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Improving Cultural Competence

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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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5 Behavioral Health Treatment for Major Racial and Ethnic Groups

IN THIS CHAPTER

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

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

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

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

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

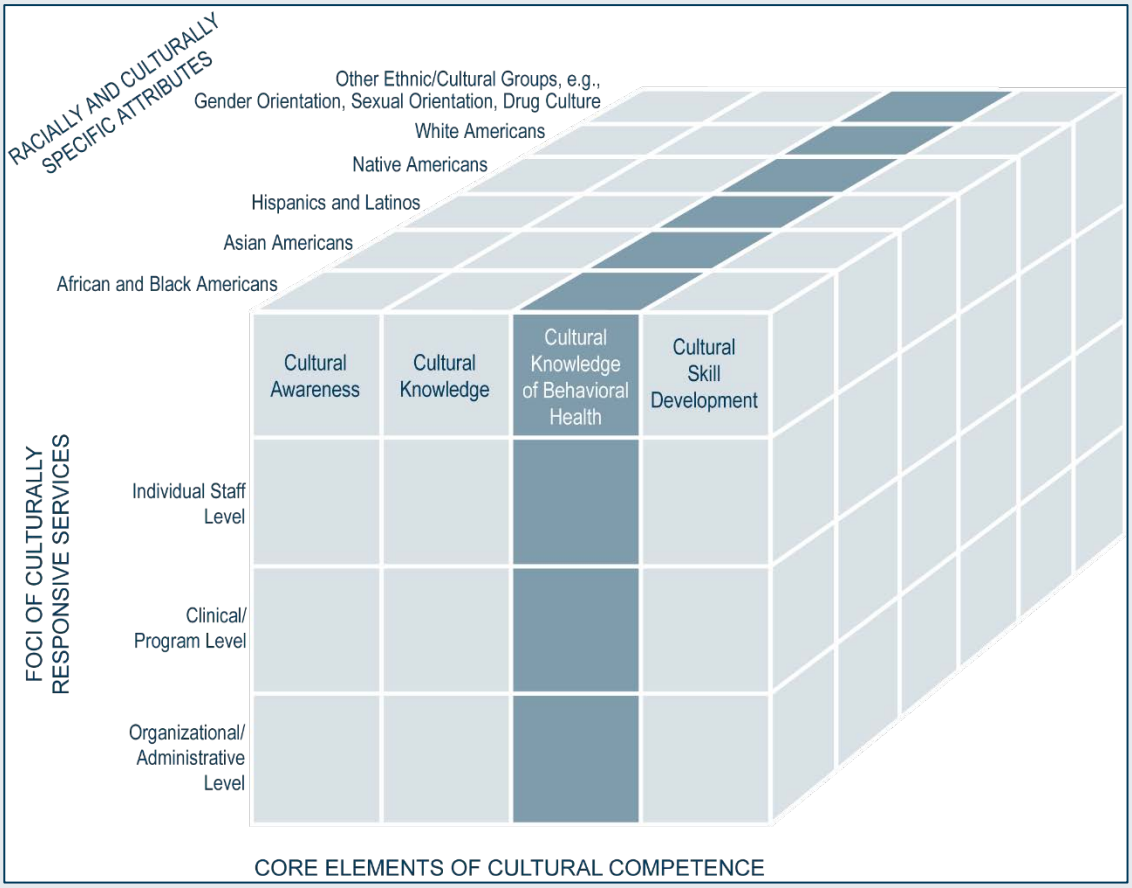
John's counselor recognizes the importance of connecting John to his community and, if possible, to a source of traditional healing. After much research, his counselor is able to locate and contact an Indian service organization in a larger city nearby. The agency puts him in touch with an older woman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

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

Introduction

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

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



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

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

Counseling for African and Black Americans

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

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

Beliefs About and Traditions Involving Substance Use

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

Substance Use and Substance Use Disorders

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

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

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

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

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

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

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

Mental and Co-Occurring Disorders

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

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

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

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

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

Treatment Patterns

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

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

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

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

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

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

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

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

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

Beliefs and Attitudes About Treatment

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

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

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

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

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

Treatment Issues and Considerations

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

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

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

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

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

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

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

Theoretical Approaches and Treatment Interventions

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

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

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

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

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

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

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

Family therapy

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

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

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

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

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

Advice to Counselors: Strengths of African American Families

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

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

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

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

Group therapy

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

Mutual-help groups

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

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

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

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

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

Traditional healing and complementary methods

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

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

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

Relapse prevention and recovery

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

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

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

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

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

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

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

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

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

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

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

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

Beliefs About and Traditions Involving Substance Use

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

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

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

Substance Use and Substance Use Disorders

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

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

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

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

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

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

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

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

Mental and Co-Occurring Disorders

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

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

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

Treatment Patterns

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

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

Beliefs and Attitudes About Treatment

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

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

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

Treatment Issues and Considerations

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

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

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

Advice to Counselors: Assessing Shame in Asian American Clients

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

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

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

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

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

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

Advice to Administrators: Culturally Responsive Program Development

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

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

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

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

Theoretical Approaches and Treatment Interventions

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

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

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

Family therapy

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

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

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

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

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

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

Source: Kim et al. 2004.

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

Group therapy

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

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

Mutual-help groups

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

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

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

Traditional healing and complementary methods

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

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

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

Behavioral Health Counseling for Native Hawaiians and Other Pacific Islanders

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

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

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

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

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

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

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

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

Relapse prevention and recovery

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

Counseling for Hispanics and Latinos

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

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

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

Beliefs About and Traditions Involving Substance Use

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

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

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

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

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

Substance Use and Substance Use Disorders

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

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

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

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

Source: Alegria et al. 2008a.

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

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

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

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

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

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

Mental and Co-Occurring Disorders

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

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

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

Treatment Patterns

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

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

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

Beliefs and Attitudes About Treatment

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

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

Treatment Issues and Considerations

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

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

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

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

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

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

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

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

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

Theoretical Approaches and Treatment Interventions

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

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

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

Family therapy

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

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

Case Study: A Puerto Rican Client

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

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

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

Source: Medina 2001. Adapted with permission.

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

Group therapy

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

Mutual-help groups

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

Advice to Counselors: Family Therapy Guidelines for Latino Families

- Provide bilingual services.
- Use family therapy as a primary method of treatment.
- Assess cultural identity and acculturation level for each family member.
- Determine the family's level of belief in traditional and complementary healing practices; integrate these as appropriate.
- Discuss the family's beliefs, history, and experiences with standard American behavioral health services.
- Explore migration and immigration experiences, if appropriate.
- Provide additional respect to the father or father figure in the family.
- Interview family members or groups of family members (e.g., children) separately to allow them to voice concerns.
- Generate solutions with the family. Do not force changes in family relationships.
- Provide specific, concrete suggestions for change that can be quickly implemented.
- Focus on engaging the family in the first session using warmth and *personalismo*.

Sources: Bean et al. 2001; Hernandez 2005; Lynch and Hanson 2011.

of mutual-help participation among people with drug use disorders are also lower for Latinos (Perron et al. 2009). Language can present a barrier to mutual-help group participation for Spanish-speaking Latinos; however, Spanish-language meetings are held in some locations. Counselors should consider the appropriateness of 12-Step participation on a case-by-case basis (Alvarez and Ruiz 2001). For example, Mexican American men who identify with attitudes of *machismo* can feel uncomfortable with the 12-Step approach. Concern about divulging family issues in public can cause hesitation to address substance-related problems in public meetings.

For Latinos who do participate in 12-Step programs, findings suggest higher rates of abstinence, degree of commitment, and level of engagement than for White American participants (Hoffman 1994; Tonigan et al. 1998). For some Latinos, 12-Step groups can appeal to religious and spiritual beliefs. Hernandez (2000) suggests that mutual-help groups composed solely of Latinos make it easier for participants to address the cultural context of substance abuse. Some Latino 12-Step groups do not hold that substance abuse is a biopsychosocial problem, instead conceptualizing the disorder as a weakness of character that must be corrected. Hoffman (1994) studied Latino 12-Step groups in Los Angeles and observed that, in addition to a more traditional form of AA, there were groups that practiced *terapia dura* (i.e., rough therapy), which often uses a confrontational approach and endorses family values related to *machismo* (e.g., by reinforcing that overcoming substance abuse rather than drinking is manly). However, these groups were not overly welcoming of female members and gay men. In such cases, gay Latino men and Latinas can benefit from attending 12-Step groups that are not culturally specific or that do not use *terapia dura*.

Traditional healing and complementary methods

In a study of the use of alternative and complementary medical therapies, Latinos were less likely to use medical alternatives than were White Americans (Graham et al. 2005). However, those who did use such approaches were more likely to do so because they could not afford standard medical care (Alegria et al. 2012). As in other areas, the use of complementary and traditional medicine likely varies according to acculturation level and country of origin. For instance, the use of faith and religious practices to cope with mental and emotional problems is significantly more common among foreign-born Latinos than among those born in the United States (Nadeem et al. 2008; Vega et al. 2001).

Many Latinos place great importance on the practice of Roman Catholicism. Yamamoto and Acosta (1982) describe the central tenets of Latino Catholicism as sacrifice, charity, and forgiveness. These beliefs can hinder assertiveness in some Latinos, but they can also be a source of strength and recovery. Traditionally, Latinos have been Catholic, although several Protestant and evangelical groups have converted millions of Latinos to their religions since the 1970s. Some Latinos also believe in syncretistic religions (e.g., Santería or Curanderismo) or practices derived from them and make use of a variety of traditional healing practices and rituals to heal mental and spiritual ailments (Lefley et al. 1998; Sandoval 1979). Among Puerto Ricans, *espiritismo* (spiritualism) is a popular traditional healing system successfully used to address mental health issues (Lynch and Hanson 2011; Molina 2001). Some Mexican Americans rely on *curanderos*, folk healers who address problems that might be framed as psychological (Falicov 2005, 2012). For a review of culturally responsive interventions with Latinos, refer to Gallardo and Curry (2009).

Relapse prevention and recovery

There are no substantial studies evaluating the use of relapse prevention and recovery promotion with Latinos, yet literature suggests that they would be appropriate and effective for this population (Blume et al. 2005; Castro et al. 2007). Overall, Latinos can face somewhat different triggers for relapse relating to acculturative stress or the need to uphold particular cultural values (e.g., *personalismo, machismo*; Castro et al. 2007), which can lead to higher rates of relapse among some Latino clients. For example, in a study of relapse patterns among White American and Latino individuals who used methamphetamine, Brecht et al. (2000) found that Latino participants relapsed more quickly than White American participants.

Data are lacking on long-term recovery for Latinos. Given the many obstacles that block accessibility to treatment for Latinos, continuing care planning can benefit from greater use of informal or peer supports. For example, White and Sanders (2004) recommend the use of a recovery management approach with Latinos. They point to an early example of the East Harlem Protestant Parish's work, which helped Puerto Rican individuals recovering from heroin dependence connect to social clubs and religious communities that supported recovery. Latinos use community and family support in addition to spirituality to address mental disorders (Lynch and Hanson 2011; Molina 2001). Castro et al. (2007) also note that family support systems can be especially important for Latinos in recovery.

Counseling for Native Americans

There are 566 federally recognized American Indian Tribes, and their members speak more than 150 languages (U.S. Department of the Interior, Indian Affairs 2013*a*); there are numerous other Tribes recognized only by states and others that still go unrecognized by government agencies of any sort. According to the 2010 U.S. Census (Norris et al. 2012), the majority (78 percent) of people who identified as American Indian or Alaska Native, either alone or in combination with one or more other races, lived outside of American Indian and Alaska Native areas. Approximately 60 percent of the 5.2 million people who identified as American Indian or Alaska Native, alone or in combination with one or more other races, reside in urban areas (Norris et al. 2012). The category of Alaska Natives includes four recognized Tribal groups—Alaskan Athabascan, Aleut, Eskimo, and Tingit-Haida—along with many other independent communities (Ogunwole 2006).

Native Americans who belong to federally recognized Tribes and communities are members of sovereign Indian nations that exist within the United States. On lands belonging to these Tribes and communities, Native Americans are able to govern themselves to a large extent and are not subject to most state laws—only to federal legislation that is specifically designated as applying to them (Henson 2008). Although health care (including substance abuse treatment) is provided to many Native Americans by Indian Health Services (IHS), Tribal governments do have the option of taking over those services. Counselors working with these populations should remember that Native Americans, by virtue of their membership in sovereign Tribal entities, have rights that are different from those of other Americans; this distinguishes them from members of other ethnic/racial groups.

American Indians live in all 50 states; the states with the largest populations of American Indians are Oklahoma, California, and Arizona. The 2000 Census allowed people to identify, for the first time, as a member of more than one race. Of persons who checked two or more races, nearly one in five indicated that they were part American Indian or Alaska Native (U.S. Census Bureau 2001*a*,*b*).

Behavioral health service providers should recognize that Native American Tribes represent a wide variety of cultural groups that differ from one another in many ways (Duran et al. 2007). Alaska Natives who live in coastal areas have very different customs from those inhabiting interior areas (Attneave 1982). The diversity of Native American Tribes notwithstanding, they also share a common bond of respect for their cultural heritages, histories, and spiritual beliefs, which are different from those of mainstream American culture. For more information on the treatment and prevention of substance abuse and mental illness among Native Americans, see the planned TIP, *Behavioral Health Services for American Indians and Alaska Natives* (SAMHSA planned *a*).

Beliefs About and Traditions Involving Substance Use

Few American Indian Tribes and no Alaska Natives consumed alcoholic beverages prior to contact with non-Native people, and those who did used alcohol primarily for special occasions and ceremonies. Most Tribes first encountered the use of alcohol when they encountered European settlers and traders. Because of this lack of experience with alcohol, few Native Americans had a context for drinking besides what they learned from these non-Natives, who at the time drank in large quantities and often engaged in binge drinking. Although patterns of alcohol consumption in the mainstream population of the United States changed over time, they remained relatively the same in the more isolated Native American communities. According to an NSDUH report on American Indian and Alaska Native adults, binge drinking continues to be a significant problem for these populations. Both binge drinking and illicit drug use is higher among Native Americans than the national average (30.2 percent versus 23 percent and 12.7 percent versus 9.2 percent, respectively; SAMHSA 2013*d*).

American Indian drinking patterns vary a great deal by Tribe. Tribal attitudes toward alcohol influence consumption in complicated ways. For example, in Navajo communities, excessive drinking was acceptable if done in a group or during a social activity. However, solitary drinking (even in lesser amounts) was considered to be deviant (Kunitz et al. 1994). Kunitz et al. (1994) observed that during the 1960s, binge drinking was acceptable among the Navajo during public celebrations, whereas any drinking was considered unacceptable among the neighboring Hopi population,

wherein regular drinkers were shunned or, in some cases, expelled from the community. Hopi individuals who did drink tended to do so alone or moved off the reservation to border towns where heavy alcohol use was common. The ostracism of Hopi drinkers seemed to lead to even greater levels of abuse, given that there were much higher death rates from alcoholic cirrhosis among the Hopi than among the Navajo.

Native American recovery movements have often viewed substance abuse as a result of cultural conflict between Native and Western cultures, seeing substances of abuse as weapons that have caused further loss of traditions (Coyhis and White 2006). To best treat this population, substance abuse treatment providers need to expand their perspectives regarding substance abuse and dependence and must embrace a broader view that explores the spiritual, cultural, and social ramifications of substance abuse (Brady 1995; Duran 2006; Jilek 1994).

Substance Use and Substance Use Disorders

According to 2012 NSDUH data, American Indian and Alaska Native peoples have the highest rates of substance use disorders and binge drinking (SAMHSA 2013*d*). Although rates of substance abuse are high among Native Americans, so too are rates of abstinence. American Indians and Alaska Natives are more likely to report no alcohol use in the past year than are members of all other major racial and ethnic groups (OAS 2007). The American Indian Services Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (AI-SUPER PFP) also found that rates of lifetime abstinence from alcohol for American Indians in the study were significantly higher than lifetime abstinence rates among the general population (Beals et al. 2003). Data on alcohol consumption also show that Alaska Natives are significantly more likely to abstain than are other Alaskans (Wells 2004).

The most common pattern of abusive drinking among American Indians appears to be binge drinking followed by long periods of abstinence (French 2000; May and Gossage 2001). A similar pattern is seen among Alaska Natives (Seale et al. 2006; Wells 2004). As an example, the Urban Indian Health Institute (2008) found that binge drinking was significantly more common among the Native American population (with 21.3 percent engaging in binge drinking in the prior 30 days compared with 15.8 percent of non-Native Americans) and that, among those who drank, 40.7 percent of Native American participants engaged in binge drinking compared with 26.9 percent of non-Natives.

There are a number of historical reasons for the development of binge drinking among Native Americans. The existence of dry reservations (which can limit the times when individuals are able to get alcohol), high levels of poverty, lack of availability (e.g., in remote Alaska Native villages), a history of trauma, and the loss of cultural traditions can all contribute to the development and continuation of this pattern of drinking. Native Americans are also more likely than members of other major racial/ethnic groups to have had their first drink before the age of 21 or before the age of 16, which also may shape drinking patterns (SAMHSA 2011*c*).

However, data on heavy and binge drinking do not reflect the same pattern of alcohol consumption for all Native American Tribes. One analysis of alcohol dependence among members of seven different Tribes found rates of dependence varying from 56 percent of men and 30 percent of women in one Tribe to 1 percent of men and 2 percent of women in another (Koss et al. 2003). Other research

confirms significant differences in alcohol use among diverse Native American communities (O'Connell et al. 2005; Whitesell et al. 2006).

In addition to alcohol, methamphetamine and inhalant abuse are major concerns for a number of Native American communities. Nonetheless, there are considerable regional differences in patterns and prevalence of drug use (Miller et al. 2012). According to the National Congress of American Indians (2006), 74 percent of Tribal police forces ranked methamphetamine as the drug causing the most problems in their communities. Methamphetamine abuse can be even more serious for Native Americans living in rural areas than for those in urban areas, but it is also a serious problem for growing numbers of American Indians, especially women, entering treatment in urban areas (Spear et al. 2007).

American Indians and Alaska Natives are more likely to report having used inhalants at some time during their lives, but use tends to peak in 8th grade and then decrease (Miller et al. 2012). In some Native American communities (e.g., on the Kickapoo reservation in Texas), inhalants have been a major drug of abuse for adults as well as youth. During the early 1990s, about 46 percent of the adult population on that reservation were thought to abuse inhalants (Fredlund 1994). Although more recent data are not available, reports from the area suggest that inhalant abuse remains a significant problem (Morning Star 2005).

Rates of substance use disorders appear to be higher in individuals who consider themselves exclusively Native American than for those who identify as more than one race/ethnicity, but even when surveys ask whether people are of mixed race, those who report themselves to be partially Native American still have high rates of substance use disorders (OAS 2007). Native Americans are about 1.4 times more likely than White Americans to have a lifetime diagnosis of an alcohol use disorder (Gilman et al. 2008). Illicit drug use is also more common for Native Americans than for members of other major racial/ethnic groups.

Among Native Americans entering treatment in 2010, alcohol use disorders alone or in conjunction with drug use disorders were the most pressing substance-related problem, with cannabis and opioids other than heroin being the next most common primary substances of abuse. One of the largest studies on American Indian substance use and abuse to date, the AI-SUPER PFP, found that 31.2 percent of American Indians met criteria for a lifetime diagnosis of a substance use disorder, and 13.4 percent met criteria for a past-year diagnosis (Beals et al. 2003). The study found that rates of alcohol use disorders were high among men from the three Tribes represented but varied to a greater degree among women across Tribes (Mitchell et al. 2003).

American Indians have high rates of certain diseases and conditions. In particular, the incidence of diabetes is increasing among Native Americans, and approximately 38 percent of elder Native Americans have diabetes (Moulton et al 2005). Diabetes is also associated with both substance use disorders and depression in this population (Tann et al. 2007). Other health problems associated with alcohol use include fetal alcohol syndrome, cirrhosis, and depression.

Mental and Co-Occurring Disorders

According to the 2012 NSDUH, 28.3 percent of American Indians and Alaska Natives report having a mental illness, with approximately 8.5 percent indicating serious mental illness in the past year (SAMHSA 2013*c*). Native Americans were nearly twice as likely to have serious thoughts of suicide as members of other racial/ethnic populations, and more

than 10 percent reported a major depressive episode in the past year. Common disorders include depression, anxiety, and substance use.

As with other groups, substance use disorders among Native Americans have been associated with increased rates of a variety of different mental disorders (Beals et al. 2002; Tann et al. 2007; Westermeyer 2001). The 2012 NSDUH revealed that 14 percent of Native Americans reported both past-year substance use disorders and mental illness. Among those who reported mental illness, nearly 5 percent reported several mental illnesses co-occurring with substance use disorders (SAMHSA 2013*c*).

Native American communities have experienced severe historical trauma and discrimination (Brave Heart and DeBruyn 1998; Burgess et al. 2008). Studies suggest that many Native Americans suffer from elevated exposure to specific traumas (Beals et al. 2005; Ehlers et al. 2006; Manson 1996; Manson et al. 2005), and they may be more likely to develop PTSD as a result of this exposure than members of other ethnic/racial groups. PTSD comparison rates taken from the AI-SUPER PFP study and the National Comorbidity Study show that 12.8 percent of the Southwest Tribe sample and 11.5 percent of the Northern Plains Tribe sample met criteria for a lifetime diagnosis of PTSD compared with 4.3 percent of the general population (Beals et al. 2005). Trauma histories and PTSD are so prevalent among Native Americans in substance abuse treatment that Edwards (2003) recommends that assessment and treatment of trauma should be a standard procedure for behavioral health programs serving this population. For example, Native American veterans with substance use disorders are significantly more likely to have co-occurring PTSD than the general population of veterans with substance use disorders (Friedman et al. 1997).

Treatment Patterns

Despite a number of potential barriers to treatment (Venner et al. 2012), Native Americans are about as likely as members of other racial/ethnic groups to enter behavioral health programs. According to data from the 2003 and 2011 NSDUH (SAMHSA, CBHSQ 2012), Native Americans were more likely to have received substance use treatment in the past year than persons from other racial/ethnic groups (15.0 percent versus 10.2 percent). Other studies indicate that about one-third of Native Americans with a current substance use disorder had received treatment in the prior year (Beals et al. 2006; Herman-Stahl and Chong 2002). The 2012 NSDUH reported that approximately 15 percent of Native Americans received mental health treatment (SAMHSA 2013*c*).

Native Americans were least likely of all major ethnic/racial groups to state that they could not find the type of program they needed and were the next least likely after Native Hawaiians and other Pacific Islanders to state that they did not know where to go or that their insurance did not cover needed treatment. Among Native Americans who identified a need for treatment in the prior year but did not enter treatment, the most commonly cited reasons for not attending were lack of transportation, lack of time, and concerns about what one's neighbors might think (SAMHSA 2011*c*).

Many Native Americans, especially those residing on reservations or other Tribal lands, seek mental health and substance abuse treatment through Tribal service providers or IHS (Jones-Saumty 2002; McFarland et al. 2006). However, an analysis using multiple sources found that 67 percent of Native Americans entering substance abuse treatment over the course of a year did so in urban areas, and the majority of those urban-based programs were not operated by IHS (McFarland et al. 2006).

The same research also found that Native Americans were somewhat more likely than the general treatment-seeking population to enter residential programs.

Native Americans were more likely to enter treatment as a result of criminal justice referrals than were White Americans or African Americans: 47.9 percent of American Indians and Alaska Natives entering public treatment programs in 2010 were court-ordered to treatment compared with 36.6 percent of White Americans and 36.4 percent of African Americans (SAMHSA, CBHSQ 2012). The lack of recognition of special needs and knowledge of Native American cultures within behavioral health programs may be the main reasons for low treatment retention and underuse of help-seeking behaviors among Native Americans (LaFromboise 1993; Sue and Sue 2013*e*).

Beliefs and Attitudes About Treatment

Duran et al. (2005) evaluated obstacles to treatment entry among American Indians on three different reservations; most frequently mentioned were the perception that good-quality or suitable services were unavailable and the perceived need for individuals to be self-reliant. They also found social relationships to be extremely important in overcoming these barriers. Jumper-Thurman and Plested (1998) reported that focus groups of American Indian women listed mistrust as one of the primary barriers for seeking treatment. This is due, in part, to the women's belief that they would encounter people they knew among treatment agency staff; they also doubted the confidentiality of the treatment program.

Treatment Issues and Considerations

Each Tribe and community will likely have different customs, healing traditions, and beliefs about treatment providers that can influence not only willingness to participate in treatment services, but also the level of trust clients have for providers. Counselors and other behavioral health workers must develop ongoing relationships within local Native American communities to gain knowledge of the unique attributes of each community, to show investment in the community, and to learn about community resources (Exhibit 5-3). Identifying and developing resources within Native communities can help promote culturally congruent relationships.

Exhibit 5-3: Native Americans and Community

Many Native Americans believe that recovery cannot happen for individuals alone and that their entire community has become sick. Coyhis calls this the "healing forest" model: one cannot take a sick tree from a sick forest, heal it, and put it back in the same environment expecting that it will thrive. Instead, the community must embrace recovery.

Today, community development models are being implemented in American Indian and Alaska Native communities to address prevention and treatment issues for mental and substance use disorders as well as related issues, such as suicide prevention (Edwards and Egbert-Edwards 1998; HHS 2010; May et al. 2005). Using these models, communities move toward greater commitment to social problem-solving and the development of effective, culturally congruent strategies relevant to their Tribes or villages. According to Edwards et al. (1995), community approaches often lead to:

- A reduction of substance use.
- Breaking intergenerational cycles of alcohol abuse.
- Increased community support.
- The strengthening of individual and group cultural identity.
- Leadership development.
- Increased interpersonal and inter-Tribal problem-solving skills and solidarity.

For an example, see Jumper-Thurman et al. (2001).

To provide culturally responsive treatment, providers need to understand the Native American client's Tribe; its history, traditions, worldview, and beliefs; the dimensions of its substance abuse problem and other community problems; the incidence of trauma and abuse among its members; its traditional healing practices; and its intrinsic strengths. Providers who work with Native Americans but do not have an understanding of their cultural identity and acculturation patterns are at a distinct disadvantage (Ponterotto et al. 2000). Before beginning any treatment, providers should routinely seek consultation with knowledgeable professionals who are experienced in working with the specific Tribal group in question (Duran 2006; Edwards and Egbert-Edwards 1998; Straits et al. 2012) and should conduct thorough client assessments that evaluate cultural identity (see Appendix F and Chapter 2 for resources). Some Native American persons have a strong connection to their cultures and others do not; some identify with a blend of American Indian cultural groups called pan-Indianism or inter-Tribal identity. Still others are comfortable with a dual identity that embraces both Native and non-Native cultural groups.

Native Americans often approach the beginning of a relationship in a calm, unhurried manner, and they may need more time to develop trust with providers. Concerns about confidentiality can be an important issue to address with Native American clients, especially for those in small, tightly-knit communities. For providers, it is very important to make clear to clients that what they say to the counselor will be held in confidence, except when there is an ethical duty to report.

Native American cultural groups generally believe that health is nurtured through balance and living in harmony with nature and the community (Duran 2006; Garrett et al. 2012). They also, for the most part, have a holistic view of health that incorporates physical, emotional, and spiritual elements (Calabrese 2008), individual and community healing (Duran 2006; McDonald and Gonzalez 2006), and prevention and treatment activities (Johnston 2002). For many, culture is the path to prevention and treatment.

However, not all Native Americans have a need to develop stronger connections to their communities and cultural groups. As Brady (1995) cautions, culture is complex and changing, and a return to the values of a traditional culture is not always desired. An initial inquiry into each client's connection with his or her culture, cultural identity, and desire to incorporate cultural beliefs and practices into treatment is an essential step in culturally competent practice. When appropriate, providers can help facilitate the client's reconnection with his or her community and cultural values as an integral part of the treatment plan. In addition, treatment providers need to adapt services to be culturally responsive. In doing so, outcomes are likely to improve not only for Native American clients, but for all clients within the program. Fisher et al. (1996) modified a therapeutic community in Alaska to incorporate Alaska Native spiritual and cultural practices and found that retention rates improved for White and African American clients as well as Alaska Native clients participating in the program.

In working with Native American clients, providers should be prepared to address spirituality and to help clients access traditional healing practices. Culturally responsive treatment should involve community events, group activities, and the ability to participate in ceremonies to help clients achieve balance and find new insight (Calabrese 2008). Stronger attachment to Native American cultural groups protects against substance use and

abuse; therefore, strengthening this connection is important in substance abuse treatment (Duran 2006; Moss et al. 2003; Spicer 2001; Stone et al. 2006).

Theoretical Approaches and Treatment Interventions

Some clinicians caution that a model of counseling that requires self-disclosure to relative strangers can be counterproductive with Native American clients. Other authors recommend CBT and social learning approaches for Native American clients, as such approaches typically have less cultural bias, focus on problem-solving and skill development, emphasize client strengths and empowerment, recognize the need to accept personal responsibility for change, and make use of learning styles that many Native Americans find culturally appropriate (Heilbron and Guttman 2000; McDonald and Gonzalez 2006). Motivational interviewing is also recommended for Native American clients. In a small study, Villanueva et al. (2007) found that all treatment modalities resulted in improvements at 15-month follow-up, but clients who received motivational enhancement therapy reported significantly fewer drinks per drinking day during the 10- to 15-month posttreatment follow-up period. Venner et al. (2006) wrote a manual for motivational interviewing with Native American clients.

Advice to Counselors: Counseling Native Americans

When working with Native American clients, providers should:

- Use active listening and reflective responses.
- Avoid interrupting the client.
- Refrain from asking about family or personal matters unrelated to substance abuse without first asking the client's permission to inquire about these areas.
- Avoid extensive note-taking or excessive questioning.
- Pay attention to the client's stories, experiences, dreams, and rituals and their relevance to the client.
- Recognize the importance of listening and focus on this skill during sessions.
- Accept extended periods of silence during sessions.
- Allow time during sessions for the client to process information.
- Greet the client with a gentle (rather than firm) handshake and show hospitality (e.g., by offering food and/or beverages).
- Give the client ample time to adjust to the setting at the beginning of each session.
- Keep promises.
- Offer suggestions instead of directions (preferably more than one to allow for client choice).

Sources: Aragon 2006; Trimble et al. 2012.

Family therapy

Family involvement in treatment leads to better outcomes for Native Americans at the time of discharge from treatment (Chong and Lopez 2005). Research also suggests that family and community support can have a significant effect on recovery from substance use disorders for this population (Jones-Saumty 2002; Paniagua 1998). Family therapy can be quite helpful and perhaps even essential for American Indian clients (Coyhis 2000), especially when other social supports are lacking (Jones-Saumty 2002).

American Indians place high value on family and extended family networks; restoring or healing family bonds can be therapeutic for clients with substance use disorders. Moreover, Native American clients are sometimes less motivated to engage in "talk therapy" and more willing to participate in therapeutic activities that involve social and family relationships (Joe and Malach 2011). Treatment approaches should remain flexible and include clients' families when appropriate. Counselors should be able to recognize what constitutes family, family constellations, and

family characteristics. The Native American concept of family can include elders, others from the same clan, or individuals who are not biologically related. In many Tribes, all members are considered relatives. Families can be matrilineal (i.e., kinship is traced through the female line) and/or matrilocal (i.e., married couples live with wife's parents).

When families do enter treatment, they may initially prefer to focus on a concrete problem, but not necessarily on the most significant family issue. Discussion of a clearly defined presenting problem enables families to assess the therapeutic process and better understand what is expected of them in treatment. Providers should be aware that the entire clan and/or Tribe could know about a given client's treatment and progress. Family therapy models such as network therapy, which makes use of support structures outside the immediate family and which were originally developed for Native American families living in urban communities, can be particularly effective with Native clients, especially when they have been cut off from their home communities because of substance abuse or other issues. For more information on network therapy and similar approaches, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*).

Group therapy

Although researchers and providers once viewed group therapy as ineffective for American Indian clients (Paniagua 1998), opinion has shifted to recognize that, when appropriately structured, group therapy can be a powerful treatment component (Garrett 2004; Garrett et al. 2001; Trimble and Jumper-Thurman 2002). Garrett (2004) notes that many Native American Tribes have traditional healing practices that involve groups; for many of these cultural groups, healing needs to occur within the context of the group or community (e.g., in talking circles). Thus, if properly adapted, group therapy can be very beneficial and culturally congruent. It is important, however, to determine Native American clients' level of acculturation before recommending Western models of group therapy, as less acculturated Native clients are likely to be less comfortable with group talk therapy (Mail and Shelton 2002). Group therapy for Alaska Natives should also be nonconfrontational and focus on clients' strengths.

Group therapy can incorporate Native American traditions and rituals to make it more culturally suitable. For example, the talking circle is a Native tradition easily adapted for behavioral health treatment. In this tradition, the members of the group sit in a circle. An eagle feather, stone, or other symbolic item is passed around, and each person speaks when he or she is handed the item. Based on a review of the literature, Paniagua (1998) recommends that providers using group therapy with Native American clients:

- Earn support or permission from Tribal authorities before organizing group therapy.
- Consult with Native professionals.
- If group members consent, invite respected Tribal members (e.g., traditional healers or elders) to participate in sessions.

Mutual-help groups

Native American peoples have a long history of involvement in mutual-help activities that predates the 12-Step movement (Coyhis and White 2006). Depending on acculturation, availability of a community support network, and the nature of their presenting problems, Native American clients may be more likely to solicit help from significant others, extended family members, and community members. Contemporary manifestations of Native American mutual-help efforts include adaptations of the 12 Steps (Exhibit 5-4) and of 12-Step meeting rituals and practices (Coyhis and White 2006). Another modified element of

Exhibit 5-4: The Lakota Version of the 12 Steps

The Lakota Tribe has adapted the 12 Steps to suit its particular belief system as follows:

1. I admit that because of my dependence on alcohol, I have been unable to care for myself and my family.
2. I believe that the Great Spirit can help me to regain my responsibilities and model the life of my forefathers (ancestors).
3. I rely totally on the ability of the Great Spirit to watch over me.
4. I strive every day to get to know myself and my position within the nature of things.
5. I admit to the Great Spirit and to my Indian brothers and sisters the weaknesses of my life.
6. I am willing to let the Great Spirit help me correct my weaknesses.
7. I pray daily to the Great Spirit to help me correct my weaknesses.
8. I make an effort to remember all those that I have caused harm to and, with the help of the Great Spirit, achieve the strength to try to make amends.
9. I do make amends to all those Indian brothers and sisters that I have caused harm to whenever possible through the guidance of the Great Spirit.
10. I do admit when I have done wrong to myself, those around me, and the Great Spirit.
11. I seek through purification, prayer, and meditation to communicate with the Great Spirit as a child to a father in the Indian way.
12. Having addressed those steps, I carry this brotherhood and steps to sobriety to all my Indian brothers and sisters with alcohol problems and together we share all these principles in all our daily lives.

Source: CSAT 1999b, p. 56. Reprinted from material in the public domain.

the 12 Steps is use of a circular, rather than a linear, path to healing. The circle is important to American Indian philosophy, which sees the great forces of life and nature as circular (Coyhis 2000). In addition, staff members of the White Bison program have also rewritten the AA "Big Book" from a Native American perspective (Coyhis and Simonelli 2005). The principles of the 12 Steps, which involve using the group or community to provide support and motivation while emphasizing spiritual reconnection, appeal to many Native Americans who see treatment as social in nature and who view addiction as a spiritual problem.

The Native American Wellbriety movement is a modern, indigenous mutual-help program that has its roots in 12-Step groups but incorporates Native American spiritual beliefs and cultural practices (Coyhis and Simonelli 2005; Coyhis and White 2006; White Bison, Inc. 2002; also see http://www.whitebison.org). Although the Wellbriety movement is popular with many Native Americans in recovery, a considerable number also continue to participate in traditional 12-Step groups. In the AI-SUPER-PFP, 47 percent of Northern Plains Tribe respondents and 28.8 percent of Southwest Tribe respondents with a past-year substance use disorder reported 12-Step group attendance in the prior year (Beals et al. 2006). Mohatt et al. (2008*b*) found that more Alaska Natives in recovery reported participation in 12-Step groups than in substance abuse treatment. In Venner and Feldstein's (2006) research with American Indians in recovery, 84 percent of respondents had attended some mutual-help meetings.

Traditional healing and complementary methods

Native American peoples have a range of beliefs about health care—from traditional beliefs to strong support for modern science—and may use a number of strategies when addressing health problems. Traditional healing practices are often used in conjunction with modern medicine. For example, American Indians

traditionally view all things as deeply interconnected. Disruption of the physical, mental, spiritual, or emotional sides of a person can result in illness. A Native American client may consult a medical doctor to address part of the problem and a traditional healer to help regain balance and harmony.

The use of traditional healing for substance abuse and mental health problems is fairly common among Native Americans (Herman-Stahl and Chong 2002; Herman-Stahl et al. 2003). For example, among Native American individuals who reported a substance use disorder in the past year, 57.4 percent of those from a Southwest Tribe and 31.7 percent from a Northern Plains Tribe used traditional healers or healing practices (Beals et al. 2006). In a survey of American Indians from three different Arizona Tribes, 27.4 percent stated that they had used traditional healers and/or healing practices to help with mental health problems (Herman-Stahl and Chong 2002). Overall, many Native Americans believe that culture is the primary avenue of healing and that connecting with one's culture is not only a means of prevention, but also a healing treatment (Bassett et al. 2012)

Each Native American culture has its own specific healing practices, and not all of those practices are necessarily appropriate to adapt to behavioral health treatment settings. However, many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treatment settings (Castro et al. 1999*b*; Coyhis 2000; Coyhis and White 2006; Mail and Shelton 2002; Sue 2001; White 2000). These practices include sacred dances (such as the Plains Indians' sun dance and the Kiowa's gourd dance), the four circles (a model for conceptualizing a harmonious life), the talking circle, sweat lodges, and other purification practices (Cohen 2003; Mail and Shelton 2002; White 2000). The sweat lodge, in particular, is frequently used in substance abuse treatment settings (Bezdek and Spicer 2006; Schiff and Moore 2006).

Alaskan behavioral health programs have developed recovery camps to provide a treatment setting that incorporates Native beliefs and seasonal practices (e.g., Old Minto Family Recovery Camp: http://www.tananachiefs.org/ health-services/old-minto-family-recovery-camp-new/). Recovery camps are based on the model of traditional Native Alaskan fishing camps and provide a context in which clients can learn about traditional practices, such as sustenance activities. Another program, the Village Sobriety Project, incorporates traditional Yup'ik and Cup'ik Eskimo traditions of hunting, chopping wood, berry picking, and taking tundra walks (Mills 2003). See Niven (2010) for a review of client-centered, culturally responsive behavioral health techniques for use with Alaska Natives.

It is difficult to measure the effectiveness of Native American healing practices using

There are a number of potential pitfalls that can occur when trying to integrate Native spiritual and cultural practices into treatment. Cultural groups are complex systems; removing pieces of them for implementation as part of a treatment program can be a disservice to the culture as well as the clients (Kunitz et al. 1994; Moss et al. 2003); a breach of customs and traditions; and a sign of disrespect for the community and Tribe, Tribal leadership, and Native American practices. It is important to take the time to build relationships and seek consultation with Tribal elders, and other Tribal leaders to ensure that the best and most appropriate steps are taken in creating a culturally relevant and responsive treatment model and program.

Western standards and practices. Limited or inconsistent funding, migration patterns, culturally incompetent or incongruent evaluation practices, and abuses incurred during or after data collection are major confounding variables that have limited knowledge on the effectiveness of incorporating traditional practices into Western approaches to the treatment of substance abuse and mental illness. Nonetheless, Mail and Shelton (2002) reviewed earlier literature on the use of "indigenous therapeutic interventions" for alcohol abuse and dependence and suggest that a number of these interventions have been of value to Native Americans with substance use disorders. Other authors have concurred (Coyhis and White 2006; Sabin et al. 2004).

Regardless of whether a program adapts specific Native American healing practices, providers working with this population should recognize that spirituality is central to its values and is perceived as an integral part of life itself. It is through spiritual experiences that Native Americans believe they will find meaning in life. Some Native languages have words that refer to spirituality as "walking around" or "living the path." In many cases, the spiritual traditions of Native Americans are not (and have never been) conceived of as a religion, but rather as a set of beliefs and practices that pervades every aspect of daily life (Deloria 1973).

Despite religion and spirituality often playing important roles in recovery from mental and substance use disorders for Native Americans, providers should not assume that only indigenous spirituality is relevant. The majority of Native Americans do not practice their traditional spirituality exclusively, and Christian religious institutions like the Native American Church and Pentecostal churches have been instrumental in helping many Native Americans overcome substance use disorders (Garrity 2000). In 2001, roughly 20 percent of American Indians identified as Baptist, 17 percent as Catholic, 17 percent as having no religious preference, and 3 percent as following a Tribal religion (Kosmin et al. 2001).

The relative importance of religion can also vary among diverse Native American communities. Before pursuing traditional methods, assessment of clients' spiritual orientation is important. Spirituality is a personal issue that treatment providers must respect; clients should choose which spiritual and cultural methods to incorporate into treatment. Providers should also be wary of an obsession with their clients' cultural activities, which may be considered intrusive (LaFromboise et al. 1993). Checking with community resources on the subject and asking the client "What feels right for you?" are appropriate steps to take in identifying whether traditional healing practices will have therapeutic value. Providers should consult with Native healers or Tribal leaders about the appropriateness of using a particular practice as part of behavioral health services. Rather than using traditional healing methods themselves, counselors may wish to refer clients to a Native American healer in the community or in the treatment program.

Relapse prevention and recovery

Despite limited data on long-term recovery for Native Americans who have substance use disorders, a few studies have found high rates of relapse following substance abuse treatment (see review in Chong and Herman-Stahl 2003). White and Sanders (2004) recommend that long-term recovery plans for Native Americans make use of a recovery management rather than a traditional continuing care approach. Such an approach emphasizes the use of informal recovery communities and traditional healing approaches to provide extended monitoring and support for Native Americans leaving treatment.

Researchers have conducted interviews with both American Indians (Bezdek and Spicer 2006) and Alaska Natives (Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004) who have achieved extended periods of recovery. Bezdek and Spicer (2006) identified two key tasks for American Indians entering recovery. First, they need to learn how to respond to family and friends who drank with them and to those who supported their recovery. Next, they have to find new ways to deal with boredom and negative feelings. By accomplishing these tasks, Native clients can build new social support systems, develop effective coping strategies for negative feelings, and achieve long-term recovery. The People Awakening Project found that, among Alaska Natives who had a substantial period of recovery, the development of active, culturally appropriate coping strategies was essential (e.g., distancing themselves from friends or family who drank heavily, getting involved in church, doing community service, praying; Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004).

Counseling for White Americans

According to the 2010 U.S. Census definition, White Americans are people whose ancestors are among those ethnic groups believed to be the original peoples of Europe, the Middle East, or North Africa (Humes et al. 2011). The racial category of White Americans includes people of various ethnicities, such as Arab Americans, Italian Americans, Polish Americans, and Anglo Americans (i.e., people with origins in England), among others. Many Latinos will also identify racially (if not ethnically) as White American. Non-Latino White Americans constitute the largest racial group in the United States (making up 63.7 percent of the population in the 2010 Census; Mather et al. 2011).

White Americans, like other large ethnic and cultural groups, are extremely heterogeneous in historical, social, economic, and personal features, with many (often subtle) distinctions among subgroups. Perhaps because White Americans have been the majority in the United States, it is sometimes forgotten how historically important certain distinctions between diverse White American ethnic heritages have been (and continue to be, for some). Conversely, many White American people prefer not to see themselves as such and instead identify according to their specific ethnic background (e.g., as Irish American). For similar reasons, certain cross-cutting cultural issues (see Chapter 1) like geographic location, sexual orientation, and religious affiliation are important in defining the cultural orientations of many White Americans.

Beliefs About and Traditions Involving Substance Use

Historically, use of alcohol was accepted among White/European cultural groups because it provided an easy way to preserve fruit and grains and did not contain bacteria that might be found in water. Over time, the production and consumption of alcohol became an often-integral part of cultural activities, which can be seen in the way some White cultural groups take particular pride in national brands of alcoholic beverages (e.g., Scotch whisky, French wine; Abbott 2001; Hudak 2000). A number of European cultural groups (e.g., French, Italian) traditionally believed that daily alcohol use was healthy for both mind and body (Abbott 2001; Marinangeli 2001), and for others (e.g., English, Irish), the bar or pub was the traditional center of community life (O'Dwyer 2001). Despite some variations in cultural attitudes toward appropriate drinking practices, alcohol has been and

remains the primary recreational substance for Whites in the United States. Predominant attitudes toward drinking in the United States more closely reflect those of Northern Europe; alcohol use is generally accepted during celebrations and recreational events, and, at such times, excessive consumption is more likely to be acceptable.

Typically, White European cultural groups accept alcohol use as long as it does not interfere with responsibilities, such as work or family, or result in public drunkenness (Hamid 1998). However, among certain groups of White Americans (usually defined by religious beliefs), the use of alcohol or any other intoxicant is considered immoral (van Wormer 2001). These religious beliefs, combined with concerns about the effects of problematic drinking patterns (especially among men in the frontier; White 1998), became the impetus for the early 19th-century creation of the Temperance Movement and culminated in the passing of the 18th Amendment to the United States Constitution, which enacted Prohibition. Although the Temperance Movement is no longer a major political force, belief in the moral and social value of abstinence continues to be strong among some segments of the White American population.

Illicit drug use, on the other hand, has historically been demonized by White American cultural groups and seen as an activity engaged in by people of color or undesirable subcultures (Bonnie and Whitebread 1970; Hamid 1998; Whitebread 1995). For example, White Americans typically link drug use to perceived threat of crime—particularly crimes perpetrated by people of color (Hamid 1998; Whitebread 1995). Attitudes have changed over time, but White American cultural groups continue to enforce strong cultural prohibitions against most types of illicit drug use. At the same time, White Americans are often more accepting of prescription medication abuse and less likely to perceive prescription medications as potentially harmful (Hadjicostandi and Cheurprakobkit 2002).

Despite illicit drug use now being as common among White Americans as people of color, White Americans still tend to perceive drug use as an activity that occurs outside their families and communities. In a 2001 survey, only 54 percent of White Americans expressed concern that someone in their family might develop a drug abuse problem compared with 81 percent of African Americans (Pew Research Center for the People and the Press 2001). In the same survey, White Americans expressed less concern about drug abuse in their neighborhoods than did other racial and ethnic groups. However, in terms of seeing drugs as a national problem, White Americans and other racial and ethnic groups are in closer agreement. Perhaps as a result of this misperception about the prevalence of drug use in their homes and communities, White American parents are less likely to convey disapproval of drug use to their children than African American parents (National Center on Addiction and Substance Abuse 2005) and much more likely than Latino or African American parents to think that their children have enough information about drugs (Pew Research Center for the People and the Press 2001).

There are also differences in how White Americans, Latinos, and African Americans perceive drug and alcohol addictions. White Americans are less likely than African Americans, but more likely than Latinos, to state that they believe a person can recover fully from addiction (Office of Communications 2008). However, White Americans are more likely than African Americans to indicate that substance use disorders should be treated as diseases (Durant 2005).

Substance Use and Substance Use Disorders

According to 2012 NSDUH data, rates of past-year substance use disorders were higher for White Americans than for Native Hawaiians, other Pacific Islanders, and Asian Americans; rates of current alcohol use were higher than for every other major ethnic/racial group (SAMHSA 2013*d*). Alcohol has traditionally been the drug of choice among White Americans of European descent; however, not all European cultural groups have the same drinking patterns. Researchers typically contrast a Northern/Eastern European pattern, in which alcohol is consumed mostly on weekends or during celebrations, with that of Southern Europe, in which alcohol is consumed daily or almost daily but in smaller quantities and almost always with food. The Southern European pattern involves more regular use of alcohol, but it is also associated with less alcohol-related harm overall (after controlling for total consumption; Room et al. 2003). The pattern of White Americans typically follows that of Northern and Eastern Europe, but individuals from some ethnic groups maintain the Southern European pattern.

White Americans, on average, begin drinking and develop alcohol use disorders at a younger age than African Americans and Latinos (Reardon and Buka 2002). White Americans are more likely to have their first drink before the age of 21 and to have their first drink before the age of 16 than members of any other major racial/ethnic group except Native Americans (SAMHSA 2011*c*). Some data suggest that White Americans begin using illicit drugs at an earlier age than African Americans (Watt 2008) and that the mean age for White Americans who inject heroin has decreased (Broz and Ouellet 2008).

White Americans who use heroin are less likely than people who use heroin from all other major racial/ethnic groups except African Americans to have injected the drug (SAMHSA 2011*c*). White Americans are also more likely than members of other major racial/ethnic groups, except Native Hawaiians and other Pacific Islanders (for whom estimates may not be accurate), to have tried ecstasy. Except for Native Americans (some of whom may use the hallucinogen peyote for religious purposes), they are also more likely than other racial/ethnic groups to have tried hallucinogens (SAMHSA 2011*c*). Research confirms that prescription drug misuse is more common among White Americans than African Americans or Latinos (Ford and Arrastia 2008; SAMHSA 2011*c*), and they are more likely to have used prescription opioids in the past year and to use them on a regular basis.

Comparative studies indicate that White Americans are more likely than all other major racial/ethnic groups except Native Americans to have an alcohol use disorder (Hasin et al. 2007; Perron et al. 2009; Schmidt et al. 2007). White Americans are at a greater risk of having severe alcohol withdrawal symptoms (such as delirium tremens) than are African Americans or Latinos with alcohol use disorders (Chan et al. 2009). So too, White Americans are more likely than African Americans or Latinos to meet diagnostic criteria for a drug use disorder at some point during their lives (Perron et al. 2009). Overall, substance use disorders vary considerably across and within non-European White American cultural groups. For example, rates of substance abuse treatment admissions in Michigan from 2005 suggest that substance use disorders may be considerably lower for Arab Americans than other White Americans (Arfken et al. 2007).

Mental and Co-Occurring Disorders

About 20 percent of White Americans reported some form of mental illness in the past year, and they were more likely to have past-year serious psychological distress than other population groups excluding Native Americans (SAMHSA 2012*a*).

White Americans appear to be more likely than Latinos or Asian Americans to have CODs (Alegria et al. 2008*a*; Vega et al. 2009) and more likely to have concurrent serious psychological distress and substance use disorders (SAMHSA 2011*c*). White Americans with CODs are also more likely to receive treatment for both their substance use and mental disorders than are African Americans with CODs (Alvidrez and Havassy 2005; Hatzenbuehler et al. 2008), but they are perhaps less likely to receive treatment for their substance use disorder alone (Alvidrez and Havassy 2005). White Americans are more likely to receive family counseling and mental health services while in substance abuse treatment and less likely to have unmet treatment needs (Marsh et al. 2009; Wells et al. 2001). In addition, White Americans are significantly less likely than Latinos or African Americans to believe that antidepressants are addictive (Cooper et al. 2003).

The most common mental disorders among White Americans are mood disorders (particularly major depression and bipolar I disorder) and anxiety disorders (specifically phobias, including social phobia, and generalized anxiety disorder; Grant et al. 2004*b*). Among White Americans, these disorders are more prevalent than in any other ethnic/racial groups save Native Americans (Grant et al. 2005; Hasin et al. 2005). For example, rates of a lifetime diagnosis of generalized anxiety disorder are about 40 percent lower for African Americans and Latinos than for White Americans and about 60 percent lower for Asian Americans (Grant et al. 2005). A similar pattern exists for major depressive disorder (Hasin et al. 2005).

Treatment Patterns

White Americans are more likely to receive mental health treatment or counseling than other racial/ethnic groups (SAMHSA 2012*b*). White Americans are more likely than African Americans to receive substance abuse treatment services from a private physician or other behavioral health or primary care professional (Perron et al. 2009). Among White American clients entering substance abuse treatment programs in 2010, alcohol (alone or in conjunction with illicit drugs) was most often the primary substance of abuse, followed by heroin and cannabis. However, findings are inconsistent concerning the relative frequency with which White Americans enter substance abuse treatment. Some studies have found that White Americans are more likely to receive needed behavioral health services than both African Americans and Latinos (Marsh et al. 2009; Wells et al. 2001). In contrast, other studies have found that African Americans with an identified need are somewhat more likely to enter treatment for drug use disorders and about as likely to receive treatment for alcohol use disorders when compared with White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009; SAMHSA, CBHSQ 2012; Schmidt et al. 2006).

Beliefs and Attitudes About Treatment

White Americans appear to be generally accepting of behavioral health services. They have better access to health care and are more likely to use services than people of color, but this varies widely based on socioeconomic status and cultural affiliation. Most treatment services have historically been developed for

White American populations, so it is not surprising that White Americans are more likely than other racial/ethnic groups to be satisfied with treatment services (Tonigan 2003).

Still, attitudes differ among certain cultural subgroups of White Americans. For example, Russian immigrants from the former Soviet Union have a longstanding distrust of mental health systems and hence may avoid substance abuse treatment (Kagan and Shafer 2001). Other groups who have a strong family orientation, such as Italian Americans or Scotch-Irish Americans, might avoid treatment that asks them to reveal family secrets (Giordano and McGoldrick 2005; Hudak 2000).

According to 2010 NSDUH data regarding people who recognized a need for substance abuse treatment in the prior year but did not receive it, White Americans were more likely than members of other major racial/ethnic groups to state that it was because they had no time for treatment, that they were concerned what their neighbors might think, that they did not want others to know, and/or that they were concerned about how it might affect their jobs (SAMHSA 2011*c*). Other research confirms that White Americans are significantly more likely to avoid treatment due to fear of what others might think or because they are in denial (Grant 1997). White Americans may also have different attitudes toward recovery, at least regarding alcohol use disorders, than do members of other ethnic/racial groups. According to NESARC data on people who met criteria for a diagnosis of alcohol dependence at some point during their lives, White Americans were more likely than African Americans, Latinos, or other non-Latinos to have achieved remission from that disorder but were also less likely than African Americans or other non-Latinos (but not Latinos) to currently abstain from drinking, as opposed to being in partial remission or drinking without symptoms of alcohol dependence (Dawson et al. 2005).

Treatment Issues and Considerations

Most major treatment interventions have been evaluated with a population that is largely or entirely White American, although the role of White American cultural groups is rarely considered in evaluating those interventions. For example, as Straussner (2001) notes, "the paradox of writing about substance abusers of European background is that they are a group that is believed to be the group for whom the traditional alcohol and other drug treatment models have been developed, and yet they are a group whose unique treatment needs and treatment approaches have rarely been explored" (p. 165). Very few evaluations of treatment strategies and interventions (whether based on research or clinical observation) have taken into account ethnic and cultural differences among White American clients, and therefore it is generally not possible to make culturally responsive recommendations for specific subgroups of White Americans.

Culturally responsive treatment for many White Americans will involve helping them rediscover their cultural backgrounds, which sometimes have been lost through acculturation and can be an important part of their long-term recovery. Giordano and McGoldrick (2005) note that ethnic identity and culture can be more important for some White Americans "in times of stress or personal crisis," when they may want to "return to familiar sources of comfort and help, which may differ from the dominant society's norms" (p. 503). Appendix B provides information on instruments for assessing cultural identification. For an overview of challenges in maintaining mental health, access to health care,

and help-seeking among White Americans, see Downey and D'Andrea (2012).

Theoretical Approaches and Treatment Interventions

Overall, the optimum treatment approach with White Americans is a comprehensive one; the more tools in the toolkit, the greater the chance of success (McCaul et al. 2001). Within-group differences arise regarding education level, socioeconomic status, gender, and other factors, which must be considered. Providers can, however, assume that most well-accepted treatment approaches and interventions (e.g., CBT, motivational interviewing, 12-Step facilitation, contingency management, pharmacotherapies) have been tested and evaluated with White American clients.

Still, treatment is not uniformly appropriate even for White Americans. Approaches may need modification to suit class, ethnic, religious, and other client traits. Providers should establish not only the client's ethnic background, but also how strongly the person identifies with that background. Few clinicians have made observations on best therapeutic approaches for members of particular White American cultural/ethnic subgroups.

Family therapy

In White American families, individuals are generally expected to be independent and self-reliant; as a result, families in therapy can have trouble adjusting to work that focuses more on communication processes than specific problems or content (McGill and Pearce 2005). Van Wormer (2001) notes that many White Americans need help addressing communication issues. In family therapy, useful approaches include those that encourage open, direct, and nonthreatening communication.

There is no singular description that fits White American families within or across ethnic heritages, and there is no approach that is effective for all White Americans in family therapy (Hanson 2011). Hierarchical families, such as German American families, may expect the counselor to be authoritative, at least in the initial sessions (Winawer and Wetzel 2005), although a more egalitarian German American family might not respond well to such imperatives. In the same vein, one client of French background could readily accept direct and clear therapeutic assignments that contain measurable goals (Abbot 2001), whereas another French American client may value counseling that is more process oriented. Thus, it is imperative to assess the cultural identification of clients and their families, along with the treatment needs that best match their cultural worldviews.

In some White American families, there is a longstanding culture of drinking. Attempts at abstinence can be perceived by family members as culturally inappropriate. In other families, there is deep denial about alcohol abuse or dependence, especially when talking about substance use to those outside the family. For example, some Polish American families can be resistant to the idea that drinking is the cause of family problems (Folwarski and Smolinski 2005) and sometimes believe that to admit an alcohol problem, especially to someone outside the family, signals weakness.

Group therapy

Standard group therapies developed for mental health and substance abuse treatment programs have generally been used and evaluated with White American populations. For details on group therapy in substance abuse treatment, see TIP 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005*c*).

Mutual-help groups

Mutual-help groups, of which AA is the most prevalent, have a largely White American

membership (AAWS 2008; Atkins and Hawdon 2007). In a 2011 survey, 87 percent of AA members indicated their race as White (AAWS 2012). In research with largely White populations, AA participation has been found to be an effective strategy for promoting recovery from alcohol use disorders (Dawson et al. 2006; McCrady et al. 2004; Moos and Moos 2006; Ritsher et al. 2002; Weisner et al. 2003). Other mutual-help groups, such as Self-Management and Recovery Training, Secular Organizations for Sobriety/Save Our Selves, and Women for Sobriety, also have predominately White American membership and are based on Western ideas drawn from psychology (Atkins and Hawdon 2007; White 1998).

The appeal of mutual-help groups among White Americans rests on the historical origins of this model. The 12-Step model was originally developed by White Americans based on European ideas of spirituality, faith, and group interaction. Although the model has been adopted worldwide by different cultural groups (White 1998), the 12-Step model works especially well for White ethnic groups, including Irish Americans, Polish Americans, French Americans, and Scotch-Irish Americans, because it incorporates Western cultural traditions involving spiritual practice, public confession, and the use of anonymity to protect against humiliation (Abbott 2001; Gilbert and Langrod 2001; Hudak 2000; McGoldrick et al. 2005; Taggart 2005).

In addition to mutual-help groups for substance abuse, numerous recovery support groups, Internet resources, Web-based communities, and peer support programs are available to promote mental health recovery. Many resources are available through the National Alliance on Mental Illness (http://www.nami.org).

Traditional healing and complementary methods

Only 12 percent of White Americans consider themselves atheist, agnostic, or secular without a religious affiliation, meaning that, as a group, White Americans are more religious than Asian Americans but less so than Latinos or African Americans (Pew Forum on Religion and Public Life 2008). As with other groups, White Americans belong to many different religions, although the vast majority belong to various Christian denominations, with approximately 57 percent identifying as Protestant and 25.9 percent as Catholic (National Center on Addiction and Substance Abuse, 2001). White Americans also make up 91 percent of practitioners of Judaism in the United States, 14 percent of followers of Islam, and 32 percent of the American Buddhist population (Kosmin et al. 2001). For more religious White Americans, pastoral counseling or prayer can be useful aids in the treatment of substance use disorders. However, White Americans are significantly less likely to use prayer as a method of coping (Graham et al. 2005). White Americans are more likely than members of other major racial/ethnic groups to use complementary or alternative medical therapies, such as herbal medicine, acupuncture, chiropractors, massage therapy, yoga, and special diets (Graham et al. 2005).

Relapse prevention and recovery

Factors that promote recovery for White Americans include the learning and use of coping skills (Litt et al. 2003; Litt et al. 2005; Maisto et al. 2006). Even though some research suggests that White Americans are less likely to use coping skills than African Americans (Walton 2001) and have lower levels of self-efficacy upon leaving treatment (Warren et al. 2007), the development of these skills and of self-efficacy is important in managing relapse risks and in maintaining recovery. Counselors

may offer psychoeducation on the value of coping strategies, specific skills to manage stressful situations or environments, and opportunities to practice these skills during treatment. Some coping skills or strategies may be more important than others in managing high-risk situations, but research suggests that greater use of a variety of coping strategies is more important than the use of any one specific skill (Gossop et al. 2002).

Social and family supports are also important in maintaining recovery and preventing relapse among White Americans (Laudet et al. 2002; McIntosh and McKeganey 2000; Rumpf et al. 2002). Other important factors include continuing care, the development of substitute behaviors (i.e., reliance on healthy or positive activities in lieu of substance use), the creation of new caring relationships that do not involve substance use, and increased spirituality (Valliant 1983). Valliant (1983) and others (e.g., Laudet et al. 2002; McCrady et al. 2004; Moos and Moos 2006) conclude, based on research with mostly White participants, that mutual-help groups often play an important role in maintaining recovery.

TIPs That Provide Supplemental Information on Topics in This Chapter

TIP 34: *Brief Interventions and Brief Therapies for Substance Abuse* (CSAT 1999*a*)

TIP 35: *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT 1999*c*)

TIP 39: *Substance Abuse Treatment and Family Therapy* (CSAT 2004*b*)

TIP 41: *Substance Abuse Treatment: Group Therapy* (CSAT 2005*c*)

TIP 42: *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT 2005*d*)

TIP 44: *Substance Abuse Treatment for Adults in the Criminal Justice System* (CSAT 2005*b*)

TIP 47: *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (CSAT 2006*c*)

TIP 51: *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT 2009*c*)

TIP 57: *Trauma-Informed Care in Behavioral Health Services* (SAMHSA 2014)

Planned TIP: *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e*)

6 Drug Cultures and the Culture of Recovery

IN THIS CHAPTER

- What Are Drug Cultures?
- The Role of Drug Cultures in Substance Abuse Treatment

Lisa is a 19-year-old White college student living in San Diego, CA, who was sent to treatment by her parents after failing her college classes and being placed on academic probation. While home on break earlier that year, her parents found pills in her room but let her return to school after she promised to stop using. The academic probation is only part of the reason her parents sent her to treatment. They were also concerned about her recent weight loss, as her older sister had previously struggled with bulimia.

Lisa began using marijuana at age 15 with a cousin. In her first year of high school, she had difficulty fitting in. However, the next year, she became friendly with an electronic dance music clique that helped her define an identity for herself and introduced her to ecstasy (3,4-methylenedioxymethamphetamine, or MDMA), methamphetamine, and various hallucinogens, along with new ideas about politics, music, and art. She has since found similar friends at college and keeps in touch with several members of her high school clique.

In treatment, Lisa tells her counselor that she has long felt neglected by her parents, who are too interested in material things. She sees her drug use and that of her friends as a rebellion against the materialistic attitudes of their parents. She also dismisses her family's cultural heritage, insisting that her parents only identify as Americans even though they are first-generation Americans with European backgrounds. She talks at length about ways to acquire and prepare relatively unknown hallucinogens, the best music to listen to while using, and how to evaluate the quality of marijuana.

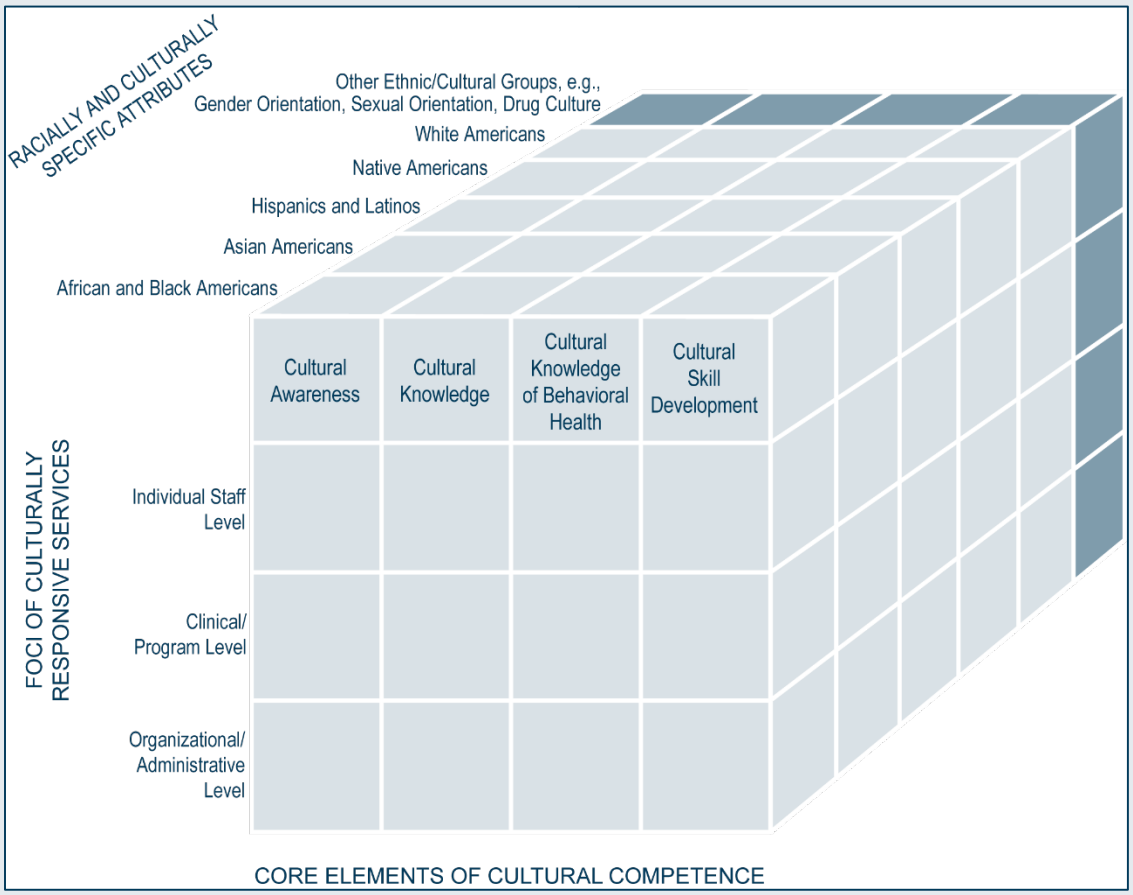
Lisa says that she doesn't believe she has a problem. She thinks that her failing grades reflect her lack of interest in college, which she says she is attending only because people expect it of her. When asked what she would rather be doing, she says she does not have any clearly defined goals and just wants to do "something with art

This Treatment Improvement Protocol (TIP) emphasizes the concept that many subcultures exist within and across diverse ethnic and racial populations and cultures. Drug cultures are a formidable example—these are cultures that can influence the presentation of mental, substance use, and co-occurring disorders as well as prevention and treatment strategies and outcomes.

or music." Lisa points out that, unlike most of her classmates, she doesn't drink and has stopped doing addictive drugs like ecstasy and methamphetamine, which were responsible for her weight loss. She is convinced that she can continue to smoke pot and *Salvia divinorum*, which she notes "isn't even illegal," and take other botanical hallucinogens. She is adamant about keeping her friends, who she says have been supportive of her and are not materialistic "sellouts" like her parents.

Her counselor places a priority on connecting Lisa with other people her age who are in recovery. She asks a client who graduated from the program and is only a year older than Lisa to accompany her to Narcotics Anonymous (NA) meetings attended mostly by younger people in recovery. The counselor also encourages Lisa's friendships with other young people in the program. When Lisa complains about her parents' materialism and the materialism of mainstream culture, her counselor brings up the spiritual elements of mutual-help recovery groups and how they provide an

Multidimensional Model for Developing Cultural Competence: Drug Cultures



alternative model for interacting with others. The counselor begins to help Lisa explore how her drug use may be an attempt to fill her unmet emotional and social needs and may hinder the development of her own interests, identity, and goals.

Treatment providers should consider how cultural aspects of substance use reinforce substance use, substance use disorders, and relapses. Factors to note include clients' possible self-medication of psychological distress or mental disorders. Beyond specific biopsychosocial issues that contribute to the risk of substance-related disorders and the initiation and progression of use, counselors and treatment organizations must continually acquire knowledge about the ever-changing, diverse drug cultures in which client populations may participate and which reinforce the use of drugs and alcohol. Moreover, behavioral health service providers and program administrators need to translate this knowledge into clinical and administrative practices that address and counter the influence of these cultures within the treatment environment (e.g., by instituting policies that ban styles of dress that indicate affiliation with a particular drug culture).

Adopting Sue's multidimensional model (2001) for developing cultural competence, this chapter identifies drug cultures as a domain that requires proficiency in clinical skills, programmatic development, and administrative practices. It explores the concept of drug cultures, the relationship between drug cultures and mainstream culture, the values and rituals of drug cultures, and how and why people value their participation in drug cultures. This chapter describes how counselors can determine a client's level of involvement in a drug culture, how they can help clients identify and develop alternatives to the drug cultures in which they participate, and the importance of assisting clients in developing a culture of recovery.

What Are Drug Cultures?

Up to this point, this TIP has focused on cultures based on ethnicity, race, language, and national origin. The TIP looks primarily at those cultural groups because they are the major cultural forces that shape an individual's life and worldview. However, there are other types of cultural groups (sometimes referred to as subcultures) that are also organized around shared values, beliefs, customs, and traditions; these cultural groups can have, as their core organizing theme, such factors as sexuality, musical styles, political ideologies, and so on. For most clients in treatment for substance use disorders (including those who have a co-occurring mental disorder), the drug subculture will likely have affected their substance use and can affect their recovery; that is the primary rationale for the development of this unique chapter. Research literature in this topic area is considerably limited.

Some people question whether a given drug culture is in fact a subculture, but many seem to have all the elements ascribed to a culture (see Chapter 1). A drug culture has its own history (pertaining to drug use) that is usually orally transmitted. It has certain shared values, beliefs, customs, and traditions, and it has its own rituals and behaviors that evolve over time. Members of a drug culture often share similar ways of dressing, socialization patterns, language, and style of communication. Some even develop a social hierarchy that gives different status to different members of the culture based on their roles within that culture (Jenkot 2008). As with other cultures, drug cultures are localized to some extent. For example, people who use methamphetamines in Hawaii and Missouri could share certain attitudes, but they will also exhibit regional differences. The text boxes in this chapter offer examples of the distinct values, languages,

rituals, and types of artistic expression associated with particular drug cultures.

Many subcultures exist outside mainstream society and thus are prone to fragmentation. A single subculture can split into three or four related subcultures over time. This is especially true of drug cultures, in which people use different substances, are from different locales, or have different socioeconomic statuses; they may also have very different cultural attitudes related to the use of substances. Bourgois and Schonberg (2007) described how ethnic and racial differences can affect the drug cultures of users of the same drugs to the point that even such things as injection practices can differ between Black and White heroin users in the same city. Exhibit 6-1 lists of some of the ways in which drug cultures can differ from one another.

Differences in the physiological and psychological effects of drugs account for some differences among drug cultures. For example, the drug culture of people who use heroin is typically less frenetic than the drug culture involving methamphetamine use. However, other differences seem to be more clearly related to the historical development of the culture itself or to the effects of larger social forces. Cultural and socioeconomic components contributed to the rise in methamphetamine use among gay men on the West Coast (Reback 1997) and among Whites of lower socioeconomic status in rural Missouri (Topolski and Anderson-Harper 2004). However, in these two cases, the details of those change factors are quite different. In Missouri, the low cost and easy production of the drug influenced development of a methamphetamine drug culture. Missouri leads the nation in the number of methamphetamine labs seized by police; a disproportionately large number of seizures occur in rural areas (Carbone-Lopez et al. 2012; Topolski and Anderson-Harper 2004). The popularity of the drug among

Exhibit 6-1: How Drug Cultures Differ

- There is overlap among members, but drug cultures differ based on substance used—even among people from similar ethnic and socioeconomic backgrounds. The drug culture of heroin use (McCoy et al. 2005; Pierce 1999; Spunt 2003) differs from the drug culture of ecstasy use (Reynolds 1998).
- Drug cultures differ according to geographic area; people who use heroin in the Northeast United States are more likely to inhale than inject the drug, whereas the opposite is true among people in the Western United States who use heroin (Office of Applied Studies [OAS] 2004).
- Drug cultures can differ according to other social factors, such as socioeconomic status. The drug culture of young, affluent people who use heroin can occasionally mirror the drug culture of the street user, but it will also have notable differences (McCoy et al. 2005; Pierce 1999; Spunt 2003).
- Drug cultures (even involving the same drugs and the same locales) change over time; older people from New York who use heroin and who entered the drug culture in the 1950s or 1960s feel marginalized within the current drug scene, which they see as promoting a different set of values (Anderson and Levy 2003).

How To Identify Key Characteristics of a Drug Culture

Counselors and clinical supervisors must acquire knowledge about drug cultures represented within the client population. Drug cultures can change rapidly and vary across racial and ethnic groups, geographic areas, socioeconomic levels, and generations, so staying informed is challenging. Besides needing an understanding of current drug cultures (to help prevent infiltration of related behaviors and attitudes within the treatment environment), counselors also need to help clients understand how such cultures support use and pose dynamic relapse risks.

(Continued on the next page.)

How To Identify and Discuss Key Characteristics of a Drug Culture (continued)

Counselors can use this exercise to begin to educate clients about the influence of drug cultures and help them identify the specific behaviors, values, and attitudes that constitute their experience of using alcohol and drugs. It can be a helpful tool in improving clients' understanding of the reinforcing aspects of alcohol and drug use beyond physiological effects. In addition, this exercise can be used as a training tool in clinical supervision to help counselors understand the influence and potential reinforcing qualities of a drug culture among clients and within the treatment milieu.

Materials needed: Diagram handout and pencils.

Instructions:

- Determine whether this exercise is more appropriate as an individual or group exercise. Assess the newness and variability of recovery within the group constellation. If several group members support recovery-related behavior, conducting this exercise may be a beneficial educational tool and means of intervention with clients who continue to identify mainly with their drug culture. Conversely, if most group members are new or have had difficulty accepting treatment or treatment guidelines, this exercise may be more aptly used as an individual tool.
- Attention: In group settings, strict parameters need to be established at the beginning of the session to ensure that the discussion remains centered on attitudes, values, and behaviors surrounding drug and alcohol use—not on specific techniques or procedures for using drugs or rituals surrounding intake or injection.
- Start the discussion by first presenting the idea that drug cultures exist—describing the main elements that constitute culture (refer to Chapter 1 or the categories identified in the "Drug Culture" diagram below). Next, provide examples of how drug culture can support continued use and relapse. Keep in mind that not all clients are engaged in a drug culture.
- Following the general introduction, review each block in the diagram and ask clients to provide examples related to their own use and involvement with drugs and alcohol. After discussing their examples, ask them to identify the most significant behaviors, attitudes, and values that reinforce their use (e.g., a feeling of acceptance or camaraderie).
- Counselors can redirect this general discussion to related topics—for example, by identifying behaviors, values, and attitudes likely to support recovery or by shifting from discussion to role-plays that will help clients address relapse risks associated with their drug culture and practice coping skills (e.g., assertiveness or refusal skills to counter the influence of others once they are discharged from the program or to address situations that arise during the course of treatment).

Drug Culture		
Establishing Trust and Credibility *How do you go about establishing credibility?*	**Socialization** *How were you introduced to the culture?*	**Values** *What values are upheld or devalued in the group?*
Status *In what ways can you obtain status or be seen as a success?*	**Rules** *Are there spoken and unspoken rules or norms?*	**Gender Roles and Relationships** *What gender expectations exist surrounding drug use?*
Concepts of Sanction, Punishment, and Conflict Mediation *How does the group deal with in-group conflicts?*	**Symbols and Images** *Are there symbols that represent a particular association with a group or substance?*	**Dress** *Are there specific ways to dress that show allegiance to a specific substance or group?*
View of Past, Present, and Future *Are there specific beliefs about the past, present, and/or future?*	**Language & Communication** *Are there special verbal or nonverbal ways to communicate about substance-related activities?*	**Attitudes** *What are common attitudes toward others (nonusers, police, etc.)?*

Whites could be linked to the historical development of the methamphetamine trade by White motorcycle gangs (Morgan and Beck 1997). On the other hand, most gay men who use the drug report having first used it at parties with the expectation of involvement in sexual activity (Hunt et al. 2006). In studies of gay men who used methamphetamine, the main reason for use was to heighten sexual experience (Halkitis et al. 2005; Kurtz 2005; Reback 1997). Morgan and Beck (1997) found that increased sexual activity was one reason why certain women and heterosexual men used methamphetamine, but it was not as important a reason as it was for gay men.

This chapter aims to explain that people who use drugs participate in a drug culture, and further, that they value this participation. However, not all people who abuse substances are part of a drug culture. White (1996) draws attention to a set of individuals whom he calls "acultural addicts." These people initiate and sustain their substance use in relative isolation from other people who use drugs. Examples of acultural addicts include the medical professional who does not have to use illegal drug networks to abuse prescription medication, or the older, middle-class individual who "pill shops" from multiple doctors and procures drugs for misuse from pharmacies. Although drug cultures typically play a greater role in the lives of people who use illicit drugs, people who use legal substances—such as alcohol—are also likely to participate in such a culture (Gordon et al. 2012). Drinking cultures can develop among heavy drinkers at a bar or a college fraternity or sorority house that works to encourage new people to use, supports high levels of continued or binge use, reinforces denial, and develops rituals and customary behaviors surrounding drinking. In this chapter, drug culture refers to cultures that evolve from drug and alcohol use.

The Relationship Between Drug Cultures and Mainstream Culture

To some extent, subcultures define themselves in opposition to the mainstream culture. Subcultures may reject some, if not all, of the values and beliefs of the mainstream culture in favor of their own, and they will often adapt some elements of that culture in ways quite different from those originally intended (Hebdige 1991; Issitt 2009; Exhibit 6-2). Individuals often identify with subcultures—such as drug cultures—because they feel excluded from or

Exhibit 6-2: The Language of a Drug Culture

One of the defining features of any culture is the language it uses; this need not be an entire language, and may simply comprise certain jargon or slang and a particular style of communication. The use of slang regarding drugs and drug activity is a well-recognized aspect of drug culture. Not as well-known is the diversity of that language and how it varies across time and place. Rather than coining new words, the language of drug culture often borrows words from mainstream culture and adapts them to new purposes.

For example, Williams (1992) examined the use of Star Trek terminology among people who used crack cocaine in New York during the 1980s. They adopted the persona of members of the Star Trek Enterprise crew in their use of language—such as "going on a mission" when they went looking for cocaine; "beam me up, Scotty" when they wanted to get high; and referring to crack cocaine itself as "Scotty." Crack cocaine users even created an imaginary book entitled *The Book of Tech* that they referred to as if it contained important information for people who use and sell crack cocaine (e.g., how to cook freebase cocaine from cocaine hydrochloride). This language (and other terms derived from other sources) helped members of this drug culture recognize other members. People who did not understand the terms used were typically taken advantage of during drug transactions.

unable to participate in mainstream society. The subculture provides an alternative source of social support and cultural activities, but those activities can run counter to the best interests of the individual. Many subcultures are neither harmful nor antisocial, but their focus is on the substance(s) of abuse, not on the people who participate in the culture or their well-being.

Mainstream culture in the United States has historically frowned on most substance use and certainly substance abuse (Corrigan et al. 2009; White 1979, 1998). This can extend to legal substances such as alcohol or tobacco (including, in recent years, the increased prohibition against cigarette smoking in public spaces and its growing social unacceptability in private spaces). As a result, mainstream culture does not—for the most part—have an accepted role for most types of substance use, unlike many older cultures, which may accept use, for example, as part of specific religious rituals. Thus, people who experiment with drugs in the United States usually do so in highly marginalized social settings, which can contribute to the development of substance use disorders (Wilcox 1998). Individuals who are curious about substance use, particularly young people, are therefore more likely to become involved in a drug culture that encourages excessive use and experimentation with other, often stronger, substances (for a review of intervention strategies to reduce discrimination related to substance use disorders, see Livingston et al. 2012).

When people who abuse substances are marginalized, they tend not to seek access to mainstream institutions that typically provide sociocultural support (Myers et al. 2009). This can result in even stronger bonding with the drug culture. A marginalized person's behavior is seen as abnormal even if he or she attempts to act differently, thus further reducing the chances of any attempt to change behavior (Cohen 1992). The drug culture enables its members to view substance use disorders as normal or even as status symbols. The disorder becomes a source of pride, and people may celebrate their drug-related identity with other members of the culture (Pearson and Bourgois 1995; White 1996). Social stigma also aids in the formation of oppositional values and beliefs that can promote unity among members of the drug culture (Exhibit 6-3).

When people with substance use disorders experience discrimination, they are likely to delay entering treatment and can have less positive treatment outcomes (Fortney et al. 2004; Link et al. 1997; Semple et al. 2005). Discrimination can also increase denial and step up the individual's attempts to hide substance use (Mateu-Gelabert et al. 2005). The immorality that mainstream society attaches to substance use and abuse can unintentionally serve to strengthen individuals' ties with the drug culture and decrease the likelihood that they will seek treatment.

The relationship between the drug and mainstream cultures is not unidirectional. Since the beginning of a definable drug culture, that culture has had an effect on mainstream cultural institutions, particularly through music (Exhibit 6-4), art, and literature. These connections can add significantly to the attraction a drug culture holds for some individuals (especially the young and those who pride themselves on being nonconformists) and create a greater risk for substance use escalating to abuse and relapse.

Understanding Why People Are Attracted to Drug Cultures

To understand what an individual gains from participating in a drug culture, it is important first to examine some of the factors involved

Exhibit 6-3: The Values and Beliefs of a Heroin Culture

Many core values of illicit drug cultures involve rejecting mainstream society and its cultural values. Stephens (1991) analyzed value statements from people addicted to heroin and extracted the core tenets of this drug culture's value system. They are:

- Antisocial viewpoint—Members of this drug culture share a viewpoint that sees all people as basically dishonest and egocentric; they are especially distrustful of those who do not use heroin.
- Rejection of middle-class values—Members denigrate values such as the need for hard work, security, and honesty.
- Excitement/hedonism—Members value immediate gratification and the intense pursuit of pleasure over more stable and lasting values.
- Importance of outward appearances—As much as members of the drug culture may complain about the mainstream culture's shallowness, they strongly believe in conspicuous consumption and the importance of owning things that give an image of prosperity.
- Valence of street addict subcultures—Members of this drug culture value the continued participation of others in the culture, even to the point of expecting individuals who have stopped using to continue to participate in the culture.
- Emotional detachment—People involved in this drug culture value emotional aloofness and see emotional involvement with others as a weakness.

These core values (initially examined by Stephens et al. 1976) were taken from a specific drug culture (heroin), but they can be found in many other drug cultures that center on the use of illicit drugs. However, these same values will not be upheld in every drug culture. For instance, the drug culture of people who use MDMA does not appear to value emotional aloofness, but rather to appreciate the drug's ability to create a feeling of emotional intimacy among those who use it (Gourley 2004; Reynolds 1998). Drug cultures involving legal substances (notably alcohol) are less likely to reject the core values of mainstream society and are less likely to be rejected by that society. They will, however, still value excitement/hedonism and the participation of others in the subculture.

Exhibit 6-4: Music and Drug Cultures

Since the 1920s, when marijuana use became associated with jazz musicians, there has been a connection between certain music subcultures and particular types of substance use (Blake 2007; Gahlinger 2001). As Blackman (1996) notes, "Before the emergence of post-war youth culture, there was a direct connection between the development of the popular music—jazz—and the use of illicit drugs in terms of musicians who used drugs, including heroin, cocaine, and cannabis and their narratives about these drugs through songs" (p. 137). Early Federal legislation criminalizing marijuana was motivated, in part, by use of the drug by jazz musicians and fear that their example would influence youth (Whitebread 1995).

In recent years, the link between drug culture and music has been exemplified by the importance of MDMA in the rave music scene (Kotarba 2007; Murguia et al. 2007). Reynolds (1998) credits the development of rave music to MDMA's ability to create a feeling of intimacy among relative strangers and the way in which people who use it respond to repetitive, up-tempo music. Conversely, Adlaf and Smart (1997) found that adolescents in Canada typically became involved in the rave music scene after starting to use MDMA and other drugs. Regardless of how the relationship developed, MDMA and rave music are so closely linked that it is hard to tell where the music culture ends and the drug culture begins.

Blackman (1996) states that drug use has become an essential element of youth culture mainly through its association with musical artists. Similarly, Knutagard (1996) observes how different youth cultures, each defined in part by its members' choices in music and substance use, have made some types of substance use acceptable to many young people. Esan (2007) notes that urban music and drug

Exhibit 6-4: Music and Drug Cultures (continued)

culture have a shared appeal to young people based on their apparently antagonistic relationship to mainstream culture. Since the 1990s, rock group confessional memoirs have become increasingly popular, often depicting a lifestyle and culture of excess and providing explicit details of drug use and methods; consumption-driven, high-risk, or excessive behaviors; tragic consequences of use; and, sometimes, the author's participation in rehabilitation (Oksanen 2012).

Certain drugs and the drug-dealing lifestyle are featured prominently in different types of music, including hip hop (Esan 2007; Schensul et al. 2000) or *narcocorridos* (a popular form of Mexican and Mexican American border music that tells of the lives of drug traffickers [Edberg 2004]). However, even music that is not overtly concerned with drug use can become connected to a drug culture or to substance use in an individual's mind. According to White (1996), links between particular songs and the recall of euphoric drug experiences are especially common and may need to be addressed explicitly in treatment. Hearing these songs can act as a trigger for drug use and can, therefore, be a potential cause of relapse.

in substance use and the development of substance use disorders. Despite having differing theories about the root causes of substance use disorders, most researchers would agree that substance abuse is, to some extent, a learned behavior. Beginning with Becker's (1953) seminal work, research has shown that many commonly abused substances are not automatically experienced as pleasurable by people who use them for the first time (Fekjaer 1994). For instance, many people find the taste of alcoholic beverages disagreeable during their first experience with them, and they only learn to experience these effects as pleasurable over time. Expectations can also be important among people who use drugs; those who have greater expectancies of pleasure typically have a more intense and pleasurable experience. These expectancies may play a part in the development of substance use disorders (Fekjaer 1994; Leventhal and Schmitz 2006).

Additionally, drug-seeking and other behaviors associated with substance use have a reinforcing effect beyond that of the actual drugs. Activities such as rituals of use (Exhibit 6-5), which make up part of the drug culture, provide a focus for those who use drugs when the drugs themselves are unavailable and help them shift attention away from problems they might otherwise need to face (Lende 2005).

Drug cultures serve as an initiating force as well as a sustaining force for substance use and abuse (White 1996). As an initiating force, the culture provides a way for people new to drug use to learn what to expect and how to appreciate the experience of getting high. As White (1996) notes, the drug culture teaches the new user "how to recognize and enjoy drug effects" (p. 46). There are also practical matters involved in using substances (e.g., how much to take, how to ingest the substance for strongest effect) that people new to drug use may not know when they first begin to experiment with drugs. The skills needed to use some drugs can be quite complicated, as shown in Exhibit 6-6.

The drug culture has an appeal all its own that promotes initiation into drug use. Stephens (1991) uses examples from a number of ethnographic studies to show how people can be as taken by the excitement of the drug culture as they are by the drug itself. Media portrayals, along with singer or music group autobiographies, that glamorize the drug lifestyle may increase its lure (Manning 2007; Oksanen 2012). In buying (and perhaps selling) drugs, individuals can find excitement that is missing in their lives. They can likewise find a sense of purpose they otherwise lack in the daily need to seek out and acquire drugs. In successfully navigating the difficulties of living as a person

Exhibit 6-5: The Rituals of Drug Cultures

Several authors have noted that illicit drug use and alcohol use typically involve ritualized behaviors (Alverson 2005; Carlson 2006; Carnes et al. 2004; Grund 1993; White 1996). The rituals of substance use affect where, when, and how substances are used. Substance-related rituals serve both instrumental and social functions. Instrumental functions include maximizing drug effects, minimizing negative effects of drug use, and preventing secondary problems. Socially, the rituals display one's affiliation with the drug culture to other people and help create a sense of community within the culture. Obviously, the social function is more central to group activities than to solitary rituals.

Most drug-related social rituals involve sharing substances or sharing the experience of intoxication. Some drug cultures (e.g., marijuana) encourage the sharing of substances, but even when they are not shared, drugs are often used with other people who use, such as in crack houses and shooting galleries (Bourgois 1998; Grund 1993; Williams 1992). Rituals involving shared substance use and public substance use strengthen the bonds between members of a drug culture and sustain the drug culture. Some social rituals are so important to members of the drug culture that they participate in them even when they have no drugs, such as when marijuana smokers smoke an inert substance (e.g., horse manure, banana peels) together when they have no marijuana (White 1996). Drug use can also be incorporated into other ritualized behaviors, such as sexual activity (Carnes et al. 2004).

Individuals develop their own drug-related rituals through the influence of other members of the culture and also through trial and error. This allows them to determine what works best for them to maximize the drug's effect and minimize related problems. For example, Grund (1993) found, through observing the rituals surrounding the injection of cocaine and heroin among people in the Netherlands, that specific rituals governed the timing and administration of the drugs so that heroin lessened the unpleasant side effects of the cocaine. Other recent examples are the combination of energy drinks with alcohol to delay the normal onset of sleepiness (Howland and Rohsenow 2013; Substance Abuse and Mental Health Services Administration [SAMHSA] 2013*c*) and the combination of methylphenidate with alcohol to intensify euphoric effects (for review of central nervous system stimulant use and emergency room information, see SAMHSA 2013*b*).

Exhibit 6-6: Questions Regarding Knowledge and Skill Demands of Heroin Use

- If first use is by snorting, how is it done (assuming the person has never taken a drug intranasally)? Is there a special technique for using heroin this way?
- If first use is by injection, is it best to inject the drug under the skin (skin-popping) or into a vein?
- What equipment is required? If one doesn't have a hypodermic syringe, what other equipment can be substituted to make up a set of "works" or an "outfit"?
- How is heroin prepared (cooked) for injection?
- What techniques or procedures are used to inject the drug?
- What does one do if the needle clogs?
- Is there any way to test the purity of the drug?
- How much of the drug constitutes a desirable dose?
- If more than one person is using and an outfit is being shared, who uses it first?
- If sharing, how can the works be cleaned to prevent the transmission of disease?
- How does one know if he or she has injected too much?
- Are there any unpleasant side effects one should anticipate?
- How long will the effects of the drug last?
- Is there any way to maximize the drug's effects?
- Is there anything one should not do while high on the drug?
- How much time must pass before the drug can be used again?
- If a bruise or an abscess develops at the injection site, how can it be hidden and treated (without seeing a physician)?

Source: White 1996.

who uses drugs, they can gain approval from peers who use drugs and a feeling that they are successful at something.

In some communities, participation in the drug trade—an aspect of a drug culture—is simply one of the few economic opportunities available and is a means of gaining the admiration and respect of peers (Bourgois 2003; Simon and Burns 1997). However, drug dealing as a source of status is not limited to economically deprived communities. In studying drug dealing among relatively affluent college students at a private college, Mohamed and Fritsvold (2006) found that the most important motives for dealing were ego gratification, status, and the desire to assume an outlaw image.

Marginalized adolescents and young adults find drug cultures particularly appealing. Many individual, family, and social risk factors associated with adolescent substance abuse are also risk factors for youth involvement with a drug culture. Individual factors—such as feelings of alienation from society and a strong rejection of authority—can cause youth to look outside the traditional cultural institutions available to them (family, church, school, etc.) and instead seek acceptance in a subculture, such as a drug culture (Hebdige 1991; Moshier et al. 2012). Individual traits like sensation-seeking and poor impulse control, which can interfere with functioning in mainstream society, are often tolerated or can be freely expressed in a drug culture. Family involvement with drugs is a significant risk factor due to additional exposure to the drug lifestyle, as well as early learning of the values and behaviors (e.g., lying to cover for parents' illicit activities) associated with it (Haight et al. 2005). Social risk factors (e.g., rejection by peers, poverty, failure in school) can also increase young people's alienation from traditional cultural institutions. The need for social acceptance is a major reason many young people begin to use drugs, as social acceptance can be found with less effort within the drug culture.

In addition to helping initiate drug use, drug cultures serve as sustaining forces. They support continued use and reinforce denial that a problem with alcohol or drugs exists. The importance of the drug culture to the person using drugs often increases with time as the person's association with it deepens (Moshier et al. 2012). White (1996) notes that as a person progresses from experimentation to abuse and/or dependence, he or she develops a more intense need to "seek for supports to sustain the drug relationship" (p. 9). In addition to gaining social sanction for their substance use, participants in the drug culture learn many skills that can help them avoid the pitfalls of the substance-abusing lifestyle and thus continue their use. They learn how to avoid arrest, how to get money to support their habit, and how to find a new supplier when necessary.

The more an individual's needs are met within a drug culture, the harder it will be to leave that culture behind. White (1996) gives an example of a person who was initially attracted in youth to a drug culture because of a desire for social acceptance and then grew up within that culture. Through involvement in the drug culture, he was able to gain a measure of self-esteem, change his family dynamic, explore his sexuality, develop lasting friendships, and find a career path (albeit a criminal one). For this individual, who had so much of his life invested in the drug culture, it was as difficult to conceive of leaving that culture as it was to conceive of stopping his substance use.

Online Drug Cultures

One major change that has occurred in drug cultures in recent years is the development of

How To Lead an Exercise Examining Benefits, Losses, and the Future

Counselors and clinical supervisors can help clients identify reinforcing aspects (besides physiological effects) of their drug and alcohol use and the losses associated with use, including unmet goals and dreams. The physiological, social, and emotional gains and losses that have transpired during their use (whether or not they associate these losses with their use) can serve as risks for relapse. This exercise works well as an interactive psychoeducational lecture for clients, as a training tool for counselors, and as a group counseling exercise. It can also be adapted for individual sessions.

Materials needed: Group room with sufficient space to move around.

Instructions:

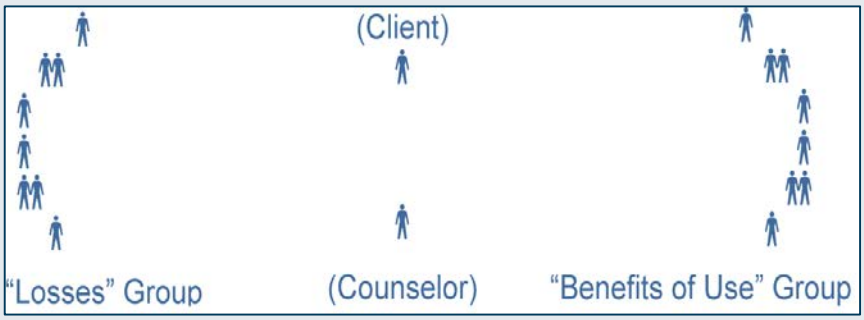
- Select an amenable client aware of the losses and consequences associated with his/her use. Later in the exercise, select other clients to give other group members a more direct experience.
- Divide the group in two. For large groups, select only 6 to 8 people for each side. Have each subgroup stand on opposite sides of the room facing each other. One group will represent the benefits of use; the other, losses associated with use (see diagram for room set-up).
- Rather than using the client's personal benefits and losses (at least initially), ask group members to brainstorm about their experiences that represent each side. Begin with the side of the room that represents "benefits of use" and ask everyone in the room to name some benefits. Then, assign a specific benefit to each person in the "benefits of use" group and create a one-line message for each (a first-person statement describing the benefit), asking the representative client to remember the line. For example, if the group named a benefit of use as immediate acceptance from others who use, assign this benefit to one person and create a message to capture it: "I make you feel like you belong," or "We are family now." Continue brainstorming until you have assigned six or more benefits.
- Next, go to the opposite group that represents the losses associated with use and begin to solicit losses from everyone in the room. Assign a loss to each person in the "loss" group, create a one-line message that coincides with each loss, and then ask an individual to remember each loss message (e.g., "I am the loss of your children," "I am the loss of your self-respect," "I am the loss of your health"). In addition, ask the group to name future goals and plans that were curtailed because of use. Assign these losses as well, following the same format (e.g., "I am the loss of a college degree," "I am the loss of intimate relationships," "I am the loss of belief in the future"). Note: If you run out of people, you can assign two roles to one person.
- At this point, the exercise can already be a powerful experience for many clients. Now, have the person who was originally selected as the client stand facing the "benefits of use" group. Have the client process what it is like to see the benefits of use. You can also have each person in the "benefits of use" group state his or her one-line message to help facilitate this process. Stand with the client as he or she moves to the "loss" group. Again, have the client stand and face this group while asking him or her what it is like to see the losses, including the losses related to goals and the future. Note: It is not important as an exercise to have benefits or losses specific only to this client. It is far better to gain a sample from the entire group so that everyone is involved and to maximize the exercise's effectiveness as a psychoeducational tool.
- After the client has stood in front of both groups, ask him or her to move back and forth between each group several times to see what emotional changes occur in experiencing each group. It is important to process this experience as a group. You can invite other members to switch out of their roles and stand in as clients to experience this exercise more directly. Clients are likely to see how seductive the "benefits of use" group can be and how this attraction can lead back to relapse. This exercise may also help clients connect with the losses associated with their use. At times, clients may gain awareness that the very losses associated with their use can also serve as a trigger for use as a means of self-medicating feelings.

(Continued on the next page.)

How To Lead an Exercise Examining Benefits, Losses, and the Future (continued)

- Allot sufficient time for this psychoeducational lecture—not only to demonstrate the benefits and losses associated with use, but also to enable the group to process their thoughts and feelings.

Group Room Setup



Internet communities organized around drug use (Gatson 2007*a*; Murguia et al. 2007) and drug use facilitation, including information on use, production, and sales (Bowker 2011; U.S. Department of Justice 2002). Such communities develop around Web sites or discussion boards where individuals can describe their drug-related experiences, find information on acquiring and using drugs, and discuss related issues ranging from musical interests to legal problems. Many of the Web sites where these online communities develop are originally created to lessen the negative consequences of substance use by informing people about various related legal and medical issues (Gatson 2007*b*; Murguia et al. 2007). As in other drug cultures, users of these Web sites and discussion boards develop their own language and values relating to drug use. Club drugs and hallucinogenics are the most often-discussed types of drugs, but online communities involve the discussion of all types of licit and illicit substances, including stimulants and opioids (Gatson 2007*a*; Murguia et al. 2007; Tackett-Gibson 2007).

Murguia et al. (2007) reported on a survey of adult (ages 18 and older) participants in one online community. The self-selected survey sample included 1,038 respondents, 80 percent of whom were from the United States. Respondents were likely to be young (90 percent were under 30), male (76 percent), White (92 percent), relatively affluent (58 percent had household incomes of $45,000 or more), employed (41 percent were employed full time; another 28 percent, part time), and/or in school (57 percent were attending school full or part time). According to the 2011 National Survey on Drug Use and Health, approximately 0.3 percent of individuals 12 years of age or older purchase prescription drugs through the Internet (SAMHSA, 2012*b*).

The Role of Drug Cultures in Substance Abuse Treatment

Most people seek some kind of social affiliation; it is one aspect of life that gives meaning to day-to-day existence. Behavioral health service providers can better understand and help their clients if they have an understanding of the culture(s) with which they identify. This understanding can be even more important when addressing the role of drug culture in a client's life because, of all cultural affiliations, it is likely to be the one most intimately connected with his or her substance

abuse. The drug culture is likely to have had a considerable influence on the client's behaviors related to substance use.

Drug Cultures in Assessment and Engagement

The first step in understanding the role a drug culture plays in a client's life is to assess which drug culture(s) the client has been involved with and his or her level of involvement. There are no textbooks that can inform providers about the drug cultures in their areas, but counselors probably know quite a bit about them already, as they learn much about drug cultures through talking with their clients. Counselors who are themselves in recovery may be familiar with some clients' substance-using lifestyles and social environments or will have insight into how to explore the issue with clients. They can also educate their colleagues.

Providers who have never personally abused substances can learn from recovered counselors as well as from their clients. However, asking a client point-blank about his or her involvement in a drug culture is likely to be answered with a blank stare. Instead, talking to clients about their relationships, daily activities and habits relating to substance use, values, and views of other people and the world can allow providers to develop a good sense of the meanings drug cultures hold for clients.

To engage a client in treatment, understanding his or her relationship with a drug culture may be as important as understanding elements of that client's racial or ethnic identity. Clients are unlikely to self-identify as members of the drug culture in the same way that they would identify as an African American or Asian American, for example, but they can still be offended or distrustful if they think the provider or program does not understand how their lifestyle relates to their substance use. Affiliation with a drug culture is a source of client identity; the client's place in the drug culture can be important to his or her self-esteem.

After the assessment and engagement stage, the provider's attitude toward the client's participation in a drug culture will be significantly different from his or her attitude toward the client's other cultural affiliations. As most providers already know (even if they do not use the term drug culture), if a client

How To Learn About Clients' Daily Routines and Rituals

One way to gain an understanding of a client's involvement in a specific drug culture is to learn about his or her daily routines and rituals. Keep in mind that there can be different routines on weekends or specific days of the week; ask about exceptions to the typical daily schedule.

Materials needed: Weekly calendar.

Instructions:

- To elicit information about the client's daily activities, use a cue or anchor to initiate this exploration, such as a calendar highlighting each day of a week—Monday through Sunday.
- Placing the calendar in front of the client, ask him or her to describe a typical day, beginning with the time that he or she generally wakes up and building on the morning routines (e.g., "What does an average morning look like for you?").
- Encourage the client to provide a specific account of his or her routine rather than a general response. Important information can be obtained by asking the client about feelings or reactions to daily activities as they unfold in the session.
- After completing an example of an entire day, ask the client if there are exceptions to this schedule that routinely occur on another day of the week or during the weekend. Once these are processed, it can be beneficial to ask what it was like for him or her to talk about these daily routines.

> "The culture of recovery is an informal social network in which group norms (prescribed patterns of perceiving, thinking, feeling, and behaving) reinforce sobriety and long-term recovery from addiction."
>
> (White 1996, p. 222)

continues to be closely affiliated with the drug-using life, then he or she is more likely to relapse. The people, places, things, thoughts, and attitudes related to drug and/or alcohol use act as triggers to resume use of substances. Behavioral health service providers need to help their clients weaken and eventually eliminate their connections to the drug culture. White (1996) identifies an important issue to address during transition from engagement to treatment—in the process of engaging clients, providers help them identify how their connections to the drug culture prevent them from reaching their goals and how the loss of these connections would affect them if they chose to cut ties with the drug culture.

Finding Alternatives to Drug Cultures

A client can meet the psychosocial needs previously satisfied by the drug culture in a number of ways. Strengthening cultural identity can be a positive action for the client; in some cases, the client's family or cultural peers can serve as a replacement for involvement in the drug culture. This option is particularly helpful when the client's connection to a drug culture is relatively weak and his or her traditional culture is relatively strong. However, when this option is unavailable or insufficient, clinicians must focus on replacing the client's ties with the drug culture (or the culture of addiction) with new ties to a culture of recovery.

To help clients break ties with drug cultures, programs need to challenge clients' continued involvement with elements of those cultures (e.g., style of dress, music, language, or communication patterns). This can occur through two basic processes: replacing the element with something new that is positively associated with a culture of recovery (e.g., replacing a marijuana leaf keychain with an NA keychain), and reframing something so that it is no longer associated with drug use or the drug culture (e.g., listening to music that was associated with the drug culture at a sober dance with others in recovery; White 1996). The process will depend on the nature of the cultural element.

Developing a Culture of Recovery

Just as people who are actively using or abusing substances bond over that common experience to create a drug culture that supports their continued substance use, people in recovery can participate in activities with others who are having similar experiences to build a culture of recovery. There is no single drug culture; likewise, there is no single culture of recovery. However, large international mutual-help organizations like Alcoholics Anonymous (AA) do represent the culture of recovery for many individuals (Exhibit 6-7). Even within such organizations, though, there is some cultural diversity; regional differences exist, for example, in meeting-related rituals or attitudes toward certain issues (e.g., use of prescribed psychotropic medication, approaches to spirituality).

The planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e*), provides more information on using mutual-help groups in

> Recovery from mental and substance use disorders is a process of change through which people improve their health and wellness, live in a self-directed manner, and work toward achieving their full potential.
>
> (SAMHSA 2011*b*)

treatment settings and in long-term recovery. It contains detailed information about potential recovery supports that behavioral health programs can use to foster cultures of recovery among clients and program graduates.

Most treatment programs try to foster a culture of recovery for their clients. Some modalities, with therapeutic communities being the lead example, focus on this issue as a primary treatment strategy. Even one-on-one outpatient treatment programs typically encourage attendance at mutual-help groups, such as AA, to meet sociocultural recovery needs. Most providers also recognize that clients need to replace the activities, beliefs, people, places, and things associated with substance abuse with new recovery-related associations—the central purpose of creating a culture of recovery.

Even programs that already recognize the need to create a culture of recovery for their clients can make doing so more of a focus in treatment. White (1996) explores ways to do this, including:

- Teaching clients about the existence of drug cultures and their potential influence in clients' lives.
- Teaching clients about cultures of recovery and discussing how elements of the drug

Exhibit 6-7: 12-Step Group Values and the Culture of Recovery

For historical reasons, cultures of recovery (like the recovery process in general) in the United States have been greatly influenced by 12-Step groups such as AA and NA (White 1998). These groups provide a clearly defined culture of recovery for a great many people. They provide members with a set of rituals, daily activities, customs, traditions, values, and beliefs.

The 12 Steps and 12 Traditions represent the core principles, values, and beliefs of such groups. Wilcox (1998) defines these values as surrender; faith; acceptance, tolerance, and patience; honesty, openness, and willingness; humility; willingness to examine character defects; taking life one day at a time; and keeping things simple. As seen by comparing these values with those common to the heroin culture described in the "The Values and Beliefs of a Heroin Culture" box earlier in this chapter, one of the ways in which 12-Step groups work is by instilling a set of values contrary to those found in drug cultures. However, they also provide members with a new set of values that are in some ways distinct from the values of the mainstream culture that were rejected when the individual began his or her involvement in the drug culture (Wilcox 1998).

Many of the values of AA and other 12-Step groups are embodied in rituals that take place in meetings and in members' daily lives. White (1998) lists four ritual categories:

- **Centering rituals** help members stay focused on recovery by reading recovery literature, handling recovery tokens or symbols, and taking regular self-assessments or personal inventories each day.
- **Mirroring rituals** keep members in contact with one another and help them practice sober living together. Attending meetings, telling one's story, speaking regularly by phone, and using slogans (e.g., "keep it simple," "pass it on"), among others, are mirroring activities.
- **Acts of personal responsibility** include being honest and becoming time-conscious and punctual. Activities include the creation of new rituals of daily living related to sleeping, hygiene, and other areas of self-care while also being reliable and courteous.
- **Acts of service** involve performing rituals to help others in recovery. These acts are related to the Twelfth Step, which directs members to carry the message of their spiritual awakening to others who abuse alcohol or are dependent on it, thereby encouraging them to practice the 12 Steps. Acts of service recognize that people in recovery have something of value to offer those still abusing alcohol.

These rituals aid the processes of personal transformation and integration into a new cultural group.

culture can be replaced by elements of a culture of recovery.

- Establishing clear boundaries for appropriate behavior (e.g., behavior that does not reflect drug cultures) in the program and consistently correcting behaviors that violate boundaries (e.g., wearing shirts depicting pot leaves; displaying gang-affiliated symbols, gestures, and tattoos).
- Working to shape a peer culture within the program so that longer-term clients and staff members can socialize new clients to a culture of recovery.
- Having regular assessments of clients and the entire program in which staff members and clients determine areas where work is needed to minimize cultural attitudes that can undermine treatment.
- Involving clients' families (when appropriate) in the treatment process so they can support clients' recovery as well as participate in their own healing process.

White (1996) suggests that programs build linkages with mutual-help groups; include mutual-help meetings in their programs or provide access to community mutual-help meetings; and include mutual-help rituals, symbols, language, and values in treatment processes.

Other activities that can improve integration into a recovery culture include SAMHSA's Recovery Community Services Program (http://www.samhsa.gov/grants/2011/ti_11_004.aspx), which was developed to provide and evaluate peer-based recovery support services, and Recovery Community Centers, which provide space for recovering people to socialize, organize, and develop a recovery culture (White and Kurtz 2006). Developing a culture of recovery involves connecting individuals back to the larger community and to their cultures of origin (Davidson et al. 2008). This can require efforts to educate the community about recovery as well (e.g., by promoting a recovery month in the community, hosting recovery walks or similar events, or offering outreach to community groups, such as churches or fraternal/benevolent societies).

Programs that do not have a plan for creating a culture of recovery among clients risk their clients returning to the drug culture or holding on to elements of that culture because it meets their basic and social needs. In the worst case scenario, clients will recreate a drug culture among themselves within the program. In the best case, staff members will have a plan for creating a culture of recovery within their treatment population.

SAMHSA's Guiding Principles of Recovery

- Recovery emerges from hope.
- Recovery is person driven.
- Recovery occurs via many pathways.
- Recovery is holistic.
- Recovery is supported by peers and allies.
- Recovery is supported through relationship and social networks.
- Recovery is culturally based and influenced.
- Recovery is supported by addressing trauma.
- Recovery involves individual, family, and community strengths and responsibility.
- Recovery is based on respect.

More information on the Guiding Principles of Recovery is available at the SAMHSA Store (http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf).

Source: SAMHSA 2012c.

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Appendix B—Instruments To Measure Identity and Acculturation

Some researchers have tested the usefulness of acculturation and identity models with people who abuse substances. For example, Peña and colleagues' racial identity attitude scale was found, in a study of African American men in treatment for cocaine dependence, to help counselors better understand the roles that ethnic and cultural identity play in clients' substance abuse issues (Peña et al. 2000). In 1980, Cuellar and colleagues published their acculturation rating scale for Mexican Americans, which conceptualized acculturation as progressing across a 5-point continuum ranging from Mexican or low acculturated (level 1) to American or high acculturated (level 5). The mid-level designation of bicultural (level 3) was set as the midpoint between the two extremes, although various investigators have questioned this assumption (Oetting and Beauvais 1990; Sayegh and Lasry 1993). Since then, scholars have developed new ways to conceptualize identity and acculturation, ranging from simple scales to complex multidimensional models (Skinner 2001). The table that begins on the next page summarizes the instruments available to measure acculturation and ethnic identity. (See also the Center of Excellence for Cultural Competence for additional resources at http://nyculturalcompetence.org).

Other scales have been developed to examine specific culture-related variables, including *machismo* (Cuellar et al. 1995; Fragoso and Kashubeck 2000), *simpatía* (Griffith et al. 1998), *familismo* (Sabogal et al. 1987), traditionalism–modernism (Ramirez 1999), and family traditionalism and rural preferences (Castro and Gutierres 1997). Counselors can use acculturation scales to help match patients to providers, to make treatment plans, and to identify the role of identity in substance abuse. Although these instruments can be helpful, the counselor must not rely solely on them to determine the client's identity or level of acculturation.

Acculturation and Ethnic Identity Measures

Instrument	Description	Cultural Group
African American Acculturation Scale-Revised (Klonoff and Landrine 2000)	This scale measures eight dimensions of African American culture: (1) traditional beliefs and practices, (2) traditional family structure and practices, (3) traditional socialization, (4) preparation and consumption of traditional foods, (5) preference for African American things, (6) interracial attitudes, (7) superstitions, and (8) traditional health beliefs and practices.	African Americans
Black Racial Identity Attitude Scale—Form B (Helms 1990)	This scale measures beliefs or attitudes of Blacks toward both Blacks and Whites using 5-point scales. It is available in short and long forms.	African Americans
Cross Racial Identity Scale (Worrell et al. 2001)	This scale measures six identity clusters associated with four stages of racial identity development.	African Americans
Multidimensional Inventory of Black Identity (MIBI; Sellers et al. 1997)	The MIBI measures centrality of Black identity, ideology, and regard for a Black identity. It is available online at http://sitemaker.umich.edu/aaril/files/mibiscaleandscoring.pdf.	African Americans
Scale To Assess African American Acculturation (Snowden and Hines 1999)	This is a 10-item scale that assesses media preferences, racial bias in relationships, race-related attitudes, and comfort in interacting with other races.	African Americans
African Self-Consciousness Scale (Baldwin and Bell 1985)	This scale measures within-group variability in the level of acculturation/cultural identity continuum (Baldwin and Bell 1985) based on degree of Afrocentricity or Nigrescence (White and Parham 1996). It indicates a client's level of involvement in traditional African American culture or the core African-oriented culture.	African Americans/African Immigrants
Native American Acculturation Scale (Garrett and Pichette 2000)	The Native American Acculturation scale asks 20 questions to ascertain a client's level of involvement with Native American culture.	Native Americans
Rosebud Personal Opinion Survey (Hoffmann et al. 1985)	This assessment evaluates components of acculturation, including language use, values, social behaviors, social networks, religious affiliation and practice, home community, education, ancestry, and cultural identification.	Native Americans
Asian American Multidimensional Acculturation Scale (AAMAS; Gim Chung et al. 2004)	The AAMAS was developed to be easy to use with a variety of Asian American ethnic groups. It includes questions relating to cultural identity, language use, cultural knowledge, and food preferences.	Asian Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Adjustment Difficulties Checklist (CADC; Sodowsky and Lai 1997)	The CADC helps avoid potential problems relating to acculturation by asking about language use, social customs, family interactions, perceptions of prejudice, friendship networks, and cultural adjustment.	Asian Americans (East Asians)
East Asian Acculturation Measure (Barry 2001)	This instrument includes 29 items that assess assimilation, level of separation from other Asians, integration, and marginalization.	Asian Americans (East Asians)
General Ethnicity Questionnaire (GEQ; Tsai et al. 2000)	The GEQ is an instrument designed to be used with minor modifications for assessing cultural orientation with different cultural groups. There are original and abridged versions. The original includes 75 items asking about language use, social affiliations, cultural practices, and cultural identification.	Asian Americans (although designed to be multicultural in orientation)
Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn et al. 1992)	This instrument was modeled after the Acculturation Rating Scale for Mexican Americans, and research indicates it has high reliability.	Asian Americans
Ethnocultural Identity Behavioral Index (Yamada et al. 1998)	This is a 19-item self-report assessment with high validity.	Asian Americans and Pacific Islanders
Internal-External Ethnic Identity Measure (Kwan 1997)	The instrument evaluates ethnic friendships and affiliation, ethnocommunal expression, ethnic food orientation, and family collectivism, in order to differentiate three Chinese American identity groups: (1) internal, (2) external, and (3) internal-external undifferentiated.	Chinese Americans
Marín and Marín Acculturation Scale (Marín et al. 1987)	This scale is a 12-item instrument that assesses three domains: (1) language use, (2) media preferences, and (3) ethnic diversity of social relations. It is available online at http://www.columbia.edu/cu/ssw/projects/pmap/docs/gupta_acculturation.pdf	Chinese Americans
Behavioral Acculturation Scale and Value Acculturation Scale (Szapocznik et al. 1978)	These two scales, used in conjunction with one another, ask individuals about behaviors and values in order to determine acculturation. If used singly, the behavioral scale is the superior measure for acculturation.	Cuban Americans
Na Mea Hawai'i (Hawaiian Ways), A Hawaiian Acculturation Scale (Rezentes 1993)	This is a 34-item scale. An adolescent version is available (Hishinuma et al. 2000).	Native Hawaiians

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Abbreviated Multidimensional Acculturation Scale (AMAS-ZABB; Zea et al. 2003)	The AMAS-ZABB is a multidimensional, bilinear, 42-item scale that evaluates identity, language competence, and cultural competence.	Latinos
Acculturation Scale (Marin et al. 1987)	This 12-item acculturation scale, available in English and Spanish, evaluates language use, media preferences, and social activities. It is available online at http://casaa.unm.edu/inst/MARIN%20Short%20Scale.pdf	Latinos
Bicultural Involvement Questionnaire (BIQ; Szapocznik et al. 1980)	The BIQ assesses language use and involvement in both Latino and mainstream American activities. It relates two sets of scores to derive a measure of bicultural involvement, with individuals who are highly involved in both cultures scoring highest on the scale.	Latinos
The Bidimensional Acculturation Scale for Hispanics (Marin and Gamba 1996)	This 24-item scale asks questions about language use, language proficiency, and media preferences.	Latinos
Brief Acculturation Scale for Hispanics (Norris et al. 1996)	This scale has only four items, but scores on the scale have been correlated highly with generation, nativity, length of time in the United States, language preferences, and subjective perceptions of acculturation.	Latinos
Multidimensional Measure of Cultural Identity for Latinos (Felix-Ortiz et al. 1994)	This measure places adolescents in one of four categories based on language, behavior/familiarity, and values/attitudes: (1) bicultural, (2) Latino-identified, (3) American-identified, and (4) low-level bicultural.	Latinos
Acculturation Rating Scale for Mexican Americans-I (ARSMA-I; Cuellar et al. 1980)	The ARSMA-I differentiates between 5 levels of acculturation: (1) Very Mexican, (2) Mexican-Oriented Bicultural, (3) True Bicultural, (4) Anglo-Oriented Bicultural, and (5) Very Anglicized. Established validity.	Mexican Americans
Acculturation Rating Scale for Mexican Americans-II (Cuellar et al. 1995)	This scale is like the ARSMA-I, except that it includes separate subscales to measure multidimensional aspects of cultural orientation toward Mexican and Anglo cultures independently.	Mexican Americans
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates five dimensions of acculturation: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans

(Continued on the next page.)

Acculturation and Ethnic Identity Measures (continued)

Instrument	Description	Cultural Group
Cultural Life Style Inventory (Mendoza 1989)	This self-report instrument, available in Spanish and English, evaluates acculturation on five dimensions: intrafamily language use, extrafamily language use, social activities and affiliations, cultural knowledge and activities, and cultural identification and pride.	Mexican Americans
Mexican American Acculturation Scale (Montgomery 1992)	This 28-item scale evaluates cultural orientation and comfort with ethnic identity. Items ask about language use, media preferences, cultural activities/traditions, and self-perceived ethnic identity.	Mexican Americans
Padilla's Acculturation Scale (Padilla 1980)	Padilla's Acculturation Scale is a 155-item questionnaire that assesses cultural knowledge and ethnic loyalties.	Mexican Americans
Bidimensional Acculturation Scale for Hispanics (Marín and Gamba 1996)	This scale measures evaluates two major dimensions of acculturation (Hispanic and non-Hispanic) using 12 items measuring 3 language-related areas. It has been found to have high consistency and validity.	Mexican Americans and Central Americans
Stephenson Multigroup Acculturation Scale (Stephenson 2000)	This is a 32-item instrument that evaluates immersion in both culture of origin and the dominant culture of the society.	Multicultural
Vancouver Index of Acculturation (Ryder et al. 2000)	This instrument includes 20 questions that assess interest/participation in one's "heritage culture" and "typical American culture" (available online at http://www2.psych.ubc.ca/~dpaulhus/Paulhus_measures/VIA.American.doc).	Multicultural
Bicultural Acculturation Scale (Cortés and Rogler 1994)	Developed for use with first- and second-generation Puerto Rican adults, this scale measures involvement in American culture and Puerto Rican culture, but it has limited evidence of validity and reliability.	Puerto Rican Americans
Psychological Acculturation Scale (Tropp et al. 1999)	The items on this scale pertain to the client's sense of psychological attachment to and belonging within Anglo American and Hispanic/Latino cultures.	Puerto Ricans on the U.S. mainland
Acculturation Scale for Southeast Asians (Anderson et al. 1993)	This 13-item scale evaluates languages proficiency and preferences regarding social interactions, cultural activities, and food. It includes two subscales for proficiency in languages, as well as language, social, and food preferences.	Cambodian, Laotian, and Vietnamese Americans
White Racial Identity Attitude Scale (Helms and Carter 1990)	This 50-item instrument rates items on a 5-point scale to measure attitudes associated with Helms's stages of racial identity development for Caucasians.	White Americans

Appendix C—Tools for Assessing Cultural Competence

There are numerous assessment tools available for evaluating cultural competence in clinical, training, and organizational settings. These tools are not specific to behavioral health treatment. Though more work is needed in developing empirically supported instruments to measure cultural competence, there is a wealth of multicultural counseling and healthcare assessment tools that can provide guidance in identifying areas for improvement of cultural competence. This appendix examines three resource areas: counselor self-assessment tools, guidelines and assessment tools to implement and evaluate culturally responsive services within treatment programs and organizations, and forms addressing client satisfaction with and feedback about culturally responsive services. Though not an exhaustive review of available tools, this appendix does provide samples of tools that are within the public domain. For additional resources and cultural competence assessment tools, visit the National Center for Cultural Competence (http://nccc.georgetown.edu) or refer to the University of Michigan Health System's Program for Multicultural Health (http://www.med.umich.edu/multicultural/).

Counselor Self-Assessment Tools

Multicultural Counseling Self Efficacy Scale—Racial Diversity Form

This 60-item self-report instrument assesses perceived ability to perform various counselor behaviors in individual counseling with a racially diverse client population. For additional information on psychometric properties and scoring, refer to Sheu and Lent (2007).

Self-Assessment Checklist for Personnel Providing Services and Supports to Children and Youth With Special Health Needs and Their Families

This instrument was developed by Tawara D. Goode of the Georgetown University Center for Child and Human Development. This version is adapted with permission from *Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings* (June 1989). It is available from the Web site of the National Center for Cultural Competence (http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf).

Select A, B, or C for each numbered item listed:
A = Things I do frequently B = Things I do occasionally C = Things I do rarely or never

Physical Environment, Materials and Resources

_____ 1. I display pictures, posters, and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I [e]nsure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films, or other media resources for health education, treatment, or other interventions, I ensure that they reflect the cultures of children and families served by my program or agency.

_____ 4. When using food during an assessment, I [e]nsure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

_____ 5. I [e]nsure that toys and other play accessories in reception areas and those used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment, or other interventions.

_____ 7. I attempt to determine any familial colloquialisms used by children and families that may have an impact on assessment, treatment, or other interventions.

_____ 8. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 9. I use bilingual staff members or trained/certified interpreters for assessment, treatment, and other interventions with children who have limited English proficiency.

_____ 10. I use bilingual staff members or trained/certified interpreters during assessments, treatment sessions, meetings, and for other events for families who would require this level of assistance.

11. When interacting with parents who have limited English proficiency I always keep in mind that:

> _____ Limitation in English proficiency is in no way a reflection of their level of intellectual functioning.
>
> _____ Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.
>
> _____ They may or may not be literate in their language of origin or English.

_____ 12. When possible, I ensure that all notices and communiqués to parents are written in their language of origin.

_____ 13. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

_____ 14. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 15. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

_____ 16. I screen books, movies, and other media resources for negative cultural, ethnic, or racial stereotypes before sharing them with the children and their parents served by my program or agency.

_____ 17. I intervene in an appropriate manner when I observe other staff members or parents within my program or agency engaging in behaviors that show cultural insensitivity, bias, or prejudice.

_____ 18. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

_____ 19. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 20. I accept and respect that male–female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play, and social interactions expected of male and female children).

_____ 21. I understand that age and lifecycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

_____ 22. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decisionmakers for services and supports for their children.

_____ 23. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 24. I recognize and understand that beliefs and concepts of emotional well-being vary significantly from culture to culture.

_____ 25. I understand that beliefs about mental illness and emotional disability are culturally based. I accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.

_____ 26. I accept that religion and other beliefs may influence how families respond to illnesses, disease, disability, and death.

_____ 27. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a physical/emotional disability or special health care needs.

_____ 28. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 29. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding, and other self-help skills.

_____ 30. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 31. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs, and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 32. I seek information from family members or other key community informants that will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 33. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate values and engage in practices that promote a culturally diverse and culturally competent service delivery system for children with disabilities or special health care needs and their families.

Ethnic-Sensitive Inventory (ESI; Ho 1991, reproduced with permission)

Here are some statements made by some practitioners with ethnic minority clients. How often do you feel this way when you work with ethnic minority clients? Every statement should be answered by circling one number ranging from 5 (always) to 4 (frequently), 3 (occasionally), 2 (seldom), and 1 (never).

In working with ethnic minority clients, I . . .

A. Realize that my own ethnic and class background may influence my effectiveness.

B. Make an effort to ensure privacy and/or anonymity.

C. Am aware of the systematic sources (racism, poverty, and prejudice) of their problems.

D. Am against speedy contracting unless initiated by them.

E. Assist them to understand whether the problem is of an individual or a collective nature.

F. Am able to engage them in identifying major progress that has taken place.

G. Consider it an obligation to familiarize myself with their culture, history, and other ethnically related responses to problems.

H. Am able to understand and "tune in" the meaning of their ethnic dispositions, behaviors, and experiences.

I. Can identify the links between systematic problems and individual concerns.

J. Am against highly focused efforts to suggest behavioral change or introspection.

K. Am aware that some techniques are too threatening to them.

L. Am able at the termination phase to help them consider alternative sources of support.

M. Am sensitive to their fear of racist or prejudiced orientations.

N. Am able to move slowly in the effort to actively "reach for feelings."

O. Consider the implications of what is being suggested in relation to each client's ethnic reality (unique dispositions, behaviors, and experiences).

P. Clearly delineate agency functions and respectfully inform clients of my professional expectations of them.

Q. Am aware that lack of progress may be related to ethnicity.

R. Am able to understand that the worker–client relationship may last a long time.

S. Am able to explain clearly the nature of the interview.

T. Am respectful of their definition of the problem to be solved.

U. Am able to specify the problem in practical, concrete terms.

V. Am sensitive to treatment goals consonant to their culture.

W. Am able to mobilize social and extended family networks.

X. Am sensitive to the client's premature termination of service.

Scoring: The 24 items include four items for each of six treatment phases of client–counselor interaction. The sum of the numbers circled for each item relating to a treatment phase is the score for that phase. The scoring grid is given below.

Scoring Grid for ESI

Process Phase	Items
Precontact	A _____ G _____ M _____ S _____
Problem Identification	B _____ H _____ N _____ T _____
Problem Specification	C _____ I _____ O _____ U _____
Mutual Goal Formulation	D _____ J _____ P _____ V _____
Problem Solving	E _____ K _____ Q _____ W _____
Termination	F _____ L _____ R _____ X _____

Source: Ho 1991. Reproduced with permission.

Evaluating Cultural Competence in Treatment Programs and Organizations

Agency Cultural Competence Checklist—Revised Form (Dana 1998, reproduced with permission)

Staff and policy attitudes

_____ Bilingual/bicultural
_____ Bilingual
_____ Bicultural
_____ Culture broker
_____ Flexible hours/appointments/home visits
_____ Treatment immediate/day/week
_____ Indigenous intake
_____ Match client–staff
_____ Agency environment reflects culture

Total possible = 9 Total obtained = _____

Services

_____ Culture-relevant assessment
_____ Cultural context for problems
_____ Cultural-specific intervention model
_____ Culture-specific services:

___ Prevention ___ Crisis ___ Brief ___ Individual
___ Couple ___ Family ___ Child ___ Outreach
___ Community ___ Education ___ Non-mental health
___ Resource linkage ___ Natural helpers/systems

Total possible = 4 Total obtained = _____

Total possible services = 13 Total obtained = _____

Relationship to community

_____ Agency operated by minority community
_____ Agency in minority community
_____ Easy access
_____ Uses existing minority community facilities
_____ Agency ties to minority community
_____ Community advocate for services
_____ Community as adviser
_____ Community as evaluator

Total possible = 8 Total obtained = _____

Training

_____ In-service training for minority staff
_____ In-service training for nonminority staff

Total possible = 2 Total obtained = _____

Evaluation

_____ Evaluation plan/tool
_____ Clients as evaluators/planners

Total possible = 2 Total obtained = _____

Enhanced National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

The standards presented in this section were developed by the Office of Minority Health (OMH 2013) in the Centers for Disease Control and Prevention (CDC) and are available online (https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedNationalCLASStandards.pdf). This section is reproduced from material in the public domain. Note that the Centers for Medicare and Medicaid Services (CMS) have also developed tools to assess linguistic competence and interpreter services as well as guidelines for planning culturally responsive services (see the CMS Web site at http://www.cms.gov). The National Standards for Culturally and Linguistically Appropriate Services (CLAS) are meant to advance health equity, improve quality, and help eliminate health disparities by establishing a blueprint for health and health care organizations to:

Principal standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, leadership, and workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and language assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, continuous improvement, and accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The Organizational Cultural Competence Assessment Profile

The Health Resources and Services Administration (HRSA) developed the Organizational Cultural Competence Assessment Profile from the cultural competence literature, guided by a team of experts. The profile was used during site visits to a variety of healthcare settings. It is an organizing framework and set of specific indicators to assist in examining, demonstrating, and documenting cultural responsiveness in organizations involved in the direct delivery of health care and services. The profile is not intended to be prescriptive; rather, it is designed to be adapted, modified, or applied in ways that best fit within an organization's context. The profile is presented as a matrix that classifies indicators by critical domains of organizational functioning and by whether the indicators relate to the structures, processes, outputs, or outcomes of the organization. The indicators suggest that assessment of cultural competence should encompass both qualitative and quantitative data and evaluate progress toward achieving results, not just the end results. Although the profile can be used in whole or in part, the full application enables an organization to assess its level of cultural competence comprehensively. Adapted here from material in the public domain are the matrices for process and capacity/structure measures. For more information, see http://www.hrsa.gov/culturalcompetence/ healthdlvr.pdf.

Sample of Process Measures by Domain

Domain	Topic Areas	Measures/Indicators
Communication	Interpreter	Yearly updated directory of trained interpreters is available within 24 hours for routine situations and within 1 hour or less for urgent situations.
Communication	Interpreter	Percentage of clients with limited English proficiency who have access to bilingual staff or interpretation services.

(Continued on the next page.)

Sample of Process Measures by Domain (continued)

Domain	Topic Areas	Measures/Indicators
Communication	Linguistically competent organization	Number of trained translators and interpreters available Number of staff proficient in languages of the community
Communication	Language ability, written and oral, of the consumer	Consumer reading and writing levels of primary languages and dialects is recorded.
Policies and procedures	Choice of health plan network	Contract continuation and renewal with health plan is contingent upon successful achievement of performance targets that demonstrate effective service, equitable access, and comparability of benefits for populations of racial/ethnic groups.
Policies and procedures	Staff hiring, recruitment	Number of multilingual/multicultural staff Ratio by culture of staff to clients
Family and community participation	Community and consumer participation	Degree to which families participate in key decisionmaking activities: • Family participation on advisory committees or task forces • Hiring of family members to serve as consultants to providers/programs • Inclusion of family members in planning, implementation, and evaluation of activities
Communication	Translated materials	Allocated resources for interpretation and translation services for medical encounters and health education/promotion material.
Communication	Linguistic capacity of the provider	Ability to conduct audit of the provider network, which includes the following components: • Languages and dialects of community available at point of first contact. • Number of trained translators and interpreters available. • Number of clinicians and staff proficient in languages of the community.
Communication	Provide information, education	• Organization has the capacity to disseminate information on health care plan benefits in languages of community. • Organization has the capacity to disseminate information and explanation of rights to enrollees.
Policies and procedures	Grievance and conflict resolution	Organization has structures in place to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive, or discriminatory treatment, or difficulty in accessing services or denial of services.
Policies and procedures	Grievance and conflict resolution	Organization has feedback mechanisms in place to track number of grievances and complaints and number of incidents.
Policies and procedures	Planning and governance	Composition of the governing board, advisory committee, other policymaking and influencing groups, and consumers served reflects service area demographics.

Sample of Capacity/Structure Measures by Domain

Domain	Topic Areas	Measures/Indicators
Facility characteristics, capacity, and infrastructure	Available and accessible services	• Transportation is available from residential areas to culturally competent providers. • Organization has the flexibility to conduct home visits and community outreach. • Culturally responsive services are available evenings and weekends.
Facility characteristics, capacity, and infrastructure	Information systems	Capacity for tracking of access and utilization rates for population of different racial/ethnic groups in comparison to the overall service population.
Monitoring, evaluation, and research	Organizational assessment	Ability to conduct ongoing organizational self-assessments of cultural and linguistic competence and integration of measures of access, satisfaction, quality, and outcomes into other organizational internal audits and performance improvement programs.

Multiculturally Competent Service System Assessment Guide

Reproduced with permission from The Connecticut Department of Children and Families, Office of Multicultural Affairs (2002).

Instructions: Rate your organization on each item in Sections I through VIII using the following scale:

1 2 3 4 5

Not at all To a moderate degree To a great degree

Suggested Rating Interpretations:
#1 and #2: "Priority Concerns"; #3: "Needs Improvement"; #4 and #5: "Adequate"

When you have rated all items and assessed each section, please follow the instructions in Section IX to make an assessment of your program or agency and then formulate a culturally competent plan that addresses the need you feel is a priority.

I. Agency demographic data (assessment)

A culturally competent agency uses basic demographic information to assess and determine the cultural and linguistic needs of the service area.

____ Have you identified the demographic composition of the program's service area (from recent census data, local planning documents, statement of need, etc.) which should include ethnicity, race, and primary language spoken as reported by the individuals?

____ Have you identified the demographic composition of the persons served?

____ Have you identified the staff composition (ethnicity, race, language capabilities) in relation to the demographic composition of your service area?

____ Have you compared the demographic composition of the staff with the client demographics?

II. Policies, procedures and governance

A culturally competent agency has a board of directors, advisory committee, or policy-making group that is proportionally representative of the staff, client/consumers, and community.

____ Has your organization appointed executives, managers, and administrators who take responsibility for, and have authority over, the development, implementation, and monitoring of the cultural competence plan?

____ Has your organization's director appointed a standing committee to advise management on matters pertaining to multicultural services?

____ Does your organization have a mission statement that commits to cultural competence and reflects compliance with all federal and state statutes, as well as any current *Connecticut Commission on Human Rights and Opportunities* nondiscriminatory policies and affirmative action policies?

____ Does your organization have culturally appropriate policies and procedures communicated orally and/or written in the principal language of the client/consumer to address confidentiality, individual patient rights and grievance procedures, medication fact sheets, legal assistance, etc. as needed and appropriately?

III. Services/programs

A culturally competent agency offers services that are culturally competent and in a language that ensures client/consumer comprehension.

A. Linguistic and communication support

____ Has the program arranged to provide materials and services in the language(s) of limited English-speaking clients/consumer (e.g., bilingual staff, in-house interpreters, or a contract with outside interpreter agency and/or telephone interpreters)?

____ Do medical records indicate the preferred languages of service recipients?

____ Is there a protocol to handle client/consumer/family complaints in languages other than English?

____ Are the forms that client/consumers sign written in their preferred language?

____ Are the persons answering the telephones, during and after-hours, able to communicate in the languages of the speakers?

____ Does the organization provide information about programs, policies, covered services, and procedures for accessing and utilizing services in the primary language(s) of client/consumers and families?

____ Does the organization have signs regarding language assistance posted at key locations?

____ Are there special protocols for addressing language issues at the emergency room, treatment rooms, intake, etc.?

____ Are cultural and linguistic supports available for clients/consumers throughout different service offerings along the service continuum?

B. Treatment/rehabilitation planning

____ Does the program consider the client/consumer's culture, ethnicity and language in treatment planning (assessment of needs, diagnosis, interventions, discharge planning, etc.)?

____ Does the program involve client/consumers and family members in all phases of treatment, assessment, and discharge planning?

____ Has the organization identified community resources (community councils, ethnic cultural social entities, spiritual leaders, faith communities, voluntary associations, etc.) that can exchange information and services with staff, client/consumers, and family members?

____ Have you identified natural community healers, spiritual healers, clergy, etc., when appropriate, in the development and/or implementation of the service plan?

____ Have you identified natural supports (relatives, traditional healers, spiritual resources, etc.) for purposes of reintegrating the individual into the community?

____ Have you used community resources and natural supports to reintegrate the individual into the community?

C. Cultural assessments

____ Is the client/consumer's culture/ethnicity taken into account when formulating a diagnosis or assessment?

____ Are culturally relevant assessment tools utilized to augment the assessment/diagnosis process?

___ Is the client/consumer's level of acculturation identified, described, and incorporated as part of cultural assessment?

____ Is the client/consumer's ethnicity/culture identified, described, and incorporated as part of cultural assessment?

D. Cultural accommodations

____ Are culturally appropriate, educative approaches, such as films, slide presentations, or video tapes, utilized for preparation and orientation of client/consumer family members to your program?

____ Does your program incorporate aspects of each client/consumer's ethnic/cultural heritage into the design of specialized interventions or services?

____ Does your program have ethnic/culture-specific group formats available for engagement, treatment, and/or rehabilitation?

____ Is there provider collaboration with natural community healers, spiritual healers, clergy, etc., where appropriate, in the development and/or implementation of the service plan?

E. Program accessibility

____ Do persons from different cultural and linguistic backgrounds have timely and convenient access to your services?

____ Are services located close to the neighborhoods where persons from different cultures and linguistic backgrounds reside?

____ Are your services readily accessible by public transportation?

____ Do your programs provide needed supports to families of clients/consumers (e.g., meeting rooms for extended families, child support, drop-in services)?

____ Do you have services available during evenings and weekends?

IV. Care management

____ Does the level and length of care meet the needs for clients/consumers from different cultural backgrounds?

___ Is the type of care for clients/consumers from different backgrounds consistently and effectively managed according to their identified cultural needs?

____ Is the management of the services for people from different groups compatible with their ethnic/cultural background?

V. Continuity of care

____ Do you have letters of agreement with culturally oriented community services and organizations?

____ Do you have integrated, planned, transitional arrangements between one service modality and another?

____ Do you have arrangements, financial or otherwise, for securing concrete services needed by clients/consumers (e.g., housing, income, employment, medical, dental, other emergency personal support needs)?

VI. Human resources development

A culturally competent agency implements staff training and development in cultural competence at all levels and across all disciplines, for leadership and governing entities as well as for management, supervisory, treatment, and support staff.

____ Are the principles of cultural competence (e.g., cultural awareness, language training, skills training in working with diverse populations) included in staff orientation and ongoing training programs?

____ Is the program making use of other programs or organizations that specialize in serving persons with diverse cultural and linguistic backgrounds as a resource for staff education and training?

____ Is the program maximizing recruitment and retention efforts for staff who reflect the cultural and linguistic diversity of populations needing services?

____ Has the staff's training needs in cultural competence been assessed?

____ Has the staff attended training programs on cultural competence in the past two years? Describe:_____
_____

VII. Quality monitoring and improvement

A culturally competent agency has a quality monitoring and improvement program that ensures access to culturally competent care.

____ Does the quality improvement (QI) plan address the cultural/ethnic and language needs?

____ Are client/consumers and families asked whether ethnicity/culture and language are appropriately addressed in order to receive culturally competent services in the organization?

____ Does the organization maintain copies of minutes, recommendations, and accomplishments of its multicultural advisory committee?

____ Is there a process for continually monitoring, evaluating, and rewarding the cultural competence of staff?

VIII. Information/management system

____ Does the organization monitor, survey, or otherwise access, the QI utilization patterns, Against Medical Advice (AMA) rates, etc., based on the culture/ethnicity and language?

____ Are client/consumer satisfaction surveys available in different languages in proportion to the demographic data?

____ Are there data collection systems developed and maintained to track clients/consumers by demographics, utilization and outcomes across levels of care, transfers, referrals, re-admissions, etc.?

IX. Formulating a culturally competent plan based on the assessment of your program or agency

Focus on the following critical areas of concern as you develop goals for a culturally competent plan for your agency's service system.

Access: Degree to which services to persons are quickly and readily available.

Engagement: The skill and environment to promote a positive personal impact on the quality of the client's commitment to be in treatment.

Retention: The result of quality service that helps maintain a client in treatment with continued commitment.

Based on an assessment of your agency, determine whether, in your initial plan, you need to direct efforts of developing cultural competency toward one, or a combination, of the above critical areas. **Then, structure your agency's cultural competence plan using the following instructions:**

1. Based on the results of this assessment, summarize and describe your organization's perceived **strengths** in providing **services to persons from different cultural groups**. Please provide specific examples. Attach supporting documentation (e.g., Data, Policies, Procedures, etc.)

2. Based on your assessment, summarize and describe your organization's primary areas considered either "**Priority Concerns" (#1 and/or #2)**, or **"Needs Improvement" (#3)** in providing services to persons from different cultural groups.
3. Based on your organization's **strengths** and **needs, prioritize** both the organizational goals and objectives addressed in your **cultural competence plan**. Describe clearly what you will do to provide services to persons who are culturally and linguistically different.
4. Using the developed goals and objectives, please describe in detail the plans, activities, and/or strategies you will implement to assist your organization in meeting each of the goals and objectives indicated.

Patient Satisfaction and Feedback on Clinical and Program Culturally Responsive Services

Iowa Cultural Understanding Assessment–Client Form

Please indicate your level of agreement with the statements below by circling the number to the right of the statement that best fits your opinion. All responses are confidential. When you have completed the survey, please either use the pre-addressed, stamped envelope to return the survey by mail or place it in the drop box at the facility. **Thank you very much for your participation!**

Demographic Information

What is your sex? ____Male ____Female

What is your race? ____Alaskan Native ____American Indian ____Asian ____Black or African American ____Native Hawaiian or other Pacific Islander ____White

Are you Hispanic or Latino? ____Yes ____No

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1. The staff here understands some of the ideas that I, my family, and others from my cultural, racial, or ethnic group may have.	1	2	3	4	5
2. Staff here understands the importance of my cultural beliefs in my treatment process.	1	2	3	4	5
3. The staff here listens to me and my family when we talk to them.	1	2	3	4	5
4. If I want, the staff will help me get services from clergy or spiritual leaders.	1	2	3	4	5
5. The services I get here really help me work toward things like getting a job, taking care of my family, going to school, and being active with my friends, family, and community.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
6. The staff here seems to understand the experiences and problems I have in my past life.	1	2	3	4	5
7. The waiting room and/or facility has pictures or reading material that show people from my racial or ethnic group.	1	2	3	4	5
8. The staff here knows how to use their knowledge of my culture to help me address my current day-to-day needs.	1	2	3	4	5
9. The staff here understands that I might want to talk to a person from my own racial or ethnic group about getting the help I want.	1	2	3	4	5
10. The staff here respects my religious or spiritual beliefs.	1	2	3	4	5
11. Staff from this program comes to my community to let people like me and others know about the services they offer and how to get them.	1	2	3	4	5
12. The staff here asks me, my family, or others close to me to fill out forms that tell them what we think of the place and services.	1	2	3	4	5
13. Staff here understands that people of my racial or ethnic group are *not* all alike.	1	2	3	4	5
14. It was easy to get information I needed about housing, food, clothing, child care, and other social services from this place.	1	2	3	4	5
15. The staff here talks to me about the treatment they will give me to help me.	1	2	3	4	5
16. The staff here treats me with respect.	1	2	3	4	5
17. The staff seems to understand that I might feel more comfortable working with someone who is the same sex as me.	1	2	3	4	5

(Continued on the next page.)

Iowa Cultural Understanding Assessment–Client Form (continued)

STATEMENT	RESPONSE				
	Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
18. Most of the time, I feel I can trust the staff here who work with me.	1	2	3	4	5
19. The waiting room has brochures or handouts that I can easily understand that tell me about services I can get here.	1	2	3	4	5
20. If I want, my family or friends are included in discussions about the help I need.	1	2	3	4	5
21. The services I get here deal with the problems that affect my day-to-day life such as family, work, money, relationships, etc.	1	2	3	4	5
22. Some of the staff here understand the difference between their culture and mine.	1	2	3	4	5
23. Some of the counselors are from my racial or ethnic group.	1	2	3	4	5
24. Staff members are willing to be flexible and provide alternative approaches or services to meet my cultural/ethnic treatment needs.	1	2	3	4	5
25. If I need it, there are translators or interpreters easily available to assist me and/or my family.	1	2	3	4	5

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Appendix D—Screening and Assessment Instruments

Important Note: The following tables provide an overview of selected instruments that screen and assess for substance use disorders and mental disorders and symptoms. These tables only represent a sample of instruments. In reviewing the tables, do not assume that the instruments have normative data across race and ethnicities. The citations and information listed in this appendix serve only as a starting point for investigating the appropriateness of available instruments within specific populations. Citations reflect information about the effectiveness of the testing measurements as well as research that suggests modifications or reports testing discrepancies among racial and ethnic populations.

Screening and Assessment Instruments for Substance Use Disorders

Instrument	Description	Clinical Utility
Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; Humeniuk et al. 2010)	The ASSIST (version 3.1) has eight items to screen for use of tobacco products, alcohol, and drugs	ASSIST was developed by the World Health Organization (WHO) as a culturally neutral tool for use in primary and general medical care settings. This paper-pencil instrument takes 5 to 10 minutes to complete and is designed to be administered by a health worker. ASSIST determines a risk score for each substance; the score starts a discussion with clients about their substance use. For information about the instrument and its availability in other languages, see http://www.who.int/substance_abuse/activities/assist/en/
Alcohol Use Disorders Identification Test (AUDIT; Babor et al. 1992; Saunders et al. 1993)	This 10-item screening questionnaire was developed to identify people whose alcohol consumption is hazardous or harmful to their health.	The AUDIT was developed by WHO for use in multinational settings—the original sample included subjects from Australia, Bulgaria, Kenya, Mexico, Norway, and the United States (Allen et al. 1997; Saunders et al. 1993). **Populations researched:** Latinos (Cherpitel 1999; Cherpitel and Bazargan 2003; Cherpitel and Borges 2000; Frank et al. 2008; Reinert and Allen 2007; Volk et al. 1997), northern (Asian) Indians (Pal et al. 2004); Vietnamese (Giang et al. 2005); Brazilians (Lima et al. 2005), and Nigerians (Adewuya 2005).

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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

(Continued on the next page.)

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.

Ana Anders, M.S.W., LICSW
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Appendix K—Acknowledgments

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

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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

TIP 6 Screening for Infectious Diseases Among Substance Abusers—*Archived*

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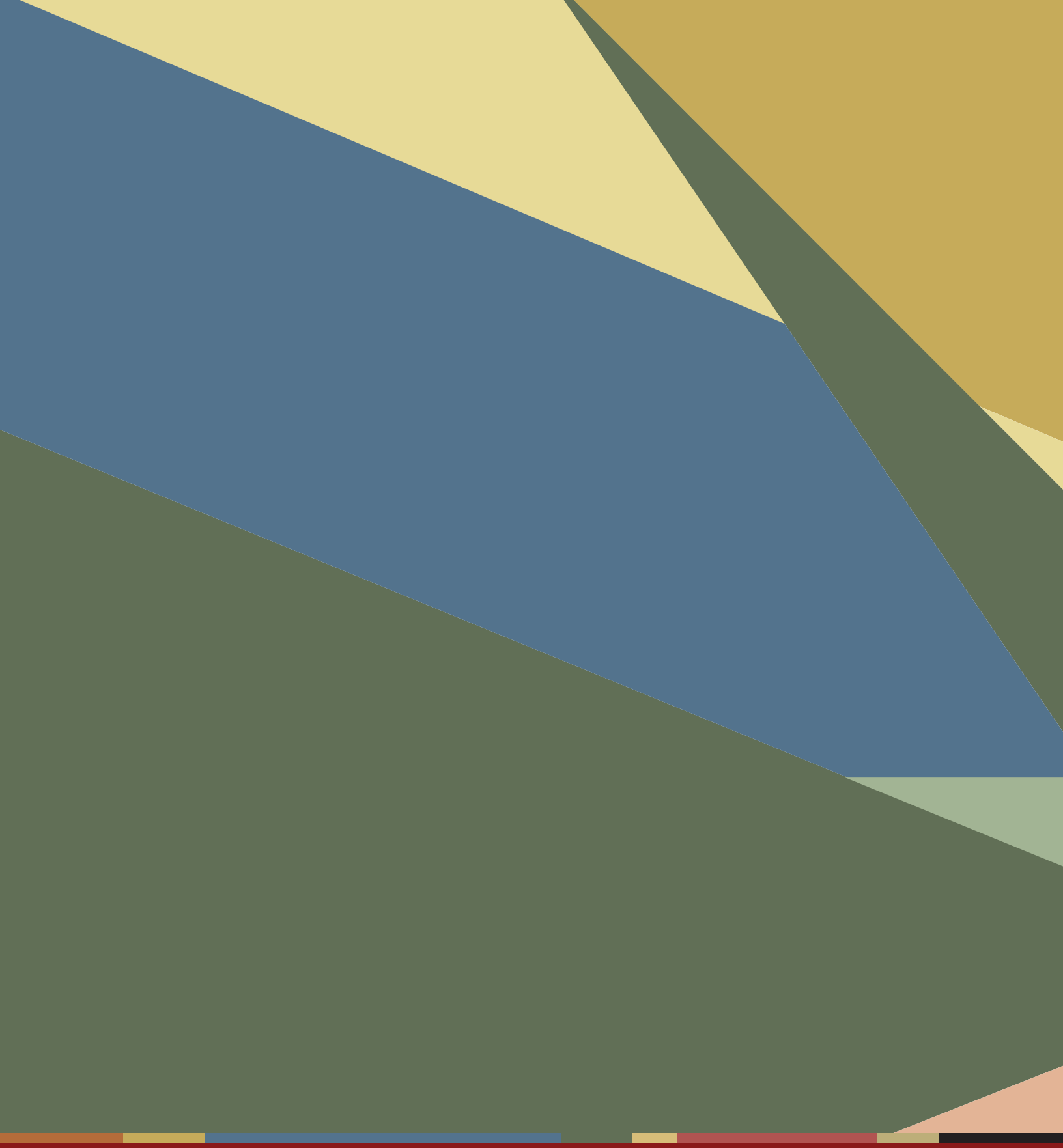

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