addressing cultural aspects of alcohol and drug addiction has been an important, controversial, and somewhat polarizing subject on both sides of the Atlantic. There is little debate that culture affects both who becomes chemically dependent and who is successful at recovery. The real question is how and to what extent culture impacts addiction and, more importantly, how should programs be modified to reflect these concerns.

It appears that ethnic groups and cultures that have established clear rules, norms, and standards regarding alcohol/drug use and abuse tend to have lower rates of addiction. Cultural groups as diverse as Orthodox Jews today and Native Americans 200 years ago both are associated with low rates of chemical abuse. There appears to be a direct connection between their low rates of abuse and their clear cultural norms in the following areas:

1. They identified which chemicals were legitimate to use (wine and organic hallucinogens, respectively).
2. They identified a clear context for chemical use (primarily religious or medicinal).
3. They established methods to communicate chemical use and abuse rules (family, religious institutions).
4. They established a clear cultural system of accountability (which often ostracized group members who disregarded the established rules).

The above stated norms can be contrasted with the “anything goes” mindset in many of our communities today.

A second concern is to what degree does cultural influence when an individual is receptive to treatment. In the U.S., individuals of color tend to access treatment much later in the progression of the illness than their white counterparts. Whites often access treatment from family members, friends, employers, doctors, or via schools. Individuals of color tend to disproportionately access treatment from the courts. Individuals of any race who are caught up in the criminal justice system are less likely to live in intact stable families, have a job, or be literate. The prognosis for treatment success in multi-problem individuals is clearly diminished. The task at hand is often one of “habilitation” (which historically has been a cultural process undertaken by families, religious organizations, and other mediating institutions) rather than rehabilitation, which is a clinical process based on an individual having a core set of values.

One truism I learned as a frontline counselor is that clients change in direct proportion to their ability to withstand emotional pain. The implications of my observation are significant for multi-problem individuals.

For instance, if a person’s environment is chaotic and full of questionable behavior by family members and friends, they are more likely to “normalize” dysfunctional behavior and develop an accompanying higher tolerance of emotional pain. If the tolerance of pain is high, a situation must often become more dysfunctional before an individual is receptive to treatment. This is common when a higher tolerance of emotional pain is coupled with unclear cultural rules.

Family members and friends are not able to recognize addiction until very late in the progression of the illness. While this situation is not uniquely tied to low-income communities of color, it disproportionately exists there. One of the most important services we need to develop in the chemical dependency field is the ability to diagnose and intervene in the lives of multi-problem individuals and families earlier. This type of service will do more to improve treatment outcomes for low-income minority clients than virtually any programs or services we can provide. The third area of interest is culture’s role in cross-cultural counseling. There are a number of issues here that need to be explored.

The first is the fact that many whites don’t have a clear racial identity. As a result, it is often difficult for them to facilitate a person of color to look at issues of race in their recovery. The saying that you “can’t facilitate growth past your own” applies to this situation.

Another cross-cultural clinical issue is perhaps best illustrated by a personal experience I had in my recovery. When I went through treatment in 1974, I sensed that many of the white counselors had a disproportionate interest in my getting sober - in order to reinforce their own self image as an open, tolerant, and liberal person. It seemed that my recovery would serve as a validation of their ability to work across racial and cultural lines. In effect, it would become a cultural badge of honor for them. This situation is similar when many whites first meet a person of color and feel the need to share all the contacts they have had with minorities as a way to demonstrate their openness to different cultures. Unfortunately, a person of color can use this dynamic in a manipulative way. In reality, a form of “cultural seduction” often develops where the client has a measure of control or influence over their counselor’s self-perception.

Other issues for individuals of color in treatment are a constellation of concerns I call “cultural pain.” These issues range from racial self-hate to the color caste system that still exists for many individuals of color. One major issue for a person of color to address as a part of his/her recovery pertains to discovering what it means to be authentic and loyal in a racial/ethnic context. This has significant and painful implications ranging from selecting a dating and marriage partner, to location of housing, selection of a religious institution, style of clothing, speech patterns, etc.

To illustrate this point, a number of years ago I developed an integration continuum. On one end of the continuum was separation, with both positive and negative issues that are often associated with that position.

On the other end of the continuum was assimilation, also with a list of positive and negative associations, and in the middle was integration. I would ask clients to place themselves, their parents, siblings, friends, and lovers on the continuum. Overwhelmingly, clients would remark that where a person was at on the continuum would have a significant impact on their views and interactions with individuals who were at a different place. Clients often felt that this had a profound and fundamental influence on how their families functioned. Helping professionals need to realize that there are as many differences within racial and ethnic groups as there are between groups. While these issues can be very painful for clients, they rarely, if ever, surfaced in a counseling context. In reality, it may be easier for a woman to talk about incest in many treatment centers than for a person of color to talk about racial self-hate or how the worldwide “White standard of beauty” affects their self-perception. Many white therapists are either unaware that these issues exist or feel inadequate to address them. Clients of color, like all clients, tend to resist or minimize their most painful issues, which often have to do with racial identity. As a result, a cultural conspiracy of silence develops. These cultural secrets can significantly undermine a client’s recovery.

A final clinical issue worth noting is what I term cultural boundaries. Everyone has both physical and emotional boundaries. If you are overweight you may not like fat jokes, or be sensitive to people watching you eat. If you are Jewish, you may feel awkward in discussing issues pertaining to money. For individuals of color, “cultural boundaries” are often issues that are tied to many of the stereotypes we face. For example, I often heard clients of color express discomfort with subjects like crime, basketball, dancing, or sun tanning. Learning how to address cultural boundary violations in a mature, non-defensive manner is a major racial identity recovery task.
All of my above stated concerns have to be balanced with the reality that clients will often use legitimate issues and feelings pertaining to racism, bias and prejudice, and reposition them as excuses for dysfunctional behavior. One of the biggest challenges for a therapist is to determine when he/she should accept a cultural rationale for a behavior and when they should challenge that rationale and label it as an excuse. The treatment of Islamic women in the West, female circumcision, or different menstrual practices as examples, requires that therapists confront a client to challenge it from a different perspective.

I have long felt that a balanced and nuanced approach was needed in addressing cultural issues. The image that comes to mind is a thin line between two polarities. On one side of the line is the historic position that the CD field has taken, which is that an alcoholic is an alcoholic and “difference” is simply a euphemism for excuse. On the other side of the line is a need to respond to differences in a way that allows a client to justify any behavior as deeply imbedded in their culture thereby immunizing it from challenge.

Striking the appropriate balance that allows and recognizes legitimate differences, but does not allow those differences to be used as excuses is the goal. This approach will encourage a counselor to explore with a client when a cultural norm should be respected and honored, and when acculturation is more appropriate. It also allows cultural issues to be on an equal level with issues of gender, sexual orientation, class, age, disability, etc.

Finally, clients and counselors must work towards acknowledging, honoring and even “celebrating our differences.” They should do so, however, in a context that reinforces our more numerous similarities and common humanity.

Most recently, Peter Bell was Executive Vice President of Publishing & Educational Services at the Hazelden Foundation in Center City, Minnesota. Prior to his position with Hazelden, he was co-founder and, for 15 years, executive director of the Institute on Black Chemical Abuse. He can be reached via e-mail at pbell51@hotmail.com.

Addiction and Recovery in Native America: Lost History, Enduring Lessons By Don Coyhis and William L. White, MA. Published by North-east Addiction Technology Transfer Center 2005

The persistence and revival of indigenous American healing is due, not to a lack of modern treatment services, but to a need for culture-congruent and holistic therapeutic approaches. ... - Dr. W. Jilek

Hear me, not for myself, but for my people. ... Hear me that they may hear me and not for my sake alone. Hear me for the sake of my people. ... - Dr. W. Jilek

The dawn of the 21st century marks a time of great cultural renewal and individual and collective healing among the Native peoples of North America. The growing sobriety movement in Indian Country represents just one dimension of this larger process of personal and tribal revitalization.

The authors have collaborated for some time on researching the history of addiction and recovery among the indigenous peoples of North America. This history is being assembled from archival records and from the oral testimony of tribal elders. In our first report of this research, we: 1) explored the historical roots of Native alcohol problems, 2) challenged the “firewater myths” that have long permeated conceptions of the etiology of Native alcohol problems, 3) detailed the role Native leaders played in organizing America’s first sobriety-based, mutual aid societies, and 4) described the recent “Indianization” of Alcoholics Anonymous, the revival of Native cultural revitalization and therapeutic movements, and the development of culturally meaningful alcoholism treatment philosophies and techniques (Coyhis and White, In Press).

In this article, movements are identified that, for more than 250 years, have provided frameworks of alcoholism recovery for Native peoples, and explore what can be learned from these historical movements to enhance the quality of contemporary addiction counseling.

**Five movements**

Five overlapping movements have provided a framework for alcoholism recovery within and across Native American tribal cultures. The first to emerge were the 18th and 19th century recovery “circles” and abstinence-based cultural revitalization movements of the Delaware Prophets (Papouyunan, Wangomend, Neolin, Scattameck), the Shawnee Prophet (Tenskwatata) and the Kickapoo Prophet (Kenneuk). These prophetic leaders used their own recoveries from alcoholism to launch abstinence-based, pan-Indian movements that called for the rejection of alcohol and a return to ancestral traditions. Native preachers like Samson Occom, William Apeess, and George Copway used their own lives as living proof of the power of Christian conversion and worship to cure alcoholism.

The development of new abstinence-based Native religions continued in the 19th century, including the Longhouse Religion (Code of Hand-some Lake), the Indian Shaker Church and the Native American Church (White, 2000, 2001). These Native religions constitute the most historically enduring frameworks for alcoholism recovery within Native communities. The fourth movement, the “Indianization of Alcoholics Anonymous” (A.A.) (Womak, 1996), began in the 1960s, and represents the growing adaptation of A.A. steps (Coyhis, 1990) and meeting rituals (Jilek-Aall, 1981) to enhance A.A. effectiveness within Native communities.

The threads of these earlier movements are being woven into the contemporary Wellbriety movement (Coyhis, 2000).

White Bison, Inc., an American Indian nonprofit organization and one of the leaders of this new movement, is working to expand recovery support structures within Native communities across North America. This goal is being achieved through recovery education (Well Nations Magazine), national recovery awareness walks (“Hoop Journeys”), training indigenous leaders to organize recovery circles (“Firestarters”), hosting recovery celebration events in local Native communities, and advocating for culturally informed social policies and treatment approaches.

One of White Bison’s most recent projects is publication of The Red Road To Wellbriety, a Nativeadaptation of the basic text of Alcoholics Anonymous (see www.whitebison.org). These five movements share many characteristics. They were created by Native men and women who entered recovery after each had been wounded by alcoholism. The religious and revitalization movements they created provided an opportunity for healing themselves, to heal their families and communities as well. The tradition of “wounded healers” in the arena of alcoholism recovery begins in 18th century Native America (White, 2000). This practice drew deeply from the belief in many Native cultures that a dramatic recovery from an illness was a potential sign of one’s calling as a healer. The Native leaders of America’s first mutual aid societies assumed this role more through ecstatic ( experiential) initiation than didactic (formal education) initiation (Jilek, 1971; Jilek, 1978) - a practice that was later emulated in the rise of alcoholism counseling.

Native American recovery movements rose from the prophetic visions of their leaders. These visions portrayed alcohol as a weapon of cultural conquest and sobriety as a strategy of cultural resistance. The movements identified above were multidimensional movements, with each containing a unique combination of spiritual/religious rebirth, cultural revitalization, personal healing, and, in some cases, political advocacy. All provided a pathway and framework for recovery from alcoholism that inextricably linked the sobriety and health of the individual to the survival and health of the tribe.

**Therapeutic functions**

Viewed as a whole, these indigenous movements provide a striking list of therapeutic benefits. In fact, one might assess current treatment designs by their ability to achieve these very utilities. Here’s some of what they provided:

* Commitment: culturally framed rationales for radical abstinence and a call for sobriety and sacrifice to a higher purpose than self (the People).
* Purification: rituals of physical and emotional detoxification (fasting, purging, sweating, herbal medicines) and spiritual connection (vision quests).
* Substitution: replacement of alcohol with other sacred substances, e.g., the “Black Drink,” peyote, tobacco, sage, and cedar.
* Identity: affirmation of personal and cultural identity $\frac{1}{2}$ connection with ancestral traditions and innate knowledge (the ancestors within).
* Reconciliation: mending of family and social relationships.
* Prescriptions for living: a reconstruction of values and daily lifestyle (e.g., the Code of Handsome Lake, Peyote Way, the Red Road).
* Re-connection to community: sustained affiliation with a stable network of recovering people supported by a larger cultural community.
* Ceremony: participation in rituals that solidify pro-recovery values and relationships.
* Story: the transmission of life-changing ideas through the ancient oral tradition of storytelling.
* Meaning: a worldview of oneself and one’s sobriety within the context of Native history, culture, and religion.

**Legacies and lessons**

What can today’s addiction counselor draw from these movements? We would suggest at least five interrelated lessons.

1. Alcohol and other drug problems in Native America are rooted within complex historical, cultural, political, and economic processes, and the resolution of these problems must reflect a deep understanding of such processes. Native alcohol problems emerged and continue to emerge through a collision of context and person. While the understanding of the unique vulnerability of each client is essential, so is an understanding of the ecology within which Native alcohol problems arose and have continued. More specifically, this ecology must be understood in terms of the interconnectedness between the wounding and intergenerational healing of the individual, the family and a people: the honor of one is the honor of all ... the hurt of one is the hurt of all. The resolution of Native alcohol problems must be linked to hope for a people as well as hope for the individual being counseled.

2. The most viable frameworks of addiction recovery for Native Americans tap the deepest roots of tribal cultures. The job of the conscientious addiction counselor is to become a student of these cultures - their histories, their organization, their values, their ceremonies and folkways, and their systems of healing. The addiction counselor can help forge a bridge between the treatment agency and tribal cultures by encouraging the involvement of family elders, tribal elders and traditional medicine people (herbalists, shamanic healers, spiritual advisors) in the design and delivery of treatment services for Native clients. The goal here is to create a menu of words, ideas, rituals and experiences within the counseling milieu that can be selectively used by Native people who bring enormous diversity in terms of their personal histories, personalities, religious and spiritual beliefs, and degree of acculturation (Weibel-Orlando, 1987).

   Such an approach recognizes the multiple sources and patterns of Native alcohol problems as well as the multiple pathways and styles of long-term recovery among Native peoples.

3. Traditional treatment and mutual support require significant adaptation to enhance their effectiveness with Native Americans. Native purification and healing practices (sacred dances, the sweat lodge, and talking circles) may have special applicability to Native people suffering from alcoholism who are also estranged from tribal identity, language, and ceremonies (Hall, 1985) Dr. Wolfgang Jilek (1978, 1981) has described the potential therapeutic effects of ceremonies (the Spirit Dance, the Sun Dance and the Gourd Dance) and the potential value in the cross cultural collaboration between Western and Native healers in the treatment of alcoholism. Bridging the gap between Native and Western healing practices begins with the mastery of cultural etiquette - the etiquette of respect inherent within verbal and non-verbal (e.g., eye contact, touch, boundaries of personal space) communication rituals, and the recognition that such etiquette varies across and within tribes. Bridging that gap requires delivering such assistance within the elements of particular Native cultures. Such elements include: values (e.g., patience, generosity, cooperation, humility), teaching metaphors (e.g., the medicine wheel), symbols (e.g., the sacred pipe, eagle feathers), rituals (e.g., sweat lodge, smudging ceremonies), traditional skills (e.g., carving, silversmithing), stories, and cultural events (e.g., powwows). It calls for the presence of Indian men and women within the treatment milieu who offer living proof of the redemptive power of recovery and cultural re-connection. The addiction counselor is best viewed as a midwife who helps combine and elicit these healing experiences rather than as the expert who “treats” the client.

4. Personal recovery for Native Americans is best framed within a broader umbrella of Wellbriety - physical, psychological, relational, and spiritual health. The concept of Wellbriety is an affirmation of the interconnectedness of all aspects of one’s life. At its most practical level, the focus on Wellbriety calls for global rather than categorical assessment, treatment plans that reflect the total vulnerabilities and assets of the person/family/tribe, and advocacy for sustained recovery support systems in the client’s physical and cultural environment.

5. Addiction treatment and recovery support services are best framed within a broader concern for the global health of Native communities, rather than through a singular focus on alcohol or other drug-related problems. The danger in the sometimes exaggerated and narrow focus on Native alcohol problems is that one comes to see alcoholism treatment and alcoholism recovery as a panacea for individuals and tribes instead of viewing Native alcoholism as nested within a much more complex network of political, economic and social problems that are linked to the history of Native tribes within the United States (Westermeyer, 1974). It is this nexus between the individual, the community and history that has long given religious and cultural revitalization movements an important role in the resolution of Native alcohol problems. This fifth principle, by affirming the inextricable link between personal health and community health, calls upon the addiction treatment agency and the addiction counselor to become actively involved in the communities within which their clients reside or to which they identify.

This person-community link is being conveyed to Native communities across the country within the cultural model of the Healing Forest. When a sick tree is removed from diseased soil, treated, and returned and replanted in the same diseased soil, it gets sick again. What is called for instead is a healing of the tree AND the replacement of diseased elements in the soil with nurturing elements (Red Road to Wellbriety, in press). Personal recovery flourishes best in a climate of family health, cultural vitality, political sovereignty, and economic security. What White Bison and other Native recovery advocacy organizations are trying to do is mobilize all segments of Native communities - the tribal councils, schools, churches, service programs, and political and cultural organizations - to forge and then actualize a healing vision for the community. The goal is to create a Healing Forest that creates a synergy between personal and community wellness. Such a synergy is reflected in the words of Andy Chelsea, who as the Shuswap tribal chief at Alkali Lake, declared, “The community is the treatment center” (Abbott, 1998).

**A closing thought**

There is a long history of harm done in the name of good in the relationship between Native tribes and federal and state governments and other organizations. One of the most egregious of such injuries was the enforced removal of Native children to Indian boarding schools that were designed to destroy the “Indianness” of these children. The motto of William Pratt, the founder of the Carlisle School in Pennsylvania, was “Kill the Indian and save the man” (Coyhis, 2000). It is instructive that this systematic dismantling of Native family structure and deculturation of Native children was implemented with promises of its potential benefit to Native peoples. A history of such misguided and harmful interventions calls upon professional helpers today to enter into our relationship with
each Native client and each Native community with an attitude of quiet humility, observing the ultimate ethical mandate to “First do no harm!” The capacity of addiction counselors to be part of this era of healing and renewal will be enhanced if we enter into partnership with Native communities, or serve these communities from within, as observers, as listeners, and as students.

Don Coyhis (don@whitebison.org) is the President and co-founder of White Bison, Inc., Colorado Springs, Colorado, and a member of the Mohican Nation from the Stockbridge-Munsee Reservation in Wisconsin. William L. White, MA, (bwhite@chestnut.org) is a Senior Research Consultant at Chestnut Health Systems, Bloomington, IL, and author of Slaying the Dragon: The History of Addiction Treatment and Recovery in America.

HOW CULTURE CHANGE AFFECTS LATINOS AND THEIR DRUG USE
Rafaela Robles, EdD, Wanda Rodríguez, J.D., Maria del Mar Garcia, MSW Published by Caribbean Basin and Hispanic Addiction Technology Transfer Center 2006

Why is culture relevant to drug treatment? Culture defines whether behavior is acceptable or not, under what circumstances, and how others whose opinions we value will think about it. Cultures also provide explanations about why behaviors occur and supply appropriate responses. In the instance of Latinos, hybrid cultural experiences are the rule because there is such a mixing of national origins and generational differences within the American population. It is possible to identify some common themes and even inconsistencies and conflicts in those themes, such as expectations about gender roles, which can be highly contentious and even perplexing. Is the family perceived as an asset or part of the problem, or both, by a drug-abusing client?

Immigration
Immigration is so much a part of the Latino cultural experience in the U.S. that it deserves special consideration. Immigration represents two major sources of stress, (1) family dislocation, fragmentation, and reconstruction, and (2) culture change for individuals and across generations. These two processes are often intermeshed but it is useful to distinguish them in order to understand how they have shaped the life course of clients leading them to the present moment.

Since drug addiction is rare in most Latin American countries the advent of a major drug addiction problem among U.S. Latinos is a signal of breakdowns in family processes.

There is a greater stigma associated with use of illicit drugs in Latin American societies than in the United States despite the fact that drugs are widely available in most major urban centers in those nations and in the U.S. – Mexico border region.

Back to Immigration
Immigration and resettlement involves many contingencies. The process of immigration and resettlement can be relatively uncomplicated and complete, or in the other extreme, can last years and separate family members for extended periods causing irreparable emotional harm. Each immigrant family has a unique story to tell about their rite of passage in becoming Americans, even if they don’t recognize themselves as such and remain committed in spirit to their culture of origin. For a drug counselor it is certainly worth hearing the story of a family’s immigration process. Did the process of resettlement disjoint families? Were children separated from parents for long periods of time which affected their relationships? What was the impact on the structure and cohesiveness of the family, how was the family reconstituted, and was continuity maintained with the extended family in the nation of origin? What occurred in the process of resettlement? Were many moves required, and were family and close friends available to supply assistance or not? Of special interest is the extent to which parental relations were improved, damaged, or changed by the transition. Many immigrants retain the belief that someday they will return to their birthplace and some do so temporarily or permanently while others simply keep hoping for their return but never accomplish it. Obviously, these features that occur in many immigrant families can cause frictions among family members, and even undermine relationships especially among children who have grown and matured in the United States, and are often citizens of the United States even when their parents are not.

Family Difficulties
Serious strains among family members, especially intergenerational conflicts, are the types of situations that evolve into problem behaviors of adolescents that often create pathways to addiction by fueling breakdowns in communication. Parents that never had the time to parent or were too tired to do so, as commonly occurs in low-income immigrant households, may resort to belittling comments and physical punishment to control their children.

Often parents, especially fathers, have alcohol problems that have created or contributed to serious problems and family crises including domestic violence and possibly sexual abuse.

While many of these problems are common in Latin America as well, the difference in social environment of adolescents and young adults in the United States is very consequential. The adolescent who wants to separate himself from parental hostility and conflict too often finds support among friends and acquaintances that have drugs available. In families where functioning is especially problematic substance abuse may occur relatively early in life. During the earliest teen years, experimentation and use of legal substances (i.e., tobacco, alcohol, inhalants) begins leading to the use of illicit drugs in mid-adolescence and progressing to drug dependence by late adolescence – quite often totally outside of the knowledge of parents. These adolescents are prime candidates for addiction lifestyles and all of the associated problems of faltering performance and early school termination and traumatic transitions into adult life responsibilities. Males seem particularly vulnerable to initiating this cycle into addiction in early adolescence because they are more likely to be influenced by the external environment outside the family, however, the ultimate impact on addiction and the conditions that support it may be more irreversible for females.

For Latino children and adolescents whose parents were born in the United States, vulnerability for addiction is higher because of the greater likelihood that they will be living in problematic family situations. These children are more likely to live in families that will divorce, thus ending up in single parent households and in poverty, and their parents are much more likely to have a history of mental health problems that include substance abuse. While divorce in immigrant families is less common, many immigrant women find themselves alone with children anyway and attempting to manage both domestic and breadwinner roles. While the children of immigrants face the conflicts provoked by the unequal “Americanization” processes among family members, the U.S. born families are already highly “Americanized” in most instances and inherently at higher risk for intergenerational substance abuse problems and problematic family histories if they are low income. While immigrants have actually increased their income and social status by coming to the United States, U.S. born Latinos in poverty are much more likely to feel frustrated by their social position and to have bad outcomes. It is the children of these families that are most likely to fall prey to peer groups and gang life including the violence and drug use, which accompanies it.

LATINA / FEMALE ADDICTS IN THE FAMILY
Adolescent girls who begin drug experimentation can be expected to be particularly difficult cases to treat primarily because Latino families stigmatize them in a more complete and isolating manner than they do male family members. Within the Latino culture women are supposed to be highly controlled and circumspect regarding their personal demeanor and guardians of their maternal role. These cultural controls are strong ones, thus the adolescent girl who violates these norms has usually experienced some serious ruptures in family relationships and been a victim of situations that have motivated
drug addiction occurs issues of acculturation and cultural orientation are linked to addiction, treatment, or recovery is lacking. It may be that once evidence about how cultural differences among family members are blame their drug use on Latino culture and reject it altogether. Hard of these women are highly Americanized so their affinity with Latino relationships. It is the case that female Latinas who end up in prison are These relationship problems may carry over into their own romantic situations. It is often difficult for females who have developed drug problems that progress to addiction and require intervention to enlist the support of their parents because their behavior is viewed as willful (if not sinful) and a product of their own volition. This brings shame to the family. The ostracism is more complete for women who are drug involved and have a history of serious conflicts and communication problems with father figures. This forms as an impediment to recovery when parental emotional and instrumental supports are needed. Daughters in recovery may need to return to their families during this vulnerable period but the heavily damaged relationships with parents and siblings that motivated them to leave remain intact and opening up old issues to improve communication must be done to make the reintegration feasible.

Motherhood and associated roles
Motherhood is fundamental for the formation of Latina self-concept. It is often difficult for females who have developed drug problems that progress to addiction and require intervention to enlist the support of their parents because their behavior is viewed as willful (if not sinful) and a product of their own volition. This brings shame to the family. The treatment of drug addiction among Latinas has several unique aspects. One very important indicator is language selection. Spanish speaking or highly bilingual clients can be assumed to possess more knowledge about Latino culture and this may provide some cultural information for more accurate interpretation of information. However, it should not be concluded that being Spanish speaking is somehow a more favorable prognosticator of recovery because this is not likely to be the case.

In the culture of many Latino immigrants addiction is not understood as a sickness or disease but as willful, self-destructive conduct that threatens the well being of the entire family. This cultural perception of addiction must also be a target of intervention in the recovery from addiction because the family has a very powerful symbolic value for Latinos and banishment from the family is an enormous threat to the recovering client.

As a general tool, mapping the family and support system of clients is extremely useful to determine what social assets are available to support recovery. This is also important because some family members may have played a role in the drug use career of the client, especially siblings and cousins. On the other hand, there may be pockets of family support that are available that are more instrumental to provide support in a client’s recovery than their family of origin. Some of these potential support figures may provide opportunities for exiting the physical environment altogether to avoid the inevitable dangers of coming in contact with peers and other figures from the past that were players in their world of addiction.

For further study on cultural issues, try the following links:

- Institute for Research Education Training in Addiction www.ireta.org
- Northeast Addiction Technology Transfer Center www.neattc.org
- Caribbean Basin and Hispanic Addiction Technology Transfer Center http://www.thatc.org/regcenters/index_caribbeanbasin.asp

However, parents will deny often abuse and dysfunctional parenting if asked directly because of general patterns of denial and hidden guilt that have built up over the years with families. This mythologizing about family history by pretending bad things didn’t happen or that they can be easily forgotten serves to lift the weight of responsibility from parents for explanations about conduct problems such as drug abuse of their children. It is a pragmatic protective mechanism to preserve family harmony but really amounts to “shoving the dirt under the rug.”

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The way a Latino describes him/her self as a cultural being may help a counselor determine whether family or individual counseling are more useful, or whether a certain type of self-help group or a religious counselor should be used to support recovery.

One of the advantages of a careful culturally based assessment is to place the client in their social world and understand how these background factors not only contributed to their addiction but continue to affect the environment for their recovery. This exploration should include an identification of both strengths and weaknesses in their social world, how they describe themselves in it and perceive their relations to others, and the cultural reasons and explanations they offer for their situation. What is the relationship between the aspects of their self-perception related to drug use and those aspects related to cultural identity? Do they feel discriminated against and how do they believe this has affected them? Do they feel more comfortable within Latino cultural settings, non-Latino settings, or both, and how (if at all) is this linked to their drug dependence problems? Do they feel cultural conflicts in their lives, either as internal struggles with their own values and behaviors and/or among family, friends, and other peers? How much stress do they feel from these life experiences and has their mood or behavior been influenced as a result?

**LANGUAGE SELECTION AND RECOVERY**

One very important indicator is language selection. Spanish speaking or highly bilingual clients can be assumed to possess more knowledge about Latino culture and this may provide some cultural information for more accurate interpretation of information. However, it should not be concluded that being Spanish speaking is somehow a more favorable prognosticator of recovery because this is not likely to be the case.

The Spanish-speaking addict is likely to be the most isolated from natural support systems or to have the most troubling family history. They are the true “outsiders” precisely because their behavior is a far more serious violation of cultural expectations.

In the culture of many Latino immigrants addiction is not understood as a sickness or disease but as willful, self-destructive conduct that threatens the well being of the entire family. This cultural perception of addiction must also be a target of intervention in the recovery from addiction because the family has a very powerful symbolic value for Latinos and banishment from the family is an enormous threat to the recovering client.

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The way a Latino describes him/her self as a cultural being may help a
SELF STUDY GUIDE

ETHICS: CULTURAL COMPETENCE
Chemical Dependency and the African American

1. What are the ‘real questions’ being posed in this article?

2. Two examples are given of cultural groups with low rates of addiction, who are they?

3. There appears to be a _______________ between their ___________ of ___________ and their clear ____________.

4. Briefly list these four cultural norms.

5. What ‘mindset’ in many communities today is in contrast to the above cultural norms?

6. What are some factors that contribute to ‘multiple problem individuals’ having a poor prognosis for treatment?

7. When a person’s environment is chaotic and full of questionable behavior by family and friends, what two things is that person likely to do?

8. One of the most important services we need to develop in the chemical dependency field is the ability to __________ and __________ in the lives of multi-problem individuals and families earlier.

9. The first issue addressed in cross-cultural counseling is what?

10. What was the second issue? (List briefly)

11. The third issue mentioned is that of ‘cultural pain’. What are examples of this?

12. Clients of color, like all clients, tend to __________ or __________, which often have to do with ___________.

13. What are some cultural boundaries for people of color?

14. Clients will often use legitimate issues of racism, bias and prejudice to make excuses for dysfunctional behavior. What are the two ways a counselor can respond to this?

15. Striking the appropriate balance that allows and recognizes __________ to be used as __________ is the goal.

Peter Bell has also done some work on cultural types within the Black community which includes the following.

- Acculturated Interpersonal Style - has made a conscious decision to live, work, and play outside of the black community. Acculturated blacks tend to reflect very few black mannerisms: in dress, speech, or movement. They are usually well-educated.
- Bicultural Blacks - have the ability to function and interact within both the black and the white communities. Often, however, they feel somewhat unaccepted in both. They have a sense of pride, which is not defensive, regarding their racial identity.
- Culturally Immersed Conformists - have a strong sense of themselves as black people. They were raised and continue living in predominantly black communities. The have their survival needs met in a white context. Their education level is usually high school graduate, and they typically work in relatively high-paying trades or in factories. Their interaction with whites, however, is generally limited to the workplace.
- Culturally Immersed Afrocentrics - tend to be well-educated, articulate, and self-confident. They are often employed by social service agencies or in academia. The driving force in CIAs’ lives is to build a politically powerful and economically independent black community. They are often contemptuous of whites and even more so of acculturated blacks.
- Culturally Immersed Deviants – often were raised in single-parent households, lived in public housing, are functionally illiterate, and hold “survival of the fittest” as a worldview. They have little interaction with whites. Culturally immersed deviants are contemptuous of whites and acculturated blacks and tend to see both groups as potential targets for their illegal activities.

A Deeper Look

16. As you review Bell’s cultural types, consider the counselor who is not aware of these styles of relating. How could this pose a problem in the counseling relationship? How can the knowledge of these styles help?

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1 Bell, Peter (1990) Chemical Dependency and the African American: Counseling Strategies and Community Issues (Pamphlet) Hazelden, Center City, MN.

In the winter of 2008, the Orlando Sentinel reported the following statistics on adults in jail in America. One out of every 100 adults in America is in jail or prison, including one in 36 Hispanic adults; one in 15 black adults and one in nine black men between the ages of 20 and 34. If you break these statistics down into percentages, it paints an even clearer picture. 1% of the overall adult population in America is in jail. 2.7% of all Hispanic adults are in jail, 6.6% of Black adults are in jail and 11% of all Black men between 20 - 34 are in jail.

Referring to 2005 jail statistics Joseph Califano states the following in his book on addiction in America 2 “Though blacks are disproportionately represented in prison, the common marker among inmates is not race.
It’s drug and alcohol abuse. Essentially the same proportion 61–65% of black, white and Hispanic inmates are regular drug users.’ He also states ‘Some 80% of America’s inmates – 1.8 million – either were high at the time of their crimes, committed their offenses to buy drugs, violated alcohol or drug laws, have a history of alcohol or drug abuse and addiction, or share some mix of these characteristics.’

A Deeper Look
17. From each of these statements, it is clear that crime and drug or alcohol use and abuse have a high correlation. It is also clear that young black men are the most at risk for crime and addiction. In light of these statistics, how important is it to reach those in the Black community in need of addiction treatment and Recovery Support Services?

2Califano, Joseph A., Jr. (2007) High Society Published by the United States by Public AffairsTM, a member of Perseus Book Group, Cambridge, MA.

Addiction and Recovery in Native America: Lost History, Enduring Lessons
18. In the cultural revitalization movements, prophetic leaders used their own recoveries from alcoholism to launch abstinence-based, pan-Indian movements that called for what two things?

19. Abstinence-based native religions continued in the 19th century and they constitute the most historically _____ for _____ within native communities.

20. What movement started in the 1960’s?

21. Who were these five movements specifically created by?

22. Explain the belief that many native cultures have regarding the tradition of the ‘wounded healers’.

23. How did the visions of prophetic leaders portray alcohol and sobriety?

24. These multidimensional movements contained a unique combination of what four things?

25. List the nine therapeutic functions of these indigenous movements.

26. Describe the therapeutic function of ‘commitment’.

27. Describe the therapeutic function of ‘meaning’.

28. The first lesson of these movements asserts that the resolution of Native alcohol problems must be linked to _____ for a _____ as well as _____ for the ________ being counseled.

29. In the second lesson – what is the job of the conscientious addiction counselor?

30. In lesson three, how is the addiction counselor best viewed?

31. Explain the concept of Wellbriety and list its four components.

32. Addiction treatment and Recovery Support Services are best framed within a concern for the _______ of Native communities, rather than through a ________ on alcohol or other drug related problems.

33. Explain the concept of ‘The Healing Forest’.

Personal Reflection
34. Having read this article on Native American Indians and Recovery, what stands out to you the most as the main difference in serving this population as opposed to other populations? What is it about their history that makes them so different?

How Culture Affects Latinos and Drug Use
35. What does culture define?

36. What are the two major sources of stress that immigration represents?

37. For the U.S. Latino, what does a major drug addiction problem signal?

38. There is a greater ______ associated with the use of illicit drugs in _______ ________ than in the U.S.

39. What types of questions might the drug counselor ask the drug user whose family has immigrated?
40. What commonly occurs in low income immigrant households?

41. What happens in the U.S. to the adolescent who wants to separate himself from parental hostility and conflict?

42. What is the general difference in attitude between immigrant Latinos and U.S. born Latinos that are poor?

**A Deeper Look**

43. Describe the ‘Mythologizing’ that happens with Latino families. How is this detrimental?

44. What is fundamental to the formation of the Latina self-concept and why?

45. The way a Latino describes him or herself culturally may help the counselor to determine what?

46. Culturally based assessment will bring understanding of what two factors?

47. What would be an important indicator to an individual’s acculturation and why?

48. How is addiction understood within Latino culture?

49. Why is mapping the family and support system of a client useful?
Ethics: Cultural Competence

Final Examination

(Course meets the qualifications for 5 hours of continuing education credit.)
Select the best answer for each question and complete your test online at www.elitecme.com.

1. What are the two examples given of cultural groups with low rates of addiction?
   a. Latinos & Native Americans
   b. Orthodox Jews and Latinos
   c. Orthodox Jews and American Indians of 200 years ago
   d. Native Americans and African Americans

2. An example of ‘cultural pain’ is racial self-hate.
   a. True
   b. False

3. What group is the most vulnerable to going to jail for drug related offenses?
   a. Hispanic males
   b. black males
   c. black males age 20-34
   d. white males age 18-30

4. Individuals of color tend to access treatment equally whether it be from family, friends, employers or the courts.
   a. True
   b. False

5. Which of the following describes the black person who has made a conscious decision to live, work, and play outside of the black community?
   a. Culturally Immersed Conformist
   b. Bicultural Black
   c. Acculturated Interpersonal Style
   d. Culturally Immersed Deviant

6. The Culturally Immersed Afrocentric tends to:
   a. reflect very few black mannerisms
   b. have a sense of pride which is not defensive regarding their racial identity
   c. be well educated, articulate and self-confident

7. The Indian tradition of the ‘Wounded Healer’ refers to:
   a. a shaman who was a victim of Indian warfare
   b. counselors who still carry the pain of addiction
   c. a ‘right of passage’ ritual for the medicine man
   d. a dramatic healing that may indicate a calling to heal

8. The resolution of Native alcohol problems must focus more on hope for the individual rather than hope for a people.
   a. True
   b. False

9. In Indian culture the counselor is viewed as:
   a. the ‘wounded healer’
   b. the authority figure
   c. the ‘midwife’
   d. the white man’s solution

10. T or F: Culture defines whether a behavior is acceptable or not.
    a. T
    b. F

11. In the concept of ‘The Healing Forest’ a sick tree needs to be healed and replanted …
    a. immediately
    b. in soil that has been healed
    c. in old soil
    d. in another forest

12. For the Latino, what does a major drug addiction problem signal?
    a. that they are in willful sin
    b. that they have probably immigrated
    c. that there is a breakdown in the family
    d. that they are ready to return to their native homeland

13. There is a greater stigma associated with drug use in the U.S. than in Latin American countries.
    a. True
    b. False

14. What is fundamental to the formation of the Latina self-concept?
    a. motherhood
    b. non-drug use
    c. early matrimony
    d. family ties

15. Language is an important indicator of an individual’s acculturation.
    a. True
    b. False