

## **ETHNIC, CULTURAL AND GENDER ISSUES**

**Presented by Nancy Jainchill, Ph.D.**

This presentation reviewed issues of cultural identification, ethnicity, gender and co-morbidity in relation to the treatment needs of adolescents with substance abuse problems.

### **WHAT IS CULTURE?**

Culture is described by the values, beliefs and customs of a group of people and includes their thoughts, ideas, behavior patterns, customs, beliefs, values, arts and prejudices (at a given point in time). Only recently, have we acknowledged the reality of a culture of gender and a culture of race/ethnicity.

### ***CULTURAL IDENTIFICATION***

Among adolescents cultural identification is influenced by many factors including the attitudes of established social institutions (e.g., schools, government), peer attitudes toward a specific culture and parental feelings about their culture of origin as well as the host culture. The extent to which specific factors impact cultural identification will vary among individuals, even among those who share the same culture of origin. For example, a person's age is likely to affect the experience of acculturation.

### ***ACCULTURATION***

Acculturation involves the adaptation from the person's culture of origin to the host culture, in this case, the American culture. Acculturation is not a unidirectional process going from culture A to culture B; rather it is both a multi-directional and multi-dimensional process. Successful acculturation usually involves some adaptation and acceptance of elements from both the culture of origin and the new culture.

For most immigrant groups, acculturation involves adaptation from a traditional culture, which provides controls on behavior, to the more modern American culture, which places fewer constraints on nonconventional behavior (Rodriquez, Recio-Adrados & De La Rosa, 1993). The acculturation process is influenced by a complexity of contextual factors including

socioeconomic status, accessibility to educational and vocational opportunities, and the person's neighborhood ecology - the environment where the family lives, who lives nearby, the youngsters' peers and the neighborhood norms.

The acculturation experience involves an individual's ongoing adjustment (or not) to mainstream values, living a life that requires a continual shifting back and forth between different cultural orientations and alliances, and encountering and countering disrespect for one's traditions and values (i.e., discrimination). An individual's personal resources i.e., his/her self-image and emotional stability, will moderate the impact of the experience. Also, if the two cultures are compatible and if the acculturation is agreeable with significant others, then it is more likely to be a successful and less stressful process (De La Rosa, Vega & Radlich, 2000).

There is a relationship between acculturation, mental health and substance abuse. The loss of cultural identity is a risk factor for both substance abuse and psychopathology. Adolescence is the period of identity formation, and this is made even more challenging by additional issues of identity. Among adolescents who experience conflicts with their parents over cultural adaptation or identification, there is the increased likelihood for problems such as substance abuse and psychopathology.

### **THE ROLE OF CULTURAL COMPETENCE IN TREATMENT.**

Treatment programs that admit individuals from a diversity of cultural backgrounds need to provide services that are culturally competent. Three essential components of cultural competence have been identified: (1) cultural knowledge – having familiarity with the cultural characteristics of another group; (2) cultural awareness – reflecting sensitivity and understanding of another group; and, (3) cultural sensitivity – seeing differences without judgment. Treatment must also be culturally responsive in terms of language and non-verbal cues. Programs that offer treatment to individuals from different cultures ideally should have staff who speaks the client's language, and has familiarity with the cultures and cultural issues of those in treatment. It is also helpful to have someone on staff who shares physical similarities with the people entering treatment (e.g., skin color).

Assessment of substance abuse and mental illness problems must go beyond the reliance upon a nosological system that is defined by the mainstream culture. For example, the social undesirability of symptoms or the mental health significance of experiences may be not equivalent across cultures. And cultural differences between the diagnostician and the “patient” influence the complexity of cognitive, affective and behavioral exchanges that are involved in the process of mental health assessment (Rogler, 1993).

The spectrum of life experiences of immigrants, as well as their current life situation may require attention to a range of health concerns, for example, primary medical care, prenatal care, treatment for mental health and/or substance abuse, as well as educational and vocational training. Access to a variety of health care options is therefore critical.

### ***ACCESSING TREATMENT***

Often, particularly with cultural minorities, there are difficulties in accessing needed services because of real and perceived barriers. One barrier to treatment among those who are not from the host culture is social-cultural stigmatization that is external. Individuals may perceive or experience disrespect from the host culture. A second barrier to treatment is social-cultural stigmatization that is internal and this may be reflected in several ways. Commonly, the self-perception of being different is experienced as “abnormal.” And, among many non-American groups, there is greater stigma attached to receiving psychiatric care or getting treatment for substance abuse. An example of the latter is demonstrated by the reluctance among Latinos (including the variety of subcultures) to seek treatment for substance abuse. The close family-orientation of the culture, in addition to other culturally specific ways of relating (e.g., personalismo) and language barriers, discourages the sharing of problems outside of the family.

Socio-economic conditions also influence self-perceptions in terms of how individuals feel about themselves and how they feel others experience them. Often those who have less feel they are worth less and they do not view themselves as having options. A goal of treatment is to have people enhance their self-worth, to develop a sense that they have alternatives to their original lifestyle and to provide them with the tools to begin to pursue those options.

## **RACE/ETHNICITY AND CULTURE**

Acculturating to European-American mainstream values will have an impact on the social-behavioral and psychological characteristics of individuals. In particular, substance abuse among other cultural groups has been associated with a stressful acculturation process.

According to Glazer (1998), African Americans comprise the most distinct cultural group in the United States. Because they are Americans, their different heritage has not been acknowledged or respected and this has been a continual source of disenfranchisement. Controlling for known risk factors for substance abuse (e.g., familial drug use), studies show less substance abuse among African Americans than other ethnic groups in this country including European Americans, and they also show less psychiatric disturbance.

Among Hispanics, both adolescents and adults, skin color, home location, educational and economic status of those who are foreign or U.S. born, influence the social and personal adjustments that they make to the American society. For adolescents, the level of dissonance experienced because of differences between the values of their (or their parents') culture of origin and the dominant American cultural values will impact the young person's acculturation process.

Poorly acculturated U.S. born Hispanic adolescents experience the highest rate of substance abuse initiation and of continued experimentation. A study of young adult men in New York showed that there were different factors that contributed to drinking problems in each of three different Latino groups. Similarly, among New York City Latinos, the acculturation of Puerto Ricans is less successful than that of other groups. One reason is that they came from a society and a culture that has not been respected by mainstream America and they have internalized that disrespect. This highlights the importance of distinguishing among subgroups within the more comprehensive race/ethnic classification.

Asian American adolescents have lower rates of substance abuse than European Americans; one explanation is that they have fewer role models for substance abuse. They tend to be more connected to their families and less influenced by peers (Au & Donaldson, 2000).

## **CULTURE AND GENDER**

There have been a number of studies that have examined gender differences in relation to psychiatric disturbance and substance abuse. The results are equivocal: some of the studies have reported a different profile of comorbidity, while others have found similar levels of severity and types of psychopathology among males and females. Several studies suggest overall greater comorbidity among drug-using girls in comparison with drug-using boys, while others have indicated more internalizing problems among girls and more externalizing disorders among boys.

**Community samples.** As early as 1978, investigators reported a positive relationship between illicit multiple drug use, depression, and normlessness for girls (Paton & Kandel, 1978). Conduct disorder is predictive of later drug use for both genders, however there are gender differences in the pattern and progression of substance use. Females are more likely to have a diagnosis of nicotine dependence, and start drinking at a later age than males, however, the age at which they qualified for a diagnosis of alcohol abuse/dependence did not differ. Females also revealed a shorter interval between experimental marijuana use and abuse/dependence (Mezzich et al., 1994). Conduct disorder has also been found to be predictive of internal disorders such as depression, among girls.

Alcohol use has been associated with increased lifetime occurrence of depressive disorders, disruptive behavior disorders, and other drug use. Among females there is a trend for increased alcohol use to be associated with anxiety disorders (Rhode, Lewinsohn & Seeley, 1995).

**Treatment samples.** A higher incidence of psychopathology among substance abusing adolescents has been reported for those with histories of physical and/or sexual abuse (e.g., Blood & Cornwall, 1996; Dembo et al., 1989). Among a sample of adolescent psychiatric in-patients with a substance use disorder diagnosis, almost one-third had co-morbid major depression. Significantly more females had co-morbid affective disorder and, for both genders, secondary major depressive disorder was more common in its primary form (Bukstein, Glancy & Kaminer, 1992).

Among drug abusing adolescents, females showed higher scores than males on scales measuring physical symptoms, escape, and emotional consequences of drug use. The small number of scales that yielded differences, as well as the relatively small magnitude of the differences suggest that the gender are more similar than not (Opland, Winters & Stinchfield, 1995).

Other studies report that among males in residential treatment for comorbid conduct disorder and substance abuse, poorer outcomes were predicted by more severe symptomatology at admission (Crowley, Mikulich, MacDonald, Young & Zerbe, 1998); and, that girls use drugs and engage in externalizing behaviors as extensively as do their male counterparts, but they also have higher levels of internalizing symptoms and family dysfunction (Dakof, 2000).

### **PSYCHOPATHOLOGY AND SUBSTANCE ABUSE**

The directionality of the relationship between psychopathology and substance abuse may vary. Psychopathology can serve as a risk factor for addictive disorders. In this regard, psychopathology can influence the process of the addictive disorder, its repetition, its symptom picture and its response to treatment. Thus, an individual may initiate drug use to “feel better” as suggested by the self-medication hypothesis. On the other hand, psychiatric symptoms may emerge during the course of an addiction or as a consequence of sustained substance abuse. The negative impact of substance use/abuse on an individual’s life may produce symptoms of depression or other psychiatric disturbance.

Psychiatric disorders may be unrelated to substance dependence/abuse. In contrast, psychopathology and substance use disorders may originate from a common vulnerability, whether an organic vulnerability, a cultural vulnerability, or a contextual vulnerability (i.e., a troubled family environment).

### **THE THERAPEUTIC COMMUNITY TREATMENT APPROACH FOR ADOLESCENT SUBSTANCE ABUSERS**

Residential therapeutic communities ("TCs") established in the 1960s focused on the

treatment of adults who were primarily involved with heroin, and treatment ranged anywhere from two to three years. The therapeutic community is distinguished from other treatment approaches by its adherence to “community as method” which refers to the purposive use of the peer community to facilitate social and psychological change in individuals (De Leon, 1994; 2000; Jainchill, 2000). This paradigm is reflected in the fact that all of the activities in a TC are designed to produce therapeutic and educational change in the participants, and all of the participants (residents) are themselves, mediators of this change (De Leon, 1997). The group process is the primary therapeutic tool, and one-on-one therapy sessions between a client (resident) and counselor are infrequent.

Over the past two decades TCs have been considerably modified. Most programs no longer see people who abuse opiates. The primary drug of abuse for adults is usually cocaine or crack cocaine, and for adolescents, it is marijuana and alcohol. The planned duration of treatment typically ranges between 6 and 12 months; this change, however, has been based more on funding exigencies and the influence of managed care, than on empirical data. Today, the reduction in treatment tenure challenges the possibility of effecting the kind of holistic change or habilitation that is required.

Historically, individuals with severe psychiatric disturbance were generally not admitted to TCs because of their treatment needs. However, currently, 90% of the people who come into therapeutic communities have a co-occurring disorder, although only a small minority will have a diagnosis of schizophrenia or other psychosis. Adolescents who enter TCs are often at the extreme end of the continuum in terms of antisocial or conduct disorder problems, as well as emotional and psychological distress. They usually have a history of school problems such as truancy, poor performance, learning disabilities, and problems with authority. They are also struggling with the general turbulence that characterizes the normal transition to adulthood (De Leon, 1988; Jainchill, 1997).

## **STUDY RESULTS**

The remainder of this presentation summary describes a study that has been funded by the National Institute on Drug Abuse to describe the profile of adolescents who entered TCs for

adolescents and to evaluate their post-treatment outcomes programs (Jainchill et al., 1995, 1997, 2000). Data were obtained on more than 900 adolescents who entered six TCs (9 sites) in the United States and Canada during the years 1992-1994. A one-year post-treatment follow-up study was conducted on a subsample of those who completed an interview at admission to treatment and a 5-year post treatment follow-up study is nearing completion.

### ***DESCRIPTION OF STUDY SAMPLE***

The large majority of the 938 admissions to treatment were male (77%) and most were European American (49%). The majority (56%) were 16-17 years of age, while almost a third were under 16 years old. The distribution of primary drug of abuse at admissions was: marijuana (56%), alcohol (20%), crack/cocaine (9%) heroin/opiates (5%) and “other” (10%).

There were several other gender and race/ethnic differences: proportionately fewer Hispanic females enter treatment; more African Americans report marijuana as their primary drug of abuse, while among Hispanics (males) there is more use of heroin/opiates. The latter finding is of particular significance as Hispanics have the highest increase in the rate of HIV transmission of all race/ethnic groups in the United States.

The mean age for initiation of drug use is 12 years, and the age of first involvement with an illegal activity was thirteen. Females began their criminal activity earlier than did males, however twice as many males than females had been arrested and booked.

Sixty-eight percent of the admissions were mandated to treatment by the legal system. Males were more likely to be referred by the criminal justice system, while females were more likely to be sent to treatment by family court. Fifty-seven percent of the Caucasians were referred to treatment by the criminal justice system, compared with 85% of African Americans and 71% of Hispanics, a difference that likely reflects the bias of the legal system. A minority of adolescents was self-referred (less than 9%) reflecting their low internal motivation for treatment or recovery.

### ***PSYCHIATRIC STATUS***

A structured psychiatric interview, the revised Diagnostic Interview for Children and Adolescents (DICA-R-A; Reich, Shayka & Taibleson, 1991) was used to assess the presence/absence of DSM-III-R disorders among the adolescents. Initially, trained research assistants administered the interview. However, a computerized version became available and was employed for the majority of the data collection because this approach was preferred by the youth. (A research assistant remained nearby.) The DICA was not employed to diagnose substance abuse or dependence for several reasons. First, an extensive Baseline Interview developed by the research team elicited sufficient information concerning the adolescents' drug use to generate diagnoses according to both DSM-III-R and DSM-IV criteria. Second, the interview battery was lengthy and the amount of additional information that might have been obtained was considered unwarranted. Third, the validity of current diagnostic systems for the classification of adolescent substance use disorders has been questioned (e.g., Bukstein et al., 1989).

Approximately 90% of those who completed a psychiatric interview (n=829) yielded at least one psychiatric diagnosis. The majority (61%) had both a developmental/behavioral and affective/anxiety disorder. Nineteen percent had an affective/anxiety disorder only while 13% had a developmental/behavioral disorder only. The most frequently occurring diagnoses were, in order: conduct disorder, oppositional defiant disorder, simple phobia, separation anxiety, attention deficit-hyperactivity, overanxious disorder, and depression or dysthymia.

In the current sample, females yielded significant more positive non-substance diagnoses than did the males (mean=5, females; mean=3, males). Of note is that a higher percentage of females than males were diagnosed with all of the developmental/ behavioral disorders (i.e., conduct disorder, oppositional defiant disorder, attention deficit-hyperactivity). Significantly more females were diagnosed with affective disorders and twice as many had post traumatic stress, which may relate to incidents of abuse (discussed below).

Differences by race/ethnicity were generally consistent. African Americans obtained significantly fewer DSM-III-R diagnoses, as well as fewer psychotic symptoms and psychosocial stressors.

In summary, being female and being European American is associated with psychiatric disturbance on admission to treatment. More psychiatric disturbance is also associated with having lower motivation for treatment, and with a greater number of previous drug treatment episodes.

### ***PHYSICAL AND SEXUAL ABUSE***

Histories of physical and sexual abuse were assessed with a face-to-face interview conducted by a research assistant, and with a standardized paper and pencil questionnaire (PEI: Winters & Henly, 1989) completed by the adolescent her/himself. The questions on the face-to-face interview required clients to identify themselves as abuse victims and to report their abuse status to an interviewer. In contrast, the PEI was completed by the interviewee, and screened for the *potential* of sexual and/or physical abuse as well as for actual abuse experiences. Both methods were employed because there was a concern that the youth might be reluctant to disclose incidents of abuse in a face-to-face interview, which lacks the anonymity of a self-administered questionnaire.

The data presented include adolescents admitted to mixed gender programs only so that the sample is reduced to n=703 (females, n=193; males, n=500). Utilizing information obtained from both sources of data, 36% of the sample reported a history of sexual abuse and almost 47% reported physical abuse. There were significant gender differences: 65% of the females compared with 25% of the males reported some kind of sexual abuse, and 75% of the females and 46% of the males reported some kind of physical abuse. Even using the more conservative criteria of the face-to-face interviews, 61% of the females and 32% of the males reported abuse. Fifty-two percent of Caucasians report some kind of sexual or physical abuse compared with 18% of African Americans and 14% of Hispanics.

### ***POST TREATMENT OUTCOMES***

Of the original 938 adolescents who were admitted to TC treatment during the interview period, a minority was excluded from the follow-up component of the study for any of several

reasons (for more information see Jainchill et al., 2000). A follow-up status was obtained for 64% of the sample and data are reported for 485 adolescents who completed one-year post-treatment follow-up interviews. Of this subsample, approximately 31% graduated or completed the residential phase of treatment; 52% dropped out of treatment; and, the remainder were terminated for a variety of other reasons (e.g., referred elsewhere, discharged for behavioral reasons).

Analyses of one-year post-treatment data revealed generally significant reductions in drug use and criminal activity. Those who completed treatment showed reductions in use of all categories of drugs (i.e., alcohol, marijuana, crack/cocaine, heroin/opiates) while the findings were not as consistent for those who did not complete treatment. Both those who completed treatment and those who did not complete treatment showed significant improvement on measures of criminal activity, i.e., sale and distribution of drugs, property crimes, violent crimes and arrests, however the changes were larger for those who had completed treatment.

Logistic regression analyses were run to identify factors that predicted post-treatment outcomes. Declines in drug use were predicted by: race/ethnicity (being Hispanic), lower levels of drug use pre-treatment, positive relations with counselors (reductions in marijuana use), and having completing treatment (reductions in alcohol use and use of illicit drugs). Two post-treatment variables were related to declines in drug use: the adolescent's living situation (away from the family of origin) and association with "positive" peers were associated with less alcohol and illicit drug use. Criminal activity was assessed as present or absent post-treatment. The absence of criminal activity was associated with being female, not associating with deviant peers pre- or post-treatment, being satisfied with one's social life and having completed treatment. The most consistent predictor for lowered criminal activity and/or drug use was having completed treatment. Those who complete treatment were much less likely to be involved with criminal activity and much more likely to have reductions in drug use post-treatment.

### **ISSUES FOR TREATMENT, POLICY AND RESEARCH**

There are outreach and recruitment issues when dealing with adolescents since they have little self-motivation for treatment. Furthermore, gender and ethnic identity issues must be

addressed since, for example, females often feel pulled by family issues and those of Hispanic background are generally less comfortable with public acknowledgement of personal problems. Overall, the profile that emerges is that adolescents who use and abuse drugs, particularly those who enter residential programs, present with a spectrum of disturbance and dysfunction requiring a global approach to treatment and rehabilitation. Drug involvement, criminal activity, and family problems and psychopathology are often found together. Thus, there is a need for integrated services involving cross training and a diversity of staff.

### ***CO-MORBIDITY: ISSUES OF DIAGNOSIS AND TREATMENT***

Symptom assessment must take into consideration the occurrence or onset of the symptomatology, the severity of the manifestation and the nature of the symptom profile (i.e., which symptoms are involved). Cultural issues include the social undesirability (or not) of symptoms, whether the behaviors are healthy within the context of the individual's culture and acceptable treatment modalities. The interpersonal situation of the diagnostic interview will also impact the assessment of disturbance, e.g., gender and cultural differences between the client and the interviewer/diagnostician.

### ***THERAPEUTIC APPROACHES***

The use of medication is especially challenging when dealing with issues of co-morbidity, and the reduction of medication is an important therapeutic goal. In therapeutic communities, certain treatment processes may need to be moderated and/or integrated with other approaches. For example, the "encounter" group may be less confrontational and the use of one-on-one sessions may be an important tool to teach youth how to relate to and trust senior role models. While treatment tenures have been shortened because of funding exigencies, the planned durations of treatment may need to be changed to accommodate the complexity of adolescent treatment issues.

Two hypotheses have been offered to explain the profile of psychopathology and antisocial behaviors that describe adult substance abusers also have relevance for adolescents. . The self-stigma hypothesis suggests that because females are more socially conditioned to perceive their drug use as worse or sicker, they internalize that belief. One positive result of that

is that when they stop the drug use, they get better faster and it remains a more stable improvement. The role-conditioning hypothesis suggests that among socially disadvantaged non-Caucasian groups, drug abuse and psychological symptoms are more often corollaries of chronic frustration and precede social impotency. However, for whites or those more socially advantaged, drug abuse represents a greater break from social role expectations and is more likely to be associated with increased psychopathology (De Leon & Jainchill, 1981-82; 1991).

## ***RESEARCH***

There are many research questions that remain to be answered. In particular, studies need to focus on understanding the interaction that takes place between the individual and the treatment process. What are the critical factors that treatment providers must address in dealing with issues of gender, race/ethnicity and other cultural parameters? Furthermore, we need to understand the temporal sequence of co-morbid disorders and substance abuse, the difference if the symptomologies precede or succeed one another and the interplay that they can have on each other in terms of a synergistic or ameliorating effect.

## **About the Presenter**

Deputy Director for the Center for Therapeutic Community Research at the National Development and Research Institutes, Inc. in New York, Dr. Jainchill's present research focuses are adolescent therapeutic community programs and Hispanic-American/Venezuelan Youth-Drug Use Risk Factors.

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Please note: Certain references are included that are not mentioned in the text because they are considered to be of potential interest and relevance to readers.

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