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:

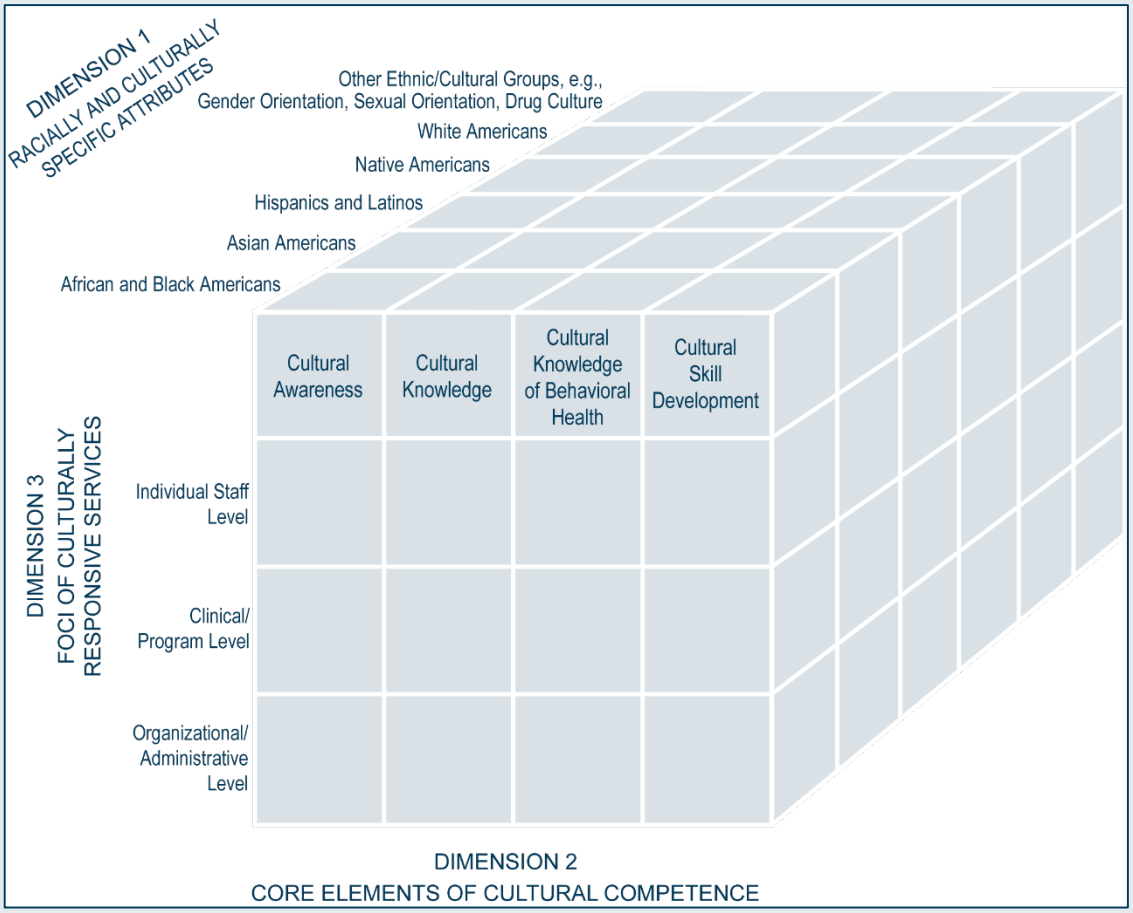
> Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, 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.

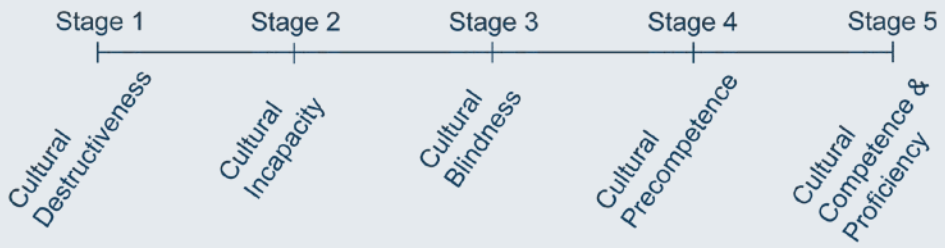
How Is Cultural Competence Achieved?

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.

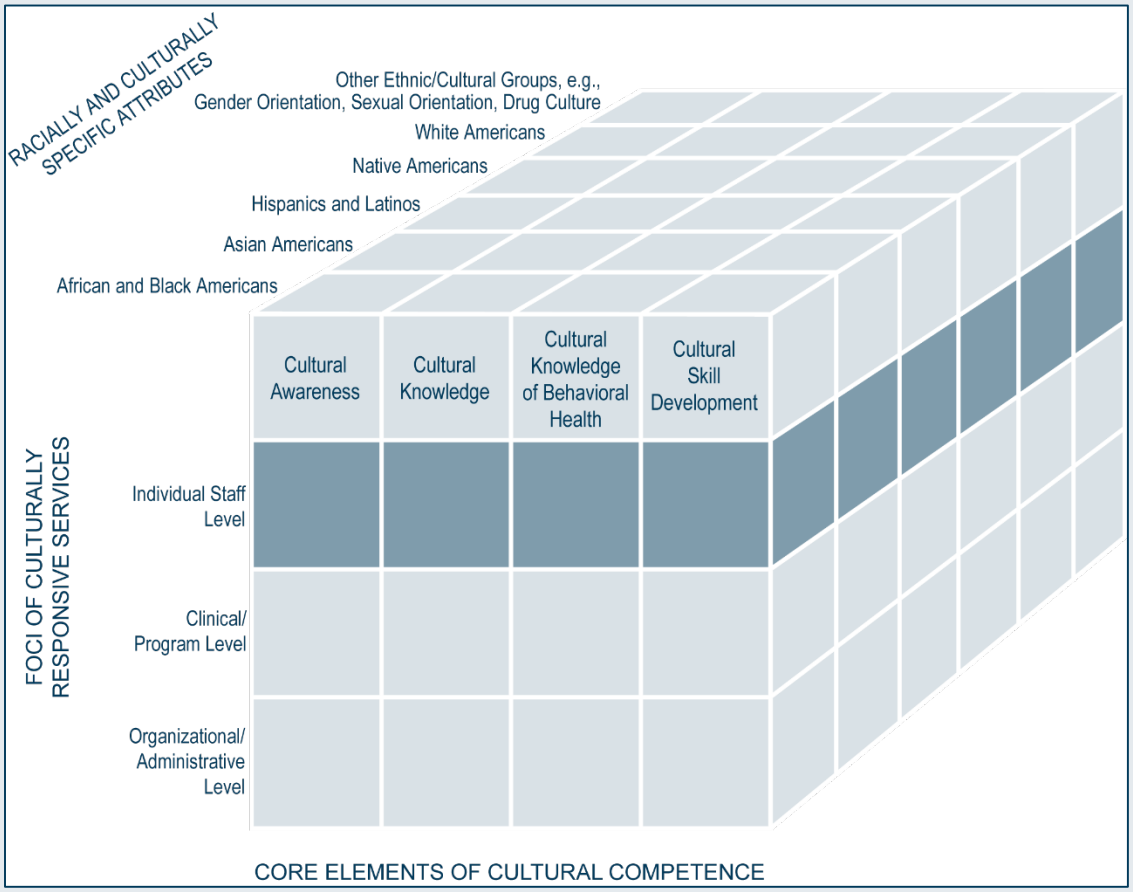
Like Gil, all clients enter treatment carrying beliefs, attitudes, conflicts, and problems shaped by their cultural roots as well as their present-day realities. As with Gil, many clients enter treatment with some reluctance and denial. Research shows that if clients such as Gil are greeted by a culturally 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.	**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.
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.	**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.
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.	**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.
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.	**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.
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.	**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

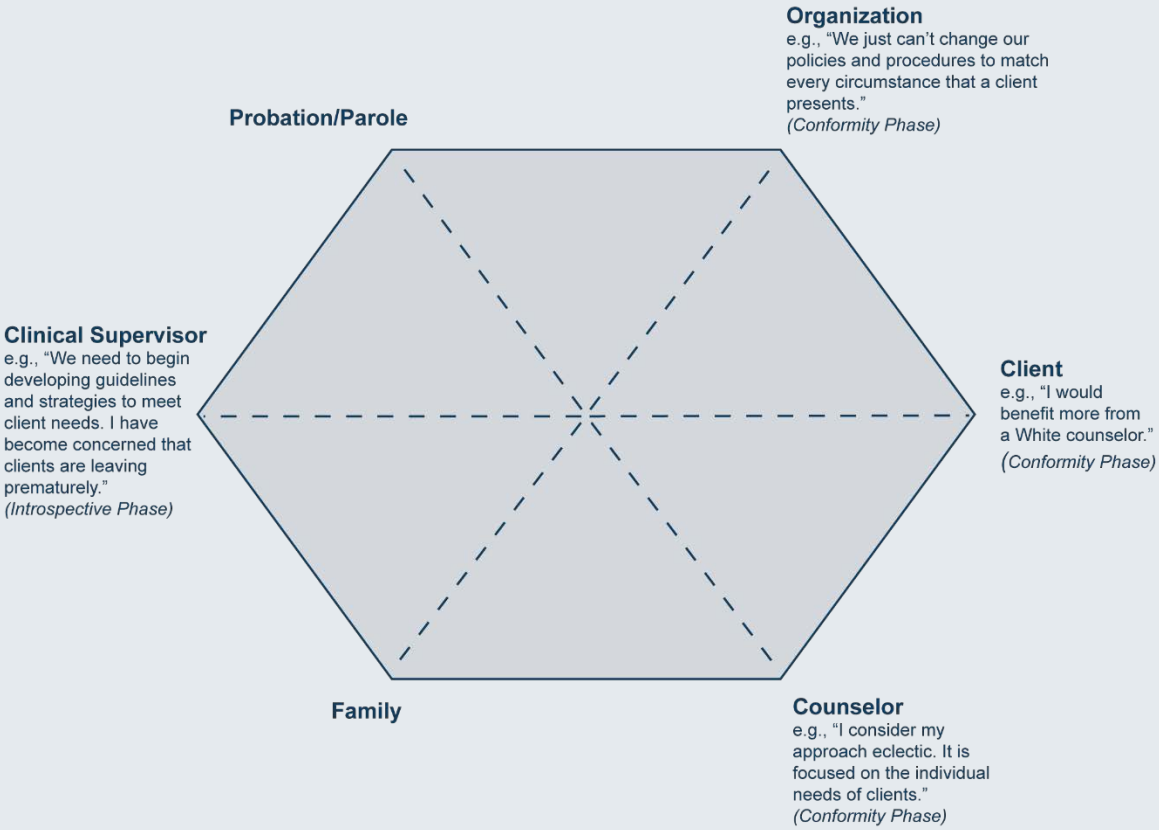
How To Map Racial and Cultural Identity Development

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.



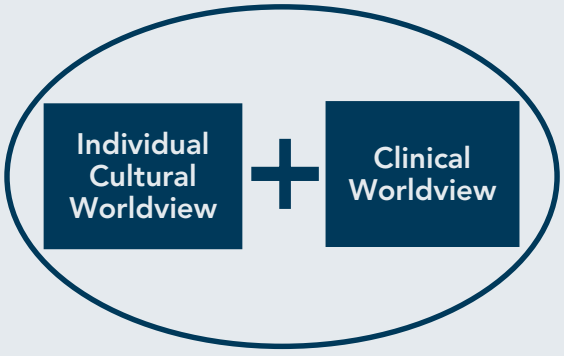
tinted view. Not unlike clients, counselors enter the treatment process with their own cultural worldviews that shape their concept of time; definition of family; organization of priorities and responsibilities; orientation to self, family, and/or community; religious or

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.

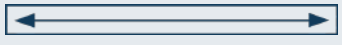
Instructions:

- 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

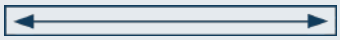
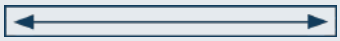
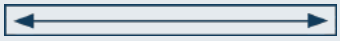
Eye Contact		
When talking: Direct, sustained		Indirect or not sustained
When listening: Direct, sustained		Indirect or not sustained
Vocal Pitch/Tone High/loud		Low/soft
More expressive		Less expressive
Speech Rate Fast		Slow
Pauses or Silence Little use of silence in dialog		Pauses; uses silence in 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.

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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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Note: Information given indicates each participant's affiliation during the time the review was conducted and may no longer reflect the individual's current affiliation.

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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.

What Are KAP Keys?

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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Publications may be ordered or downloaded for free at http://store.samhsa.gov. To order over the phone, please call 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

TIP 1 State Methadone Treatment Guidelines—*Replaced by TIP 43*

TIP 2 Pregnant, Substance-Using Women—*Replaced by TIP 51*

TIP 3 Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents—*Replaced by TIP 31*

TIP 4 Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents—*Replaced by TIP 32*

TIP 5 Improving Treatment for Drug-Exposed Infants

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Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues
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Helping Yourself Heal: A Recovering Man's Guide to Coping With the Effects of Childhood Abuse
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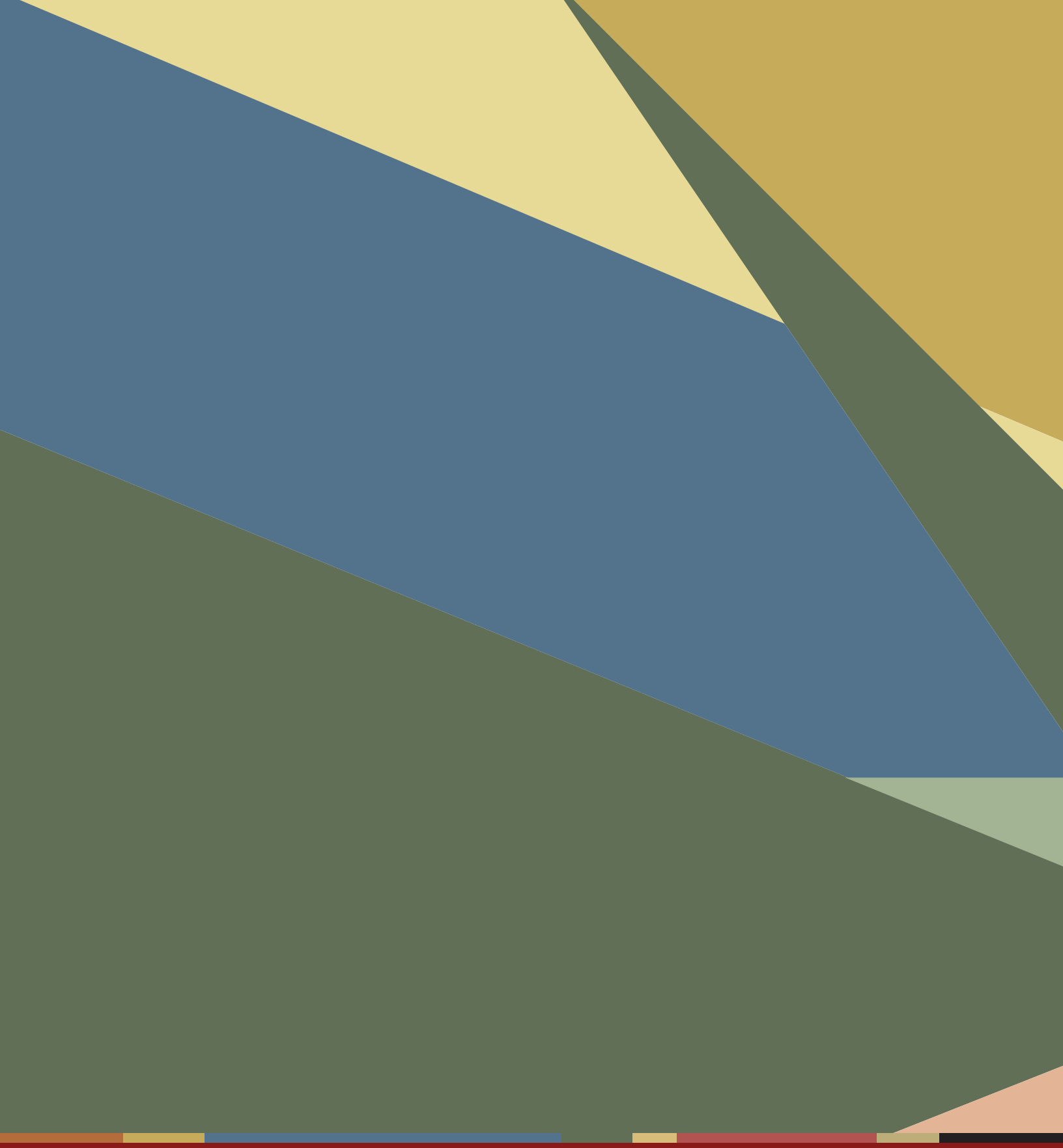

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