



SECOND EDITION

EMBRACING DIVERSITY

Treatment and Care in Addictions Counseling



Written and edited by
Tiffany Lee, Ph.D.

Embracing Diversity

Treatment and Care in Addictions Counseling

Second Edition

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Western Michigan University



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Introduction

By Tiffany Lee

Addiction is an equal opportunity disease, impacting people of any age, gender, race, ethnicity, religion, sexual orientation, geographic location, education level, and socioeconomic status. Not all people, however, experience substance use, misuse, and addiction in the same way. The etiology differs among and between groups of people, and not everyone enters treatment for the same reasons. Treatment efficacy can be affected by cultural variables, and these variables must be taken into account by researchers and clinicians as well as clients and their family members. In other words, aspects of culture and diversity have vast implications for the delivery and success of substance abuse treatment services provided to special populations.

The term “special populations” has been used in the substance abuse field since the 1970s (Hegamin et al., 2002). By definition, a *special population* is a subgroup that historically has been underrepresented in prevention and treatment clinical research and are considered vulnerable (Winter et al., 2018). The term originated in an effort to address the unique needs of underserved populations and provide appropriate and efficient services to these groups. These vulnerable groups tend to have limited access to resources and disproportionately experience premature mortality and morbidity (Hailemariam et al., 2020). Therefore, population-based approaches have been widely advocated in an effort to reduce these concerns. According to Grimsrud et al. (2013):

Special populations should not be forced to remain “special” out of ignorance of their conditions, treatments, adverse events, and outcomes. Research must be conducted to enhance our knowledge and provide better care for each individual within those populations, for the same ethical reason that they are considered special. (p. 13)

Special populations include, but are not limited to, the following subgroups:

RACIAL AND ETHNIC POPULATIONS:

Alaska Natives	Arab Americans	Asian Americans
Black/African Americans	Latino/a Americans	Native Americans
Native Hawaiians and Other Pacific Islanders		

CULTURALLY DIVERSE POPULATIONS:

Adolescents	People in the criminal justice system	People living with HIV/AIDS
College students	People with disabilities	People identifying as lesbian, gay, bisexual, or transgender
Older adults	People who are economically disadvantaged	People within the military
Women	People living in various geographic locations	People without permanent housing
Young adults	People with co-occurring disorders	People identifying as spiritual and/or religious
People with chronic pain		

Most clients have multiple, intersecting identities and can fit into more than one category of special populations. For instance, a client can present for substance abuse treatment who is:

- A 20-year-old, gay, partnered, Chinese American man who was arrested for driving under the influence and is coming in for an assessment. He recently revealed his sexual orientation to his family, and he reports his family members had a negative reaction to this disclosure. He indicates an increase in alcohol consumption to cope with his feelings.
- A 35-year-old, heterosexual, married, White man who was released from the military a year ago. He was diagnosed 2 months ago with posttraumatic stress disorder and a traumatic brain injury. He now goes to the Veterans' Affairs Medical Center to address his concerns, which is almost an hour away from his home in rural Alabama. He reports daily use of cannabis and alcohol.
- A 43-year-old, divorced, African American woman who is required to attend counseling due to involvement with Child Protective Services. Her partner was arrested for domestic violence, and during the incident, police officers found cocaine at the residence.
- A 78-year-old, widowed, White woman who has been prescribed Norco, an opioid pain medication, for the past 3 years. The client's daughter has noticed her mother feeling "sick" and taking more pills than prescribed. Recently, the client's daughter accompanied her mother to a doctor's appointment and told the physician that she found her own Vicodin pill bottle empty, and the client admitted taking the medication.
- A 55-year-old, divorced, Mexican American woman who was released from prison last month. She was convicted of manufacturing methamphetamine. She is unemployed, lives at the local shelter, has lost custody of her two children, and has a past diagnosis of bipolar disorder and borderline personality disorder.

Consideration must be given to each identity and how they intersect in an effort to effectively conceptualize clients. The term “intersectionality” was first coined by law professor Kimberle Crenshaw in 1989 and added to the Oxford Dictionary in 2015. *Intersectionality* is defined as the interconnected nature of social categorizations (e.g., race, class, gender, etc.) as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage. Substance abuse counselors should be able to understand how the various multicultural aspects of a person’s identity impact not only the use of substances but also how these aspects correspond with particular barriers, counseling strategies, risk factors, preventive factors, and treatment outcomes.

“We tend to talk about race inequality as separate from inequality based on gender, class, sexuality or immigrant status. What’s often missing is how some people are subject to all of these, and the experience is not just the sum of its parts.”

—Kimberle Crenshaw

On the other hand, counselors must be careful with generalizations, as each group is highly heterogeneous. Intragroup differences exist among racial and ethnic groups. For instance, Latino/a Americans can include Cuban Americans, Mexican Americans, Central and South Americans, and Puerto Rican Americans. Although individuals from these places of origin may identify as Latino/a American, their country of origin, upbringing, level of acculturation, age, education, religion, and current place of residence are very important to consider. All of these have the potential to influence worldview, spirituality, community orientation, definition of family, communication styles, boundaries, authority issues, learning styles, views of respect, and attitudes related to helping professionals.

Moreover, a client’s identity is fluid and can change over time. For example, a middle-aged woman born in the United States was raised by a Latino, Catholic father born in Mexico and a White, Protestant mother born in the United States. As a youth, the woman did not self-identify as a Latina, but over the years she has identified with that ethnicity and culture. An individual’s categorization of self may deviate from what the therapist believes to be the “membership” of various identities. The reactions, behaviors, attitudes, and characteristics of a person may be erroneously attributed to a particular identity and, in fact, perpetuate stereotypes and misperceptions of a specific population.

An Asian saying posits, “All individuals, in many respects, are (a) like no other individuals; (b) like some individuals; and (c) like all other individuals” (Sue et al., 2019, p. 33). One’s identity has three levels: (1) individual; (2) group; and (3) universal. Individuals have universal commonalities because we are human (e.g., biological and physical similarities); as part of a group identity (e.g., gender, race, sexual orientation), individuals have similarities and differences; and at an individual level, we are all unique (refer to Figure 0.1 below). In summary, practitioners and researchers must recognize these three aspects of a client’s personal identity, as each influences the lived experience of a person.

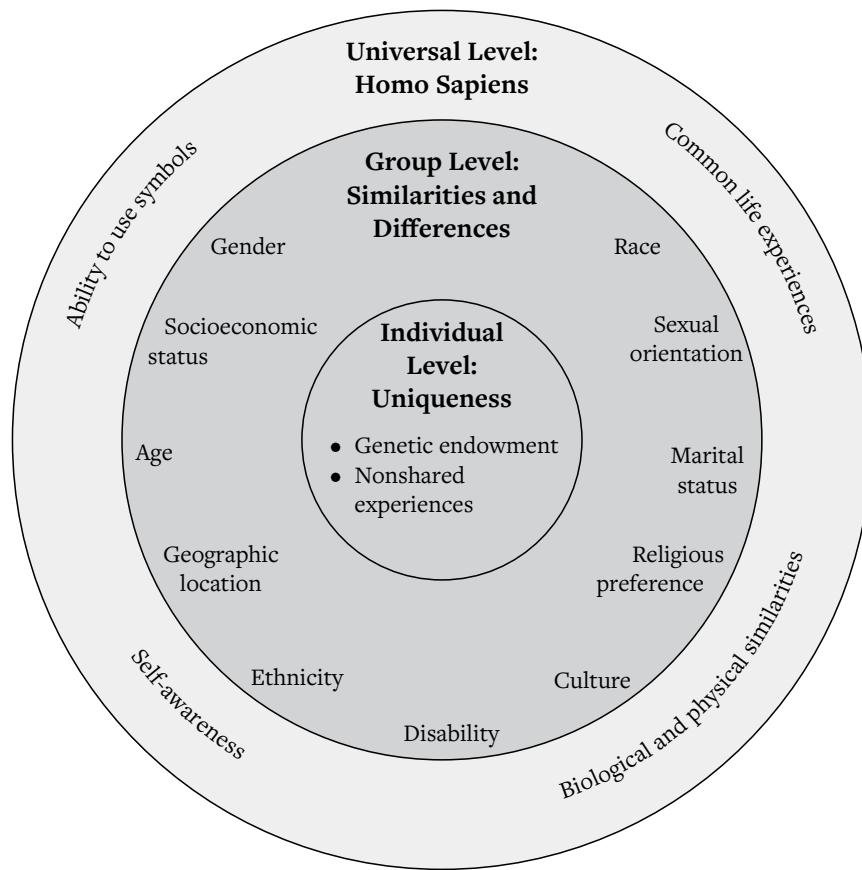


FIGURE 0.1 Tripartite Development of Personal Identity (Sue et al., 2019)

Research on Special Populations

For over 40 years, the National Survey of Substance Abuse Treatment Services (N-SSATS) has collected data on the location and characteristics of addiction treatment facilities and services throughout the United States. In 2020, 94% of clients in treatment programs were at outpatient settings; 5% of clients were in residential facilities; and 1% of clients were in hospital inpatient facilities (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021a). N-SSATS results indicated that the use of medications in treatment have increased from 2011 to 2020. For instance, the proportion of all clients receiving methadone increased from 25% in 2011 to 29% in 2020, and those receiving buprenorphine increased from 3% to 16%. Another noteworthy finding of the survey is that 55% of clients in treatment were diagnosed with a co-occurring mental disorder.

To explore this treatment data further, the author would like to include an overview of admission data that is collected from the Treatment Episodes Data Set (TEDS) and analyzed by SAMHSA each year. The TEDS report provides information on the demographic

and substance abuse characteristics of admissions to treatment by agencies that report to individual state administrative data systems. (Note: The data includes adults, aged 12 and older.) The most frequently reported primary substances of use in 2019 were opiates (30%), alcohol (17%), stimulants (12%), marijuana/hashish (11%), and cocaine (6%) (SAMHSA 2021B). Of those admissions, the two racial groups admitted into treatment at the highest rate were non-Hispanic Whites (66%) and non-Hispanic Blacks (20%). Refer to Table 0.1 for a full listing.

Substance abuse patterns also differ between racial/ethnic subgroups, as indicated by the TEDS data. Also shown in Table 0.1 is the data related to the primary substance of use by race and ethnicity. Opiates were the drugs reported most often as the primary substance by far, with heroin being the reason for most admissions. In Table 0.1, each column shows which group reported that drug as their primary substance of use at admission. Looking down each column, the data indicates White individuals consistently held the highest percentage for almost each drug category. In other words, White persons more frequently reported their primary substance was alcohol, opiates, marijuana, methamphetamine, and so forth, as compared to people from other racial or ethnic groups. The only two drugs that White persons did not most often report as their primary substance was smoked cocaine and PCP. Of those who reported that their primary substance of use was smoked cocaine, 52% were Black, 40% were White, and 9% were Hispanic. When PCP was the primary substance of use reported, 67% of those indicating so were Black, 21% were Hispanic, and 19% were White.

When looking at racial/ethnic groups individually (in Table 0.2), the reader is asked to scan the data across, by row. To highlight some of the findings, the following are the top three most reported substances for each population:

A. Indian/Al. Native	alcohol (27%)	other (22%)	methamp/amp (14%)
Asian	alcohol (24%)	methamp/amp (18%)	heroin (18%)
Black	heroin (21%)	marijuana (20%)	alcohol (14%)
Hispanic	heroin (25%)	alcohol (17%)	marijuana (15%)
Native Hawaiian/ Pacific Isl.	methamp/amp (27%)	heroin (20%)	alcohol (13%)
White	heroin (25%)	alcohol (18%)	methamp/amp (14%)

Another finding worth highlighting is the data among those who identified as different Hispanic origins. For instance, 28% of individuals of Mexican origin reported methamines and amphetamines as the primary substances of use, while only 2% of individuals of Puerto Rican origin indicated so. Additionally, 46% of individuals of Puerto Rican origin reported heroin as their primary substance of use, but only 17% of individuals of Mexican origin indicated such.

TABLE O.1 Primary Substance of Use Indicated at Admission

Race and ethnicity	Primary substance use at admission									
	Alcohol		Opiates							
	All admissions	Alcohol only	With secondary drug	Heroin	Other opiates	Smoked cocaine	Other route	Marijuana/ hashish	Methamphetamine/ amphetamines	Tranquilizers
Race	Total	1,864,367	321,789	252,359	438,288	127,322	63,912	43,451	208,843	219,824
American Indian or Alaska Native	2.9	4.5	3.3	1.1	1.5	0.7	1.0	1.8	3.5	0.8
Asian ¹	0.6	0.9	0.5	0.5	0.4	0.3	0.7	0.7	1.0	0.8
Black or African American	20.0	15.5	26.8	17.3	10.7	52.2	32.5	34.8	6.1	8.6
Native Hawaiian or Other Pacific Islander	0.4	0.3	0.3	0.2	0.2	0.2	0.3	0.4	0.8	0.3
White	66.3	69.7	59.5	70.0	81.4	39.6	53.8	50.0	77.2	80.3
Other	9.7	9.2	9.6	10.8	5.8	6.9	11.6	12.4	11.4	9.3
Total	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ethnicity										
Specific Hispanic or Latino origin	14.5	14.3	14.3	15.2	8.8	9.5	17.6	19.3	17.0	12.1
Mexican	4.2	4.3	4.0	2.9	2.0	0.8	2.6	5.7	9.7	1.7
Puerto Rican	3.7	2.4	3.7	7.0	2.0	3.6	5.8	3.7	0.5	4.2
Cuban	0.3	0.3	0.2	0.2	0.2	0.7	0.6	0.5	0.2	0.3
Other	6.4	7.3	6.4	5.1	4.6	4.4	8.6	9.4	6.6	5.8
Not of Hispanic or Latino origin	85.5	85.7	84.8	91.2	90.5	82.4	80.7	83.0	87.9	87.2
Total	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

- Quantity is zero.

¹For some states, "Asian" includes "Pacific Islanders."

NOTE: Based on administrative data reported to TEDS by all reporting states and jurisdictions. Percentages may not sum to 100 percent due to rounding. Admissions for which values were not collected, unknown, or missing are excluded from the percentage base (denominator).

Source: SAMHSA. "Primary Substance of Use Indicated at Admission." Copyright © 2021 by SAMHSA.

TABLE O.2 Primary Substance of Use Indicated at Admission, by Race/Ethnicity

Race and ethnicity	Primary substance use at admission															
	Alcohol		Opiates		Cocaine		Marijuana/ hashish		Methamphetamine/ amphetamines							
	All admissions	With alcohol only	Secondary drug	Heroin	Other opiates	Smoked cocaine route	Tranquilizers	Sedatives	Hallucinogens	Phencyclidine (PCP)	Inhalants	Other/ none specified				
Total	1,783,115	17.3	13.5	23.5	6.8	3.4	2.3	11.2	11.8	1.0	0.2	0.1	0.3	•	8.6	100.0
Race																
American Indian or Alaska Native	52,388	26.7	15.6	9.2	3.3	0.9	0.8	6.9	14.4	0.3	0.1	0.1	0.1	21.7	100.0	
Asian ¹	11,320	23.9	10.2	18.0	4.7	1.9	2.7	11.9	18.0	1.3	0.2	0.1	0.1	0.1	7.0	100.0
Black or African American	357,433	13.6	18.5	20.8	3.6	9.2	3.9	19.8	3.6	0.4	0.1	0.2	0.9	•	5.5	100.0
Native Hawaiian or Other Pacific Islander	6,684	13.5	11.1	19.6	3.9	1.8	2.2	12.9	26.9	0.7	0.2	0.1	0.4	•	6.7	100.0
White	1,183,769	18.4	12.4	25.4	8.2	2.1	1.9	8.6	13.9	1.2	0.2	0.1	0.1	•	7.5	100.0
Other	173,426	16.5	13.6	26.8	4.0	2.5	2.8	14.5	14.0	0.9	0.1	0.1	0.4	•	3.6	100.0
Total	1,785,020	17.5	13.8	24.1	6.7	3.5	2.4	11.4	12.0	1.0	0.2	0.1	0.3	•	7.1	100.0
Ethnicity																
Specific Hispanic or Latino origin	258,311	17.4	13.6	25.3	4.0	2.3	2.9	15.1	14.1	0.8	0.1	0.1	0.4	•	3.8	100.0
Mexican	74,657	18.2	13.0	16.9	3.2	0.7	1.5	15.4	27.9	0.4	0.2	0.1	0.2	•	2.3	100.0
Puerto Rican	65,228	11.6	14.0	46.0	3.6	3.5	3.8	11.4	1.8	1.1	0.1	0.1	0.8	•	2.1	100.0
Cuban	5,043	15.8	8.4	18.7	4.3	8.1	5.4	21.7	7.2	1.2	0.1	0.1	0.4	-	8.7	100.0
Other	113,383	20.2	13.9	19.3	4.8	2.4	3.2	16.7	12.4	0.9	0.1	0.1	0.3	•	5.6	100.0
Not of Hispanic or Latino origin	1,524,804	17.6	13.8	23.9	7.1	3.7	2.3	107	11.6	1.0	0.2	0.1	0.3	•	7.6	100.0
Total	1,783,115	17.6	13.8	24.1	6.6	3.5	2.4	11.3	12.0	1.0	0.2	0.1	0.3	•	7.1	100.0

¹ - Quantity is zero; * Less than 0.05 percent.² For some states, "Asian" includes "Pacific Islanders."

NOTES: Based on administrative data reported to TEDS by all reporting states and jurisdictions. Percentages may not sum to 100 percent due to rounding. Admissions for which values were not collected, unknown, or missing are excluded from the percentage base (denominator).

Source: SAMHSA, "Primary Substance of Use Indicated at Admission, by Race/Ethnicity," Copyright © by SAMHSA.

The percentages discussed above have meaning, but the readers are encouraged to critically analyze the data presented. These numbers are based on self-report and from a database of information that is put into the system by clinicians at intake. The clients do not represent all people admitted into treatment facilities (e.g., private entities). In addition, these are admission reports by clients seeking treatment. What about those who are not admitted? Moreover, usually those seeking addiction services have more severe substance use concerns than those who have not accessed treatment. These are important factors to consider when interpreting this research.

Specialized Programming and Services

In an effort to meet the needs of all persons entering substance abuse treatment, specialized programming has been suggested by researchers and clinicians for decades. Over 20 years ago, the 2000 N-SSATS results indicated that approximately 90% of facilities offered at least one program designed specifically for certain populations (Olmstead & Sindelar, 2004). In 2020, the N-SSATS data indicated a reduction: 84% of facilities reported doing so (SAMHSA, 2021a). However, it appears that more services are being offered when compared to the 2011 data (SAMHSA, 2012).

The following is a list of treatment programming found to be available for diverse populations and the percentage of facilities that offer them (SAMHSA, 2021a):

- clients with co-occurring mental and substance abuse disorders (55%)
- adult women (51%)
- adult men (49%)
- persons involved in criminal justice system (38%)
- young adults (32%)
- interpersonal violence or domestic violence (30%)
- pregnant or postpartum women (26%)
- seniors or older adults (25%)
- persons identifying as lesbian, gay, bisexual, or transgender (24%)
- adolescents (24%)
- veterans (23%)
- persons arrested for a driving offense (23%)
- persons living with chronic pain (22%)
- persons living with HIV or AIDS (21%)

Not only is the specialization of treatment programming suggested but offering key services to the various populations is also recommended. Addiction is considered a primary, progressive problem that causes secondary problems within all life areas, such as physical or mental health, unemployment, and housing. In an effort to provide a holistic, recovery-oriented system of care, addiction must be culturally responsive and viewed as a chronic issue (Conner & Anderson, 2020). Therefore, treatment services must be grounded in the community and available for those who need comprehensive, wraparound assistance.

For example, the attractiveness and accessibility of treatment for women are affected by child care and transportation issues. Thus, programs providing assistance with obtaining these ancillary services increase the likelihood of attracting women who are seeking addiction treatment. Moreover, retention outcomes for women in treatment will improve as well as their overall functioning, wellness, and quality of life. (Refer to Chapter 10 for the full list of recommended services for women.)

Persons who abuse substances are at higher risk for medical issues (e.g., hepatitis, cirrhosis, high blood pressure, cancer, infection with HIV, etc.). Moreover, those who use drugs intravenously are even more at risk for various infections. Due to the increased likelihood of clients practicing unsanitary injections as well as unsafe sexual behaviors, treatment programs are encouraged to integrate prevention, intervention, and treatment protocols into their practices. Health services that have been recommended include:

- provider education
- patient screening and risk assessment
- patient education
- biologic testing
- medical examinations
- counseling
- treatment
- treatment monitoring

Other services that treatment personnel are encouraged to provide to specific populations include sign language for persons who are hard of hearing as well as providing treatment in languages other than English. In 2020, N-SSATS data indicated that sign language was offered in 36% of all agencies in the study and that treatment in languages other than English were offered at 55% of all facilities (SAMHSA, 2021a). To be more specific, Spanish was the most frequently spoken language (94%).

Using the Term “Special Populations”

The term “special populations” can be widely seen throughout scholarly literature and on countless websites, especially when it relates to groups such as students (education) and patients (health care). Over the years, there have been discussions surrounding the appropriate terminology to address specific populations in addictions. Differences even exist with regard to the meaning of the term “diversity” and how addiction research and programming should attend to diversity issues (Loue, 2003). The author would like to take a brief moment to delineate the opposing perspectives. Some scholars suggest several advantages for continued use of the term “special populations.” The concept of special populations increases the likelihood that therapists will be trained to competently serve all of their clientele. This designation:

- fosters research agendas to focus on specific groups
- directs new resources toward treatment services

- advocates for the consideration of group-based external factors that impact effectiveness of treatment (e.g., cultural beliefs and practices)
- aids in dispelling myths and stereotypes

Government agencies have also used this designation; however, some have changed the title of their programs to no longer include the term. For instance, the National Institute on Drug Abuse (NIDA) is one of the leading organizations in the field of addiction research and, in 1993, created an office called the Special Populations Office (SPO) that was designed to address diversity. The SPO had work groups specific to African American, Latino/a American, Asian American, Native Hawaiian/Pacific Islander, and American Indian and Alaska Native communities. NIDA has since changed the title from SPO to the Office of Diversity and Health Disparities. While eliminating the wording, the office still identifies similar aims, which are the following:

- Recruit and retain underrepresented scholars and researchers actively participating in research.
- Enhance the pool of independently funded, underrepresented scholars and researchers conducting substance use and addiction research.
- Develop strategies to reduce health disparities and improve the health of vulnerable populations. (NIDA, 2021)

As stated above, there are advantages to the term's utility, and it is still considered appropriate. However, there is the potential to marginalize groups outside of the norm. The "norm" is usually considered White, heterosexual, Christian, economically advantaged, adult men without a disability, and it is not expected to become more inclusive. As Lawson and Lawson (2011) ask in their textbook *Alcoholism and Substance Abuse in Diverse Populations*, "Who is to say who is 'special'?" (p. xxi). If the addiction field continues to label certain groups as "special," the result may be the tendency to segregate these populations. Labels can influence and perpetuate stereotypes, biases, incorrect perceptions, and negative attitudes regarding people who present for substance abuse concerns. Moreover, using the term "special populations" attaches homogeneity. As discussed earlier, people have multiple identities, and these identities may come with unique needs, which may not be attended to if classified under only one of those identities.

After much consideration, the terms "specific" and "culturally diverse" are used throughout the text in an effort to more accurately represent various populations. The author is selective on the populations chosen to comprise this text and acknowledges an exclusion of some subgroups (e.g., persons without permanent housing, persons living with HIV/AIDS, and persons with spiritual/religious beliefs). As such, the author attempts to address some of these subgroups within other chapters. Moreover, this text was written primarily with counselor trainees in mind. Much of the cited research is from the counselor education literature; however, the information is transferable to the disciplines of social work, criminal justice, sociology, and psychology as well as the medical and educational fields. As students, teachers, and practitioners, we must continue our journey toward cultural humility, sensitivity, responsiveness, and competency. Thus, in an effort to assist in this

process, self-awareness exercises, discussion questions, and case studies are included in the chapters. These activities will explore your knowledge, skills, attitudes, awareness, and motivation related to specific populations.

Before moving on to the first chapter, take about 5–10 minutes to complete the Personal Identity Questionnaire and reflect on your answers.

Personal Identity Questionnaire

- 1.** Who are you (i.e., identify your various intersecting identities)?
- 2.** Describe your primary racial, ethnic, and cultural background(s).
- 3.** How would you describe yourself as a member of these cultural identities? (Hint: Think about the group level in Figure 0.1.)
- 4.** Where were you raised? Describe how this/these location(s) may have impacted your worldview.
- 5.** What were the spiritual/religious beliefs with which you were raised?
- 6.** Describe the gender roles that are primarily promoted in your culture.
- 7.** Describe at least two important core values that you were raised to follow.
- 8.** What were your beliefs regarding alcohol and other substance use when you were growing up? What are they now? How did you develop these beliefs?
- 9.** To whom do people in your culture usually turn to for help?
- 10.** Who has the responsibility of caring for those who become ill (e.g., the individual, family, community, and/or doctor)?
- 11.** Are there any reasons why you would have barriers to accessing, retaining, and/or successfully completing counseling/treatment?
- 12.** Explain why clients from two specific populations may be reluctant to seek out counseling.
- 13.** What two populations do you feel most comfortable interacting with, and why?
- 14.** What two populations do you feel most uncomfortable interacting with, and why?

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Credit

Fig. 0.1: Adapted from: Derald Wing Sue, "Tripartite Development of Personal Identity," *Counseling the Culturally Diverse: Theory and Practice*, p. 42, John Wiley & Sons, Inc.

■ CHAPTER 1

Diversity Concepts and a Discussion of Racism

By *Tiffany Lee*

Learning Goals

At the end of the chapter, students will be able to:

- ✓ Recognize the difference between terms such as culture, race, and ethnicity.
- ✓ Understand the various types of racism and provide examples of each.
- ✓ Conceptualize the potential interplay between multiple identities (both privileged and oppressed) and the effects of this interplay.
- ✓ Describe how racism is institutionalized and how racism impacts substance abuse treatment efficacy and the clients of color who seek help at these agencies.

All substance abuse counseling is multicultural in nature. Many cultural differences can exist between clients and their therapists, thus potentially impacting the efficacy of treatment. These differences include one's identities, including race, gender, sexual orientation, class, age, and so on. The majority of this text includes various chapters that address a specific population. Several identities may be discussed within one chapter (e.g., women who also identify as lesbian) to highlight the complex nature of intersecting identities (Crenshaw, 1989) and how they can correlate with substance use.

Within the chapters focusing on specific populations, the following information is delivered:

- overview (e.g., statistics, prevalence of use, definitions of a specific population)
- specific concerns (e.g., etiology, risk factors, stigmas)

- barriers to treatment
- resiliency factors
- screening and assessment (e.g., outlining the valid/reliable tools frequently used with or focused on a specific group and any identified diversity concerns associated with these instruments)
- treatment recommendations

Before attending to specific populations, the first few chapters present definitions and key concepts associated with race and ethnicity. At first, racism, White privilege, and White racial identity are explored, then a discussion of sexism, heterosexism, and classism follows. Next, the reader has the opportunity to understand topics related to cultural humility, broaching behaviors, and how to use antibias strategies to identify and attend to microaggressions.

Diversity Concepts

Exercise

1. Take a moment and write a definition for each of the following concepts:
(a) culture, (b) worldview, (c) ethnicity, and (d) race.
2. Reflect on this process. Which were the hardest to define, and why? Where did you learn these definitions?

The most obvious cultural differences between the therapist and client are likely to be gender, race, ethnicity, and age. However, other aspects of diversity are less discernible when you meet a client for the first time. For example, during an intake session, you may sit down with someone who has a disability, is economically disadvantaged, is a member of the LGBTQ+ community, or has different spiritual/religious beliefs and practices from yours. In essence, all of these identities are considered part of a person's culture. However, it is likely that you may not be privy to all of a client's identities unless the client shares this information with you.

Culture is defined as the thoughts, beliefs, norms, symbols, practices, and behaviors of a group in the areas of history, religion, social organization, economic organization, political organization, and collective production. The United Nations Educational, Scientific, and Cultural Organization (UNESCO) states culture is the set of distinctive spiritual, material, intellectual, and emotional features of society or a social group, and it encompasses language, food, dress, art, literature, music, lifestyles, value systems, traditions, and beliefs (UNESCO, 2009). In addition, culture is considered to be the sum total of life patterns within a given community over generations, and it also determines who will be oppressed and who will benefit in a particular society.

Culture provides a system in which people:

- set and achieve goals
- make decisions
- solve problems

- define social roles
- emphasize cooperation or competition
- perceive human nature, truth, time orientation, and property
- define identity and individuality

Each person is born into a cultural context, and the process of socialization is generally the function of the family and occurs through participation in cultural subgroups. These subgroups influence our *worldview*, which is defined as the perceptions, attitudes, beliefs, and assumptions that individuals and groups hold about the world, including the use of alcohol and other drugs. Sue and colleagues (2019) outline two psychological orientations that represent differing worldviews: (a) locus of control (internal/external); and (b) locus of responsibility (internal/external). Most White, middle-class people fall into the internal loci of control and responsibility (e.g., “I am a master of my own fate and am responsible for my success or lack of success”). People of color who have external loci of control and responsibility (due to oppression in our society) think there is little they can do about the injustices and give up (e.g., learned helplessness), which can also result in mental health concerns (e.g., depression). A person of color can also have an external locus of control and internal locus of responsibility. They may believe the plight of their own people is due to laziness and stupidity and accept the dominant group’s cultural standards (e.g., “It is up to me and society is okay the way it is”). Lastly, people of color can have an internal locus of control and an external locus of responsibility and believe that they can shape events in their life if given a chance (e.g., “I have pride in my identity, and I have control over my life. Society is not okay, and I seek to change it”).

While culture is a global concept, ethnicity is a more focused notion. *Ethnicity* refers to a person’s identity based on a group’s social and cultural heritage passed on to group members from one generation to the next. The term comes from *ethnos*, which is a Greek word for “people” or “nation.” While not synonymous, this term is commonly used interchangeably with the term “race.” How did you define race? How is it similar to or different than ethnicity?

Before discussing what race is, let’s look at what race is not. Race is NOT:

- scientific, biological, or based on genetics
- neutral or harmless
- the same as culture or ethnicity
- defined by color or other physical attributes
- the same as religious identity (Barndt, 2007; Lee et al., 2021)

More than 400 years ago, in the days of the European colonial expansion, racial identity was imposed and there was a forced process of “lumping” people together based on a social construct. This is known as racialization. *Racialization* has historically been identified as a process where one group defines another as morally and/or genetically inferior to dominate and oppress others. There are scholars who argue that this term should be used as a replacement when referring to race (Gonzalez-Sobrino & Goss, 2018). Therefore, race is a myth, yet it is also a reality. It is a societal construct that was designed and used for control and exploitation. In essence, race is a racist concept created to support racism.

When defining race, did you think about how a person looks or include skin color in your definition? Phenotypical features such as skin color, hair texture, or facial structure are interpreted as evidence that two groups are indeed separate “types” of people and are used to strategically demarcate the boundaries between groups. To define race based on phenotype is not accurate. A Latino man, for example, can also be of African American, European American, or Native American racialized background and cultures. Thus, racialized categorization can negate the other various identities of a person. Through DNA analysis, physical appearance has been found by researchers to determine nothing about a person’s ancestry. If you are interested in learning more about this topic, the author recommends a video called *Race: The Power of an Illusion*, which is available along with other informative videos online (<https://racepowerofanillusion.org>).

In this text, the concepts of culture, worldview, ethnicity, and race are addressed as they relate to each population. The issues associated with substance use, misuse, and abuse must be viewed within the context of a people’s past, present, and future. Counselors must consider the history of the United States. Historical events that have occurred (and incidents that continue to occur) influence (a) the current environment in which the client lives; (b) the client’s mental health status; (c) the client’s self-perception, self-esteem, and self-worth; (d) perceptions of others (including you); (e) coping skills; and (f) the consumption of alcohol and other drugs. Exploring addiction as it relates to diversity and specific populations cannot be assessed and interpreted only in terms of prevalence of use and treatment protocols. In order to treat substance use problems effectively, we must not ignore the societal constructs that have enormous negative impacts on the health and well-being on all of us—but even more so on marginalized individuals.

Racism and Prejudice

In an effort to accurately conceptualize the factors impacting alcohol and other drug use by specific populations, counselors should understand the diversity issues that exist within the United States. Attempts should be made to empathize with the lived experiences of people who do not identify as White, heterosexual, Christian, economically advantaged, cisgender, adult males without a disability. First, let’s take a closer look at racism and prejudice.

Exercise

Take a moment and answer the following questions:

1. How do you define racism?
2. What are five examples of racism?
3. What is prejudice? How is it different from racism?

When defining racism, there are various words or phrases commonly used, and they can be grouped by category (e.g., individual racism or institutional/societal racism). Take

a look at Table 1.1. Did you include any of the words or phrases outlined below? You were also asked to come up with five examples. These examples can be racist at an individual or systemic level. One example you may have thought of is an overt act of individual racism, such as the use of a racial epithet or slur. Refer to your examples and identify the category for each.

TABLE 1.1 List of Common Words or Phrases Used to Define Racism

Individual racism	Institutional or societal racism
Personal prejudice	Systemic power
Bigotry	Institutional discrimination
Hate	Oppression
Bias	Segregation
Personal dislike	Economic inequality
Stereotyping	Political control
Personal belief in superiority	White supremacy

Source: Joseph Barndt, from *Understanding and Dismantling Racism: The Twenty-First Century Challenge to White America*, p. 56. Copyright © 2007 by Augsburg Fortress.

Types of Racism

While there is variation in thought as to how many types of racism exist, for purposes of this text, definitions for three categories are presented: (a) individual; (b) cultural; and (c) institutional (Helms, 2020). *Individual racism* can be viewed as the thoughts, feelings, attitudes, and behaviors of an individual that can be verbal or nonverbal, overt or covert, and intentional or unintentional. While using a racial slur would be considered a verbal, overt, intentional act of racism, saying to a person of color, “When I see you, I don’t see color” is a verbal, covert, unintentional act. *Cultural racism* occurs when there is cultural heritage superiority by the dominant group and the imposition of practices and beliefs as the norm. For instance, specific appearances or characteristics that are deemed most desirable by beauty standards results in the disintegration of the culture of people of color. *Institutional racism* is when the policies, practices, or structures of the educational, governmental, criminal justice, political, medical, economic, corporate, communications and media, and religious systems oppress people of color; thus, White individuals benefit. Table 1.2 displays a few examples of the general characteristics and societal expressions for the different types of racism.

TABLE 1.2 General Characteristics and Societal Expressions of Racism

TYPE	General characteristics	Societal expression
Individual	Belief that White people are superior	Violence against non-White individuals; making fun of physical characteristics or customs of non-White group; racial harassment; laughing at racist jokes
	Denial of the existence of racism	
	Belief that the lack of success of “non-White persons” is due to genetic inferiority or racial-group malaise	Nonsupport of race-related civil rights legislation; uncritical acceptance of all-White work environments
Cultural	Language superiority	Using derogatory racial epithets; unthinking adherence to “bootstrap” philosophy; unwillingness to support race-related affirmative action; promulgation of racial stereotypes
	In education, science, philosophy, and so on, the contributions of Whites are considered the best	Limiting access to work and education to “standard” English speakers
Institutional	Law enforcement policies are more stringent for people of color	Products (e.g., music, literature, ideas) of other racial groups are “better” when presented by a White person, and contributions from people of color are invisible
	Inadequate housing	Police brutality; severe sentences for the same crimes
		Discriminatory pricing; mortgage loan discrimination; segregation of housing by race

Source: Janet E. Helms, “General Characteristics and Societal Expressions of Racism,” *A Race Is a Nice Thing to Have: A Guide to Being a White Person or Understanding the White Persons in Your Life*. Copyright © 2020 by Cognella, Inc.

Racism-Related Stress

All people experience stress. However, individual, cultural, and institutional racism cause additional stress to people of color and can be considered chronic in nature. Racism-related stress has negative consequences on emotional, physical, mental, and spiritual health as well as social connectedness, job performance, academic achievement, and parental functioning. These consequences (due to racism) frequently result in higher levels of anxiety, guilt/shame, avoidance/numbing, and hypervigilance often seen with posttraumatic stress disorder (Kirkinis et al., 2021). Six types of racism-related stress exist: (1) race-related life events; (2) vicarious racism experiences; (3) daily racism microstressors; (4) chronic-contextual

stress; (5) collective experiences of racism; and (6) transgenerational transmission of group traumas.

Addiction counselors are encouraged to explore these stressors with regard to clients who do not identify as White. The author provides a more in-depth discussion on how to do this through a presentation of the multidimensional model of broaching behavior a bit later in Chapter 3. In the meantime, take a moment to review Table 1.3 and consider how these stressors can influence substance use and the treatment of addictions.

TABLE 1.3 Six Types of Racism-Related Stress

Type	Definition	Examples
Race-related life events	Time limited, have a beginning and an end, may lead to other events, and may occur infrequently	Police harassment Being rejected for a loan Housing discrimination
Vicarious racism experiences	Through observation and report of family members, friends, and strangers	Learning about incidents like those of Breonna Taylor, George Floyd, Ahmaud Arbery, Trayvon Martin, and Rodney King
Daily racism experiences or microstressors	Frequent, subtle, unintentional offenses; most often not confronted; also called microaggressions	Being ignored Being followed while shopping Locking car doors or clutching purse tighter when a person of color walks by
Chronic-contextual stress	Due to social structure, political dynamics, and institutional racism	Prevalence of liquor stores in a neighborhood Out-of-date textbooks in urban public schools Disparities in resources, access to health care, living conditions, and quality of life
Collective experiences	Cultural-symbolic and sociopolitical manifestations of racism	Economic conditions of one's racial/ethnic group Lack of political representation Media portrayals
Transgenerational transmission	Historical contexts (and traumas) of diverse groups transmitted through discussions, storytelling, and lessons taught to children	Slavery of African people Tuskegee experiment Removal of Indigenous peoples from their lands Internment of Japanese Americans

Adapted from: Shelly P. Harrell, "A Multidimensional Conceptualization of Racism-related Stress: Implications for the Well-being of People of Color," *American Journal of Orthopsychiatry*, vol. 70, no. 1.

Now, we can all think of incidents that occur in daily life that may cause stress for all people, regardless of race or ethnicity. However, the frequency, intensity, meaning, and consequences of these incidents can vary drastically based on one's racial identity. For example, a person can feel anxious as they are sitting in slow-moving traffic due to a car accident up ahead and thinking about being late for work. Most White people would become stressed out. However, a person of color may encounter additional stress due to this incident. The person could be concerned about the tardiness as a confirmation of a stereotype given to their racial or ethnic group (e.g., unprofessional, lazy, or having a poor work ethic). Can you think of another example?

The six types of racism-related stress can also be compounded for a person of color if they are also a member of another oppressed group. If a person of color identifies as LGBTQ+, is a woman, is economically disadvantaged, has a disability, or is an older adult, they are in *double or multiple jeopardy* (Beal, 1970). Researchers have investigated the phenomenon of double/multiple jeopardy and argue the lived experiences of this intersection of two or more identities differ qualitatively to the experiences of having only one identity of an oppressed group. Women are oppressed; however, a woman of color in the workplace experiences different stressors than a White woman. The LGBTQ+ community also experiences stress from discrimination and oppression, but a Black person who is lesbian or gay has different stressors on well-being, as compared to a White person who identifies as lesbian or gay (Hancock & Daigle, 2021). While interactive effects of multiple cultural identities are experienced (i.e., double jeopardy), when asked to describe the effects specifically, people may have difficulty explaining the interplay, or they may end up focusing on describing the effects of one particular identity (Croteau et al., 2002).

The effect of possessing multiple identities (both privileged and oppressed) has been described as placing a transparency sheet of one color over a transparency sheet of another color. The color of one “is sometimes so strong or pervasive that it completely covers or obscures the other; at other times, overlaying one transparency on top of another merely changes the tint of the original transparency” (Croteau et al., 2002, p. 246). Refer to Figure 1.1 for the following illustration. Imagine if there is a transparency sheet with a blue circle representing a man's racial identification as Latino. This particular man considers his Latino identity to hold much value. At the same time, it is viewed as an oppressed status in the United States. The other transparency sheet has an orange circle representing his sexual orientation as heterosexual. While relevant, his sexual orientation neither has much weight on his identification nor is recognized often in his daily life. However, identifying as heterosexual is a privileged status in our country. If the circles were to be placed over one another, the blue circle would cover the orange circle. In essence, the weight, recognition, and value of one (privileged or oppressed) status have the potential to affect the weight, recognition, and value of the other (privileged or oppressed) status.