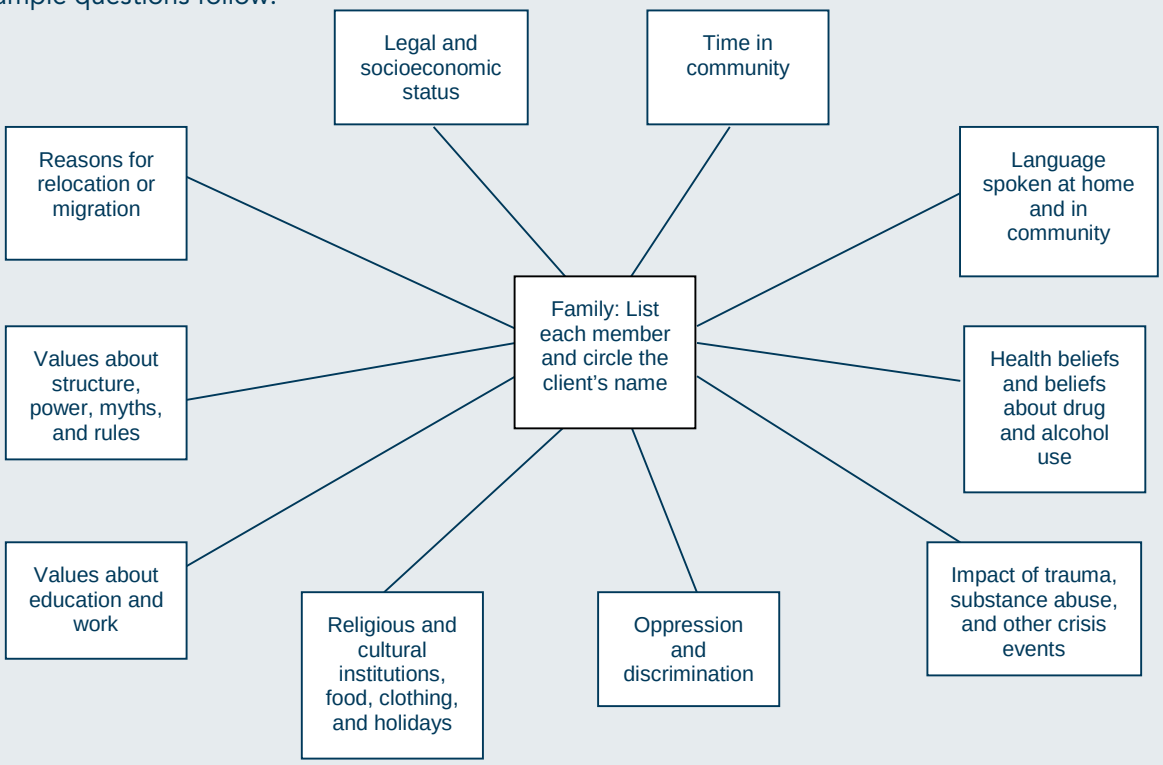
The consensus panel does not recommend any specific instruments for screening or assessing mental or substance use disorders. Rather, when selecting instruments, practitioners should consider their cultural applicability to the client being served (AACE 2012; Jome and Moody 2002). For example, a screening instrument that asks the respondent about his or her guilt about drinking could be ineffective for members of cultural, ethnic, or religious groups that prohibit any consumption of alcohol. Al-Ansari and Negrete's (1990) research supports this point. They found that the Short Michigan Alcoholism Screening Test was highly sensitive with people who use alcohol in a traditional Arab Muslim society; however, one question—"Do you ever feel guilty about your drinking?"—failed to distinguish between people with alcohol dependency disorders in treatment and people who drank in the community. Questions designed to measure conflict that results from the use of alcohol can skew test results for participants from cultures that expect complete abstinence from alcohol and/or drugs. Appendix D summarizes instruments tested on specific populations (e.g., availability of normative data for the population being served).

Culturally Valid Clinical Scales

As the literature consistently demonstrates, co-occurring mental disorders are common in people who have substance use disorders. Although an assessment of psychological problems helps match clients to appropriate

How To Use a Culturagram for Mapping the Role of Culture

The culturagram is an assessment tool that helps clinicians understand culturally diverse clients and their families (Congress 1994, 2004; Congress and Kung 2005). It examines 10 areas of inquiry, which should include not only questions specific to clients' life experiences, but also questions specific to their family histories. This diagram can guide an interview, counseling, or clinical supervision session to elicit culturally relevant multigenerational information unique to the client and the client's family. Give a copy of the diagram to the client or family for use as an interactive tool in the session. Throughout the interview, the client, family members, and/or the counselor can write brief responses in each box to highlight the unique attributes of the client's history in the family context. This diagram has been adapted for clients with co-occurring mental and substance use disorders; sample questions follow.



Values about family structure, power, myths, and rules:

- Are there specific gender roles and expectations in your family?
- Who holds the power within the family?
- Are family needs more important than, or equally as important as, individual needs?
- Whom do you consider family?

Reasons for relocation or migration:

- Are you and your family able to return home?
- What were your reasons for coming to the United States?
- How do you now view the initial reasons for relocation?
- What feelings do you have about relocation or migration?
- Do you move back and forth from one location to another?
- How often do you and your family return to your homeland?
- Are you living apart from your family?

Legal status and SES:

- Has your SES improved or worsened since coming to this country?
- Has there been a change in socioeconomic status across generations?

(Continued on the next page.)

How To Use a Culturagram for Mapping the Role of Culture (continued)

- What is the family history of documentation? (Note: Clients often need to develop trust before discussing legal status; they may come from a place where confidentiality is unfamiliar.)

Time in the community:
- How long have you and your family members been in the country? Community?
- Are you and your family actively involved in a culturally based community?

Languages spoken in and outside the home:
- What languages are spoken at home and in the community?
- What is your and your family's level of proficiency in each language?
- How dependent are parents and grandparents on their children for negotiating activities surrounding the use of English? Have children become the family interpreters?

Health beliefs and beliefs about help-seeking:
- What are the family beliefs about drug and alcohol use? Mental illness? Treatment?
- Do you and your family uphold traditional healing practices?
- How do help-seeking behaviors differ across generations and genders in your family?
- How do you and your family define illness and wellness?
- Are there any objections to the use of Western medicine?

Impact of trauma and other crisis events:
- How has trauma affected your family across generations?
- How have traumas or other crises affected you and/or your family?
- Has there been a specific family crisis?
- Did the family experience traumatic events prior to migration—war, other forms of violence, displacement including refugee camps, or similar experiences?

Oppression and discrimination:
- Is there a history of oppression and discrimination in your homeland?
- How have you and your family experienced discrimination since immigration?

Religious and cultural institutions, food, clothing, and holidays:
- Are there specific religious holidays that your family observes?
- What holidays do you celebrate?
- Are there specific foods that are important to you?
- Does clothing play a significant cultural or religious role for you?
- Do you belong to a cultural or social club or organization?

Values about education and work:
- How much importance do you place on work, family, and education?
- What are the educational expectations for children within the family?
- Has your work status changed (e.g., level of responsibility, prestige, and power) since migration?
- Do you or does anyone in your family work several jobs?

Sources: Comas-Diaz 2012; Congress 1994, 2004; Singer 2007.

treatment, clinicians are cautioned to proceed carefully. People who are abusing substances or experiencing withdrawal from substances can exhibit behaviors and thinking patterns consistent with mental illness. After a period of abstinence, symptoms that mimic mental illness can disappear. Moreover, clinical instruments are imperfect measurements of equally imperfect psychological constructs that were created to organize and understand clinical patterns and thus better treat them; they do not provide absolute answers. As research and science evolve, so does our understanding of mental illness (Benuto 2012). Assessment tools are generally developed for particular populations and can be inapplicable

to diverse populations (Blume et al. 2005; Suzuki and Ponterotto 2008). Appendix D summarizes research on the clinical utility of instruments for screening and assessing co-occurring disorders in various cultural groups.

Diagnosis

Counselors should consider clients' cultural backgrounds when evaluating and assessing mental and substance use disorders (Bhugra and Gupta 2010). Concerns surrounding diagnoses of mental and substance use disorders (and the cross-cultural applicability of those diagnoses) include the appropriateness of specific test items or questions, diagnostic criteria, and psychologically oriented concepts (Alarcon 2009; Room 2006). Research into specific techniques that address cultural differences in evaluative and diagnostic processes so far remains limited and underrepresentative of diverse populations (Guindon and Sobhany 2001; Martinez 2009).

Does the DSM-5 accurately diagnose mental and substance use disorders among immigrants and other ethnic groups? Caetano and Shafer (1996) found that diagnostic criteria seemed to identify alcohol dependency consistently across race and ethnicity, but their sample was limited to African Americans, Latinos, and Whites. Other research has shown mixed results.

In 1972, the World Health Organization (WHO) and the National Institutes of Health (NIH) embarked on a joint study to test the cross-cultural applicability of classification systems for various diagnoses, including substance use disorders. WHO and NIH identified factors that appeared to be universal aspects of mental and substance use disorders and then developed instruments to measure them. These instruments, the Composite International Diagnostic Interview (CIDI) and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), include some DSM and International Statistical Classification of Diseases and Related Health Problems criteria. Studies report that both the CIDI and SCAN were generally accurate, but the investigators urge caution in translation and interview procedures (Room et al. 2003).

Advice to Counselors and Clinical Supervisors: Culturally Responsive Screening and Assessment

- Assess the client's primary language and language proficiency prior to the administration of any evaluation or use of testing instruments.
- Determine whether the assessment materials were translated using specific terms, including idioms that correspond to the client's literacy level, culture, and language. Do not assume that translation into a stated language exactly matches the specific language of the client. Specifically, the client may not understand the translated language if it does not match his or her ways of thinking or speaking
- Educate the client on the purpose of the assessment and its application to the development of the treatment plan. Remember that testing can generate many emotional reactions.
- Know how the test was developed. Is normative data available for the population being served? Test results can be inflated, underestimated, or inaccurate due to differences within the client's population.
- Consider the role of acculturation in testing, including the influence of the client's worldview in responses. Unfamiliarity with mainstream United States culture can affect interpretation of questions, the client–evaluator relationship, and behavior, including participation level during evaluation and verbal and behavioral responses.

Sources: Association for Assessment in Counseling and Education (AACE) 2012; Saldaña 2001.

Overall, psychological concepts that are appropriate for and easily translated by some groups are inappropriate for others. In some Asian cultures, for example, feeling refers more to a physical than an emotive state; questions designed to infer emotional states are not easily translated. In most cases, these issues can be remedied by using culture-specific resources, measurements, and references while also adopting a cultural formulation in the interviewing process (see Appendix E for the APA's cultural formulation outline). The DSM-5 lists several cultural concepts of distress (see Appendix E), yet there is little empirical literature providing data or treatment guidance on using the APA's cultural formulation or addressing cultural concepts of distress (Martinez 2009; Mezzich et al. 2009).

Step 7: Determine Readiness and Motivation for Change

Clients enter treatment programs at different levels of readiness for change. Even clients who present voluntarily could have been pushed into it by external pressures to accept treatment before reaching the action stage. These different readiness levels require different approaches. The strategies involved in motivational interviewing can help counselors prepare culturally diverse clients to change their behavior and keep them engaged in treatment. To understand motivational interviewing, it is first necessary to examine the process of change that is involved in recovery. See TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (Center for Substance Abuse Treatment [CSAT] 1999*b*), for more information on this technique.

Stages of Change

Prochaska and DiClemente's (1984) classic transtheoretical model of change is applicable to culturally diverse populations. This model divides the change process into several stages:

- *Precontemplation.* The individual does not see a need to change. For example, a person at this stage who abuses substances does not see any need to alter use, denies that there is a problem, or blames the problem on other people or circumstances.
- *Contemplation.* The person becomes aware of a problem but is ambivalent about the course of action. For instance, a person struggling with depression recognizes that the depression has affected his or her life and thinks about getting help but remains ambivalent on how he/she may do this.
- *Preparation.* The individual has determined that the consequences of his or her behavior are too great and that change is necessary. Preparation includes small steps toward making specific changes, such as when a person who is overweight begins reading about wellness and weight management. The client still engages in poor health behaviors but may be altering some behaviors or planning to follow a diet.
- *Action.* The individual has a specific plan for change and begins to pursue it. In relation to substance abuse, the client may make an appointment for a drug and alcohol assessment prior to becoming abstinent from alcohol and drugs.
- *Maintenance.* The person continues to engage in behaviors that support his or her decision. For example, an individual with bipolar I disorder follows a daily relapse prevention plan that helps him or her assess warning signs of a manic episode and reminds him or her of the importance of engaging in help-seeking behaviors to minimize the severity of an episode.

Progress through the stages is nonlinear, with movement back and forth among the stages at different rates. It is important to recognize that change is not a one-time process, but

rather, a series of trials and errors that eventually translates to successful change. For example, people who are dependent on substances often attempt to abstain several times before they are able to acquire long-term abstinence.

Motivational Interviewing

Motivational interventions assess a person's stage of change and use techniques likely to move the person forward in the sequence. Miller and Rollnick (2002) developed a therapeutic style called motivational interviewing, which is characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. The counselor's major tool is reflective listening and soliciting change talk (CSAT 1999*c*).

This nonconfrontational, client-centered approach to treatment differs significantly from traditional treatments in several ways, creating a more welcoming relationship. TIP 35 (CSAT 1999*c*) assesses Project MATCH and other clinical trials, concluding that the evidence strongly supports the use of motivational interviewing with a wide variety of cultural and ethnic groups (Miller and Rollnick 2013; Miller et al. 2008). TIP 35 is a good motivational interviewing resource. For specific application of motivational interviewing with Native Americans, see Venner and colleagues (2006). For improvement of treatment compliance among Latinos with depression through motivational interviewing, see Interian and colleagues (2010).

Step 8: Provide Culturally Responsive Case Management

Clients from various racial, ethnic, and cultural populations seeking behavioral health services may face additional obstacles that can interfere with or prevent access to treatment and ancillary services, compromise appropriate referrals, impede compliance with treatment recommendations, and produce poorer treatment outcomes. Obstacles may include immigration status, lower SES, language barriers, cultural differences, and lack of or poor coverage with health insurance.

Case management provides a single professional contact through which clients gain access to a range of services. The goal is to help assess the need for and coordinate social, health, and other essential services for each client. Case management can be an immense help during treatment and recovery for a person with limited English literacy and knowledge of the treatment system. Case management focuses on the needs of individual clients and their families and anticipates how those needs will be affected as treatment proceeds. The case manager advocates for the client (CSAT 1998*a*; Summers 2012), easing the way to effective treatment by assisting the client with critical aspects of life (e.g., food, childcare, employment, housing, legal problems). Like counselors, case managers should possess self-knowledge and basic knowledge of other cultures, traits conducive to working well with diverse groups, and the ability to apply cultural competence in practical ways.

Cultural competence begins with self-knowledge; counselors and case managers should be aware of and responsive to how their culture shapes attitudes and beliefs. This understanding will broaden as they gain knowledge and direct experience with the cultural groups of their client population, enabling them to better frame client issues and interact with clients in culturally specific and appropriate ways. TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT 1998a), offers more information on effective case management.

Exhibit 3-1 discusses the cultural matching of counselors with clients. When counselors cannot provide culturally or linguistically competent services, they must know when and how to bring in an interpreter or to seek other assistance (CSAT 1998*a*). Case management includes finding an interpreter who communicates well in the client's language and dialect and who is familiar with the vocabulary required to communicate effectively about sensitive subject matter. The case manager works within the system to ensure that the interpreter, when needed, can be compensated. Case managers should also have a list of appropriate referrals to meet assorted needs. For example, an immigrant who does not speak English may need legal services in his or her language; an undocumented worker may need to know where to go for medical assistance. Culturally competent case managers build and maintain rich referral resources for their clients.

The Case Management Society of America's *Standards of Practice for Case Management* (2010) state that case management is central in meeting client needs throughout the course of treatment. The standards stress understanding relevant cultural information and communicating effectively by respecting and being responsive to clients and their cultural contexts. For standards that are also applicable to case management, refer to the National Association of Social Workers' *Standards on Cultural Competence in Social Work Practice* (2001).

Step 9: Incorporate Cultural Factors Into Treatment Planning

The cultural adaptation of treatment practices is a burgeoning area of interest, yet research is limited regarding the process and outcome of culturally responsive treatment planning in behavioral health treatment services for

Exhibit 3-1: Client–Counselor Matching

The literature is inconclusive about the value of client–counselor matching based on race, ethnicity, or culture (Imel et al. 2011; Larrison et al. 2011; Suarez-Morales et al. 2010). Sue et al. (1991) found that for people whose primary language was not English, counselor–client matching for ethnicity and language predicted longer time in treatment (more sessions) with better outcomes for all ethnic groups studied: Asian Americans, African Americans, Mexican Americans, and White Americans.

Ethnic matches may work better for Latinos in treatment; gender congruence seems more important than race or ethnicity in client–counselor matching, particularly for female clients (Sue and Sue 2013*a*). For Asian Americans and Pacific Islanders, the many different ethnic subgroups make a cultural match more difficult. In multicultural communities, racial and ethnic matching may help develop a working alliance between the therapist and the consumer (Chao et al. 2012). Other relevant variables of both the client and therapist are age, marital status, training, language, and parental status. The extent to which a cultural match is necessary in therapy depends on client preferences, characteristics, presenting problems, and treatment needs. For example, gender matching could be more important than race/ethnicity matching to female sexual abuse survivors, who may have difficulty discussing their trauma with male counselors.

Most clients want to know that their counselors understands their worldviews, even if they do not share them. Counselors' understanding of their clients' cultures improves treatment outcomes (Suarez-Morales et al. 2010). Fiorentine and Hillhouse (1999) found that empathy, regardless of race or ethnicity of counselor and client, was the most important predictor of favorable treatment outcomes. Sue et al. (1991) found that clients using outpatient mental health services more readily attended treatment and stayed longer if services were culturally responsive. In the treatment planning process, matching clients with providers according to cultural (and subcultural, when warranted) backgrounds can help provide treatment that is responsive to the personal, cultural, and clinical needs of clients (Fontes 2008).

diverse populations. How do counselors and organizations respond culturally to the diverse needs of clients in the treatment planning process? How effective are culturally adaptive treatment goals? (For a review, see Bernal and Domenech Rodriguez 2012.) Typically, programs that provide culturally responsive services approach treatment goals holistically, including objectives to improve physical health and spiritual strength (Howard 2003). Newer approaches stress implementation of strength-based strategies that fortify cultural heritage, identity, and resiliency.

Treatment planning is a dynamic process that evolves along with an understanding of the clients' histories and treatment needs. Foremost, counselors should be mindful of each client's linguistic requirements and the availability of interpreters (for more detail on interpreters, see Chapter 4). Counselors should be flexible in designing treatment plans to meet client needs and, when appropriate, should draw upon the institutions and resources of clients' cultural communities. Culturally responsive treatment planning is achieved through active listening and should consider client values, beliefs, and expectations. Client health beliefs and treatment preferences (e.g., purification ceremonies for Native American clients) should be incorporated in addressing specific presenting problems. Some people seek help for psychological concerns and substance abuse from alternative sources (e.g., clergy, elders, social supports). Others prefer treatment programs that use principles and approaches specific to their cultures. Counselors can suggest appropriate traditional treatment resources to supplement clinical treatment activities.

In sum, clinicians need to incorporate culture-based goals and objectives into treatment plans and establish and support open client–counselor dialog to get feedback on the proposed plan's relevance. Doing so can improve client engagement in treatment services, compliance with treatment planning and recommendations, and treatment outcomes.

Group Clinical Supervision Case Study

Beverly is a 34-year-old White American who feels responsible for the tension and dissension in her family. Beverly works in the lab of an obstetrics and gynecology practice. Since early childhood, her younger brother has had problems that have been diagnosed differently by various medical and mental health professionals. He takes several medications, including one for attention deficit disorder. Beverly's father has been out of work for several months. He is seeing a psychiatrist for depression and is on an antidepressant medication. Beverly's mother feels burdened by family problems and ineffective in dealing with them. Beverly has always helped her parents with their problems, but she now feels bad that she cannot improve their situation. She believes that if she were to work harder and be more astute, she could lessen her family's distress. She has had trouble sleeping. In the past, she secretly drank in the evenings to relieve her tension and anxiety.

Most counselors agree that Beverly is too submissive and think assertiveness training will help her put her needs first and move out of the family home. However, a female Asian American counselor sees Beverly's priorities differently, saying that "a morally responsible daughter is duty-bound to care for her parents." She thinks that the family needs Beverly's help, so it would be selfish to leave them.

Discuss:

- How does the counselor's worldview affect prioritizing the client's presenting problems?
- How does the counselor's individualistic or collectivistic culture affect treatment planning?
- How might a counselor approach the initial interview and evaluation to minimize the influence of his or her worldview in the evaluation and treatment planning process?

Sources: The Office of Nursing Practice and Professional Services, Centre for Addiction and Mental Health & Faculty of Social Work, University of Toronto 2008; Zhang 1994.

4 Pursuing Organizational Cultural Competence

IN THIS CHAPTER

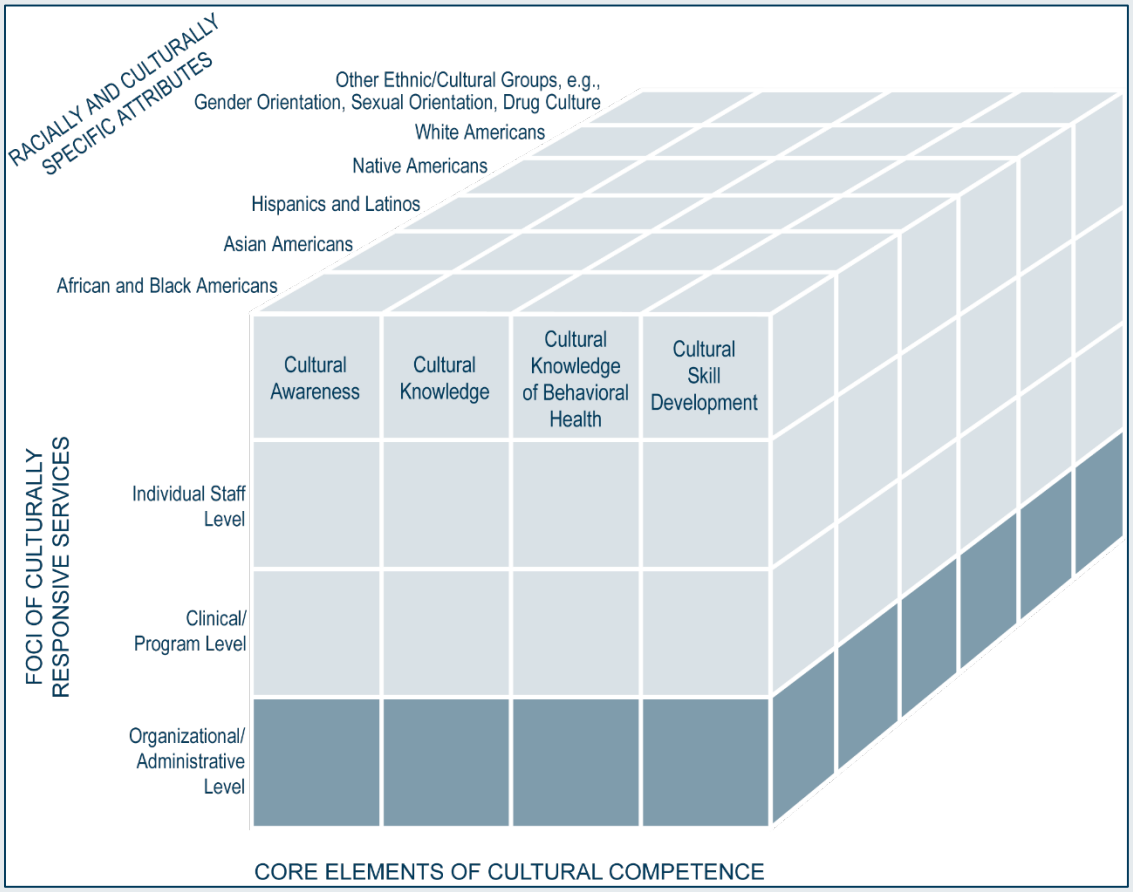
- Cultural Competence at the Organizational Level
- Organizational Values
- Governance
- Planning
- Evaluation and Monitoring
- Language Services
- Workforce and Staff Development
- Organizational Infrastructure

Cavin, a 42-year-old African American man, arrived at a well-known private substance abuse treatment center confused and unable to provide his medical history at intake. Referred to the center through his employee assistance program, he was accompanied by his spouse and 14-year-old son. Cavin's wife provided his medical history and recounted her husband's 2-year decline from a promising career as a journalist, researcher, and social commentator to a bitter, often paranoid man who abused cocaine and alcohol. Cavin, she explained, had become increasingly unpredictable.

Upon admission, Cavin was initially cooperative and grateful to his spouse for her efforts, but as withdrawal continued, he became increasingly agitated, insisting that he could detoxify on his own. He resisted any intervention by staff members whom he perceived to be critical or patronizing. On his fourth day in treatment, Cavin began to note the treatment center's "White" environment. There were almost no African American employees—none at the clinical level. He noted how decor reflected only White American culture. Driven in part by his substance use disorder, he was looking for reasons to leave. Later that evening, he checked out.

Cavin was unable to relate to his treatment. He found no cultural cues with which to identify or connect. Therefore, he started searching for reasons to leave—behavior typical in persons who abuse substances. People often leave treatment with the conscious hope of managing their substance abuse themselves and the unconscious drive to relive positive experiences associated with substance use; meanwhile, they all too easily forget the pain imposed by the use of alcohol and other substances. Cavin may have remained in treatment if services had been more culturally responsive. This is an example of how behavioral health programs benefit

Multidimensional Model for Developing Cultural Competence: Organizational/ Administrative Level



from commitment to culturally responsive services, staffing, and treatment—if they make no such commitment, their services may be underused, unwelcome, and ineffective.

Cultural Competence at the Organizational Level

At the organizational level, cultural competence or responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in multicultural environments (Cross et al. 1989). Organizational cultural responsiveness is a dynamic, ongoing process; it is not something that is achieved once and is then complete. Organizational structures and components change. The demographics and needs of communities change. Employees and their job descriptions change. Consequently, the commitment to increase cultural competence must also involve a commitment to *maintain* it through periodic reassessments and adjustments. Based on the Cross et al. (1989) definition of the culturally competent organization, Goode (2001) identifies three principal components (Exhibit 4-1) that coincide with Sue's (2001) multidimensional model for developing cultural competence in behavioral health services.

Exhibit 4-1: Requirements for Organizational Cultural Competence

- The organization needs a defined set of values and principles, along with demonstrated behaviors, attitudes, policies, and structures that enable effective work across cultures.
- The organization must value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities it serves.
- The organization must incorporate the above in all aspects of policymaking, administration, and service delivery and systematically involve consumers and families.

Source: Goode 2001.

This chapter provides a broad overview of how behavioral health organizations can create an institutional framework for culturally responsive program delivery, staff development, policies and procedures, and administrative practices. Built on the U.S. Department of Health and Human Services' (HHS's) Office of Minority Health (OMH) Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (OMH 2013; for review, see Appendix C), this chapter is organized around the Health Resources and Services Administration's (HRSA's) domains of organizational cultural competence: organizational values, governance, planning, evaluation and monitoring, communication (language services), workforce and staff development, and organizational infrastructure (Linkins et al. 2002). (Another domain, services and interventions, is covered in Chapter 3.)

Within each domain, specific organizational tasks are suggested to aid program and administrative staff in developing a culturally responsive clinical, work, and organizational environment (Exhibit 4-2); these domains and

Exhibit 4-2: Creating Culturally Responsive Treatment Environments

Organizational values tasks:
- Commit to cultural competence.
- Review and update vision, mission, and value statements.
- Address cultural competence in strategic planning processes.

Governance tasks:
- Assign a senior manager to oversee the organizational development of culturally responsive practices and services.
- Develop culturally competent governing and advisory boards.
- Create a cultural competence committee.

Planning tasks:
- Engage clients, staff, and community in the planning, development, and implementation of culturally responsive services.
- Develop a cultural competence plan.
- Review and develop policies and procedures to ensure culturally responsive organizational practices.

Evaluation and monitoring tasks:
- Create demographic profiles of the community, clientele, staff, and board.
- Conduct an organizational self-assessment of cultural competence.

Language services tasks:
- Plan for language services proactively.
- Establish practice and training guidelines for the provision of language services.

Workforce and staff development tasks:
- Develop staff recruitment, retention, and promotion strategies that reflect the population(s) served.
- Create training plans and curricula that address cultural competence.
- Give culturally congruent clinical supervision.
- Evaluate staff performance on culturally congruent and complementary attitudes, knowledge, and skills.

Organizational infrastructure:
- Invest in long-range fiscal planning to promote cultural competence.
- Create an environment that reflects the populations served.
- Develop outreach strategies to improve access to care.

Source: Linkins et al. 2002.

tasks are adapted to behavioral health services. Task overlap across domains may require work on several tasks at once. HRSA's organizational cultural competence assessment profile is available online (http://www.hrsa.gov/culturalcompetence/healthdlvr.pdf; Linkins et al. 2002).

Organizational Values

Journey Mental Health Center (JMHC), a large outpatient mental health and substance abuse treatment clinic in Wisconsin, is an organization that is committed to providing accessible, community-focused, culturally responsive behavioral health services. JMHC offers the following commentary on the importance of clear, culturally responsive organizational values (JMHC 2013, paragraphs 1-3):

> …cultural competence is fundamental to providing quality services that promote individual and family strengths, dignity, and self-reliance. Cultural competence broadens and enriches the delivery of mental health and alcohol and other drug abuse (AODA) services by providing a more holistic, relevant view of the world and the helping process. Cultural competence does not stand apart from, but is intrinsic to good clinical practice. Its threads are woven into the tapestry of effective assessment, treatment planning, intervention, advocacy, and support. In addition, cultural competence is intrinsic to effective staff relationships and business practices.
>
> Cultural competence promotes relationships based upon understanding and knowledge of how one's own cultural beliefs and values influence the organization of information, perceptions, feelings, experiences, and coping strategies. It involves being able to identify, learn from, and incorporate these into the helping process. When cultural competence is an integral part of personal competence, there is the maximum opportunity to increase the amount and quality of information and the speed with which that information can be shared and processed and to form healthy alliances.
>
> Cultural competence demands an ongoing commitment to openness and learning, taking time and taking risks, sitting with uncertainty and discomfort, and not having quick solutions or easy answers. It involves building trust, mentoring, and developing and nurturing a frame of reference that considers alliances across culture as enriching rather than threatening shared goals.

Task: Commit to Cultural Competence

Counselors are typically a part of a larger organization or system, but the focus on and responsibility for developing culturally responsive services has historically fallen on individual practitioners rather than on organizations. Most literature on cultural competence addresses the cultural awareness, knowledge, and skills of the practitioner, but until recently, it has failed to apply these same concepts to agencies. Cultural competence among counselors is only as effective as their agencies' commitment to and support of cultural competence and ability to value diversity through culturally congruent administrative practices, including—but not limited to—policies and procedures, programming, staffing, and community involvement.

Counselors are unlikely to affect organizational change to the same degree as the agency's overall administration can. Hence, culturally responsive treatment cannot be sustained without an agency's commitment and support. In fact, the organization itself can prevent clients from receiving culturally responsive services or treatment opportunities. Organizations that are unaware of cultural issues can fail to recognize that diverse groups may have difficulty accessing and engaging in treatment. Also, counselors who attempt to use culturally responsive practices—such as the involvement of family members (as defined by the client) and traditional healers—can encounter insurmountable hurdles if their agencies' policies

Organizations that fail to endorse and make a commitment to cultural competence will more than likely displace the responsibility of cultural competence onto counselors or clients. If the responsibility is on the clients, it is likely that the clients will have to "fit" or change to match the treatment or program rather than treatment services being adapted to fit the needs of clients.

and resources do not support these practices. The system can actually impede efforts made by counselors invested and trained in cultural competence. Thus, the development of cultural competence begins at the top level of the organization, with an initial focus on systemic changes.

Cultural competence does not occur by accident. To maximize its effectiveness in working with diverse groups, the organization must first view diversity as an asset. As importantly, the organization must ensure that its process of developing cultural competence has the genuine, full, and lasting support of the organization's leadership. The chief executive officer (CEO), senior management, and board of directors play critical roles. A strong mandate from the board or CEO, coupled with a commitment to provide resources, can be a good motivator for staff and committees to undertake major organizational change. Support of cultural competence must be made clear throughout the organization and community in meaningful ways, in words and actions.

Leadership can make a difference in the implementation of culturally responsive practices by creating an organizational climate that encourages and supports such practices. This includes a willingness to discuss the importance of cultural competence, try new practices or approaches, tolerate the uncertainty that accompanies transitional periods during which practices and procedures are evolving, respond to unforeseen barriers, and revise innovations that are not working as intended. It is important that leadership be genuinely committed to the effort and that their support be tangibly apparent in the allocation of relevant resources. A strong commitment to improving organizational cultural competence should include the obligation to monitor procedures after they have been implemented, maintain and reevaluate new practices, and provide resources and opportunities for ongoing training and culturally competent supervision.

Task: Review and Update Vision, Mission, and Value Statements

The organization's mission, vision, and value statements are vitally important in creating a conceptual framework that promotes culturally responsive behavioral health services. Agencies should examine how these statements are developed. Are stakeholders involved in the development process? In what ways does the organization ensure that its values and mission reflect the community and populations that it serves? Does the organization see this task as a singular event, or has it planned for periodic review of its values and mission to ensure continued organizational responsiveness as needs, populations, or environments change?

Initially, the planning committee should determine how the culture of the organization as well as the surrounding community can support achievement of the mission and vision statements. Culturally responsive organizational statements cannot provide a tangible framework unless supported by community, referral, and client demographics; a needs assessment; and an implementation plan. Mission and vision statements need to be operationalized through identified goals as well as measurable indicators to track progress. The Hands Across Cultures Corporation of

northern New Mexico, which serves Native peoples within pueblos (American Indians), the City of Española, Pojoaque Valley, and surrounding communities (predominantly Latino), addresses the importance of the cultural context of its work in its mission and philosophy statements (Exhibit 4-3).

Task: Address Cultural Competence in Strategic Planning Processes

The strategic planning process provides an opportunity to reevaluate an agency's values, mission, and vision regarding cultural competence. A comprehensive process involves evaluating the organization's internal and external environments prior to holding planning meetings; this evaluation involves conducting staff, client, and community assessments. From assessing current needs to evaluating global factors that influence the direction and delivery of services (e.g., funding sources, treatment mandates, changes in health insurance), organizations can begin to gain insight into the demands and challenges of providing culturally responsive services. Moreover, strategic planning is an opportunity to explore and develop short- and long-term goals that focus on incorporating culturally responsive delivery systems while addressing issues of sustainability (i.e., how to provide resources and support the implementation of culturally responsive policies and procedures over time). A formal strategic planning meeting should be held to determine specific goals, objectives, and tasks that will ensure quality improvement in culturally responsive services. The development of timelines and methods to evaluate progress, obstacles, and directions for each goal are equally important. For organizations that do not have a specific cultural competence plan prior to the strategic planning meeting, this process can provide the forum for developing the steps needed to create a formal plan.

Exhibit 4-3: Hands Across Cultures Mission Statement

Mission
To improve the health, education and well being of the people of Northern New Mexico through family-centered approaches deeply rooted in the multicultural traditions of their communities.

Philosophy
To believe in culture as the foundation of human growth; spirituality as the strength of the people; each person's need to love and be loved; family preservation; individual responsibility; and the pursuit of human potential.

With a firm commitment to these beliefs, Hands Across Cultures' Board of Directors, staff, and collaborators hold that:

Culture Is the Cure
La Cultura Cura

Source: Hands Across Cultures 2014.

Governance

Task: Assign a Senior Manager To Oversee the Development of Culturally Responsive Practices and Services

From the outset, a senior staff member with the authority to implement change should be assigned to oversee the developmental process of planning, evaluating, and implementing culturally responsive administrative and clinical services. Key responsibilities include the ongoing development and facilitation of cultural competence committees and advisory boards, management of evaluative processes, facilitation of the development of a cultural competence plan and its implementation, and oversight of policies and procedures to ensure cultural competence within the organization and among staff. Cultural competence cannot come to fruition with only one voice being heard, but assigning a key person to oversee

the process will more likely keep top-priority goals and objectives in view.

Task: Develop Culturally Competent Governing and Advisory Boards

Beyond having the foresight to plan for and develop culturally responsive services, it is vital that executive staff members on governing and advisory boards and committees are educated about and invested in the organization's mission and plan. For example, the board's human resources committee may be more invested in developing and reinforcing culturally responsive recruitment and hiring policies and practices if they are involved in the strategic planning process and educated about the organization's mission, values, and vision. At the same time, the organization should seek outside direction. Given that sharing information about the agency's activities with others outside the organization can create some hesitancy or be a potential barrier, the executive staff can frame the planning process as an opportunity for positive development and community involvement as a powerful resource. The organization should establish a community advisory board that includes stakeholders, specialists, and/or experts in multicultural behavioral health services along with key administrators and staff. This advisory board should consist of local community members from whom the organization can solicit valuable advice, input, and potential support for the development of culturally responsive treatment (Minnesota Department of Human Services 2004).

Representation should include clients, alumni, family members, and community-based organizations and institutions (e.g., community centers, faith communities, social service organizations). Developing an inclusive advisory board of community members can enhance and extend use of and referral from other community agencies. Moreover, this board can help identify community leaders and culturally appropriate resources for the client population to supplement treatment activities, such as traditional healing practices (Castro et al. 1999*a*). The advice box on the next page reviews strategies for engaging communities in the development of culturally responsive services.

Task: Establish a Cultural Competence Committee

By creating a committee within the organization to guide the process of becoming culturally competent and responsive, the organization ensures that a core group will provide oversight and direction. This committee should be inclusive not only in terms of the racial and ethnic composition of the population served, but also in terms of drawing from all levels of the organization (Whaley and Longoria 2008). Representatives of the advisory board should also be included. Program administrators should provide direction to the cultural competence committee. The person assigned to take the lead on cultural competence should chair the committee, and the CEO should be noticeably involved.

The cultural competence committee will oversee the organization's self-assessment process while also creating the demographic profile of the organization's community, developing a cultural competence plan, and formulating and monitoring procedures that evaluate the implementation and effectiveness of the organization's plan in developing culturally responsive services and practices. The committee should ensure that the organization's plans are continually updated. To succeed, this team must be empowered to influence, formulate, implement, and enforce initiatives on all levels and throughout every department of the organization (Constantine and Sue 2005; Fung et al. 2012), including, for example,

Advice to Administrators: Strategies To Engage Communities in Developing Culturally Responsive Treatment Services

- Ask board members to help recruit key members of the local community.
- Create a community advisory group to complement the governing boards in assessing and recommending culturally responsive policies, procedures, and practices.
- Develop local community focus groups to discuss key treatment needs, health beliefs, and attitudes and behaviors related to substance use, mental illness, and help-seeking that could be unknown to others outside of the community and in the organization.
- Develop a policy that supports the use of culturally congruent communication modalities and technologies for sharing information with communities.
- Provide inservice training, continuing education, and other professional development activities (e.g., networking events) that focus on strengthening skills for collaboration with culturally and linguistically diverse communities.
- Develop policies and procedures to support community involvement in the treatment setting (e.g., incorporating peer support programs, having a presence at community housing events, developing partnerships with traditional healers).
- Develop local outreach and educational programs in multiple languages (e.g., provide family education on substance use patterns and community issues in Spanish at a community center).
- Participate in community events to raise awareness of services, to develop trust and build relationships, and to gain further knowledge of local cultural groups and community practices.
- Periodically analyze community demographic trends and populations served by the treatment organization; ensure representation of these diverse populations on the advisory board.
- Become knowledgeable about and use available local goods and services.

Sources: Goode 2001; National Center for Cultural Competence 2013; Washington State Department of Social and Health Services 2011.

presenting data and subsequent recommendations to the administration and boards based on employee feedback about their experiences with newly adopted, culturally responsive procedures in the organization. Exhibit 4-4 highlights key issues in behavioral health treatment that must be addressed in providing culturally responsive services.

Planning

Task: Engage Clients, Staff, and the Community in the Planning, Development, and Implementation of Culturally Responsive Services

Organizations can sometimes have the best intentions of creating culturally responsive services but miss the mark by operating in a vacuum. Initially, the vacuum approach can appear less time consuming, complex, and expensive, but it can also represent paternalism whereby organizations or administrators assume that they inherently know what is best for the program, clients, staff, and community. Instead, organizations and the services that

Exhibit 4-4: Critical Treatment Issues To Consider in Providing Culturally Responsive Services

- Access: Degree to which services for clients are quickly and readily available.
- Engagement: Having appropriate skills and an environment that have a positive personal impact on the quality of clients' commitment to treatment.
- Retention: The result of quality services that help maintain clients in treatment with continued commitment.

Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

they provide need to be congruent with the specific populations being served; clients and the community should have an opportunity to provide input on how services are delivered and the types of services that are needed. Otherwise, services may be poorly matched to clients, underused by the community, and detrimental to agency financial resources. For example, an agency could decide that family therapy is a culturally appropriate service and proceed to create a multifamily program (treating several families together in a group format) without considering that, for some cultural groups, family shame associated with seeking help can deter the use of such services.

Staff members are likely to have specific knowledge of client needs and to be able to identify potential obstacles or challenges in how an organization attempts to implement culturally responsive policies and procedures. A parallel process that can influence the potential success of staff involvement and commitment to the development of cultural competence is the organizational culture. Suppose, for example, that the staff perceives the organization's new commitment to cultural competence as another expectation of more work without training, adequate clinical supervision, or ongoing support. Maybe staff members have historically experienced frequent announcements, mandates, or excitement generated by the administration that fade quickly. Perhaps the organization arranges committees and meetings, purporting that they want staff input despite the fact that decisions have already been made.

The organizational climate sets the stage for staff responsiveness and motivation in developing cultural competence and in implementing culturally responsive services. Without an organizational history and culture of supporting change across time, staff members will likely resent an increase in expectations without some means of compensating for additional work, perceive themselves as powerless over the proposed changes, or minimize the need to make any immediate changes. For example, staff members may view changes as temporary or a phase and believe that the organization will focus on other issues or new directions once the pressure or attention on this specific issue subsides.

Task: Develop a Cultural Competence Plan

To ensure the delivery of culturally responsive services, it is important to develop a cultural competence plan (see the "Criteria for Developing an Organizational Cultural Competence Plan" advice box on the next page). Using demographic data and an organizational self-assessment (including community and advisory board input), the organization's cultural competence committee can begin writing an organizational plan for improving cultural competence. The committee will need to assign staff members to research and write each component of the plan, which should outline specific objectives, means of achieving these objectives, and recommend timelines and processes for evaluating progress. The plan should contain at least the following components:

- A narrative introduction that covers community demographics and history, organizational self-assessment and other evaluation tools, the rationale for providing culturally responsive services, and the organization's strengths and needs for improvement in providing services that are responsive to client cultural groups; a brief overview of current priorities, goals, and tasks to help the organization develop and improve culturally responsive clinical services and administrative practices is also advisable.

Advice to Administrators: Criteria for Developing an Organizational Cultural Competence Plan

Using the core elements of access, engagement, and retention as criteria in developing a cultural competence plan, the following recommendations are offered:

- Develop a thorough knowledge and understanding of the social, cultural, and historical experiences of the community of people your agency is serving.
- Identify and clearly articulate an understanding of the ethnic, cultural, linguistic, and social groups in the area your agency serves.
- Document, track, and evaluate/assess the reasons why clients are not accepted for services.
- Know the demographics of clients within the program and their rates of program completion.
- Keep profiles of clients who do not complete services.
- Design steps for your agency to take to remove identified barriers that keep clients from using your agency's services.
- Establish steps your agency will implement or sustain to create a consumer-friendly environment that reflects and respects the diversity of the clients that use your services.
- Establish internal criteria the agency will use to measure the impact of the services and programs that it offers.

Source: The Connecticut Department of Children and Families, Office of Multicultural Affairs 2002.

- Strategies for recruiting, hiring, retaining, and promoting qualified diverse staff.
- Resources and policies to support language services and culturally responsive services.
- Methods to enhance professional development (e.g., staff education and training, peer consultation, clinical supervision) in culturally responsive treatment services.
- Mechanisms for community involvement, beginning with the development of a community advisory board and cultural competence committee and including community participation in relevant treatment activities or in support of treatment services (e.g., spiritual direction).
- Approaches to amending facility design and operations to present a culturally congruent atmosphere.
- Identification of and recommendations for culturally and linguistically appropriate program materials.
- Programmatic strategies to incorporate culturally congruent clinical and ancillary treatment services.
- Fiscal planning for funding and human resources needed for priority activities (e.g., training, language services, program development, organizational infrastructure).
- Guidelines for implementation that describe roles, responsibilities, timeframes, and specific activities for each step.

The committee must determine how to oversee the plan (e.g., by tracking accomplishments, obstacles, and remediation strategies). Who will develop and revise guidelines for treatment planning, introduce new guidelines to the staff and provide counselor training, and coordinate revisions with the information technology specialist or department?

Task: Develop and Review Policies and Procedures To Ensure Culturally Responsive Organizational Practices

In essence, policies and procedures are the backbone of an organization's implementation of culturally responsive services. By creating, reviewing, and adapting clinical and administrative policies and procedures in response to the ever-changing needs of client populations, the agency is able to provide counselors and

other workers with support and the means to respond in a consistent, yet flexible, manner. Programs are likely to have the foresight to develop relevant policies and procedures through the planning and evaluative processes outlined in this chapter, but it is unlikely that they will anticipate every situation. Thus, ongoing flexibility is paramount.

When putting together an organizational cultural competence plan, providers should be careful to follow the requirements set by state licensing boards, accreditation agencies, and professional organizations that oversee certification and licensing of treatment professionals. Much of the push for cultural competence throughout the healthcare field is in response to the mandates of accrediting agencies, funders, and managed care organizations. These entities have standards and guidelines that state minimum expectations for client rights, program structure, and staffing, along with treatment content and conditions. Behavioral health organizations, including substance abuse treatment programs, must meet these standards to be accredited by national organizations and compensated by funders.

Although many accrediting bodies require a cultural competence plan that is assessed as part of the accreditation process, their requirements can be minimal. Consequently, organizations should go beyond such requirements in their own thinking and planning to ensure that they are responding adequately to the needs of the communities they serve. Above all, are the policies, procedures, and systems of care suited to the served populations? Do policies reflect the organization's commitment to cultural competence in administrative practices? For example, are strategies for professional development, personnel recruitment, and retention of culturally competent staff members reflective of the populations and cultures that they serve?

If an organization fails to develop culturally responsive policies or procedures yet claims to endorse or support culturally responsive services, counselors and staff members will likely carry the entire burden of implementing these services and will face numerous obstacles that could prevent the delivery of responsive services. Take, for example, a counselor from a county-funded program who was directed by her supervisor to complement her counseling approach with the client's traditional healing beliefs and practices. The agency did not provide staff support, have policies or procedures consistent with this request, or exhibit a willingness to adapt current procedures to meet the client's needs. The counselor had difficulty following this direction because of barriers in finding an appropriate traditional practitioner in the local area, coordinating services, establishing and securing confidentiality for the client and with the practitioner (including educating the practitioner about confidentiality), arranging transportation for the client, obtaining a stipend for services, and discerning how and when to incorporate the traditional practice into the treatment milieu.

Counselors who feel that they have been left to go it alone can view implementation of culturally responsive practices as an insurmountable challenge when the agency provides limited support or fails to endorse adaptive policies that are congruent with the needs of the client population. Counselors may have high motivation to incorporate culturally responsive care but find themselves without appropriate agency resources, permission, or infrastructure to implement it. By developing and endorsing culturally responsive policies and procedures, an organization can provide carefully thought-out strategies and processes to help staff members provide real-time responsive services. Well-defined policies and procedures reinforce commitment to and expectations of cultural competence.

Evaluation and Monitoring

To develop a viable cultural competence plan, information must be gathered from all levels of the organization, from clients and community, and from other stakeholders. Beginning with acquiring initial demographic data from the populations that are or could be served by the agency and extending to soliciting feedback from various stakeholders, gathering information prior to plan development helps the organization provide direction and determine priorities. Gathering information also allows ongoing monitoring and feedback regarding the plan's effectiveness and areas in need of improvement. Areas of evaluation and monitoring can include a demographic profile of the client, community, staff, and board constellations; community needs assessment; client, family, and referral feedback; administrative, clinical, medical, and nonclinical staff assessments; and more (American Evaluation Association 2011; LaVeist et al. 2008).

Task: Create a Demographic Profile of the Community, Clientele, Staff, and Board

Intake, admission, and discharge data provide a good starting point for determining the demographics of current populations being served. Programs would likely benefit from developing a demographic summary for each population served, consisting of age, gender, race, ethnic and cultural heritage, religion, socioeconomic status, spoken and written language preferences and capabilities, employment rates, treatment level, and health status (HHS 2003*b*). With adequate resources, the organization can generate reports dating back 5 years to determine program trends.

Agencies should also gather demographic information on groups in the agency's local community (Hernandez et al. 2009). This information can be easily obtained through census data and national centers (e.g., Bureau of Labor Statistics) or through local sources, including the library, city hall, or the county commissioner's office (Whealin and Ruzek 2008). Community demographics can provide a quick benchmark on how well an agency serves the local community and how the community is represented at all levels of the organization. A demographic profile should also summarize information about clinical, medical, and nonclinical staff members as well as board members. Other information can also be helpful for specific agencies, as can hiring a consultant to gather demographic information and conduct the organization's self-assessment of cultural competence to limit bias; however, lack of funding can prohibit this possibility.

Task: Conduct Organizational Self-Assessment of Cultural Competence

An organization must have an awareness of how it functions within the context of a multicultural environment, evaluating operational aspects of the agency as well as staff ability and competence in providing culturally congruent services to racially and ethnically diverse populations. Therefore, an agency should assess how well it currently provides culturally responsive treatment. An honest and thorough organizational self-assessment can serve as a blueprint for the cultural competence plan and as a benchmark to evaluate progress across time (National Center for Cultural Competence 2013). To review a sample assessment guide, refer to Appendix C.

The importance of organizational self-assessment cannot be overstated. Thorough, reliable, valid evaluations can gauge the effectiveness of an agency's services, structure, and practices (e.g., clinical services, governing practices, policy development, staff composition, and professional development) with culturally and racially diverse clients, staff, and

communities. More and more, public and private funding sources—as well as accrediting bodies—use an organization's self-assessment as a means of measuring compliance, effectiveness, or quality improvement practices.

A self-assessment can seem intensive in terms of both labor and capital, but in the long run, it can guide an organization's quality improvement process more efficiently by helping it provide the most relevant services at the right time. Gathering feedback from many internal and external sources gives agencies considerable information needed to effectively evolve as a culturally responsive organization, including data on current performance, areas needing improvement, and development needs. In the initial self-assessment, an organization should obtain demographic information and seek feedback from key stakeholders—including community members, clients, families, and referral sources (e.g., probation and parole offices, family and child services, private practitioners)—and from all levels of the organization, including administrative, managerial, clinical, medical, and support staff. The following steps are recommended to help an agency gain the information necessary to guide and support the development of its cultural competence plan.

Step 1: With the advisory board and cultural competence committee, identify key stakeholders who can provide valuable feedback about current strengths and areas in need of improvement regarding the function of the organization and the needs of its community.

Step 2: Adopt a self-assessment guideline for organizational cultural competence (see Appendix C).

Step 3: Determine the feasibility of using consultants and/or external evaluators to select, analyze, and manage assessment.

For many organizations, hiring outside consultants is financially prohibitive. Nonetheless, the cultural competence committee could recommend hiring outside evaluators and consultants to help them plan, conduct, and assess the results of the organizational self-evaluation. The committee should ensure that consultants understand the population being served by the treatment facility. This means understanding the population's cultural groups across dimensions: language and communication, cultural beliefs and values, history, socioeconomic status, education, gender roles, substance use patterns, spirituality, and other distinctive aspects. Candidates should be able to articulate a clear understanding of cultural competence (American Evaluation Association 2011). If consultants will train staff, they should have specific knowledge and proficiency in training development and delivery.

If financially feasible, it can be useful for the agency to consider using more than one consultant and to invite each prospective consultant to present their qualifications to the board of directors and/or to a cultural competence

The Consumer Assessment of Healthcare Providers and Systems Cultural Competence Item Set

This assessment tool evaluates provider cultural competence through client surveys. It helps identify strengths and weaknesses of individual behavioral health service providers and organizations, aids in provider comparisons, and assesses the extent to which client responses differ based on race, ethnicity, or primary language. The surveys are available online through the Agency for Healthcare Research and Quality (https://cahps.ahrq.gov/clinician_group/), as is an overview and instructions (https://cahps.ahrq.gov/surveys-guidance/hp/instructions/index.html).

committee so that the best match can be achieved between the agency's needs and the consultant based on his or her expertise, cost, and consulting style. If a consultant is hired, the organization should establish guidelines for working closely with that person, including reporting requirements to the cultural competence committee. The organization must retain ownership of the process and provide clear oversight and guidance.

Step 4: Select assessment tools suitable for each stakeholder group (e.g., clinical staff, agency referrals, clients). Several self-assessment tools are available, including checklists and surveys, for use in evaluation or as development guides. To date, most instruments available have limited empirical support (Delphin-Rittmon et al. 2012*b*; Shorkey et al. 2009).

More often than not, surveys and feedback questionnaires will need to be individually developed and tailored to the organization and stakeholder group depending upon setting; available resources; racial, ethnic, and cultural backgrounds; language preferences; and community accessibility (e.g., rural versus urban). Appendix C provides standards and lists the items that should be included in evaluating an agency and its services. Additional resources for provider and organizational assessment of cultural competence are available through the National Center for Cultural Competence (http://nccc.georgetown.edu/) and the Hogg Foundation for Mental Health (http://www.hogg.utexas.edu/index.php).

Step 5: Determine distribution, administration, and data collection procedures (e.g., confidentiality, participant selection methods, distribution time frames). Whatever methods are used to gather data for the self-assessment process, it is critical to explain the context of the assessment to all participants. They need to know why the assessment is being conducted and how the information they give will be used. Confidentiality can be a major concern for some respondents, especially staff members and clients, and every effort should be made to address this concern. Ideally, the evaluation

Advice to Administrators: Gathering Feedback From Clients, Community Members, and Referrals

Agencies should incorporate a client satisfaction survey into the assessment process. This survey should include questions to help determine whether clients believe that the organization relates well to persons of their ethnicity or race and gives them an opportunity to pinpoint problem areas. To review a sample assessment tool for clients, refer to the Iowa Cultural Understanding Assessment–Client Form (White et al. 2009), available in Appendix C. The tool is also available in Spanish.

If desired, external consultants can conduct interviews with a representative sample of clients, family members, and local community members. The key question should be "What can the treatment provider do to be more responsive to community needs?" The survey process can be as simple as a questionnaire, or it can involve interviews or focus groups with key people in touch with community issues. It can also be helpful to obtain a small but representative sample of community members at large to determine their level of awareness of the services available and their perceptions of the treatment agency based on what they have heard. Information from people not in treatment can be revealing and could suggest areas in which publicity is needed to counter misinformation. Likewise, facilitators can develop, from the information gathered, a map that highlights where people go to receive various services (Center for Substance Abuse Prevention 1995). The agency could also ask their sources of referrals, such as faith-based organizations, community agencies, or primary care physicians, whether they are referring clients to the agency, and if not, why. It is important to know who is not walking through the door.

instrument(s) should be administered by an objective third party, such as a consultant or a member of the cultural competence committee. Staff members should be asked about their attitudes toward cultural issues with the understanding that their attitudes are not necessarily indicative of the degree to which the staff mirrors the cultural groups served. In soliciting community feedback, the more credibility the organization has in the community, the higher the return rate will likely be. The lower the credibility, the more the organization needs to reassure respondents that it intends to listen to, and act on, what it hears. If many survey forms are to be distributed, the organization could consider hiring students or community members on a temporary basis to make follow-up or reminder calls.

Step 6: Compile and analyze the data. The process of reviewing and assessing data should be overseen by the cultural competence committee. Basic data analysis procedures should be used to ensure the accuracy of results and credibility of reported information. For most well-designed instruments, there are relatively simple and appropriate ways to present data. All available data should be assembled in a report, along with interpretive comments and recommended action steps. The report should note areas of strength and needed improvement and should offer possible explanations for any shortcomings. For example, if the community is 20 percent African American, but only 2 percent of the agency's clientele are African American, what are some possible explanations for this group's apparent underuse of services? It is also particularly important to share results with those who participated in the assessment process. Findings should be made available to staff, clients, community members, boards, and managers. This increases overall sense of ownership in the assessment and cultural competence development process and in implementing the changes that will be made based on the findings of and the priorities established through this assessment.

Step 7: Establish priorities for the organization and incorporate these priorities into the cultural competence plan. After obtaining the results of the self-assessment process, the organization—including boards, cultural competence committee, community stakeholders, and staff members—needs to establish realistic priorities based on the current needs of clients and the community. Significant consideration should be given to the level of influence any given priority could have in effecting organizational change that will improve culturally responsive services. Some priorities will require more planning to implement and can involve more financial and staff resources, whereas other priorities will be easier to implement from the outset (e.g., hiring culturally competent counselors who are bilingual versus translating intake and program forms). Therefore, long- and short-range priorities should be established at the same time to maintain the momentum of change in the organization.

Step 8: Develop a system to provide ongoing monitoring and performance improvement strategies. Similar to the clinical assessment process with clients, the organizational self-assessment is only valuable if it provides guidance, determines direction and priorities, and facilitates action. Assessment is not a one-time activity. It is important to continue monitoring to identify barriers that may impede the full implementation of the cultural competence plan, to evaluate progress and performance, and to identify new service needs. Establishing a system to monitor an organization's cultural responsiveness equips it with the information necessary to formulate strategies to meet new demands and to continuously improve quality of services.

Language Services

Task: Plan for Language Services Proactively

An organization must anticipate the need for language services and the resources required to support these services, including funding, staff composition, program materials, and translation services. Assessing the language needs of the population to be served is essential. Upon determination, the foremost task is letting clients with limited English proficiency know that language services are available as a basic right for a client. Treatment providers need to plan for the provision of linguistically appropriate services, beginning with actively recruiting bicultural and bilingual clinical staff, establishing translation services and contracts, and developing treatment materials prior to client contact. Although it is not realistic to anticipate the language needs of all potential clients, it is important to develop a list of available resources and program procedures that staff members can follow when a client's language needs fall outside the organization's usual client demographics (The Joint Commission 2009).

How To Inform Clients About Language Assistance Services

- Use language identification or "I speak…" cards.
- Post signs in regularly encountered languages at all points of entry.
- Establish uniform procedures for timely, effective telephone communication between staff members and persons with limited English proficiency.
- Include statements about the services available and the right to free language assistance services in appropriate non-English languages in brochures, booklets, outreach materials, and other materials that are routinely distributed to the public.

Source: OMH 2000.

Planning for language services is crucial, and the need for these services must be assessed by staff members who have initial contact with clients, their family members, and/or other individuals in their support systems (American Psychological Association [APA] 1990, 2002). If frontline administrative and clinical staff members are bilingual, the initial screening and assessment process can begin uninterrupted. If this is not the case, receptionists or frontline clinical staff members should at least be familiar with some rudimentary phrases in the preferred languages of their client base. The conversation can be scripted so that they can convey their limited ability to speak the client's language, obtain contact information and inquire about language service needs, and inform the client that someone who can speak the language more fluently will be made available to facilitate the initial screening process. Most importantly, procedures should be in place to provide pretreatment contact and follow-up in the client's language to bridge the gap between initial contact and subsequent arrangement of language services.

Written and illustrated materials or a video about the program in the languages spoken by the client population should be available to answer frequently asked questions. All materials given to clients, family members, and community members should be available in their primary languages. It is preferable to develop the materials initially in those languages rather than simply translating materials from one language to another. Along with language, one should also consider the level of literacy of the group in question. Some clients may be functionally illiterate even in their native languages. Materials should graphically reflect the population served through pictures or photographs, using ethnic themes and traditional elements familiar to the target audience. Also, materials should be tested with the populations with whom they

will be used, perhaps through focus groups, to ensure that they communicate effectively.

Task: Establish Practice and Training Guidelines for the Provision of Language Services

Key issues to consider in implementing and overseeing language services within an organization include staff monitoring of language proficiencies, selection of translators and interpreters, confidentiality issues, and training needs. First, agencies need to assess language proficiencies among staff members and encourage them to learn a language relevant to the population served. At a minimum, staff members should acquire in the given language some basic terminology and phrases that are commonly used in the treatment setting.

In recruiting and hiring translators and interpreters, administrative staff members should consider experience, motivation, skill level, mastery of English, and fluency in the language in need of interpretation (OMH 2000; American Translators Association 2011). Be aware, however, that there can be considerable variation in dialects and levels of proficiency within the language, and these must be determined in the selection process. To supplement hiring practices, administrative policies should provide a means for determining the credentials of any language services organizations (Appendix F lists American Translators Association credentialing information).

Other important hiring issues revolve around potential ethical dilemmas. In particular, care should be taken in using interpreters from the local community, which can create potential challenges with confidentiality and dual relationships (e.g., the interpreter may also be client's cousin or neighbor). Policies should place the burden on language service providers to identify and disclose dual relationships to supervisors immediately and on supervisors to assess and determine the appropriateness of using certain translator. Once a selection has been made, a confidentiality agreement should be signed. Organizations need to provide information routinely to clients about their confidentiality rights in using language services. Implementing a procedure for handling client grievances is also recommended.

In planning for the use of language services, organizations should initially provide training for staff on how to incorporate these services and should familiarize translators and interpreters with the clinical setting, terminology, behavioral expectations, and content related to behavioral health (see the "Training Content for Language Service Personnel" advice box on the next page). The language of mental health and substance abuse services requires an additional degree of specialization. Experienced translators and interpreters who are unfamiliar with concepts of addiction, illness, and recovery could convey information adequately from a linguistic perspective but not accurately convey the intent or meaning of clinically oriented information or dialog. Various training approaches can be used, including role-plays mirroring intakes, evaluations, and counseling sessions; indirect exposure to client sessions through audio or video recordings of sessions or viewing from an observation room; direct observation by sitting in on a session, if appropriate; and consultation with other experienced language service providers and clinical staff. Using other experienced translators and interpreters for training and/or for consultations, as well as sharing experiences in a peer support format, can be very beneficial for new language service providers.

Organizations must also create opportunities for translators and interpreters to inquire about and clarify clinical content and meaning. Language service providers often attempt to convey terminology or concepts that do not exactly match the words or meaning of the client's language or culture by becoming more descriptive, taking longer to deliver the message in an effort to match the intent of a specific word or concept in English.

Advice to Clinical Supervisors and Administrators: Training Content for Language Service Personnel

Translators and interpreters need additional training to work in a clinical setting. Initial training should include:

- General mental health and substance abuse information.
- Introduction to behavioral health services.
- Familiarity with interviewing and assessment questions, instruments, and formats.
- Legal and ethical issues, including confidentiality and professional boundaries.
- Relevant programmatic policies and procedures.
- Review of program materials, forms, questionnaires, and other written clinical materials that clients receive during the course of treatment.
- Knowledge of technical vocabulary relevant to the behavioral health field.
- Emphasis on the importance of accurate interpretation and translation without additions or omissions.
- Behavioral and professional guidelines on how to manage potential client reactions in and outside the session (e.g., outward displays of anger or hostility; grief reactions; disclosing information to the translator with a request to keep it a secret from clinical staff; discomfort with translator's biological, social, and/or demographic characteristics, such as gender orientation, age, or socioeconomic status).
- Importance of cultural sensitivity in dialog between translator and client, including how questions are asked.
- General guidelines on how to handle personal issues that can be elicited by participation in the intake, assessment, and treatment processes, including identification with similar clinical issues (e.g., substance use patterns, family dynamics, traumatic events, emotional distress).

Workforce and Staff Development

Task: Develop Staff Recruitment, Retention, and Promotion Strategies That Reflect the Populations Served

To determine whether it adequately reflects the population it serves, an organization has to assess its personnel, including counselors, administrators, and board of directors. According to a 10-year study that collected data on treatment admissions, racial and ethnic composition of treatment populations has not significantly changed. Racially diverse groups (excluding non-Latino Whites) represent approximately 40 percent of treatment admissions (Substance Abuse and Mental Health Services Administration [SAMHSA] 2011*c*), yet 80 percent of counselors are non-Latino Whites (Duffy et al. 2004). In striving to improve cultural responsiveness, staff composition should be a major strategic planning consideration. As much as possible, the staff should mirror the client population.

Nevertheless, providers should avoid hiring "ethnic representatives," which means hiring a single person from an ethnic or cultural group and expecting him or her to serve as the cultural resource on that group for the entire staff. This can be burdensome, if not offensive, to that person. Belonging to a group does not ensure cultural responsiveness toward, knowledge of, or skill in working with members of that group, nor does it guarantee that the person culturally identifies with that cultural group or its heritage. Hiring ethnic

> "Improving the workforce to provide competent services to diverse populations goes far beyond merely increasing the number of individuals from each of the respective groups. While this is clearly an important strategy, there is a need not only to increase the numbers but also to improve the quality of training for all clinicians, regardless of their racial, ethnic, cultural, or linguistic background. This also includes the necessity to recruit, train, and support interpreters."
> (Hoge et al. 2007, p. 192).

representatives undermines the expansion of diversity at all organizational levels and the importance of developing opportunities for all staff members to gain awareness and improve their ability to effectively work with clients.

Some organizations struggle to find multicultural staff members that represent the diversity of their communities and clienteles. If recruitment is perceived as an immediate short-term goal, ongoing difficulties are likely in hiring, promoting, and retaining a diverse staff. Instead, recruitment strategies need to embrace a more comprehensive and long-term approach that includes internships, marketing to those interested in the field at an early age, mentoring programs for clinical and administrative roles, support networks, educational assistance, and training opportunities.

Task: Create Training Plans and Curricula That Address Cultural Competence

The primary purpose of training is to increase cultural competence in the delivery of services, beginning with outreach and extending to continuing care services that support behavioral health. Training should increase staff self-awareness and cultural knowledge, review culturally responsive policies and procedures, and improve culturally responsive clinical skills (Anderson et al. 2003; Brach and Fraser 2000; Lie et al. 2011). The organization should be prepared to offer relevant professional development experiences consistent with counselors' personal goals and assigned responsibilities as well as the organization's goals for culturally responsive services. Board members, volunteers, and interpreters should all receive appropriate training.

A professional development training plan details the frequency, content, and schedule for staff training and continuing education. Because becoming culturally competent is a process, training and support for engaging in culturally responsive services can be more appropriate when delivered across a period of time involving follow-up sessions rather than through a single session. Outcome research that evaluates the effectiveness of cultural competence training materials, format, and content in mental health services, including treatment for substance use disorders (Bhui et al. 2007; Lie et al. 2010), is limited. Nonetheless, numerous resources have suggested that effective cultural training does feature certain qualities (Exhibit 4-5).

Sometimes, staff members will express resistance to participation in training activities aimed at promoting cultural competence—they may feel forced to learn about cultural competence, or they may feel unable to take the time away from their clients to attend the

> "The learning objectives of a professional development program should include awareness- and knowledge-based objectives and skills-based objectives that motivate students to explore personal perspectives and multiple worldviews, understand and embrace culturally competent health promotion strategies, and engage in self-directed competency development."
> (Perez and Luquis 2008, p. 178).

Exhibit 4-5: Qualities of Effective Cultural Competence Training

The qualifications of the trainer, the selection of training strategies, and the use of reputable training curricula are extremely important in developing culturally competent staff and responsive services. The following concepts should be considered in the development and implementation of cultural training:

- Cultural training should begin with educating new staff members about the organization's vision, values, and mission as related to culturally responsive services. Orientation should address the demographic composition of clientele, policies and procedures for cultural and linguistic services, counseling and performance expectations for assessment, treatment planning, and delivery of culturally responsive services.
- Before developing and initiating a training plan for culturally responsive services, ask staff members about their training needs specific to the cultural groups that they serve. Receptivity will likely increase if managers and administrators involve clinical staff in the planning process rather than assuming that they know exactly what staff members need regarding cultural training.
- Training should occur across time, and a training plan should detail how to provide training for new employees. Too often, trainings occur at one time, ignoring the complexity of cultural groups and suggesting that one training session is sufficient to achieve cultural competence. Cultural competence evolves from ongoing professional development.
- Training should incorporate diverse learning strategies, including experiential learning and cultural immersion when appropriate (e.g., participation in community activities, role-plays, case presentations). Training should be experientially based and process oriented, allowing self-reflection as part of the training and assigning self-reflection activities between training sessions (see the how-to box on self-reflection on the next page).
- Training should provide information that is practice- or research-based to ensure that participants see it as reputable and clinically sound.
- Training should create a welcoming, nonjudgmental, and professional atmosphere in which staff members, regardless of race, ethnicity, or cultural group, have the freedom and safety to explore their own beliefs and to learn about other cultural groups. Training efforts should not scapegoat mainstream cultural groups or make general statements about specific racial or ethnic groups without noting that there are many cultural subgroups within a given racial or ethnic group—often characterized by, but not limited to, geographic location, socioeconomic status, or educational levels. Participation guidelines should be clarified for each training.
- Training should be conducted by an interdisciplinary, multicultural training team that is experienced in training and well versed in cultural competence.
- Trainers should allow time for staff members to ask questions and process the presented materials and experiential exercises, and they should use staff questions and exercises to explore and correct misperceptions in a nonjudgmental manner.

Sources: Brach and Fraser 2000; Dixon and Iron 2006; Gilbert 2003; Pack-Brown and Williams 2003; Roysircar 2006; Russell 2009.

trainings. Others might object on the grounds that they treat everyone equally, thus ignoring their own cultural blindness.

The organization's leadership needs to address staff reluctance and concerns regarding training through initial education on the rationale for cultural competence. Assume that staff members are invested in creating the best opportunities for their clients to achieve success, and use this premise to introduce the need for training centered on culturally responsive care. Some staff members may respond to incentives or predetermined objectives and criteria reflected in employee performance evaluations. Others may be more motivated by opportunities that arise from the organization's commitment to culturally responsive services or by other factors, such as specialized training and supervision, the

How To Engage in Self-Reflection: A Tool for Counselor Training and Supervision

Ask participants to preselect three clients whom they are currently counseling and will likely continue to counsel prior to the next training or supervision session. Selection should be based on clients' diversity in age, race, gender, ethnicity, socioeconomic status, education, and/or geographic location. After each participant has selected three clients (remind participants not to disclose actual client identity if this is an external training outside of the agency), ask them to keep a self-reflection journal wherein the number of entries coincide with each client session until the next training. Participants should write about their internal process, including reactions such as feelings, thoughts, or behaviors during the session that relate to the influence of culture. For example:

- Identify racial, ethnic, and cultural similarities and differences between you and your client.
- Explain how your cultural and clinical worldviews influence your dialog, treatment planning, and expectations of yourself and your client in the session.
- Describe assumptions that you have learned to make about your client's specific race, ethnicity, or culture(s).
- Even if you think these assumptions, beliefs, or biases do not play a role in your current counseling relationship and approach, discuss how they could influence your counseling. Provide a specific example.
- Describe the feelings that you have about your client. How do these feelings relate to your client's racial, ethnic, or cultural identity?
- Explain the differences and similarities in worldviews between you and your client.
- Discuss how your and your client's beliefs about health, healing, disease, and addiction differ.
- Describe how your client's experience with discrimination, oppression, and prejudice could influence his/her current level of distress, psychological functioning, and response to treatment.
- Explore how you attend to your client's worldview in each session.
- Describe a misunderstanding or erroneous counseling response during a counseling session that appears related to differences in cultural identification, values, or behavior.
- Identify cultural knowledge that you must obtain to gain a better understanding of your client.
- Discuss the most important lessons that you have learned from your client.

desire to be perceived by other staff members as team players, or their roles as agents of change with other staff members.

Opportunities for cultural competence training abound. National organizations, agencies dedicated to multicultural learning, academic institutions, government agencies, and information clearinghouses offer training or have information about training opportunities and curricula on cultural competence on their Web sites. In addition to OMH guidelines on staff education and training (Exhibit 4-6), guidelines are available from psychological and counseling associations (APA 2002). To review sample training modules, see *Cultural Competence for Health Administration and Public Health* (Rose 2011).

> "It takes time and energy to work through significant changes, whether in the workplace or in our personal lives. Many times, resistance to change is a natural reaction of people trying to understand what is expected of them and how the change will impact their lives."
> (Addiction Technology Transfer Center 2004, p. 28)

Task: Provide Culturally Congruent Clinical Supervision

Little research is available that measures cultural competence among clinical supervisors or evaluates the effects of supervision on cultural competence among counselors (Colistra and Brown-Rice 2011; Constantine and Sue 2005). Not much is known about the effectiveness of clinical supervision in enhancing culturally competent behavior among counselors,

Exhibit 4-6: OMH Staff Education and Training Guidelines

Only general agreement exists as to what constitutes an acceptable cultural competence curriculum. OMH (2000) recommends tailoring curriculum topics to the roles and responsibilities of trainees and the specific needs of populations served over time but suggests that training should at least address:

- The effects of cultural differences between counselors and clients/consumers on clinical and other workforce encounters, such as the therapeutic alliance.
- The elements of effective communication among staff members and clients/consumers from diverse cultural groups who use different languages, including how to work with interpreters and telephone language services.
- Strategies for resolving racial, ethnic, or cultural conflicts between staff members and clients.
- The organization's policies and procedures for written language access, including how to gain access to interpreters and translated written materials.
- Parts of the Civil Rights Act of 1964 that address services for clients with limited English proficiency.
- The organization's complaint or grievance procedures.
- The effects of cultural differences on health promotion and disease prevention, diagnosis and treatment, and supportive care.
- The impact of poverty and socioeconomic status, race and racism, ethnicity, and sociocultural factors on access to care, service use, quality of care, and health outcomes.
- Differences in the clinical management of diseases and conditions indicated by differences in the race or ethnicity of clients.
- The effects of cultural differences among clients/consumers and staff members on health outcomes, client satisfaction, and treatment planning.

Source: OMH 2000. Adapted from material in the public domain.

although some research with a multicultural focus has measured counselor self-efficacy after receiving supervision and has examined the dynamics of supervisee–supervisor relationships. Even though educational institutions have developed curricula and standards to reinforce the need for a multicultural perspective in training, many clinical supervisors lack sufficient training in this area (e.g., avoid cultural topics in supervision, have difficulty giving culturally appropriate consultations or direction, fail to guide/reinforce timely implementation of policies or procedures that support culturally responsive services with their supervisees). This can significantly impede organizations attempting to introduce or improve culturally responsive clinical services.

It is essential for organizations to provide counselors with clinical supervisors who are culturally aware, have engaged in multicultural training, and model culturally competent behaviors in clinical supervision sessions (e.g., allowing or engaging in discussions centered on race, ethnicity, and cultural groups in the session). Clinical supervision is the glue that

Advice to Clinical Supervisors: Culturally Competent Clinical Supervision

Supported by a review of research on multicultural clinical supervision, Miville et al. (2005) suggest that clinical supervisors gain awareness of and assess:

- Their own racial, ethnic, and cultural identities and attitudes and those of their supervisees.
- Their own knowledge base, strengths, and weaknesses and those of their supervisees.
- Racial, ethnic, and cultural issues that generate reactions in supervisors and in supervisees.
- Current engagement in professional development activities that support culturally responsive practices (see the professional development advice box on the next page).

How To Discuss Professional Development in Multicultural Counseling

This tool facilitates supervisee–supervisor discussions surrounding professional development activities that promote cultural competence. Supervisors can ask supervisees to review the list and check off activities that they have engaged in recently or in the past several months. Supervisors can then use the completed exercise as a starting point for gaining more specific information on activities endorsed by supervisees. Even if supervisees check off no items, reviewing the list reinforces activities that build cultural competence.

Materials needed: A printed copy of the checklist and a pen or pencil.

Instructions: Mark off the activities you have engaged in during the past month and/or 6 months.

Past month	Past 6 months	
____	____	I recognized a prejudice I have about certain people.
____	____	I talked to a colleague about a cultural issue.
____	____	I sought guidance about a cultural issue that arose in therapy.
____	____	I attended a multicultural training seminar.
____	____	I attended a cultural event.
____	____	I attended an event in which most other people weren't of my race.
____	____	I reflected on my racial identity and how it affects my work with clients.
____	____	I read a chapter or an article about multicultural issues.
____	____	I read a novel about a racial group other than my own.
____	____	I sought consultation or supervision about multicultural issues.
____	____	I talked to a friend/associate about how our racial differences affect our relationship.
____	____	I challenged a racist remark—my own or someone else's.

Source: Pack-Brown and Williams 2003, p. 136. Used with permission.

reinforces culturally competent behavior, and it is often the only avenue of ongoing clinical training and follow-up after specific workshops or trainings are offered by the organization.

Clinical supervisors should adopt a multicultural framework to guide the supervision process (e.g., Sue's [2001] multidimensional model for developing cultural competence). Endorsement of a model for developing and enhancing cultural competence helps both supervisors and supervisees understand how to address cultural issues in supervision and pursue personal and professional development that supports culturally responsive clinical services. (For a specific example, see Field and colleagues' [2010] Latina–Latino multicultural developmental supervisory model.) The model guides supervision and reinforces the premise that cultural variables influence each aspect of supervision: the relationship between supervisors and supervisees, the supervisors' and supervisees' perceptions and assessments of clients' presenting issues, the interactions between supervisees and their clients, and the treatment recommendations and directions that evolve from supervision.

Task: Evaluate Staff Performance on Culturally Congruent and Complementary Attitudes, Knowledge, and Skills

Organizations committed to endorsing and implementing culturally responsive services need policies and procedures that reflect this commitment in job descriptions and staff evaluations across all levels of the organization. By incorporating specific goals,

Advice to Administrators and Clinical Supervisors: Culturally Responsive Performance Evaluation Criteria

Cultural competence is measured by the degree to which counselors, administrators, and other staff members engage in observable actions and attitudes that reflect cultural responsiveness. Following are examples of descriptive evaluation criteria that address a few aspects of culturally responsive behavior:

- Engages in ongoing self-analysis to identify and address personal and cultural biases.
- Actively seeks to view life through the eyes of others and, through doing so, develops a greater level of sensitivity for the values and life challenges of other groups.
- Participates in hands-on training opportunities and seeks practice and feedback that build toward mastery of responsive needs assessment techniques.
- Seeks opportunities to engage in cross-cultural activities and interactions.

expectations, and tasks into performance evaluations, staff members will receive an important and consistent message from the organization that culturally competent behavior and responsive services are valued and rewarded.

Organizational Infrastructure

Task: Plan Long-Range Fiscal Support of Cultural Competence

An organization's commitment to providing culturally responsive treatment services will only succeed if resources are consistently dedicated to supporting the plan. Realistically, treatment program funds may be insufficient to initially meet the goals outlined in the organization's self-assessment. More often than not, the committee, executive staff, and board will have to prioritize the specific changes that are financially feasible. However, this necessity does not preclude the organization from soliciting help from the community, finding creative and inexpensive ways to make organizational changes, and using strategic and financial planning to build resources designated for culturally responsive services.

Task: Create an Environment That Reflects the Populations Served

The self-assessment process should include an environmental review of the organization's physical facilities in which barriers to access are examined. The plan should address identified deficits. For example, signage should be written in all primary languages spoken by the clients served; it should be written at an appropriate level of literacy in those languages. When possible, signs should use pictures and graphics to replace written instructions. The design of the facility, including use of space and décor, should be inviting, comfortable, and culturally sensitive. The plan should establish how to make facilities more accessible and culturally appropriate. In addition, the organization should create an environment that reflects the culture(s) of its clients not only within the facility, but through business practices, such as using local and community vendors.

Task: Develop Outreach Strategies To Improve Access to Care

The best-laid plans for providing culturally competent treatment are futile if clients cannot access treatment. Providers should develop outreach plans for diverse ethnic and

Advice to Administrators: Improving Outreach and Access to Care

Whenever it is not feasible to provide behavioral health services in the neighborhoods or communities where they are needed, treatment providers should consider the following:

- **Referring clients to community resources:** Ensure that all counselors and referral sources know where to refer individuals for culturally appropriate community services. Individuals should not have to "bounce around" through the system seeking care that is already difficult to access. Have culturally and linguistically appropriate brochures available that describe community services, eligibility, and the referral process.
- **Collaborating with other community services:** Collaboration with other community-based organizations is essential to compensate for the limitations faced by any single agency. Behavioral health service providers can reach larger numbers of underserved populations by teaming with others who have complementary missions and, at times, greater funding, such as other behavioral health agencies and programs dealing with welfare-to-work services, homelessness, or HIV/AIDS. Additional collaboration to increase use includes sending culturally competent counselors to work at another agency or community group on at least a part-time basis, training community members or other agency personnel to provide brief interventions or referral services, and supporting the establishment of mutual-help groups with translated/adapted literature in neighborhood locations.
- **Co-locating community services (creating a one-stop facility):** Co-locating with other agencies is often highly desirable, as it can facilitate connections among various community services that clients need and provide an easy central location to access these services (e.g., a substance abuse intensive outpatient treatment program, a community health service agency, and a community outpatient mental health program offered at one location). For culturally diverse people, the process of accessing services across agencies can be complex because of the need to obtain linguistically and culturally appropriate services and to overcome other barriers, such as economic challenges, issues surrounding eligibility, or the cumbersome repetition of completing forms for each agency. An effective one-stop facility ensures close coordination between each agency that participates while also ensuring client confidentiality. Co-location with a community-based organization that already has solid, positive visibility in the community and a culturally competent workforce can help improve the outreach and treatment efforts of behavioral health organizations that have had difficulty connecting with the communities that they serve.
- **Eliciting support from the community and employing outreach workers:** It is often easier and more persuasive for people who abuse substances or need mental health services to receive information and be encouraged to seek treatment by persons who are ethnically similar to them and speak the same language as they do. This is especially important for new immigrants, who do not yet know their way around the new country and could be unsure of whom they can trust. When possible, outreach workers should be of similar cultural origin as the population being served and should be familiar with the community where they are working. This allows them to explain the advantages of treatment in culturally appropriate ways, speak the appropriate language or dialect, address the concerns of community members, and respect clients' priorities and issues. Outreach efforts can forge connections with important members of the community who encourage people with mental and substance use disorders and their families to seek treatment. These efforts are particularly important with new immigrants who may face legal and language barriers or may have a limited understanding of contemporary medicine and treatment possibilities. For example, lay people trained as *promotores de salud* (promoters of health) have been successful in reaching Latino migrant workers (Azevedo and Bogue 2001).
- **Supplying support services:** Providers can use a variety of means to make treatment accessible to culturally diverse clients. One strategy is to provide transportation from clients' neighborhoods to the provider site. In many areas, people must travel long distances to receive culturally appropriate services. This limits the number of people able to receive treatment, especially

(Continued on the next page.)

Advice to Administrators: Improving Outreach and Access to Care (continued)

individuals with incomes too low to support travel. In addition, lengthy travel requirements reduce the chances of a person in the early stages of change with low motivation reaching a counselor who can help increase motivation and move the person toward recovery. Other strategies are the inclusion of child care and language services within the program. In addition, home-based outpatient treatment and telemedicine strategies can work, particularly for rural populations.

- **Selecting culturally appropriate strategies to provide community education:** Certain forms of outreach are more likely to be successful in some populations than in others. For example, in Chinese and Korean communities, community fairs are often an excellent way to publicize treatment services. Notices in community newspapers, on radio and television channels, on billboards, and in stores in the languages spoken locally can reach other potential clients. The person chosen to deliver or represent the messages in such situations should be someone familiar with the community and likely to inspire trust. Some agencies serving American Indian people have experienced success in publishing a monthly newsletter that is sent to individual American Indians and agencies serving the Native American community.

racial communities, particularly those whose members may find it difficult to seek services on their own. For example, see *Community-Defined Solutions for Latino Mental Health Care Disparities* (Aguilar-Gaxiola et al. 2012). From the outset, effective outreach and improved access to care should include formal and informal contacts with community organizations, spiritual leaders, and media. Providers can learn from these contacts about the behavioral health concerns in the community, special considerations for working with members of the community, cultural impediments to treatment, and cultural resources to aid treatment and recovery.

Unfortunately, many providers lack sufficient funding to offer the level of outreach services needed by the communities they serve. Because they are overwhelmed already, the issue of outreach to underserved populations is often seen as a low priority, which can cause these providers to send people in need of treatment away, disappointed and disheartened. However, thoughtful and strategic use of community resources can result in more members of underserved populations receiving the treatment they need and deserve. At minimum, outreach enables providers to offer accurate information and referral to appropriate mutual-help or community groups.

Regarding fiscal planning and funding opportunities, some HHS initiatives support outreach through integrated care. For example, the Health Resources and Services Administration (HRSA) Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use concerns. Resources are available to help physicians screen for behavioral health problems and refer individuals to appropriate treatment. SAMHSA's Center for Substance Abuse Treatment has a Targeted Capacity Expansion Program that offers grants in support of outreach to specific populations.

The challenges outlined in this chapter are burdensome but can be overcome. Many organizations have been able to develop cultural competence over time (for a historical perspective of one organization's journey, see Exhibit 4-7). A well-defined and organized plan, coupled with a consistent organizational commitment, will enable organizations to initiate and accomplish the tasks necessary to promote culturally responsive services.

Exhibit 4-7: Cultural Competence Initiative Across Time in One Organization

Late 1980s
- The executive director and board endorse the need to pursue cultural competence and outline agency goals.
- An agency cultural competence committee forms to help develop policies, procedures, and a cultural competence plan. Community and client representation is established.
- A senior staff member is hired to oversee the organization's efforts to diversify staff.

Early 1990s
- The executive director, board of directors, and advisory board endorse the need to pursue culturally competent practices throughout the organization.
- General goals are established and senior management and staff members begin educating the staff on cultural competence.

Mid 1990s
- Culturally competent clinical standards are developed and implemented.
- Initial vision, mission, and value statements are modified to include cultural competence.
- Training for management and clinical supervisors incorporates cultural competence in practice.
- The agency begins a community cultural assessment and introduces a client satisfaction survey to gain feedback on current implementation of culturally responsive practices and to guide future direction and focus.
- Ongoing clinical supervisor training on cultural competence is initiated.
- The cultural competence committee develops recommendations for job descriptions and performance appraisals to reflect cultural competence skills and responsibilities.

Late 1990s
- Individuals and families who receive services are now involved in focus groups, orientations, and trainings.
- Partnerships with other agencies to promote cultural competence throughout the community are more strongly encouraged.
- A curriculum to train all staff members in the foundations of cultural competence is developed and implemented.

2000s
- Across the organization, clinical and administrative programs engage in cultural competence review and goal-setting.
- The mission statement is redefined to formally acknowledge the organization's values of respect for cultural differences, recovery, and advocacy.

5 Behavioral Health Treatment for Major Racial and Ethnic Groups

IN THIS CHAPTER

- Introduction
- Counseling for African and Black Americans
- Counseling for Asian Americans, Native Hawaiians, and Other Pacific Islanders
- Counseling for Hispanics and Latinos
- Counseling for Native Americans
- Counseling for White Americans

John, 27, is an American Indian from a Northern Plains Tribe. He recently entered an outpatient treatment program in a midsized Midwestern city to get help with his drinking and subsequent low mood. John moved to the city 2 years ago and has mixed feelings about living there, but he does not want to return to the reservation because of its lack of job opportunities. Both John and his counselor are concerned that (with the exception of his girlfriend, Sandy, and a few neighbors) most of his current friends and coworkers are "drinking buddies." John says his friends and family on the reservation would support his recovery—including an uncle and a best friend from school who are both in recovery—but his contact with them is infrequent.

John says he entered treatment mostly because his drinking was interfering with his job as a bus mechanic and with his relationship with his girlfriend. When the counselor asks new group members to tell a story about what has brought them to treatment, John explains the specific event that had motivated him. He describes having been at a party with some friends from work and watching one of his coworkers give a bowl of beer to his dog. The dog kept drinking until he had a seizure, and John was disgusted when people laughed. He says this event was "like a vision;" it showed him that he was being treated in a similar fashion and that alcohol was a poison. When he first began drinking, it was to deal with boredom and to rebel against strict parents whose Pentecostal Christian beliefs forbade alcohol. However, he says this vision showed him that drinking was controlling him for the benefit of others.

Later, in a one-on-one session, John tells his counselor that he is afraid treatment won't help him. He knows plenty of people back

home who have been through treatment and still drink or use drugs. Even though he doesn't consider himself particularly traditional, he is especially concerned that there is nothing "Indian" about the program; he dislikes that his treatment plan focuses more on changing his thinking than addressing his spiritual needs or the fact that drinking has been a poison for his whole community.

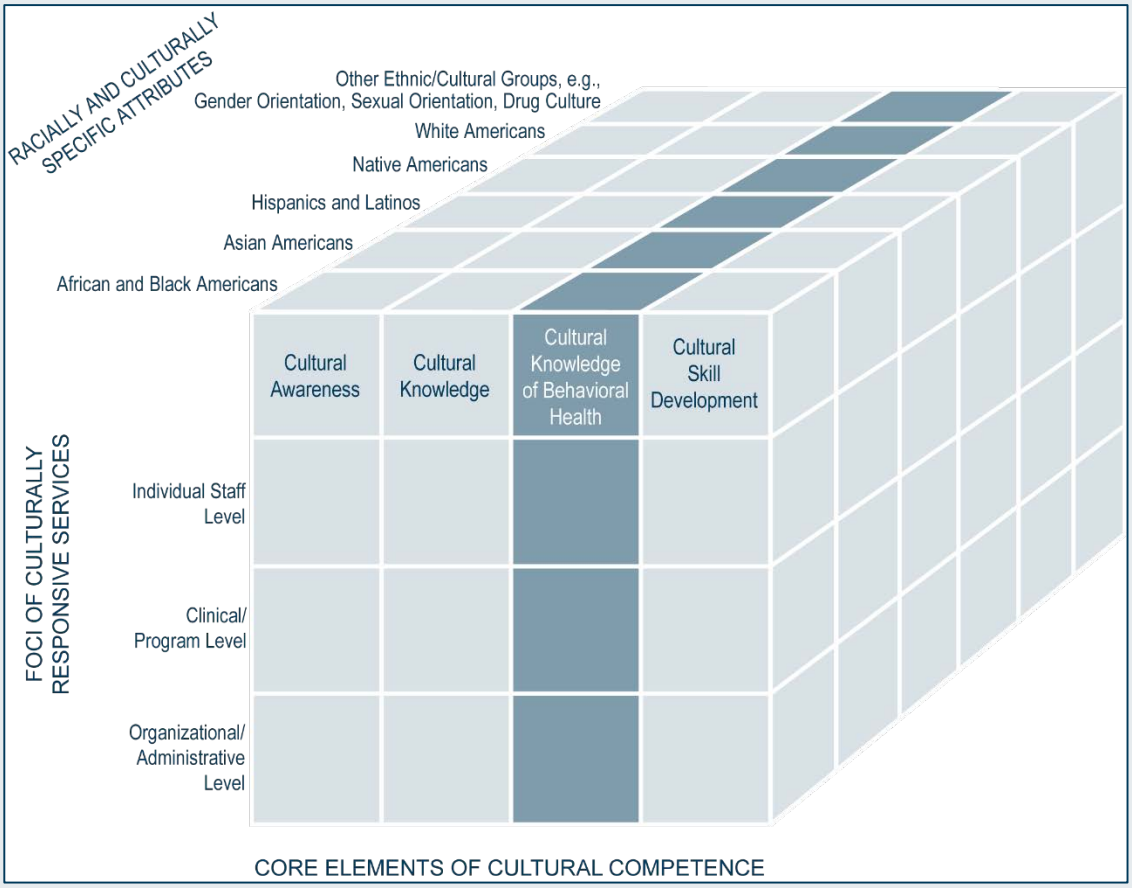
John's counselor recognizes the importance of connecting John to his community and, if possible, to a source of traditional healing. After much research, his counselor is able to locate and contact an Indian service organization in a larger city nearby. The agency puts him in touch with an older woman from John's Tribe who resides in that city. She, in turn, puts the counselor in touch with another member of the Tribe who is in recovery and had been staying at her house. This man agrees to be John's sponsor at local 12-Step meetings. With John's permission, the counselor arranges an initial family therapy session that includes his new sponsor, the woman who serves as a local "clan mother," John's girlfriend, and, via telephone, John's uncle in recovery, mother, and brother. With John's permission and the assistance of his new sponsor, the counselor arranges for John and some other members of his treatment group to attend a sweat lodge, which proves valuable in helping John find some inner peace as well as giving his fellow group members some insight into John and his culture.

To provide culturally responsive treatment, counselors and organizations must be committed to gaining cultural knowledge and clinical skills that are appropriate for the specific racial and ethnic groups they serve. Treatment providers need to learn how a client's identification with one or more cultural groups influences the client's identity, patterns of substance use, beliefs surrounding health and healing, help-seeking behavior, and treatment expectations and preferences. Adopting Sue's (2001) multidimensional model in developing cultural competence, this chapter identifies cultural knowledge and its relationship to treatment as a domain that requires proficiency in clinical skills, programmatic development, and administrative practices. This chapter focuses on patterns of substance use and co-occurring disorders (CODs), beliefs about and traditions involving substance use, beliefs and attitudes about behavioral health treatment, assessment and treatment considerations, and theoretical approaches and treatment interventions across the major racial and ethnic groups in the United States.

Introduction

Culture is a primary force in the creation of a person's identity. Counselors who are culturally competent are better able to understand and respect their clients' identities and related cultural ways of life. This chapter proposes strategies to engage clients of diverse racial and ethnic groups (who can have very different life experiences, values, and traditions) in treatment. The major racial and ethnic groups in the United States covered in this chapter are African Americans, Asian Americans (including Native Hawaiians and other Pacific Islanders), Latinos, Native Americans (i.e., Alaska Natives and American Indians), and White Americans. In addition to providing epidemiological data on each group, the chapter discusses salient aspects of treatment for these racial/ethnic groups, drawing on clinical and research literature. This information is only a starting point in gaining cultural knowledge as it relates to behavioral health. Understanding the diversity within a specific culture, race, or ethnicity is essential; not all information presented in this chapter will apply to all individuals. The material in this chapter has a scientific basis, yet cultural beliefs,

Multidimensional Model for Developing Cultural Competence: Cultural Knowledge of Behavioral Health



traditions, and practices change with time and are not static factors to consider in providing services for clients, families, or communities.

Although these broad racial/ethnic categories are often used to describe diverse cultural groups, the differences between two members of the same racial/ethnic group can be greater than the differences between two people from different racial/ethnic groups (Lamont and Small 2008; Zuckerman 1998). It is not possible to capture every aspect of diversity within each cultural group. Behavioral health workers should acknowledge that there will be many individual variations in how people interact with their environments, as well as in how environmental context affects behavioral health. However, to provide a framework for understanding many diverse cultural groups, some generalizations are necessary; thus, broad categories are used to organize information in this chapter. Counselors are encouraged to learn as much as possible about the specific populations they serve. Sources listed in Appendix F provide additional information.

Counseling for African and Black Americans

According to the 2010 U.S. Census definition, African Americans or Blacks are people whose

origins are "in any of the black racial groups of Africa" (Humes et al. 2011, p. 3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individuals from these latter regions, if they come from Spanish-speaking cultural groups, identify or are identified primarily as Latino). The term "Black" is often used interchangeably with African American, although sometimes the term "African American" is used specifically to describe people whose families have been in this country since at least the 19th century and thus have developed distinct African American cultural groups. "Black" can be a more inclusive term describing African Americans as well as more recent immigrants with distinct cultural backgrounds.

Beliefs About and Traditions Involving Substance Use

In most African American communities, significant alcohol or drug use may be socially unacceptable or seen as a sign of weakness (Wright 2001), even in communities with limited resources, where the sale of such substances may be more acceptable. Overall, African Americans are more likely to believe that drinking and drug use are activities for which one is personally responsible; thus, they may have difficulty accepting alcohol abuse/dependence as a disease (Durant 2005).

Substance Use and Substance Use Disorders

To date, there has not been much research analyzing differences in patterns of substance use and abuse among different groups of Blacks, but there are indications that some gender differences exist. For example, alcohol consumption among African American women increases as they grow older, but Caribbean Black women report consistently low alcohol consumption as they grow older (Center for Substance Abuse Treatment [CSAT] 1999*a*; Galvan and Caetano 2003). Rates of overall substance use among African Americans vary significantly by age. Several researchers have observed that despite Black youth being less likely than White American youth to use substances, as African Americans get older, they tend to use at rates comparable with those of White Americans (Watt 2008). This increase in substance use with age among Blacks is often referred to as a crossover effect.

However, Watt (2008), in her analysis of 4 years of National Survey on Drug Use and Health (NSDUH) data (1999–2002), found that when controlling for factors such as drug exposure, marriage, employment, education, income, and family/social support, the crossover effect disappeared for Blacks ages 35 and older; patterns for drug and heavy alcohol use among Black and White American adults remained the same as for Black and White American adolescents (i.e., White Americans were significantly more likely to use substances). Watt concludes that systemic issues, such as lower incomes and education levels, and other factors, such as lower marriage rates, contribute to substance use among Black adults. Additional research also suggests that exposure to discrimination increases willingness to use substances in African American youth and their parents (Gibbons et al. 2010).

When comparing African Americans with other racial and ethnic groups, NSDUH data from 2012 suggest that they are somewhat more likely than White Americans to use illicit drugs and less likely than White Americans to use alcohol. They also appear to have an incidence of alcohol and drug use disorders similar to that seen in White Americans (Substance Abuse and Mental Health Services Administration [SAMHSA] 2013*d*). Crack cocaine use is more prevalent among Blacks

than White Americans or Latinos, whereas rates of abuse of methamphetamine, inhalants, most hallucinogens, and prescription drugs are lower (SAMHSA 2011*a*). Phencyclidine use also appears to be a more serious problem, albeit affecting a relatively small group, among African Americans than among members of other racial/ethnic groups.

There appear to be some other differences in how African Americans use substances compared with members of other racial/ethnic groups. For example, Bourgois and Schonberg (2007) observed that among people who injected heroin in San Francisco, White Americans tended to administer the drug quickly whether or not they could find a vein, which led them to inject into fat or muscle tissue and resulted in a higher rate of abscesses. However, African Americans who injected heroin were more methodical and took the time to find a vein, even if it took multiple attempts. This, in turn, often resulted in using syringes that were already bloodied and increased their chances of contracting HIV/AIDS and other bloodborne diseases. African Americans who injected heroin were significantly more likely to also use crack cocaine than were White Americans who injected heroin (Bourgois et al. 2006).

African American patterns of substance use have changed over time and will likely continue to do so. Based on treatment admission data, admissions of African Americans who injected heroin declined by 44 percent during a 12-year period, whereas admissions declined by only 14 percent among White Americans (Broz and Ouellet 2008). Additionally, during this period, the peak age for African Americans who injected heroin increased by 10 years, yet it decreased by 10 years for White Americans. This suggests that the decrease in injectable heroin use among African Americans was largely due to decreased use among younger individuals.

Some preliminary evidence suggests that African Americans are less likely to develop drug use disorders following initiation of use (Falck et al. 2008), yet more research is needed to identify variables that influence the development of drug use disorders. Even though African Americans seem less likely than White Americans to develop alcohol use disorders, a number of older studies have found that they more frequently experience liver cirrhosis and other alcohol-related health problems (Caetano 2003; Polednak 2008). In tracking 25 years of data, Polednak (2008) found that the magnitude of difference has decreased over time; nonetheless, health disparities continue to exist for African Americans in terms of access to and quality of care, which can affect a number of health problems (Agency for Healthcare Research and Quality 2009; Smedley et al. 2003).

Mental and Co-Occurring Disorders

A number of studies have found biases that result in African Americans being overdiagnosed for some disorders and underdiagnosed for others. African Americans are less likely than White Americans to receive treatment for anxiety and mood disorders, but they are more likely to receive treatment for drug use disorders (Hatzenbuehler et al. 2008). In one study evaluating posttraumatic stress disorder (PTSD) among African Americans in an outpatient mental health clinic, only 11 percent of clients had documentation referring to PTSD, even though 43 percent of the clients showed symptoms of PTSD (Schwartz et al. 2005). Black immigrants are less likely to be diagnosed with mental disorders than are Blacks born in the United States (Burgess et al. 2008; Miranda et al. 2005*b*).

African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with affective disorders than

White Americans, even though multiple studies have found that rates of both disorders among these populations are comparable (Baker and Bell 1999; Bresnahan et al. 2000; Griffith and Baker 1993; Stockdale et al. 2008; Strakowski et al. 2003). African Americans are about twice as likely to be diagnosed with a psychotic disorder as White Americans and more than three times as likely to be hospitalized for such disorders. These differences in diagnosis are likely the result of clinician bias in evaluating symptoms (Bao et al. 2008; Trierweiler et al. 2000; Trierweiler et al. 2006). Clinicians should be aware of bias in assessment with African Americans and with other racial/ethnic groups and should consider ways to increase diagnostic accuracy by reducing biases. For an overview of mental health across populations, refer to *Mental Health United States, 2010* (SAMHSA 2012*a*).

In some African American communities, incidence and prevalence of trauma exposure and PTSD are high, and substance use appears to increase trauma exposure even further (Alim et al. 2006; Breslau et al. 1995; Curtis-Boles and Jenkins-Monroe 2000; Rich and Grey 2005). Black women who abuse substances report high rates of sexual abuse (Ross-Durow and Boyd 2000). Trauma histories can also have a greater effect on relapse for African American clients than for clients from other ethnic/racial groups (Farley et al. 2004). There are few integrated approaches to trauma and substance abuse that have been evaluated with African American clients, and although some have been found effective at reducing trauma symptoms and substance use, the extent of that effectiveness is not necessarily as great as it is for White Americans (Amaro et al. 2007; Hien et al. 2004; SAMHSA 2006).

African Americans are less likely than White Americans to report lifetime CODs (Mericle et al. 2012). However, limited research indicates that, as with other racial groups, there are differences across African American groups in the screening and symptomatology of CODs. Seventy-four percent of African Americans who had a past-year major depressive episode were identified as also having both alcohol and marijuana use disorders (Pacek et al. 2012). Miranda et al. (2005*b*) found that American-born Black women were more than twice as likely to be screened as possibly having depression than African- or Caribbean-born Black women, but this could reflect, in part, differences in acculturation (see Chapter 1). However, research findings strongly suggest that cultural responses to some disorders, and possibly the rates of those disorders, do vary among different groups of Blacks. Differences do not appear to be simply reflections of differences in acculturation (Joe et al. 2006). For a review of African American health, see Hampton et al. (2010).

Treatment Patterns

African Americans may be less likely to receive mental health services than White Americans. In the Baltimore Epidemiologic Catchment Services Area study conducted during the 1980s, African Americans were less likely than White Americans to receive mental health services. However, at follow-up in the early 1990s, African American respondents were as likely as White Americans to receive such services, but they were much more likely to receive those services from general practitioners than from mental health specialists (Cooper-Patrick et al. 1999). Stockdale et al. (2008) analyzed 10 years of data from the National Ambulatory Medical Care Survey; they found significant improvements in diagnosis and care for mental disorders among African Americans in psychiatric settings

between 1995 and 2005, but they also found that disparities persisted in the diagnosis and treatment of mental disorders in primary care settings. Fortuna et al. (2010) suggest that persistent problems exist in the delivery of behavioral health services, as evidenced by lower retention rates for treating depression.

Even among people who enter substance abuse treatment, African Americans are less likely to receive services for CODs. A study of administrative records from substance abuse and mental health treatment providers in New Jersey found that African Americans were significantly more likely than White Americans to have an undetected co-occurring mental disorder, and, if detected, they were significantly less likely than White Americans or Latinos to receive treatment for that disorder (Hu et al. 2006). Among persons with substance use disorders and co-occurring mood or anxiety disorders, African Americans are significantly less likely than White Americans to receive services (Hatzenbuehler et al. 2008). African Americans who do receive services for CODs are more likely to obtain them through substance abuse treatment programs than mental health programs (Alvidrez and Havassy 2005).

According to the Treatment Episode Data Sets (TEDS) from 2001 to 2011, African American clients entering substance abuse treatment most often reported alcohol as their primary substance of abuse, followed by marijuana. However, gender differences are evident, indicating that women report a broader range of substances as their primary substance of abuse than men do (SAMHSA, Center for Behavioral Health Statistics and Quality [CBHSQ], 2013). Most recent research suggests that African Americans are about as likely to seek and eventually receive substance abuse treatment as are White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009; SAMHSA, CBHSQ 2011; Schmidt et al. 2006). Data analyzed by Perron et al. (2009) indicate that among African Americans with lifetime diagnoses of drug use disorders, 20.8 percent had received some type of treatment, as defined broadly to include resources such as pastoral counseling and mutual-help group attendance. This made them more likely to have received treatment than White Americans (15.5 percent of whom received treatment) or Latinos (17.3 percent of whom received treatment). Although data indicate that African Americans were less likely to receive services from private providers, they also indicate that African Americans were more likely to use more informal services (e.g., pastoral counseling, mutual help).

Although most major studies have found that race is not a significant factor in receiving treatment, African Americans report lengthier waiting periods, less initiation of treatment, more barriers to treatment participation (e.g., lack of childcare, lack of insurance, lack of knowledge about available services), and shorter lengths of stay in treatment than do White Americans (Acevedo et al. 2012; Brower and Carey 2003; Feidler et al. 2001; Grant 1997; Hatzenbuehler et al. 2008; Marsh et al. 2009; SAMHSA 2011*c*; Schmidt et al. 2006). In SAMHSA's 2010 NSDUH, 33.5 percent of African Americans who had a need for substance abuse treatment but did not receive it in the prior year reported that they lacked money or the insurance coverage to pay for it (SAMHSA, CBHSQ 2011). Economic disadvantage does leave many Africans Americans uninsured; approximately 16.1 percent of non-Latino Blacks had no coverage in 2004 (Schiller et al. 2005).

Likewise, some researchers have found that African Americans are less likely than White Americans to receive needed services or an appropriate level of service (Alegria et al.

2011; Bluthenthal et al. 2007; Marsh et al. 2009). For example, African Americans and Latinos are less likely than White Americans to receive residential treatment and are more likely to receive outpatient treatment, even when they present with more serious substance use problems (Bluthenthal et al. 2007). Other studies have found that African Americans with severe substance use or CODs were less likely to enter or receive treatment than White Americans with equally severe disorders (Schmidt et al. 2006, 2007).

African Americans are overrepresented among people who are incarcerated in prisons and jails (for review, see Fellner 2009), and a substantial number of those who are incarcerated (64.1 percent of jail inmates in 2002) have substance use disorders (Karberg and James 2005) and mental health problems (SAMHSA 2012*a*). However, according to Karberg and (James 2005), African Americans with substance dependence disorders who were in jail in 2002 were less likely than White Americans or Latinos to participate in substance abuse treatment while under correctional supervision (32 percent of African Americans participated compared with 37 percent of Latinos and 45 percent of White Americans). In the 2010 TEDS survey, African Americans entering treatment were also less likely than Asian Americans, White Americans, Latinos, Native Hawaiians/Pacific Islanders, or American Indians in the same situation to be referred to treatment through the criminal justice system (SAMHSA, CBHSQ 2012). Notwithstanding, African Americans are more likely to be referred to treatment from criminal justice settings rather than self-referred or referred by other sources (Delphin-Rittmon et al. 2012)

Beyond issues related to diagnosis and care that can prevent African Americans from accessing mental health services, research suggests that a lack of familiarity with the value and use of specialized behavioral health services among some African Americans may limit service use. Hines-Martin et al. (2004) found a positive relationship between familiarity and use of mental health services among African Americans. Additionally, factors such as social and familial prejudices (Ayalon and Alvidrez 2007; Mishra et al. 2009; Nadeem et al. 2007) and fears relating to past abuses of African Americans within the mental health system (Jackson 2003) can contribute to the lack of acceptance and subsequent use of these services. An essential step in decreasing disparity in behavioral health services among African Americans involves conducting culturally appropriate mental health screenings and using culturally sensitive instruments and evaluation tools (Baker and Bell 1999).

Beliefs and Attitudes About Treatment

According to 2011 NSDUH data, African Americans were, next to Asian Americans, the least likely of all major ethnic and racial groups to state a need for specialized substance abuse treatment (SAMHSA, CBHSQ 2013*a*). Still, logistical barriers may pose a greater challenge for African Americans than for members of other major racial and ethnic groups. For example, 2010 NSDUH data regarding individuals who expressed a need for substance abuse treatment but did not receive it in the prior year indicate that African Americans were more likely than members of other major ethnic/racial groups to state that they lacked transportation to the program or that their insurance did not cover the cost of such treatment (SAMHSA 2011*a*). African Americans experience several challenges in accessing behavioral health treatment, including fears about the therapist or therapeutic process and concerns about discrimination and costs (Holden et al. 2012;

Holden and Xanthos 2009; Williams et al. 2012).

Longstanding suspicions regarding established healthcare institutions can also affect African Americans' participation in, attitudes toward, and outcomes after treatment (for review, see Pieterse et al. 2012). Historically, the mental health system has shown bias against African Americans, having been used in times past to control and punish them (Boyd-Franklin and Karger 2012; Jackson 2003). After controlling for socioeconomic factors, African Americans are significantly more likely to perceive the healthcare system as poor or fair and significantly more likely to believe that they have been discriminated against in healthcare settings (Blendon et al. 2007). Attitudes toward psychological services appear to become more negative as psychological distress increases (Obasi and Leong 2009). In many African American communities, there is a persistent belief that social and treatment services try to impose White American values, adding to their distrust of the treatment system (Larkin 2003; Solomon 1990).

African Americans, even when receiving the same amount of services as White Americans, are less likely to be satisfied with those services (Tonigan 2003). However, recent evidence suggests that, once engaged, African American clients are at least as likely to continue participation as members of other ethnic/racial groups (Harris et al. 2006). Because distrust of the healthcare system can make it more difficult to engage African American clients initially in treatment, Longshore and Grills (2000) recommend culturally congruent motivational enhancement strategies to address African American clients' ambivalence about treatment services. Providers also need to craft culturally responsive health-related messages for African Americans to improve treatment engagement and effectiveness (Larkin 2003).

Most importantly, providers need to demonstrate multicultural experience. In a study comparing outcomes among Black and White clients at community mental health centers, the only clinician factor that predicted more favorable outcomes was clinicians' general experiences and relationships with people from racial/ethnic and cultural groups other than their own (Larrison et al. 2011).

Treatment Issues and Considerations

African American clients generally respond better to an egalitarian and authentic relationship with counselors (Sue 2001). Paniagua (1998) suggests that in the initial sessions with African American clients, counselors should develop a collaborative client–counselor relationship. Counselors should request personal information gradually rather than attempting to gain information as quickly as possible, avoid information-gathering methods that clients could perceive as an interrogation, pace the session, and not force a data-gathering agenda (Paniagua 1998; Wright 2001). Counselors must also establish credibility with clients (Boyd-Franklin 2003).

Next, counselors should establish trust. Self-disclosure can be very difficult for some clients because of their histories of experiencing racism and discrimination. These issues can be exacerbated in African American men whose experience of racism has been more severe or who have had fewer positive relationships with White Americans (Reid 2000; Sue 2001). Counselors, therefore, need to be willing to address the issue of race and to validate African American clients' experiences of racism and its reality in their lives, even if it differs from their own experiences (Boyd-Franklin 2003; Kelly and Parsons 2008). Moreover, racism and discrimination can lead to feelings of anger, anxiety, or depression. Often, these feelings are not specific to any given event;

rather, they are pervasive (Boyd-Franklin et al. 2008). Counselors should explore with clients the psychological effects of racism and develop approaches to challenge internal negative messages that have been received or generated through discrimination and prejudice (Gooding 2002).

Additional methods that may enhance engagement and promote participation include peer-supported interventions and strategies that promote empowerment by emphasizing strengths rather than deficits (Paniagua 1998; Tondora et al. 2010; Wright 2001). It is important to explore with clients the strengths that have brought them this far. What personal, community, or family strengths have helped them through difficult times? What strengths will support their recovery efforts? Exhibit 5-1 gives an overview of core guiding principles in working with African American clients.

Exhibit 5-1: Core Culturally Responsive Principles in Counseling African Americans

According to Schiele (2000), culturally responsive counseling for African American clients involves adherence to six core principles:

1. Discussion of clients' substance use should be framed in a context that recognizes the totality of life experiences faced by clients as African Americans.
2. Equality is sought in the therapeutic counselor–client relationship, and counselors are less distant and more disclosing.
3. Emphasis is placed on the importance of changing one's environment—not only for the good of clients themselves, but also for the greater good of their communities.
4. Focus is placed on alternatives to substance use that underscore personal rituals, cultural traditions, and spiritual well-being.
5. Recovery is a process that involves gaining power in the forms of knowledge, spiritual insight, and community health.
6. Recovery is framed within a broader context of how recovery contributes to the overall healing and advancement of the African American community.

Theoretical Approaches and Treatment Interventions

Research suggests that culturally congruent interventions are effective in treating African Americans (Longshore and Grills 2000; Longshore et al. 1998*a*; Longshore et al. 1998*b;* 1999). Although there are conflicting results on the effectiveness of motivational interviewing among African American clients (Montgomery et al. 2011), some motivational interventions have been found to reduce substance use among African Americans (Bernstein et al. 2005; Longshore and Grills 2000). Longshore and Grills (2000) describe a culturally specific motivational intervention for African Americans involving both peer and professional counseling that makes use of the core African American value of communalism by addressing the ways in which the individual's substance abuse affects his or her whole community. The motivational program affirms "the heritage, rights, and responsibilities of African Americans…using interaction styles, symbols and values shared by members of the group" (Longshore et al. 1998*b*, p. 319). So too, African American music, artwork, and food can help programs create a welcoming and familiar atmosphere, as is the case for other racial and ethnic groups when familiar cultural symbols appear in the clinical setting.

Many of the interventions developed for substance abuse treatment services in general have been evaluated with populations that were at least partly composed of African Americans; many of these interventions are as effective for African Americans as they are for White Americans (Milligan et al. 2004; Tonigan 2003). One intervention that appears to work better for African American (and Latino) clients than for White American clients—perhaps because it focuses on improving

client–counselor communication—is node-link mapping (visual representation using information diagrams, fill-in-the-blank graphic tools, and client-generated diagrams or visual maps). This approach was associated with lower rates of substance use, better treatment attendance, and better counselor ratings of motivation and confidence among African Americans than among White Americans (Dansereau et al. 1996; Dansereau and Simpson 2009).

In addition, cognitive–behavioral therapy (CBT) has certain distinct advantages for African American clients; it fosters a collaborative relationship and recognizes that clients are experts on their own problems (Kelly and Parsons 2008). Maude-Griffin et al. (1998) compared CBT and 12-Step facilitation for a group of mostly African American (80 percent) men who were homeless and found that CBT achieved significantly better abstinence outcomes, except among those who considered themselves very religious (these individuals had better outcomes with 12-Step facilitation).

Other interventions that use CBT principles have also been effective with African American populations. For example, a number of studies have evaluated contingency management approaches with predominantly African American client populations, finding that this model was effective at reducing cocaine and illicit opioid use, improving employment outcomes for clients in methadone maintenance (Silverman et al. 2002; Silverman et al. 2007), reducing substance use during and after treatment, and improving self-reported quality of life (Petry et al. 2004; Petry et al. 2005; Petry et al. 2007). The Living in the Balance intervention, which uses psychoeducation and CBT techniques, has also been evaluated with a mostly African American sample and has been shown to improve treatment retention and reduce substance use (Hoffman et al. 1996).

Another therapy that has been evaluated with African American clients and found effective is supportive–expressive psychotherapy, which reduces substance use and improves psychological functioning for individuals in methadone maintenance (Woody et al. 1987; Woody et al. 1995). Medications for substance abuse can also work well with African American clients. In one large study, African Americans were more likely than Latinos or White Americans to indicate that they found methadone helpful (Gerstein et al. 1997), and in another study, they reported greater perceived quality of life as a result of participation in a methadone program (Geisz 2007). Schroeder et al. (2005) also reported that African Americans in a methadone program had significantly fewer adverse medical events (e.g., infections, gastrointestinal complaints) than did White American participants. African Americans who were being treated for cocaine dependence remained in treatment significantly longer than did other African Americans if they received disulfiram (Milligan et al. 2004).

A review of cultural adaptations of evidence-based practices is given by Bernal and Domenech Rodriguez (2012). For an overview of gender-specific treatment considerations for mental and substance use disorders among African American men and women, see Shorter-Gooden (2009).

Family therapy

African American clients appear more likely to stay connected with their families throughout the course of their addiction. For instance, Bourgois et al. (2006) reported that in comparing African American and White American individuals who injected heroin, African Americans appeared to be more likely to maintain contact with their extended families. Some research also suggests that African Americans with substance use disorders are more likely to have family members with

histories of substance abuse, suggesting an even greater need to address substance abuse within the family (Brower and Carey 2003).

Strong family bonds are important in African American cultural groups. African American families are embedded in a complex kinship network of biologically related and unrelated persons. Hence, counselors should be willing to expand the definition of family to a more extended kinship system (Boyd-Franklin 2003; Hines and Boyd-Franklin 2005). Clients need to be asked how they define family, whom they would identify as family or "like family," who resides with them in their homes, and whom they rely on for help. Hines and Boyd-Franklin (2005) discuss the importance of both blood and nonblood kinship networks for African American families. To build a support network for African American clients, counselors should start by asking clients to identify people (whether biological kin or not) who would be willing and able to support their recovery and then ask clients for permission to contact those people and include them in the treatment process.

Family therapy is often a productive approach to treatment with African Americans (Boyd-Franklin 2003; Hines and Boyd-Franklin 2005; Larkin 2003). However, the extended family can be large and have many ties with other families in a community; therefore, the family therapist sometimes needs to take on other roles to assist with case management or other activities, including involvement in community-wide interventions (Sue 2001). In reviewing specific family therapy approaches for African Americans, Boyd-Franklin (2003) discusses the use of a multisystem family therapy approach, which incorporates an extended network of relationships that play a part in clients' lives. Using this model, social service and other community agencies can be considered a significant part of the family system. Network therapy, which involves clients' extended social networks, has also been found to improve substance use outcomes for African American clients when added to standard treatment (Keller and Galanter 1999). Likewise, the family team conference model can be a useful approach, given that it also engages both families and communities in the helping process by attempting to stimulate extensive mobilization of activity in the formal and informal relationships in and around clients' families (State of New Jersey Department of Human Services 2004).

Brief structural family therapy and strategic family therapy reduce substance use as well, but research has primarily focused on African American youth (Santisteban et al. 1997; Santisteban et al. 2003; Szapocznik and Williams 2000). Multidimensional family therapy has increased abstinence from substance use among African American adolescents and produced more lasting effects than CBT, but it also has not been evaluated with adult clients (Liddle et al. 2008). In reviewing specific family programs, Larkin (2003) reports promising preliminary data on a family therapy intervention among African Americans in public housing that addresses substance abuse.

Advice to Counselors: Strengths of African American Families

African American kinship bonds have historically been sources of strength. Although substance abuse lessens the strength of the family and can erode relationships, counselors can use the inherent strengths of the family to benefit clients and their families (Boyd-Franklin and Karger 2012; Larkin 2003; Reid 2000). Bell-Tolliver et al. (2009) and Hill (1972) suggest that strengths of African American family life include:

- Strong bonds and extensive kinship.
- Adaptability of family roles.
- A strong family hierarchy.
- A strong work orientation.
- A high achievement orientation.
- A strong religious orientation.

The program initially engages families via psychoeducation on substance abuse and its effects on the family, followed by a strength-based family therapy intervention. Despite the small sample size, all 10 families admitted to the program completed treatment, and 7 of 10 family members with substance abuse problems entered recovery and continuing care. Participant surveys indicated that 60 percent of families preferred multiple-family therapy over single-family therapy, and 80 percent preferred services delivered in the housing project community center to other venues.

Engaging Moms is another family-oriented program and intervention developed specifically for African American mothers that has been shown to significantly improve treatment engagement (Dakof et al. 2003). The intervention is designed for women who have children and have been identified as cocaine users. The program focuses on mobilizing family members who would be likely to motivate the mothers to enroll and remain in substance abuse treatment. Research has shown no long-term impact, yet women who received the intervention were significantly more likely to enter treatment (88 percent of women involved in the program versus 46 percent of the control group) and remain for at least 2 weeks.

Group therapy

Because of the communal, cooperative values held by many African Americans, group therapy can be a particularly valuable component of the treatment process (Sue and Sue 2013*b*). A strong oral tradition is one of many forms of continuity with African tradition maintained in the African American experience; therefore, speaking in groups is generally acceptable to African American clients. However, Bibb and Casimer (2000) note that Black Caribbean Americans can be less comfortable with the group process, particularly the requirement that they self-disclose personal problems to people who are relative strangers. African Americans seem less likely to self-disclose about the past in group settings that include non-Hispanic Whites (Johnson et al. 2011; Richardson and Williams 1990). Consequently, groups composed only of African Americans can be more beneficial. Homogenous African American groups can also be good venues for clients to deal with systemic problems, such as racism and lack of economic opportunities in the African American community (Jones et al. 2000).

Mutual-help groups

A variety of mutual-help groups are available for African Americans entering recovery from substance use and mental disorders. However, most of the literature focuses on 12-Step groups, including Alcoholics Anonymous (AA) and Narcotics Anonymous. Some find that the 12-Step approach warrants careful consideration with African Americans, who can find the concept of powerlessness over substances of abuse to be too similar to experiences of powerlessness via discrimination. Additionally, the disease concept of addiction presented in 12-Step meetings can be difficult for many African Americans (Durant 2005). In some instances, the Black community has changed the mutual-help model for substance use and mental health to make it more empowering and relevant to African American participants. For additional information on the 12 Steps for African Americans, visit Alcoholics Anonymous World Services (AAWS), AA for the Black and African American Alcoholic, available online (http://www.aa.org/pdf/products/p-51_CanAAHelpMeToo.pdf).

Despite their emphasis on the concept of powerlessness, 12-Step programs are significant support systems for many African Americans. In AA's 2011 membership survey, 4 percent of members identified their race as Black (AAWS 2012). Analysis of 2006–2007

NSDUH data showed that African Americans were less likely to use mutual-help groups in the past year for substance use (about 11 percent did) than White Americans (about 67 percent did) or Latinos (about 16 percent did; SAMHSA 2013*d*). However, the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) survey did find that African Americans who had a lifetime drug use disorder diagnosis and had sought help were more than three times as likely to have attended mutual-help meetings as were White Americans or Latinos (Perron et al. 2009). Several other surveys suggest that African Americans with alcohol-related problems are at least as likely to participate in AA as White Americans and that greater problem severity is associated with increased likelihood of participation (Kingree and Sullivan 2002). Of the participants who attended mutual-help group sessions for mental health in the past year, approximately 10 percent were Black or African American, 75 percent were White American, and 11.4 percent were Latino (SAMHSA 2010).

Durant (2005) observes that African American 12-Step participants tend to participate differently in meetings where participants are mostly White Americans than in meetings where most participants are African American. In some areas, there are 12-Step meetings that are largely or entirely composed of African American members, and some African American clients feel more comfortable participating in these meetings. Mutual-help groups can be particularly helpful for African Americans who consider themselves religious. Maude-Griffin et al. (1998) found that individuals who identified as highly religious did significantly better when receiving 12-Step facilitation than when receiving CBT, but that pattern was reversed for those who did not consider themselves highly religious. Other studies have found that African Americans express a greater degree of comfort with sharing in meetings, and they are more likely to engage in AA services and state that they had a spiritual awakening as a result of AA participation (Bibb and Casimer 2000; Kaskutas et al. 1999; Kingree 1997).

Research suggests that African Americans who attend 12-Step programs have higher levels of affiliation than White Americans in the same programs (Kingree and Sullivan 2002). However, they are less likely to have a sponsor or to read program materials (Kaskutas et al. 1999), and their abstinence appears to be less affected by meeting attendance (Timko et al. 2006). Other research has found that African Americans who participate in 12-Step groups report an increase in the number of people within their social networks who support their recovery efforts (Flynn et al. 2006). Other mutual-help groups for African Americans are available, particularly faith-based programs to support recovery from mental illness and substance use disorders and to aid individuals in the process of transitioning from correctional institutions. For example, the Nation of Islam has been involved in successful substance abuse recovery efforts, especially for incarcerated persons (Sanders 2002; White and Sanders 2004).

Traditional healing and complementary methods

In general, African Americans are less likely to make use of popular alternative or complementary healing methods than White Americans or Latinos (Graham et al. 2005). However, the African American culture and history is steeped in healing traditions passed down through generations, including herbal remedies, root medicines, and so forth (Lynch and Hanson 2011). The acceptance of traditional practices by African American clients and their families does not necessarily indicate that they oppose or reject the use of modern

therapeutic approaches or other alternative approaches. They can accept and use all forms of treatment selectively, depending on the perceived nature of their health problems. That said, psychological and substance abuse problems can be seen as having spiritual causes that need to be addressed by traditional healers or religious practices (Boyd-Franklin 2003). Moreover, African Americans are much more likely to use religion or spirituality as a response to physical or psychological problems (Cooper et al. 2003; Dessio et al. 2004; Graham et al. 2005; Nadeem et al. 2008).

African American cultural and religious institutions (see advice box below) play an important role in treatment and recovery, and African Americans who use spirituality or religion to cope with health problems are nearly twice as likely as other African Americans to also make use of complementary or alternative medicine (Dessio et al. 2004). Likewise, African American churches and mosques play a central role in education, politics, recreation, and social welfare in African American communities. To date, African Americans report the highest percentage (87 percent) of religious affiliation of any major racial/ethnic group (Kosmin and Keysar 2009; Pew Forum on Religion and Public Life 2008). Even though most are committed to various Christian denominations (with the Baptist and African Methodist Episcopal churches accounting for the largest percentages), a growing number of African Americans are converts to Islam, and many recent immigrants from Africa to the United States are also Muslims (Boyd-Franklin 2003; Pew Forum on Religion and Public Life 2008).

Relapse prevention and recovery

African Americans appear to be responsive to continuing care participation and recovery activities associated with substance use and mental disorders, yet research is very limited. According to NESARC data (Dawson et al.

Advice to Counselors: The Role of African American Religious Institutions in Treatment and Recovery

Within African American communities, religious institutions and clergy often function as service providers as well as counselors (Boyd-Franklin 2003; Reid 2000; Taylor et al. 2000). It is not uncommon for African Americans to approach clergy first when faced with their own or family members' mental health or substance abuse problems, but many African American clergy members believe they are not well-prepared to address those problems (Neighbors et al. 1998; Sexton et al. 2006). According to NESARC data, African Americans are twice as likely as Latinos and nearly three times as likely as White Americans to receive pastoral counseling for their drug use (Perron et al. 2009).

For many African Americans in recovery, churches play a significant role in helping them maintain abstinence (Perron et al. 2009). Beyond pastoral counseling, research suggests that other means of engagement within the church can lead to recovery. For example, participation in religious services has been associated with significantly better outcomes for African American men in continuing care following court-mandated treatment (Brown et al. 2004). Stahler et al. (2007) also report successful use of peer mentors drawn from churches for African American women in treatment, marked by significantly fewer drug-positive urine samples in the 6 months following treatment.

Counselors working with African American clients should prepare to include churches, mosques, or other faith communities in the therapeutic process, and they should develop a list of appropriate spiritual resources in the community. Treatment providers may consider involving African American clergy in treatment programs to improve clergy members' understanding of behavioral health problems and treatments and to better engage clients and their families. Programs can conduct outreach with local faith-based institutions and clergy to facilitate treatment referrals (Taylor et al. 2000).

2005), African Americans in recovery from alcohol dependence were more than twice as likely as White Americans to maintain abstinence rather than just limiting alcohol consumption or changing drinking patterns. In another study analyzing the use of continuing care following residential treatment in the U.S. Department of Veterans Affairs care system, African American men were significantly more likely than White Americans to participate in continuing care (Harris et al. 2006). Other research evaluating continuing care for African American men who had been mandated to outpatient treatment by a parole or probation office found that participants assigned to a continuing care intervention were almost three times as likely to be abstinent and five times less likely to be using any drugs on a weekly basis during the 6-month follow-up period compared with those who did not receive continuing care (Brown et al. 2004).

In evaluating appropriate relapse prevention strategies for African American clients, Walton et al. (2001) found that African American clients leaving substance abuse treatment reported fewer cravings, greater use of coping strategies, and a greater belief in their self-efficacy. However, they also expected to be involved in fewer sober leisure activities, to be exposed to greater amounts of substance use, and to have a greater need for continuing care services (e.g., housing, medical care, assistance with employment). Walton notes that these findings could reflect a tendency of African American clients to underestimate the difficulties they will face after treatment; they report a greater need for resources and greater exposure to substance use, but they still have a greater belief in their ability to remain free of substances. Although an individual's belief in coping can have a positive effect on initially managing high-risk situations, it also can lead to a failure to recognize the level of risk in a given situation, anticipate the consequences, secure resources and appropriate support when needed, or engage in coping behaviors conducive to maintaining recovery. Counselors can help clients practice coping skills by role-playing, even if clients are confident that they can manage difficult or high-risk situations.

Counseling for Asian Americans, Native Hawaiians, and Other Pacific Islanders

Asian Americans, per the U.S. Census Bureau definition, are people whose origins are in the Far East, Southeast Asia, or the Indian subcontinent (Humes et al. 2011). The term includes East Asians (e.g., Chinese, Japanese, and Korean Americans), Southeast Asians (e.g., Cambodian, Laotian, and Vietnamese Americans), Filipinos, Asian Indians, and Central Asians (e.g., Mongolian and Uzbek Americans). In the 2010 Census, people who identified solely as Asian American made up 4.8 percent of the population, and those who identified as Asian American along with one or more other races made up an additional 0.9 percent. Census data includes specific information on people who identify as Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, and "other Asians." The largest Asian populations in the United States are Chinese Americans, Filipino Americans, Asian Indian Americans, Korean Americans, and Vietnamese Americans. Asian Americans overwhelmingly live in urban areas, and more than half (51 percent) live in just three states (NY, CA, and HI; Hoeffel et al. 2012).

Not all people with origins in Asia belong to what is commonly conceived of as the Asian race. Some Asian Indians, for example, self-identify as White American. For this reason, among others, counselors should be careful to learn from their Asian American clients how

they identify themselves and which national heritages they claim. Counselors should recognize that clients who appear to be Asian may not necessarily think of themselves primarily as persons of Asian ancestry or have a deep awareness of the traditions and values of their countries of origin. For example, Asian orphans who have been adopted in the United States and raised as Americans in White American families may have very little connection with the cultural groups of their biological parents (St. Martin 2005). Counselors should not make generalizations across Asian cultures; each culture is quite distinct.

Little literature on substance use and mental disorders, rates of co-occurrence, and treatment among Asian Americans focuses on behavioral health treatment for Native Hawaiians and Pacific Islanders; thus, a text box at the end of this section summarizes available information.

Beliefs About and Traditions Involving Substance Use

Within many Asian societies, the use of intoxicants is tolerated within specific contexts. For example, in some Asian cultural groups, alcohol is believed to have curative, ceremonial, or beneficial value. Among pregnant Cambodian women, small amounts of herbal medicines with an alcohol base are sometimes used to ensure an easier delivery. Following childbirth, similar medicines are generally used to increase blood circulation (Amodeo et al. 1997). Some Chinese people believe that alcohol restores the flow of *qi* (i.e., the life force). The written Chinese character for "doctor" contains the character for alcohol, which implies the use of alcohol for medicinal purposes.

Some Asian American cultural groups make allowances for the use of other substances. Marijuana, for instance, has been used medicinally in parts of Southeast Asia for many years (Iversen 2000; Martin 1975). However, some Asian Americans tend to view illicit substance use and abuse as a serious breach of acceptable behavior that cannot readily be discussed. Nonetheless, there are broad differences in Asian cultures' perspectives on substance use, thus requiring counselors to obtain more specific information during intake and subsequent encounters.

Acknowledging a substance abuse problem often leads to shame for Asian American clients and their families. Families may deny the problem and inadvertently, or even intentionally, isolate members who abuse substances (Chang 2000). For example, some Cambodian and Korean Americans perceive alcohol abuse and dependence as the result of moral weakness, which brings shame to the family (Amodeo et al. 2004; Kwon-Ahn 2001).

Substance Use and Substance Use Disorders

According to the 2012 NSDUH, Asian Americans use alcohol, cigarettes, and illicit substances less frequently and less heavily than members of any other major racial/ethnic group (SAMHSA 2013*d*). However, large surveys may undercount Asian American substance use and abuse, as they are typically conducted in English and Spanish only (Wong et al. 2007*b*). Despite the limitations of research, data suggest that although Asian Americans use illicit substances and alcohol less frequently than other Americans, substance abuse problems have been increasing among Asian Americans. The longer Asian Americans reside in the United States, the more their substance use resembles that of other Americans. Excessive alcohol use, intoxication, and substance use disorders are more prevalent among Asians born in the United States than among foreign-born Asians living in the United States (Szaflarski et al. 2011).

Among Asian Americans who entered substance abuse treatment between 2000 and 2010, methamphetamine and marijuana were the most commonly reported illicit drugs (SAMHSA, CBHSQ 2012). Methamphetamine abuse among Asian Americans is particularly high in Hawaii and on the West Coast (OAS 2005*a*). As with other racial and ethnic groups, numerous factors—such as age, birth country, immigration history, acculturation, employment, geographic location, and income—add complexity to any conclusions about prevalence among specific Asian cultural groups. Asian Americans who are recent immigrants, highly acculturated, unemployed, or living in Western states are generally more likely than other Asian Americans to abuse drugs or alcohol (Makimoto 1998). For example, according to the National Latino and Asian American Study (NLAAS), Asians who are more acculturated are at greater risk for prescription drug abuse (Watkins and Ford 2011).

There are variations among particular groups of Asians; some Asian cultural groups have different attitudes toward substance use than others, and these differences tend to be obscured in large-scale surveys. Researchers have found that Korean American college students drank more frequently and drank greater quantities than did Chinese American students at the same schools and were more likely to consider drinking socially acceptable (Chang et al. 2008). Another study in the District of Columbia and surrounding metropolitan area compared substance use among different groups of Southeast Asians (i.e., Cambodian, Laotian, and Vietnamese Americans); Vietnamese Americans had the highest rates of alcohol use, but Cambodian Americans had the highest rates of illicit drug use (Wong et al. 2007*b*). Research in San Francisco found Chinese Americans to be less likely than Vietnamese or Filipino Americans to use illicit drugs, whereas Filipino Americans had the highest rate of illicit drug use (Nemoto et al. 1999). In that same study, Filipino American immigrants were also significantly more likely to have begun using substances prior to immigrating than were Chinese or Vietnamese immigrants. Other studies have found that Filipino Americans are more likely to use illicit drugs and to inject drugs than other Asian American populations (see review in Nemoto et al. 2002).

To date, the largest national study to assess substance use and mental disorders across Asian American groups is the NLAAS (Takeuchi et al. 2007). This study found that Filipino American men were 2.38 times more likely to have a lifetime substance use disorder than were Chinese American men, whereas the differences among women of diverse Asian ethnicities were much smaller. Other research suggests that Korean Americans are more likely to have family histories of alcohol dependence than are Chinese Americans (Ebberhart et al. 2003).

Besides the variations across different cultures, substance use and abuse among Asian Americans is also influenced by age. Substance abuse appears higher for young Asian Americans than for those who are older (possibly reflecting differences in acculturation). A study conducted in New York City showed that Asian American junior and senior high school students had the lowest percentage of heavy drinkers of any ethnic group, but those who were heavy drinkers drank twice as much daily as those who did not drink heavily (Makimoto 1998). Asian American youth, especially immigrants, tend to start using substances at a later age than members of other ethnic groups, which could be a factor in the lower levels of abuse seen among Asian Americans.

Despite rates of substance use disorders among Asian Americans having increased over

time, research has regularly found that, of all major racial/ethnic groups in United States, Asian Americans have the lowest rates of alcohol use disorders (Grant et al. 2004; SAMHSA 2012*b*). This phenomenon has typically been explained in part by the fact that some Asians lack the enzyme aldehyde dehydrogenase, which chemically breaks down alcohol (McKim 2003). Thus, high levels of acetaldehyde, a byproduct of alcohol metabolism, accumulate and cause an unpleasant flushing response (Yang 2002). The alcohol flushing response primarily manifests as flushing of the neck and face but can also include nausea, headaches, dizziness, and other symptoms.

Additional factors that could play a part in increasing the likelihood of substance use disorders among Asian Americans include experiences of racism and the absence of ethnic identification. Compared with Asian Americans who do not have alcohol use disorders, Asian Americans who have alcohol use disorders are more than five times as likely to report unfair treatment because of their race and are more than twice as likely to deny strong ethnic identification (Chae et al. 2008). Compared with other racial and ethnic groups, Asian Americans who drink heavily are more likely to have friends or peers who also drink heavily (Chi et al. 1989).

Mental and Co-Occurring Disorders

Overall, health and mental health are not seen as two distinct entities by Asian American cultural groups. Most Asian American views focus on the importance of virtue, maturity, and self-control and find full emotional expression indicative of a lack of maturity and self-discipline (Cheung 2009). Given the potential shame they often associate with mental disorders and their typically holistic worldview of health and illness, Asian Americans are more likely to present with somatic complaints and less likely to present with symptoms of psychological distress and impairment (Hsu and Folstein 1997; Kim et al. 2004; Room et al. 2001; U.S. Department of Health and Human Services [HHS] 2001; Zhang et al. 1998), even though mental illness appears to be nearly as common among Asian Americans as it is in other ethnic/racial groups. In 2009, approximately 15.5 percent of Asians reported a mental illness in the past year, but only 2 percent reported past-year occurrence of serious mental illness (SAMHSA 2012*a*). Asian Americans have a lower incidence of CODs than other racial/ethnic groups because the prevalence of substance use disorders in this population is lower. In the 2012 NSDUH, 0.3 percent of Asian Americans indicated co-occurring serious psychological distress and substance use disorders, and 1.1 percent had some symptoms of mental distress along with a substance use disorder—the lowest rates of any major racial/ethnic group in the survey (SAMHSA 2013*c*).

Considerable variation in the types of mental disorders diagnosed among diverse Asian American communities is evident, although it is unclear to what extent this reflects diagnostic and/or self-selection biases. For example, Barreto and Segal (2005) found that Southeast Asians were more likely to be treated for major depression than other Asians or members of other ethnic/racial groups; East Asians were the most likely of all Asian American groups to be treated for schizophrenia (nearly twice as likely as White Americans). Traumatic experiences and PTSD can be particularly difficult to uncover in some Asian American clients. Although Asian Americans are as likely to experience traumatic events (e.g., wars experienced by first-generation immigrants from countries such as Vietnam and Cambodia) in their lives, their cultural responses to trauma can conceal its psychological

effects. For instance, some Asian cultural groups believe that stoic acceptance is the most appropriate response to adversity (Lee and Mock 2005*a,b*).

Treatment Patterns

Treatment-seeking rates for mental illness are low among most Asian populations, with rates varying by specific ethnic/cultural heritage and, possibly, level of acculturation (Abe-Kim et al. 2007; Barreto and Segal 2005; Lee and Mock 2005*a,b*). Asian Americans who seek help for psychological problems will most likely consult family members, clergy, or traditional healers before mental health professionals, in part because of a lack of culturally and linguistically appropriate mental health services available to them (HHS 2001; Spencer and Chen 2004). However, among those Asian Americans who seek behavioral health treatment, the amount of services used is relatively high (Barreto and Segal 2005).

Asian Americans tend to enter treatment with less severe substance abuse problems than members of other ethnic/racial groups and have more stable living situations and fewer criminal justice problems upon leaving treatment (Niv et al. 2007). However, for Asian Americans involved in the criminal justice system, there is a more pronounced relationship between crime and drug abuse than for other ethnic and racial groups. In the early 1990s, an estimated 95 percent of Asian Americans in California prisons were there because of drug-related crimes (Kuramoto 1994). According to SAMHSA's 2010 TEDS data, 48.5 percent of Asian Americans in treatment were referred by the criminal justice system in that year, compared with 36.4 percent of African Americans and 36.6 percent of White Americans (SAMHSA, CBHSQ 2012). According to 2010 NSDUH data regarding individuals who reported a need for treatment but did not receive it in the prior year, Asian Americans were also the most likely of all major racial/ethnic groups to report that they could not afford or had no insurance coverage for substance abuse treatment (SAMHSA, CBHSQ 2011).

Beliefs and Attitudes About Treatment

Compared with the general population, Asian Americans are less likely to have confidence in their medical practitioners, feel respected by their doctors, or believe that they are involved in healthcare decisions. Many also believe that their doctors do not have a sufficient understanding of their backgrounds and values; this is particularly true for Korean Americans (Hughes 2002). Even so, Asian Americans, especially more recent immigrants, seem more likely to seek help for mental and substance use disorders from general medical providers than from specialized treatment providers (Abe-Kim et al. 2007). Many Asian American immigrants underuse healthcare services due to confusion about eligibility and fears of jeopardizing their residency status (HHS 2001).

As with other groups, discrimination, acculturation stress, and immigration and generational status, along with language needs, have a large influence on behavioral health and treatment-seeking for Asian Americans (Meyer et al. 2012; Miller et al. 2011). The NLAAS found that although rates of behavioral health service use were lower for Asian Americans who immigrated recently than for the general population, those rates increased significantly for U.S.-born Asian Americans; third-generation U.S.-born individuals' rates of service use also were relatively high (Abe-Kim et al. 2007). Of those Asian Americans who had any mental disorder diagnosis in the prior year, 62.6 percent of third-generation Americans sought help for it in the prior year compared with 30.4 percent of first-generation Americans.

Overall, Asian Americans place less value on substance abuse treatment than other population groups and are less likely to use such services (Yu and Warner 2012). Niv et al. (2007) found that Asian and Pacific Islanders entering substance abuse treatment programs in California expressed significantly more negative attitudes toward treatment and rated it as significantly less important than did others entering treatment. Seeking help for substance abuse can be seen, in some Asian American cultural groups, as an admission of weakness that is shameful in itself or as an interference with family obligations (Masson et al. 2013). Among 2010 NSDUH respondents who stated a need for substance abuse treatment in the prior year but did not receive it, Asian Americans were more likely than members of all other major racial/ethnic groups to say that they could handle the problem without treatment or that they did not believe treatment would help (SAMHSA 2011*c*). Combining NSDUH data from 2003 to 2011 NSDUH, Asian Americans who needed but did not receive treatment in the past year were the least likely of all major ethnic/racial groups to express a need for such treatment (SAMHSA, CBHSQ 2013*c*).

Treatment Issues and Considerations

It is important for counselors to approach presenting problems through clients' culturally based explanations of their own issues rather than imposing views that could alter their acceptance of treatment. In Asian cultural groups, the physical and emotional aspects of an individual's life are undifferentiated (e.g., the physical rather than emotional or psychological aspect of a problem can be the focus for many Asian Americans); thus, problems as well as remedies are typically handled holistically. Some Asian Americans with traditional backgrounds do not readily accept Western biopsychosocial explanations for substance use and mental disorders. Counselors should promote discussions focused on clients' understanding of their presenting problems as well as any approaches the clients have used to address them. Subsequently, presenting problems need to be reconceptualized in language that embraces the clients' perspectives (e.g., an imbalance in *yin* and *yang*, a disruption in *chi*; Lee and Mock 2005*a,b*). It is advisable to educate Asian American clients on the role of the counselor/therapist, the purpose of therapeutic interventions, and how particular aspects of the treatment process (e.g., assessment) can help clients with their presenting problems (Lee and Mock 2005*a*,*b*; Sue 2001). Asian American clients who receive such education participate in treatment longer and express greater satisfaction with it (Wong et al. 2007*a*).

As with other racial/ethnic groups, Asian American clients are responsive to a warm and empathic approach. Counselors should realize, though, that building a strong, trusting relationship takes time. Among Asian American clients, humiliation and shame can permeate the treatment process and derail engagement with services. Thus, it is essential to assess and discuss client beliefs about shame (see the "Assessing Shame in Asian American Clients" advice box on the next page). In some cases, self-disclosure can be helpful, but the counselor should be careful not to self-disclose in a way that will threaten his or her position of respect with Asian American clients.

Asian American clients may look to counselors for expertise and authority. Counselors should attempt to build client confidence in the first session by introducing themselves by title, displaying diplomas, and mentioning his or her experience with other clients who have similar problems (Kim 1985; Lee and Mock 2005*a,b*). Asian American clients may expect and be most comfortable with formalism on

Advice to Counselors: Assessing Shame in Asian American Clients

Shame and humiliation can be significant barriers to treatment engagement for Asian Americans. Gaw (1993) suggests that the presence of the following factors may indicate that a client has shame about seeking treatment:

- The client or a family member is extremely concerned about the qualifications of the counselor.
- The client is hesitant to involve others in the treatment process.
- The client is excessively worried about confidentiality.
- The client refuses to cover expenses with private insurance.
- The client frequently misses or arrives late for treatment.
- Family members refuse to support treatment.
- The client insists on having a White American counselor to avoid opening up to another Asian.
- The client refuses treatment even when severe problems are evident.

the part of counselors, especially at the beginning of treatment and prior to assessment of clients' needs (Paniagua 1998). Many Asian American clients expect counselors to be directive (Leong and Lee 2008). Passivity on the part of the counselor can be misinterpreted as a lack of concern or confidence.

Counselors who are unaccustomed to working with Asian populations will likely encounter conflict between their theoretical worldview of counseling and the deference to authority and avoidance of confrontation that is common among more traditional Asian American clients. Some clients can be hesitant to contradict the counselor or even to voice their own opinions. Confrontation can be seen as something to avoid whenever possible. Furthermore, many Asian cultural groups have high-context styles of communication, meaning that members often place greater importance on nonverbal cues and the context of verbal messages than on the explicit content of messages (Hall 1976). Asian Americans often use indirect communication, relying on subtle gestures, expressions, or word choices to convey meaning without being openly confrontational. Counselors must not only be observant of nuances in meaning, but also learn about verbal and nonverbal communication styles specific to Asian cultural groups (for a review of guidelines to use when working with Asian Americans, see Gallardo et al. 2012).

Asian American clients appear to respond more favorably to treatment in programs that provide services to other Asian clients. Takeuchi et al. (1995) found that Asian Americans were much more likely to return to mental health clinics where most clients were Asian American than to programs where that was not the case (98 percent and 64 percent returned, respectively). When demographic differences were controlled for, those who attended programs that had predominantly Asian clients were 15 times more likely to return after the initial visit. Asian Americans were also more likely to stay in treatment when matched with an Asian American counselor regardless of the type of program they attended. Sue et al. (1991) also found that Asian American clients attended significantly more treatment sessions if matched with an Asian American counselor.

Among Asian American women, crucial strategies include reducing the shame of substance abuse and focusing on the promotion of overall health rather than just addressing substance abuse. Such strategies reduce the chance of a woman and her family seeing substance abuse as an individual flaw. Home visits, when agreed in advance with the client, can be appropriate in some cases as a way to gain the trust of, and show respect for, Asian American women. Asian American women may not be as successful in mixed-gender

Advice to Administrators: Culturally Responsive Program Development

Behavioral health service program administrators can improve engagement and retention of Asian clients by making culturally appropriate accommodations in their programs. The accommodations required will vary according to the specific cultural groups, language preferences, and levels of acculturation in question. The following culturally responsive program suggestions were initially identified for Cambodian clients but can be adapted to match the unique needs of other Asian clients from different ethnic and cultural backgrounds:

- Create an advisory committee using representatives from the community.
- Incorporate cultural knowledge and maintain flexible attitudes as a counselor.
- Use cotherapist teams in which one member is Asian and bilingual.
- Provide services in the clients' primary language.
- Develop culturally specific questionnaires for intake to capture information that may be missed by standard questionnaires.
- Conduct culturally appropriate assessments of trauma that ask about the traumatic experiences common to the population in question.
- Visit client homes to improve family involvement in treatment.
- Provide support to families during transitions from and to professional care.
- Emphasize traditional values.
- Explore client coping mechanisms that draw upon cultural strengths.
- Use acupuncture or other traditional practices for detoxification.
- Integrate Buddhist ideas, values, and practices into treatment when appropriate.
- Emphasize relationship-building; help clients with life problems beyond behavioral health concerns.
- Provide concrete services, such as housing assistance and legal help.

Sources: Amodeo et al. 2004; Park et al. 2011.

groups if strict gender roles exist whereby communication is constricted within and outside the family; women will likely remain silent or defer to the men in the group (Chang 2000). For more information on treating women, see Treatment Improvement Protocol (TIP) 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT 2009*c*).

Theoretical Approaches and Treatment Interventions

Some Asian cultural groups emphasize cognitions. For instance, Asian cultural groups that have a Buddhist tradition, such as the Chinese, view behavior as controlled by thought. Thus, they accept that addressing cognitive patterns will affect behaviors (Chen 1995). Some Asian cultural groups encourage a stoic attitude toward problems, teaching emotional suppression as a coping response to strong feelings (Amodeo et al. 2004; Castro et al. 1999*b*; Lee and Mock 2005*a,b*; Sue 2001). Treatment can be more effective if providers avoid approaches that target emotional responses and instead use strategies that are more indirect in discussing feelings (e.g., saying "that might make some people feel angry" rather than asking directly what the client is feeling; Sue 2001).

Asian Americans often prefer a solution-focused approach to treatment that provides them with concrete strategies for addressing specific problems (Sue 2001). Even though little research is available in evaluating specific interventions with Asian Americans, clinicians tend to recommend cognitive–behavioral, solution-focused, family, and acceptance commitment therapies (Chang 2000; Hall et al. 2011; Iwamasa et al. 2006; Rastogi and Wadhwa 2006; Sue 2001). Asian American clients are likely to expect that their counselors take an active role in structuring the therapy session and provide clear guidelines about what they expect from clients. CBT has the

advantages of being problem focused and time limited, which will likely increase its appeal for many Asian Americans who might see other types of therapy as failing to achieve real goals (Iwamasa et al. 2006). Although specific data on the effectiveness of CBT among Asian Americans is not available, there is some research indicating that CBT is effective for treating depressive symptoms in Asians (Dai et al. 1999; Fujisawa et al. 2010). In China, a Chinese Taoist version of CBT has been developed to treat anxiety disorders and was found to be effective, especially in conjunction with medication (Zhang et al. 2002).

Family therapy

Some Asian Americans, particularly those who are less acculturated, prefer individual therapy to group or family interventions because it better enables them to save face and keep their privacy (Kuramoto 1994). Some clients may wish to enter treatment secretly so that they can keep their families and friends from knowing about their problems. Once treatment is initiated, counselors should strongly reinforce the wisdom of seeking help through statements such as "you show concern for your husband by seeking help" or "you are obviously a caring father to seek this help."

The norm in Asian families is that "all problems (including physical and mental problems) must be shared only among family members"; sharing with others can cause shame and guilt, exacerbating problems (Paniagua 1998, pp. 59–60). Counselors should expect to take more time than usual to learn about clients' situations, anticipate client needs for reassurance in divulging sensitive information, and frame discussions in a culturally competent way. For example, counselors can assure clients that discussing problems is a step toward resuming their full share of responsibility in their families and removing some of the stress their families have been feeling.

For most Asian Americans, particularly those who are less acculturated, successful treatment involves the client's family (Chang 2000; Kim et al. 2004; Rastogi and Wadhwa 2006). Even in individual treatment, it is important to understand the client's family and his or her relationship with its members, the dynamics and style of the family, and the family's role in the client's substance abuse (Meyer et al. 2012). Particularly among Asian American women, family involvement can be essential due to the client's concern about being responsive to her family's needs. Nonetheless, involving the family can be quite difficult, as both male and female clients may wish to conceal their substance abuse from their families because of the shame that it brings.

Advice to Counselors: Culturally Responsive Family Therapy Guidelines for Asian Families

Kim et al. (2004) reviewed references that provide guidelines for family therapy with Korean Americans. They established 11 essential ingredients applicable to Korean and other Asian American groups and families. To provide culturally responsive therapy to Asian Americans, counselors should:

- Assess support from community and extended family systems.
- Assess immigration history, if appropriate.
- Establish credibility as a professional in the initial meeting with the family.
- Explain the key principles and expectations of family therapy and the family roles (especially elders/decisionmakers) in the process.
- Enable clients, particularly male elders or decisionmakers, to save face.
- Validate and address somatic complaints.
- Be both problem focused and present focused.
- Be directive in guiding therapy.
- Respect the family's hierarchy.
- Avoid being confrontational and facilitate interactions that are nonconfrontational.
- Reframe problems in positive terms.

Source: Kim et al. 2004.

To engage family members in the client's treatment, the counselor first needs to be familiar with the way the family functions. Different acculturation levels among individual family members and across generations can affect how the family functions, producing significant stress and internal conflict. Also, the counselor must be aware of how gender roles and generational status influence the communication patterns and rules within each family (e.g., expectations of how a child addresses a parent, the potential relegation of authority among female family members). Even more than for other clients, it is critical for Asian Americans to "avoid embarrassing the family members in front of each other. The counselor should always protect the dignity and self-respect of the client and his or her family" (Paniagua 1998, p. 71).

Group therapy

Group therapy may not be a good choice for Asian Americans, as many prefer individual therapy (Lai 2001; Sandhu and Malik 2001). Paniagua (1998, p. 73) suggests that "group therapy…would be appropriate in those cases in which the client's support system (relatives and close friends) is not available and an alternative support system is quickly needed." Some Asian Americans participating in group therapy will find it difficult to be assertive in a group setting, preferring to let others talk. They can also abide by more traditional roles in this context; men might not want to divulge their problems in front of women, women can feel uncomfortable speaking in front of men, and both men and women might avoid contradicting another person in group (especially an older person). It may not make sense to Asian American clients to hear about the problems of strangers who are not part of their community.

Asian Americans are likely to be motivated to work for the good of the group; presenting group goals in this framework can garner active participation. Still, in group settings and in other instances, Asian American clients may expect a fair amount of direction from the group leader. Chen (1995) described leadership of a culturally specific therapy group for Chinese Americans, noting that clients expect a group leader to act with authority and give more credence to his or her expertise than to other group members. If members of the group belong to the same Asian American community, the issue of confidentiality will loom large, because the community is often small. Asian cultural groups generally appreciate education in more formal settings, so psychoeducation groups can work well for Asian Americans. It is possible for a psychoeducational group with Asian American participants to evolve comfortably into group therapy.

Mutual-help groups

According to 2012 NSDUH data, Asian Americans were less likely than other racial and ethnic groups to report the use of mutual-help groups in the past year (SAMHSA 2013*d*). Mutual-help groups can be challenging for Asian Americans who find it difficult and shaming to self-disclose publicly. The degree of emotion and candor within these groups can further alienate traditional Asian American clients. Furthermore, linguistically appropriate mutual-help groups are not always available for people who do not speak English. Highly acculturated Asian Americans may perceive participation in mutual-help groups as less of a problem, but nevertheless, Asian Americans can benefit from culture-specific mutual-help groups where norms of interpersonal interaction are shared. Asian American 12-Step groups are available in some locales. It is important for counselors to assess client attitudes toward mutual-help participation and find alternative strategies and resources,

including encouragement to attend without sharing (Sandhu and Malik 2001).

Although they are not mutual-help groups in the traditional sense, mutual aid societies and associations are important in some Asian American communities. Some mutual aid societies have long histories and have provided assistance ranging from financial loans to help with childcare and funerals. The Chinese have family associations for people with the same last name who share celebrations and offer each other help. Japanese, Chinese, and South Asians have specific associations for people from the same province or village. For some Asian American groups, such as Koreans, churches are the primary organizational vehicles for assistance. These social support groups can be important resources for Asian American clients, their families, and the behavioral health agencies that provide services to them.

Traditional healing and complementary methods

Asian Americans are twice as likely as other Americans to report making use of acupuncture and traditional healers. Even though there is considerable variation in their use of complementary and traditional medicine (Hughes 2002), many Asian Americans highly regard traditional healers, herbal preparations, and other culturally specific interventions as a means of restoring harmony and balance. However, Asian American clients do not always readily disclose the use of traditional medicine to Western treatment providers. Ahn et al. (2006) found that about two-thirds of Chinese and Vietnamese Americans who spoke no or limited English had used traditional medicine, but only 7.6 percent had discussed the use of these therapies with their Western medical providers.

Traditional treatment to restore physical and emotional balance for Asian Americans occurs through a variety of culture-specific interventions. For example, some Southeast Asian cultural groups practice *cao gio*—massaging the skin with ointment and hot coins (Chan and Chen 2011). The Chinese have developed enormously complex systems of medical treatment over centuries of pragmatic experimentation. Traditional herbal medicine combines plant substances according to precise formulas to have the desired influence on the affected organs of the body. Acupuncture techniques involve regulating the flow of energy (*qi*) through the body by inserting needles at precise locations called acupuncture points. In traditional Chinese medicine, which has influenced traditional medical practices in other Asian cultural groups, illness is seen as an imbalance of *yin* and *yang*; a return to physical wellness can require introducing elements such as herbs to increase *yin* or *yang* as needed (Torsch and Ma 2000).

Among less acculturated Asian Americans, Western medicine, including Western behavioral health services, can be insufficient to deal with a problem such as substance abuse and its effects on clients and their families. For example, all health problems for the Hmong (whether physical or psychological) are considered spiritual in nature; if providers ignore the clients' understanding of their problems as spiritual maladies, they are unlikely to effect positive change (Fadiman 1997). Even for more acculturated Asian Americans, the use of traditional healing methods and spirituality can be a very important aspect of treatment (see Chan and Chen 2011 for an overview of health beliefs and practices). Such use can provide a spiritual connection that helps manage feelings that are especially difficult to express to others. Many practices associated with meditation, yoga, and Eastern religious traditions can help disperse the stress and anxiety experienced during treatment and recovery. In the United States, there are few

Behavioral Health Counseling for Native Hawaiians and Other Pacific Islanders

The ancestors of Native Hawaiians and other Pacific Islanders were the original inhabitants of Hawaii, Guam, Samoa, and other Pacific islands. The population of Native Hawaiians and other Pacific Islanders grew more than three times faster than the total U.S. population from 2000 to 2010. More than half of Native Hawaiian and other Pacific Islanders live in Hawaii and California. The largest Pacific Islander populations in the United States comprise Hawaiians, Samoans, and Chamorros—the indigenous people of the Mariana Islands, of which Guam is the largest (Hixson et al. 2012).

Native Hawaiians and other Pacific Islanders make up a relatively small proportion of the total United States population. In the 2010 Census, 540,000 people, or 0.2 percent of the population, reported their race as Native Hawaiian or other Pacific Islander, and another 685,000 people (0.2 percent of the population) stated that they were Native Hawaiian or other Pacific Islander in addition to one or more other races (Hixson et al. 2012). The largest concentration of Native Hawaiians and other Pacific Islanders is in Hawaii, where individuals with at least some of this ancestry made up 23.3 percent of the population.

In 2012, according to NSDUH data, 5.4 percent of Native Hawaiians and other Pacific Islanders interviewed had a substance use disorder in the prior year, and 7.8 percent engaged in current illicit drug use (SAMHSA 2013*d*). Binge and heavy drinking appear to be relatively high, especially among Native Hawaiian/Pacific Islander women. Data from the 2001–2011 TEDS surveys indicate that the most common primary substances of abuse among Native Hawaiians and other Pacific Islanders entering substance abuse treatment are alcohol, cannabis, and methamphetamine (SAMHSA 2013*c*). Because of its relatively small size, many studies have either ignored or been unable to make conclusions about substance use and abuse in this population; other research has grouped Native Hawaiians and other Pacific Islanders together with Asians (more for the sake of convenience than for underlying cultural similarities).

According to NSDUH data, 1.8 percent of adult Native Hawaiians and other Pacific Islanders reported serious mental illness. Insufficient data were available to analyze past-year mental illness rates (SAMHSA 2013*c*). Similar to substance use data, specific mental health data are limited across national studies, primarily because the population has been grouped with Asians. However, the evidence that is available suggests that Native Hawaiians are less likely than other racial/ethnic groups in Hawaii to access treatment services even though they experience higher rates of mental health problems (for a review of health beliefs and practices, see Mokuau and Tauili'ili 2011).

A few examples of culturally specific interventions for Native Hawaiians have been presented in the literature. For example, the Rural Hawai'i Behavioral Health Program, which provides substance abuse and mental health services to Native Hawaiians living in rural areas, incorporates Native Hawaiian beliefs and practices into all areas of the program, emphasizing the value of '*ohana* (family) relations, including the importance of respecting and honoring ancestors and elders and passing on cultural ways to the next generation. Program staff members are trained in Native Hawaiian culture and beliefs, including spirituality and the essential value of graciousness, the honoring of *mana* (life energy), healing rituals such as *pule* (prayer), the use of healing herbs, and Native Hawaiian beliefs about the causes of illness, such as wrongdoing and physical disruption (Oliveira et al. 2006).

Ho'oponopono is a form of group therapy used by Native Hawaiians; it involves family members and is facilitated by a *Küpuna* (elder). A qualitative study by Morelli and Fong (2000) of *Ho'oponopono* with pregnant or postpartum women with substance use disorders (primarily methamphetamine abuse) reported high client satisfaction and positive outcomes (80 percent were abstinent 2 years after treatment). The Na Wahine Makalapua Project, sponsored by the Hawaii Department of Health's Alcohol and Drug Abuse Division and SAMHSA's Center for Substance Abuse Prevention, uses elements of Hawaiian culture to treat women with substance use disorders, such as by having *Küpuna* counsel younger generations.

examples of culturally specific treatment programs that focus on Asian religious or spiritual treatment; however, there are programs overseas, such as the Thai Buddhist treatment center described by Barrett (1997).

Asian Americans are much more likely than members of other racial/ethnic groups to label themselves as secular, agnostic, or atheist (Kosmin and Keysar 2009; Pew Forum on Religion and Public Life 2008). That said, a substantial number of Asian Americans still have religious affiliations. About 45 percent are Protestant; 17 percent, Catholic; 14 percent, Hindu; 9 percent, Buddhist; and 4 percent, Muslim (Pew Forum on Religion and Public Life 2008). More acculturated Asian Americans are likely to enter treatment through medical settings and to be comfortable with a medical model for treatment, but those who are less acculturated or are foreign-born can prefer the use of traditional healing and/or religious traditions and beliefs as part of their treatment (Ja and Yuen 1997). Religious institutions can play an important part in the treatment of some groups of Asian Americans. For example, Kwon-Ahn (2001) notes that many Korean Americans, particularly more recent immigrants, turn to Christian clergy or church groups for assistance with family and personal problems, such as substance abuse, before seeking professional help. Amodeo et al. (2004) suggest that, in working with Cambodian immigrants, providers integrate Buddhist philosophy and practices into treatment, and, if possible, partner with Buddhist temples to facilitate treatment entry or to provide services for clients who choose to reside in Buddhist temples.

Relapse prevention and recovery

Little research has evaluated relapse prevention and recovery promotion strategies specifically for Asian Americans. However, issues involving shame can make the adjustment to abstinence difficult for Asian clients. Counselors should take this into account and address difficulties that can arise for clients with families who have shame about mental illness or substance use disorders. To date, there are no indications that standard approaches are unsuitable for Asian American clients. For more information on these approaches, see the planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e*).

Counseling for Hispanics and Latinos

The terms "Hispanic" and "Latino" refer to people whose cultural origins are in Spain and Portugal or the countries of the Western Hemisphere whose culture is significantly influenced by Spanish or Portuguese colonization. Technically, a distinction can be drawn between Hispanic (literally meaning people from Spain or its former colonies) and Latino (which refers to persons from countries ranging from Mexico to Central and South America and the Caribbean that were colonized by Spain, and also including Portugal and its former colonies); this TIP uses the more inclusive term (Latino), except when research specifically indicates the other. The term "Latina" refers to a woman of Latino descent.

Latinos are an ethnic rather than a racial group; Latinos can be of any race. According to 2010 Census data, Latinos made up 16 percent of the total United States population; they are its fastest growing ethnic group (Ennis et al. 2011). Latinos include more than 30 national and cultural subgroups that vary by national origin, race, generational status in the United States, and socioeconomic status (Padilla and Salgado de Snyder 1992; Rodriguez-Andrew 1998). According to Ennis et al. (2011), of Latinos currently living in the United States (excluding Puerto Rico and

other territories), Mexican Americans are the largest group (63 percent), followed by Central and South Americans (13.4 percent), Puerto Ricans (9.2 percent), and Cubans (3.5 percent).

Beliefs About and Traditions Involving Substance Use

Attitudes toward substance use vary among Latino cultural groups, but Latinos are more likely to see substance use in negative terms than are White Americans. Marin (1998) found that Mexican Americans were significantly more likely to expect negative consequences and less likely to expect positive outcomes as a result of drinking than were White Americans. Similarly, Hadjicostandi and Cheurprakobkit (2002) note that most Latinos believe that prescription drug abuse could have dangerous effects (85.7 percent), that individuals who abuse substances cause their whole families to suffer (81.4 percent), and that people who use illicit drugs will participate in violent crime (74.9 percent) and act violently toward family members (78.9 percent). Driving under the influence of alcohol is one of the most serious substance use problems in the Latino community.

Other research suggests that some Latinos hold different alcohol expectancies. When comparing drinking patterns and alcohol expectancies among college students, Velez-Blasini (1997) found that Puerto Rican participants were more likely than other students to see increased sociability as a positive expectancy related to drinking and sexual impairment as a negative expectancy. Puerto Rican participants were also significantly more likely to report abstinence from alcohol. In another study comparing Puerto Ricans and Irish Americans, Puerto Rican participants who expected a loss of control when drinking had fewer alcohol-related problems, whereas Irish Americans who expected a loss of control had a greater number of such problems (Johnson and Glassman 1999). The authors concluded that "losing control" has a different cultural meaning for these two groups, which in turn affects how they use alcohol.

For many Latino men, drinking alcohol is a part of social occasions and celebrations. By contrast, solitary drinking is discouraged and seen as deviant. Social norms for Latinas are often quite different, and those who have substance abuse problems are judged much more harshly than men. Women can be perceived as promiscuous or delinquent in meeting their family duties because of their substance use (Hernandez 2000). Amaro and Aguiar (1995) note that the heavy emphasis on the idealization of motherhood contributes to the level of denial about the prevalence of substance use among Latinas. Women who use injection drugs feel the need to maintain their roles as daughters, mothers, partners, and community members by separating their drug use from the rest of their lives (Andrade and Estrada 2003), yet research suggests that substance abuse among women does not go unrecognized within the Latino community (Hadjicostandi and Cheurprakobkit 2002).

Among families, Latino adults generally show strong disapproval of alcohol use in adolescents of either gender (Flores-Ortiz 1994). Adults of both genders generally disapprove of the initiation of alcohol use for youth 16 years of age and under (Rodriguez-Andrew 1998). Long (1990) also found that even among Latino families in which there has been multigenerational drug abuse, young people were rarely initiated into drug abuse by family members. However, evidence regarding parental substance use and its influence on youth has been mixed; most studies show some correlation between parental attitudes toward alcohol use and youth drinking (Rodriguez-Andrew 1998). For instance, research with college students found that family influences

had a significant effect on drinking in Latinos but not White Americans; the magnitude of this effect was greater for Latinas than for Latino men (Corbin et al. 2008).

Substance Use and Substance Use Disorders

According to 2012 NSDUH data, rates of past-month illicit substance use, heavy drinking, and binge drinking among Latinos were lower than for White Americans, Blacks, and Native Americans, but not significantly so (SAMHSA 2013*d*). The same data showed that 8.3 percent of Latinos reported past-month illicit drug use compared with 9.2 percent of White Americans and 11.3 percent of African Americans.

Although data are available from a number of studies regarding Latino drinking and drug use patterns, more targeted research efforts are needed to unravel the complexities of substance use and the many factors that affect use, abuse, and dependence among subgroups of Latino origin (Rodriguez-Andrew 1998). For example, some studies show that Latino men are more likely to have an alcohol use disorder than are White American men (Caetano 2003), whereas others have found the reverse to be true (Schmidt et al. 2007). Disparities in survey results may reflect varying efforts to develop culturally responsive criteria (Carle 2009; Hasin et al. 2007). The table in Exhibit 5-2 shows lifetime prevalence of substance use disorders among Latinos based on

Exhibit 5-2: Lifetime Prevalence of Substance Use Disorders According to Ethnic Subgroup and Immigration Status

Ethnic Subgroup	Any Substance Use Disorder, %	Alcohol Abuse, %	Alcohol Dependence, %	Drug Abuse, %	Drug Dependence, %
Puerto Ricans (born in the U.S. mainland)	15.9	7.7	5.6	4.6	4.3
Puerto Ricans (born in Puerto Rico)	11.1	4.6	5.3	4.3	3.6
Cuban Americans (born in the U.S.)	20.9	6.5	8.2	3.6	5.7
Cuban Americans (foreign-born)	6.4	3.4	2.2	2.2	1.9
Mexican Americans (born in the U.S.)	21.4	9.4	7.7	5.8	5.3
Mexican Americans (foreign-born)	7	3.5	2.8	2.0	1.7
Other Latino (born in the U.S.)	20.4	10.4	5.3	8.4	5.2
Other Latino (foreign-born)	5.7	3.2	2.2	2.1	1.0

Source: Alegria et al. 2008a.

immigration status and ethnic subgroup (Alegria et al. 2008*a*).

Among diverse Latino cultural groups, different patterns of alcohol use exist. For example, some older research suggests that Mexican American men are more likely to engage in binge drinking (having five or more drinks at one time; drinking less frequently, but in higher quantities) than other Latinos but use alcohol less frequently (Caetano and Clark 1998). There are also differences regarding the abuse of other substances. Among Latinos entering substance abuse treatment in 2006, heroin and methamphetamine use were especially high among Puerto Ricans and Mexican Americans, respectively. Other research has found that Puerto Ricans are more likely to inject drugs and tend to inject more often during the course of a day than do other Latinos (Singer 1999).

Patterns of substance use are also linked to gender, age, socioeconomic status, and acculturation in complex ways (Castro et al. 1999*a*; Wahl and Eitle 2010). For instance, increased frequency of drinking is associated with greater acculturation for Latino men and women, yet the drinking patterns of Latinas are affected significantly more than those of Latino men (Markides et al. 2012; Zemore 2005).

Age appears to influence Latino drinking patterns somewhat differently than it does for other racial/ethnic groups. Research indicates that White Americans often "age out" of heavy drinking after frequent and heavy alcohol use in their 20s, but for many Latinos, drinking peaks between the ages 30 and 39. Latinos in this age range have the lowest abstention rates and the highest proportions of frequent and heavy drinkers of any age group (Caetano and Clark 1998). In the same study, Latino men between 40 and 60 years of age had higher rates of substance use disorders than men in the same age group across other racial/ethnic populations.

Latino youth appear to start using illicit drugs at an earlier age than do members of other major ethnic/racial groups. Cumulative data from 28 years of the Monitoring the Future Study show Latino eighth graders as having higher rates of heavy drinking, marijuana use, cocaine use, and heroin use than African or White Americans in the same grade. Among youth in grade 12, the rates of use among Latino and White American students are more similar, but Latinos still had the highest rates of crack cocaine and injected heroin use (Johnston et al. 2003).

Patterns of substance use and abuse vary based on Latinos' specific cultural backgrounds. Among Latinos, rates of past-year alcohol dependence were higher among Puerto Rican and Mexican American men (15.3 percent and 15.1 percent, respectively) than among South/Central American or Cuban American men (9 percent and 5.3 percent, respectively). Among Latinas, past-year alcohol dependence rates were significantly higher for Puerto Rican women (6.4 percent) than for Mexican American (2.1 percent), Cuban American (1.6 percent), or South/Central American (0.8 percent) women (Caetano et al. 2008).

Mental and Co-Occurring Disorders

As with other populations, it is important to address CODs in Latino clients, as CODs have been associated with higher rates of treatment dropout (Amodeo et al. 2008). There are also reports of diagnostic bias, suggesting that some disorders are underreported and others are overreported. Minsky et al. (2003) found that, at one large mental health treatment site in New Jersey, major depression was overdiagnosed among Latinos, especially Latinas, whereas psychotic symptoms were

sometimes ignored. Among Latinos with CODs, other mental disorders preceded the development of a substance use disorder 70 percent of the time (Vega et al. 2009).

Overall, research indicates fewer mental disorders and CODs among Latinos than among White Americans (Alegria et al. 2008*a*; Vega et al. 2009). However, data from the 2012 NSDUH indicate that the magnitude of the difference may be decreasing; 1.2 percent of Latinos had both serious mental illness and substance use disorders in the prior year, as did White Americans, similar to the rate seen among African Americans (0.9 percent; SAMHSA 2013*c*). When any mental disorder symptoms co-occurring with a substance use disorder diagnosis were evaluated, Latinos had a slightly higher rate of co-occurrence (3.4 percent) than did African Americans (3.3 percent; SAMHSA 2013*c*). Rates of mental disorders and CODs also vary by Latino subgroup (Alegria et al. 2008*a*), and acculturation can play a confounding, but inconsistent, role in the identification and development of CODs in Latino populations (Alegria et al. 2008*a*; Vega et al. 2009).

Treatment Patterns

Barriers to treatment entry for Latinos include, but are not limited to, lack of Spanish-speaking service providers, limited English proficiency, financial constraints, lack of culturally responsive services, fears about immigration status and losing custody of children while in treatment, negative attitudes toward providers, and discrimination (Alegria et al. 2012; Mora 2002). Among all ethnic/racial groups included in the 2010 NSDUH, Latinos were the most likely to report that they had a need for treatment but did not receive it because they could not find a program with the appropriate type of treatment or because there were no openings in programs that they wished to attend, which may reflect a lack of linguistically and/or culturally appropriate services (SAMHSA 2011*c*). They were about twice as likely to state the former and four times as likely to state the latter as members of the group that was the next most likely to make such statements.

A significant problem prohibiting participation in substance abuse treatment among Latinos is the lack of insurance coverage to pay for treatment. In SAMHSA's 2010 NSDUH, 32 percent of Latinos who needed but did not receive substance abuse treatment in the past year reported that they lacked money or insurance coverage to pay for it compared with 29.5 percent of White Americans and 33.5 percent of African Americans (SAMHSA 2011*c*). Other national surveys also found that Latinos with self-identified drinking problems were significantly more likely than either White Americans or African Americans to indicate that they did not seek treatment because of logistical barriers, such as a lack of funds or being unable to obtain childcare (Schmidt et al. 2007).

Latinos with substance use disorders are about as likely to enter substance abuse treatment programs as White Americans (Hser et al. 1998; Perron et al. 2009; Schmidt et al. 2006). Latinos tend to enter treatment at a younger age than either African Americans or White Americans (Marsh et al. 2009). There are also significant differences in treatment-seeking patterns among Latino cultural groups. For example, Puerto Ricans who inject heroin are much more likely to participate in methadone main-tenance and less likely to enter other less-effective detoxification programs than are Dominicans, Central Americans, and other Latinos (Reynoso-Vallejo et al. 2008). The researchers note, however, that this could be due partially to the fact that Puerto Ricans, compared with other Latinos, have a greater awareness of treatment options.

Beliefs and Attitudes About Treatment

In general, Latino attitudes toward health care are shaped by a lack of access to regular quality care, including inability to afford it (see review of health beliefs and help-seeking behaviors among Mexican Americans and Mexicans dwelling in the United States in Rogers 2010). DeNavas-Walt et al. (2006) found that Latinos are less likely to have health insurance (32.7 percent were uninsured in 2005) than either non-Latino White Americans (11.3 percent were uninsured) or African Americans (19.6 percent were uninsured). They are also less likely to have had a regular place to go for conventional medical care (Schiller et al. 2005). Lack of knowledge about available services can be a major obstacle to seeking services (Vega et al. 2001). In their review, Murguia et al. (2000) identified several factors that influence the use of medical services, including cultural health beliefs, demographic barriers, level of acculturation, English proficiency, accessibility of service providers, and flexibility of intake procedures; they found that many Latinos only seek medical care for serious illnesses.

Research on substance abuse indicates that Latinos who use illicit drugs appear to have relatively unfavorable attitudes toward treatment and perceive less need for treatment than do illicit drug users among every other major ethnic and racial group but Native Americans (Brower and Carey 2003). However, in the 2011 NSDUH, Latinos were more likely than White Americans, African Americans, or Asian Americans to indicate that they had a need for substance abuse treatment in the prior year but did not receive it (SAMHSA 2012*b*). Other studies have found that Latinos with substance use disorders are about as likely to enter substance abuse treatment programs as other racial and ethnic groups (Hser et al. 1998; Perron et al. 2009; Schmidt et al. 2006). Latinos who receive substance abuse treatment also report less satisfaction with the services they receive than White or African Americans (Wells et al. 2001). Even when receiving a level of substance abuse treatment services comparable to those received by White and African Americans, Latinos are more likely to be dissatisfied with treatment (Tonigan 2003).

Treatment Issues and Considerations

Latino clients' responsiveness to therapy is influenced not only by counselor and program characteristics, but also by individual characteristics, including worldview, degree of acculturation, gender orientation, religious beliefs, and personality traits. As with other cultural groups, efforts to establish clear communication and a strong therapeutic alliance are essential to positive treatment outcomes among Latino clients. Foremost, counselors should recognize the importance of—and integrate into their counseling style and approach—expressions of concern, interest in clients' families, and personal warmth (*personalismo*; Ishikawa et al. 2010).

Counselors and clinical supervisors need to be educated about culturally specific attributes that can influence participation and clinical interpretation of client behavior in treatment. For instance, some Latino cultural groups view time as more flexible and less structured; thus, rather than negatively interpreting the client's behavior regarding the keeping of strict schedules or appointment times, counselors should adopt scheduling strategies that provide more flexibility (Alvarez and Ruiz 2001; Sue 2001). However, counselors should also advise Latino clients of the need to take relevant actions with the aim of arriving on time for each appointment or group session. Counselors should try to avoid framing noncompliance in Latino clients as resistance or anger. It

is often, instead, a *pelea nonga* (relaxed fight) showing both a sense of being misunderstood and *respeto* (respect that also encompasses a sense of duty) for the counselor's authority (Barón 2000; Medina 2001).

Unfortunately, many providers who work with Latino cultural groups continue to have misperceptions and can even see culture as a hindrance to effective treatment rather than as a source of potential strength (Quintero et al. 2007). For instance, in treating the alcohol problems of Latinas, many counselors believe that they should not incorporate endorsement of traditional and possibly harmful cultural patterns into the services they provide (Mora 2002). However, other counselors note that the transformative value of the most positive aspects of Latino cultural groups can be emphasized: strength, perseverance, flexibility, and an ability to survive (Gloria and Peregoy 1996). Respecting women's choices can mean supporting empowerment to pursue new roles and make new choices free of alcohol, guilt, and discrimination (Mora 2002). For others, it can mean reinvigorating the positivity of Latina culture to promote abstinence while respecting and maintaining traditional family roles for women (Gloria and Peregoy 1996).

Because some research has found that Latinos have higher rates of treatment dropout than other populations (Amaro et al. 2006), programs working with this population should consider ways to improve retention and outcomes. Treatment retention issues for Latinos can be similar to those found for other populations (Amodeo et al. 2008), but culturally specific treatment has been associated with better retention for Latinos (Hohman and Galt 2001). Research evaluating ethnic matching with brief motivational interventions also found more favorable substance abuse treatment outcomes at 12-month follow-up when clients and providers were ethnically matched (Field and Caetano 2010). Available literature and research highlight four main themes surrounding general counseling issues and programmatic strategies for Latinos, as follows.

Socializing the client to treatment: Latino clients are likely to benefit from orientation sessions that review treatment and counseling processes, treatment goals and expectations, and other components of services (Organista 2006).

Reassurance of confidentiality: Regardless of the particular mode of therapy, counselors should explain confidentiality. Many Latinos, especially undocumented workers or recent immigrants, are fearful of being discovered by authorities like the United States Citizenship and Immigration Services and subsequently deported back to their countries of origin (Ramos-Sanchez 2009).

Client–counselor matching based on gender: To date, research does not provide consistent findings on client–counselor matching based on similarity of Latino ethnicity. However, client–counselor matching based on gender alone appears to have a greater effect on improving engagement and abstinence among Latinos than it does for clients of other ethnicities (Fiorentine and Hillhouse 1999).

Client–program matching: Matching clients to ethnicity-specific programs appears to improve outcomes for Latinos. Takeuchi et al. (1995) found that only 68 percent of Mexican American clients in programs that had a majority of White American clients returned after the first session compared with 97 percent in those programs where the majority of clients were Mexican American.

Theoretical Approaches and Treatment Interventions

Overall, research evaluating cultural adoption of promising or evidence-based practices in

treatment specifically for Latinos is scarce (Carvajal and Young 2009). For instance, empirical literature evaluating CBT specifically for substance abuse and substance use disorders in Latinos is quite limited. Still, a number of authors recommend CBT for Latinos in mental health and substance abuse treatment settings because it is action oriented, problem focused, and didactic (Alvarez and Ruiz 2001; Organista 2006; Organista and Muñoz 1998). CBT's didactic component can educate Latinos about disorders and frame therapy as an educational (and hence less shameful) experience. However, Organista's (2006) review of available research on CBT for mental disorders among Latinos suggests that this approach is not always as effective with Latinos as it is with other populations.

Other effective interventions include contingency management and motivational interviewing; see the review by Amaro et al. (2006) for more on these interventions. Methadone maintenance, too, has been associated with long-term reductions in the use of alcohol as well as heroin and other illicit drugs among Mexican Americans with opioid use disorders, although 33 percent of the original cohort died before the 22-year longitudinal study concluded (Goldstein and Herrera 1995). Another therapeutic intervention that can improve outcomes for Latino clients is node-link mapping (visual representation using information diagrams, fill-in-the blank graphic tools, and client-generated diagrams or visual maps), which has been associated with lower levels of opioid and cocaine use, better treatment attendance, and higher counselor ratings of motivation and confidence for Latinos in methadone maintenance treatment (Dansereau et al. 1996; Dansereau and Simpson 2009). For a review of Latino outcome studies in health, substance abuse, and mental health in social work, refer to Jani and colleagues (2009).

Family therapy

Family therapy is often recommended for treating Latinos with substance use disorders (Amaro et al. 2006; Barón 2000; Hernandez 2000). Although there is little research evaluating the effectiveness of family therapy for adults, both multidimensional family therapy (Liddle 2010) and brief strategic family therapy (Santisteban et al. 1997; Santisteban et al. 2003; Szapocznik and Williams 2000) have been found to reduce substance use and improve psychological functioning among Latino youth. The term *familismo* refers to the centrality of the family in Latino culture and can include valuing and protecting children, respecting the elderly, preserving the family name, and consulting with one another before making important decisions. As highlighted in the case study of a Puerto Rican client on the next page, counselors must consider the potentially pivotal roles families can play in supporting treatment and recovery. Latino families are likely to have a strong sense of obligation and commitment to helping their members, including those who have substance use disorders. Even so, the level of family support for people who have substance use or mental disorders varies among Latinos depending on country of origin, level of acculturation, degree of family cohesion, socioeconomic status, and factors related to substance use (Alegria et al. 2012). For example, Reynoso-Vallejo et al. (2008) concluded that significantly higher rates of homelessness found among people from Central American countries who injected heroin compared with other Latinos could stem from lower levels of tolerance for injection drug use among their families.

For counselors who lack cultural understanding, it can be easy to simply label and judge families' behavior as enabling or codependent. Instead, counselors should move away from labeling the behavior and focus more on helping families recognize how their behavior can

Case Study: A Puerto Rican Client

Anna is a 27-year-old woman who was born in New York and self-identifies as Puerto Rican. She has a 12th-grade education, is unemployed, and lives with her parents, her 4-year-old daughter, and a nephew. Anna is separated from her partner, who is also her daughter's father. She entered treatment as a result of feeling depressed ever since her partner physically assaulted her because she refused to use heroin (the event that sparked their separation). She states, "I want to be clean and take care of my family." At intake, she had just undergone detoxification and had stopped using alcohol, crack cocaine, and heroin.

Anna states that she feels guilty about her drug use and the way it caused her to neglect her family. She has been having serious problems with her mother, who is critical of her substance use, but believes that her mother is important in her recovery because of the structure she provides at home. She describes her father as a very important figure with whom she enjoys spending time. Her father had stopped drinking 9 years before and is very supportive of her abstinence. He is willing to help in any way he can but has been very sick lately and was diagnosed with prostate cancer. Her father had never received treatment for his drinking problem, and her mother believes that Anna should be able to stop just like her father did. As she describes her situation in treatment, Anna's *vergüenza* (shame) and sense of hopelessness is very evident. She fears her father's death and her mother's subsequent rejection of her for not helping out.

Anna's treatment includes family therapy to restructure communication patterns, rules, expectations, and roles. For family sessions, either her mother or both parents participate, depending on her father's physical condition. Initially, her parents displayed a tendency to focus on the problems of the past, but the counselor directed them to focus on changes needed to help Anna's recovery. The counselor has also worked with other family members to rally support and use their strengths while also clarifying perceptions, feelings, and behaviors that will help them function as a family unit. Anna's counselor recognizes that, within the context of her culture, her reliance on her family can be used to aid her recovery and that her family, as defined by Anna, can be used as a support system.

Source: Medina 2001. Adapted with permission.

affect one member's substance abuse and how best to handle it. The advice box on the next page provides general therapeutic guidelines for working with Latino families.

Group therapy

Little information is available concerning Latinos' preferences in behavioral health services, but a study evaluating mental health treatment preferences for women in the United States found that Latinas were significantly more likely to prefer group treatment (Nadeem et al. 2008). According to Paniagua (1998), the use of group therapy with Latino clients should emphasize a problem-focused approach. Group leaders should allow members to learn from each other and resist functioning as a content expert or a representative of the rules of the system. Otherwise, members could see group therapy as oppressive. Facilitators in groups consisting mostly of Latino clients must establish trust, responsibility, and loyalty among members. In addition, acculturation levels and language preferences should be assessed when forming groups so that culturally specific or Spanish-speaking groups can be made available if needed.

Mutual-help groups

Findings on the usefulness of 12-Step groups for Latino clients are inconsistent. Membership surveys of AA indicate that Latinos comprise about 5 percent of AA membership (AAWS 2012). Latinos who received inpatient treatment were less likely to attend AA than White Americans (Arroyo et al. 1998). Rates

Advice to Counselors: Family Therapy Guidelines for Latino Families

- Provide bilingual services.
- Use family therapy as a primary method of treatment.
- Assess cultural identity and acculturation level for each family member.
- Determine the family's level of belief in traditional and complementary healing practices; integrate these as appropriate.
- Discuss the family's beliefs, history, and experiences with standard American behavioral health services.
- Explore migration and immigration experiences, if appropriate.
- Provide additional respect to the father or father figure in the family.
- Interview family members or groups of family members (e.g., children) separately to allow them to voice concerns.
- Generate solutions with the family. Do not force changes in family relationships.
- Provide specific, concrete suggestions for change that can be quickly implemented.
- Focus on engaging the family in the first session using warmth and *personalismo*.

Sources: Bean et al. 2001; Hernandez 2005; Lynch and Hanson 2011.

of mutual-help participation among people with drug use disorders are also lower for Latinos (Perron et al. 2009). Language can present a barrier to mutual-help group participation for Spanish-speaking Latinos; however, Spanish-language meetings are held in some locations. Counselors should consider the appropriateness of 12-Step participation on a case-by-case basis (Alvarez and Ruiz 2001). For example, Mexican American men who identify with attitudes of *machismo* can feel uncomfortable with the 12-Step approach. Concern about divulging family issues in public can cause hesitation to address substance-related problems in public meetings.

For Latinos who do participate in 12-Step programs, findings suggest higher rates of abstinence, degree of commitment, and level of engagement than for White American participants (Hoffman 1994; Tonigan et al. 1998). For some Latinos, 12-Step groups can appeal to religious and spiritual beliefs. Hernandez (2000) suggests that mutual-help groups composed solely of Latinos make it easier for participants to address the cultural context of substance abuse. Some Latino 12-Step groups do not hold that substance abuse is a biopsychosocial problem, instead conceptualizing the disorder as a weakness of character that must be corrected. Hoffman (1994) studied Latino 12-Step groups in Los Angeles and observed that, in addition to a more traditional form of AA, there were groups that practiced *terapia dura* (i.e., rough therapy), which often uses a confrontational approach and endorses family values related to *machismo* (e.g., by reinforcing that overcoming substance abuse rather than drinking is manly). However, these groups were not overly welcoming of female members and gay men. In such cases, gay Latino men and Latinas can benefit from attending 12-Step groups that are not culturally specific or that do not use *terapia dura*.

Traditional healing and complementary methods

In a study of the use of alternative and complementary medical therapies, Latinos were less likely to use medical alternatives than were White Americans (Graham et al. 2005). However, those who did use such approaches were more likely to do so because they could not afford standard medical care (Alegria et al. 2012). As in other areas, the use of complementary and traditional medicine likely varies according to acculturation level and country of origin. For instance, the use of faith and religious practices to cope with mental and emotional problems is significantly more common among foreign-born Latinos than among those born in the United States (Nadeem et al. 2008; Vega et al. 2001).

Many Latinos place great importance on the practice of Roman Catholicism. Yamamoto and Acosta (1982) describe the central tenets of Latino Catholicism as sacrifice, charity, and forgiveness. These beliefs can hinder assertiveness in some Latinos, but they can also be a source of strength and recovery. Traditionally, Latinos have been Catholic, although several Protestant and evangelical groups have converted millions of Latinos to their religions since the 1970s. Some Latinos also believe in syncretistic religions (e.g., Santería or Curanderismo) or practices derived from them and make use of a variety of traditional healing practices and rituals to heal mental and spiritual ailments (Lefley et al. 1998; Sandoval 1979). Among Puerto Ricans, *espiritismo* (spiritualism) is a popular traditional healing system successfully used to address mental health issues (Lynch and Hanson 2011; Molina 2001). Some Mexican Americans rely on *curanderos*, folk healers who address problems that might be framed as psychological (Falicov 2005, 2012). For a review of culturally responsive interventions with Latinos, refer to Gallardo and Curry (2009).

Relapse prevention and recovery

There are no substantial studies evaluating the use of relapse prevention and recovery promotion with Latinos, yet literature suggests that they would be appropriate and effective for this population (Blume et al. 2005; Castro et al. 2007). Overall, Latinos can face somewhat different triggers for relapse relating to acculturative stress or the need to uphold particular cultural values (e.g., *personalismo, machismo*; Castro et al. 2007), which can lead to higher rates of relapse among some Latino clients. For example, in a study of relapse patterns among White American and Latino individuals who used methamphetamine, Brecht et al. (2000) found that Latino participants relapsed more quickly than White American participants.

Data are lacking on long-term recovery for Latinos. Given the many obstacles that block accessibility to treatment for Latinos, continuing care planning can benefit from greater use of informal or peer supports. For example, White and Sanders (2004) recommend the use of a recovery management approach with Latinos. They point to an early example of the East Harlem Protestant Parish's work, which helped Puerto Rican individuals recovering from heroin dependence connect to social clubs and religious communities that supported recovery. Latinos use community and family support in addition to spirituality to address mental disorders (Lynch and Hanson 2011; Molina 2001). Castro et al. (2007) also note that family support systems can be especially important for Latinos in recovery.

Counseling for Native Americans

There are 566 federally recognized American Indian Tribes, and their members speak more than 150 languages (U.S. Department of the Interior, Indian Affairs 2013*a*); there are numerous other Tribes recognized only by states and others that still go unrecognized by government agencies of any sort. According to the 2010 U.S. Census (Norris et al. 2012), the majority (78 percent) of people who identified as American Indian or Alaska Native, either alone or in combination with one or more other races, lived outside of American Indian and Alaska Native areas. Approximately 60 percent of the 5.2 million people who identified as American Indian or Alaska Native, alone or in combination with one or more other races, reside in urban areas (Norris et al. 2012). The category of Alaska Natives includes four recognized Tribal groups—Alaskan Athabascan, Aleut, Eskimo, and Tingit-Haida—along with many other independent communities (Ogunwole 2006).

Native Americans who belong to federally recognized Tribes and communities are members of sovereign Indian nations that exist within the United States. On lands belonging to these Tribes and communities, Native Americans are able to govern themselves to a large extent and are not subject to most state laws—only to federal legislation that is specifically designated as applying to them (Henson 2008). Although health care (including substance abuse treatment) is provided to many Native Americans by Indian Health Services (IHS), Tribal governments do have the option of taking over those services. Counselors working with these populations should remember that Native Americans, by virtue of their membership in sovereign Tribal entities, have rights that are different from those of other Americans; this distinguishes them from members of other ethnic/racial groups.

American Indians live in all 50 states; the states with the largest populations of American Indians are Oklahoma, California, and Arizona. The 2000 Census allowed people to identify, for the first time, as a member of more than one race. Of persons who checked two or more races, nearly one in five indicated that they were part American Indian or Alaska Native (U.S. Census Bureau 2001*a*,*b*).

Behavioral health service providers should recognize that Native American Tribes represent a wide variety of cultural groups that differ from one another in many ways (Duran et al. 2007). Alaska Natives who live in coastal areas have very different customs from those inhabiting interior areas (Attneave 1982). The diversity of Native American Tribes notwithstanding, they also share a common bond of respect for their cultural heritages, histories, and spiritual beliefs, which are different from those of mainstream American culture. For more information on the treatment and prevention of substance abuse and mental illness among Native Americans, see the planned TIP, *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA planned *a*).

Beliefs About and Traditions Involving Substance Use

Few American Indian Tribes and no Alaska Natives consumed alcoholic beverages prior to contact with non-Native people, and those who did used alcohol primarily for special occasions and ceremonies. Most Tribes first encountered the use of alcohol when they encountered European settlers and traders. Because of this lack of experience with alcohol, few Native Americans had a context for drinking besides what they learned from these non-Natives, who at the time drank in large quantities and often engaged in binge drinking. Although patterns of alcohol consumption in the mainstream population of the United States changed over time, they remained relatively the same in the more isolated Native American communities. According to an NSDUH report on American Indian and Alaska Native adults, binge drinking continues to be a significant problem for these populations. Both binge drinking and illicit drug use is higher among Native Americans than the national average (30.2 percent versus 23 percent and 12.7 percent versus 9.2 percent, respectively; SAMHSA 2013*d*).

American Indian drinking patterns vary a great deal by Tribe. Tribal attitudes toward alcohol influence consumption in complicated ways. For example, in Navajo communities, excessive drinking was acceptable if done in a group or during a social activity. However, solitary drinking (even in lesser amounts) was considered to be deviant (Kunitz et al. 1994). Kunitz et al. (1994) observed that during the 1960s, binge drinking was acceptable among the Navajo during public celebrations, whereas any drinking was considered unacceptable among the neighboring Hopi population,

wherein regular drinkers were shunned or, in some cases, expelled from the community. Hopi individuals who did drink tended to do so alone or moved off the reservation to border towns where heavy alcohol use was common. The ostracism of Hopi drinkers seemed to lead to even greater levels of abuse, given that there were much higher death rates from alcoholic cirrhosis among the Hopi than among the Navajo.

Native American recovery movements have often viewed substance abuse as a result of cultural conflict between Native and Western cultures, seeing substances of abuse as weapons that have caused further loss of traditions (Coyhis and White 2006). To best treat this population, substance abuse treatment providers need to expand their perspectives regarding substance abuse and dependence and must embrace a broader view that explores the spiritual, cultural, and social ramifications of substance abuse (Brady 1995; Duran 2006; Jilek 1994).

Substance Use and Substance Use Disorders

According to 2012 NSDUH data, American Indian and Alaska Native peoples have the highest rates of substance use disorders and binge drinking (SAMHSA 2013*d*). Although rates of substance abuse are high among Native Americans, so too are rates of abstinence. American Indians and Alaska Natives are more likely to report no alcohol use in the past year than are members of all other major racial and ethnic groups (OAS 2007). The American Indian Services Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (AI-SUPER PFP) also found that rates of lifetime abstinence from alcohol for American Indians in the study were significantly higher than lifetime abstinence rates among the general population (Beals et al. 2003). Data on alcohol consumption also show that Alaska Natives are significantly more likely to abstain than are other Alaskans (Wells 2004).

The most common pattern of abusive drinking among American Indians appears to be binge drinking followed by long periods of abstinence (French 2000; May and Gossage 2001). A similar pattern is seen among Alaska Natives (Seale et al. 2006; Wells 2004). As an example, the Urban Indian Health Institute (2008) found that binge drinking was significantly more common among the Native American population (with 21.3 percent engaging in binge drinking in the prior 30 days compared with 15.8 percent of non-Native Americans) and that, among those who drank, 40.7 percent of Native American participants engaged in binge drinking compared with 26.9 percent of non-Natives.

There are a number of historical reasons for the development of binge drinking among Native Americans. The existence of dry reservations (which can limit the times when individuals are able to get alcohol), high levels of poverty, lack of availability (e.g., in remote Alaska Native villages), a history of trauma, and the loss of cultural traditions can all contribute to the development and continuation of this pattern of drinking. Native Americans are also more likely than members of other major racial/ethnic groups to have had their first drink before the age of 21 or before the age of 16, which also may shape drinking patterns (SAMHSA 2011*c*).

However, data on heavy and binge drinking do not reflect the same pattern of alcohol consumption for all Native American Tribes. One analysis of alcohol dependence among members of seven different Tribes found rates of dependence varying from 56 percent of men and 30 percent of women in one Tribe to 1 percent of men and 2 percent of women in another (Koss et al. 2003). Other research

confirms significant differences in alcohol use among diverse Native American communities (O'Connell et al. 2005; Whitesell et al. 2006).

In addition to alcohol, methamphetamine and inhalant abuse are major concerns for a number of Native American communities. Nonetheless, there are considerable regional differences in patterns and prevalence of drug use (Miller et al. 2012). According to the National Congress of American Indians (2006), 74 percent of Tribal police forces ranked methamphetamine as the drug causing the most problems in their communities. Methamphetamine abuse can be even more serious for Native Americans living in rural areas than for those in urban areas, but it is also a serious problem for growing numbers of American Indians, especially women, entering treatment in urban areas (Spear et al. 2007).

American Indians and Alaska Natives are more likely to report having used inhalants at some time during their lives, but use tends to peak in 8th grade and then decrease (Miller et al. 2012). In some Native American communities (e.g., on the Kickapoo reservation in Texas), inhalants have been a major drug of abuse for adults as well as youth. During the early 1990s, about 46 percent of the adult population on that reservation were thought to abuse inhalants (Fredlund 1994). Although more recent data are not available, reports from the area suggest that inhalant abuse remains a significant problem (Morning Star 2005).

Rates of substance use disorders appear to be higher in individuals who consider themselves exclusively Native American than for those who identify as more than one race/ethnicity, but even when surveys ask whether people are of mixed race, those who report themselves to be partially Native American still have high rates of substance use disorders (OAS 2007). Native Americans are about 1.4 times more likely than White Americans to have a lifetime diagnosis of an alcohol use disorder (Gilman et al. 2008). Illicit drug use is also more common for Native Americans than for members of other major racial/ethnic groups.

Among Native Americans entering treatment in 2010, alcohol use disorders alone or in conjunction with drug use disorders were the most pressing substance-related problem, with cannabis and opioids other than heroin being the next most common primary substances of abuse. One of the largest studies on American Indian substance use and abuse to date, the AI-SUPER PFP, found that 31.2 percent of American Indians met criteria for a lifetime diagnosis of a substance use disorder, and 13.4 percent met criteria for a past-year diagnosis (Beals et al. 2003). The study found that rates of alcohol use disorders were high among men from the three Tribes represented but varied to a greater degree among women across Tribes (Mitchell et al. 2003).

American Indians have high rates of certain diseases and conditions. In particular, the incidence of diabetes is increasing among Native Americans, and approximately 38 percent of elder Native Americans have diabetes (Moulton et al 2005). Diabetes is also associated with both substance use disorders and depression in this population (Tann et al. 2007). Other health problems associated with alcohol use include fetal alcohol syndrome, cirrhosis, and depression.

Mental and Co-Occurring Disorders

According to the 2012 NSDUH, 28.3 percent of American Indians and Alaska Natives report having a mental illness, with approximately 8.5 percent indicating serious mental illness in the past year (SAMHSA 2013*c*). Native Americans were nearly twice as likely to have serious thoughts of suicide as members of other racial/ethnic populations, and more

than 10 percent reported a major depressive episode in the past year. Common disorders include depression, anxiety, and substance use.

As with other groups, substance use disorders among Native Americans have been associated with increased rates of a variety of different mental disorders (Beals et al. 2002; Tann et al. 2007; Westermeyer 2001). The 2012 NSDUH revealed that 14 percent of Native Americans reported both past-year substance use disorders and mental illness. Among those who reported mental illness, nearly 5 percent reported several mental illnesses co-occurring with substance use disorders (SAMHSA 2013*c*).

Native American communities have experienced severe historical trauma and discrimination (Brave Heart and DeBruyn 1998; Burgess et al. 2008). Studies suggest that many Native Americans suffer from elevated exposure to specific traumas (Beals et al. 2005; Ehlers et al. 2006; Manson 1996; Manson et al. 2005), and they may be more likely to develop PTSD as a result of this exposure than members of other ethnic/racial groups. PTSD comparison rates taken from the AI-SUPER PFP study and the National Comorbidity Study show that 12.8 percent of the Southwest Tribe sample and 11.5 percent of the Northern Plains Tribe sample met criteria for a lifetime diagnosis of PTSD compared with 4.3 percent of the general population (Beals et al. 2005). Trauma histories and PTSD are so prevalent among Native Americans in substance abuse treatment that Edwards (2003) recommends that assessment and treatment of trauma should be a standard procedure for behavioral health programs serving this population. For example, Native American veterans with substance use disorders are significantly more likely to have co-occurring PTSD than the general population of veterans with substance use disorders (Friedman et al. 1997).

Treatment Patterns

Despite a number of potential barriers to treatment (Venner et al. 2012), Native Americans are about as likely as members of other racial/ethnic groups to enter behavioral health programs. According to data from the 2003 and 2011 NSDUH (SAMHSA, CBHSQ 2012), Native Americans were more likely to have received substance use treatment in the past year than persons from other racial/ethnic groups (15.0 percent versus 10.2 percent). Other studies indicate that about one-third of Native Americans with a current substance use disorder had received treatment in the prior year (Beals et al. 2006; Herman-Stahl and Chong 2002). The 2012 NSDUH reported that approximately 15 percent of Native Americans received mental health treatment (SAMHSA 2013*c*).

Native Americans were least likely of all major ethnic/racial groups to state that they could not find the type of program they needed and were the next least likely after Native Hawaiians and other Pacific Islanders to state that they did not know where to go or that their insurance did not cover needed treatment. Among Native Americans who identified a need for treatment in the prior year but did not enter treatment, the most commonly cited reasons for not attending were lack of transportation, lack of time, and concerns about what one's neighbors might think (SAMHSA 2011*c*).

Many Native Americans, especially those residing on reservations or other Tribal lands, seek mental health and substance abuse treatment through Tribal service providers or IHS (Jones-Saumty 2002; McFarland et al. 2006). However, an analysis using multiple sources found that 67 percent of Native Americans entering substance abuse treatment over the course of a year did so in urban areas, and the majority of those urban-based programs were not operated by IHS (McFarland et al. 2006).

The same research also found that Native Americans were somewhat more likely than the general treatment-seeking population to enter residential programs.

Native Americans were more likely to enter treatment as a result of criminal justice referrals than were White Americans or African Americans: 47.9 percent of American Indians and Alaska Natives entering public treatment programs in 2010 were court-ordered to treatment compared with 36.6 percent of White Americans and 36.4 percent of African Americans (SAMHSA, CBHSQ 2012). The lack of recognition of special needs and knowledge of Native American cultures within behavioral health programs may be the main reasons for low treatment retention and underuse of help-seeking behaviors among Native Americans (LaFromboise 1993; Sue and Sue 2013*e*).

Beliefs and Attitudes About Treatment

Duran et al. (2005) evaluated obstacles to treatment entry among American Indians on three different reservations; most frequently mentioned were the perception that good-quality or suitable services were unavailable and the perceived need for individuals to be self-reliant. They also found social relationships to be extremely important in overcoming these barriers. Jumper-Thurman and Plested (1998) reported that focus groups of American Indian women listed mistrust as one of the primary barriers for seeking treatment. This is due, in part, to the women's belief that they would encounter people they knew among treatment agency staff; they also doubted the confidentiality of the treatment program.

Treatment Issues and Considerations

Each Tribe and community will likely have different customs, healing traditions, and beliefs about treatment providers that can influence not only willingness to participate in treatment services, but also the level of trust clients have for providers. Counselors and other behavioral health workers must develop ongoing relationships within local Native American communities to gain knowledge of the unique attributes of each community, to show investment in the community, and to learn about community resources (Exhibit 5-3). Identifying and developing resources within Native communities can help promote culturally congruent relationships.

Exhibit 5-3: Native Americans and Community

Many Native Americans believe that recovery cannot happen for individuals alone and that their entire community has become sick. Coyhis calls this the "healing forest" model: one cannot take a sick tree from a sick forest, heal it, and put it back in the same environment expecting that it will thrive. Instead, the community must embrace recovery.

Today, community development models are being implemented in American Indian and Alaska Native communities to address prevention and treatment issues for mental and substance use disorders as well as related issues, such as suicide prevention (Edwards and Egbert-Edwards 1998; HHS 2010; May et al. 2005). Using these models, communities move toward greater commitment to social problem-solving and the development of effective, culturally congruent strategies relevant to their Tribes or villages. According to Edwards et al. (1995), community approaches often lead to:

- A reduction of substance use.
- Breaking intergenerational cycles of alcohol abuse.
- Increased community support.
- The strengthening of individual and group cultural identity.
- Leadership development.
- Increased interpersonal and inter-Tribal problem-solving skills and solidarity.

For an example, see Jumper-Thurman et al. (2001).

To provide culturally responsive treatment, providers need to understand the Native American client's Tribe; its history, traditions, worldview, and beliefs; the dimensions of its substance abuse problem and other community problems; the incidence of trauma and abuse among its members; its traditional healing practices; and its intrinsic strengths. Providers who work with Native Americans but do not have an understanding of their cultural identity and acculturation patterns are at a distinct disadvantage (Ponterotto et al. 2000). Before beginning any treatment, providers should routinely seek consultation with knowledgeable professionals who are experienced in working with the specific Tribal group in question (Duran 2006; Edwards and Egbert-Edwards 1998; Straits et al. 2012) and should conduct thorough client assessments that evaluate cultural identity (see Appendix F and Chapter 2 for resources). Some Native American persons have a strong connection to their cultures and others do not; some identify with a blend of American Indian cultural groups called pan-Indianism or inter-Tribal identity. Still others are comfortable with a dual identity that embraces both Native and non-Native cultural groups.

Native Americans often approach the beginning of a relationship in a calm, unhurried manner, and they may need more time to develop trust with providers. Concerns about confidentiality can be an important issue to address with Native American clients, especially for those in small, tightly-knit communities. For providers, it is very important to make clear to clients that what they say to the counselor will be held in confidence, except when there is an ethical duty to report.

Native American cultural groups generally believe that health is nurtured through balance and living in harmony with nature and the community (Duran 2006; Garrett et al. 2012). They also, for the most part, have a holistic view of health that incorporates physical, emotional, and spiritual elements (Calabrese 2008), individual and community healing (Duran 2006; McDonald and Gonzalez 2006), and prevention and treatment activities (Johnston 2002). For many, culture is the path to prevention and treatment.

However, not all Native Americans have a need to develop stronger connections to their communities and cultural groups. As Brady (1995) cautions, culture is complex and changing, and a return to the values of a traditional culture is not always desired. An initial inquiry into each client's connection with his or her culture, cultural identity, and desire to incorporate cultural beliefs and practices into treatment is an essential step in culturally competent practice. When appropriate, providers can help facilitate the client's reconnection with his or her community and cultural values as an integral part of the treatment plan. In addition, treatment providers need to adapt services to be culturally responsive. In doing so, outcomes are likely to improve not only for Native American clients, but for all clients within the program. Fisher et al. (1996) modified a therapeutic community in Alaska to incorporate Alaska Native spiritual and cultural practices and found that retention rates improved for White and African American clients as well as Alaska Native clients participating in the program.

In working with Native American clients, providers should be prepared to address spirituality and to help clients access traditional healing practices. Culturally responsive treatment should involve community events, group activities, and the ability to participate in ceremonies to help clients achieve balance and find new insight (Calabrese 2008). Stronger attachment to Native American cultural groups protects against substance use and

abuse; therefore, strengthening this connection is important in substance abuse treatment (Duran 2006; Moss et al. 2003; Spicer 2001; Stone et al. 2006).

Theoretical Approaches and Treatment Interventions

Some clinicians caution that a model of counseling that requires self-disclosure to relative strangers can be counterproductive with Native American clients. Other authors recommend CBT and social learning approaches for Native American clients, as such approaches typically have less cultural bias, focus on problem-solving and skill development, emphasize client strengths and empowerment, recognize the need to accept personal responsibility for change, and make use of learning styles that many Native Americans find culturally appropriate (Heilbron and Guttman 2000; McDonald and Gonzalez 2006). Motivational interviewing is also recommended for Native American clients. In a small study, Villanueva et al. (2007) found that all treatment modalities resulted in improvements at 15-month follow-up, but clients who received motivational enhancement therapy reported significantly fewer drinks per drinking day during the 10- to 15-month posttreatment follow-up period. Venner et al. (2006) wrote a manual for motivational interviewing with Native American clients.

Advice to Counselors: Counseling Native Americans

When working with Native American clients, providers should:

- Use active listening and reflective responses.
- Avoid interrupting the client.
- Refrain from asking about family or personal matters unrelated to substance abuse without first asking the client's permission to inquire about these areas.
- Avoid extensive note-taking or excessive questioning.
- Pay attention to the client's stories, experiences, dreams, and rituals and their relevance to the client.
- Recognize the importance of listening and focus on this skill during sessions.
- Accept extended periods of silence during sessions.
- Allow time during sessions for the client to process information.
- Greet the client with a gentle (rather than firm) handshake and show hospitality (e.g., by offering food and/or beverages).
- Give the client ample time to adjust to the setting at the beginning of each session.
- Keep promises.
- Offer suggestions instead of directions (preferably more than one to allow for client choice).

Sources: Aragon 2006; Trimble et al. 2012.

Family therapy

Family involvement in treatment leads to better outcomes for Native Americans at the time of discharge from treatment (Chong and Lopez 2005). Research also suggests that family and community support can have a significant effect on recovery from substance use disorders for this population (Jones-Saumty 2002; Paniagua 1998). Family therapy can be quite helpful and perhaps even essential for American Indian clients (Coyhis 2000), especially when other social supports are lacking (Jones-Saumty 2002).

American Indians place high value on family and extended family networks; restoring or healing family bonds can be therapeutic for clients with substance use disorders. Moreover, Native American clients are sometimes less motivated to engage in "talk therapy" and more willing to participate in therapeutic activities that involve social and family relationships (Joe and Malach 2011). Treatment approaches should remain flexible and include clients' families when appropriate. Counselors should be able to recognize what constitutes family, family constellations, and

family characteristics. The Native American concept of family can include elders, others from the same clan, or individuals who are not biologically related. In many Tribes, all members are considered relatives. Families can be matrilineal (i.e., kinship is traced through the female line) and/or matrilocal (i.e., married couples live with wife's parents).

When families do enter treatment, they may initially prefer to focus on a concrete problem, but not necessarily on the most significant family issue. Discussion of a clearly defined presenting problem enables families to assess the therapeutic process and better understand what is expected of them in treatment. Providers should be aware that the entire clan and/or Tribe could know about a given client's treatment and progress. Family therapy models such as network therapy, which makes use of support structures outside the immediate family and which were originally developed for Native American families living in urban communities, can be particularly effective with Native clients, especially when they have been cut off from their home communities because of substance abuse or other issues. For more information on network therapy and similar approaches, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*).

Group therapy

Although researchers and providers once viewed group therapy as ineffective for American Indian clients (Paniagua 1998), opinion has shifted to recognize that, when appropriately structured, group therapy can be a powerful treatment component (Garrett 2004; Garrett et al. 2001; Trimble and Jumper-Thurman 2002). Garrett (2004) notes that many Native American Tribes have traditional healing practices that involve groups; for many of these cultural groups, healing needs to occur within the context of the group or community (e.g., in talking circles). Thus, if properly adapted, group therapy can be very beneficial and culturally congruent. It is important, however, to determine Native American clients' level of acculturation before recommending Western models of group therapy, as less acculturated Native clients are likely to be less comfortable with group talk therapy (Mail and Shelton 2002). Group therapy for Alaska Natives should also be nonconfrontational and focus on clients' strengths.

Group therapy can incorporate Native American traditions and rituals to make it more culturally suitable. For example, the talking circle is a Native tradition easily adapted for behavioral health treatment. In this tradition, the members of the group sit in a circle. An eagle feather, stone, or other symbolic item is passed around, and each person speaks when he or she is handed the item. Based on a review of the literature, Paniagua (1998) recommends that providers using group therapy with Native American clients:

- Earn support or permission from Tribal authorities before organizing group therapy.
- Consult with Native professionals.
- If group members consent, invite respected Tribal members (e.g., traditional healers or elders) to participate in sessions.

Mutual-help groups

Native American peoples have a long history of involvement in mutual-help activities that predates the 12-Step movement (Coyhis and White 2006). Depending on acculturation, availability of a community support network, and the nature of their presenting problems, Native American clients may be more likely to solicit help from significant others, extended family members, and community members. Contemporary manifestations of Native American mutual-help efforts include adaptations of the 12 Steps (Exhibit 5-4) and of 12-Step meeting rituals and practices (Coyhis and White 2006). Another modified element of

Exhibit 5-4: The Lakota Version of the 12 Steps

The Lakota Tribe has adapted the 12 Steps to suit its particular belief system as follows:

1. I admit that because of my dependence on alcohol, I have been unable to care for myself and my family.
2. I believe that the Great Spirit can help me to regain my responsibilities and model the life of my forefathers (ancestors).
3. I rely totally on the ability of the Great Spirit to watch over me.
4. I strive every day to get to know myself and my position within the nature of things.
5. I admit to the Great Spirit and to my Indian brothers and sisters the weaknesses of my life.
6. I am willing to let the Great Spirit help me correct my weaknesses.
7. I pray daily to the Great Spirit to help me correct my weaknesses.
8. I make an effort to remember all those that I have caused harm to and, with the help of the Great Spirit, achieve the strength to try to make amends.
9. I do make amends to all those Indian brothers and sisters that I have caused harm to whenever possible through the guidance of the Great Spirit.
10. I do admit when I have done wrong to myself, those around me, and the Great Spirit.
11. I seek through purification, prayer, and meditation to communicate with the Great Spirit as a child to a father in the Indian way.
12. Having addressed those steps, I carry this brotherhood and steps to sobriety to all my Indian brothers and sisters with alcohol problems and together we share all these principles in all our daily lives.

Source: CSAT 1999b, p. 56. Reprinted from material in the public domain.

the 12 Steps is use of a circular, rather than a linear, path to healing. The circle is important to American Indian philosophy, which sees the great forces of life and nature as circular (Coyhis 2000). In addition, staff members of the White Bison program have also rewritten the AA "Big Book" from a Native American perspective (Coyhis and Simonelli 2005). The principles of the 12 Steps, which involve using the group or community to provide support and motivation while emphasizing spiritual reconnection, appeal to many Native Americans who see treatment as social in nature and who view addiction as a spiritual problem.

The Native American Wellbriety movement is a modern, indigenous mutual-help program that has its roots in 12-Step groups but incorporates Native American spiritual beliefs and cultural practices (Coyhis and Simonelli 2005; Coyhis and White 2006; White Bison, Inc. 2002; also see http://www.whitebison.org). Although the Wellbriety movement is popular with many Native Americans in recovery, a considerable number also continue to participate in traditional 12-Step groups. In the AI-SUPER-PFP, 47 percent of Northern Plains Tribe respondents and 28.8 percent of Southwest Tribe respondents with a past-year substance use disorder reported 12-Step group attendance in the prior year (Beals et al. 2006). Mohatt et al. (2008*b*) found that more Alaska Natives in recovery reported participation in 12-Step groups than in substance abuse treatment. In Venner and Feldstein's (2006) research with American Indians in recovery, 84 percent of respondents had attended some mutual-help meetings.

Traditional healing and complementary methods

Native American peoples have a range of beliefs about health care—from traditional beliefs to strong support for modern science—and may use a number of strategies when addressing health problems. Traditional healing practices are often used in conjunction with modern medicine. For example, American Indians

traditionally view all things as deeply interconnected. Disruption of the physical, mental, spiritual, or emotional sides of a person can result in illness. A Native American client may consult a medical doctor to address part of the problem and a traditional healer to help regain balance and harmony.

The use of traditional healing for substance abuse and mental health problems is fairly common among Native Americans (Herman-Stahl and Chong 2002; Herman-Stahl et al. 2003). For example, among Native American individuals who reported a substance use disorder in the past year, 57.4 percent of those from a Southwest Tribe and 31.7 percent from a Northern Plains Tribe used traditional healers or healing practices (Beals et al. 2006). In a survey of American Indians from three different Arizona Tribes, 27.4 percent stated that they had used traditional healers and/or healing practices to help with mental health problems (Herman-Stahl and Chong 2002). Overall, many Native Americans believe that culture is the primary avenue of healing and that connecting with one's culture is not only a means of prevention, but also a healing treatment (Bassett et al. 2012)

Each Native American culture has its own specific healing practices, and not all of those practices are necessarily appropriate to adapt to behavioral health treatment settings. However, many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings (Castro et al. 1999*b*; Coyhis 2000; Coyhis and White 2006; Mail and Shelton 2002; Sue 2001; White 2000). These practices include sacred dances (such as the Plains Indians' sun dance and the Kiowa's gourd dance), the four circles (a model for conceptualizing a harmonious life), the talking circle, sweat lodges, and other purification practices (Cohen 2003; Mail and Shelton 2002; White 2000). The sweat lodge, in particular, is frequently used in substance abuse treatment settings (Bezdek and Spicer 2006; Schiff and Moore 2006).

Alaskan behavioral health programs have developed recovery camps to provide a treatment setting that incorporates Native beliefs and seasonal practices (e.g., Old Minto Family Recovery Camp: http://www.tananachiefs.org/ health-services/old-minto-family-recovery-camp-new/). Recovery camps are based on the model of traditional Native Alaskan fishing camps and provide a context in which clients can learn about traditional practices, such as sustenance activities. Another program, the Village Sobriety Project, incorporates traditional Yup'ik and Cup'ik Eskimo traditions of hunting, chopping wood, berry picking, and taking tundra walks (Mills 2003). See Niven (2010) for a review of client-centered, culturally responsive behavioral health techniques for use with Alaska Natives.

It is difficult to measure the effectiveness of Native American healing practices using

There are a number of potential pitfalls that can occur when trying to integrate Native spiritual and cultural practices into treatment. Cultural groups are complex systems; removing pieces of them for implementation as part of a treatment program can be a disservice to the culture as well as the clients (Kunitz et al. 1994; Moss et al. 2003); a breach of customs and traditions; and a sign of disrespect for the community and Tribe, Tribal leadership, and Native American practices. It is important to take the time to build relationships and seek consultation with Tribal elders, and other Tribal leaders to ensure that the best and most appropriate steps are taken in creating a culturally relevant and responsive treatment model and program.

Western standards and practices. Limited or inconsistent funding, migration patterns, culturally incompetent or incongruent evaluation practices, and abuses incurred during or after data collection are major confounding variables that have limited knowledge on the effectiveness of incorporating traditional practices into Western approaches to the treatment of substance abuse and mental illness. Nonetheless, Mail and Shelton (2002) reviewed earlier literature on the use of "indigenous therapeutic interventions" for alcohol abuse and dependence and suggest that a number of these interventions have been of value to Native Americans with substance use disorders. Other authors have concurred (Coyhis and White 2006; Sabin et al. 2004).

Regardless of whether a program adapts specific Native American healing practices, providers working with this population should recognize that spirituality is central to its values and is perceived as an integral part of life itself. It is through spiritual experiences that Native Americans believe they will find meaning in life. Some Native languages have words that refer to spirituality as "walking around" or "living the path." In many cases, the spiritual traditions of Native Americans are not (and have never been) conceived of as a religion, but rather as a set of beliefs and practices that pervades every aspect of daily life (Deloria 1973).

Despite religion and spirituality often playing important roles in recovery from mental and substance use disorders for Native Americans, providers should not assume that only indigenous spirituality is relevant. The majority of Native Americans do not practice their traditional spirituality exclusively, and Christian religious institutions like the Native American Church and Pentecostal churches have been instrumental in helping many Native Americans overcome substance use disorders (Garrity 2000). In 2001, roughly 20 percent of American Indians identified as Baptist, 17 percent as Catholic, 17 percent as having no religious preference, and 3 percent as following a Tribal religion (Kosmin et al. 2001).

The relative importance of religion can also vary among diverse Native American communities. Before pursuing traditional methods, assessment of clients' spiritual orientation is important. Spirituality is a personal issue that treatment providers must respect; clients should choose which spiritual and cultural methods to incorporate into treatment. Providers should also be wary of an obsession with their clients' cultural activities, which may be considered intrusive (LaFromboise et al. 1993). Checking with community resources on the subject and asking the client "What feels right for you?" are appropriate steps to take in identifying whether traditional healing practices will have therapeutic value. Providers should consult with Native healers or Tribal leaders about the appropriateness of using a particular practice as part of behavioral health services. Rather than using traditional healing methods themselves, counselors may wish to refer clients to a Native American healer in the community or in the treatment program.

Relapse prevention and recovery

Despite limited data on long-term recovery for Native Americans who have substance use disorders, a few studies have found high rates of relapse following substance abuse treatment (see review in Chong and Herman-Stahl 2003). White and Sanders (2004) recommend that long-term recovery plans for Native Americans make use of a recovery management rather than a traditional continuing care approach. Such an approach emphasizes the use of informal recovery communities and traditional healing approaches to provide extended monitoring and support for Native Americans leaving treatment.

Researchers have conducted interviews with both American Indians (Bezdek and Spicer 2006) and Alaska Natives (Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004) who have achieved extended periods of recovery. Bezdek and Spicer (2006) identified two key tasks for American Indians entering recovery. First, they need to learn how to respond to family and friends who drank with them and to those who supported their recovery. Next, they have to find new ways to deal with boredom and negative feelings. By accomplishing these tasks, Native clients can build new social support systems, develop effective coping strategies for negative feelings, and achieve long-term recovery. The People Awakening Project found that, among Alaska Natives who had a substantial period of recovery, the development of active, culturally appropriate coping strategies was essential (e.g., distancing themselves from friends or family who drank heavily, getting involved in church, doing community service, praying; Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004).

Counseling for White Americans

According to the 2010 U.S. Census definition, White Americans are people whose ancestors are among those ethnic groups believed to be the original peoples of Europe, the Middle East, or North Africa (Humes et al. 2011). The racial category of White Americans includes people of various ethnicities, such as Arab Americans, Italian Americans, Polish Americans, and Anglo Americans (i.e., people with origins in England), among others. Many Latinos will also identify racially (if not ethnically) as White American. Non-Latino White Americans constitute the largest racial group in the United States (making up 63.7 percent of the population in the 2010 Census; Mather et al. 2011).

White Americans, like other large ethnic and cultural groups, are extremely heterogeneous in historical, social, economic, and personal features, with many (often subtle) distinctions among subgroups. Perhaps because White Americans have been the majority in the United States, it is sometimes forgotten how historically important certain distinctions between diverse White American ethnic heritages have been (and continue to be, for some). Conversely, many White American people prefer not to see themselves as such and instead identify according to their specific ethnic background (e.g., as Irish American). For similar reasons, certain cross-cutting cultural issues (see Chapter 1) like geographic location, sexual orientation, and religious affiliation are important in defining the cultural orientations of many White Americans.

Beliefs About and Traditions Involving Substance Use

Historically, use of alcohol was accepted among White/European cultural groups because it provided an easy way to preserve fruit and grains and did not contain bacteria that might be found in water. Over time, the production and consumption of alcohol became an often-integral part of cultural activities, which can be seen in the way some White cultural groups take particular pride in national brands of alcoholic beverages (e.g., Scotch whisky, French wine; Abbott 2001; Hudak 2000). A number of European cultural groups (e.g., French, Italian) traditionally believed that daily alcohol use was healthy for both mind and body (Abbott 2001; Marinangeli 2001), and for others (e.g., English, Irish), the bar or pub was the traditional center of community life (O'Dwyer 2001). Despite some variations in cultural attitudes toward appropriate drinking practices, alcohol has been and

remains the primary recreational substance for Whites in the United States. Predominant attitudes toward drinking in the United States more closely reflect those of Northern Europe; alcohol use is generally accepted during celebrations and recreational events, and, at such times, excessive consumption is more likely to be acceptable.

Typically, White European cultural groups accept alcohol use as long as it does not interfere with responsibilities, such as work or family, or result in public drunkenness (Hamid 1998). However, among certain groups of White Americans (usually defined by religious beliefs), the use of alcohol or any other intoxicant is considered immoral (van Wormer 2001). These religious beliefs, combined with concerns about the effects of problematic drinking patterns (especially among men in the frontier; White 1998), became the impetus for the early 19th-century creation of the Temperance Movement and culminated in the passing of the 18th Amendment to the United States Constitution, which enacted Prohibition. Although the Temperance Movement is no longer a major political force, belief in the moral and social value of abstinence continues to be strong among some segments of the White American population.

Illicit drug use, on the other hand, has historically been demonized by White American cultural groups and seen as an activity engaged in by people of color or undesirable subcultures (Bonnie and Whitebread 1970; Hamid 1998; Whitebread 1995). For example, White Americans typically link drug use to perceived threat of crime—particularly crimes perpetrated by people of color (Hamid 1998; Whitebread 1995). Attitudes have changed over time, but White American cultural groups continue to enforce strong cultural prohibitions against most types of illicit drug use. At the same time, White Americans are often more accepting of prescription medication abuse and less likely to perceive prescription medications as potentially harmful (Hadjicostandi and Cheurprakobkit 2002).

Despite illicit drug use now being as common among White Americans as people of color, White Americans still tend to perceive drug use as an activity that occurs outside their families and communities. In a 2001 survey, only 54 percent of White Americans expressed concern that someone in their family might develop a drug abuse problem compared with 81 percent of African Americans (Pew Research Center for the People and the Press 2001). In the same survey, White Americans expressed less concern about drug abuse in their neighborhoods than did other racial and ethnic groups. However, in terms of seeing drugs as a national problem, White Americans and other racial and ethnic groups are in closer agreement. Perhaps as a result of this misperception about the prevalence of drug use in their homes and communities, White American parents are less likely to convey disapproval of drug use to their children than African American parents (National Center on Addiction and Substance Abuse 2005) and much more likely than Latino or African American parents to think that their children have enough information about drugs (Pew Research Center for the People and the Press 2001).

There are also differences in how White Americans, Latinos, and African Americans perceive drug and alcohol addictions. White Americans are less likely than African Americans, but more likely than Latinos, to state that they believe a person can recover fully from addiction (Office of Communications 2008). However, White Americans are more likely than African Americans to indicate that substance use disorders should be treated as diseases (Durant 2005).

Substance Use and Substance Use Disorders

According to 2012 NSDUH data, rates of past-year substance use disorders were higher for White Americans than for Native Hawaiians, other Pacific Islanders, and Asian Americans; rates of current alcohol use were higher than for every other major ethnic/racial group (SAMHSA 2013*d*). Alcohol has traditionally been the drug of choice among White Americans of European descent; however, not all European cultural groups have the same drinking patterns. Researchers typically contrast a Northern/Eastern European pattern, in which alcohol is consumed mostly on weekends or during celebrations, with that of Southern Europe, in which alcohol is consumed daily or almost daily but in smaller quantities and almost always with food. The Southern European pattern involves more regular use of alcohol, but it is also associated with less alcohol-related harm overall (after controlling for total consumption; Room et al. 2003). The pattern of White Americans typically follows that of Northern and Eastern Europe, but individuals from some ethnic groups maintain the Southern European pattern.

White Americans, on average, begin drinking and develop alcohol use disorders at a younger age than African Americans and Latinos (Reardon and Buka 2002). White Americans are more likely to have their first drink before the age of 21 and to have their first drink before the age of 16 than members of any other major racial/ethnic group except Native Americans (SAMHSA 2011*c*). Some data suggest that White Americans begin using illicit drugs at an earlier age than African Americans (Watt 2008) and that the mean age for White Americans who inject heroin has decreased (Broz and Ouellet 2008).

White Americans who use heroin are less likely than people who use heroin from all other major racial/ethnic groups except African Americans to have injected the drug (SAMHSA 2011*c*). White Americans are also more likely than members of other major racial/ethnic groups, except Native Hawaiians and other Pacific Islanders (for whom estimates may not be accurate), to have tried ecstasy. Except for Native Americans (some of whom may use the hallucinogen peyote for religious purposes), they are also more likely than other racial/ethnic groups to have tried hallucinogens (SAMHSA 2011*c*). Research confirms that prescription drug misuse is more common among White Americans than African Americans or Latinos (Ford and Arrastia 2008; SAMHSA 2011*c*), and they are more likely to have used prescription opioids in the past year and to use them on a regular basis.

Comparative studies indicate that White Americans are more likely than all other major racial/ethnic groups except Native Americans to have an alcohol use disorder (Hasin et al. 2007; Perron et al. 2009; Schmidt et al. 2007). White Americans are at a greater risk of having severe alcohol withdrawal symptoms (such as delirium tremens) than are African Americans or Latinos with alcohol use disorders (Chan et al. 2009). So too, White Americans are more likely than African Americans or Latinos to meet diagnostic criteria for a drug use disorder at some point during their lives (Perron et al. 2009). Overall, substance use disorders vary considerably across and within non-European White American cultural groups. For example, rates of substance abuse treatment admissions in Michigan from 2005 suggest that substance use disorders may be considerably lower for Arab Americans than other White Americans (Arfken et al. 2007).

Mental and Co-Occurring Disorders

About 20 percent of White Americans reported some form of mental illness in the past year, and they were more likely to have past-year serious psychological distress than other population groups excluding Native Americans (SAMHSA 2012*a*).

White Americans appear to be more likely than Latinos or Asian Americans to have CODs (Alegria et al. 2008*a*; Vega et al. 2009) and more likely to have concurrent serious psychological distress and substance use disorders (SAMHSA 2011*c*). White Americans with CODs are also more likely to receive treatment for both their substance use and mental disorders than are African Americans with CODs (Alvidrez and Havassy 2005; Hatzenbuehler et al. 2008), but they are perhaps less likely to receive treatment for their substance use disorder alone (Alvidrez and Havassy 2005). White Americans are more likely to receive family counseling and mental health services while in substance abuse treatment and less likely to have unmet treatment needs (Marsh et al. 2009; Wells et al. 2001). In addition, White Americans are significantly less likely than Latinos or African Americans to believe that antidepressants are addictive (Cooper et al. 2003).

The most common mental disorders among White Americans are mood disorders (particularly major depression and bipolar I disorder) and anxiety disorders (specifically phobias, including social phobia, and generalized anxiety disorder; Grant et al. 2004*b*). Among White Americans, these disorders are more prevalent than in any other ethnic/racial groups save Native Americans (Grant et al. 2005; Hasin et al. 2005). For example, rates of a lifetime diagnosis of generalized anxiety disorder are about 40 percent lower for African Americans and Latinos than for White Americans and about 60 percent lower for Asian Americans (Grant et al. 2005). A similar pattern exists for major depressive disorder (Hasin et al. 2005).

Treatment Patterns

White Americans are more likely to receive mental health treatment or counseling than other racial/ethnic groups (SAMHSA 2012*b*). White Americans are more likely than African Americans to receive substance abuse treatment services from a private physician or other behavioral health or primary care professional (Perron et al. 2009). Among White American clients entering substance abuse treatment programs in 2010, alcohol (alone or in conjunction with illicit drugs) was most often the primary substance of abuse, followed by heroin and cannabis. However, findings are inconsistent concerning the relative frequency with which White Americans enter substance abuse treatment. Some studies have found that White Americans are more likely to receive needed behavioral health services than both African Americans and Latinos (Marsh et al. 2009; Wells et al. 2001). In contrast, other studies have found that African Americans with an identified need are somewhat more likely to enter treatment for drug use disorders and about as likely to receive treatment for alcohol use disorders when compared with White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009; SAMHSA, CBHSQ 2012; Schmidt et al. 2006).

Beliefs and Attitudes About Treatment

White Americans appear to be generally accepting of behavioral health services. They have better access to health care and are more likely to use services than people of color, but this varies widely based on socioeconomic status and cultural affiliation. Most treatment services have historically been developed for

White American populations, so it is not surprising that White Americans are more likely than other racial/ethnic groups to be satisfied with treatment services (Tonigan 2003).

Still, attitudes differ among certain cultural subgroups of White Americans. For example, Russian immigrants from the former Soviet Union have a longstanding distrust of mental health systems and hence may avoid substance abuse treatment (Kagan and Shafer 2001). Other groups who have a strong family orientation, such as Italian Americans or Scotch-Irish Americans, might avoid treatment that asks them to reveal family secrets (Giordano and McGoldrick 2005; Hudak 2000).

According to 2010 NSDUH data regarding people who recognized a need for substance abuse treatment in the prior year but did not receive it, White Americans were more likely than members of other major racial/ethnic groups to state that it was because they had no time for treatment, that they were concerned what their neighbors might think, that they did not want others to know, and/or that they were concerned about how it might affect their jobs (SAMHSA 2011*c*). Other research confirms that White Americans are significantly more likely to avoid treatment due to fear of what others might think or because they are in denial (Grant 1997). White Americans may also have different attitudes toward recovery, at least regarding alcohol use disorders, than do members of other ethnic/racial groups. According to NESARC data on people who met criteria for a diagnosis of alcohol dependence at some point during their lives, White Americans were more likely than African Americans, Latinos, or other non-Latinos to have achieved remission from that disorder but were also less likely than African Americans or other non-Latinos (but not Latinos) to currently abstain from drinking, as opposed to being in partial remission or drinking without symptoms of alcohol dependence (Dawson et al. 2005).

Treatment Issues and Considerations

Most major treatment interventions have been evaluated with a population that is largely or entirely White American, although the role of White American cultural groups is rarely considered in evaluating those interventions. For example, as Straussner (2001) notes, "the paradox of writing about substance abusers of European background is that they are a group that is believed to be the group for whom the traditional alcohol and other drug treatment models have been developed, and yet they are a group whose unique treatment needs and treatment approaches have rarely been explored" (p. 165). Very few evaluations of treatment strategies and interventions (whether based on research or clinical observation) have taken into account ethnic and cultural differences among White American clients, and therefore it is generally not possible to make culturally responsive recommendations for specific subgroups of White Americans.

Culturally responsive treatment for many White Americans will involve helping them rediscover their cultural backgrounds, which sometimes have been lost through acculturation and can be an important part of their long-term recovery. Giordano and McGoldrick (2005) note that ethnic identity and culture can be more important for some White Americans "in times of stress or personal crisis," when they may want to "return to familiar sources of comfort and help, which may differ from the dominant society's norms" (p. 503). Appendix B provides information on instruments for assessing cultural identification. For an overview of challenges in maintaining mental health, access to health care,

and help-seeking among White Americans, see Downey and D'Andrea (2012).

Theoretical Approaches and Treatment Interventions

Overall, the optimum treatment approach with White Americans is a comprehensive one; the more tools in the toolkit, the greater the chance of success (McCaul et al. 2001). Within-group differences arise regarding education level, socioeconomic status, gender, and other factors, which must be considered. Providers can, however, assume that most well-accepted treatment approaches and interventions (e.g., CBT, motivational interviewing, 12-Step facilitation, contingency management, pharmacotherapies) have been tested and evaluated with White American clients.

Still, treatment is not uniformly appropriate even for White Americans. Approaches may need modification to suit class, ethnic, religious, and other client traits. Providers should establish not only the client's ethnic background, but also how strongly the person identifies with that background. Few clinicians have made observations on best therapeutic approaches for members of particular White American cultural/ethnic subgroups.

Family therapy

In White American families, individuals are generally expected to be independent and self-reliant; as a result, families in therapy can have trouble adjusting to work that focuses more on communication processes than specific problems or content (McGill and Pearce 2005). Van Wormer (2001) notes that many White Americans need help addressing communication issues. In family therapy, useful approaches include those that encourage open, direct, and nonthreatening communication.

There is no singular description that fits White American families within or across ethnic heritages, and there is no approach that is effective for all White Americans in family therapy (Hanson 2011). Hierarchical families, such as German American families, may expect the counselor to be authoritative, at least in the initial sessions (Winawer and Wetzel 2005), although a more egalitarian German American family might not respond well to such imperatives. In the same vein, one client of French background could readily accept direct and clear therapeutic assignments that contain measurable goals (Abbot 2001), whereas another French American client may value counseling that is more process oriented. Thus, it is imperative to assess the cultural identification of clients and their families, along with the treatment needs that best match their cultural worldviews.

In some White American families, there is a longstanding culture of drinking. Attempts at abstinence can be perceived by family members as culturally inappropriate. In other families, there is deep denial about alcohol abuse or dependence, especially when talking about substance use to those outside the family. For example, some Polish American families can be resistant to the idea that drinking is the cause of family problems (Folwarski and Smolinski 2005) and sometimes believe that to admit an alcohol problem, especially to someone outside the family, signals weakness.

Group therapy

Standard group therapies developed for mental health and substance abuse treatment programs have generally been used and evaluated with White American populations. For details on group therapy in substance abuse treatment, see TIP 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005*c*).

Mutual-help groups

Mutual-help groups, of which AA is the most prevalent, have a largely White American

membership (AAWS 2008; Atkins and Hawdon 2007). In a 2011 survey, 87 percent of AA members indicated their race as White (AAWS 2012). In research with largely White populations, AA participation has been found to be an effective strategy for promoting recovery from alcohol use disorders (Dawson et al. 2006; McCrady et al. 2004; Moos and Moos 2006; Ritsher et al. 2002; Weisner et al. 2003). Other mutual-help groups, such as Self-Management and Recovery Training, Secular Organizations for Sobriety/Save Our Selves, and Women for Sobriety, also have predominately White American membership and are based on Western ideas drawn from psychology (Atkins and Hawdon 2007; White 1998).

The appeal of mutual-help groups among White Americans rests on the historical origins of this model. The 12-Step model was originally developed by White Americans based on European ideas of spirituality, faith, and group interaction. Although the model has been adopted worldwide by different cultural groups (White 1998), the 12-Step model works especially well for White ethnic groups, including Irish Americans, Polish Americans, French Americans, and Scotch-Irish Americans, because it incorporates Western cultural traditions involving spiritual practice, public confession, and the use of anonymity to protect against humiliation (Abbott 2001; Gilbert and Langrod 2001; Hudak 2000; McGoldrick et al. 2005; Taggart 2005).

In addition to mutual-help groups for substance abuse, numerous recovery support groups, Internet resources, Web-based communities, and peer support programs are available to promote mental health recovery. Many resources are available through the National Alliance on Mental Illness (http://www.nami.org).

Traditional healing and complementary methods

Only 12 percent of White Americans consider themselves atheist, agnostic, or secular without a religious affiliation, meaning that, as a group, White Americans are more religious than Asian Americans but less so than Latinos or African Americans (Pew Forum on Religion and Public Life 2008). As with other groups, White Americans belong to many different religions, although the vast majority belong to various Christian denominations, with approximately 57 percent identifying as Protestant and 25.9 percent as Catholic (National Center on Addiction and Substance Abuse, 2001). White Americans also make up 91 percent of practitioners of Judaism in the United States, 14 percent of followers of Islam, and 32 percent of the American Buddhist population (Kosmin et al. 2001). For more religious White Americans, pastoral counseling or prayer can be useful aids in the treatment of substance use disorders. However, White Americans are significantly less likely to use prayer as a method of coping (Graham et al. 2005). White Americans are more likely than members of other major racial/ethnic groups to use complementary or alternative medical therapies, such as herbal medicine, acupuncture, chiropractors, massage therapy, yoga, and special diets (Graham et al. 2005).

Relapse prevention and recovery

Factors that promote recovery for White Americans include the learning and use of coping skills (Litt et al. 2003; Litt et al. 2005; Maisto et al. 2006). Even though some research suggests that White Americans are less likely to use coping skills than African Americans (Walton 2001) and have lower levels of self-efficacy upon leaving treatment (Warren et al. 2007), the development of these skills and of self-efficacy is important in managing relapse risks and in maintaining recovery. Counselors

may offer psychoeducation on the value of coping strategies, specific skills to manage stressful situations or environments, and opportunities to practice these skills during treatment. Some coping skills or strategies may be more important than others in managing high-risk situations, but research suggests that greater use of a variety of coping strategies is more important than the use of any one specific skill (Gossop et al. 2002).

Social and family supports are also important in maintaining recovery and preventing relapse among White Americans (Laudet et al. 2002; McIntosh and McKeganey 2000; Rumpf et al. 2002). Other important factors include continuing care, the development of substitute behaviors (i.e., reliance on healthy or positive activities in lieu of substance use), the creation of new caring relationships that do not involve substance use, and increased spirituality (Valliant 1983). Valliant (1983) and others (e.g., Laudet et al. 2002; McCrady et al. 2004; Moos and Moos 2006) conclude, based on research with mostly White participants, that mutual-help groups often play an important role in maintaining recovery.

TIPs That Provide Supplemental Information on Topics in This Chapter

TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*)

TIP 35: *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*)

TIP 39: *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*)

TIP 41: *Substance Abuse Treatment: Group Therapy* (CSAT 2005*c*)

TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*d*)

TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*b*)

TIP 47: *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*c*)

TIP 51: *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT 2009*c*)

TIP 57: *Trauma-Informed Care in Behavioral Health Services* (SAMHSA 2014)

Planned TIP: *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e*)

6 Drug Cultures and the Culture of Recovery

IN THIS CHAPTER

- What Are Drug Cultures?
- The Role of Drug Cultures in Substance Abuse Treatment

Lisa is a 19-year-old White college student living in San Diego, CA, who was sent to treatment by her parents after failing her college classes and being placed on academic probation. While home on break earlier that year, her parents found pills in her room but let her return to school after she promised to stop using. The academic probation is only part of the reason her parents sent her to treatment. They were also concerned about her recent weight loss, as her older sister had previously struggled with bulimia.

Lisa began using marijuana at age 15 with a cousin. In her first year of high school, she had difficulty fitting in. However, the next year, she became friendly with an electronic dance music clique that helped her define an identity for herself and introduced her to ecstasy (3,4-methylenedioxymethamphetamine, or MDMA), methamphetamine, and various hallucinogens, along with new ideas about politics, music, and art. She has since found similar friends at college and keeps in touch with several members of her high school clique.

In treatment, Lisa tells her counselor that she has long felt neglected by her parents, who are too interested in material things. She sees her drug use and that of her friends as a rebellion against the materialistic attitudes of their parents. She also dismisses her family's cultural heritage, insisting that her parents only identify as Americans even though they are first-generation Americans with European backgrounds. She talks at length about ways to acquire and prepare relatively unknown hallucinogens, the best music to listen to while using, and how to evaluate the quality of marijuana.

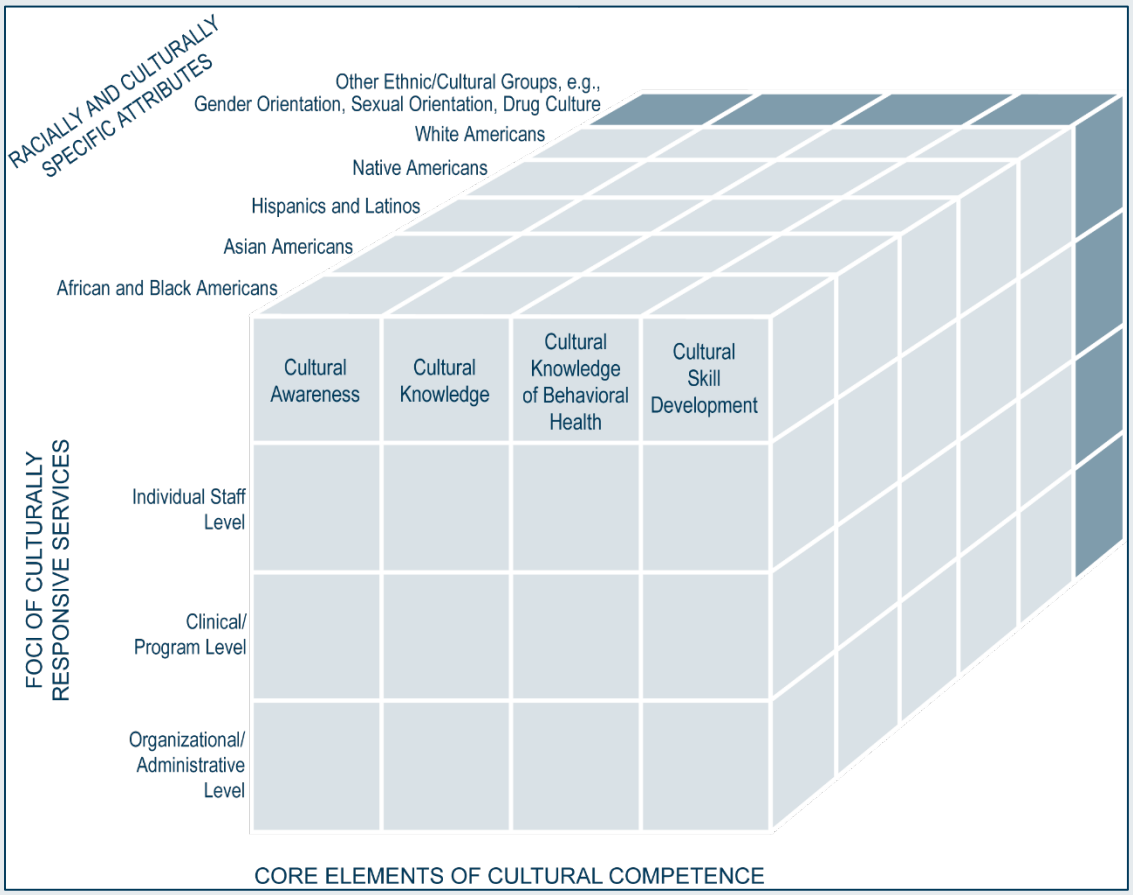
Lisa says that she doesn't believe she has a problem. She thinks that her failing grades reflect her lack of interest in college, which she says she is attending only because people expect it of her. When asked what she would rather be doing, she says she does not have any clearly defined goals and just wants to do "something with art

This Treatment Improvement Protocol (TIP) emphasizes the concept that many subcultures exist within and across diverse ethnic and racial populations and cultures. Drug cultures are a formidable example—these are cultures that can influence the presentation of mental, substance use, and co-occurring disorders as well as prevention and treatment strategies and outcomes.

or music." Lisa points out that, unlike most of her classmates, she doesn't drink and has stopped doing addictive drugs like ecstasy and methamphetamine, which were responsible for her weight loss. She is convinced that she can continue to smoke pot and *Salvia divinorum*, which she notes "isn't even illegal," and take other botanical hallucinogens. She is adamant about keeping her friends, who she says have been supportive of her and are not materialistic "sellouts" like her parents.

Her counselor places a priority on connecting Lisa with other people her age who are in recovery. She asks a client who graduated from the program and is only a year older than Lisa to accompany her to Narcotics Anonymous (NA) meetings attended mostly by younger people in recovery. The counselor also encourages Lisa's friendships with other young people in the program. When Lisa complains about her parents' materialism and the materialism of mainstream culture, her counselor brings up the spiritual elements of mutual-help recovery groups and how they provide an

Multidimensional Model for Developing Cultural Competence: Drug Cultures



alternative model for interacting with others. The counselor begins to help Lisa explore how her drug use may be an attempt to fill her unmet emotional and social needs and may hinder the development of her own interests, identity, and goals.

Treatment providers should consider how cultural aspects of substance use reinforce substance use, substance use disorders, and relapses. Factors to note include clients' possible self-medication of psychological distress or mental disorders. Beyond specific biopsychosocial issues that contribute to the risk of substance-related disorders and the initiation and progression of use, counselors and treatment organizations must continually acquire knowledge about the ever-changing, diverse drug cultures in which client populations may participate and which reinforce the use of drugs and alcohol. Moreover, behavioral health service providers and program administrators need to translate this knowledge into clinical and administrative practices that address and counter the influence of these cultures within the treatment environment (e.g., by instituting policies that ban styles of dress that indicate affiliation with a particular drug culture).

Adopting Sue's multidimensional model (2001) for developing cultural competence, this chapter identifies drug cultures as a domain that requires proficiency in clinical skills, programmatic development, and administrative practices. It explores the concept of drug cultures, the relationship between drug cultures and mainstream culture, the values and rituals of drug cultures, and how and why people value their participation in drug cultures. This chapter describes how counselors can determine a client's level of involvement in a drug culture, how they can help clients identify and develop alternatives to the drug cultures in which they participate, and the importance of assisting clients in developing a culture of recovery.

What Are Drug Cultures?

Up to this point, this TIP has focused on cultures based on ethnicity, race, language, and national origin. The TIP looks primarily at those cultural groups because they are the major cultural forces that shape an individual's life and worldview. However, there are other types of cultural groups (sometimes referred to as subcultures) that are also organized around shared values, beliefs, customs, and traditions; these cultural groups can have, as their core organizing theme, such factors as sexuality, musical styles, political ideologies, and so on. For most clients in treatment for substance use disorders (including those who have a co-occurring mental disorder), the drug subculture will likely have affected their substance use and can affect their recovery; that is the primary rationale for the development of this unique chapter. Research literature in this topic area is considerably limited.

Some people question whether a given drug culture is in fact a subculture, but many seem to have all the elements ascribed to a culture (see Chapter 1). A drug culture has its own history (pertaining to drug use) that is usually orally transmitted. It has certain shared values, beliefs, customs, and traditions, and it has its own rituals and behaviors that evolve over time. Members of a drug culture often share similar ways of dressing, socialization patterns, language, and style of communication. Some even develop a social hierarchy that gives different status to different members of the culture based on their roles within that culture (Jenkot 2008). As with other cultures, drug cultures are localized to some extent. For example, people who use methamphetamines in Hawaii and Missouri could share certain attitudes, but they will also exhibit regional differences. The text boxes in this chapter offer examples of the distinct values, languages,

rituals, and types of artistic expression associated with particular drug cultures.

Many subcultures exist outside mainstream society and thus are prone to fragmentation. A single subculture can split into three or four related subcultures over time. This is especially true of drug cultures, in which people use different substances, are from different locales, or have different socioeconomic statuses; they may also have very different cultural attitudes related to the use of substances. Bourgois and Schonberg (2007) described how ethnic and racial differences can affect the drug cultures of users of the same drugs to the point that even such things as injection practices can differ between Black and White heroin users in the same city. Exhibit 6-1 lists of some of the ways in which drug cultures can differ from one another.

Differences in the physiological and psychological effects of drugs account for some differences among drug cultures. For example, the drug culture of people who use heroin is typically less frenetic than the drug culture involving methamphetamine use. However, other differences seem to be more clearly related to the historical development of the culture itself or to the effects of larger social forces. Cultural and socioeconomic components contributed to the rise in methamphetamine use among gay men on the West Coast (Reback 1997) and among Whites of lower socioeconomic status in rural Missouri (Topolski and Anderson-Harper 2004). However, in these two cases, the details of those change factors are quite different. In Missouri, the low cost and easy production of the drug influenced development of a methamphetamine drug culture. Missouri leads the nation in the number of methamphetamine labs seized by police; a disproportionately large number of seizures occur in rural areas (Carbone-Lopez et al. 2012; Topolski and Anderson-Harper 2004). The popularity of the drug among

Exhibit 6-1: How Drug Cultures Differ

- There is overlap among members, but drug cultures differ based on substance used—even among people from similar ethnic and socioeconomic backgrounds. The drug culture of heroin use (McCoy et al. 2005; Pierce 1999; Spunt 2003) differs from the drug culture of ecstasy use (Reynolds 1998).
- Drug cultures differ according to geographic area; people who use heroin in the Northeast United States are more likely to inhale than inject the drug, whereas the opposite is true among people in the Western United States who use heroin (Office of Applied Studies [OAS] 2004).
- Drug cultures can differ according to other social factors, such as socioeconomic status. The drug culture of young, affluent people who use heroin can occasionally mirror the drug culture of the street user, but it will also have notable differences (McCoy et al. 2005; Pierce 1999; Spunt 2003).
- Drug cultures (even involving the same drugs and the same locales) change over time; older people from New York who use heroin and who entered the drug culture in the 1950s or 1960s feel marginalized within the current drug scene, which they see as promoting a different set of values (Anderson and Levy 2003).

How To Identify Key Characteristics of a Drug Culture

Counselors and clinical supervisors must acquire knowledge about drug cultures represented within the client population. Drug cultures can change rapidly and vary across racial and ethnic groups, geographic areas, socioeconomic levels, and generations, so staying informed is challenging. Besides needing an understanding of current drug cultures (to help prevent infiltration of related behaviors and attitudes within the treatment environment), counselors also need to help clients understand how such cultures support use and pose dynamic relapse risks.

(Continued on the next page.)

How To Identify and Discuss Key Characteristics of a Drug Culture (continued)

Counselors can use this exercise to begin to educate clients about the influence of drug cultures and help them identify the specific behaviors, values, and attitudes that constitute their experience of using alcohol and drugs. It can be a helpful tool in improving clients' understanding of the reinforcing aspects of alcohol and drug use beyond physiological effects. In addition, this exercise can be used as a training tool in clinical supervision to help counselors understand the influence and potential reinforcing qualities of a drug culture among clients and within the treatment milieu.

Materials needed: Diagram handout and pencils.

Instructions:

- Determine whether this exercise is more appropriate as an individual or group exercise. Assess the newness and variability of recovery within the group constellation. If several group members support recovery-related behavior, conducting this exercise may be a beneficial educational tool and means of intervention with clients who continue to identify mainly with their drug culture. Conversely, if most group members are new or have had difficulty accepting treatment or treatment guidelines, this exercise may be more aptly used as an individual tool.
- Attention: In group settings, strict parameters need to be established at the beginning of the session to ensure that the discussion remains centered on attitudes, values, and behaviors surrounding drug and alcohol use—not on specific techniques or procedures for using drugs or rituals surrounding intake or injection.
- Start the discussion by first presenting the idea that drug cultures exist—describing the main elements that constitute culture (refer to Chapter 1 or the categories identified in the "Drug Culture" diagram below). Next, provide examples of how drug culture can support continued use and relapse. Keep in mind that not all clients are engaged in a drug culture.
- Following the general introduction, review each block in the diagram and ask clients to provide examples related to their own use and involvement with drugs and alcohol. After discussing their examples, ask them to identify the most significant behaviors, attitudes, and values that reinforce their use (e.g., a feeling of acceptance or camaraderie).
- Counselors can redirect this general discussion to related topics—for example, by identifying behaviors, values, and attitudes likely to support recovery or by shifting from discussion to role-plays that will help clients address relapse risks associated with their drug culture and practice coping skills (e.g., assertiveness or refusal skills to counter the influence of others once they are discharged from the program or to address situations that arise during the course of treatment).

Drug Culture		
Establishing Trust and Credibility *How do you go about establishing credibility?*	**Socialization** *How were you introduced to the culture?*	**Values** *What values are upheld or devalued in the group?*
Status *In what ways can you obtain status or be seen as a success?*	**Rules** *Are there spoken and unspoken rules or norms?*	**Gender Roles and Relationships** *What gender expectations exist surrounding drug use?*
Concepts of Sanction, Punishment, and Conflict Mediation *How does the group deal with in-group conflicts?*	**Symbols and Images** *Are there symbols that represent a particular association with a group or substance?*	**Dress** *Are there specific ways to dress that show allegiance to a specific substance or group?*
View of Past, Present, and Future *Are there specific beliefs about the past, present, and/or future?*	**Language & Communication** *Are there special verbal or nonverbal ways to communicate about substance-related activities?*	**Attitudes** *What are common attitudes toward others (nonusers, police, etc.)?*

Whites could be linked to the historical development of the methamphetamine trade by White motorcycle gangs (Morgan and Beck 1997). On the other hand, most gay men who use the drug report having first used it at parties with the expectation of involvement in sexual activity (Hunt et al. 2006). In studies of gay men who used methamphetamine, the main reason for use was to heighten sexual experience (Halkitis et al. 2005; Kurtz 2005; Reback 1997). Morgan and Beck (1997) found that increased sexual activity was one reason why certain women and heterosexual men used methamphetamine, but it was not as important a reason as it was for gay men.

This chapter aims to explain that people who use drugs participate in a drug culture, and further, that they value this participation. However, not all people who abuse substances are part of a drug culture. White (1996) draws attention to a set of individuals whom he calls "acultural addicts." These people initiate and sustain their substance use in relative isolation from other people who use drugs. Examples of acultural addicts include the medical professional who does not have to use illegal drug networks to abuse prescription medication, or the older, middle-class individual who "pill shops" from multiple doctors and procures drugs for misuse from pharmacies. Although drug cultures typically play a greater role in the lives of people who use illicit drugs, people who use legal substances—such as alcohol—are also likely to participate in such a culture (Gordon et al. 2012). Drinking cultures can develop among heavy drinkers at a bar or a college fraternity or sorority house that works to encourage new people to use, supports high levels of continued or binge use, reinforces denial, and develops rituals and customary behaviors surrounding drinking. In this chapter, drug culture refers to cultures that evolve from drug and alcohol use.

The Relationship Between Drug Cultures and Mainstream Culture

To some extent, subcultures define themselves in opposition to the mainstream culture. Subcultures may reject some, if not all, of the values and beliefs of the mainstream culture in favor of their own, and they will often adapt some elements of that culture in ways quite different from those originally intended (Hebdige 1991; Issitt 2009; Exhibit 6-2). Individuals often identify with subcultures—such as drug cultures—because they feel excluded from or

Exhibit 6-2: The Language of a Drug Culture

One of the defining features of any culture is the language it uses; this need not be an entire language, and may simply comprise certain jargon or slang and a particular style of communication. The use of slang regarding drugs and drug activity is a well-recognized aspect of drug culture. Not as well-known is the diversity of that language and how it varies across time and place. Rather than coining new words, the language of drug culture often borrows words from mainstream culture and adapts them to new purposes.

For example, Williams (1992) examined the use of Star Trek terminology among people who used crack cocaine in New York during the 1980s. They adopted the persona of members of the Star Trek Enterprise crew in their use of language—such as "going on a mission" when they went looking for cocaine; "beam me up, Scotty" when they wanted to get high; and referring to crack cocaine itself as "Scotty." Crack cocaine users even created an imaginary book entitled *The Book of Tech* that they referred to as if it contained important information for people who use and sell crack cocaine (e.g., how to cook freebase cocaine from cocaine hydrochloride). This language (and other terms derived from other sources) helped members of this drug culture recognize other members. People who did not understand the terms used were typically taken advantage of during drug transactions.

unable to participate in mainstream society. The subculture provides an alternative source of social support and cultural activities, but those activities can run counter to the best interests of the individual. Many subcultures are neither harmful nor antisocial, but their focus is on the substance(s) of abuse, not on the people who participate in the culture or their well-being.

Mainstream culture in the United States has historically frowned on most substance use and certainly substance abuse (Corrigan et al. 2009; White 1979, 1998). This can extend to legal substances such as alcohol or tobacco (including, in recent years, the increased prohibition against cigarette smoking in public spaces and its growing social unacceptability in private spaces). As a result, mainstream culture does not—for the most part—have an accepted role for most types of substance use, unlike many older cultures, which may accept use, for example, as part of specific religious rituals. Thus, people who experiment with drugs in the United States usually do so in highly marginalized social settings, which can contribute to the development of substance use disorders (Wilcox 1998). Individuals who are curious about substance use, particularly young people, are therefore more likely to become involved in a drug culture that encourages excessive use and experimentation with other, often stronger, substances (for a review of intervention strategies to reduce discrimination related to substance use disorders, see Livingston et al. 2012).

When people who abuse substances are marginalized, they tend not to seek access to mainstream institutions that typically provide sociocultural support (Myers et al. 2009). This can result in even stronger bonding with the drug culture. A marginalized person's behavior is seen as abnormal even if he or she attempts to act differently, thus further reducing the chances of any attempt to change behavior (Cohen 1992). The drug culture enables its members to view substance use disorders as normal or even as status symbols. The disorder becomes a source of pride, and people may celebrate their drug-related identity with other members of the culture (Pearson and Bourgois 1995; White 1996). Social stigma also aids in the formation of oppositional values and beliefs that can promote unity among members of the drug culture (Exhibit 6-3).

When people with substance use disorders experience discrimination, they are likely to delay entering treatment and can have less positive treatment outcomes (Fortney et al. 2004; Link et al. 1997; Semple et al. 2005). Discrimination can also increase denial and step up the individual's attempts to hide substance use (Mateu-Gelabert et al. 2005). The immorality that mainstream society attaches to substance use and abuse can unintentionally serve to strengthen individuals' ties with the drug culture and decrease the likelihood that they will seek treatment.

The relationship between the drug and mainstream cultures is not unidirectional. Since the beginning of a definable drug culture, that culture has had an effect on mainstream cultural institutions, particularly through music (Exhibit 6-4), art, and literature. These connections can add significantly to the attraction a drug culture holds for some individuals (especially the young and those who pride themselves on being nonconformists) and create a greater risk for substance use escalating to abuse and relapse.

Understanding Why People Are Attracted to Drug Cultures

To understand what an individual gains from participating in a drug culture, it is important first to examine some of the factors involved

Exhibit 6-3: The Values and Beliefs of a Heroin Culture

Many core values of illicit drug cultures involve rejecting mainstream society and its cultural values. Stephens (1991) analyzed value statements from people addicted to heroin and extracted the core tenets of this drug culture's value system. They are:

- Antisocial viewpoint—Members of this drug culture share a viewpoint that sees all people as basically dishonest and egocentric; they are especially distrustful of those who do not use heroin.
- Rejection of middle-class values—Members denigrate values such as the need for hard work, security, and honesty.
- Excitement/hedonism—Members value immediate gratification and the intense pursuit of pleasure over more stable and lasting values.
- Importance of outward appearances—As much as members of the drug culture may complain about the mainstream culture's shallowness, they strongly believe in conspicuous consumption and the importance of owning things that give an image of prosperity.
- Valence of street addict subcultures—Members of this drug culture value the continued participation of others in the culture, even to the point of expecting individuals who have stopped using to continue to participate in the culture.
- Emotional detachment—People involved in this drug culture value emotional aloofness and see emotional involvement with others as a weakness.

These core values (initially examined by Stephens et al. 1976) were taken from a specific drug culture (heroin), but they can be found in many other drug cultures that center on the use of illicit drugs. However, these same values will not be upheld in every drug culture. For instance, the drug culture of people who use MDMA does not appear to value emotional aloofness, but rather to appreciate the drug's ability to create a feeling of emotional intimacy among those who use it (Gourley 2004; Reynolds 1998). Drug cultures involving legal substances (notably alcohol) are less likely to reject the core values of mainstream society and are less likely to be rejected by that society. They will, however, still value excitement/hedonism and the participation of others in the subculture.

Exhibit 6-4: Music and Drug Cultures

Since the 1920s, when marijuana use became associated with jazz musicians, there has been a connection between certain music subcultures and particular types of substance use (Blake 2007; Gahlinger 2001). As Blackman (1996) notes, "Before the emergence of post-war youth culture, there was a direct connection between the development of the popular music—jazz—and the use of illicit drugs in terms of musicians who used drugs, including heroin, cocaine, and cannabis and their narratives about these drugs through songs" (p. 137). Early Federal legislation criminalizing marijuana was motivated, in part, by use of the drug by jazz musicians and fear that their example would influence youth (Whitebread 1995).

In recent years, the link between drug culture and music has been exemplified by the importance of MDMA in the rave music scene (Kotarba 2007; Murguia et al. 2007). Reynolds (1998) credits the development of rave music to MDMA's ability to create a feeling of intimacy among relative strangers and the way in which people who use it respond to repetitive, up-tempo music. Conversely, Adlaf and Smart (1997) found that adolescents in Canada typically became involved in the rave music scene after starting to use MDMA and other drugs. Regardless of how the relationship developed, MDMA and rave music are so closely linked that it is hard to tell where the music culture ends and the drug culture begins.

Blackman (1996) states that drug use has become an essential element of youth culture mainly through its association with musical artists. Similarly, Knutagard (1996) observes how different youth cultures, each defined in part by its members' choices in music and substance use, have made some types of substance use acceptable to many young people. Esan (2007) notes that urban music and drug

Exhibit 6-4: Music and Drug Cultures (continued)

culture have a shared appeal to young people based on their apparently antagonistic relationship to mainstream culture. Since the 1990s, rock group confessional memoirs have become increasingly popular, often depicting a lifestyle and culture of excess and providing explicit details of drug use and methods; consumption-driven, high-risk, or excessive behaviors; tragic consequences of use; and, sometimes, the author's participation in rehabilitation (Oksanen 2012).

Certain drugs and the drug-dealing lifestyle are featured prominently in different types of music, including hip hop (Esan 2007; Schensul et al. 2000) or *narcocorridos* (a popular form of Mexican and Mexican American border music that tells of the lives of drug traffickers [Edberg 2004]). However, even music that is not overtly concerned with drug use can become connected to a drug culture or to substance use in an individual's mind. According to White (1996), links between particular songs and the recall of euphoric drug experiences are especially common and may need to be addressed explicitly in treatment. Hearing these songs can act as a trigger for drug use and can, therefore, be a potential cause of relapse.

in substance use and the development of substance use disorders. Despite having differing theories about the root causes of substance use disorders, most researchers would agree that substance abuse is, to some extent, a learned behavior. Beginning with Becker's (1953) seminal work, research has shown that many commonly abused substances are not automatically experienced as pleasurable by people who use them for the first time (Fekjaer 1994). For instance, many people find the taste of alcoholic beverages disagreeable during their first experience with them, and they only learn to experience these effects as pleasurable over time. Expectations can also be important among people who use drugs; those who have greater expectancies of pleasure typically have a more intense and pleasurable experience. These expectancies may play a part in the development of substance use disorders (Fekjaer 1994; Leventhal and Schmitz 2006).

Additionally, drug-seeking and other behaviors associated with substance use have a reinforcing effect beyond that of the actual drugs. Activities such as rituals of use (Exhibit 6-5), which make up part of the drug culture, provide a focus for those who use drugs when the drugs themselves are unavailable and help them shift attention away from problems they might otherwise need to face (Lende 2005).

Drug cultures serve as an initiating force as well as a sustaining force for substance use and abuse (White 1996). As an initiating force, the culture provides a way for people new to drug use to learn what to expect and how to appreciate the experience of getting high. As White (1996) notes, the drug culture teaches the new user "how to recognize and enjoy drug effects" (p. 46). There are also practical matters involved in using substances (e.g., how much to take, how to ingest the substance for strongest effect) that people new to drug use may not know when they first begin to experiment with drugs. The skills needed to use some drugs can be quite complicated, as shown in Exhibit 6-6.

The drug culture has an appeal all its own that promotes initiation into drug use. Stephens (1991) uses examples from a number of ethnographic studies to show how people can be as taken by the excitement of the drug culture as they are by the drug itself. Media portrayals, along with singer or music group autobiographies, that glamorize the drug lifestyle may increase its lure (Manning 2007; Oksanen 2012). In buying (and perhaps selling) drugs, individuals can find excitement that is missing in their lives. They can likewise find a sense of purpose they otherwise lack in the daily need to seek out and acquire drugs. In successfully navigating the difficulties of living as a person

Exhibit 6-5: The Rituals of Drug Cultures

Several authors have noted that illicit drug use and alcohol use typically involve ritualized behaviors (Alverson 2005; Carlson 2006; Carnes et al. 2004; Grund 1993; White 1996). The rituals of substance use affect where, when, and how substances are used. Substance-related rituals serve both instrumental and social functions. Instrumental functions include maximizing drug effects, minimizing negative effects of drug use, and preventing secondary problems. Socially, the rituals display one's affiliation with the drug culture to other people and help create a sense of community within the culture. Obviously, the social function is more central to group activities than to solitary rituals.

Most drug-related social rituals involve sharing substances or sharing the experience of intoxication. Some drug cultures (e.g., marijuana) encourage the sharing of substances, but even when they are not shared, drugs are often used with other people who use, such as in crack houses and shooting galleries (Bourgois 1998; Grund 1993; Williams 1992). Rituals involving shared substance use and public substance use strengthen the bonds between members of a drug culture and sustain the drug culture. Some social rituals are so important to members of the drug culture that they participate in them even when they have no drugs, such as when marijuana smokers smoke an inert substance (e.g., horse manure, banana peels) together when they have no marijuana (White 1996). Drug use can also be incorporated into other ritualized behaviors, such as sexual activity (Carnes et al. 2004).

Individuals develop their own drug-related rituals through the influence of other members of the culture and also through trial and error. This allows them to determine what works best for them to maximize the drug's effect and minimize related problems. For example, Grund (1993) found, through observing the rituals surrounding the injection of cocaine and heroin among people in the Netherlands, that specific rituals governed the timing and administration of the drugs so that heroin lessened the unpleasant side effects of the cocaine. Other recent examples are the combination of energy drinks with alcohol to delay the normal onset of sleepiness (Howland and Rohsenow 2013; Substance Abuse and Mental Health Services Administration [SAMHSA] 2013*c*) and the combination of methylphenidate with alcohol to intensify euphoric effects (for review of central nervous system stimulant use and emergency room information, see SAMHSA 2013*b*).

Exhibit 6-6: Questions Regarding Knowledge and Skill Demands of Heroin Use

- If first use is by snorting, how is it done (assuming the person has never taken a drug intranasally)? Is there a special technique for using heroin this way?
- If first use is by injection, is it best to inject the drug under the skin (skin-popping) or into a vein?
- What equipment is required? If one doesn't have a hypodermic syringe, what other equipment can be substituted to make up a set of "works" or an "outfit"?
- How is heroin prepared (cooked) for injection?
- What techniques or procedures are used to inject the drug?
- What does one do if the needle clogs?
- Is there any way to test the purity of the drug?
- How much of the drug constitutes a desirable dose?
- If more than one person is using and an outfit is being shared, who uses it first?
- If sharing, how can the works be cleaned to prevent the transmission of disease?
- How does one know if he or she has injected too much?
- Are there any unpleasant side effects one should anticipate?
- How long will the effects of the drug last?
- Is there any way to maximize the drug's effects?
- Is there anything one should not do while high on the drug?
- How much time must pass before the drug can be used again?
- If a bruise or an abscess develops at the injection site, how can it be hidden and treated (without seeing a physician)?

Source: White 1996.

who uses drugs, they can gain approval from peers who use drugs and a feeling that they are successful at something.

In some communities, participation in the drug trade—an aspect of a drug culture—is simply one of the few economic opportunities available and is a means of gaining the admiration and respect of peers (Bourgois 2003; Simon and Burns 1997). However, drug dealing as a source of status is not limited to economically deprived communities. In studying drug dealing among relatively affluent college students at a private college, Mohamed and Fritsvold (2006) found that the most important motives for dealing were ego gratification, status, and the desire to assume an outlaw image.

Marginalized adolescents and young adults find drug cultures particularly appealing. Many individual, family, and social risk factors associated with adolescent substance abuse are also risk factors for youth involvement with a drug culture. Individual factors—such as feelings of alienation from society and a strong rejection of authority—can cause youth to look outside the traditional cultural institutions available to them (family, church, school, etc.) and instead seek acceptance in a subculture, such as a drug culture (Hebdige 1991; Moshier et al. 2012). Individual traits like sensation-seeking and poor impulse control, which can interfere with functioning in mainstream society, are often tolerated or can be freely expressed in a drug culture. Family involvement with drugs is a significant risk factor due to additional exposure to the drug lifestyle, as well as early learning of the values and behaviors (e.g., lying to cover for parents' illicit activities) associated with it (Haight et al. 2005). Social risk factors (e.g., rejection by peers, poverty, failure in school) can also increase young people's alienation from traditional cultural institutions. The need for social acceptance is a major reason many young people begin to use drugs, as social acceptance can be found with less effort within the drug culture.

In addition to helping initiate drug use, drug cultures serve as sustaining forces. They support continued use and reinforce denial that a problem with alcohol or drugs exists. The importance of the drug culture to the person using drugs often increases with time as the person's association with it deepens (Moshier et al. 2012). White (1996) notes that as a person progresses from experimentation to abuse and/or dependence, he or she develops a more intense need to "seek for supports to sustain the drug relationship" (p. 9). In addition to gaining social sanction for their substance use, participants in the drug culture learn many skills that can help them avoid the pitfalls of the substance-abusing lifestyle and thus continue their use. They learn how to avoid arrest, how to get money to support their habit, and how to find a new supplier when necessary.

The more an individual's needs are met within a drug culture, the harder it will be to leave that culture behind. White (1996) gives an example of a person who was initially attracted in youth to a drug culture because of a desire for social acceptance and then grew up within that culture. Through involvement in the drug culture, he was able to gain a measure of self-esteem, change his family dynamic, explore his sexuality, develop lasting friendships, and find a career path (albeit a criminal one). For this individual, who had so much of his life invested in the drug culture, it was as difficult to conceive of leaving that culture as it was to conceive of stopping his substance use.

Online Drug Cultures

One major change that has occurred in drug cultures in recent years is the development of

How To Lead an Exercise Examining Benefits, Losses, and the Future

Counselors and clinical supervisors can help clients identify reinforcing aspects (besides physiological effects) of their drug and alcohol use and the losses associated with use, including unmet goals and dreams. The physiological, social, and emotional gains and losses that have transpired during their use (whether or not they associate these losses with their use) can serve as risks for relapse. This exercise works well as an interactive psychoeducational lecture for clients, as a training tool for counselors, and as a group counseling exercise. It can also be adapted for individual sessions.

Materials needed: Group room with sufficient space to move around.

Instructions:

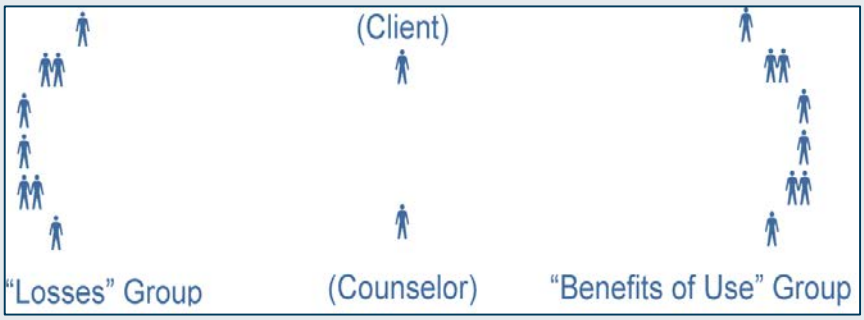
- Select an amenable client aware of the losses and consequences associated with his/her use. Later in the exercise, select other clients to give other group members a more direct experience.
- Divide the group in two. For large groups, select only 6 to 8 people for each side. Have each subgroup stand on opposite sides of the room facing each other. One group will represent the benefits of use; the other, losses associated with use (see diagram for room set-up).
- Rather than using the client's personal benefits and losses (at least initially), ask group members to brainstorm about their experiences that represent each side. Begin with the side of the room that represents "benefits of use" and ask everyone in the room to name some benefits. Then, assign a specific benefit to each person in the "benefits of use" group and create a one-line message for each (a first-person statement describing the benefit), asking the representative client to remember the line. For example, if the group named a benefit of use as immediate acceptance from others who use, assign this benefit to one person and create a message to capture it: "I make you feel like you belong," or "We are family now." Continue brainstorming until you have assigned six or more benefits.
- Next, go to the opposite group that represents the losses associated with use and begin to solicit losses from everyone in the room. Assign a loss to each person in the "loss" group, create a one-line message that coincides with each loss, and then ask an individual to remember each loss message (e.g., "I am the loss of your children," "I am the loss of your self-respect," "I am the loss of your health"). In addition, ask the group to name future goals and plans that were curtailed because of use. Assign these losses as well, following the same format (e.g., "I am the loss of a college degree," "I am the loss of intimate relationships," "I am the loss of belief in the future"). Note: If you run out of people, you can assign two roles to one person.
- At this point, the exercise can already be a powerful experience for many clients. Now, have the person who was originally selected as the client stand facing the "benefits of use" group. Have the client process what it is like to see the benefits of use. You can also have each person in the "benefits of use" group state his or her one-line message to help facilitate this process. Stand with the client as he or she moves to the "loss" group. Again, have the client stand and face this group while asking him or her what it is like to see the losses, including the losses related to goals and the future. Note: It is not important as an exercise to have benefits or losses specific only to this client. It is far better to gain a sample from the entire group so that everyone is involved and to maximize the exercise's effectiveness as a psychoeducational tool.
- After the client has stood in front of both groups, ask him or her to move back and forth between each group several times to see what emotional changes occur in experiencing each group. It is important to process this experience as a group. You can invite other members to switch out of their roles and stand in as clients to experience this exercise more directly. Clients are likely to see how seductive the "benefits of use" group can be and how this attraction can lead back to relapse. This exercise may also help clients connect with the losses associated with their use. At times, clients may gain awareness that the very losses associated with their use can also serve as a trigger for use as a means of self-medicating feelings.

(Continued on the next page.)

How To Lead an Exercise Examining Benefits, Losses, and the Future (continued)

- Allot sufficient time for this psychoeducational lecture—not only to demonstrate the benefits and losses associated with use, but also to enable the group to process their thoughts and feelings.

Group Room Setup



Internet communities organized around drug use (Gatson 2007*a*; Murguia et al. 2007) and drug use facilitation, including information on use, production, and sales (Bowker 2011; U.S. Department of Justice 2002). Such communities develop around Web sites or discussion boards where individuals can describe their drug-related experiences, find information on acquiring and using drugs, and discuss related issues ranging from musical interests to legal problems. Many of the Web sites where these online communities develop are originally created to lessen the negative consequences of substance use by informing people about various related legal and medical issues (Gatson 2007*b*; Murguia et al. 2007). As in other drug cultures, users of these Web sites and discussion boards develop their own language and values relating to drug use. Club drugs and hallucinogenics are the most often-discussed types of drugs, but online communities involve the discussion of all types of licit and illicit substances, including stimulants and opioids (Gatson 2007*a*; Murguia et al. 2007; Tackett-Gibson 2007).

Murguia et al. (2007) reported on a survey of adult (ages 18 and older) participants in one online community. The self-selected survey sample included 1,038 respondents, 80 percent of whom were from the United States. Respondents were likely to be young (90 percent were under 30), male (76 percent), White (92 percent), relatively affluent (58 percent had household incomes of $45,000 or more), employed (41 percent were employed full time; another 28 percent, part time), and/or in school (57 percent were attending school full or part time). According to the 2011 National Survey on Drug Use and Health, approximately 0.3 percent of individuals 12 years of age or older purchase prescription drugs through the Internet (SAMHSA, 2012*b*).

The Role of Drug Cultures in Substance Abuse Treatment

Most people seek some kind of social affiliation; it is one aspect of life that gives meaning to day-to-day existence. Behavioral health service providers can better understand and help their clients if they have an understanding of the culture(s) with which they identify. This understanding can be even more important when addressing the role of drug culture in a client's life because, of all cultural affiliations, it is likely to be the one most intimately connected with his or her substance

abuse. The drug culture is likely to have had a considerable influence on the client's behaviors related to substance use.

Drug Cultures in Assessment and Engagement

The first step in understanding the role a drug culture plays in a client's life is to assess which drug culture(s) the client has been involved with and his or her level of involvement. There are no textbooks that can inform providers about the drug cultures in their areas, but counselors probably know quite a bit about them already, as they learn much about drug cultures through talking with their clients. Counselors who are themselves in recovery may be familiar with some clients' substance-using lifestyles and social environments or will have insight into how to explore the issue with clients. They can also educate their colleagues.

Providers who have never personally abused substances can learn from recovered counselors as well as from their clients. However, asking a client point-blank about his or her involvement in a drug culture is likely to be answered with a blank stare. Instead, talking to clients about their relationships, daily activities and habits relating to substance use, values, and views of other people and the world can allow providers to develop a good sense of the meanings drug cultures hold for clients.

To engage a client in treatment, understanding his or her relationship with a drug culture may be as important as understanding elements of that client's racial or ethnic identity. Clients are unlikely to self-identify as members of the drug culture in the same way that they would identify as an African American or Asian American, for example, but they can still be offended or distrustful if they think the provider or program does not understand how their lifestyle relates to their substance use. Affiliation with a drug culture is a source of client identity; the client's place in the drug culture can be important to his or her self-esteem.

After the assessment and engagement stage, the provider's attitude toward the client's participation in a drug culture will be significantly different from his or her attitude toward the client's other cultural affiliations. As most providers already know (even if they do not use the term drug culture), if a client

How To Learn About Clients' Daily Routines and Rituals

One way to gain an understanding of a client's involvement in a specific drug culture is to learn about his or her daily routines and rituals. Keep in mind that there can be different routines on weekends or specific days of the week; ask about exceptions to the typical daily schedule.

Materials needed: Weekly calendar.

Instructions:

- To elicit information about the client's daily activities, use a cue or anchor to initiate this exploration, such as a calendar highlighting each day of a week—Monday through Sunday.
- Placing the calendar in front of the client, ask him or her to describe a typical day, beginning with the time that he or she generally wakes up and building on the morning routines (e.g., "What does an average morning look like for you?").
- Encourage the client to provide a specific account of his or her routine rather than a general response. Important information can be obtained by asking the client about feelings or reactions to daily activities as they unfold in the session.
- After completing an example of an entire day, ask the client if there are exceptions to this schedule that routinely occur on another day of the week or during the weekend. Once these are processed, it can be beneficial to ask what it was like for him or her to talk about these daily routines.

> "The culture of recovery is an informal social network in which group norms (prescribed patterns of perceiving, thinking, feeling, and behaving) reinforce sobriety and long-term recovery from addiction."
>
> (White 1996, p. 222)

continues to be closely affiliated with the drug-using life, then he or she is more likely to relapse. The people, places, things, thoughts, and attitudes related to drug and/or alcohol use act as triggers to resume use of substances. Behavioral health service providers need to help their clients weaken and eventually eliminate their connections to the drug culture. White (1996) identifies an important issue to address during transition from engagement to treatment—in the process of engaging clients, providers help them identify how their connections to the drug culture prevent them from reaching their goals and how the loss of these connections would affect them if they chose to cut ties with the drug culture.

Finding Alternatives to Drug Cultures

A client can meet the psychosocial needs previously satisfied by the drug culture in a number of ways. Strengthening cultural identity can be a positive action for the client; in some cases, the client's family or cultural peers can serve as a replacement for involvement in the drug culture. This option is particularly helpful when the client's connection to a drug culture is relatively weak and his or her traditional culture is relatively strong. However, when this option is unavailable or insufficient, clinicians must focus on replacing the client's ties with the drug culture (or the culture of addiction) with new ties to a culture of recovery.

To help clients break ties with drug cultures, programs need to challenge clients' continued involvement with elements of those cultures (e.g., style of dress, music, language, or communication patterns). This can occur through two basic processes: replacing the element with something new that is positively associated with a culture of recovery (e.g., replacing a marijuana leaf keychain with an NA keychain), and reframing something so that it is no longer associated with drug use or the drug culture (e.g., listening to music that was associated with the drug culture at a sober dance with others in recovery; White 1996). The process will depend on the nature of the cultural element.

Developing a Culture of Recovery

Just as people who are actively using or abusing substances bond over that common experience to create a drug culture that supports their continued substance use, people in recovery can participate in activities with others who are having similar experiences to build a culture of recovery. There is no single drug culture; likewise, there is no single culture of recovery. However, large international mutual-help organizations like Alcoholics Anonymous (AA) do represent the culture of recovery for many individuals (Exhibit 6-7). Even within such organizations, though, there is some cultural diversity; regional differences exist, for example, in meeting-related rituals or attitudes toward certain issues (e.g., use of prescribed psychotropic medication, approaches to spirituality).

The planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e*), provides more information on using mutual-help groups in

> Recovery from mental and substance use disorders is a process of change through which people improve their health and wellness, live in a self-directed manner, and work toward achieving their full potential.
>
> (SAMHSA 2011*b*)

treatment settings and in long-term recovery. It contains detailed information about potential recovery supports that behavioral health programs can use to foster cultures of recovery among clients and program graduates.

Most treatment programs try to foster a culture of recovery for their clients. Some modalities, with therapeutic communities being the lead example, focus on this issue as a primary treatment strategy. Even one-on-one outpatient treatment programs typically encourage attendance at mutual-help groups, such as AA, to meet sociocultural recovery needs. Most providers also recognize that clients need to replace the activities, beliefs, people, places, and things associated with substance abuse with new recovery-related associations—the central purpose of creating a culture of recovery.

Even programs that already recognize the need to create a culture of recovery for their clients can make doing so more of a focus in treatment. White (1996) explores ways to do this, including:

- Teaching clients about the existence of drug cultures and their potential influence in clients' lives.
- Teaching clients about cultures of recovery and discussing how elements of the drug

Exhibit 6-7: 12-Step Group Values and the Culture of Recovery

For historical reasons, cultures of recovery (like the recovery process in general) in the United States have been greatly influenced by 12-Step groups such as AA and NA (White 1998). These groups provide a clearly defined culture of recovery for a great many people. They provide members with a set of rituals, daily activities, customs, traditions, values, and beliefs.

The 12 Steps and 12 Traditions represent the core principles, values, and beliefs of such groups. Wilcox (1998) defines these values as surrender; faith; acceptance, tolerance, and patience; honesty, openness, and willingness; humility; willingness to examine character defects; taking life one day at a time; and keeping things simple. As seen by comparing these values with those common to the heroin culture described in the "The Values and Beliefs of a Heroin Culture" box earlier in this chapter, one of the ways in which 12-Step groups work is by instilling a set of values contrary to those found in drug cultures. However, they also provide members with a new set of values that are in some ways distinct from the values of the mainstream culture that were rejected when the individual began his or her involvement in the drug culture (Wilcox 1998).

Many of the values of AA and other 12-Step groups are embodied in rituals that take place in meetings and in members' daily lives. White (1998) lists four ritual categories:

- **Centering rituals** help members stay focused on recovery by reading recovery literature, handling recovery tokens or symbols, and taking regular self-assessments or personal inventories each day.
- **Mirroring rituals** keep members in contact with one another and help them practice sober living together. Attending meetings, telling one's story, speaking regularly by phone, and using slogans (e.g., "keep it simple," "pass it on"), among others, are mirroring activities.
- **Acts of personal responsibility** include being honest and becoming time-conscious and punctual. Activities include the creation of new rituals of daily living related to sleeping, hygiene, and other areas of self-care while also being reliable and courteous.
- **Acts of service** involve performing rituals to help others in recovery. These acts are related to the Twelfth Step, which directs members to carry the message of their spiritual awakening to others who abuse alcohol or are dependent on it, thereby encouraging them to practice the 12 Steps. Acts of service recognize that people in recovery have something of value to offer those still abusing alcohol.

These rituals aid the processes of personal transformation and integration into a new cultural group.

culture can be replaced by elements of a culture of recovery.

- Establishing clear boundaries for appropriate behavior (e.g., behavior that does not reflect drug cultures) in the program and consistently correcting behaviors that violate boundaries (e.g., wearing shirts depicting pot leaves; displaying gang-affiliated symbols, gestures, and tattoos).
- Working to shape a peer culture within the program so that longer-term clients and staff members can socialize new clients to a culture of recovery.
- Having regular assessments of clients and the entire program in which staff members and clients determine areas where work is needed to minimize cultural attitudes that can undermine treatment.
- Involving clients' families (when appropriate) in the treatment process so they can support clients' recovery as well as participate in their own healing process.

White (1996) suggests that programs build linkages with mutual-help groups; include mutual-help meetings in their programs or provide access to community mutual-help meetings; and include mutual-help rituals, symbols, language, and values in treatment processes.

Other activities that can improve integration into a recovery culture include SAMHSA's Recovery Community Services Program (http://www.samhsa.gov/grants/2011/ti_11_004.aspx), which was developed to provide and evaluate peer-based recovery support services, and Recovery Community Centers, which provide space for recovering people to socialize, organize, and develop a recovery culture (White and Kurtz 2006). Developing a culture of recovery involves connecting individuals back to the larger community and to their cultures of origin (Davidson et al. 2008). This can require efforts to educate the community about recovery as well (e.g., by promoting a recovery month in the community, hosting recovery walks or similar events, or offering outreach to community groups, such as churches or fraternal/benevolent societies).

Programs that do not have a plan for creating a culture of recovery among clients risk their clients returning to the drug culture or holding on to elements of that culture because it meets their basic and social needs. In the worst case scenario, clients will recreate a drug culture among themselves within the program. In the best case, staff members will have a plan for creating a culture of recovery within their treatment population.

SAMHSA's Guiding Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationship and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

More information on the Guiding Principles of Recovery is available at the SAMHSA Store (http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf).

Source: SAMHSA 2012c.

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Appendix B—Instruments To Measure Identity and Acculturation

Some researchers have tested the usefulness of acculturation and identity models with people who abuse substances. For example, Peña and colleagues' racial identity attitude scale was found, in a study of African American men in treatment for cocaine dependence, to help counselors better understand the roles that ethnic and cultural identity play in clients' substance abuse issues (Peña et al. 2000). In 1980, Cuellar and colleagues published their acculturation rating scale for Mexican Americans, which conceptualized acculturation as progressing across a 5-point continuum ranging from Mexican or low acculturated (level 1) to American or high acculturated (level 5). The mid-level designation of bicultural (level 3) was set as the midpoint between the two extremes, although various investigators have questioned this assumption (Oetting and Beauvais 1990; Sayegh and Lasry 1993). Since then, scholars have developed new ways to conceptualize identity and acculturation, ranging from simple scales to complex multidimensional models (Skinner 2001). The table that begins on the next page summarizes the instruments available to measure acculturation and ethnic identity. (See also the Center of Excellence for Cultural Competence for additional resources at http://nyculturalcompetence.org).

Other scales have been developed to examine specific culture-related variables, including *machismo* (Cuellar et al. 1995; Fragoso and Kashubeck 2000), *simpatía* (Griffith et al. 1998), *familismo* (Sabogal et al. 1987), traditionalism–modernism (Ramirez 1999), and family traditionalism and rural preferences (Castro and Gutierres 1997). Counselors can use acculturation scales to help match patients to providers, to make treatment plans, and to identify the role of identity in substance abuse. Although these instruments can be helpful, the counselor must not rely solely on them to determine the client's identity or level of acculturation.

Acculturation and Ethnic Identity Measures

Instrument	Description	Cultural Group
African American Acculturation Scale-Revised (Klonoff and Landrine 2000)	This scale measures eight dimensions of African American culture: (1) traditional beliefs and practices, (2) traditional family structure and practices, (3) traditional socialization, (4) preparation and consumption of traditional foods, (5) preference for African American things, (6) interracial attitudes, (7) superstitions, and (8) traditional health beliefs and practices.	African Americans
Black Racial Identity Attitude Scale—Form B (Helms 1990)	This scale measures beliefs or attitudes of Blacks toward both Blacks and Whites using 5-point scales. It is available in short and long forms.	African Americans
Cross Racial Identity Scale (Worrell et al. 2001)	This scale measures six identity clusters associated with four stages of racial identity development.	African Americans
Multidimensional Inventory of Black Identity (MIBI; Sellers et al. 1997)	The MIBI measures centrality of Black identity, ideology, and regard for a Black identity. It is available online at http://sitemaker.umich.edu/aaril/files/mibiscaleandscoring.pdf.	African Americans
Scale To Assess African American Acculturation (Snowden and Hines 1999)	This is a 10-item scale that assesses media preferences, racial bias in relationships, race-related attitudes, and comfort in interacting with other races.	African Americans
African Self-Consciousness Scale (Baldwin and Bell 1985)	This scale measures within-group variability in the level of acculturation/cultural identity continuum (Baldwin and Bell 1985) based on degree of Afrocentricity or Nigrescence (White and Parham 1996). It indicates a client's level of involvement in traditional African American culture or the core African-oriented culture.	African Americans/African Immigrants
Native American Acculturation Scale (Garrett and Pichette 2000)	The Native American Acculturation scale asks 20 questions to ascertain a client's level of involvement with Native American culture.	Native Americans
Rosebud Personal Opinion Survey (Hoffmann et al. 1985)	This assessment evaluates components of acculturation, including language use, values, social behaviors, social networks, religious affiliation and practice, home community, education, ancestry, and cultural identification.	Native Americans
Asian American Multidimensional Acculturation Scale (AAMAS; Gim Chung et al. 2004)	The AAMAS was developed to be easy to use with a variety of Asian American ethnic groups. It includes questions relating to cultural identity, language use, cultural knowledge, and food preferences.	Asian Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Adjustment Difficulties Checklist (CADC; Sodowsky and Lai 1997)	The CADC helps avoid potential problems relating to acculturation by asking about language use, social customs, family interactions, perceptions of prejudice, friendship networks, and cultural adjustment.	Asian Americans (East Asians)
East Asian Acculturation Measure (Barry 2001)	This instrument includes 29 items that assess assimilation, level of separation from other Asians, integration, and marginalization.	Asian Americans (East Asians)
General Ethnicity Questionnaire (GEQ; Tsai et al. 2000)	The GEQ is an instrument designed to be used with minor modifications for assessing cultural orientation with different cultural groups. There are original and abridged versions. The original includes 75 items asking about language use, social affiliations, cultural practices, and cultural identification.	Asian Americans (although designed to be multicultural in orientation)
Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al. 1992)	This instrument was modeled after the Acculturation Rating Scale for Mexican Americans, and research indicates it has high reliability.	Asian Americans
Ethnocultural Identity Behavioral Index (Yamada et al. 1998)	This is a 19-item self-report assessment with high validity.	Asian Americans and Pacific Islanders
Internal-External Ethnic Identity Measure (Kwan 1997)	The instrument evaluates ethnic friendships and affiliation, ethnocommunal expression, ethnic food orientation, and family collectivism, in order to differentiate three Chinese American identity groups: (1) internal, (2) external, and (3) internal-external undifferentiated.	Chinese Americans
Marín and Marín Acculturation Scale (Marín et al. 1987)	This scale is a 12-item instrument that assesses three domains: (1) language use, (2) media preferences, and (3) ethnic diversity of social relations. It is available online at http://www.columbia.edu/cu/ssw/projects/pmap/docs/gupta_acculturation.pdf	Chinese Americans
Behavioral Acculturation Scale and Value Acculturation Scale (Szapocznik et al. 1978)	These two scales, used in conjunction with one another, ask individuals about behaviors and values in order to determine acculturation. If used singly, the behavioral scale is the superior measure for acculturation.	Cuban Americans
Na Mea Hawai'i (Hawaiian Ways), A Hawaiian Acculturation Scale (Rezentes 1993)	This is a 34-item scale. An adolescent version is available (Hishinuma et al. 2000).	Native Hawaiians

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB; Zea et al. 2003)	The AMAS-ZABB is a multidimensional, bilinear, 42-item scale that evaluates identity, language competence, and cultural competence.	Latinos
Acculturation Scale (Marin et al. 1987)	This 12-item acculturation scale, available in English and Spanish, evaluates language use, media preferences, and social activities. It is available online at http://casaa.unm.edu/inst/MARIN%20Short%20Scale.pdf	Latinos
Bicultural Involvement Questionnaire (BIQ; Szapocznik et al. 1980)	The BIQ assesses language use and involvement in both Latino and mainstream American activities. It relates two sets of scores to derive a measure of bicultural involvement, with individuals who are highly involved in both cultures scoring highest on the scale.	Latinos
The Bidimensional Acculturation Scale for Hispanics (Marin and Gamba 1996)	This 24-item scale asks questions about language use, language proficiency, and media preferences.	Latinos
Brief Acculturation Scale for Hispanics (Norris et al. 1996)	This scale has only four items, but scores on the scale have been correlated highly with generation, nativity, length of time in the United States, language preferences, and subjective perceptions of acculturation.	Latinos
Multidimensional Measure of Cultural Identity for Latinos (Felix-Ortiz et al. 1994)	This measure places adolescents in one of four categories based on language, behavior/familiarity, and values/attitudes: (1) bicultural, (2) Latino-identified, (3) American-identified, and (4) low-level bicultural.	Latinos
Acculturation Rating Scale for Mexican Americans-I (ARSMA-I; Cuellar et al. 1980)	The ARSMA-I differentiates between 5 levels of acculturation: (1) Very Mexican, (2) Mexican-Oriented Bicultural, (3) True Bicultural, (4) Anglo-Oriented Bicultural, and (5) Very Anglicized. Established validity.	Mexican Americans
Acculturation Rating Scale for Mexican Americans-II (Cuellar et al. 1995)	This scale is like the ARSMA-I, except that it includes separate subscales to measure multidimensional aspects of cultural orientation toward Mexican and Anglo cultures independently.	Mexican Americans
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates five dimensions of acculturation: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates acculturation on five dimensions: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans
Mexican American Acculturation Scale (Montgomery 1992)	This 28-item scale evaluates cultural orientation and comfort with ethnic identity. Items ask about language use, media preferences, cultural activities/traditions, and self-perceived ethnic identity.	Mexican Americans
Padilla's Acculturation Scale (Padilla 1980)	Padilla's Acculturation Scale is a 155-item questionnaire that assesses cultural knowledge and ethnic loyalties.	Mexican Americans
Bidimensional Acculturation Scale for Hispanics (Marín and Gamba 1996)	This scale measures evaluates two major dimensions of acculturation (Hispanic and non-Hispanic) using 12 items measuring 3 language-related areas. It has been found to have high consistency and validity.	Mexican Americans and Central Americans
Stephenson Multigroup Acculturation Scale (Stephenson 2000)	This is a 32-item instrument that evaluates immersion in both culture of origin and the dominant culture of the society.	Multicultural
Vancouver Index of Acculturation (Ryder et al. 2000)	This instrument includes 20 questions that assess interest/participation in one's "heritage culture" and "typical American culture" (available online at http://www2.psych.ubc.ca/~dpaulhus/Paulhus_measures/VIA.American.doc).	Multicultural
Bicultural Acculturation Scale (Cortés and Rogler 1994)	Developed for use with first- and second-generation Puerto Rican adults, this scale measures involvement in American culture and Puerto Rican culture, but it has limited evidence of validity and reliability.	Puerto Rican Americans
Psychological Acculturation Scale (Tropp et al. 1999)	The items on this scale pertain to the client's sense of psychological attachment to and belonging within Anglo American and Hispanic/Latino cultures.	Puerto Ricans on the U.S. mainland
Acculturation Scale for Southeast Asians (Anderson et al. 1993)	This 13-item scale evaluates languages proficiency and preferences regarding social interactions, cultural activities, and food. It includes two subscales for proficiency in languages, as well as language, social, and food preferences.	Cambodian, Laotian, and Vietnamese Americans
White Racial Identity Attitude Scale (Helms and Carter 1990)	This 50-item instrument rates items on a 5-point scale to measure attitudes associated with Helms's stages of racial identity development for Caucasians.	White Americans

Appendix C—Tools for Assessing Cultural Competence

There are numerous assessment tools available for evaluating cultural competence in clinical, training, and organizational settings. These tools are not specific to behavioral health treatment. Though more work is needed in developing empirically supported instruments to measure cultural competence, there is a wealth of multicultural counseling and healthcare assessment tools that can provide guidance in identifying areas for improvement of cultural competence. This appendix examines three resource areas: counselor self-assessment tools, guidelines and assessment tools to implement and evaluate culturally responsive services within treatment programs and organizations, and forms addressing client satisfaction with and feedback about culturally responsive services. Though not an exhaustive review of available tools, this appendix does provide samples of tools that are within the public domain. For additional resources and cultural competence assessment tools, visit the National Center for Cultural Competence (http://nccc.georgetown.edu) or refer to the University of Michigan Health System's Program for Multicultural Health (http://www.med.umich.edu/multicultural/).

Counselor Self-Assessment Tools

Multicultural Counseling Self Efficacy Scale—Racial Diversity Form

This 60-item self-report instrument assesses perceived ability to perform various counselor behaviors in individual counseling with a racially diverse client population. For additional information on psychometric properties and scoring, refer to Sheu and Lent (2007).

Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families

This instrument was developed by Tawara D. Goode of the Georgetown University Center for Child and Human Development. This version is adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* (June 1989). It is available from the Web site of the National Center for Cultural Competence (http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf).

Select A, B, or C for each numbered item listed:
A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I [e]nsure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I [e]nsure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I [e]nsure that toys and other play accessories in reception areas and those used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may have an impact on assessment, treatment, or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff members or trained/certified interpreters for assessment, treatment, and other interventions with children who have limited English proficiency.

_____ 10. I use bilingual staff members or trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

> _____ Limitation in English proficiency is in no way a reflection of their level of intellectual functioning.
>
> _____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
>
> _____ They may or may not be literate in their language of origin or English.

_____ 12. When possible, I ensure that all notices and communiqués to parents are written in their language of origin.

_____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 15. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 16. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with the children and their parents served by my program or agency.

_____ 17. I intervene in an appropriate manner when I observe other staff members or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.

_____ 18. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

_____ 19. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 20. I accept and respect that male–female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play, and social interactions expected of male and female children).

_____ 21. I understand that age and lifecycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

_____ 22. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decisionmakers for services and supports for their children.

_____ 23. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 24. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 25. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____ 26. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability, and death.

_____ 27. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

_____ 28. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 29. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 30. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 32. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 33. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.

Ethnic-Sensitive Inventory (ESI; Ho 1991, reproduced with permission)

Here are some statements made by some practitioners with ethnic minority clients. How often do you feel this way when you work with ethnic minority clients? Every statement should be answered by circling one number ranging from 5 (always) to 4 (frequently), 3 (occasionally), 2 (seldom), and 1 (never).

In working with ethnic minority clients, I . . .

A. Realize that my own ethnic and class background may influence my effectiveness.

B. Make an effort to ensure privacy and/or anonymity.

C. Am aware of the systematic sources (racism, poverty, and prejudice) of their problems.

D. Am against speedy contracting unless initiated by them.

E. Assist them to understand whether the problem is of an individual or a collective nature.

F. Am able to engage them in identifying major progress that has taken place.

G. Consider it an obligation to familiarize myself with their culture, history, and other ethnically related responses to problems.

H. Am able to understand and "tune in" the meaning of their ethnic dispositions, behaviors, and experiences.

I. Can identify the links between systematic problems and individual concerns.

J. Am against highly focused efforts to suggest behavioral change or introspection.

K. Am aware that some techniques are too threatening to them.

L. Am able at the termination phase to help them consider alternative sources of support.

M. Am sensitive to their fear of racist or prejudiced orientations.

N. Am able to move slowly in the effort to actively "reach for feelings."

O. Consider the implications of what is being suggested in relation to each client's ethnic reality (unique dispositions, behaviors, and experiences).

P. Clearly delineate agency functions and respectfully inform clients of my professional expectations of them.

Q. Am aware that lack of progress may be related to ethnicity.

R. Am able to understand that the worker–client relationship may last a long time.

S. Am able to explain clearly the nature of the interview.

T. Am respectful of their definition of the problem to be solved.

U. Am able to specify the problem in practical, concrete terms.

V. Am sensitive to treatment goals consonant to their culture.

W. Am able to mobilize social and extended family networks.

X. Am sensitive to the client's premature termination of service.

Scoring: The 24 items include four items for each of six treatment phases of client–counselor interaction. The sum of the numbers circled for each item relating to a treatment phase is the score for that phase. The scoring grid is given below.

Scoring Grid for ESI

Process Phase	Items
Precontact	A _____ G _____ M _____ S _____
Problem Identification	B _____ H _____ N _____ T _____
Problem Specification	C _____ I _____ O _____ U _____
Mutual Goal Formulation	D _____ J _____ P _____ V _____
Problem Solving	E _____ K _____ Q _____ W _____
Termination	F _____ L _____ R _____ X _____

Source: Ho 1991. Reproduced with permission.

Evaluating Cultural Competence in Treatment Programs and Organizations

Agency Cultural Competence Checklist—Revised Form (Dana 1998, reproduced with permission)

Staff and policy attitudes

_____ Bilingual/bicultural
_____ Bilingual
_____ Bicultural
_____ Culture broker
_____ Flexible hours/appointments/home visits
_____ Treatment immediate/day/week
_____ Indigenous intake
_____ Match client–staff
_____ Agency environment reflects culture

Total possible = 9 Total obtained = _____

Services

_____ Culture-relevant assessment
_____ Cultural context for problems
_____ Cultural-specific intervention model
_____ Culture-specific services:

___ Prevention ___ Crisis ___ Brief ___ Individual
___ Couple ___ Family ___ Child ___ Outreach
___ Community ___ Education ___ Non-mental health
___ Resource linkage ___ Natural helpers/systems

Total possible = 4 Total obtained = _____

Total possible services = 13 Total obtained = _____

Relationship to community

_____ Agency operated by minority community
_____ Agency in minority community
_____ Easy access
_____ Uses existing minority community facilities
_____ Agency ties to minority community
_____ Community advocate for services
_____ Community as adviser
_____ Community as evaluator

Total possible = 8 Total obtained = _____

Training

_____ In-service training for minority staff
_____ In-service training for nonminority staff

Total possible = 2 Total obtained = _____

Evaluation

_____ Evaluation plan/tool
_____ Clients as evaluators/planners

Total possible = 2 Total obtained = _____

Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The standards presented in this section were developed by the Office of Minority Health (OMH 2013) in the Centers for Disease Control and Prevention (CDC) and are available online (https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf). This section is reproduced from material in the public domain. Note that the Centers for Medicare and Medicaid Services (CMS) have also developed tools to assess linguistic competence and interpreter services as well as guidelines for planning culturally responsive services (see the CMS Web site at http://www.cms.gov). The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are meant to advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint for health and health care organizations to:

Principal standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, leadership, and workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and language assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement, and accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Organizational Cultural Competence Assessment Profile

The Health Resources and Services Administration (HRSA) developed the Organizational Cultural Competence Assessment Profile from the cultural competence literature, guided by a team of experts. The profile was used during site visits to a variety of healthcare settings. It is an organizing framework and set of specific indicators to assist in examining, demonstrating, and documenting cultural responsiveness in organizations involved in the direct delivery of health care and services. The profile is not intended to be prescriptive; rather, it is designed to be adapted, modified, or applied in ways that best fit within an organization's context. The profile is presented as a matrix that classifies indicators by critical domains of organizational functioning and by whether the indicators relate to the structures, processes, outputs, or outcomes of the organization. The indicators suggest that assessment of cultural competence should encompass both qualitative and quantitative data and evaluate progress toward achieving results, not just the end results. Although the profile can be used in whole or in part, the full application enables an organization to assess its level of cultural competence comprehensively. Adapted here from material in the public domain are the matrices for process and capacity/structure measures. For more information, see http://www.hrsa.gov/culturalcompetence/ healthdlvr.pdf.

Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Interpreter	Yearly updated directory of trained interpreters is available within 24 hours for routine situations and within 1 hour or less for urgent situations.
Communication	Interpreter	Percentage of clients with limited English proficiency who have access to bilingual staff or interpretation services.

(Continued on the next page.)

Sample of Process Measures by Domain (continued)

Domain	Topic Areas	Measures/Indicators
Communication	Linguistically competent organization	Number of trained translators and interpreters available Number of staff proficient in languages of the community
Communication	Language ability, written and oral, of the consumer	Consumer reading and writing levels of primary languages and dialects is recorded.
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets that demonstrate effective service, equitable access, and comparability of benefits for populations of racial/ethnic groups.
Policies and procedures	Staff hiring, recruitment	Number of multilingual/multicultural staff Ratio by culture of staff to clients
Family and community participation	Community and consumer participation	Degree to which families participate in key decisionmaking activities: • Family participation on advisory committees or task forces • Hiring of family members to serve as consultants to providers/programs • Inclusion of family members in planning, implementation, and evaluation of activities
Communication	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education/promotion material.
Communication	Linguistic capacity of the provider	Ability to conduct audit of the provider network, which includes the following components: • Languages and dialects of community available at point of first contact. • Number of trained translators and interpreters available. • Number of clinicians and staff proficient in languages of the community.
Communication	Provide information, education	• Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.
Policies and procedures	Grievance and conflict resolution	Organization has structures in place to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services or denial of services.
Policies and procedures	Grievance and conflict resolution	Organization has feedback mechanisms in place to track number of grievances and complaints and number of incidents.
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policymaking and influencing groups, and consumers served reflects service area demographics.

Sample of Capacity/Structure Measures by Domain

Domain	Topic Areas	Measures/Indicators
Facility characteristics, capacity, and infrastructure	Available and accessible services	• Transportation is available from residential areas to culturally competent providers. • Organization has the flexibility to conduct home visits and community outreach. • Culturally responsive services are available evenings and weekends.
Facility characteristics, capacity, and infrastructure	Information systems	Capacity for tracking of access and utilization rates for population of different racial/ethnic groups in comparison to the overall service population.
Monitoring, evaluation, and research	Organizational assessment	Ability to conduct ongoing organizational self-assessments of cultural and linguistic competence and integration of measures of access, satisfaction, quality, and outcomes into other organizational internal audits and performance improvement programs.

Multiculturally Competent Service System Assessment Guide

Reproduced with permission from The Connecticut Department of Children and Families, Office of Multicultural Affairs (2002).

Instructions: Rate your organization on each item in Sections I through VIII using the following scale:

1 2 3 4 5

Not at all To a moderate degree To a great degree

Suggested Rating Interpretations:
#1 and #2: "Priority Concerns"; #3: "Needs Improvement"; #4 and #5: "Adequate"

When you have rated all items and assessed each section, please follow the instructions in Section IX to make an assessment of your program or agency and then formulate a culturally competent plan that addresses the need you feel is a priority.

I. Agency demographic data (assessment)

A culturally competent agency uses basic demographic information to assess and determine the cultural and linguistic needs of the service area.

____ Have you identified the demographic composition of the program's service area (from recent census data, local planning documents, statement of need, etc.) which should include ethnicity, race, and primary language spoken as reported by the individuals?

____ Have you identified the demographic composition of the persons served?

____ Have you identified the staff composition (ethnicity, race, language capabilities) in relation to the demographic composition of your service area?

____ Have you compared the demographic composition of the staff with the client demographics?

II. Policies, procedures and governance

A culturally competent agency has a board of directors, advisory committee, or policy-making group that is proportionally representative of the staff, client/consumers, and community.

____ Has your organization appointed executives, managers, and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the cultural competence plan?

____ Has your organization's director appointed a standing committee to advise management on matters pertaining to multicultural services?

____ Does your organization have a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current *Connecticut Commission on Human Rights and Opportunities* nondiscriminatory policies and affirmative action policies?

____ Does your organization have culturally appropriate policies and procedures communicated orally and/or written in the principal language of the client/consumer to address confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc. as needed and appropriately?

III. Services/programs

A culturally competent agency offers services that are culturally competent and in a language that ensures client/consumer comprehension.

A. Linguistic and communication support

____ Has the program arranged to provide materials and services in the language(s) of limited English-speaking clients/consumer (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters)?

____ Do medical records indicate the preferred languages of service recipients?

____ Is there a protocol to handle client/consumer/family complaints in languages other than English?

____ Are the forms that client/consumers sign written in their preferred language?

____ Are the persons answering the telephones, during and after-hours, able to communicate in the languages of the speakers?

____ Does the organization provide information about programs, policies, covered services, and procedures for accessing and utilizing services in the primary language(s) of client/consumers and families?

____ Does the organization have signs regarding language assistance posted at key locations?

____ Are there special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.?

____ Are cultural and linguistic supports available for clients/consumers throughout different service offerings along the service continuum?

B. Treatment/rehabilitation planning

____ Does the program consider the client/consumer's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?

____ Does the program involve client/consumers and family members in all phases of treatment, assessment, and discharge planning?

____ Has the organization identified community resources (community councils, ethnic cultural social entities, spiritual leaders, faith communities, voluntary associations, etc.) that can exchange information and services with staff, client/consumers, and family members?

____ Have you identified natural community healers, spiritual healers, clergy, etc., when appropriate, in the development and/or implementation of the service plan?

____ Have you identified natural supports (relatives, traditional healers, spiritual resources, etc.) for purposes of reintegrating the individual into the community?

____ Have you used community resources and natural supports to reintegrate the individual into the community?

C. Cultural assessments

____ Is the client/consumer's culture/ethnicity taken into account when formulating a diagnosis or assessment?

____ Are culturally relevant assessment tools utilized to augment the assessment/diagnosis process?

___ Is the client/consumer's level of acculturation identified, described, and incorporated as part of cultural assessment?

____ Is the client/consumer's ethnicity/culture identified, described, and incorporated as part of cultural assessment?

D. Cultural accommodations

____ Are culturally appropriate, educative approaches, such as films, slide presentations, or video tapes, utilized for preparation and orientation of client/consumer family members to your program?

____ Does your program incorporate aspects of each client/consumer's ethnic/cultural heritage into the design of specialized interventions or services?

____ Does your program have ethnic/culture-specific group formats available for engagement, treatment, and/or rehabilitation?

____ Is there provider collaboration with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan?

E. Program accessibility

____ Do persons from different cultural and linguistic backgrounds have timely and convenient access to your services?

____ Are services located close to the neighborhoods where persons from different cultures and linguistic backgrounds reside?

____ Are your services readily accessible by public transportation?

____ Do your programs provide needed supports to families of clients/consumers (e.g., meeting rooms for extended families, child support, drop-in services)?

____ Do you have services available during evenings and weekends?

IV. Care management

____ Does the level and length of care meet the needs for clients/consumers from different cultural backgrounds?

___ Is the type of care for clients/consumers from different backgrounds consistently and effectively managed according to their identified cultural needs?

____ Is the management of the services for people from different groups compatible with their ethnic/cultural background?

V. Continuity of care

____ Do you have letters of agreement with culturally oriented community services and organizations?

____ Do you have integrated, planned, transitional arrangements between one service modality and another?

____ Do you have arrangements, financial or otherwise, for securing concrete services needed by clients/consumers (e.g., housing, income, employment, medical, dental, other emergency personal support needs)?

VI. Human resources development

A culturally competent agency implements staff training and development in cultural competence at all levels and across all disciplines, for leadership and governing entities as well as for management, supervisory, treatment, and support staff.

____ Are the principles of cultural competence (e.g., cultural awareness, language training, skills training in working with diverse populations) included in staff orientation and ongoing training programs?

____ Is the program making use of other programs or organizations that specialize in serving persons with diverse cultural and linguistic backgrounds as a resource for staff education and training?

____ Is the program maximizing recruitment and retention efforts for staff who reflect the cultural and linguistic diversity of populations needing services?

____ Has the staff's training needs in cultural competence been assessed?

____ Has the staff attended training programs on cultural competence in the past two years? Describe:_____
_____

VII. Quality monitoring and improvement

A culturally competent agency has a quality monitoring and improvement program that ensures access to culturally competent care.

____ Does the quality improvement (QI) plan address the cultural/ethnic and language needs?

____ Are client/consumers and families asked whether ethnicity/culture and language are appropriately addressed in order to receive culturally competent services in the organization?

____ Does the organization maintain copies of minutes, recommendations, and accomplishments of its multicultural advisory committee?

____ Is there a process for continually monitoring, evaluating, and rewarding the cultural competence of staff?

VIII. Information/management system

____ Does the organization monitor, survey, or otherwise access, the QI utilization patterns, Against Medical Advice (AMA) rates, etc., based on the culture/ethnicity and language?

____ Are client/consumer satisfaction surveys available in different languages in proportion to the demographic data?

____ Are there data collection systems developed and maintained to track clients/consumers by demographics, utilization and outcomes across levels of care, transfers, referrals, re-admissions, etc.?

IX. Formulating a culturally competent plan based on the assessment of your program or agency

Focus on the following critical areas of concern as you develop goals for a culturally competent plan for your agency's service system.

Access: Degree to which services to persons are quickly and readily available.

Engagement: The skill and environment to promote a positive personal impact on the quality of the client's commitment to be in treatment.

Retention: The result of quality service that helps maintain a client in treatment with continued commitment.

Based on an assessment of your agency, determine whether, in your initial plan, you need to direct efforts of developing cultural competency toward one, or a combination, of the above critical areas. **Then, structure your agency's cultural competence plan using the following instructions:**

1. Based on the results of this assessment, summarize and describe your organization's perceived **strengths** in providing **services to persons from different cultural groups**. Please provide specific examples. Attach supporting documentation (e.g., Data, Policies, Procedures, etc.)

2. Based on your assessment, summarize and describe your organization's primary areas considered either "**Priority Concerns" (#1 and/or #2)**, or **"Needs Improvement" (#3)** in providing services to persons from different cultural groups.
3. Based on your organization's **strengths** and **needs, prioritize** both the organizational goals and objectives addressed in your **cultural competence plan**. Describe clearly what you will do to provide services to persons who are culturally and linguistically different.
4. Using the developed goals and objectives, please describe in detail the plans, activities, and/or strategies you will implement to assist your organization in meeting each of the goals and objectives indicated.

Patient Satisfaction and Feedback on Clinical and Program Culturally Responsive Services

Iowa Cultural Understanding Assessment–Client Form

Please indicate your level of agreement with the statements below by circling the number to the right of the statement that best fits your opinion. All responses are confidential. When you have completed the survey, please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the drop box at the facility. **Thank you very much for your participation!**

Demographic Information

What is your sex? ____Male ____Female

What is your race? ____Alaskan Native ____American Indian ____Asian ____Black or African American ____Native Hawaiian or other Pacific Islander ____White

Are you Hispanic or Latino? ____Yes ____No

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. The staff here understands some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	1	2	3	4	5
2. Staff here understands the importance of my cultural beliefs in my treatment process.	1	2	3	4	5
3. The staff here listens to me and my family when we talk to them.	1	2	3	4	5
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1	2	3	4	5
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
6. The staff here seems to understand the experiences and problems I have in my past life.	1	2	3	4	5
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	1	2	3	4	5
8. The staff here knows how to use their knowledge of my culture to help me address my current day-to-day needs.	1	2	3	4	5
9. The staff here understands that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	1	2	3	4	5
10. The staff here respects my religious or spiritual beliefs.	1	2	3	4	5
11. Staff from this program comes to my community to let people like me and others know about the services they offer and how to get them.	1	2	3	4	5
12. The staff here asks me, my family, or others close to me to fill out forms that tell them what we think of the place and services.	1	2	3	4	5
13. Staff here understands that people of my racial or ethnic group are *not* all alike.	1	2	3	4	5
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1	2	3	4	5
15. The staff here talks to me about the treatment they will give me to help me.	1	2	3	4	5
16. The staff here treats me with respect.	1	2	3	4	5
17. The staff seems to understand that I might feel more comfortable working with someone who is the same sex as me.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
18. Most of the time, I feel I can trust the staff here who work with me.	1	2	3	4	5
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	1	2	3	4	5
20. If I want, my family or friends are included in discussions about the help I need.	1	2	3	4	5
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	1	2	3	4	5
22. Some of the staff here understand the difference between their culture and mine.	1	2	3	4	5
23. Some of the counselors are from my racial or ethnic group.	1	2	3	4	5
24. Staff members are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	1	2	3	4	5
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1	2	3	4	5

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Appendix D—Screening and Assessment Instruments

Important Note: The following tables provide an overview of selected instruments that screen and assess for substance use disorders and mental disorders and symptoms. These tables only represent a sample of instruments. In reviewing the tables, do not assume that the instruments have normative data across race and ethnicities. The citations and information listed in this appendix serve only as a starting point for investigating the appropriateness of available instruments within specific populations. Citations reflect information about the effectiveness of the testing measurements as well as research that suggests modifications or reports testing discrepancies among racial and ethnic populations.

Screening and Assessment Instruments for Substance Use Disorders

Instrument	Description	Clinical Utility
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; Humeniuk et al. 2010)	The ASSIST (version 3.1) has eight items to screen for use of tobacco products, alcohol, and drugs	ASSIST was developed by the World Health Organization (WHO) as a culturally neutral tool for use in primary and general medical care settings. This paper-pencil instrument takes 5 to 10 minutes to complete and is designed to be administered by a health worker. ASSIST determines a risk score for each substance; the score starts a discussion with clients about their substance use. For information about the instrument and its availability in other languages, see http://www.who.int/substance_abuse/activities/assist/en/
Alcohol Use Disorders Identification Test (AUDIT; Babor et al. 1992; Saunders et al. 1993)	This 10-item screening questionnaire was developed to identify people whose alcohol consumption is hazardous or harmful to their health.	The AUDIT was developed by WHO for use in multinational settings—the original sample included subjects from Australia, Bulgaria, Kenya, Mexico, Norway, and the United States (Allen et al. 1997; Saunders et al. 1993). **Populations researched:** Latinos (Cherpitel 1999; Cherpitel and Bazargan 2003; Cherpitel and Borges 2000; Frank et al. 2008; Reinert and Allen 2007; Volk et al. 1997), northern (Asian) Indians (Pal et al. 2004); Vietnamese (Giang et al. 2005); Brazilians (Lima et al. 2005), and Nigerians (Adewuya 2005).

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
		Languages available in: Numerous languages, including Spanish (de Torres et al. 2009; Medina-Mora et al. 1998), French (Gache et al. 2005), Mandarin and Cantonese (Leung and Arthur 2000), Nigerian languages (Adewuya 2005), Russian, German, and Korean (Kim et al. 2008).
Addiction Severity Index (McLellan et al. 1980). Available online at http://www.tresearch.org/index.php/tools/download-asi-instruments-manuals/	Currently in its 5th edition, this instrument assesses the severity of substance use disorders. It has 200 items distributed over seven subscales.	**Populations researched:** African Americans (Drake et al. 1995; Leonhard et al. 2000; McLellan et al. 1985), and Northern Plains American Indians (Carise and McLellan 1999). **Languages available in:** Numerous languages, including Spanish (Sandí Esquivel and Avila Corrales 1990; for multimedia version see Butler et al. 2009), French (Daeppen et al. 1996; Krenz et al. 2004), Japanese (Haraguchi et al. 2009), and Chinese (Liang et al. 2008).
Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS; Grant and Hasin 1990). Available online at http://pubs.niaaa.nih.gov/publications/audadis.pdf	This structured interview is administered by nonprofessional interviewers to diagnose substance use disorders and assess some co-occurring mental disorders. It evaluates acculturation and racial/ethnic orientation. Currently in its 4th edition (AUDADIS-IV).	The AUDADIS has been found reliable in large general-population studies (Grant et al. 1995; Ruan et al. 2008). **Populations researched:** African Americans, Latinos, Asians, and Native Americans (Canino et al. 1999; Chatterji et al. 1997; Grant et al. 1995; Ruan et al. 2008). **Languages available in:** Chinese and Spanish (Canino et al. 1999; Horton et al. 2000; Leung and Arthur 2000).
CAGE (Ewing 1984; Mayfield et al. 1974)	This is a set of four questions used to detect possible alcohol use disorder.	**Populations researched:** African Americans (Cherpitel 1997; Frank et al. 2008); Latino (Saitz et al. 1999). **Languages available in:** Numerous languages, including Spanish, Creole, Chinese, and Japanese.
Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM; Cottler 2000)	This structured, detailed interview diagnoses substance abuse and dependence; it is an expanded version of the substance use section of the CIDI.	The instrument has been well evaluated with international populations from a variety of different nations and found to have good reliability for most substances of abuse (Ustün et al. 1997). **Populations researched:** African Americans (Horton et al. 2000) and Brazilians (Quintana et al. 2004; 2007). **Languages available in:** Numerous languages, including Portuguese, Spanish, Arabic, Japanese, Vietnamese, and Malay.

(Continued on the next page.)

Screening and Assessment Instruments for Substance Use Disorders (continued)

Instrument	Description	Clinical Utility
Drug Abuse Screening Test (DAST; Skinner 1982)	This self-report instrument (10- and 20-item versions) identifies people who are abusing psychoactive drugs and measures degree of related problems.	No significant differences in DAST reliability across race or cultural background were found (Yudko et al. 2007). **Languages available in:** Numerous, including Spanish for the 10-item DAST (DAST-10; Bedregal et al. 2006), Portuguese, Hebrew, Arabic, and Thai.
Rapid Alcohol Problems Screen (RAPS; Cherpitel 1995, 2000)	The RAPS is a five-question test (also available in a newer four-item version, the RAPS-4) that combines optimal questions from other instruments.	The RAPS has high sensitivity across both ethnicity and gender (Cherpitel 1997; 2002). It has also been found to work significantly better than the AUDIT for screening African American and Latino men and to be on par with the AUDIT for women (Cherpitel and Bazargan 2003). **Populations researched:** Mexican Americans (Borges and Cherpitel 2001); residents of various countries (Argentina, Belarus, Brazil, Canada, China, Czech Republic, India, Mexico, Mozambique, Poland, South Africa, and Sweden; Cherpitel et al. 2005). **Languages available in:** Numerous, including Spanish, Chinese, and Portuguese.
Short Michigan Alcohol Screening Test (S-MAST; Selzer et al. 1975)	The S-MAST screens for alcohol use disorder.	**Populations researched:** African Americans, Arab Muslims, American Indians, Asian Indians, and Thai (Al-Ansari and Negrete 1990; Pal et al. 2004; Nanakorn et al. 2000; Robin et al. 2004). **Languages available in:** Numerous, including Spanish, French, Thai, and Asian Indian languages.
TWEAK (Russell 1994)	TWEAK is a five-item screening instrument originally created to screen for risky drinking during pregnancy (but has been validated for a range of male and female populations).	**Populations researched:** Mexican Americans (Borges and Cherpitel 2001) and African Americans (Cherpitel 1997). **Languages available in:** Spanish (Cremonte and Cherpitel 2008).

Screening and Assessment Instruments for Mental Disorders and Symptoms

Instrument	Description	Clinical Utility With Specific Racial/Ethnic Groups
Beck Anxiety Inventory (BAI; Beck and Steer 1990)	The BAI is a 21-item scale that distinguishes anxiety from depression.	**Populations researched:** African Americans (Chapman et al. 2009). **Languages available in:** Numerous languages, including Spanish (Novy et al. 2001), Arabic, Chinese, Farsi, Korean, and Turkish.
Beck Depression Inventory (BDI) and Beck Depression Inventory, 2nd Edition (BDI-II; Beck et al. 1996)	The BDI is a 21-item instrument used to assess the intensity of depression.	Several versions of the BDI are available with cultural specificity. **Populations researched:** African Americans (Dutton et al. 2004; Grothe et al. 2005; Joe et al. 2008), Asian Americans (Carmody 2005; Crocker et al. 1994), Hmong (Mouanoutoua et al. 1991), Mexican Americans (Gatewood-Colwell et al. 1989), and Latinos (Contreras et al. 2004). **Languages available in:** Numerous, including Spanish (Azocar et al. 2001; Bonilla et al. 2004; Carmody 2005; Wiebe and Penley 2005), Chinese (Yeung et al. 2002; Zheng and Lin 1991), French, Arabic (Abdel-Khalek 1998; Alansari 2006), Hebrew, and Farsi (Ghassemzadeh et al. 2005).
Center for Epidemiological Studies-Depression Scale (CES-D; Radloff 1977)	The CES-D is a 20-item self-report scale designed to measure depressive symptoms.	May underestimate symptoms in African Americans (Bardwell and Dimsdale 2001; Cole et al. 2000). **Populations researched:** Latinos (Batistoni et al. 2007; Garcia and Marks 1989; Posner et al 2001; Reuland et al. 2009; Roberts et al.1990), Asian Indians (Diwan et al. 2004; Gupta et al. 2006), Native Americans (Chapleski et al. 1997), and African Americans (Canady et al. 2009; Makambi et al. 2009; Nguyen et al. 2004). **Languages available in:** Numerous languages, including Spanish (Reuland et al. 2009), Chinese (Lin 1989), Greek, Korean, and Portuguese.
Geriatric Depression Scale (Sheikh and Yesavage 1986)	Available in 30- and 15-item forms, this instrument screens for depression in older adults.	**Populations researched:** Latinos (Reuland et al. 2009) and Asians (Broekman et al. 2008; Nyunt et al. 2009). **Languages available in:** Available in 30 languages and validated with a number of different populations (available online at http://www.stanford.edu/~yesavage/GDS.html).
Millon Clinical Multiaxial Inventory-III (Millon et al. 2009)	Assesses 13 personality disorders (DSM-III-R Axis II disorders) and 9 clinical syndromes (DSM-III-R Axis I disorders); includes scales to assess substance related problems.	**Populations researched:** African Americans (Calsyn et al.1991; Craig and Olson 1998) and Latinos (Fernández-Montalvo et al. 2006). **Languages available in:** Multiple languages, including Spanish, Korean, Cantonese, and Portuguese.

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Instruments To Screen and Assess Mental Disorders and Symptoms (continued)

Minnesota Multiphasic Personality Inventory, 2nd Edition (MMPI-2) (Butcher et al. 1989)	The MMPI-2 measures personality traits and symptom patterns.	Normed for Asian Americans, African Americans, Latinos, and American Indians (Hathaway et al.1989). **Populations researched:** African Americans (Castro et al. 2008; McNulty et al. 2003; Monnot et al. 2009; Whatley et al. 2003) and Asian Americans (Tsai and Pike 2000; Tsushima and Tsushima 2009). **Languages available in:** Numerous, including French, Hmong, and Spanish (Velasquez et al. 2000).
Mini International Neuropsychiatric Interview (M.I.N.I.; Sheehan et al. 1998)	This is a short, structured, diagnostic interview that assesses the most common mental disorders (including substance use disorders).	**Populations researched:** African Americans (Black et al. 2004). The Major Depressive Episode and Posttraumatic Stress Disorder (PTSD) sections of the M.I.N.I. have been adapted for use in screening for PTSD in refugees, and found effective across cultures in a multinational sample (Eytan et al. 2007). **Languages available in:** Over 43 languages, including French, Italian (Rossi et al. 2004), Japanese (Otsubo et al. 2005), Spanish, Italian, and Arabic (Amorim et al. 1998; Lecrubier et al. 1997; Sheehan et al. 1997, 1998).
Schedules for Clinical Assessment in Neuropsychiatry, 2nd Version (SCAN-2; Wing et al. 1998)	The SCAN-2 is a set of instruments that measure psychopathology and behavior associated with major mental disorders.	**Populations researched:** The SCAN-2 was developed by WHO with an international sample that included participants from Turkey, Greece, India, the United States, Nigeria, Romania, Mexico, Spain, and South Korea and is intended to be cross-culturally appropriate (Room et al. 1996). **Languages available in:** Chinese (Cheng et al. 2001), Danish, Dutch, English, French, German, Greek, Italian, Kannada, Portuguese, Spanish, Thai, Turkish, and Yoruba.
Symptom Checklist-90-R (SCL-90R; Derogatis 1992)	This 90-item checklist evaluates psychiatric symptoms and their intensity in nine different categories and screens for a broad range of mental disorders.	The SCL-90R has been normed for adult inpatient and outpatient psychiatric patients and adult and adolescent nonpatients across a number of ethnic groups (Derogatis 1992). **Populations researched:** Latinos (Martinez et al. 2005) and African Americans (Ayalon and Young 2009). **Languages available in:** Spanish, French, Armenian, and Persian.

Appendix E—Cultural Formulation in Diagnosis and Cultural Concepts of Distress

Cultural Formulation in Diagnosis

Clinicians need to consider the effects of culture when diagnosing clients. The following cultural formulation adopted by the American Psychiatric Association (APA) in the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5; 2013, pp. 749–759) provides a systematic outline for incorporating culturally relevant information when conducting a multiaxial diagnostic assessment. Whether or not they are credentialed to diagnose disorders, counselors and other clinical staff can use the main content areas listed below to guide the interview, initial intake, and treatment planning processes. (For review, see Mezzich and Caracci 2008; for Native American application, specifically Lakota, refer to Brave Heart 2001.)

1. Cultural identity of the person. Note the person's ethnic or cultural reference groups. For immigrants and ethnic minorities, also note degree of involvement with culture of origin and host culture (where applicable). Also note language ability, use, and preference (including multilingualism).

2. Cultural explanations of the person's illness. Identify the following: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symptoms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify a condition (see the "Cultural Concepts of Distress" section of this appendix), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

3. Cultural factors related to psychosocial environment and level of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability, including stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

4. Cultural elements of the relationship between client and clinician. Indicate differences in culture and social status between client and clinician, as well as any problems these differences may cause in diagnosis and

treatment (e.g., difficulty communicating in the client's first language, eliciting symptoms or understanding their cultural significance, negotiating an appropriate relationship or level of intimacy, determining whether a behavior is normative or pathological).

5. Overall cultural assessment for diagnosis and care. Conclude cultural formulation by discussing how cultural considerations specifically influence comprehensive diagnosis and care.

Cultural Concepts of Distress

Just as standard screening instruments can sometimes be of limited use with culturally diverse populations, so too are standard diagnoses. Expressions of psychological problems are, in part, culturally specific, and behavior that is aberrant in one culture can be standard in another. For example, seemingly paranoid thoughts are to be expected in clients who have migrated from countries with oppressive governments. Culture plays a large role in understanding phenomena that might be construed as mental illnesses in Western medicine. These cultural concepts of distress may or may not be linked to particular DSM-5 diagnostic criteria (APA 2013). The table that follows lists DSM-5 cultural concepts of distress; other concepts exist that are not recognized in DSM-5.

DSM-5 Cultural Concepts of Distress

Syndrome	Description	Populations
Ataque de nervios	Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., death of a close relative, separation or divorce from a spouse, conflict with spouse or children, or witnessing an accident involving a family member). People can experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of panic attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from panic disorder. Ataques range from normal expressions of distress not associated with a mental disorder to symptom presentations associated with anxiety, mood dissociative, or somatoform disorders.	Caribbean, Latin American, Latin Mediterranean
Dhat (*jiryan* in India, *skra prameha* in Sri Lanka, *shen-k'uei* in China)	A folk diagnosis for severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, weakness, and exhaustion.	Asian Indian

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DSM-5 Cultural Concepts of Distress (continued)

Nervios	Refers both to a general state of vulnerability to stress and to a syndrome evoked by difficult life circumstances. *Nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach disturbances, sleep difficulties, nervousness, tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). *Nervios* tends to be an ongoing problem, although it is variable in the degree of disability manifested. *Nervios* is a broad syndrome that ranges from cases free of a mental disorder to presentations resembling adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders. Differential diagnosis depends on the constellation of symptoms, the kind of social events associated with onset and progress, and the level of disability experienced.	Latin American
Shenjing shuairuo	A condition characterized by physical and mental fatigue, headaches, difficulty concentrating, dizziness, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and autonomic nervous system disturbances.	Chinese
Susto (*espanto, pasmo, tripa ida, perdida del alma*, or *chibih*)	An illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with *susto* also experience significant strains in key social roles. Symptoms can appear days or years after the fright is experienced. In extreme cases, *susto* can result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, sadness, lack of motivation, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying *susto* include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings focus on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. *Susto* can be related to major depressive disorder, posttraumatic stress disorder, and somatoform disorders. Similar etiological beliefs and symptom configurations are found in many parts of the world.	Latino American, Mexican, Central and South American
Taijin kyofusho	This syndrome refers to an individual's intense fear that his or her body, its parts, or its functions displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movement. This syndrome is included in the official Japanese diagnostic system for mental disorders.	Japanese

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Appendix F—Cultural Resources

General Resources

Addiction Technology Transfer Centers

http://www.nattc.org

The Addiction Technology Transfer Centers Network identifies and advances opportunities for improving substance abuse treatment. The Network comprises 14 regional centers as well as a national office serving the United States and its territories. Regional centers cater to unique needs in their areas while supporting national initiatives. Improving cultural competence is a major focus for the Network, which seeks to improve substance abuse treatment by identifying standards of culturally competent treatment and generating ways to foster their adoption in the field.

Agency for Healthcare Research and Quality–Minority Health

http://www.ahrq.gov/research/findings/factsheets/minority/index.html

This site provides research findings, papers, and press releases related to minority health.

American Translators Association

http://www.atanet.org

The American Translators Association (ATA) offers a certification program that evaluates the competence of translators according to guidelines that reflect current professional practice. The ATA also has online directories available. The Directory of Translation and Interpreting Services is an online directory of individual translators and interpreters. The Directory of Language Services Companies is a directory of companies that offer translating or interpreting services.

Center for Research on Ethnicity, Culture, and Health

http://www.crech.org

Established in 1998 in the University of Michigan's School of Public Health, the Center provides a forum for basic and applied public health research on relationships among ethnicity, culture, socioeconomic status, and health. It develop new interdisciplinary frameworks for understanding these relationships while promoting effective collaboration among public health academicians, healthcare providers, and communities to reduce racial and ethnic disparities in health care.

Community Toolbox: Cultural Competence in a Multicultural World

http://ctb.ku.edu/en/table-of-contents/culture/cultural-competence

The cultural competence section of this Web site provides information (including examples and links) on a number of relevant topics, such

as how to build relationships with people from different cultures, reduce prejudice and racism, build organizations and communities that are responsive to people from diverse cultures, and heal the effects of internalized oppression.

The Cross Cultural Health Care Program

http://www.xculture.org

Since 1992, the Cross Cultural Health Care Program (CCHCP) has been addressing broad cultural issues that affect the health of individuals and families in ethnic minority communities in Seattle and nationwide. Through a combination of cultural competency trainings, interpreter trainings, research projects, community coalition building, and other services, CCHCP serves as a bridge between communities and healthcare institutions to ensure full access to quality health care that is culturally and linguistically appropriate.

Cultural Competence Standards in Managed Care Mental Health Services

Western Interstate Commission for Higher Education. *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups.* Boulder, CO: Western Interstate Commission for Higher Education, 1998.

The Center for Mental Health Services (CMHS) presents cultural competence standards for managed care mental health services to improve the availability of high-quality services for four underserved and/or underrepresented racial and ethnic groups—African Americans, Latinos, Native Americans, and Asian/Pacific Islander Americans. With help from the Western Interstate Commission for Higher Education Mental Health Program, CMHS convened national panels representing each major racial/ethnic group. Mental health professionals, families, and consumers on the panels prepared the document.

Diversity Rx

http://www.diversityrx.org

This Web site offers resources relating to cross-cultural communication issues in healthcare settings and information on interpreter practice, legal issues relating to language barriers and access to linguistically appropriate services, and the ways language and culture can affect the use of healthcare services.

Health Resources and Services Administration Culture, Language and Health Literacy Page

http://www.hrsa.gov/culturalcompetence/

The Health Resources and Services Administration Culture, Language and Health Literacy Web site provides links to various online resources relating to cultural competence in general and to providing culturally competent health care to a number of specific cultural/ethnic groups.

Instruments for Measuring Acculturation, University of Calgary

http://www.ucalgary.ca/~taras/_private/Acculturation_Survey_Catalogue.pdf

This document gives information on acculturation and cultural identity measures, presenting many in full. It does not always include scoring information but typically provides questions from each instrument.

Minority Health Project

http://www.minority.unc.edu/

The Minority Health Project (MHP) of the University of North Carolina's Gillings School of Global Public Health seeks to improve the

quality of racial and ethnic population data, to expand the capacity for conducting statistical research and developing research proposals on minority health, and to foster a network of researchers in minority health. MHP collaborates with the Center for Health Statistics Research, the University of North Carolina, the National Center for Health Statistics, and the Association of Schools of Public Health to conduct educational programs and provide information on minority health research and data sources.

National Center for Cultural Competence

http://nccc.georgetown.edu

The National Center for Cultural Competence's (NCCC) mission is to increase the capacity of health and mental health programs to design, implement, and evaluate culturally and linguistically responsive service delivery systems. NCCC conducts training, technical assistance, and consultation; participates in networking, linkages, and information exchange; and engages in knowledge and product development and dissemination.

The National Center on Minority Health and Health Disparities

http://www.ncmhd.nih.gov

The Center's mission is to promote minority health and reduce health disparities. It is particularly useful as a resource for information about health disparities and the best methods to address them.

International MultiCultural Institute

http://www.imciglobal.org/

The International MultiCultural Institute (iMCI) works with individuals, organizations, and communities to create a society that is strengthened and empowered by its diversity. iMCI's initiatives aim to increase communication, understanding, and respect among people of diverse backgrounds and address systemic cultural issues facing our society. The Institute accomplishes this through its conferences, individualized organizational training and consulting interventions, publications, and leading-edge projects.

Office of Civil Rights

http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/

The Office of Civil Rights of the U.S. Department of Health and Human Services investigates complaints, enforces rights, develops policies, and promulgates regulations to ensure compliance with nondiscrimination and health information privacy laws. The agency offers technical assistance and public education to ensure understanding of and compliance with these laws, including the provision of resources and tools to improve services for individuals with limited English proficiency.

Office of Minority Health Resource Center

http://minorityhealth.hhs.gov/

The Office of Minority Health (OMH) was established by the U.S. Department of Health and Human Services in 1985 to advise the Secretary and the Office of Public Health and Science on public health policies and programs affecting Native Americans, African Americans, Asian Americans, Latinos, and Native Hawaiians and other Pacific Islanders. The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of policies and programs that will eliminate health disparities.

The OMH Resource Center (OMHRC) is a national resource and referral service for

minority health issues. It collects and distributes information on various health topics, including substance abuse, cancer, heart disease, violence, diabetes, HIV/AIDS, and infant mortality. OMHRC also facilitates information exchange on minority health issues, and offers customized database searches, publications, mailing lists, referrals, and the like regarding Native American, African American, Asian American, Pacific Islander, and Latino populations.

Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the Nation's one-stop resource for information about substance abuse and mental illness prevention and behavioral health treatment. The SAMHSA Store Web site provides information on behavioral health topics such as cultural competence, healthcare-related laws, and mental health and substance abuse.

Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General.* HHS Pub. No. SMA 01-3613. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

This report highlights the roles that culture and society play in mental health, mental illness, and the types of mental health services people seek. The report finds that, although effective, well-documented treatments for mental illnesses are available, minorities are less likely to receive quality care than the general population. It articulates the foundation for understanding relationships among culture, society, mental health, mental illness, and services, and also describes how these issues affect different racial and ethnic groups.

Stanford University Curriculum in Ethnogeriatrics

http://www.stanford.edu/group/ethnoger/

This online curriculum explores healthcare issues for older adults from a variety of cultural groups (with modules on African Americans, Latinos, Native Americans, and several Asian American populations).

African and Black American Resources

Congressional Black Caucus Foundation Health

http://www.cbcfinc.org/what-we-do/researchandpolicy.html

Congressional Black Caucus Foundation Health's mission is to empower people of African descent to make better decisions about their health and that of their communities. The Web site provides information about public health issues, key legislation on public policy issues, health initiatives, and local events directly and indirectly relating to the health of people of African descent worldwide. It includes a section on substance abuse.

National Black Alcoholism and Addictions Council, Inc.

http://www.nbacinc.org

The National Black Alcoholism and Addictions Council, Inc. (NBAC) is a nonprofit, tax-exempt organization of Black individuals concerned about alcoholism and drug abuse.

NBAC educates the public about the prevention of alcohol and drug abuse and alcoholism and is committed to increasing services for persons who are dependent upon alcohol and their families, providing quality care and treatment, and developing research models designed for Blacks. NBAC helps Blacks concerned with or involved in the field of alcoholism and drug-related issues to exchange ideas, offer services, and facilitate substance abuse treatment programs for Black Americans.

National Medical Association

http://www.nmanet.org

A professional and scientific organization representing the interests of more than 25,000 physicians and their patients, the National Medical Association (NMA) is the collective voice of African American physicians and a leading force for parity and justice in medicine and health. Established in 1895, NMA aims to prevent diseases, disabilities, and adverse health conditions that disproportionately or differentially affect African American and underserved populations; improve quality and availability of health care for poor and underserved populations; and increase representation and contributions of African Americans in medicine. NMA provides educational programs and opportunities for scholarly exchange, conducts outreach to promote improved public health, and establishes national health policy agendas in support of African American physicians and their patients.

Asian American, Native Hawaiian, and Other Pacific Islander Resources

Asian and Pacific Islander American Health Forum

http://www.apiahf.org

The Asian and Pacific Islander American Health Forum (APIAHF) is a national advocacy organization that promotes policy, program, and research efforts to improve the health of Asian and Pacific Islander Americans. APIAHF established the Asian and Pacific Islander Health Information Network (APIHIN) in 1995. APIHIN was developed as an integrated telecommunications infrastructure that gives Asians and Pacific Islanders access to health information and resources through local community access points and key provider intermediaries. The organization supports two mailing lists: API-HealthInfo, which concentrates on Asian and Pacific Islander American health, and API-SAMH, which deals with issues related to behavioral health of special interest to the Asian and Pacific Islander community.

National Asian American Pacific Islander Mental Health Association

http://www.naapimha.org

The National Asian American Pacific Islander Mental Health Association (NAAPIMHA) evolved from an Asian American Pacific Islander Mental Health Summit sponsored by SAMHSA. NAAPIMHA focuses on five interrelated areas: enhancing collection of appropriate and accurate data; identifying current best practices and service models; capacity building, including provision of technical assistance and training of service providers, both professional and paraprofessional; conducting research and evaluation; and working to engage consumers and families.

National Asian Pacific American Families Against Substance Abuse

http://www.napafasa.org

The National Asian Pacific American Families Against Substance Abuse is a nonprofit

membership organization that addresses the alcohol, tobacco, and drug issues of Asian American and Pacific Islander populations; it involves providers, families, and youth in reaching Asian American and Pacific Islander communities to promote health and social justice and reduce substance abuse and related problems.

Psychosocial Measures for Asian American Populations: Tools for Direct Practice and Research

http://www.columbia.edu/cu/ssw/projects/pmap

This Web site presents information on psychosocial measures (including some related to substance abuse) found to be reliable and valid with Asian Americans (in general group or for a specific subgroup).

The Vietnamese Community Health Promotion Project

http://www.suckhoelavang.org/main.html

This project's mission is to improve the health of Vietnamese Americans. A part of the University of California–San Francisco School of Medicine, the Web site provides information in Vietnamese and English, along with links to Vietnamese Web sites related to health issues.

Hispanic and Latino Resources

Hispanic/Latino Portal to Drug Abuse Prevention

http://www.latino.prev.info

The Indiana University Prevention Resource Center created this trilingual Web site to serve the growing Latino population and those who work with Latinos. Many Latinos face a language barrier, as do many prevention professionals trying to address their needs. This Web site helps bridge the communication barrier by offering information about and links to resources for substance abuse prevention, general health information, building cultural pride, and research tools, such as databases and bibliographies.

National Alliance for Hispanic Health

http://www.hispanichealth.org

The National Alliance for Hispanic Health is the nation's oldest and largest network of Hispanic health and human service providers. Alliance members deliver quality services to more than 12 million persons annually. As the nation's action forum for Hispanic health and well-being, the programs of the Alliance inform and mobilize consumers, support providers in the delivery of quality care, promote appropriate use of technology, improve the science base for accurate decisionmaking, and promote philanthropy.

National Council of La Raza Institute for Hispanic Health

http://www.nclr.org/index.php/issues_and_programs/health_and_nutrition/hispanic_health

The Institute for Hispanic Health (IHH) works closely with National Council of La Raza affiliates, government partners, private funders, and Latino-serving organizations to deliver quality health interventions and improve access to and use of quality health promotion and disease prevention programs. IHH provides culturally responsive and linguistically appropriate technical assistance and science-based approaches that emphasize public health, rather than disease-specific, themes. Themes include behavior change communication, healthy lifestyle promotion, improving access to quality services, and

increasing the number and level of Latinos in health fields.

National Hispanic Medical Association

http://www.nhmamd.org

Established in 1994, the National Hispanic Medical Association (NHMA) is a nonprofit association representing 36,000 licensed Hispanic physicians in the United States. Its mission is to improve the health of Latinos and other underserved populations. NHMA provides policymakers and healthcare providers with expert information and support in strengthening health service delivery to Latino communities across the Nation. Its agenda includes expanding access to quality health care; increasing medical education, cultural competence, and research opportunities for Latinos; and developing policy and education to eliminate health disparities for Latinos.

Native American Resources

Centers for American Indian and Alaska Native Health

http://www.ucdenver.edu/academics/colleges/PublicHealth/research/centers/CAIANH/Pages/caianh.aspx

The Centers for American Indian and Alaska Native Health (CAIANH) at the University of Colorado, Denver promote the health and well-being of American Indians and Alaska Natives by pursuing research, training, continuing education, technical assistance, and information dissemination in a biopsychosocial framework that recognizes the unique cultural contexts of this special population. The site provides online access to the group's journal, *American Indian and Alaska Native Mental Health Research*, as well as information about ongoing research projects.

Indian Health Service

http://www.ihs.gov

The Indian Health Service (IHS) is the principal federal healthcare provider and advocate for Native Americans; it ensures that comprehensive, culturally acceptable personal and public health services are available and accessible to Native peoples. Its Web site provides a tour of the IHS and its service areas, administrative reports, legislative news, IHS job opportunities, and healthcare resources targeted to this group.

National Indian Child Welfare Association

http://www.nicwa.org

The National Indian Child Welfare Association (NICWA), a comprehensive source of information on American Indian child welfare, works on behalf of Indian children and families to provide public policy, research, and advocacy; information and training on Indian child welfare; and community development services to Tribal governments and programs, State child welfare agencies, and other organizations, agencies, and professionals interested in Indian child welfare. NICWA addresses child abuse and neglect through training, research, public policy, and grassroots community development. NICWA also supports compliance with the Indian Child Welfare Act of 1978, which seeks to keep American Indian children with American Indian families.

One Sky Center

http://www.oneskycenter.org

One Sky Center aims to improve prevention and treatment of substance abuse for Native peoples by identifying, promoting, and disseminating effective, evidence-based, culturally

appropriate substance abuse prevention and treatment services and practices for application across diverse Tribal communities. It also provides training, technical assistance, and products to expand the capacity and quality of substance abuse prevention and treatment services for this population. SAMHSA created, designed, and funds One Sky Center to work with all federal and state agencies providing services to Native Americans.

SAMHSA's Tribal Training and Technical Assistance Center

http://beta.samhsa.gov/tribal-ttac

The Tribal Training and Technical Assistance (TTA) Center uses a culturally relevant, evidence-based, holistic approach to support Native communities in their self-determination efforts through infrastructure development and capacity building, as well as program planning and implementation. The Center provides TTA on mental and substance use disorders, bullying and violence, suicide prevention, and the promotion of mental health. It offers TTA to federally recognized tribes, other American Indian and Alaska Native communities, SAMHSA Tribal grantees, and organizations serving Indian Country. The Web site provides resources across behavioral health topics relevant to Native peoples.

White Bison

http://www.whitebison.org/

This Web site offers resources related to the Wellbriety self-help movement for Native Americans, including a discussion board and access to the *Wellbriety* online magazine.

Appendix G—Glossary

Acculturation typically refers to the socialization process through which people from one culture adopt certain elements from the dominant culture in a society.

American Indian and Alaska Native people include those "having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment" (Grieco and Cassidy 2001, p. 2).

Asians are defined in the United States (U.S.) Census as "people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent," including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam (Grieco and Cassidy 2001, p. 2).

Biculturalism is "a well-developed capacity to function effectively within two distinct cultures based on the acquisition of the norms, values, and behavioral routines of the dominant culture" and one's own culture (Castro and Garfinkle 2003, p. 1385).

Biracial individuals have two distinct racial heritages, either one from each parent or as a result of racial blending in an earlier generation (Root 1992).

Blacks/African Americans are, according to the U.S. Census Bureau (2000) definition, people whose origins are "in any of the black racial groups of Africa" (p. A-3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individuals from these latter regions, if they come from Spanish-speaking cultural groups, identify or are identified primarily as Latino). The term Black is often used interchangeably with African American, although for some, the term African American is used specifically to describe those individuals whose families have been in this country since at least the 19th century and thus have developed distinctly African American cultural groups. Black can be a more inclusive term describing African Americans as well as for more recent immigrants with distinct cultural backgrounds.

Confianza means trust or confidence in the benevolence of the other person.

Conformity in Helms's model of racial identity development refers to the tendency of members of a racial group to behave in congruence with the values, beliefs, and attitudes of their own culture to which they have been exclusively exposed.

Cultural competence is "a set of congruent behaviors, attitudes, and policies that . . . enable a system, agency, or group of professionals to work effectively in cross-cultural situations"

(Cross et al. 1989, p. 13). It refers to the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing such services. "Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (U.S. Department of Health and Human Services [HHS] 2003*a*, p. 12).

Cultural competence plans are strategic plans that outline a systematic organizational approach to providing culturally responsive services to individuals and to increasing cultural competence among staff at each level of the organization.

Cultural diffusion is the process of cultural intermingling.

Cultural humility "incorporates a lifelong commitment to self-evaluation and critique" (Tervalon and Murray-García 1998, p. 123) to redress the power imbalances in counselor–client relationships.

Cultural norms are the spoken or unspoken rules or standards for a cultural group that indicate whether a certain social event or behavior is considered appropriate or inappropriate.

Cultural proficiency involves a deep and rich knowledge of a culture—an insider's view—that allows the counselor to accurately interpret the subtle meanings of cultural behavior (Kim et al. 1992).

Culture is the conceptual system that structures the way people view the world—it is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

Ethnicity refers to the social identity and mutual belongingness that defines a group of people on the basis of common origins, shared beliefs, and shared standards of behavior (culture).

Ethnocentrism is "the tendency to view one's own culture as best and to judge the behavior and beliefs of culturally different people by one's own standards" (Kottak 1991, p. 47).

Health disparity is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion (HHS 2011*a*).

Hembrismo refers to female strength, endurance, courage, perseverance, and bravery (Falicov 1998).

Latinos are those who identify themselves in one of the specific Hispanic or Latino Census categories—Mexican, Puerto Rican, or Cuban—as well as those who indicate that they are "other Spanish, Hispanic, or Latino." Origin can be viewed as the heritage, nationality, group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States.

Immersion–emersion is a stage in the identity development models of both Cross and Helms during which a transition takes place from satisfaction with the old self to commitment to personal change: from immersion in one's old identity to emerging with a more mature view of one's identity (Cross 1995*b*).

Indigenous peoples are those people native to a particular country or region. In the case of the United States and its territories, this

includes Native Hawaiians, Alaska Natives, Pacific Islanders, and American Indians.

Institutional racism generally "refers to the policies, practices, and norms that incidentally but inevitably perpetuate inequality," resulting in "significant economic, legal, political and social restrictions" (Thompson and Neville 1999, p. 167).

Language is a culture's communication system and the vehicle through which aspects of race, ethnicity, and culture are communicated.

Machismo is the traditional sense of responsibility Latino men feel for the welfare and protection of their families.

Marianismo is the traditional belief that Latinas should be self-sacrificing, endure suffering for the sake of their families, and defer to their husbands in all matters. The Virgin Mary is held up as the model to which all women should aspire.

Motivational interviewing is a counseling style characterized by the strategic therapeutic activities of expressing empathy, developing discrepancy, avoiding argument, rolling with resistance, and supporting self-efficacy. In motivational interviewing, the counselor's major tool is reflective listening.

Multiracial individuals are any racially mixed people and include biracial people, as well as those with more than two distinct racial heritages (Root 1992).

Native Hawaiians and other Pacific Islanders include those with "origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands" (Grieco and Cassidy 2001, p. 2). Other Pacific Islanders include Tahitians; Northern Mariana Islanders; Palauans; Fijians; and cultural groups like Melanesians, Micronesians, or Polynesians.

Nguzo saba are the seven African American principles celebrated during Kwanzaa:

- *Umoja* is unity with family, community, nation, and race.
- *Kujichagulia* means self-determination to define collective selves, create for collective selves, and speak for collective selves.
- *Ujima* refers to collective responsibility to build and maintain community and solve problems together.
- *Ujamaa* refers to cooperative economics to build and maintain businesses and to profit from them together.
- *Nia* is a sense of purpose to collectively build and develop community to restore people to their traditional greatness.
- *Kuumba* is creativity to always do as much as possible to leave the community more beautiful and beneficial than it was.
- *Imani* refers to belief in the community's parents, teachers, and leaders and in the righteousness and victory of the struggle.

Organizational cultural competence and responsiveness refers to a set of congruent behaviors, attitudes, and policies that enable a system, agency, or group of professionals to work effectively in cross-cultural situations (Cross et al. 1989). It is a dynamic, ongoing process.

Orgullo means pride and dignity.

Personalismo is the use of positive personal qualities to accomplish a task.

Race is a social construct that describes people with shared physical characteristics.

Racism is an attitude or belief that people with certain shared physical characteristics are better than others.

Reculturation occurs when individuals return to their countries of origin after a prolonged period in other countries and readapt to the dominant culture.

Respeto can be translated as respect but also includes elements of both emotional dependence and dutifulness (Barón 2000).

Selective perception is, in Helms's model of racial identity development, the tendency of people early in the process to observe their environment in ways that generally confirm their pre-existing beliefs.

Simpatía is an approach to social interaction that avoids conflict and confrontation. One who is *simpático* is agreeable and strives to maintain harmony within the group.

Syncretism is the result of combining differing systems, such as traditional and introduced cultural traits.

Transculturation is the acceptance of a part or a trait of one culture into another culture.

White privilege is a form of ethnocentrism and refers to a position of entitlement based on a presumed culturally superior status.

Whites/Caucasians are people "having origins in any of the original peoples of Europe, the Middle East, or North Africa." This category includes people who indicate their race as White or report entries "such as Irish, German, Italian, Lebanese, Near Easterner, Arab, or Polish" (Grieco and Cassidy 2001, p. 2).

Appendix H—Resource Panel

Note: Information given indicates each participant's affiliation during the time the panel was convened and may no longer reflect the individual's current affiliation.

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Appendix I—Cultural Competence and Diversity Network Participants

Note: Information given indicates each participant's affiliation during the time the network was convened and may no longer reflect the individual's current affiliation.

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Germantown, MD
African American Workgroup Member

Deion Cash
Executive Director
Community Treatment and Correction Center, Inc.
Canton, OH
African American Workgroup Member

Magdalen Chang, Ph.D.
Center Manager
Haight Ashbury Free Clinics, Inc.
San Francisco, CA
Asian/Pacific Islander Workgroup Member

Diana Yazzie Devine, M.B.A.
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SAMHSA TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other federal and non-federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Knowledge Application Program (KAP) to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

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Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you, the busy clinician or program administrator, to locate information easily and to use this information to enhance treatment services.

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TIP 26 Substance Abuse Among Older Adults
Substance Abuse Among Older Adults: A Guide for Treatment Providers
Substance Abuse Among Older Adults: A Guide for Social Service Providers
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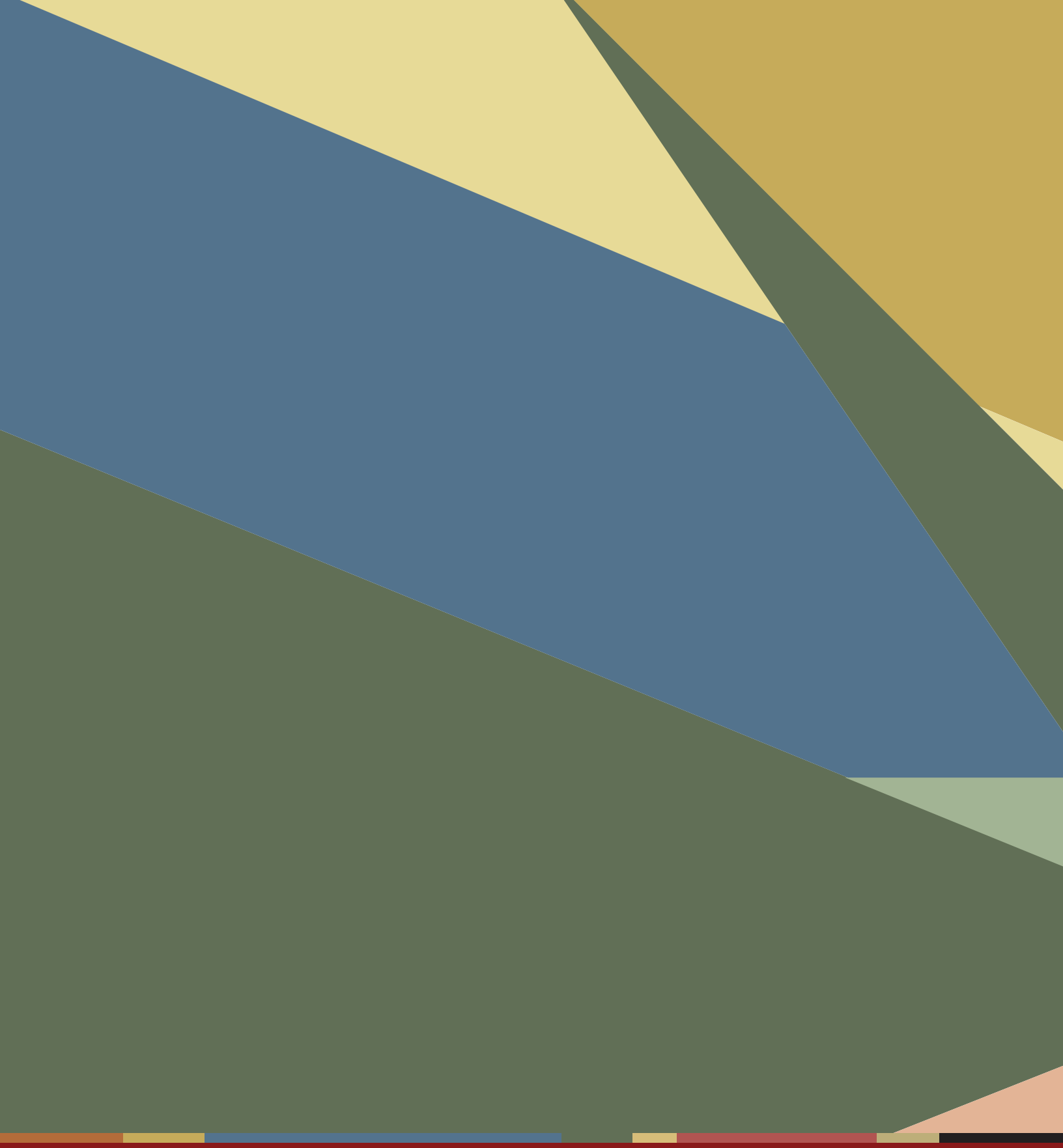

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