

Chemical Dependency and the African American

By Peter Bell

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

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

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

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

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

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

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

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

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

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

Other issues for individuals of color in treatment are a constellation of concerns I call "cultural pain." These issues range from racial self-hate to the color caste system that still exists for many individuals of color. One major issue for a person of color to address as a part of his/her recovery pertains to discovering what it means to be authentic and loyal in a racial/ethnic context. This has significant and painful implications ranging from selecting a dating and marriage partner, to location of housing, selection of a religious institution, style of clothing, speech patterns, etc. To illustrate this point, a number of years ago I developed an integration continuum. On one end of the continuum was separation, with both positive and negative issues that are often associated with that position.

On the other end of the continuum was assimilation, also with a list of positive and negative associations, and in the middle was integration. I would ask clients to place themselves, their parents, siblings, friends, and lovers on the continuum. Overwhelmingly, clients would remark that where a person was at on the continuum would have a significant impact on their views and interactions with individuals who were at a different place. Clients often felt that this had a profound and fundamental influence on how their families functioned. Helping professionals need to realize that there are as many differences within racial and ethnic groups as there are between groups.

While these issues can be very painful for clients, they rarely, if ever, surfaced in a counseling context. In reality, it may be easier for a woman to talk about incest in many treatment centers than for a person of color to talk about racial self-hate or how the worldwide "White standard of beauty" affects their self-perception. Many white therapists are either unaware that these issues exist or feel inadequate to address them. Clients of color, like all clients, tend to resist or minimize their most painful issues, which often have to do with racial identity. As a result, a cultural conspiracy of silence develops. These cultural secrets can significantly undermine a client's recovery.

A final clinical issue worth noting is what I term cultural boundaries. Everyone has both physical and emotional boundaries. If you are overweight you may not like fat jokes, or be sensitive to people watching you eat. If you are Jewish, you may feel awkward in discussing issues pertaining to money. For individuals of color, "cultural boundaries" are often issues that are tied to many of the stereotypes we face. For example, I often heard clients of color express discomfort with subjects like crime, basketball, dancing, or sun tanning. Learning how to address cultural boundary violations in a mature, non-defensive manner is a major racial identity recovery task.

All of my above stated concerns have to be balanced with the reality that clients will often use legitimate issues and feelings pertaining to racism, bias and prejudice, and reposition them as excuses for dysfunctional behavior. One of the biggest challenges for a therapist is to determine when he/she should accept a cultural rationale for a behavior and when they should challenge that rationale and label it as an excuse. The treatment of Islamic women in the West, female

circumcision, or different approaches to child discipline, are three examples.

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

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

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

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