

A TREATMENT IMPROVEMENT PROTOCOL

Improving Cultural Competence

TIP 59



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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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What Is a TIP?

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

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

Foreword

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

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

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

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Executive Summary

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

This Treatment Improvement Protocol (TIP) uses Sue’s (2001) multidimensional model for developing cultural competence. Adapted to address cultural competence across behavioral health settings, this model serves as a framework for targeting three organizational levels of treatment: individual counselor and staff, clinical and programmatic, and organizational and administrative. The chapters target specific racial, ethnic, and cultural considerations along with the core elements of cultural competence highlighted in the model. These core elements include cultural awareness, general cultural knowledge, cultural knowledge of behavioral health, and cultural skill development. The primary objective of this TIP is to

assist readers in understanding the role of culture in the delivery of behavioral health services (both generally and with reference to specific cultural groups). This TIP is organized into six chapters and begins with an introduction to cultural competence. The following subheadings provide a summary of each chapter and an overview of this publication.

Introduction to Cultural Competence

Why is the development of cultural competence and culturally responsive services important in the behavioral health field?

Culturally responsive skills can improve client engagement in services, therapeutic relationships between clients and providers, and treatment retention and outcomes. Cultural competence is an essential ingredient in decreasing disparities in behavioral health.

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

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

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

What is culture? Culture is the conceptual system developed by a community or society to structure the way people view the world. It involves a particular set of beliefs, norms, and values that influence ideas about relationships, how people live their lives, and the way people

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

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

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

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

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

- An understanding of race, ethnicity, and culture (including one's own) is necessary to appreciate the diversity of human dynamics and to treat clients effectively.
- Incorporating cultural competence into treatment improves therapeutic decisionmaking and offers alternative ways to define and plan a treatment program firmly directed toward progress and recovery.
- Organizational commitment to supporting culturally responsive treatment services,

including adequate allocation of resources, reinforces the importance of sustaining cultural competence in counselors and other clinical staff.

- Advocating culturally responsive practices increases trust within the community, agency, and staff.
- Achieving cultural competence requires the participation of racially and ethnically diverse groups and underserved populations in the development and implementation of treatment approaches and training activities.
- Consideration of culture is important at all levels of operation and in all stages of treatment and recovery.

Core Competencies for Counselors and Other Clinical Staff

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

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

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

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

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

Culturally Responsive Evaluation and Treatment Planning

The role of culture should be considered during initial intakes and interviews, in screening and assessment processes, and in the development of treatment planning. Culturally responsive treatment can only occur when the making of clinical and programmatic decisions includes culturally relevant information and practices and is endorsed and supported by clinical staff, clinical supervisors, and the

organization as a whole. Chapter 3 presents culturally responsive evaluation and treatment planning as a series of nine steps.

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

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

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

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

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

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

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

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

Step 8: Provide culturally responsive case management. Many core competencies for counselors are also relevant to case managers.

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

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

Pursuing Organizational Cultural Competence

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

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

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

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

policies and procedures, will enable counselors to respond more consistently to clients in a culturally competent manner.

Behavioral Health Treatment for Major Racial and Ethnic Groups

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

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

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

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

Drug Cultures and the Culture of Recovery

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

Understanding the role that drug cultures play in clients' lives is particularly important because these cultures, more than any other cultural connections, influence clients' substance use or abuse and the behaviors in which they engage to manage mental disorders. Through drug cultures, people new to using

learn to experience “getting high” as a pleasurable activity; they also learn the skills needed to procure and use drugs effectively and to avoid the pitfalls of the drug-using lifestyle (e.g., getting arrested, running out of money to buy drugs). Perhaps most importantly, the person who uses gains acceptance from a group of peers even as mainstream society increasingly discriminates against him or her because of his or her substance use or mental illness. Prejudice from mainstream society may make ties with the drug culture even stronger; he or she may feel as if there is no other place to turn for social and cultural support.

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

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

1 Introduction to Cultural Competence

IN THIS CHAPTER

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

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

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

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

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

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

Purpose and Objectives of the TIP

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

support allows counselors, case managers, and administrators to begin to integrate culturally congruent and responsive services more consistently across the continuum of care—including outreach and early intervention, assessment, treatment planning and intervention, and recovery services.

The key objectives of this TIP are helping readers understand:

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

Intended Audience

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

Structure of the TIP

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

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

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

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

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

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

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

Terminology

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

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

Core Assumptions

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

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

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

importance of cultural competence in the delivery of effective behavioral health services.

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

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

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

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

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

What Is Cultural Competence?

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

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

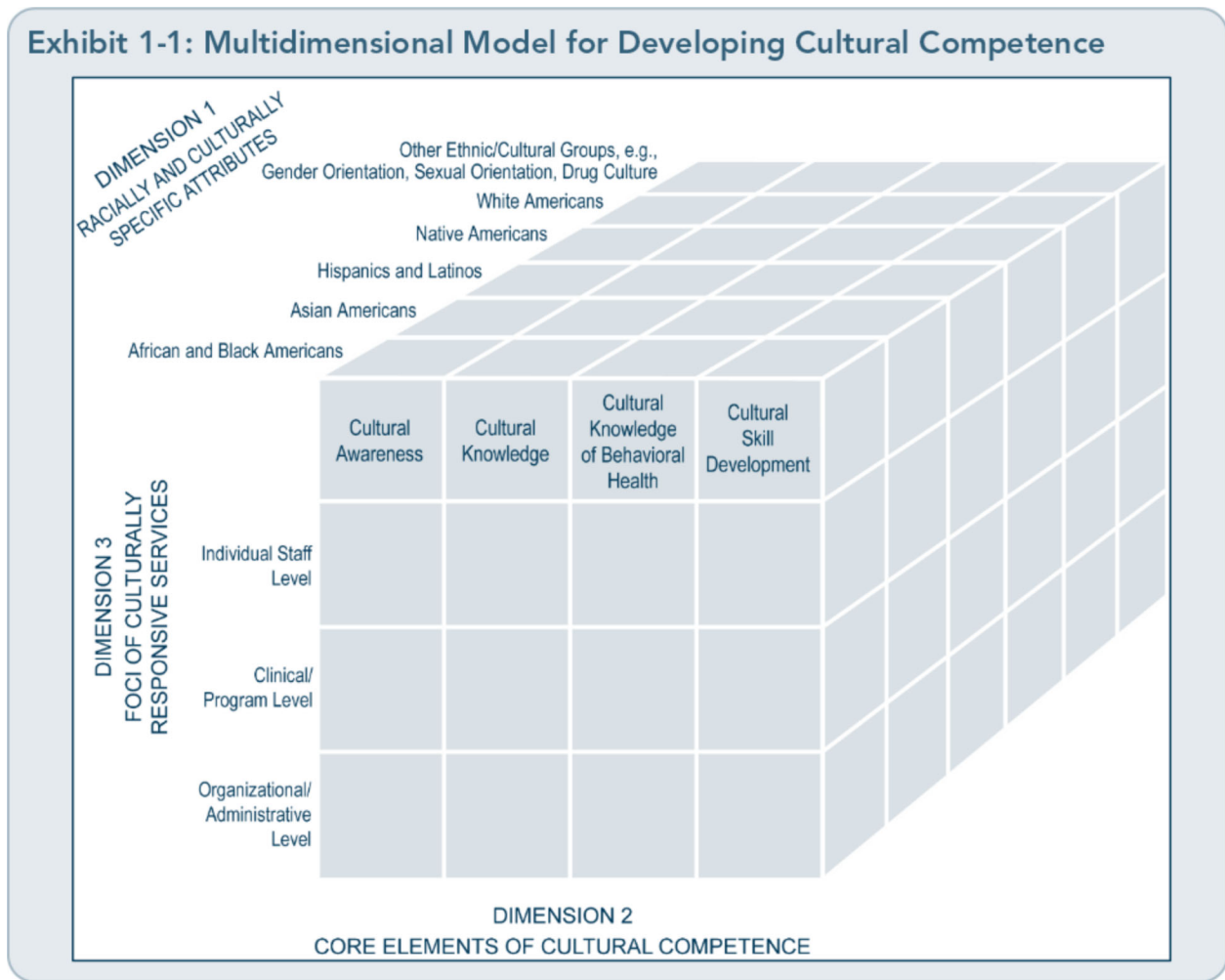
Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or

among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (p. 28)

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

Dimension 1: Racially and Culturally Specific Attributes

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



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

Dimension 2: Core Elements of Cultural Competence

This dimension includes cultural awareness, cultural knowledge, and cultural skill development. To provide culturally responsive treatment services, counselors, other clinical staff, and organizations need to become aware of their own attitudes, beliefs, biases, and assumptions about others. Providers need to invest in gaining cultural knowledge of the populations that they serve and obtaining specific cultural knowledge as it relates to help-seeking, treatment, and recovery. This dimension also involves competence in clinical

skills that ensure delivery of culturally appropriate treatment interventions. Several chapters capture the ingredients of this dimension. Chapter 1 provides an overview of cultural competence and concepts, Chapter 2 provides an indepth look at the role and effects of the counselor’s cultural awareness and identity within the counseling process, Chapter 3 provides an overview of cultural considerations and essential clinical skills in the assessment and treatment planning process, and Chapter 5 specifically addresses the role of culture across specific treatment interventions.

Dimension 3: Foci of Culturally Responsive Services

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

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

Why Is Cultural Competence Important?

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

ing translation and interpreter services. For clients, culturally responsive services honor the beliefs that culture is embedded in the clients' language and their implicit and explicit communication styles and that language-accommodating services can have a positive effect on clients' responses to treatment and subsequent engagement in recovery services.

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

Additionally, adopting and integrating culturally responsive policies and practices into

What Are Health Disparities?

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

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

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

Organizational investment in improving cultural competence and increasing culturally responsive services will likely increase use and cost effectiveness because services are more appropriately matched to clients from the beginning. A key principle in culturally responsive practices is engagement of the community, clients, and staff. As organizations

establish community involvement in the ongoing implementation of culturally responsive services, the community will be more aware of available treatment services and thus will become more likely to use them as its involvement with and trust for the organization grows. Likewise, clients and staff are more apt to be empowered and invested if they are involved in the ongoing development and delivery of culturally responsive services. Client and staff satisfaction can increase if organizations provide culturally congruent treatment services and clinical supervision.

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

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

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

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

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

How Is Cultural Competence Achieved?

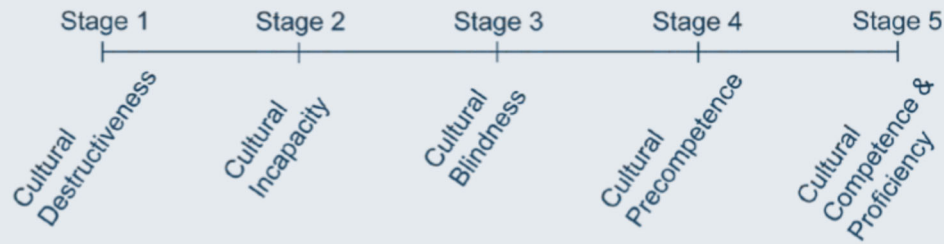
Cultural groups are diverse and continuously evolving, defying precise definitions. Cultural competence is not acquired merely by learning a given set of facts about specific populations,

changing an organization's mission statement, or attending a training on cultural competence. Becoming culturally competent is a developmental process that begins with awareness and commitment and evolves into skill building and culturally responsive behavior within organizations and among providers.

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

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

Exhibit 1-2: The Continuum of Cultural Competence



Stage 1: Cultural Destructiveness

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

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

Stage 2: Cultural Incapacity

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

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

Stage 3: Cultural Blindness

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

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

(Continued on the next page.)

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

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

Stage 4: Cultural Precompetence

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

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

Stage 5: Cultural Competence and Proficiency

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

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

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

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

What Is Culture?

Culture is defined by a community or society. It structures the way people view the world. It involves the particular set of beliefs, norms,

and values concerning the nature of relationships, the way people live their lives, and the way people organize their environments. Culture is a complex and rich concept. Understanding it requires a willingness to examine and grasp its many elements and to comprehend how they come together. Castro (1998) identified the elements generally agreed to constitute a culture as:

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

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

Although these criteria cannot be strictly applied to every cultural group, they do sufficiently define cultures so that groups are distinguishable to their members and to others (Castro 1998). Note that these criteria apply

more or less equally well to cultural groups based on nationality, ethnicity, region (e.g., Southern, Midwestern), profession, and social interests (Exhibit 1-3 reviews common characteristics of culture).

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

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

Exhibit 1-3: Common Characteristics of Culture

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

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

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

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

What Is Race?

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

Although it lacks a genetic basis, the concept of race is important in discussing cultural competence. Race is a social construct that describes people with shared physical characteristics. It can have tremendous social significance in terms of behavioral health services, social opportunities, status, wealth, and so on. The perception that people who share physical characteristics also share beliefs, values, attitudes, and ways of being can have a profound impact on people's lives regardless of whether they identify with the race to which they are ascribed by themselves or others. The major racial groupings designated by the U.S. Census Bureau—African American or Black, White American or Caucasian, Asian American,

American Indian/Alaska Native, and Native Hawaiian/Pacific Islander—are limiting in that they are categories developed to describe identifiable populations that exist currently within the United States. The U.S. Census defines Hispanics/Latinos as an ethnic group rather than a racial group (see the "What Is Ethnicity?" section later in this chapter).

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

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

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

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

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

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

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

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

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

What Is Ethnicity?

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

Because Latinos can belong to a number of races, the Census Bureau defines them as an ethnic group rather than a race. In 2010, Latinos comprised 16 percent of the United States population (Ennis et al. 2011). They are the fastest growing ethnic group in the United States; between 2000 and 2010, the number of Latinos in the country increased 43 percent, a rate nearly four times higher than that for the total population (Ennis et al. 2011). By 2050, Latinos are expected to make up 29 percent of the total population (Passel and Cohn 2008). Nearly 60 percent of Latino Americans were born in the United States, but Latinos also account for more than half of the nation’s

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

foreign-born population (Larsen 2004; Ramirez and de la Cruz 2003). Foreign-born Latinos include legal immigrants, some of whom have succeeded in becoming naturalized American citizens, as well as undocumented or illegal immigrants to the United States. Approximately three-quarters (74 percent) of the Nation’s unauthorized immigrant population are Hispanics, mostly from Mexico (Passel and Cohn 2008).

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

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

What Is Cultural Identity?

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

Some of the factors that are likely to vary among members of the same culture include socioeconomic status, geographic location, gender, education level, occupational status, sexuality, and political and religious affiliation. For individuals whose families are highly acculturated, some of these characteristics (e.g., geographic location, occupation, religion)

can be more important than ethnic culture in defining their sense of identity. The section that follows provides more detailed information on the most important cross-cutting factors involved in the creation of a person's cultural identity.

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

Language and Communication

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

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

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

A behavioral health service provider who listens only to the literal meaning of words can miss clients' actual messages. What is left unsaid, or the way in which something is said, can be more important than the words used to convey the message. African Americans have a relatively high-context culture compared with White Americans but a somewhat lower-context culture compared with Asian

Americans (Franks 2000). Thus, African Americans typically rely to a greater degree than White Americans on nonverbal cues in communicating. Conversely, White American culture is low context (as are some European cultural groups, such as German and British); communication is expected to be explicit, and formal information is conveyed primarily through the literal content of spoken or written messages.

Geographic Location

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

Advice to Counselors: Cultural Differences in Communication

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

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

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

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

In addition to its potential influence upon culture, geography can strongly affect substance use and abuse, mental health and well-being, and access to and use of health services (Baicker et al. 2005). In the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2012 National Survey on Drug Use and Health (NSDUH), past-month illicit drug use rates among individuals ages 12 and older were 9.9 percent in large metropolitan areas, 8.3 percent in nonmetropolitan urbanized areas, 5.9 percent in less urbanized nonmetropolitan areas, and 4.8 percent in rural areas (SAMHSA 2013*d*). In very rural or remote areas, illicit drug use is likely to be even less common than in rural areas

(Schoeneberger et al. 2006). Even among members of the same culture, less substance use is observed in those who live in more rural regions. For example, O'Connell and associates (2005) found that alcohol consumption was lower for American Indians living on reservations than for those who were geographically dispersed (and typically living in urban areas). Likewise, individuals born or living in urban areas may be at greater risk for serious mental illness. In one systematic study, higher distribution rates of schizophrenia were found in urban areas, particularly among people who were born in metropolitan areas (McGrath et al. 2004).

Worldview, Values, and Traditions

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

knowledge about clients' cultural beliefs and practices.

Family and Kinship

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

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

therapy appear in TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004b).

Gender Roles

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

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

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

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

Negotiating gender roles in a treatment setting is often difficult; providers should not assume that a client's traditional culture-based gender roles are best for him or her or that mainstream American ideas about gender are most appropriate. The client's degree of acculturation and adherence to traditional values must be taken into consideration and respected. Two TIPs explore the relationship of gender to substance abuse and substance abuse treatment: TIP 51, *Substance Abuse*

Treatment: Addressing the Specific Needs of Women (CSAT 2009c), and TIP 56, *Addressing the Specific Behavioral Health Needs of Men* (SAMHSA 2013a). TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders*, addresses the relationships among gender, mental illness, and substance use disorders (CSAT 2005d).

Socioeconomic Status and Education

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

What Causes Health Disparities?

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

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

Social Determinants of Health

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

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

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

Studies have had conflicting results as to whether people with high or low SES are more likely to abuse substances (Jones-Webb et al. 1995). In international studies, increases in wealth on a societal level have been associated with increases in alcohol consumption (Bergmark and Kuendig 2008; Kuntsche et al.

2006; Room et al. 2003). However, other factors, such as the availability of social support systems and education, as well as the individual’s acculturation level, can also play a role. Karriker-Jaffe and Zemore (2009) found that, in immigrants, a greater level of acculturation was associated with increased heavy drinking for those with above-average SES but not for those with lower SES. Besides lower socioeconomic status, neighborhood poverty (defined as having a high [≥ 20 percent] proportion of residents living in poverty) was associated with binge drinking and higher rates of substance-related problems, particularly for men (McKinney et al. 2012).

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

Exhibit 1-4: Education and Culture

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

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

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

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

Immigration and Migration

With the exception of American Indians, Alaska Natives, Native Hawaiians, and other Pacific Islanders, the United States is a country of immigrants. Recent immigrants, even

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

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

The Cultural Orientation Resource Center

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

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

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

For immigrant families, disruption of roles and norms often occurs upon arrival in the United States (for review, see Falicov 2012). Generally, youth adopt American customs, values, and behaviors much more easily and at

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

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

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

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

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

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

Acculturation and Cultural Identification

Many factors contribute to an individual's cultural identity, and that identity is not a static attribute. There are many forces at work that pressure a person to alter his or her cultural identity to conform to the mainstream culture's concept of a "proper" identity.

As a result, people may feel conflicted about their identities—wanting to fit in with the mainstream culture while also wanting to retain the values of their culture of origin. For clients, sorting through these conflicting cultural expectations and forging a comfortable identity can be an important part of the recovery process. Some of the more commonly used terms related to cultural identity are defined in Exhibit 1-5.

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

Exhibit 1-5: Cultural Identification and Cultural Change Terminology

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

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

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

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

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

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

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

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

Many studies have found that increased acculturation or factors related to acculturation are associated with increased alcohol and drug use

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

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

Exhibit 1-6: Five Levels of Acculturation

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

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

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

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

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

Other factors that can contribute to increased substance use among more acculturated clients include changes in traditional gender roles, exposure to socially and physically challenging inner-city environments (Amaro and Aguiar 1995), and employment outside the home (often a role-transforming change that can contribute to increased risk of alcohol dependence). Although much of the research has focused on the relationship of acculturation to male substance use/abuse patterns, women can be even more affected by acculturation. Multiple studies using international samples have found that the greater the amount of gender

equality in a society, the more similar alcohol consumption patterns are for men and women (Bloomfield et al. 2006). Many immigrants to the United States (where gender equality is relatively strong) come from societies with less gender equality and thus with greater prohibitions against alcohol use for women.

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

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

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

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

Overall, acculturation and cultural identification have tremendous implications for behavioral health services. Research has shown an association between low levels of acculturation and low usage rates of mainstream healthcare services. Individuals can feel conflicted about their identities—wanting to both fit in with

the mainstream culture and retain the traditions and beliefs of their cultures of origin. For such clients, sorting through these conflicting cultural expectations and forging a comfortable identity can be an important part of the recovery process. Familiarity with cultural identity formation models and theories of acculturation (including acculturation measurement methods; see Exhibit 1-7) can help behavioral health workers provide services with greater flexibility and sensitivity (see Appendix B for instruments that measure aspects of cultural identity and acculturation).

Heritage and History

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

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

Exhibit 1-7: Measuring Acculturation

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

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

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

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

review in Williams and Williams-Morris 2000).

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

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

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

Sexuality

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

For individuals from various ethnic/racial groups in United States, having a sexual identity different from the norm can result in increased substance use/abuse, in part because of increased stress. Additionally, alcohol and drug use can be more acceptable within some segments of gay/lesbian/bisexual cultures (Balsam et al. 2004; CSAT 2001; Mays et al.

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

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

Perspectives on Health, Illness, and Healing

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

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

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

With respect to mental health, providers should be aware that any mental disorder or symptom is only considered a disorder or problem by comparison with a socially defined norm. For instance, in some societies, someone who hears voices can be considered to have greater access to the spirit world and to be blessed in some way. Furthermore, there are mental disorders that only present in a specific cultural group or locality; these are called cultural concepts of distress. Appendix E

describes cultural concepts of distress recognized by the DSM-5. Other specific examples of cultural differences relating to the use of health care and alternative approaches to medical diagnosis and treatment are also presented in Chapter 5.

Religion and Spirituality

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

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

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

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

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

Christianity

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

Judaism

Judaism is the second most common religion in the United States (1.2 percent of the population as of 2008; Kosmin and Keysar 2009). Most Jews believe that they share a common ancient background. However, the population

has dispersed over time and now exists in various geographic regions. The majority of Jews in the United States would be considered White, but Ethiopian Jews (the Beta Israel) and members of other African-Jewish communities would likely be seen as African Americans; the Jewish community from India (Bene Israel), as Asian Americans; and Jews who immigrated to the United States from Latin America, as Latinos. In 2001, approximately 5 percent of people who identified as adherents to Judaism (the religion, as opposed to people who identify as culturally Jewish) were Latinos, and approximately 1 percent were African Americans (Kosmin et al. 2001).

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

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

Islam

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

Attitudes of Muslims toward mental illness and seeking formal mental health services are likely to be affected by cultural and religious beliefs about mental health problems, knowledge and familiarity with formal services, perceived societal prejudice, and the use of informal indigenous resources (Aloud 2004). Attitudes toward substance use, abuse, and treatment will likely be shaped by Islam's prohibition of the use of alcohol and other intoxicants. Many Muslim countries have harsh penalties for the use of alcohol and other drugs. For these reasons, Muslims

appear to have low rates of substance use disorders. Despite there being no current data regarding levels of alcohol and other substance use among Muslim immigrants in the United States, Cochrane and Bal (1990) found that, in a comparison of Sikh, Hindu, Muslim, and White (probably Christian) men in a British community, Muslims by far drank the least, yet those Muslims who consumed the most alcohol experienced a greater number of alcohol-related problems on average. High levels of alcohol consumption among Muslims who do drink could be related to feelings of guilt and shame about their behavior, thus potentially leading to further abuse and avoidance of seeking substance abuse treatment when problems arise (Abudabbeh and Hamid 2001).

Buddhism

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

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

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

As You Proceed

This chapter has established the foundation and rationale of this TIP; reviewed the core concepts, models, and terminology of cultural competence; and provided an overview of factors that are common among diverse racial, ethnic, and cultural groups. As you proceed, be aware that diversity occurs not only across racially and ethnically diverse groups, but

within each group as well—there are cultures within cultures. Clinicians and organizations need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client, as outlined earlier in this chapter in the “What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture?” section. As you read this TIP, remember that many cross-cutting factors influence the counselor–client relationship, the client’s presentation and identification of problems, the selection and interpretation of screening and assessment tools, the client’s responsiveness to specific clinical services, and the effectiveness of program delivery and organizational structure and planning.

2 Core Competencies for Counselors and Other Clinical Staff

IN THIS CHAPTER

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

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

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

Appendix A—Bibliography

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