Cultural Issues in
an Outpatient Program
for Stimulant Abusers*

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Abstract - Cocaine abuse has created widespread problems, especially in poor urban ethnic minority communities. This article discusses the cultural issues in delivering a cocaine treatment program to a predominantly minority patient population. The Stimulant Treatment Outpatient Program (STOP) of San Francisco General Hospital’s Substance Abuse Services was established in 1990 as a public service clinic. Many program elements apply equally well to various cultural groups, including individual and group counseling, limited time in treatment, and crisis intervention. Culturally linked clinical issues include provision of a supportive infrastructure, role models in leadership positions, understanding the cultural influences in patients’ lives, and establishing communication links with clients. Cultural themes are discussed as they apply to treating African-Americans, Latinos, Asian-Americans, Native Americans, and clients of different genders. Programmatic outcome indicators, including program attrition, suggest that different cultural groups benefit differentially from the treatment.

Keywords - cocaine, communities of color, cultural issues, recovery, substance abuse treatment

In the early 1980s cocaine use was predominantly a middle-class phenomenon and may have received more positive than negative attention (e.g., Gay 1981). However, through the first half of the decade cocaine use grew to a national epidemic (Dougherty 1984). By 1990, the use of crack, a highly addictive derivative of cocaine, had reached epidemic levels in the United States (town et al. In press), and its use had been linked to prenatal problems (Chasnoff et al. 1990), sharply increased criminality (Dunlap et al. 1990), adverse health consequences for adults (Creger 1989), overdose deaths (Escobedo et al. 1991), and sexually transmitted diseases (Quinn et al. 1990).

The problems of cocaine and crack abuse have been particularly acute in poor urban ethnic minority
communities. Wallace (1990) pointed out that inner-city crack smokers have distinctive treatment needs. Kleiman and colleagues (1992) indicated that African-American crack users may drop out of treatment more quickly than caucasians. The purpose of this article is to delineate the cultural issues involved in delivering cocaine treatment to a predominantly ethnic minority patient population. In addition, the Stimulant Treatment Outpatient Program (STOP) of San Francisco General Hospital’s Substance Abuse Services is described. Several aspects of the program apply equally well to various cultural groups. Other issues are closely linked to patients’ cultural heritage and cultural resources. The cultural issues, and techniques for turning them to the advantage of the treatment program, are reflected in the program’s outcome indicators.

STOP provides drug-free treatment as part of the Substance Abuse Services at San Francisco General Hospital. It is a public nonprofit clinic, and the majority of clients are African-American, followed by Euro-Americans, and in about equal numbers, Latinos and Native Americans. Clients’ connectedness and degree of compliance to the program is high, as demonstrated by an average attendance rate of 72%. Typically, there is immediate attrition from the program followed by a long-lasting commitment.

PROGRAM DESCRIPTION

History

STOP began in the spring of 1990, and its first year was rocky. In that year, the treatment approach was combined recovery work with some psychodynamic principles. While attendance to the group sessions (three times per week) was required, there were no consequences for failure to attend. Urine specimens were collected three days per week, and those from two of the days were actually analyzed. The program sought to complete a treatment episode after 12 weeks, but it became evident that this span of time was insufficient, at least as the treatment was structured; clients tended to remain in treatment approximately six months. The dropout rate during the first year was close to 75%.

After the first year, a new program director with many years of experience working with crack addicts joined the program. He developed a specific model of treatment that combined confrontation with staff support and mutual support among clients. Implementation of these methods at STOP improved client retention rates and overall program success.

Treatment Philosophy

The treatment goal at STOP is abstinence. All drugs, including alcohol and marijuana, are considered triggers to relapse that support an addictive lifestyle. Recovery is a way of life that involves coping with stress in new ways, developing a social network of people who do not use drugs, having a supportive life structure, and, very importantly, recognizing that recovery takes time and great effort.

Program Structure

Several aspects of the program apply equally well to various cultural groups. These include the following treatment elements and ground rules.

Groups. Group therapy occurs five days per week. Two sessions are for the whole community of clients (one educational, the other a process group). On the other three days, the groups are split by gender.

Morning Sessions. STOP groups begin at 9:00 a.m. Originally group sessions took place in the afternoon, as it was believed that clients would be unlikely to rise early enough for a morning group. Many clients would continue their nocturnal lifestyle and they would get up around noon to attend a 1:00 p.m. session. Switching groups to 9:00 a.m. forced clients to change their sleep cycle to approximate the larger society’s typical lifestyle more closely and facilitated making changes in their peer groups. Attendance at group sessions did not suffer.

Limited Time in Treatment. It was decided to limit a treatment episode to four months because that would be sufficient time to give those clients who had never been in treatment an understanding of the difficulty and challenge of achieving recovery. It would also drive home the concept that recovery had to become their first
priority, above their families and their work, in order to be successful. In addition, the pressure of a time limit would socialize the clients into the group and peer-confrontation model. Clients are given the message that they can apply for readmission 30 days after discharge and be reconsidered in light of their work during the earlier treatment episode. For those who have been in other treatment programs, the fourmonth episode begins with greater expectations for treatment compliance.

It is expected that by the end of the second month the client, with the active help of the counselor, will be ready to start the process of putting together a recovery package, will show consistent drug abstinence through clean urines, and will be attending a minimum of three Narcotics Anonymous (NA) or Alcoholics Anonymous (AA) meetings a week. An aftercare program must be in place by the last week of treatment. To participate in the “Moving On” ceremony, clients are expected to have abstained from drug use for two months. Recovery chips with the program’s insignia and a merit certificate are presented at this time.

Tight Structure. Clients who miss 40% of the weekly groups in the first month are terminated from treatment. Clients are not admitted into the daily groups if they arrive after the first 15 minutes, and only those who have called ahead to be excused for tardiness are allowed to enter late.

Extensions. Clients are considered for a one-month extension only if they have demonstrated complete abstinence and compliance with program expectations by the fourth month.

Buddy System. A buddy system, divided by gender, is encouraged in order to get clients to go to NA or similar 12-Step meetings, to create a support system that clients can turn to during vulnerable times, and to enhance social skills.

UNIVERSAL ASPECTS OF SUBSTANCE ABUSE TREATMENT INTERVENTIONS

The following treatment elements were found to be appropriate regardless of clients’ cultural backgrounds.

Recovery Groups

The program staff emphasizes that daily attendance at group sessions is a critical way of showing respect toward others’ recovery efforts and is an invaluable support to treatment goals, regardless of whether a client has used drugs on that day or previous days. Development of group cohesion and trust is a natural result of seeing fellow clients show up day after day and share their vulnerabilities.

Certain factors are critical in forming an alliance with patients in substance abuse outpatient treatment. One is for counselors to be straightforward and honest. A second tenet is to promote emotional and recovery support among the clients themselves. Much teaching takes place in the recovery groups in these two areas. These values and behaviors need to be modeled by the treatment providers themselves. It is within the context of the supportive confrontational model for cocaine treatment that clients begin to develop trust and to appreciate the value of not hiding behind a facade. Part of the learning process involves being able to hear constructive criticism (direct feedback) without feeling destroyed, and, reciprocally, to be willing to confront others as a sign of support and trust. The culture that evolves emphasizes interdependence and the value of each individual member to every other member as critical support in achieving and maintaining recovery.

Why are these factors important? Social transactions in the drug culture revolve around using and abusing others for a variety of reasons: to get money, to buy drugs, to sell drugs, to get high, to exchange drugs for sex. People support each other in the drug culture in a variety of ways: by boosting one another’s egos, by working for others, by reassuring others that their use is not bad, through affirmations, by watching out for the safety of other people, and by standing by and helping their partners so they do not get sick (if they are using heroin, for example). In effect, it is not the person but the protection of the drug and drug-induced state that substance abusers relate to. It is not surprising that many of the patients who come to STOP report that they do not have any friends, and, yet, they feel lost without their “using buddies.”

Patients who come to treatment for the first time bring with them the familiar armamentarium of behaviors
that have allowed them to maintain their addiction in the community and to survive in the shifting sands of the drug culture. They want to give the same type of support and receive it in return. Newcomers do not make the connection at first that these are drug-related behaviors. It takes a minimum of one four-month episode of treatment to understand the reality that people are there ultimately to stop deceiving themselves and to get on the painful road to recovery. It is through the therapeutic process of confrontation and support from staff and peers that this realization begins to sink in.

Confrontation in group involves focusing on one or two clients. Those who are in the early weeks of treatment are primarily observers and usually do not give or receive feedback; eventually they become the focus of the group. It is hoped that by this time they will have developed trust in others and in the process, and they will have learned from what has been modeled for them. Initiation into this modality is relatively unthreatening and firm. The focus may pertain to having difficulty in acknowledging the severity of one’s addiction, being dishonest in the group by stating one has not used although the urine specimens have tested positive, helping others in the group but not looking at oneself, or not sharing in the group. The program rests on the assumption that through active participation in the groups, recovery initiation and maintenance can occur.

Individual Counseling Sessions

Through individual sessions the client is helped to access specific resources and social services in the community to ease living and environmental stressors that might contribute to relapse. Individual clients may be disorganized in their ability to solve problems. The counselor’s role is to establish a structure that will help the client to take care of business in a gradual but consistent manner. It is also the responsibility of the counselor to guide and assist the client in establishing a reasonable recovery package by the time the client leaves the program, whether successfully or not. Successful completion implies a minimum of two months of drug abstinence, daily attendance at groups, and attendance at counseling sessions. Those who achieve these goals participate in a “Moving On” ceremony and are presented with a STOP chip and a certificate of completion.

Recovery is not defined by abstinence but rather as a way of life that initially includes recognizing drug-using social behaviors and self-deluding patterns, triggers, and setup behaviors. Subsequent steps include attending support recovery groups, such as NA and AA, developing new ways of coping with stress, learning appropriate social skills, broadening the repertoire of leisure activities, and shifting away from drug-using friends and toward friends who are not substance abusers or are themselves in recovery.

Given that treatment episodes last four months in STOP, it is not appropriate to conduct long-term psychodynamic psychotherapy or to start some forms of pharmacotherapy with individual clients. If psychological or psychiatric evaluation indicates such treatments are needed, the client is referred to community providers. Brief therapy models and/or cognitive behavioral interventions may be designed to focus on core conflicts or target behaviors related to addictive behavior patterns. A client may be seen with significant others as needed for a short intervention as well. In addition, following up on earlier research indicating the potential usefulness of pharmacotherapies for depression in drug abuse treatment (Batki et al. In press), patients have the opportunity to participate in pharmacotherapy research projects.

Crisis Interventions

Clinical observation indicates that many clients in STOP will experience crises. Most often these center on acknowledging the destruction of their lives by the severity of their addiction. For example, they may consume all their money, neglect their spouses and children, or lose (or are driven out of) their homes. Crises can also arise from their inability to control their substance abuse because their partners or housemates are heavy drug users themselves. The seemingly uncontrollable nature of these events may lead to severe depressive symptomatology and suicidal ideation. At these times, the staff should coordinate crisis intervention that includes a psychiatric evaluation and possible pharmacotherapy, short-term crisis-oriented psychotherapy, and possible hospitalization. Setting up therapeutic contracts with individual clients may be required to help control drug-using behavior and/or to manage suicidality in a client who does not meet all criteria for hospitalization. A client may be asked to call in to the clinic on both days of the weekend and leave a message about how he or she is doing. Crisis
Related Issues

It is important to anticipate certain problems once clients adapt to this supportive system of relating. They see that they are with similar people involved in recovery. They experience the welcoming warmth of the program and the investment and struggle of their peers through their own recovery. Emotional bonding naturally develops. Romantic liaisons or subgroupings outside of the program sometimes result. These engagements create a high level of stress, particularly when a relationship is extramarital. They can lead to relapses if one of the partners or subgroup members exposes the other(s) to predictable triggers. Hidden agendas of this sort create destructive collusions between clients. If group members become involved romantically they are discharged, or one member of the pair has to leave the program. Couples cannot be admitted jointly to receive treatment, as there are not enough split groups to allow for separation during treatment.

CULTURAL FACTORS IN TREATMENT

Substance abuse treatment programs draw clients from diverse socioeconomic levels and ethnic/cultural backgrounds. Outcome literature on the effectiveness of cocaine treatment has explored factors that may be associated with relapse prevention (Washton & Stone-Washton 1990) and with the differential effectiveness of specific treatment models (Kang et al. 1991). Culturally bound communication patterns may facilitate or impede responsiveness to specific treatment interventions, and providers may maximize their effectiveness when they integrate a cross-cultural perspective into their professional development and treatment framework.

Infrastructure

Certain infrastructural components must be in place in any treatment program in order to provide culturally relevant services. The program needs to be in the community of the target population or accessible through public transportation. Ideally, staff ethnicity and language capabilities should reflect the ethnic minority population that is being served. There must be a commitment on the part of top management to fill vacant staff positions with persons of color of both sexes. This requirement usually means that it will take longer to fill vacancies.

The multiethnic staff must receive training in cultural sensitivity and in becoming culturally proficient. An important aspect of this training is to teach counseling staff to look at themselves and assess their own stereotypes, biases, and prejudices regarding members of other cultural groups. For example, instead of expecting that the soon-to-be born fifth child of a pregnant crack addict will automatically go to a foster family, expect that the mother in treatment may turn her life around. Even when clients arrive smelly or disorganized, the provider should ask the client to sit down and explain what is going on. Dr. Dan McFarland (former director of the Redwood Center, an alcohol and other drugs residential treatment program in Redwood City, California) used to remind one of the authors, “We’re all here because we’re not all there.” Demonstrating respect for and understanding of the client’s plight goes a long way in developing trust.

Clinical meetings and case presentations provide opportunities to highlight the possible influence of cultural and ethnic factors in response to treatment. A provider must become knowledgeable about the uniqueness of the drug culture and the differences between his or her cultural values and communication patterns and those of clients who belong to a different ethnic or cultural group.

Staffing

There are different views regarding the benefits of having only bicultural-bilingual ethnic minority staff, staff in recovery, and a multicultural staff. At minimum, there must be role models in a substance abuse treatment
program for the primary ethnic group that is being served. The models should include successful men and women of color as frontline treatment providers but also as managers. Staff in recovery enhance a client’s self-esteem and heighten awareness that one can attain recovery and reintegrate into the labor force.

An African-American man seeking treatment for substance abuse, on being assigned a male African-American counselor, may sigh with relief and think hopefully, “Ali, he’s a brother, I’ve got a break coming.” A provider in this situation can more quickly cut through the manipulations and verbal games, and “talk straight.” However, the client may initially expect that the staff member is going to be more lenient. Whether or not patients and providers share the same ethnic background and/or experience with the drug culture, a bond is facilitated in that patients might feel that they will not have to explain themselves from the beginning, that critical or common experiences might be understood immediately. This sense of familiarity may lead to expectations that the relationship can be more informal or more intimate than is appropriate. Conflict may also arise with the assignment of a female counselor to a male client if the client comes from a cultural group that devalues women as authority or expert figures. Because of these issues it is imperative to set professional boundaries from the start, and, while being compassionate, to maintain the same expectations for compliance from all clients. Those in management positions play a crucial role in modeling high standards of professional respect toward male and female counselors alike.

In a program with a multicultural staff treating people of color, clients will initially resist and test limits. These behaviors may include wearing hats and sunglasses during the treatment sessions, refusing to remove heavy jackets, arriving late to sessions, acting in a hostile manner, and not responding when addressed (Gibbs 1989). African-American clients may use intimidating behaviors and speak in their own vernacular street-language that the counselor may not understand (Franklin 1982). Female African-American clients may act in a seductive or sullen manner (Gibbs 1989). These behaviors may be manipulative at the same time that they communicate uncertainty as to whether a counselor from a different culture or of different gender, or one who has not abused drugs, will understand a person’s world or predicaments, and whether they will be able to help without being judgmental.

As in any therapeutic interaction when this issue comes to the fore, whether directly or indirectly, it behooves the counselor to confront the issue head-on and reflect the possible thoughts, questions, and doubts that the client may be experiencing. At the same time, clients need to be reassured that counselors’ training and experience make them competent to work with clients from a different socioeconomic and/or cultural background (e.g., “A surgeon does not have to have had back surgery himself or herself to be able to perform surgery on a patient”). Clients must learn to identify their own prejudices and misconceptions. A client may say outright, “I don’t want a White person (or a woman, or a man)” and, when asked, most are unable to say why. This automatic response comes from old scripts that may have no current basis, and the client needs to be alerted to his or her own biases.

Finally, a culturally proficient counselor must be able to elicit information from the client so as to understand the person’s real world. Mutual education between the provider and the client can form the basis for a strong therapeutic alliance.

Cultural Influences

As described in sociological, ethnographic and anthropological literature, values, attitudes, and communication patterns are unique aspects of a culture (Thompson, Ellis & Wildavsky 1990). These variables may include the concept of time, attitudes toward health providers and authority figures, gender roles, spiritual practices, personal space, socialization patterns, utilization of leisure time, value of family network, and intergenerational relationships. In addition, culturally patterned coping strategies and defensive behaviors are developed in response to chronic environmental stressors (Franklin 1982). The treatment literature indicates that ethnicity affects patient expectancy, engagement in treatment, service utilization, patient selection bias, and attrition from treatment (Brown, Joe & Thompson 1985; Yamamoto, James & Palley 1968).

It is essential to differentiate these culturally determined behaviors and attitudes from those that result from socioeconomic status (SES) factors. Access to adequate housing, education, health, and jobs is determined
by socioeconomic and political realities. Drug abuse patterns tend to be related to SES and environmental factors and not to cultural norms. Inner-city communities of color are prey to the unchecked advertisement and marketing of licit addictive substances, such as tobacco and alcohol. The poverty, neglect, and limited access to resources that are endemic to these communities produce stresses and shifting values that emphasize survival. This systemic and entrenched deprivation may encourage escape to apathy and denial through the use of drugs (such as crack) and may also lead to a shift in achievement values in hopeless youths and adults who may see that a viable path to making money and earning respect is through dealing drugs.

While environmental triggers do not have color barriers, they do take on certain culturally bound characteristics. These can include certain friends or acquaintances, bandannas, tattoos, khaki pants, rattan shoes, housing areas, cigarette packs with cellophane wrapping, and cigarettes with filters removed. Universal triggers typically include congregating on the street corner, liquor stores, hot weather, drug paraphernalia, and money.

COMMUNICATION

The use of a common language becomes essential in a drug treatment program. Each culture, whether ethnic, drug related, gender related or of a specific sexual orientation, has or develops its own vernacular. A provider who does not belong to the culture of the client lacks a language tool. At the same time, the provider has his or her own technical language based on training and mode of treatment. The counselor’s language may be unintelligible to the client. Counselors may note that the client is not understanding or following what is being said by observing elements of body language, such as posture, facial expression, and activity level.

With time, education, and experience the provider will come to understand some of the lingo of the patient and his or her cultures (gender, ethnic, sexual orientation, and drug). It is okay for staff to use the client’s language, but in a selective manner. Using specific terminology properly, in an un-intimidating and respectful way will help the counselor to have more control of the process. It will also communicate to clients that the provider can identify with their language and understands why they are saying certain things. The staff must understand the context and the language in order to teach the client what would be the appropriate words to use in the dominant culture, if necessary.

However, it is more critical for the provider to use a language that is simple and understandable, and is his or her own. Individuals from different cultures are receptive to the way communications are delivered. The inflection of a voice, direct or indirect eye contact, posture, and other nonverbal behaviors are many times more powerful in developing trust and rapport than verbal communication.

A relevant question in the realm of communication is whether the confrontation group treatment model for substance abusers is effective across cultural groups. It does appear to be efficacious for African-American male clients in STOP, and has produced good responses from the small sample of male Latinos and Native Americans, in that they have completed their treatment. Most Asian patients and a large proportion of the women that have been admitted to the program did not complete their treatment episodes.

In working with individuals of color it is imperative to know their level of acculturation to the predominant European-American culture and whether they are of mixed parentage (biracial, bicultural). A Chicano client who is second- or third-generation American born will typically have English as his or her primary language, will have attained a higher level of education than the average Latino immigrant, and, consequently, will be of a higher socioeconomic level. The client might be bicultural; that is, able to fit in with and understand the values and behavior patterns of Latinos/Chicanos and European-Americans. Because of these characteristics the individual may benefit from a diversity of substance abuse treatment modalities. On the other hand, if the client is foreign born with adequate English ability and low educational attainment, and living in a barrio, one would expect that his or her values, attitudes, and behaviors would be more like those of the country of origin. In this case, treatment would have to be tailored specifically to the cultural context of the individual, and the provider would have to be acutely cognizant of interpreting behaviors and respecting the client’s values.

African-American
While clear class and regional differences in the African-American population lead to subcultural characteristics, nevertheless certain African-American traditions are commonly shared. The African-American culture has a highly developed oral tradition of storytelling, and humor is an integral part of this tradition (Gibbs 1989; Labov 1972). For most African-Americans, actions speak more loudly than easy words. In the African-American community, “being Black has come to symbolize honesty, capability of bearing great pain, sorrow, strength, and truth in the face of great adversity” (Yee 1990:10). The Black kinship system is very extensive, interdependent, and cohesive. Ethnographic studies give evidence that in African-American low-income families, parent-child communication has a tendency to be confrontational (Peters 1981; Bartz & Levine 1978). Because of traditional economic necessity, there is considerable flexibility in family roles and fostering of early independence in children (Peters 1981). The church is a stalwart of the culture and the family (Gibbs 1989).

The confrontational/focus group model of treatment as used in STOP clearly works for African-American male clients. It is based on verbal interaction, it promotes bonding and support systems through action, and it intensifies the therapeutic milieu through confrontation in a supportive setting.

African-American female clients do not participate in mixed group processes to the same extent as their male peers. They display great sensitivity to any words or communications that imply judgment or deprecation of women (e.g., referring to women in the drug culture as “tossups”). Many African-American female clients at STOP have expressed a feeling of being covertly judged by their male peers as bad mothers or bad women, with all that these concepts imply. These women behave very differently in all-female groups, where they become active participants.

Latinos/Chicanos

Latino/Chicano peoples may share the same formal language and specific common values; however, their geographic, ethnic (Native American, Asian, African, European), and historical diversity produce unique subcultural variations. Nevertheless, in Latino communities in general, Catholicism, strong family ties (familismo), personal connectedness (personalismo), and respect (respeto) are hallmarks of the culture (Buriel 1984). These values translate into intergenerational living arrangements, small personal space, more friendly physical contact, slowness to self-disclose, and a reluctance to disagree with persons in positions of authority. Defined sex-roles create a double standard, with extensive economic, physical, and sexual freedom for men and considerable restrictions of word and action for women. Latino males of certain socio-occupational groups tend to be bound by expectations to be forceful and not to be emotionally expressive, except when under the influence of alcohol (Alaniz 1992). Sons, regardless of their age and behavior, are particularly coddled by their mothers. It is not unusual for adult children to live at the parental home throughout their lifetime if they are single (Yee 1990; Ramirez 1989; Martinez 1988).

Given these cultural parameters, the STOP model of confrontational/support-group treatment may be effective for Latino males but not for Latinas. An immediate reaction might be that this approach may conflict with Latino males’ machismo, which has been primarily associated with three extreme aspects of masculinity: sexual virility, the withholding of tender emotions, and aggressiveness. However, the full concept of machismo also incorporates strength, the breadwinner role, personal honor, devotion to children, and a strong loyalty to the family (Ramirez 1989). Moreover, in the United States, prevalence of machismo in the Latino family is diminishing as Latinas are increasingly working outside the home. Their wage-earning power has improved their status at home and their involvement in decision-making processes (Baca Zinn 1980; Perez-Arce 1986). At STOP, Latino males who have been in treatment integrate into the recovery groups without much difficulty. They are able to give and receive feedback, and their ability to bond with other male members of color is strong.

However, depending on their level of acculturation to the European-American culture, it may take longer than European-Americans for Latino males to trust the recovery group process and feel safe in self-disclosing or appearing vulnerable and emotional. One would expect that nonverbal expression of emotion would precede verbal ones. Latinos express themselves through solid handshakes, by occupying close personal space with others they feel comfortable with, by sharing concrete things (such as writings or gifts of food), and by
introducing significant others to the people they respect. Bonding tends to occur between male clients. Women would suffer from the imputed shame of being a female drug user, sexually active, and possibly neglectful of their children. It would be unlikely that Latinas could benefit from this model of treatment, at least in a mixed-gender setting. STOP has not been successful in retaining Latinas in a mixed-group treatment model. It may be that the type of male Latino clients that access STOP fit a specific profile. They may be more acculturated to the dominant culture, they may want to change their destructive substance abuse patterns in order to uphold their family values and commitments, or they may feel more comfortable self-disclosing in a multicultural group as opposed to a homogeneous Latino male group.

Asian-American/Pacific Islanders

Even though the Asian and Pacific Islander populations living in the United States are very heterogeneous because of their diverse cultures, languages, histories and demographic characteristics, most of them appear to share certain values (Yee 1990). These include the perspective that each individual has a definite place in society and prescribed status; thus, all relationships are complementary, such as leader-follower, teacher-student, elder-youth. The needs of the family precede those of the individual. Family loyalty and maintenance of family harmony are stressed. The last value leads to avoidance of direct confrontation or criticism, as these behaviors would be considered disrespectful (Yee & Hennessey 1982). Because of these principles of behavior, a treatment approach that expects that all clients treat each other as peers regardless of their age, occupation or experience, that promotes same-sex bonding as a support mechanism, and that utilizes a direct confrontation and feedback approach as its basis, may not be appropriate for many Asian-American clients.

Native Americans

Native American tribes in the United States have many linguistic and cultural differences. They share with other communities of color an importance placed on the interdependence of the family or clan, and respect for elders. As a group, they do not dichotomize humans and nature or the spiritual and the physical. Instead, they believe in the unity and sacredness of all nature and the universe. Ritual ceremonies are a critical vehicle for bringing the tribe together. Native Americans are frequently perceived as nonassertive, nonspontaneous, and soft-spoken in verbal interactions. They maintain limited eye contact and are reluctant to self-disclose (Yee 1990; McShane 1987). Depending on the particular tribe, women may hold important leadership and decision-making roles (LaFramboise & Low 1989).

Certain presenting interpersonal behaviors of Native Americans may make it difficult to integrate them into a highly verbal, confrontational group process. It is easy to misinterpret poor eye contact, not being straightforward, and not giving feedback as representing lack of motivation or resistance to doing the work. Treatment staff who feel a client will ultimately benefit from this modality must work individually as well as through the group to draw the Native American client into the process, understanding the cultural imperative of certain ways of relating. It also may take longer to reach the desired level of preparation for and commitment to recovery for these populations. On the other hand, respecting a different mode of interpersonal communication and, at the same time, expecting the same degree of compliance may produce the same results. It is useful to see the daily recovery groups and the “Moving On” ceremony as important healing and rite of passage rituals within the context of traditional societies. The self-identified Native American clients who have stayed in STOP are of biracial parentage.

Gender

It appears that the confrontation model is not the most effective for women. This clinical observation is based on poor retention of female clients, on their limited participation in mixed-gender groups, and on their contrasting active participation in all-female groups. Direct experience-substantiated by those who have worked with female crack abusers through other programs (Noel Day, personal communication, President, Polaris Research and Communication, San Francisco) - and research studies (Inciardi, Lockwood & Pottieger 1991) provide evidence that men and women experience being high on crack very differently. Two of the authors conducted a pre- and postrecovery education group on sexuality with all the clients in the program present.
There was a marked difference between the graphic descriptions of the male and female clients of both their sexual experiences and fantasies while smoking “the pipe.” While the men seemed transported to some heaven of ecstasy, the women watched and listened with amusement, but when they in turn described their experience, no sense of sexual pleasure was expressed. Repeatedly these women attested to not being involved with the sexual aspect of the experience; rather, all they could think about was the pipe. One woman revealed that she would usually have sex before smoking the pipe so that she could feel and enjoy the sexual experience.

Clinical observation indicates that mixed-group dynamics using the confrontation model are not conducive to women’s participation as full peers. This differing experiential pattern may be related to the way men and women relate in the drug culture, where the latter are most likely to be exploited, misjudged, and made to feel guilty and ashamed (Inciardi, Lockwood & Pottieger 1991). At the same time, it may be that women benefit the most from same-sex groups, as female peers know and can relate to what it is to be a woman, mother, grandmother, wife, old lady, daughter, worker, and drug user. Notwithstanding the fact that the value and sex-role expectations for women differ depending on the ethnic and cultural groups, it may be that confrontational tactics in recovery groups need to be modified to fit the communication and relational patterns of women (Tanner 1990).

Childcare is one of the most critical elements for assisting and keeping women in treatment. Most of STOP’s female clients have children out of wedlock and are involved in the social service system (e.g., Assistance to Families with Dependent Children and Child Protective Services). They lack the resources that are necessary to fulfill their obligations or to maintain custody of their children. Many are told that they “must go to a parenting class in the Haight Ashbury district, then must attend vocational training at Glide Memorial Church, and in addition they must attend drug treatment at STOP” In some instances, the mothers must attend these programs on the same day. Without childcare help or transportation or stable housing, it is extremely difficult for these women to succeed. Substance abuse treatment programs must integrate into their structures ways of meeting the special needs and communication styles of women.

PROGRAM OUTCOME
INDICATORS

STOP is an intensive and structured program. It requires daily attendance to 90-minute morning groups plus weekly counseling sessions. Clients who fail to attend a high proportion (at least 60%) of the groups during the first month are likely to be terminated from treatment. In June 1992, 29 clients had been actively enrolled in STOP for, at minimum, one month of treatment. The ethnic makeup consisted of 69% African-American, 17% non-Latino White, 7% Latino, and 7% Native American. While this sample is very limited, the authors believe it does approximate the general ethnic constitution of STOP In October 1992, 50% of the clients who had been admitted in June and were still in treatment at the one-month cutoff, completed the four-month treatment episode. All of the nonLatino White clients had dropped out of treatment.

In a four-month sample, May to August 1992, 23 (60%) of the 39 clients admitted into treatment completed the first cutoff point of four weeks. An average of 80% of the one-month completers were still in treatment three months later and an average of 45% completed the four-month treatment episode. Of this latter group, eight (80%) were African-American, one (10%) was non-Latino White, and one (10%) was Latino.

One explanation for the high average retention rate from month two to completion (45%) is the screening out that results from the intake process and the treatment expectations by the first month after admission. A seemingly effective filtering process occurs from the time of the telephone intake screening. In the telephone screening, the individual inquirer is informed of the strict requirements for attendance. On the average, 41% of those who decide to schedule an intake at STOP ultimately show up for their appointments. Of those who go through the final intake process and are admitted into the program, approximately 60% stay in treatment longer than four weeks. To illustrate, in June 1992, 35 persons called to inquire about STOP; of these, 16 scheduled an intake appointment. Six of the scheduled potential clients were in treatment past the fourth week of treatment. Some of these individuals never showed up for their appointments, others dropped out after starting treatment,
and others were terminated by the fourth week because of poor compliance with treatment expectations. The dropout rate decreases dramatically after the first month to an average of 45%.

CONCLUSION

The experience thus far at STOP in developing a treatment program for cocaine (primarily crack) dependence suggests that distinct cultural groups benefit from this treatment modality. It appears that males, primarily African-American males but not excluding Latinos and Native Americans, are receptive to and challenged by a confrontational treatment approach in groups that emphasize interdependence and emotional support. Once initiated into the modus operandi of the groups, clients participate fully in the process. It has been observed that a strong bonding develops across males of color in this process. Those attempting to follow concrete steps to recovery will call each other when experiencing cravings and will go together to 12-Step recovery groups in the community.

Importantly, STOP has a multiethnic staff and a clear infrastructure. People and communities are not insular. In order to survive socially and occupationally, one must learn the language of other cultural groups as well as their value systems. That is why the counseling staff are encouraged to be themselves, to bring what they know and have experienced into their work with clients as therapeutic and educational tools. The demanding structure of the program, with its emphasis on timeliness and accountability, attempts to replicate the demands imposed by any work setting. Recovery is viewed as a process of learning to adapt to the dominant society; it implies being able to function in a world where one must play by different rules in order to succeed; that is, to maintain recovery.

As has been mentioned, the confrontational group model used at STOP has not been fully tested with members of other ethnic-cultural groups. Asian and female clients have not been able to stay in treatment on a consistent basis. It may be that female crack addicts of color need an altogether different treatment modality. Major components of any program for women must include training in assertive behaviors and adaptive coping mechanisms for stress. Women in particular rely on social networks, such as the extended family, for strength and support. Strong female role models are essential. Thus treatment staff must include managers and counselors who are female, of color, and in recovery. In regard to Asian populations, cultural patterns of behavior may conflict with the confrontational approach used in STOP.

Another factor that may affect dropout rate is feeling alone or like an outcast in the group setting, however subjective this perception might be. It will be difficult for a client who can only understand or relate to the culture of one other client (or none at all) to survive within the predominant culture if it is very different from the client’s own. These lone individuals in treatment would need a greater support system within the treatment setting and stronger links to their family and community in order to stay in treatment. Such supports within the clinic could possibly include more frequent individual counseling, a greater effort to bring in significant others as part of the treatment, a strong but subtle attempt to connect the client to at least one other client of the same sex for the purpose of going to 12-Step meetings or calling when cravings are experienced, or a gentle but frequent focus in groups that would include explorations of how the client felt being the only person from his or her culture. Hiring staff and recruiting other clients of the same ethnic cultural background would be equally important.

The newly developed STOP modality described in this article has not yet reached one year of development. It has begun to lay a foundation on which other critical components must be built once there are sufficient staff and space. Childcare, transportation money for clients lacking resources, and case management services for those with poor organizational and follow-up skills are important elements that need to be developed. Clinically, aftercare groups for those who have “moved on” are necessary to provide building blocks for recovery. Fortunately, STOP will be able to start an aftercare group in the spring of 1993. Another very important service would be to add couples’ counseling. Approximately 50% of STOP clients come into treatment involved in relationships, usually with a partner who also uses drugs. Many of these clients have the misconception that they are in a relationship, but in the view of STOP, many end up “taking hostages” (i.e., they hang on to a partner out of the fear of loneliness, and are unable at present to understand and function as true partners): It is through couples’
counseling that these destructive behavior patterns can begin to be identified.

It is evident that extensive research needs to be conducted on the applicability of specific crack cocaine treatment approaches to a diversity of ethnic or cultural groups and by gender. For example, the substance abuse literature abounds with studies of alcohol use and abuse in women, yet little is written about the developmental cycle of use and abuse of illicit substances, such as crack and heroin, in women. Substance abuse treatment providers must receive education, training, supervision, and consultation opportunities to work with clients of different cultural backgrounds.

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REFERENCES


