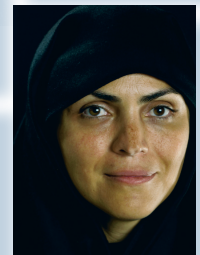


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# CULTURAL COMPETENCY:

## ITS IMPACT ON ADDICTION TREATMENT AND RECOVERY



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Dear Colleagues:

America is undeniably a multicultural country. We have known this for a long time, but this fact really “jumped off the page” during the 2008 election cycle. It is something to appreciate and celebrate. But there also is no denying that for counselors in the addiction field that fact presents challenges as well.

This issue of *Resource Links* tries to put those challenges in perspective and turn them into opportunities—opportunities for counselors to grow personally and to expand their knowledge and skills in the area of cultural competency and relevance.

The noted medieval philosopher/theologian Thomas Aquinas once said, “Quidquid recipitur recipitur secundum modum recipientis.” For those of you who used Latin class in high school to work on your other homework, it translates simply as “Whatever is received is received according to the mode of the receiver.”

This simple truth serves as the basis for why counselors must improve their cultural competency. The professional counselor has an obligation to understand the context of the client and learn to communicate in a manner that the client is likely to be able to hear, understand and accept. Because of the cultural diversity of those seeking help for their substance use problems, it is imperative that counselors take the need to become culturally competent very seriously. And they also need to have the courage and insight to face their own prejudices and biases along the way, since, as Anais Nin (see page 5) reminds us, “We don’t see things as they are, we see things as we are.”

It is our hope that this issue will inspire you to undertake the task of developing cultural competency. Not only will you enhance your ability to help others, but you will enrich yourselves in the process.

As always, the Northeast ATTC website and the ATTC network website are available to you if you want to learn more about this and other important issues. Visit [www.neattc.org](http://www.neattc.org) and take some time to browse. You’ll be glad you did. If you have any comments about this issue of *Resource Links*, they are most welcome at [jaiello@ireta.org](mailto:jaiello@ireta.org).

Jim Aiello, MA, MEd

Director, Northeast ATTC

# CULTURAL COMPETENCY AND ITS IMPACT ON ADDICTION TREATMENT AND RECOVERY

**Curtis Upsher Jr., MS, Director, Community Relations, Community Care Behavioral Health, Pittsburgh**

In its Cultural Competence Strategic Plan of 2000 (CCSP), Pennsylvania's Department of Public Welfare (DPW) and the Office of Mental Health and Substance Abuse Services (OMHSAS) stated that inequities in service delivery and care in the health care system are associated with discrimination, structural discrimination, and a lack of culturally competent practices, including a lack of cultural awareness and sensitivity systemically and by service providers.

The CCSP acknowledges that longstanding research and information lends credence to the need to consider cultural factors in the design and delivery of behavioral health care services (BHCS) and to understand its role in treatment outcomes. The lack of cultural competency in the design and delivery of BHCS has resulted in negative effects and poor outcomes in these key areas impacting recovery:

- Program access and engagement strategies
- The experience of mental illness and symptom expression
- Receptivity to treatment through standard treatment media
- Problem conceptualization
- Diagnosis
- Problem resolution behaviors
- Help-seeking behaviors
- Culturally sanctioned coping styles
- Treatment goals
- Treatment interventions
- Family responsibilities

## Defining cultural competency

As suggested by Cross, Bazron, Dennis, & Issacs (1989), Pennsylvania OMHSAS poses a core definition of cultural competency as the melding of philosophical and operational practices among three major program administrative levels: 1) attitudes, beliefs, values, and skills at the provider level; 2) policies and procedures that clearly state and outline the requirements for the quality and consistency of care; and 3) readiness and availability of administrative structures and procedures to support such commitments.

In an excellent review, "Cultural Competency in Healthcare: A Clinical Review and Video Vignettes from the National Medical Association," authors Melissa E. Clarke, MD and Christopher N. DeGannes, MD define cultural competence, present a rationale for the provision of culturally competent healthcare services, and offer strategies for confronting the health

practitioner's personal biases and misconceptions of others with different cultural and ethnic differences.

The authors look at cultural competence from an operational context in healthcare service as the "capacity to provide effective medical care to persons of varied backgrounds through use of appropriate knowledge, skills, attitudes, and behaviors."

Clarke and DeGannes define culture as patterns of behavior that include the language, communications, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Competence is defined as having the capacity to function effectively in one's role as an individual or as an organization or agency within the context of the cultural beliefs, behaviors, and needs presented by the consumer and the community in which they reside or come.

Other cultural variables that also have influential effects on health disparities and the healthcare encounter—age, gender, sexual orientation, religious affiliation, language and literacy abilities, educational level, physical ability, and social class—can also be influential in the therapeutic process and play a role in the outcome of the clinical encounter. These variables must be considered in the assessment, evaluations and treatment planning process.

## Applying the principles to practice

The Pennsylvania Office of Medical Assistance Programs (OMAP) in Appendix CC of "Indicators of the Application of Cultural Competence" (Second Edition, 2003) suggests ten Principles of Cultural Competence as indicators of the application of a culturally competent system of care.

The principle, Universality of Ethnicity and Culture, states that all consumers of service should be valued and understood within his/her cultural context and that individual differences are to be valued as strengths and resources for recovery.

The idea is that each person's cognitive style, personal and social history, and family culture contain both the origins and understanding of their problems and are keys to their recovery. Understanding the whole person is necessary in the process of evaluation, assessment, and clinical intervention in determining an appropriate treatment course.

The second principle suggests that clinical interventions and a person's recovery are more successful when the services offered are compatible with cultural values and views of the individual, family, and community.

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It states that “Cultural competency entails knowledge of consumers’ literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. Making this knowledge a service requirement of the provider encourages the services system to increase consumer access to services and to better design, implement and evaluate services to particular cultural groups.”

It is interesting to note that these principles are also contained within and seen as an integral part in the “new” recovery models currently being promoted within the behavioral health service system.

OHMSAS charged its Cultural Competence Advisory Committee (CCAC) to develop goals and strategies that would meet the behavioral health care needs of the full range of the Commonwealth’s different populations including “differences between urban and rural cultures, the deaf, hard of hearing, late deafened and deaf-blind populations, lesbian, gay, bi-sexual and transgender communities, and other ethnically or culturally defined groups within Pennsylvania.” The goal is to address cultural competence in the delivery of behavioral health services across Pennsylvania and have it implemented by all state-enrolled behavioral health care providers.

## Recovery models

OMHSAS presently has asked behavioral health providers to develop and utilize client-centered, strength-based, recovery-oriented, patient-directed models of behavioral health care that include awareness of and sensitivity to cultural competence factors in the delivery of services.

There is growing consensus that patient-centered, strength-based approaches to health care produce better clinical outcomes. The findings of Clarke and DeGannes suggest that developing culturally competent approaches to providing health care services inherently includes a patient-centered and directed approach to service plan design and implementation that will affect the clinical outcomes of any group or specific community, including those defined by gender, sexual orientation, disability, or other cultural variables including age and social class.

Behavioral health care organizations and agencies in Pennsylvania are currently exploring ‘new’ recovery models or

variants. Information regarding some of the ‘new’ recovery models can be found at:

<http://www.recoverylearning.com>

<http://www.yale.edu/PRCH/people/PriscillaRidgewayPh.D.html>

<http://www.patdeegan.com>

<http://www.recoverie.org/index.html>

OMAP’s “Indicators of the Application of Cultural Competence” (Second Edition, 2003) Appendix CC states that services that are culturally competent must be provided by individuals who are trained and skilled to “recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.”

The literature suggests that a systemic approach to examining health care delivery education regarding cultural competence should consider and take place on three levels of the BHCS: organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounter).

Cultural diversity and competency training should contain an emphasis on inclusion—the acknowledgement and understanding that cultural variables and dynamics are not exclusive to race and ethnicity only. The importance of considering each individual’s unique differences, needs, and perspectives, as well as those of the system of care, is essential to having a culturally competent system of care.

Considering that communication is an essential and often key cultural variable in the therapeutic process, a number of models regarding cross-cultural communication are available to improve providers’ ability to elicit patients’ understanding of their illnesses and preferences in treatment during the clinical encounter. One model is LEARN, an acronym for Listen, Explain, Acknowledge, Recommend, Negotiate. **Listen** with sympathy and understanding to the patient’s perception of the problem. **Explain** your perceptions of the problem. **Acknowledge** and discuss the differences and similarities in perceptions. **Recommend** treatment. **Negotiate** treatment. This model reflects the National Standards on Culturally and Linguistically Appropriate Services (CLAS).



CLAS also suggests that health care organizations must provide services to patients in their preferred language for both verbal offers and written notices informing them of their right to receive language-assisted services. The health care organization must ensure the competence of language assistance provided to limited English proficiency (LEP) patients/consumers by interpreters and bilingual staff. They must make available easily understood patient-related materials and post signage in the languages of commonly encountered groups and/or groups represented in their service area. It is suggested that family and friends not be used to provide interpretation services except on request by the patient/consumer so as not to compromise the integrity of the therapeutic session.

## **Cultural diversity training considerations**

At the core of any meaningful cultural competency training should be a thorough exploration of definitions and descriptions of culture including a review of the concepts of assimilation and acculturation. Exercises involving self-examination and discussion of the evolution of one's own personal beliefs, attitudes, values, customs, rituals, religious beliefs, and social class are important elements to help persons to understand their role and responsibility in contributing to the quality and outcome in the therapeutic dynamic.

Those who have been in the drug and alcohol field for some time will recognize the mantra of D&A therapist training 101 - "A drug is a drug is a drug," and "An addict is an addict, is an addict." These old saws formed core concepts of how many D&A counselors and therapists were taught to think about and understand substance abuse and addiction. They helped shape attitudes about treatment models including interventions and treatment approaches. Given today's science, these old saws are no longer valid in their universality and application of treatment to all clients and patients.

It is estimated that up to 60% or more of persons entering into drug and alcohol treatment programs present with both mental and substance abuse disorders. It is noted that these individuals frequently relapse to D&A use or psychiatric symptoms within one year of detox and inpatient treatment. Persons who present with concurrent disorders complicate diagnosis and treatment planning, suggesting more than a universal approach to treatment for all.

Of interest to our discussion is that despite the proven success of long-used therapeutic methodologies such as twelve step programs, pharmacological interventions, and new personal and group techniques such as motivational interviewing, DBT, and cognitive behavioral methodologies, outcome studies show poorer outcomes in general for ethnic and racial populations.

These differences have generally been explained as being due to inherent tendencies for African Americans, especially males, such as lack of motivation, non-compliance, and resistance in treatment. Similar reasons in addition to language barriers have been given for the poor outcomes of recovering Hispanics and Latinos.

It is interesting to note that while poor outcomes for women are more readily attributed to and accepted as being due to "gender differences," the field has been less ready to accept poor treatment outcomes for ethnic and racial minorities as related to "cultural differences," prejudicial dynamics, or racism.

Unfortunately, this defensiveness has often interfered with a thorough and open discussion of this issue. The consequences of the lack of or perpetuation of inadequate treatment for those struggling for recovery are unacceptable when possible explanations and solutions for poor treatment outcomes for ethnic minorities and other special populations are available. Discomfort in discussing race, ethnicity, prejudice, racism, homophobia, and sexism as a possible explanation can result in anger, resentment and defensive denials on the part of organization and staff.

Cultural variables that may influence treatment outcomes are not always simply issues of race. A number of other factors may be involved in the success of the therapeutic intervention.

While substance abuse and chemical dependence are equal opportunity disease, all do not necessarily encounter them in the same way, do not enter treatment in the same fashion, and do not use substances for the same reason. Persons may actually select their substance(s) of choice for different purposes. Some may be more or less affected by treatment due to individual and cultural variables.

## **Cultural diversity and treatment options**

Epidemiological studies indicate differences in substance use and treatment responses between men and women, with race and ethnicity also proving to be mitigating factors. The data suggest that treatment options need to consider culture and ethnicity and gender factors in the engagement, assessment, service planning and aftercare processes. For example, some studies have shown that drug usage among African American women was higher than was drug use among African American men from the same socio-economic group, and some studies have shown that particular ethnic groups are more likely to use particular substances than are other ethnic groups. (Dassori, A.M., Neff, J.A., & Hoppe, S. K, 1993).

A relatively new area of exploration has been the field of ethnopsychopharmacology, where studies indicate that racial and ethnic groups may respond to psychiatric medications differently. Studies in pharmacokinetics and pharmacodynamics indicate that some ethnic and racial groups such as Asians, African Americans, and Hispanics metabolize medications differently, leading to interesting differences in drug and medication sensitivity and tolerance, side effects, and medication effectiveness. (Chien, C., 1993).

Sensitivity and susceptibility differences between men and women to drugs and medications suggest differential approaches to education and prevention efforts, assessment, evaluation, and treatment procedures. The implications regarding treatment compliance related to possible medication side effects, medication effectiveness, and negative previous

**CONTINUED ON PAGE 4**

treatment experiences related to medications suggest more consideration and discussion.

Studies continue to indicate that assessment and diagnosis of ethnic and racial minorities versus those of whites continue to show a higher rate of diagnosis error, uncertainty, and inconsistency among therapists when evaluating African Americans as opposed to whites. Given this information, the implications for treatment planning, compliance, and outcomes are clear (Baker, F.M., & Bell, C.C., 1999).

Social class, education, family, legal, and social environmental factors are interdependently linked and are seen as cultural variables that play a significant role in contributing to a person's personality and behavior. They often define a cultural group's cultural difference and uniqueness. These variables influence the understanding of chemical dependence and offer some insight as to possible approaches to treatment engagement and therapeutic options. Sexual orientation and the lifestyles of those belonging to other particular groups suggest service plans focused on social-environmental concerns as well as substance use issues in cultural context.

In addition to organizational and staff cultural competency and diversity training, the consideration and use of substance abuse and addiction assessment and evaluation tools that consider personal, social, environmental, and cultural factors in the development of treatment plans is recommended. To this end, multi-axial instruments such as the PEF (Psychiatric Evaluation Form) and the Addiction Severity Index and those that consider family, cultural, and social environmental variables and that include a comprehensive and holistic view of the individual seeking care are suggested.

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## CULTURAL COMPETENCY TRAINING SOURCES

### C. Thomas Brown

Bureau of Drug and Alcohol Programs  
PA Department of Health  
Harrisburg, PA  
[bdap.health.state.pa.us/btms/Logon.aspx](http://bdap.health.state.pa.us/btms/Logon.aspx)

### Kristine H. Pond

Institute for Research, Education and Training in Addictions / Northeast Addiction Technology Transfer Center  
Pittsburgh, PA 412-258-8569  
[pondk@ireta.org](mailto:pondk@ireta.org)

### Medscape

[www.medscape.com/viewprogram/12540\\_pnt](http://www.medscape.com/viewprogram/12540_pnt)

### Joanne Slappo, PhD, CPRP

Office of Education and Regional Programming  
Western Psychiatric Institute and Clinic  
Pittsburgh, PA 412-802-6918  
[www.wpic.pitt.edu/oerp](http://www.wpic.pitt.edu/oerp)

### Diversity Inc

Newark, NJ  
[KBeekman@DiversityInc.com](mailto:KBeekman@DiversityInc.com)

### Drexel University College of Medicine/BHE

Philadelphia, PA 215-831-3912  
[Cheri.Avery-Black@DrexelMed.Edu](mailto:Cheri.Avery-Black@DrexelMed.Edu)

### National MultiCultural Institute

<http://www.nmci.org/publications/index.html>

### Training Unit of New York State Office of Alcoholism and Substance Abuse Services - OASAS

Albany, NY 518-473-3460  
[www.oasas.state.ny.us](http://www.oasas.state.ny.us)

### Institute for Professional Development in the Addictions

Albany, New York  
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[www.ipdany.org](http://www.ipdany.org)

# CULTURAL DIVERSITY AND COMPETENCY: IT'S ABOUT WHO YOU ARE!

*It is just as important to know what sort of patient has a disease as what sort of disease a patient has.*

— William Osler, MD

In the broadest sense, cultural diversity includes race, ethnicity, gender, age, sexual orientation, religion, spirituality, language, disability, class, socio-economic status, and topics that continue to evolve as society changes.

To increase awareness of the impact of cultural competency in addictions treatment, prevention, and recovery, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) has conducted training courses in both an 18-hour, three-day classroom format and as an on-line, 90-minute Webinar.

In developing the three-day course, OASAS worked for more than a year with the New York Association of Alcoholism and Substance Abuse Providers' (ASAP) Cultural Diversity Committee, as developed with input from a workgroup of addictions professionals and cultural competency experts. In addition, OASAS facilitated 14 regional focus groups to develop a framework for the OASAS cultural competency curriculum. Twelve of the focus groups consisted of addiction treatment and prevention providers and two consisted of patients. To date, OASAS has trained 201 participants via the 18-hour classroom training and 219 participants via the 90-minute Webinar.

Two of the OASAS trainers, Johny Barnes, CASAC, and John Reddy, LCSW-R, CASAC, share their experiences below.

## Know thyself

"Perhaps the most telling revelation for the training participants," Barnes reports, "is when we introduce the fact that the first step toward cultural competency is self-awareness on a micro and macro level. For those of us who are counselors, we are forced to follow the advice we dispense each day to clients—know yourself. We must also explore the biases and prejudices which exist in our profession."

Cultural competency cannot occur without people confronting their own biases and prejudices. Historically, education and training in this area has remained in the cognitive and objective domain, preventing self-exploration (Sue, D., & Sue, S., 2008).

Barnes also cites reports from authors/researchers Derald Wing Sue, PhD and David Sue, PhD who indicate that mental health professionals must realize that "good counseling" in the United States uses white Euro-American norms that exclude 75 percent of the world's population. While the extrapolation for the United States was not stated, this fact alone is enough to give pause, they say.

Sue and Sue state, "Without awareness and knowledge of race, culture, and ethnicity, helping professionals and other support staff could unwittingly engage in cultural oppression."

*We don't see things as they are, We see things as we are.*

— Anais Nin

## Know your client

Barnes and Reddy say that it is imperative that cultural competency courses should be:

- Consciousness-raising and Affective
- Knowledge Building
- Skill Developing
- Utilizing Change Agents
- Geographic Specific

For the Consciousness-raising and Affective component, both agree it is critical to address the stages of Racial/Cultural Identity Development models for all people (Sue, D., & Sue, S., 2008).

According to the model, all people have the following stages of development in common:

- Conformity
- Dissonance
- Resistance and Immersion
- Introspection
- Integrative Awareness

However, with the Sues' work in 2008, two stages were added to the white model, Naiveté and Commitment to Antiracist Action. These added stages correspond with the circumstance of whites being the dominant group in the United States.

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# COMMUNITY IS HEALING AND HEALING IS THE COMMUNITY

**Harlan Pruden, Co-founder and Council Member, Northeast Two Spirit Society, New York, NY**

For the Native American community—an estimated 85,000 to 100,000 in New York alone (the largest population of urban Indians in the country)—there are many challenges that we have to confront. Not least among them is overwhelming, purposeful and continuing ignorance that has been clouded by myth and stereotyping for centuries, usually to the detriment of our peoples and as a means to colonize our lands and take our resources.

“Cultural competency” is almost beside the point in working in Native communities. It has been repeatedly shown, whether the issue is politics, health care, or beadwork, interventions designed outside the community and implemented by non-community members are almost guaranteed to fail. In Native America, cultural competency means involving Native peoples from the very beginning of any project. Without a connection to the community, the leaders and/or the elders, outsiders have little chance of success. This is the result of centuries of lies, betrayal and a total inability to comprehend a perspective totally alien to western culture.

Contemporarily, one of the first things that must be acknowledged is the lasting effects of historical trauma from more than five centuries of colonization, oppression, and the forced removal of our people from our land. The result has been generations suffering from the trauma of genocide and cultural annihilation, now more gently referred to as ethnic *cleansing* (can you imagine—removing people from the face of the Earth and then referring to it as “cleansing”). For the past two or three generations, we have been raised by mothers, fathers, aunts, uncles, and grandparents, many of whom had their “Indianness” beaten out of them at state-sponsored, church-run boarding schools. The cycle of abuse was learned in an attempt to “kill the Indian and save the man,” an intentional policy of “cleansing” by church and state. This was subsequent to, and parallel with the outright massacre and military invasion of our territories. The parents and grandparents suffering that trauma passed that on to the generations that were then subject to the boarding schools. Five hundred years later, as a result, we struggle with extremely negative statistics in poverty, health, housing, joblessness, lack of education, and abuse.

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## It's about who YOU are! (continued)

### From sensitivity to appreciation

Cultural competence, then, is a set of attitudes, skills, behaviors, and policies that enable organizations and staff to work effectively in cross-cultural situations. It reflects the ability to acquire and use knowledge of the health-related beliefs, attitudes, practices, and communication patterns of clients and their families to improve services, strengthen programs, increase community participation, and close the gap in health status among diverse population groups (NYS OASAS, Dick Van Dyke ATC).

This suggests another dramatic shift—from sensitivity to appreciation.

Barnes says, “While we have a long way to go as a profession, just one example is the field’s use of Evidenced-Based Practices as highlighted in the October 2008 *Journal of the National Association of Social Workers* article entitled ‘Evidenced-Based Practice in Mental Health Care to Ethnic Minority Communities: Has its Practice Fallen Short of its Evidence?’ However, participants can individually return to their workplaces, homes and communities as change agents and make an immediate difference.”

They concur that it may be difficult at first to change an entire agency, but they offer some tips: Object to the racist jokes. Discuss racial and cultural issues with coworkers, family and friends. Barnes and Reddy believe that the ripple effect can begin to eradicate bias in schools and workplaces at earlier stages.

In terms of cultural competency, both men agree: “Each individual can make a difference.”

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It is difficult to find a statistic in which Native peoples are not at the bottom of the proverbial totem pole. Just one small example in a sea of devastation is that the Pine Ridge Indian Reservation in South Dakota, home to the Oglala Lakota (the major part of the indigenous military force that defeated Custer at the Little Big Horn), has been the poorest or second poorest county in the United States for decades!

After many years of broken promises and treaties leading to our current situation, it is hardly surprising then that we, as Indian peoples, tend to be wary of outsiders and find it very difficult to trust white people.

Native peoples have centuries of wisdom and knowledge particularly related to ecosystems, conservation, medicine, climate, peace, justice, educational technique, family structure, family preservation, sustainable development, and the importance of diversity between peoples and the natural world. Miraculously, our elders have passed this down through the generations of genocide and criminalization of our ways. Thus exists the contempt we often have for outsiders who come in, even with the best of intentions, and begin dictating what we need to do and how we should do it!

For Native American individuals, our responsibility to the community is always our priority (unlike the prevailing 19th century liberalism model). For us, within the community we find healing. Strengthening that cornerstone of our way of life is indeed the key to our future, one in which we are already seeing progress after a generation of Indian “movement” and reclamation.

Within many Native American cultures, there exists a tradition of alternative gender roles and sexuality. In many cases, these individuals were revered for their uniqueness. The historical roles of what we call “two-spirit” today contributed enormously to the well being of the community and that tradition of community service continues. Working with two-spirit peoples in Native communities is one important way non-Indian institutions can seek guidance and help in relating to the entire community being served. In honoring two-spirit peoples, or any of our traditionally respected leadership in this way, especially if culturally appropriate steps are taken to adhere to protocol, a provider’s actions will demonstrate its desire to work under the direction of the community.

The strength of Native programs is that we work with one another to help an individual make healthy decisions that come about from the development of self-esteem. Context is everything. By understanding or seeing the context in which an unhealthy behavior is occurring, one also can see how to work within that context to change that behavior.

Participation in the community and an understanding and pride in any Native person’s heritage is an integral component in the development of self-esteem. By combating isolation and developing self-esteem, we address some of the most

*“For Native American individuals, our responsibility to the community is always our priority. . .”*



basic needs in our community and concurrently provide HIV/AIDS education, substance abuse prevention, and a forum in which to respond to intergenerational trauma and mental health issues. Because our approach is entirely based on the community and our historical culture, it is the very definition of peer-based recovery and support services.

These are ongoing services and the cultural component is indivisible from any of our efforts. In fact, one problem for Native programs, especially those incorporated into non-Native institutions, is the inconsistency of their application. Programs will “try” to incorporate Native American components into their work and/or do so within a limited time frame (usually based on grant periods and grants that should rightfully go to Native organizations that could more ably do the work). Instead of adding to the value of program work, this inconsistency actually exacerbates the problem. We are a community who has been historically betrayed and repeatedly lied to so each unfulfilled commitment actually dissuades Native participation in institutional work.

Making a safe and welcoming space for two-spirit programs (or any Native programs), must be a component in any program or institutional work to be undertaken. The programs themselves must be guided by two-spirit people. Reaching out to two-spirit organizations and/or leaders and asking for their input shows respect for their knowledge and experience and makes for a more holistic approach to the issues of the entire community.

A good place to start is to meet with community members, participate in community functions only at the invitation of the hosts, and work to win our trust and respect. This approach is, in and of itself, anathema to many non-Indian methodologies that are concerned with deadlines, measurable

**CONTINUED ON PAGE 8**

outcomes within very strict time limits, and other culturally inappropriate demands that are often unknown to non-Indian organizations. Some examples would include signatures for services received (many of us loathe signing anything coming from the “white man”), requirements that our organizations have a board of directors or other formalities that are unfamiliar to our own institutional systems. We often have multiple leaders, complete transparency, decisions by consensus (requiring a great deal more attention to negotiations), absence of formal structures, and/or no “membership” lists.

We also are more likely to have multi-generational input on our work and difficulty in compartmentalizing our issues (ceremony, ceremonial art, healing, healing the land, and health care are all the same thing). Maybe most importantly, our plans do not include finite schemes. This may be because for us

*It is not always easy to work with Indian communities. It requires a real commitment, willingness to maintain a completely open and absorbent perspective, and readiness to admit that other people, from divergent cultures, sometimes have better solutions.*

process is often more important than outcome. In executing anything, we must consider its impact for the next seven generations as well as its environmental implications.

These are demanding responsibilities in working as or with Native communities. Obviously, there are no “rules” defining these points of view and protocol. This comes only from being raised in Indian communities or intensive participation in our live ways, not something many program directors of non-Indian organizations have the time to do. I stress again that to work successfully with Indian peoples, our peoples must be involved. There is no circumventing or short-cutting this. As Nike says, “Just do it.”

When hiring members of the Native community to participate in non-Native supported programming (which is a very welcome compromise position) it is critical to avoid tokenism and/or hiring people who do not have the respect and support of their Indian nation. Candidates should be viewed as an expert and their compensation and treatment should befit their responsibilities irrespective of their ‘paper’ education. Of course, the most direct and easiest way to ensure that cultural competency is a component of non-Indian programming is to partner with community based organizations and empower and support their work. However, a note of caution: this does not mean meet with us and discuss it and then just do what you want. It means that real solutions must be found when merging two very different perspectives to accomplish goals established by the Indian communities involved. This means, for a lot of non-Indian peoples, setting aside the exercise of long-held, often unrealized and subconscious, privilege and domination.

It is not always easy to work with Indian communities. It requires a real commitment, willingness to maintain a completely open and absorbent perspective, and readiness to admit that other people from divergent cultures sometimes have better solutions. However, the experience in working with Indian people can also be an enormous privilege. We are traditionally generous, friendly people who are so acculturated into community perspectives that anyone who spends any time with us respectfully is easily embraced. Less dramatic ways to participate in our communities are available. For example, in New York City, the NorthEast Two-Spirit Society regularly holds workshops, panel discussions, and cultural presentations on issues of interest to our peoples. We also have a speakers’ bureau, a very effective tool for educating people within and without the community. We also try to work with a network of organizations within the LGBT (Lesbian Gay Bisexual Transgender) and the Native American communities to share our purpose and work. Finally, we promote our Web site as a source of current information on the organization, its events and the issues that we work on. (Visit [www.ne2ss.org](http://www.ne2ss.org))

Our programs are targeted but not limited to the two-spirit community. The larger Native community is always welcome to attend and participate and some do. The concepts of coming together and mutual support are the basis of the programs—concepts that are now cited in current research as essential to recovery.

Cultural components are the basis of all of our work. We are trying to make it clear though that we are not simply a two-spirit organization. First and foremost, we intend to serve everyone within our indigenous communities.

Diversity, not just in word but in action on every level, is the nature of the universe and to believe that culture, society or even human existence can continue without it puts humankind in severe danger by removing us from the ecosystem upon which we rely.

Equity must be found in diversity, not conformity.

### **Cultural Elements in Treating Hispanic Populations**

The Caribbean Basin and Hispanic ATTC collaborated in the development of “Cultural Elements in Treating Hispanic Populations: Dialogue on Science and Addiction” written by William A. Vega, PhD. Dr. Vega was recently named founding director of the Luskin Center for Innovation. The Luskin Center will conduct world-class research on major urban issues in Los Angeles.

Counselors can access this publication under Resources at [www.attcnetwork.org/regcenters/index\\_caribbeanbasin.asp](http://www.attcnetwork.org/regcenters/index_caribbeanbasin.asp).

# COMMUNICATE...

## IN ORDER TO KNOW EACH OTHER

Sajeda Bhallo, MS, CAC, CCJP, Al Ahad Islamic Center, Allentown, PA

“Cultural competency” is among the buzzwords in the field of behavioral health. For those of us who studied in the social sciences, we know there are numerous theories of human development. Outside of academia, our experiences have shaped our own understanding of human development. Our social environment influences us all. By being around people different than ourselves, our social competency increases. This is also true when looking at cultural competency.

I am a Tanzanian-born, American-raised Muslim woman. This is the first line of my cover letter and bio. These identifiers are “fully-loaded” as is the training I facilitate entitled “Training on Cultural Diversity—Islam: An Overview.” The focus of this article will be on the training I facilitate, factors to consider when selecting training courses, and a few points to consider when working with staff and clients.

Post September 11, 2001, the religion of Islam has been under scrutiny. Like all religions, Islam has many sects. The most relevant point to note is that Islam crosses all peoples, nations and cultures—not just Arabs or Arab-speaking people. In fact, the quote that is the basis of the entire presentation is “O you men, surely We have created you from a male and a female, and made you tribes and families that you may know each other; surely the most honorable of you with Allah (God) is the one among you most careful (of his duty); surely Allah (God) is Knowing, Aware” (49:13).

The premise of the training is based on the above verse from the Holy Islamic Book, the *Qur’an*. The training is NOT aimed at converting people. Rather it provides a broad knowledge base so as to understand the world of a Muslim—those who follow the religion of Islam. The trainees are educated on basic terminology and the universal Islamic greeting, *Assalam Alaikum*—Peace be upon you. To learn the response, come to the training. You will be able to then talk to any Muslim you encounter anywhere.

The religion of Islam is a way of life. So in working with a Muslim client, a treatment provider must understand the basic tenets. Muslims have rules to live by that will impact daily life. These are learned through exploration of the five pillars of Islam: *Shahada*—Faith; *Salat*—Prayers; *Sawm*—Fasting; *Hajj*—Pilgrimage; *Zakat*—Charity. Some controversial topics,

like dietary restrictions, women, marriage, abortion, games of chance, and intoxicants are discussed.

Another interesting part is the exploration of the similarities among the monotheistic religions. Contrary to popular belief, Orthodox Judaism,

Christianity and Islam have much in common. Issues pertaining to modesty in dress for women is one example. Chastity is a common theme that has manifested differently due to various cultures. The difference between cultures is explored and the trainee has the opportunity to see, feel and even try on *Hijab*—veil. Other Islamic items are shown: *Tasbeeh*—rosary beads; *Musalah*—Prayer rug; and *Adhan* Clock—a clock that chants the Call to Prayer. Many books also are available for perusal, like Arabic Alphabet, Prophet Stories and the Qur’an.

In addition to learning about Islam and some of the associated cultures (as Muslims come from all backgrounds), the trainee engages in an activity aimed at self-reflection. As treatment providers, we must be aware of our own thoughts and beliefs before we are able to see the world through the eyes of our clients.

Therefore, when selecting training on cultural competency, it is important that the objectives be clear, not only to help the trainee learn about the culture but also to have a component where the trainee gets an opportunity for self-reflection.

Ultimately, no matter how much training you have on the topic of cultural competency, no one can be the expert. It is noteworthy to learn about others. Despite larger cultures, each individual has a subculture unique to their experiences.

In working with staff and clients, it is vital to ask questions and understand the unique world of the individual. Assumptions are dangerous! The most important point is to communicate in order to know each other as we all come from different “tribes” and “families.”

I hope to see you at my training!

*“We have... made you tribes and families that you may know each other...”*

—Qur’an 49:13

# LGBT CULTURAL COMPETENCY CHALLENGES ARE MANY AND COMPLEX

Anne Helene Skinstad, PhD, Program Director, **Prairielands Addiction Technology Transfer Center, Iowa City, IA**

The cultural competency challenges for substance abuse treatment for lesbian, gay, bisexual and transgender (LGBT) individuals are many and complex, according to CSAT's "Provider Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals." There is, for example, still a lively debate within the LGBT community about what comprises the LGBT culture.

LGBT people are from all cultural backgrounds, ethnicities and racial groups; can have attained any education or income level; and live in all geographic areas of the country. The precise size of the LGBT community is not known due to limited available data and difficulties attaining representative samples of people who openly identify as LGBT.

Each ethnic minority group has norms and values about LGBT members and behavior. LGBT persons from an ethnic or racial minority cope with their sexual orientation amid a web of cultural traditions and norms. LGBT persons of color try to fit into the gay and lesbian communities amid racism and discrimination. Major ethnic minority groups react differently to issues of sexual orientation. For some, these factors make finding a comfortable place in society even more difficult.

It is no wonder this 2001 publication became one of the most sought-after publications for practitioners working with LGBT clients.

The product of a CSAT-convened Consensus Panel, it was at last an important step toward assisting providers in improving substance abuse treatment for lesbian, gay, bisexual and transgender clients by raising awareness about the issues unique to LGBT clients.

The publication offers countless insights, for example:

- It is important for the provider to assess how an LGBT client from a minority group feels about his or her culture. Some may be alienated from it while others may be supported by it.
- In addition to understanding a client's ethnic background, counselors should keep in mind how the client's culture views LGBT individuals and the effect this viewpoint has on the client.
- Providers may be helpful to a client if they remember these multi-layered, and sometimes opposing, influences on the client.

This heightened awareness gave rise to a call for additional follow up in the form of training curriculum development. Dr. Barbara Warren and Elijah C. Nearly wrote and trained

the first version of this curriculum on the East Coast. In 2006, Prairielands ATTC was approached to modify this work for wider application. Dr. Anne Helene Skinstad and Candace Peters, MA, formed a group of colleagues in the ATTC network with experiences in LGBT issues and including representatives of Northeast ATTC as well. The ATTC-LGBT committee prepared a train-the-trainer (TOT) program that was first offered in May 2008.

Reflecting the complexity of issues, the training has 22 modules, addressing clinical as well as administrative issues. You can review them in detail at: [www.public-health.uiowa.edu/pattc/lgbtrainingcurriculum/](http://www.public-health.uiowa.edu/pattc/lgbtrainingcurriculum/)

The May 2008 rollout of the new train-the-trainer model attracted representatives from nearly every ATTC and elicited a very positive response.

The modules can each be free-standing, combined in groups, or taken as a whole. Security issues of this client base are tantamount. The flexibility is intended to gradually introduce the training among practitioners who may be reluctant to participate in various sessions for reasons ranging from fear to discomfort. Sessions to date conducted primarily in the Midwest play out that reality. Some have as few as two to four participants, some 17, and other general awareness programs draw 120. Training program managers are wise not to focus on numbers, but rather on the inroads being made. As each trainer goes out to train others and that cascade continues, the numbers will come. If awareness is the only output so far, so be it. It is still progress.

Trainer selection is critical. Dr. Tom Freese, Director of Pacific Southwest ATTC, is the master trainer for the Prairielands ATTC future TOT on this curriculum. The National Association for Lesbian and Gay Addiction Professionals (NALGAP) has several very experienced trainers, and have three representatives who are prepared to train the curriculum in collaboration with the local ATTCs. NALGAP's President Joe Amico and NALGAP's board members Marty Perry (representing the Midwest on the board) and Phillip McCabe (representing the East Coast) are collaborating with Prairielands ATTC to determine guidelines and standards, such as command of the curriculum and personal experience (lifestyle as well as professional). A mature, knowledgeable trainer who is secure when challenged and presents a clear message of respect of human rights may be the ideal job description.

Cultural sensitivity often results in more effective treatment. And that's our end goal!



# SEEING THROUGH THE LENS OF HISTORICAL TRAUMA

**Onaje Muid, MSW, LMHC, CASAC, Clinical Associate Director, Reality House, Inc., Long Island City, NY**

**Co-chair: OASAS Talent Management/Organization Culture and Workforce Experience Committee**

**H**istorical trauma is often related but not limited to slavery and the African American population and genocide among the Native American communities.

Currently, historical trauma is surfacing in the literature and research as a key factor in the (in)effectiveness of treatment of persons with substance use disorders. The screening for historical trauma among substance users adds a new lens through which we can begin to understand those who have experienced other trauma, for example, rape, traumatic brain injury, war, post traumatic stress disorder, and the Holocaust.

Historical trauma may be best understood as a paradigm shift from pathology (what's wrong with you) to healing (what happened to you). This evolving healing orientation is creating a new frontier for the chemical dependency field by assessing human behavior in the social environment. Seeing clients in their fullness will lead to culturally inclusive programs that ultimately can reduce the rate of recidivism.

Notable for their study of historical trauma are Maria Yellow Horse Braveheart, PhD, and Joy DeGruy Leary, PhD. Each in her extensive work has observed that no intervention will be fully successful if mass trauma is not publicly recognized and understood.

When human rights are trampled through slavery, genocide, violence, and any number of other traumatic events, the phenomenon takes on a social justice aspect as well. The breaking of a people, their will, and their identity often lead to negative consequences in succeeding generations (intergenerational trauma).

Historical trauma can create a pseudo-culture of lateral violence, internalized oppression, and abuse in stark contrast to authentic culture that serves to support and nourish as a mother would. Judith Herman has described trauma as “the affliction of the powerless.” Often the coping mechanism of choice becomes drugs and alcohol, thereby re-labeling addiction as an effect in the larger scheme and not a cause. The persistence of induced self-hatred can play out in other ways, too—for example, hair straightening, and skin lightening.

As counselors, we need to keep in mind that oppressed communities have never had sufficient opportunities to discuss:

- The loss of authentic culture, land, cosmology or their peoplehood.
- The effect of the adaptive, induced culture as a consequence of the submission to another power (government, slave owner, etc.).
- The ways needed to remedy these human rights violations.

It is critical to give the client, whose voice has been silenced, that voice and a chance to speak about his or her pain. Three levels merit the counselor's and client's attention: the original assault, the recognition of it and the resolution.

Effective cultural competence training

starts with agency policy, then moves to the staff level. Tracks that explore racial identity development, how people come to see themselves, and how the agency is going to participate in an anti-racist/anti-oppression/social justice agency model are essential. It is important for the provider agency to make an effort to support staff in the agency-wide application of what is learned.

These issues are not easily resolved. Admittedly there is tension within the field about whether historical trauma is a personal issue or a social problem. Fortunately, the conversation has been broadened by the Recovery Oriented Systems of Care (ROSC) focus championed by William L. White and Recovery Management and People of Color (Mark Saunders et al). The People's Institute for Survival and Beyond ([www.pisab.org](http://www.pisab.org)) has introduced their Undoing Racism Workshop. Tony Porter, co-founder of A Call to Men ([www.acalltomen.com](http://www.acalltomen.com)), has adopted the PISAB approach to create a social justice drug treatment model.

We are onto something new, vital, and essential to this field. But much is yet to be done. Reversing the damage of 300 years will take time. But the movement is underway. Awareness is heightened. Though few courses can be found among curricula across the country, a handful of universities are leading the charge to change that.

As a field, we prepare ourselves for this new level of inclusivity and human equity by looking at our organizational culture and questioning how open are we to these emerging paradigms of systems transformation. The OASAS Talent Management/Organization Culture and Workforce Experience Committee has taken up this very task. Reality House has embraced a cultural competency, social justice, trauma-informed approach to treatment.

As the movement unfolds, it is us — *all of us, each of us* — who can start today wherever we practice to broaden the conversation with the lens of historical trauma. We welcome and encourage your participation to create a field and a society that embraces human rights, healing, and recovery.

**HISTORICAL TRAUMA:**  
*The collective emotional and psychological injury both over the life span and across generations, resulting from a cataclysmic history of genocide.*

**EFFECTS:** *unsettled trauma, increase of alcohol abuse, child abuse, and domestic violence*

**CONTINUED ON PAGE 12**

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# ADDITIONAL WEB RESOURCES

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## **The Annapolis Coalition**

[www.annapoliscoalition.org](http://www.annapoliscoalition.org)

## **The Authentic History Center**

[www.authentichistory.com/diversity](http://www.authentichistory.com/diversity)

## **American Association of Colleges and Universities**

[www.diversityweb.org](http://www.diversityweb.org)

## **Asian Nation: Asian American History, Demographics and Issues**

[www.asian-nation.org/index.shtml](http://www.asian-nation.org/index.shtml)

## **The Blues and Race Relations in the U.S.**

[www.angelfire.com/sc/bluesthesis/#top](http://www.angelfire.com/sc/bluesthesis/#top)

## **Caribbean ATTC Resources**

[www.recoverymonth.gov/2008/kit/Resources/recovery\\_month\\_resources\\_brochure.aspx](http://www.recoverymonth.gov/2008/kit/Resources/recovery_month_resources_brochure.aspx)

## **The Center for Wellbriety Movement**

[www.whitebison.org](http://www.whitebison.org)

## **Cornell University ILR School**

[www.ilr.cornell.edu](http://www.ilr.cornell.edu)

## **CSAT Provider Introduction to Substance Abuse Treatment for Lesbian, Gay and Transgender Individuals**

[www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf](http://www.kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf)

## **Diversity Rx**

[www.diversityrx.org](http://www.diversityrx.org)

## **Georgetown University Center for Child and Human Development**

<http://gucchd.georgetown.edu>

## **Gender and Health Collaborative Curriculum Project, Ontario**

<http://genderandhealth.ca/en/modules/sexandsexuality>

## **The Gilder Lehrman Institute of American History**

[www.gilderlehrman.org](http://www.gilderlehrman.org)

## **Harvard Project Implicit**

<http://implicit.harvard.edu/implicit>

## **Indian Country Today**

[www.indiancountry.com](http://www.indiancountry.com)

## **James Hollis, Author and Jungian Analyst**

[www.jameshollis.net](http://www.jameshollis.net)

## **The Mid-Atlantic Center, Chevy Chase, MD**

[www.maec.org/cross](http://www.maec.org/cross)

## **The Missouri Alliance to Curb Problem Gambling**

[www.888betsoff.org](http://www.888betsoff.org)

## **Multicultural Education Pavilion**

[www.edchange.org/multicultural](http://www.edchange.org/multicultural)

## **NAACP's *The Crisis* Magazine**

[www.thecrisismagazine.com/about.htm](http://www.thecrisismagazine.com/about.htm)

## **National Association for Multicultural Education**

[www.nameorg.org](http://www.nameorg.org)

## **National Center for Cultural Competence**

[www.ncccurrecula.info/sitemap.html](http://www.ncccurrecula.info/sitemap.html)

## **New England Nonviolence Trainers Network**

[www.nonviolencetraining.org](http://www.nonviolencetraining.org)

## **N.Y. Association of Psychiatric Rehabilitation Services**

[www.nyaprs.org](http://www.nyaprs.org)

## **Public Broadcasting Service (PBS)**

[www.pbs.org/race/001\\_WhatIsRace](http://www.pbs.org/race/001_WhatIsRace)  
[www.pbs.org/wnet/jimcrow/segregation.html](http://www.pbs.org/wnet/jimcrow/segregation.html)

## **Perspectives on Psychology in Daily Life**

[www.psychpage.com](http://www.psychpage.com)

## **Social Psychology Network**

[www.socialpsychology.org](http://www.socialpsychology.org)  
[www.understandingprejudice.org](http://www.understandingprejudice.org)

## **Southern Poverty Law Center, Teaching Tolerance**

[www.tolerance.org](http://www.tolerance.org)

## **The True History Museum**

<http://mypages.blackvoices.com/museum/door>

## **U.S. Dept. of Health & Human Services, Health Resources & Services Org.**

[www.hrsa.gov/culturalcompetence/](http://www.hrsa.gov/culturalcompetence/)  
[hrsa.gov/culturalcompetence/indicators](http://hrsa.gov/culturalcompetence/indicators)

## **University of Michigan, Program for Multicultural Health**

[www.med.umich.edu/multicultural](http://www.med.umich.edu/multicultural)

## **University of Washington Patient and Family Education Services**

<http://healthlinks.washington.edu/>

## **Center for Multicultural Education**

<http://faculty.washington.edu/jbanks>

## **Webster's World of Cultural Democracy, Seattle**

[www.wgcd.org](http://www.wgcd.org)

## **Women of Color Resource Center**

[www.coloredgirls.org](http://www.coloredgirls.org)





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**ATTC**  
Unifying science, education  
and services to transform lives.

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**ireta** Institute for Research,  
Education and Training  
[www.ireta.org](http://www.ireta.org) in Addictions



**DENIAL:** Does not recognize cultural differences

**DEFENSE:** Recognizes some differences, but sees them as negative

**MINIMIZATION:** Unaware of projection of own cultural values; sees own values as superior

**ACCEPTANCE:** Shifts perspectives to understand that the same "ordinary" behavior can have different meanings in different cultures

**ADAPTATION:** Can evaluate others' behavior from their frame of reference and can adapt behavior to fit the norms of a different culture

**INTEGRATION:** Can shift frame of reference and also deal with resulting identity issues

Milton Bennett's model provides a way for individuals to assess where they are on the continuum for other cultural groups and subgroups while indicating a way to move forward to greater intercultural sensitivity.

**SOURCES:**

Bennett, M.J. (1993). Towards ethnocentrism: A developmental model of intercultural sensitivity. In R.M. Page (Ed.), *Education for the intercultural experience* (pp. 21-71). Yarmouth, ME: Intercultural Press.

Hammer, M.R. & Bennett, M.J. (1998). *The intercultural development inventory (IDI) manual*. Portland, OR: Intercultural Communication Institute.

Sheffield, D. (2007). Assessing intercultural sensitivity in mission candidates and personnel. *Evangelical Missions Quarterly*, 43 (1), 1-8.

**Intercultural Sensitivity: The Bennett Model**

Milton Bennett developed a model to describe intercultural sensitivity in *Developmental Model of Intercultural Sensitivity* (1993). This intercultural sensitivity model describes movement across a continuum from **ethnocentrism** to **ethnorelativism** from the individual person's/counselor's cultural lens.

*Ethnocentrism* refers to the experience of viewing one's culture as central to reality.

*Ethnorelativism* refers to the experience of viewing one's culture as just one organization of reality among many legitimate possibilities (Sheffield, 2007).

**THE INTERCULTURAL SENSITIVITY CONTINUUM**



**2 Continuing Education Hours for \$20**

You are eligible to receive (2) Continuing Education (CE) credits by completing a post-test based on this issue of the *Resource Links*. Return the completed post-test and a \$20 check for processing fee to the Institute for Research, Education and Training in Addictions (IRETA). Please make check payable to IRETA. A passing grade for the post-test is 80%. Applicants who receive an 80% or above will receive a certificate by return mail stating that they have been awarded 2 CEs. Credits are issued by the National Association for Addiction Professionals (NAADAC).

**— REGISTRATION FORM —**

**CULTURAL COMPETENCY: IMPACT ON ADDICTION TREATMENT & RECOVERY**

NAME AND DEGREE AS YOU WISH THEM TO APPEAR ON YOUR CERTIFICATE (PLEASE PRINT):

NAME: \_\_\_\_\_ DEGREE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_ LICENSE #: \_\_\_\_\_

I confirm that I personally have completed the accompanying test. I am submitting it for evaluation and certification.

SIGNATURE: \_\_\_\_\_ DATE COMPLETED: \_\_\_\_\_

Evaluation: Overall, this issue of *Resource Links* (circle appropriate response)

PROVIDED INFORMATIVE UPDATES	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	WAS NOT INFORMATIVE
EXPANDED MY KNOWLEDGE	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	DID NOT EXPAND MY KNOWLEDGE
PROVIDED USEFUL RESOURCES	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	DID NOT PROVIDE USEFUL RESOURCES
WAS APPROPRIATE FOR MY TRAINING LEVEL	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>	WAS NOT APPROPRIATE



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The NeATTC is a federally funded program administered by IRETA.

**CULTURAL COMPETENCY:  
IMPACT ON ADDICTION TREATMENT & RECOVERY  
POST-TEST**

You are eligible to receive two (2) Continuing Education (CE) credits by completing this quiz based on this issue of *Resource Links*. INSTRUCTIONS: Indicate the best answer to each of the following questions and return the completed test and application form (on back) with a check for \$20 to The Institute for Research, Education and Training in Addictions.

1. Cultural diversity and competency training should contain an emphasis on inclusion.  
 True       False
2. Cultural competency can occur without practitioners confronting their own biases and prejudices.  
 True       False
3. Cultural variables that may influence the understanding of chemical dependence and offer some insight into possible approaches to treatment engagement and therapeutic options include: race, social class, education, family, legal, and social environmental factors.  
 True       False
4. How an LGBT client from a minority group feels about his or her culture is irrelevant to treatment.  
 True       False
5. Each person's cognitive style, personal and social history, and family culture contain both the origins and understanding of their problems and offer the key to their recovery.  
 True       False
6. The professional counselor has an obligation to understand the context of their client and learn to communicate in a manner that the client is likely to be able to hear, understand, and accept.  
 True       False
7. Historical trauma can be:  
a) slavery  
b) genocide  
c) assaults  
d) all of the above
8. A treatment provider must understand how to address controversial topics like dietary restrictions, women, marriage, abortion, games of chance, and intoxicants when working with clients who are:  
a) Asian  
b) Muslim  
c) Latino
9. Without awareness and knowledge of race, culture, and ethnicity, helping professionals could unwittingly engage in:  
a) gender bias  
b) cultural oppression  
c) ethnorelativism
10. The literature suggests that a systemic approach to examining health care delivery education regarding cultural competence should consider and take place on which levels of the BHCS?  
a) Clinical (provider-patient encounter)  
b) Organizational (leadership/workforce)  
c) Structural (processes of care)  
d) All of the above

**Visit the Northeast ATTC for  
training updates and online  
courses [www.neattc.org](http://www.neattc.org)**

You don't have to go farther than your computer to learn about the latest and greatest evidence-based practices from expert trainers. Beginning on February 11, 2009, the Northeast ATTC will be kicking off its monthly "Webinar Wednesday" series. Join us for a two-hour online live webinar training focusing on an "Overview of Evidenced-Based Practices." You can register, participate and earn 2 continuing education credits (CEUs). We will be offering general continuing education credits, NAADAC, PCB Social Work, and APA credits.

**2009 WEBINAR WEDNESDAYS held  
from 10 am - 12 pm EST on the  
following topics:**

- |                    |                                                       |
|--------------------|-------------------------------------------------------|
| <b>FEBRUARY 11</b> | <b>Overview of Evidenced-based Practices</b>          |
| <b>MARCH 11</b>    | <b>Promoting Awareness of Motivational Incentives</b> |
| <b>APRIL 8</b>     | <b>Overview of Co-occurring Disorders</b>             |
| <b>MAY 13</b>      | <b>Ethics</b>                                         |



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