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Introduction

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Ethnocultural Issues in Substance Abuse Treatment

An Overview

Shulamith Lala Ashenberg Straussner

America is the melting pot where nothing melted.
—TONY KUSHNER, *Angels in America*

The traditional view of the United States as an "ethnic melting pot" (Glazer & Moynihan, 1970; Park, 1950) in which all ethnic and cultural groups lose their cultural identifications and form a new American ethnocultural "puree" has changed. This change is a reflection of what had been termed the "unmeltable ethnics" (Novak, 1973) and the desire of different ethnic groups "to affirm their right to a separate identity within the framework of a pluralistic nation" (Steinberg, 1981, p. ix). The current view may be best conceptualized as having the various ethnocultural groups in the United States form a "mosaic," or better yet, an "ethnocultural salad"—a mixture in which all the ethnic and cultural ingredients of various groups are tossed together while still retaining their unique "flavor and taste." It is those unique ethnocultural "flavors" that make working with substance-abusing clients today so fascinating, yet so challenging.

The increase in ethnic pride among Blacks and Hispanics during the 1960s and 1970s (Steinberg, 1981; Sue & Sue, 1990), combined with the diversity among immigrants during the past two decades, has led to a re-

newed interest in the uniqueness of different ethnocultural groups in the United States. As pointed out by Hayton (1994), "One of the ironies of our time is that the unique customs, values and traditions of cultural groups have become more important as the world has become smaller and the inhabitants of the planet realize that they live in a global village" (p. 99). Yet, despite the growing recognition of the need for ethnoculturally sensitive provision of services and a tremendous increase in the literature on this topic among all mental health professions, the application of such knowledge to the field of addictions remains limited, with much of it focused on prevention of substance abuse among people of color—a reaction to the earlier focus on substance abuse among Whites (Amodeo & Jones 1997, 1998; Amodeo, Robb, Peou, & Tran, 1996; Bennett & Ames, 1985; de la Rosa & Recio Adrados, 1993; Gordon, 1994; Griffith et al., 1996; Maddahian, Newcomb, & Bentler, 1988; Mayers, Kail, & Watts, 1993; National Institute on Drug Abuse [NIDA], 1995; Orlandi, Weston, & Epstein, 1992; Philleo, Brisbane, & Epstein, 1995; Szapocznik, 1995; Trimble, Bolek, & Niemcryk, 1992; Tucker, 1985; Turner & Cooper, 1997).

This chapter provides an introduction to ethnocultural issues as they apply to alcohol and other drug (AOD)-related problems and treatment approaches. It explores such concepts as race, culture, and ethnicity. And, in order to avoid stereotyping, it focuses on variables such as social class, encounters with prejudice, migration, acculturation, language, socioeconomic status, family roles, and gender—factors that create diversity even among specific ethnic and cultural groups. The relationship of these variables to substance abuse problems and the implications for treatment with alcohol- and drug-abusing individuals and their families are considered.

THE MEANING AND IMPORTANCE OF RACE, ETHNICITY, AND CULTURE

As pointed out by Hays (1996), "despite distinct differences in their meanings, the terms *race*, *ethnicity*, and *culture* continue to be used interchangeably and in ways that reinforce Eurocentric assumptions" (p. 333). Thus it is important to have a clear understanding of these concepts and the impact they have on the treatment of those affected by substance abuse problems.

Definition of Race

Although awareness of racial differences has existed for ages, the modern notion of "race" originated in the 17th century as an attempt to classify

people on the basis of genetically transmitted physical characteristics, such as skin color and hair texture (Hays, 1996; Orlandi et al., 1992). Although most scientists today agree that the concept of race has no scientific meaning, it remains a powerful sociopolitical construct that plays an important role in understanding social attitudes, prejudice, stereotypes, and discrimination, as well as in the interactions between patients and clinicians (Davis & Proctor, 1989; Lu, Lim, & Mezzich, 1995; McGoldrick, Giordano, & Pearce, 1996).

Moreover, what may be viewed as racial characteristics are frequently manifestations of socioeconomic and cultural differences, thereby confounding the use of race an explanatory factor in behavior—particularly in relationship to the use and abuse of alcohol and other drugs. Thus the typical classification of substance use and abuse within such population categories as "White, Black, and Hispanic" and the more recently added "Asian/Pacific Islanders" is not helpful because it obscures the ethnic and cultural background of those so classified. Such classification is particularly problematic in relation to those of Hispanic/Latino background, because a substance-abusing "Hispanic" client can be of Black, White, or of Native American or other indigenous racial background, representing a variety of different cultures. Furthermore, such classification negates the identification of the growing number of people of mixed racial backgrounds.

Definition of Culture

As stated by Devore and Schlesinger (1996), "culture is a commonly used concept that is difficult to define. It revolves around the fact that human groups differ in the way they structure their behavior, in their world view, in their perspectives on the rhythms and patterns of life, and in their concept of the essential nature of the human condition" (p. 43). In essence, culture is the sum total of life patterns passed on from generation to generation within a given community. It includes institutions, language, religious ideals, artistic expressions, and patterns of social and interpersonal relationships. Culture also includes values, attitudes, customs, and beliefs that are shared by group members (Lu et al., 1995; Lum, 1996; Sue & Sue, 1990). Cultural beliefs, moreover, determine who will be oppressed and who will benefit from socioeconomic and political privileges in any given society.

It is within a cultural context that attitudes and reactions to the use and abuse of alcohol and other drugs are formed. And it is only within such a context that we can understand the differential meaning of the snorting of methamphetamine by a group of White upper-class teens at a

private club, the drinking of beer at a local bar by a group of Polish American working-class men, or the passing of a bottle of wine by a group of underemployed African American men on an inner-city street corner. As found by Maddahian and colleagues (1988) in their exploration of risk factors for adolescent substance abuse: "One of the most interesting findings of our research was that the same behavior [drug use] may have different causes among different demographic groups or populations because of their unique traditions, cultures, and expectations from life" (p. 12).

Definition of Ethnicity

Whereas the concept of *culture* is a global one, the concept of *ethnicity* is more narrow: "Ethnicity refers to the sense of peoplehood experienced by members of the same ethnic group" (Devore & Schlesinger, 1996, p. 45). The term "ethnicity" comes from the Greek work *ethnos,* meaning "people" or "nation," and refers to the notion that members of an ethnic group share common identity, ideals, and aspirations and a sense of continuity (Gordon, 1964). These commonalities provide an individual with an "ethnic identity"—a major form of group identification. According to Alba (1985), it is the "self-definition in terms of the past [that] makes an ethnic group different from most other kinds of social groups and constitutes the sine qua non of its existence" (p. 17).

Ethnic values and identification are retained for many generations: "Second-, third-, and even fourth-generation Americans, as well as new immigrants differ from the dominant culture in values, life-style and behavior. . . . Ethnicity patterns our thinking, feeling and behavior in both obvious and subtle ways. It plays a major role in determining what we eat, how we work, how we relax, how we celebrate holidays and rituals, and how we feel about life, death and illness" (McGoldrick, 1982, p. 3). Thus, although the surrounding culture may affect an individual's access to a given substance such as alcohol, crack cocaine, or Ecstasy, one's ethnic identity plays an important role in when and how a substance is used and in one's reactions to these substances.

Ethnocultural Awareness

Although an exclusive focus on the ethnic and cultural backgrounds of people can readily lead to stereotyping of individuals and communities, ignoring them can lead to inadequate understanding of a client and inappropriate provision of services. As pointed out by Cunningham (1994):

> The cultural beliefs of a group of people are directly related to how alcohol and other drug problems are defined. The very definition of health differs by ethnicities and cultures. Therefore, it is of critical importance to understand how the members of an ethnic group define alcohol and other drug problems; what is considered to be a positive outcome; and what they feel are appropriate ways to prevent these problems from occurring. (p. viii)

Moreover, because ethnicity and culture interact and influence each other, clinicians and agencies need to focus on both the specific ethnicity and the broader cultural context, that is, to become *ethnoculturally competent,* in their delivery of substance abuse services.

ETHNOCULTURAL COMPETENCY

Ethnocultural competency can be defined as the ability of a clinician to function effectively in the context of ethnocultural differences. Ethnocultural competency has been shown to influence client–clinician communication and trust (Tirado, 1998) and is a crucial component in the effective provision of substance abuse services and the retention of clients. It includes awareness and acceptance of differences—differences that need to be explored respectfully, nonjudgmentally, and with curiosity (Dyche & Zayas, 1995).

Ethnocultural competency is a developmental process that moves beyond "cultural sensitivity" and includes cognitive, affective, and skills dimensions (Orlandi, 1992). It includes an understanding of one's own ethnocultural background and values; a basic knowledge about the ethnoculture of clients with whom one is working; a commitment to working with diverse clients; and an ability to adapt practice skills to fit the client's ethnocultural background, including flexibility in reaching out to appropriate cultural resources in a given ethnic community (Amodeo & Jones, 1998; Center for Mental Health Services, 1997; Gordon, 1994; Hays, 1996; Lum, 1996; Orlandi et al., 1992).

Ethnocultural competence includes not only the individual clinician but also the setting in which the individual works (Tirado, 1998). A substance abuse clinician cannot provide ethnoculturally competent services in a setting that does not support and validate such values. The agency should strive to include some recognition and celebration of ethnocultural holidays, customs, and rituals—including food, music, and art—of the diverse ethnic groups seen in the agency; to hire professional and paraprofessional staff that reflect the ethnic and linguistic diversity of clients; and to provide

ongoing training and supervision to help the counseling staff understand their clientele and their own countertransferential reactions to them.

Establishing close linkages with community groups that represent the ethnocultural background of clients and cross-training of staff can be extremely beneficial to all. For example, a substance abuse clinic with a number of Russian or Dominican immigrant clients may offer to provide a lecture on the signs and symptoms of AOD addictions to an ethnic Russian or Dominican community organization while inviting staff from such an organization to offer in-service training regarding issues that affect the particular ethnic group.

In addition, ethnoculturally competent organizations use computerized management information systems that have the capacity to record data regarding clients' ethnicity, migration and immigration information, religious and spiritual beliefs, and languages spoken. They also track information regarding accessibility to and frequency of the need for interpreters (Tirado, 1998). Moreover, an ethnoculturally competent organization makes use of treatment outcome research in order to identify its abilities and deficits in providing ethnoculturally competent treatment services to its clientele.

SUBSTANCE ABUSE AMONG DIFFERENT ETHNOCULTURAL AND RACIAL GROUPS

Recognition of variation in substance abuse patterns among different ethnocultural groups is not new; neither are its political implications. As pointed out by Room (1985),

> The social sciences have considered ethnic differences in the United States at least as far back as the Progressive era, when the descendants of earlier immigrants became concerned about the living conditions and cultural patterns of the new waves of immigrants crowding into American cities. Not least among the concern, both of "know-nothing" nativists and of well-wishing social reformers were the drinking patterns and problems of the new immigrants. . . . (pp. xi–xii)

Consequently, the early years of the 20th century saw numerous studies focusing on drinking patterns among different ethnic groups and on the interplay of ethnicity and alcoholism. Most sociological studies of ethnic variations dropped out of favor following World War II because "such a focus went against the prevailing melting-pot ideology of American society . . .

[and] any emphasis on ethnic differentiation was uncomfortably reminiscent of the Nazis' racist ideology and its genocidal consequences" (Room, 1985, p. xii). Nevertheless, studies of ethnic difference in drinking patterns continued. These studies were viewed, in today's terminology, as "politically correct," because their findings "cut against the grain of racist and nativist assumptions of cultural superiority. In terms of their drinking practices, ethnicities that had borne the brunt of racist and nativist attacks—such as Italians, Jews, and the Chinese—could be presented as paragons others might aspire to copy" (Room, 1985, p. xii). Thus it is evident that the use of substances is not just an individual or even a familial dynamic but an issue that has important sociocultural meanings for different ethnic groups and for society as a whole. Consequently, research and discussion of substance abuse among different ethnic groups has been and continues to be a highly charged social and political issue.

Current State of Knowledge

Despite the long-standing awareness that the use and abuse of alcohol and other drugs is governed by specific ethnocultural norms and values, current national databases that survey alcohol and other drug abuse in the United States tend to aggregate individuals into global racial or ethnocultural categories, such as Black, White, Hispanic, Asian, or Native American. Such classifications tend to ignore the distinctions in the drinking and drug use patterns among the various subgroups within each ethnocultural category. Consequently, there is limited data regarding alcohol and other drug problems among various Asian/Pacific Islander populations or the numerous European American groups or within the various subgroups classified as Native American or Black. Moreover, due to the absence of an appropriate category, there is total lack of information about substance abuse among people of Middle Eastern background. Fortunately, the most recent federal analysis of data obtained from the national household surveys during 1991–1993 has recognized some subcategories within the Hispanic grouping, providing much needed information (Substance Abuse and Mental Health Services Administration [SAMHSA], 1998).

As reflected in Table 1.1, the prevalence of alcohol and drug problems does vary among different ethnic and racial groups. Alcohol dependence is more of a problem among Native Americans and those of Mexican background, whereas other drug problems (see the column "Need for drug abuse treatment") are higher among Native Americans, Blacks, and those of Mexican and Puerto Rican background when compared with the "total

TABLE 1.1. Prevalence of Substance Use and Abuse

	Substance used						
Race/ethnicity	Alcohol use past year	Any illicit drug use past year	Marijuana use past year	Cocaine use past year	Need drug abuse treatment	Alcohol dependence	Cigarette use past year
Total surveyed population	66.4%	11.9%	9.0%	2.5%	2.7%	3.5%	30.9%
White (non-Hispanic)	68.9%	11.8%	8.9%	2.4%	2.5%	3.4%	31.5%
Native American	63.7%	19.8%	15.0%	5.2%	7.8%	5.6%	52.7%
Black (non-Hispanic)	55.4%	13.1%	10.6%	3.1%	3.9%	3.4%	29.9%
Asian/Pacific Islander	53.2%	6.5%	4.7%	1.4%	1.7%	1.8%	21.7%
Hispanic–Caribbean	60.8%	7.6%	5.6%	1.5%	1.6%	1.9%	21.2%
Hispanic–Central American	51.1%	5.7%	2.7%	1.1%	1.5%	2.8%	17.9%
Hispanic–Cuban	65.7%	8.2%	5.9%	1.7%	2.6%	0.9%	27.3%
Hispanic–Mexican	63.7%	12.7%	9.1%	3.9%	3.6%	5.6%	29.1%
Hispanic–Puerto Rican	59.5%	13.3%	10.8%	3.7%	3.7%	3.0%	32.7%
Hispanic–South American	74.1%	10.7%	8.4%	2.0%	1.7%	2.1%	31.3%

Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, National Household Survey on Drug Abuse, 1991–1993.

surveyed population." Asians/Pacific Islanders tend to have an almost equal problem with drugs as compared with alcohol, with all substances being abused to a much lower degree than among the other populations studied.

It is important to note that, whereas our culturally approved substance, alcohol, is a bigger problem nationwide and particularly among the White population in the United States than is other drug use, illegal drugs are more of a problem among Native Americans, Blacks, Cubans, and Puerto Ricans. The implications of these differences are profound both in terms of social policy and clinical practice. The negative consequences of using a substance that is culturally defined as "illegal" are reflected in legal, familial, social, and economic sequelae and affect the availability of quality treatment and on the recovery process:

> Since the time and effort necessary to obtain drugs and to pay for the addiction are considerable, the lifestyle associated with opiate [and crack] addiction is highly unstructured and generally characterized by poverty and illegal activities, which tend to have a severe negative impact on family life. Numerous live-in partners, prostitution and incarcerations are common. . . . The use of crack in the United States has had a particularly destructive and tragic impact on black families and communities, due in part to the high rate of use among black women, thereby diminishing their availability to maintain familial and community life. (Straussner, 1994, pp. 394–395)

Moreover, African American and Hispanic communities have been severely affected by AIDS resulting from intravenous drug use or sexual relations with HIV-infected individuals (Friedman, 1997; Strom, 1993). According to Day (1999), during 1997, AIDS was the leading cause of death among African Americans between the ages of 25 and 44, with over 60% of these deaths being injection related: "Among those who inject drugs, African Americans are five times as likely as whites to get AIDS" (p. 1). For Latinos in the same age group, AIDS was the second leading cause of death, with over half of the deaths related to drug injection compared with less than one quarter for Whites. Both African American and Latino women suffer disproportionately from this epidemic: African American women, who represent only 12% of the population, account for over half of all injection-related AIDS cases among women, whereas Latino women, who represent 10% of the female population in the United States, account for 20% of all injection-related AIDS cases (Day, 1999).

Given the differential patterns and impact of alcohol and other drug use among different ethnic and cultural groups, it is evident that ethno-

cultural dynamics have to be taken into account during substance abuse treatment process.

ETHNOCULTURALLY COMPETENT TREATMENT

Ethnoculturally competent substance abuse treatment, like any effective substance abuse treatment, must begin with a comprehensive assessment of the client's alcohol and other drug use and its impact on the client and his or her family (Straussner, 1993) and with the utilization of good counseling skills. However, to make it ethnoculturally competent, treatment must take into account the client's ethnocultural beliefs, customs, and values, particularly as they relate to AOD issues, as well as the social conditions that have an impact on the client's ethnocultural group.

The disease concept of addiction is often unknown to many immigrants, who are more likely to see the abuse of alcohol and other drugs as immoral behavior reflecting a weakness of character; as mental illness requiring institutionalization; as a sinful or criminal behavior; as a reflection of cosmic or supernatural forces; as an understandable reaction to life stressors or social oppression; as a harmless use of a substance that is widely used in one's culture; or even as a helpful way of coping with psychic pain (Amodeo & Jones, 1997). Most, however, see it as a shameful, stigmatizing issue that has to be kept secret from the outside world. An open admission of such problems may be considered a disgrace not just for the individual but for the whole family and community. For many individuals from traditional cultures, particularly those in which marriages are arranged, admitting that a family member has a substance abuse problem may make not only this individual but others in the family unmarriageable. In addition, fear of deportation may also keep many immigrants and refugees from admitting to having a problem, whereas a general distrust of authority may make many African Americans reluctant to admit the truth about their substance use (Debro & Conley, 1993). Thus an important aspect in ethnoculturally competent substance abuse treatment is an assessment of how AOD problems are viewed not only by the individual client and his or her family but also by the client's ethnic culture. For example, a Jamaican-born male referred for treatment by his Employee Assistance Program (EAP) due to a positive marijuana screen may come from a very different ethnocultural context of substance use and beliefs about such use and thus have different treatment needs than his Greek American coworker who also tested positive for the same substance. Moreover, cultural rituals and celebrations provide a context for the use and abuse of alcohol and

other drugs. Drinking may be an expected ritual during a wake in an Irish American family but totally unacceptable during a funeral, or even a birthday party, in a traditional Anglo-Saxon Southern Baptist family.

Ethnoculturally Competent Assessment of Substance Abusers

It is evident, without minimizing genetic, health, familial, and personality dynamics (Straussner, 1993), that ethnocultural factors play an important role in the development and in the consequences of AOD problems in the United States. The following are among the most important ethnoculturally affected dynamics that must be taken into account during assessment.

Ethnic, Racial, and Religious Identification

Ethnic and racial identification are not always clearly evident when a counselor first sees a client, and most intake forms do not allow for mixed racial or ethnic identifications. Thus it is important to ask clients how they identify themselves, rather than assume a certain classification based on the client's physical looks or place of birth. For example, Lynda, a cocaine- and heroin-snorting 24-year-old daughter of an African American father and a White Jewish mother, identified herself as a "Black Jew" even though she looked White and put down "agnostic" as a religious identification on the intake form. Angelo, a 38-year-old alcohol- and marijuana-abusing client, identified himself as Italian American Roman Catholic, the ethnic and religious background of his foster mother who raised him from age 4, even though he and his birth parents were born in Puerto Rico and his family there is still involved with a Pentecostal church.

Because much of current substance abuse treatment in the United States remains spiritually focused, clinicians will find it helpful to assess the role that religion and spirituality play in the current life of the client and his or her family. For example, a middle-aged client who identifies himself as Catholic but who has not been in a church since being expelled from parochial school for smoking pot in the sixth grade may feel more negatively about religion and spirituality than a client who has never been involved in any formal religion but who recently had been reading about Zen Buddhism and meditation. A Muslim male client from Pakistan may resist participating in an Alcoholics Anonymous (AA) meeting that ends with the Lord's Prayer, whereas an African American woman may find the spiritual aspect of her Narcotics Anonymous (NA) meeting of crucial importance in her recovery.

Religious rituals provide important affirmations of one's ethnocultural

identity and may offer an important source of support during recovery for some clients; however, they also may provide a dangerous context for the use of substances. For example, a Jewish client trying to maintain her recovery from alcohol dependence may find it difficult to deal with the offer of wine, an important aspect of Jewish religious services and holiday rituals. Thus it is crucial that clinicians assess both the benefits and potential dangers when encouraging clients to reconnect with their religious upbringing.

Encounters with Prejudice and Discrimination

Encounters with discrimination based on one's ethnic or racial identity are part of both past and current reality of many clients. It may be racism based on skin color, such as that experienced by African Americans, Black Caribbeans, or the more recent African immigrants; it may be based on differences in physical characteristics and historical stereotypes as experienced by Asians or Native Americans; it may be anti-Semitic Jewish or anti-Muslim prejudice due to religious differences; or it may be prejudice and discrimination based on country of origin, such as that historically experienced by Irish, Polish, and Italian immigrants in the United States. In all these cases cultural memories and the impact of such experiences remain long after the experience ends. When prejudicial experiences are institutionalized and continue to affect the daily lives of our clients today, as reflected in the experience of many Black, Native American, and some Latino, Asian, and Middle Eastern clients, it is even more critical that clinicians assess the impact of such experiences on a given client, their connection to AOD problems, and their effect on the client–clinician relationship.

Circumstances of Migration and Immigration Status

The abuse of AOD has been long associated with loss, grief, and mourning (van Wormer, 1995). For many immigrants, the process of migration to a new country is connected to numerous losses: the loss of one's homeland, of friends and loved ones, of familiar food, sounds, and smells. Moreover, many immigrants, particularly refugees who escaped or who were expelled from their country of origin, have suffered trauma prior to or during their process of migration to the United States (Castex, 1997; Lu et al., 1995; Marsella, Friedman, & Spain, 1994). These dynamics need to be clearly understood if treatment is to be effective, because using alcohol and other drugs may be one way of self-medicating for posttraumatic stress disorder

or of numbing the pain of homesickness and loneliness (Westermeyer, 1993b).

In addition, clinicians need to be sensitive to the current antirefugee and anti-immigrant sentiment in the United States that may lead clients to increased feelings of alienation from the mainstream culture, thereby contributing to substance abuse, while at the same time making it more difficult to seek and obtain treatment. In many immigrant communities, fear of possible deportation leads to greater tolerance for pathological behavior both within the family and the community, so that the individual is often sheltered from the consequences of his or her drug use until it is out of control ("Abused Illegal," 1999).

Acculturation and Assimilation

As indicated previously, ethnocultural mores and norms regulate the behaviors of individuals, including the use and abuse of alcohol and other drugs. In general, the further removed in generation from the country of origin, the more assimilated one becomes to the mainstream or dominant culture. This dynamic and highly complex process is called "acculturation."

For many immigrants, the acculturation process is a very painful one. Adapting to a new cultural environment, different lifestyles, and a new language can lead to increased personal stress and interpersonal conflicts (Akhtar, 1995; Gaw, 1993; Lu et al., 1995; Sandhu, Portes, & McPhee, 1996). Difficulties with the process of acculturation and assimilation have been linked to the development of emotional and behavioral problems, including mental illness, delinquency, and substance abuse (Oetting & Beauvais, 1991; Rogler, Cortes, & Malgady, 1991). Moreover, because different generations and genders assimilate at different rates (Rotheram-Borus & Wyche, 1994), risk of AOD problems vary among different people in a family and in immigrant communities. According to researchers (Kim, McLeod, & Shantzis, 1992; Oetting & Beauvais, 1990), those at highest risk of AOD problems are individuals who lack connections to both their original culture and to the mainstream one and who have access to a substance. For example, Karin, a 38-year-old German-born woman who was isolated from both her family of origin and her German culture and at the same time disconnected from any supportive network in the United States, quickly slid from social drinking to alcohol dependence and pill abuse following her divorce from her American husband. A similar dynamic played a role in the abuse of drugs and gang membership for Da Wai (David), a 15-year-old U.S.-born adolescent whose parents fled from China

shortly before his birth. Disconnected from his parents' culture yet not assimilated to the adolescent culture in the United States, Da Wai feels closest to his gang peers, who form their own subculture with their own rituals, values, and norms.

Language

An important aspect of ethnocultural assessment is an exploration of the language or languages spoken by the client in childhood and the client's current level of verbal, comprehension, and writing proficiency in both English and the native language. In addition, many individuals, although fluent in English, may feel stigmatized by their foreign accent. Moreover, from an ethnocultural perspective, language refers not only to different spoken words but also to nonverbal communication such as physical gestures, distance between speakers, and eye contact (Lu et al., 1995). It also includes different usages and meanings of the same language by people of different ethnocultural and social class backgrounds. For example, the idioms and nonverbal modes of expression used among a group of substance-abusing Spanish-speaking Chicano former gang members may be as foreign to their upper-class, well-educated, Spanish-speaking Argentinean-born group therapist as to a non-Spanish-speaking clinician.

Moreover, it is through the use of language that experiences, memories, and perceptions are coded and organized (Buxbaum, 1949; Greenson, 1950; Perez Foster, 1996). Thus a French-born alcohol-dependent woman who was sexually abused during childhood by her father may be devoid of affect when talking in English about her early life experiences. For such a bilingual client, the second language can be used to intellectualize the emotional content—the emotional content can be recaptured only by shifting to the original language in which it was stored (Perez Foster, 1996). Although it is not possible to provide a bilingual clinician for every bilingual client, it is important that substance abuse clinicians have an understanding of the client's language dominance and the language used during the traumatic experience in order to understand their client's current reactions.

Although studies of native language speakers indicate "an almost complete breakdown in the transmission of non-English language between the second and third generations" of immigrants (Steinberg, 1981, p. 45), certain emotionally laden words continue to be transmitted from one generation to another and may play an important role in emotional communication about the use of substances. They can also be triggers for resumption of substance abuse. For example, Peter, the grandson of Swedish immi-

grants, vividly remembered certain Swedish words and sayings his bilingual alcoholic father used to put him down during his childhood. Although Peter never learned to speak Swedish, hearing these words while on a business trip was enough of a trigger for him to resume drinking after months of sobriety.

Educational Attainment

The level of educational attainment, both abroad and in the United States, provides important cues in assessment and in terms of appropriate interventions. An immigrant with a third-grade education in his native Ecuador will have a hard time following the literature given out in his treatment program, even though it may be in Spanish. On the other hand, the Croatian woman who works as an office cleaner may have been trained as a physician prior to her migration. A realistic assessment of her retraining potential and educational and professional opportunities may play a crucial role in her recovery from her alcohol abuse and coexisting depression.

Past and Current Socioeconomic Status

Although often related to level of education, clients' current socioeconomic status in comparison with their previous one is an important factor to assess. Such assessment not only offers important clues in the possible downhill progression due to substance abuse but is also a crucial factor in understanding immigrant clients who may have held high educational and economic status in their homelands but are reduced to poverty level or low-status positions in the United States. These are factors that may play a role in their substance abuse.

Unfortunately, "many cultural attributes commonly associated with ethnicity are not rooted in ethnicity as such, but are artifacts of social class" (Steinberg, 1981, p. 67). Consequently, the therapist must separate attitudes resulting from physical and environmental adversity from cultural or individual traits of the client (Sue & Sue, 1990). As pointed out by Orlandi (1992), "It is very important to distinguish between the culture of the underclass in our society . . . and the culture of the ethnic/racial subgroups. The experience of being poor in our society is different, for example, from that of being Hispanic, and these conditions must be further distinguished from the experience of being both poor *and* Hispanic" (p. 295).

Unemployment has been correlated with substance abuse, both among native and immigrant populations (NIDA, 1995), and lack of economic resources may interfere with accessing treatment resources or obtaining high-

level treatment. In addition, some individuals, particularly inner-city African American and Latino adolescents and young adults, may turn to selling and then using illicit substances as a form of compensation for the scarcity of opportunity to attain economic independence through traditional means (Johnson, Williams, Dei, & Sanabria, 1990).

Socioeconomic dynamics also affect many immigrants who may work long hours in menial jobs, supporting not only their immediate families but also their extended family members in their native countries (Kim, McLeod, & Shantzis, 1992). Their lack of time to monitor their children may play a role in the abuse of substances by their adolescent children.

Family Structure and Roles

An important aspect of ethnocultural assessment is understanding the client's family structure and role expectations and the relationship of substance abuse to these characteristics. As pointed out by Kim and colleagues (1992), "In families in which the parents do not speak English, children who do may be forced to accept certain adult responsibilities—e.g. spokesperson for the family. This is a clear role reversal for the father in his traditional role as the source of authority in the family" (p. 223). This is a particularly painful situation for those families, such as Asians and Latinos, whose culture emphasizes a clear hierarchy of family roles and respect for the older generations. Such role reversal can lead to a loss of respect of children for their parents, which in turn contributes to alienation of the children from their ethnic culture and to intergenerational conflict within the family (Kim et al., 1992; Lu et al., 1995)—all risk factors for substance abuse. It is also important to keep in mind the findings of Maddahian and colleagues (1988) that, compared with White, Hispanic, and Asian adolescent substance abusers, "the single salient high-risk factor for blacks . . . was poor relationship with family members" (p. 20).

Another factor is the cultural variation in child-rearing practices, including the use of physical force. For many families who migrated to provide a better life for their children, having children who are exhibiting academic, emotional, or substance abuse problems may be viewed as a personal failure on the part of the parents, leading to feelings of depression, helplessness, and rage against the child (McQuiston, 1996). Most clinicians are mandated to report cases of child abuse; however, it is also important to help parents understand cultural differences in child-rearing practices, as well as their own expectations of their children and the best ways of dealing with them.

Gender-Related Issues and Roles

Available data indicates that in most ethnic cultures men are more likely to use alcohol and other drugs than women but that substance abuse among women is more stigmatizing than for men (Rebach, 1992). However, such findings may be changing with the latest national data indicating that Hispanic Caribbean women are as likely as Caribbean men to use cocaine (SAMHSA, 1998, Table 4.6), whereas Native American women are even more likely than men to use alcohol, as well as illegal drugs (SAMHSA, 1998, Tables 4.3 and 4.4). The implications of these dynamics for a particular ethnic group and for society in general call for further research.

According to Coll (1992), "gender differences have been noted in the processes of migration, acculturation, and adaptation" (p. 7). Women have been found to see their ethnic identity as more important than do men; at the same time, however, they tend to acculturate more rapidly than men (Coll, 1992). Because the role of women in U.S. society often differs from that in more traditional and more patriarchal cultures, couple and familial conflicts may increase as immigrant women become acculturated to the U.S. norm and more independent of the men in their lives. Such change in familial dynamics can lead not only to the abuse of substances but also to an increase in domestic violence—an issue that must be explored during the assessment process.

Beliefs about homosexuality and about individuals with gender identity disorders are important dynamics among many ethnic groups. Although gays and lesbians are stigmatized in most ethnic cultures, in some cultures they are more likely to be ostracized than in others. Because recovery often requires acceptance of one's sexuality, the impact of open admission of such identity within one's ethnocultural group must be fully explored.

Coexisting Disorders

Not much is known regarding coexisting disorders and ethnocultural differences, particularly as they relate to both mental illness and substance abuse. As discussed previously, it is likely that many immigrants suffer from mood and anxiety disorders, as well as adjustment and posttraumatic stress disorders (Marsella et al., 1994; Westermeyer, 1993b). It also appears that, regardless of culture, the prevalence of psychopathology is higher among female substance abusers than among males, although research data are limited

(Robins & Regier, 1991). A culturally sensitive mental health assessment should be part of every substance abuse assessment.

Ethnoculturally Competent Intervention Approaches

The literature on specific ethnoculturally competent substance abuse treatment skills and techniques is limited. Most substance abusers who do enter treatment, regardless of their ethnic group, receive the same treatment approach. Given the possible difference in treatment expectations among various ethnocultural groups, the clinician should carefully describe the rationale for recommending a particular treatment approach and its goals. Providing clients with or helping them share positive information about their ethnic history, cultural values, traditions, and contributions enhances their self-worth and potential for recovery (see Gilbert & Langrod, Chapter 12, this volume; Gordon, 1994). Moreover, helping clients connect to recovering peers from the same ethnocultural group can provide essential role models and support.

As indicated previously, some ethnic groups, particularly those among the newer immigrant groups, may be unfamiliar with the disease model of addiction that is commonly used in many treatment settings. There are two different approaches in dealing with this issue. One is to help clients and their family members become more familiar with the disease model, thereby helping them better utilize the treatment process and at the same time removing some of the stigma of having an AOD problem (Straussner, 1993). Such an approach is best done by using a psychoeducational didactic model of group lecture or on a more private basis during individual or family sessions. Depending on the literacy level of the client and his or her family members and on the availability of literature in the native language, providing take-home literature is usually helpful.

A different approach is based more on the harm-reduction model, which emphasizes limiting the negative consequences of substance use while at the same time utilizing more ethnoculturally congruent treatment approaches. Such treatment methods may include using culturally appropriate case management to help the client and family meet their basic needs before addressing the substance abuse (see Bromley & Sip, Chapter 16, this volume); focusing on medical problems associated with AOD abuse and working together with medical personnel to address the impact of AOD on the body (see Matsuyoshi, Chapter 19, this volume); and/or recruiting native healers or religious, cultural, and community leaders to provide support and address specific life issues affecting the individual

and his or her family (see Weaver, Chapter 4, and Medina, Chapter 7, this volume).

Whether one or a combination of the two approaches may be best for a given individual is highly variable. It depends on the client's entry point into the treatment system, on the client's openness to address AOD problems directly, on the availability of specific ethnic and general community resources, and on specific agency philosophy.

It is important to note that the use of family and group confrontation—a common treatment approach in many settings—may not be effective for those ethnic groups, such as Asians or Native Americans, for whom confrontation is not a culturally common method of communication (Amodeo et al., 1996). Moreover, individual counseling or the use of more ethnically homogeneous treatment groups may be a better treatment approach for some populations, such as Hispanics (Booth, Castro, & Anglin, 1990; Prendergast, Hser, & Gil-Rivas, 1998), than for others.

Studies of family rituals point out their preventative and therapeutic functions in substance abuse problems (Bennett, Wolin, & Reiss, 1988). Therefore, identifying and restoring ethnoculturally appropriate rituals may play an important role in treatment (Harvey & Rauch, 1997; Weaver, Chapter 4, this volume). Connecting or reconnecting to religious and ethnic holiday celebrations while also adapting new rituals, such as anniversary celebrations in 12-step programs, may provide important linkages between past and present cultures. However, for many individuals whose cultural values emphasize the family more than the individual, traditional 12-step programs may be less beneficial than other treatments, such as cognitive behavioral approaches or support groups that include the family or other significant individuals (Draguns, 1995).

Use of interpreters is often a necessary but a complicating factor. Family members, especially children, are usually not appropriate or reliable interpreters. Moreover, even when using a trained interpreter, it is not uncommon to find biases, distortions, and limitations in such communications (Amodeo et al., 1996; Westermeyer, 1990).

Intervention with Women

Given the previously discussed greater stigma regarding substance-abusing women, clinicians need to pay attention to the special issues that bear on women of diverse ethnocultural groups. Depending on ethnic culture and immigration status, women may find themselves with fewer support systems than men, more endangered in terms of losing their children, and more trapped in destructive lifestyles and relationships (for a fuller discus-

sion of women's issues, see Straussner & Zelvin, 1997). Concrete needs such as housing, child care, or vocational training have to be addressed. The possibility for special outreach to, or protection from, the men in their lives must be an important consideration during the treatment process of women; at the same time clinicians must be cognizant of any ethnocultural conflicts that this consideration may cause the client.

ETHNOCULTURAL ISSUES IN CLIENT–WORKER INTERACTIONS

A crucial issue in offering ethnoculturally competent services is the question of matching the ethnocultural characteristics of the staff with those of the clients (Sue, 1998). Clinicians bring their own cultural assumptions, both conscious and unconscious, into the treatment arena (Perez Foster, 1998). The difficulties in working with clients of different cultural groups from the clinician was recognized as early as 1918 by Freud in his classic case of the Russian "Wolf Man," when he noted that not only the "personal peculiarities" in the patient but also "a national character different from ours made the task of feeling one's way into his mind a laborious one" (1918/1955, p. 7). More recently, in an exploratory study of seven prevention and treatment programs for childbearing and pregnant substance-abusing women, Kirk and Amaranth (1998) found that staff that reflected the client's culture, race, socioeconomic level, and community:

> provided a much needed role model for a population that was poor, undereducated, unemployed and the target of racism and sexism . . . staff who were immediately recognizable as a member of the client's own race or culture had a much easier time and were more successful in engaging and retaining the clients. . . . The agencies contended that staff who did not share the cultural heritage of the participants could be effective, but that the engagement process with the program participants would be longer. (p. 263)

Based on such findings, confirmed by my own supervisory work with a wide variety of clinicians, it becomes crucial that those working with clients who are unlike themselves become aware that they may need to work harder and longer to engage these clients in treatment.

Moreover, staff members may act out what has been termed as "cultural countertransference" (Perez Foster, 1998; Westermeyer, 1993a), communicating their ethnic prejudice to their clients, thereby undermining treatment. Furthermore, "politically correct" clinicians may be afraid to explore the interrelationships between their own ethnocultural values

and those of the clients, thereby driving "away those clients who we do not want to treat, covertly betraying and deftly blaming the patient for their lack of 'suitability' to the treatment process" (Perez Foster, 1999, p. 18). For example, a White clinician may be afraid of confronting a Black client for fear of being called a racist, at the same time blaming the client for denying the impact of his or her substance abuse problems on his or her life.

Although clinicians who are themselves from the same ethnocultural background as their clients may find it easier to initially connect with their clients, it does not mean that they may not have their own negative countertransferential reactions and prejudices toward their clients that result from internalized shame of or discomfort with their own ethnocultural background. At the same time, it is important to realize that clients may have their own prejudices and transferential reactions toward the ethnocultural background of the staff, as well as toward other clients. Thus it is crucial that the power and impact of ethnicity and culture be recognized in every treatment encounter.

CONCLUSION

The provision of ethnoculturally competent substance abuse services is no longer an option but a necessity. As pointed out in this chapter and as elaborated on in the chapters that follow, different ethnocultural groups have different experiences and values and different worldviews. Much research needs to be done on substance abuse among specific ethnocultural populations, not just global ethnic and racial categories: We need to know more about what specific treatment and prevention efforts are most effective for different ethnocultural groups, how to engage diverse clients in treatment, and what is the best way to educate staff to be ethnoculturally competent.

In the meantime, clinicians must learn to walk the fine line between ethnocultural awareness and stereotyping of individual clients and groups. They must be careful to assess each individual client, determining the client's views regarding his or her ethnocultural background and current identification and the connection of the substance abuse problem to the client's ethnicity and culture, and must utilize appropriate ethnoculturally competent intervention skills. Most of all, they must remain aware of their own feelings and reactions to their own and their clients' ethnic and cultural backgrounds and make sure that their agencies and communities recognize and value the wonderful diversity of the "ethnocultural salad" that comprises the population of the United States—and our clients—today.

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