Working with People of Color—
Factors to Consider in Treatment and Prevention

The physical development of the disease has been recognized by many researchers and physicians as being relatively universal among most substance abusing groups, regardless of their cultural identity. One notable exception is the way a predominant diet among some cultural groups may alter the progression (positive or negative) of the disease. This factor comes into play among some sub-cultural groups of African Americans, European Americans, Native Americans, and others.

However, when we see the person in our treatment facilities, they are there because they have the disease. Hence, to provide the most effective treatment, our mantra and our mission should be: Culture Matters.

Contrary to common belief: Everyone is endowed with an often function from an overt or covert *cultural reality*. We tend to think of People of Color as the only groups for which we should factor culture into a prevention and treatment program. However, I maintain that

the group we list as White or of European American ancestry would be better served if we paid more attention to the magnitude of cultural differences as well as sameness of German Americans vs. Italian Americans, South African Americans vs. Irish Americans, Polish Americans vs. French Americans, and

Nevertheless, my task is more narrowly defined. I will continue the discussion already started by Dr. Hayden. I hope my comments will give context to both our prevention and treatment of People of Color, keeping in mind that among this group are many sub-groups, namely: Caribbean Americans, some Hispanic/Latino groups, Black Americans, Black Europeans, and Blacks in America who self-define by their religion rather than their race or culture. Again, for this discussion, I will refer to all Blacks as People of African ancestry, commonly known as People of Color.

I have tried to isolate those factors that are most commonly found among people of African ancestry, including attitudes about prevention and treatment, belief systems that govern things they will

or will not do, how prevention messages can best reach them, and the professional knowledge and skills that engage and sustain them in treatment.

A basic fact or reminder is always appropriate. And that is: no matter what anyone shares with you, it does not alleviate the necessity of the professional getting to know if these things apply to "Mr. Jones, Ms. Hernandez, or adolescents Judy and John." Because they were gathered from focus groups I conducted, my practice wisdom of more than 40 years working in prevention and treatment with People of Color, and the latest research done by others on the relevance of culture in working with People of Color.

I. Attitudes about Prevention

Because of an attitude about *what will be will be* and/or *it's already written (from birth to death) what will happen*, many, if not most, believe there are forces over which they have no control. Thus, these forces play a significant role in determining their fate.

Since most are or were reared to believe in God, help them to accept that God gave them the ability to make decisions. And their decision making is factored in to determining *what will be*. Also, provide prevention messages that highlight people like them so it can be more believable. Use symbols rather than speeches; pictures rather than preaching. This is not only true among the people with limited education, it is often found among those persons who are well educated and also die in great numbers from preventable diseases.

II. **Attitudes about Treatment**

Because the stigma of being an addict is still quite prominent among People of Color, many of them, particularly women, refuse treatment in order not to confirm the *diagnosis* or *label* of being an addict. This contributes to the high incidences of DUIs, lost employment, parental neglect/abuse, and the traumatization of children,

death from the disease or an illness caused by alcohol and other drugs of abuse. Educate non-professionals (those working in barber shops, nail salons, Laundromats, churches, neighborhood grocery stores), who are not in the field of substance abuse, to recognize the symptoms and progression of the disease and to serve as preventionist and resources to direct alcoholics and drug addicts to treatment.

III. **Belief System that Dictates Behavior**

In addition to believing there are forces outside of themselves that will determine their fate, many People of Color groups—irrespective of their level of education—have imprints of superstition, intuition, and hunches. Many important life events and decisions are made or not made due to fear of a negative consequence (example: If a black cat crosses in front of an individual, bad luck lies ahead, so the person may turn around or redirect the route s/he is traveling; Friday the 13th may cause them not to travel or

plan anything important for that day). While the age of a person may determine the intensive of one's belief, their level of education does not. Hence, do not directly ask about their "belief and practice" of superstition. The "better educated" person may admit it more readily than the "lesser educated" person. The lesser educated individual will believe you are most likely to label her or him crazy, while the better educated person believes her or his education will not lead the professional to make a similar conclusion. However, each individual should have a level of comfort with the professional before the question is asked. Never give the person an indication that you don't believe in superstition and you cannot understand why s/he does. Older clients/patients who are 60 years and older may be more inclined to respond to a "hunch" they have about something s/he should or should not do than a much younger person who has little or no contact with an older

relative who is superstitious or relies on intuition and hunches. Many people may believe that praying is the way they can help a child or grandchild overcome her or his addiction. If you think this is the case, ask the person if s/he will consider *also* praying that treatment works for the person. Do not give the person a litany of reasons why the daughter, son, or grandchild's disease needs medical attention. Embrace their belief and at the same time, suggest that the person pray for a positive treatment outcome. The strategy is to get the person, often an adolescent, into treatment and to avoid a "war of different beliefs" that will not serve the addicted person's treatment needs.

Additionally, one way to test out someone's superstition and if it will be a barrier in her or his ability to comply with treatment is the following: "Oh! I am giving you an appointment for Friday, August 13th; I wonder if that

is a day you'd like not to come in . . . . I ask because I know people (or I have a relative) who will not start (or go any place by plane) on a Friday that falls on the 13th." The person's response can open up a "floodgate" to their beliefs (or lack of beliefs) in superstitions, intuition, and hunches.

IV. Information to Enhance Knowledge and Skills for Working with People of Color

A. People of Color usually have a high regard for the interpersonal relationship, which is considered their "world view." Therefore, treatment cannot be mechanistic but needs to be engaging and emanating from a relationship between two people: the client/patient and professional. The professional needs to have an attitude and behavior of friendliness and acceptance of the client/patient regardless of the reason the person needs treatment or the crime, problem, concern that makes treatment necessary or mandated. For the professional to appear disinterested in

the client/patient will be interpreted by her or him as "the (professional) does not like me." When the person believes this, it is extremely difficult to remain in treatment with the professional or to follow the directives of the person.

B. Most People of Color find it difficult to remain in treatment that is more painful than their problem. Hence, treatment that appears to them as *punishment*, they seldom endure it, even when they are mandated clients/patients.

C. Incorporate *therapeutic novelty*: Activities that *are serious* but may appear to be fun. For example, the person can be given an "assignment" between visits that asks her or him to jot down on paper or in her or his memory the things they saw clearly for the first time, in years, since they stopped drinking and drugging. Give an example of what you believe the person may see: "I was able to see the love for me in my daughter's eyes." "I was able to distinguish night from day as a time to work and a different time to sleep. They didn't

just run into each other." "I noticed when I went into a store, I wasn't looking to see if there were cameras watching me." The professional can also give the client/patient a card with a message on it that stimulates discussion on the part of the client/patient. If a movie or TV program that has treatment value or rewards that are possible when someone is drug-free, tell the person that you will be watching it. Ask if s/he can watch it, and the two of you will discuss it next time.

V. Demonstrate a Sense of Unity with Client/Patient When it is Appropriate

To close the client/patient distance-gap, demonstrate a sense of unity with clients/patients. Use words such as *us, we, our* and show your commitment to helping them move into recovering because it will be a "victory" for both of you.

In the addictions field, it is relatively common for a recovering person to be the professional treating the still

addicted or recovering client/patient. A unity response, when appropriate, from the professional can serve to role model the professional as someone who has overcome the situation the client/patient is presently in.

Relative to client/patient and professional being of the same culture, this, too, may be an appropriate time to use unity statements.