Chapter 5 Specific Populations

Culturally competent practices and attitudes can be implemented at all levels of a treatment program to ensure appropriate treatment for families with substance abuse issues. The effectiveness of substance abuse treatment is undermined if treatment does not include community and cultural aspects—the broadest components of an ecological approach. Concerted efforts are instituted to identify and change preconceived notions or biases that people may have about other people's cultural beliefs and customs.

This chapter provides information about several specific populations: children, adolescents, and older adults; women; cultural, racial, and ethnic groups; gays and lesbians; people with physical and cognitive disabilities; people in rural locations; and people with co-occurring substance use and mental disorders. In addition, information is provided regarding people who are HIV positive, people who are homeless, and veterans. Each section discusses relevant background issues and applications to family therapy.

Introduction

This TIP uses the term *specific populations* to examine features of families based on specific, common groupings that influence the process of therapy. Whenever people are categorized or classified in this way, it is important to remember that individuals belong to multiple groups, possess multiple identities, and live their lives within multiple contexts. Different statuses may be more or less prominent at different times. The most important general guideline for the therapist is to be flexible and meet the family "where it is."

It is vital that counselors be continuously aware of and sensitive to the differences between themselves and the members of the group they are counseling. Therapists bring their own cultural issues to therapy, and the therapist's age, gender, ethnicity, and other characteristics may figure in the therapeutic process in some way. Differences within the family also should be explored. Is the family a homogeneous group or one that represents several different backgrounds? What is the significance that family members assign to their own identities and to the identity of the therapist? These considerations and sensitivity to the specific cultural norms of the family in treatment must be respected from the start of therapy. If these factors are not apparent or explicit, the therapist should ask.

Age

Age is an important factor in the therapeutic process. Substance use may have different causes and different profiles based on an individual's age and developmental stage. For example, a teenager may drink for different reasons than does a middle-aged father. The age of the person abusing substances is also likely to have different effects on the family. This TIP discusses three age groups: children, adolescents, and older adults.

Children

Background issues

While actual numbers of children who abuse substances are small compared to other age groups, children who use drugs are an underserved population—one as poorly identified as it is poorly understood. Nonetheless, substance abuse among children is of grave importance. Drug or alcohol use can have a severe effect on the developing brain and can set a potential pattern of lifelong behavior (Oxford et al. 2001).

The use of inhalants is especially prevalent among children. The National Institute on Drug Abuse (NIDA)-funded 2001 Monitoring the Future survey found that more than 17 percent of eighth graders said they had abused inhalants at least once in their lives (Johnston et al. 2002). In a recent policy statement, the American Academy of Pediatrics (AAP) described inhalant abuse as "an under-recognized form of substance abuse with a significant morbidity and mortality" (AAP 1996, n.p.). For more information, see also TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (*c* Center for Substance Abuse Treatment [CSAT] 1999*c*).

Application to family therapy

When a child is abusing substances, single family therapy is probably the most useful approach. Regardless of the approach, the therapist will need to make accommodations and adjustments for children in therapy. For instance, children should not be left too long in the waiting room and should not be expected to sit still for an hour while adult conversation takes place around them.

Stith et al. (1996) interviewed 16 children between the ages of 5 and 13 who were involved in family therapy with their parents and siblings and found these children wanted to be involved in therapy, even when they weren't the identified patient (IP). They were aware that important things were happening in therapy and wanted to be part of them. They did, however, indicate that being part of family sessions often had been an unsatisfying experience dominated by adult conversation and time spent out of the session in the waiting room. The personal qualities of the therapist were

important to the children. Finally, they said that if they were to be part of therapy, they needed to participate in ways that fit their styles of communication—activity and play.

Approaches to incorporate children in therapy via play—such as family puppet shows, family art projects, and board games with a therapeutic focus—can be modified to fit family therapy, and play therapy can be a valuable component of family sessions. The Association for Play Therapy defines play therapy as "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development" (Bratton et al. n.d., p. 1). Cooklin (2001) points out that play therapy does not mean playful interactions in therapy, but refers to more structured and often nonverbal processes such as the use of toys, games, puppets, models, or role playing. Its goal is to reduce the child's anxiety and to facilitate emotional processing. He also emphasizes, though, that when the client is a child, a level of playfulness is helpful in the therapist–client relationship.

Adolescents

Background issues

Youthful substance use is usually transitory, episodic, or experimental, but for some, it may be a serious, long-lasting indicator of other life problems (Furstenberg 2000). A growing body of research, primarily using animals, addresses the sensitivity of adolescents' brains to alcohol (see, e.g., Spear 2000). Substance use in the teen years is associated with disruptive behaviors such as conduct disorders, oppositional disorders, eating disorders, and attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD).

The United States has the highest rate of adolescent drug abuse of all industrialized nations (Liddle et al. 2001). The Overview of Findings From the 2002 National Survey on Drug Use and Health found that 17.6 percent of 12- to 17-year-olds reported drinking in the month preceding the survey, and 11.6 percent of 12- to 17-year-olds said they had used an illicit drug (Office of Applied Studies [OAS] 2003*a*). More than 65 percent of young people who were classified as heavy drinkers were also using illicit drugs (OAS 2002*b*).

Alcohol is the substance most often used and abused by adolescents, and its usage reflects troubling patterns (AAP 2001). In 2001, of people age 12 to 17, 10.7 percent reported binge alcohol use in the past month and 2.5 percent reported heavy alcohol use in the past month (binge drinking is defined as five or more drinks on the same occasion; heavy use is five or more drinks on the same occasion at least 5 days in the past month) (OAS 2003*a*).

Substance use among adolescents is associated with poor school performance, problems with authority, and high-risk behaviors, including driving while intoxicated and unprotected sexual activity. Fifteen-year-olds who drink have been found to be seven times as likely to have sexual intercourse as their nondrinking contemporaries (AAP 2001). Sexually active teenagers who use alcohol or drugs are at greater risk of acquiring sexually transmitted diseases, including HIV/AIDS (AAP 2001).

Some specific risk factors for adolescent substance abuse include

- Antisocial behavior at a young age, especially aggression
- Poor self-esteem
- School failure
- ADD and AD/HD
- Learning disabilities
- Peers who use drugs
- Alienation from peers or family
- Depression and other mood disorders (e.g., bipolar disorder)
- Physical or sexual abuse (AAP 2001)

Application to family therapy

A growing body of evidence supports family therapy's capacity to engage and retain clients in therapy and its efficacy in ameliorating adolescent drug use, as compared to other approaches (Liddle and Dakof 1995*a*). Specific family therapy approaches such as Brief Strategic Family Therapy (Szapocznik and Williams 2000) and Multidimensional Family Therapy (Liddle et al. 2001) have shown great promise in terms of usage reduction in adolescents and improvements in family functioning.

Part of the treatment process involves teaching adolescents to make choices and encouraging them to find alternatives to substance use. Parents can be instrumental in this process and the importance of modeling behavior should be emphasized. Siblings also should be drawn into therapy—sometimes the problems of an adolescent IP will overwhelm the needs of a quieter sibling. In general, family therapists can support families by providing opportunities for them to work on negotiation skills with their adolescent child. Therapists can teach parents techniques to decrease reactivity and

ways to provide real and acceptable choices for their children. Children should be encouraged to handle developmentally appropriate tasks and to understand that outcomes are tied to behavior.

Moving therapy from the clinic to settings with which the adolescent is familiar and comfortable can be a helpful strategy. Conducting sessions at an adolescent's home may promote a more open and sharing tone than sessions in a therapist's office. Scheduling of sessions must be sensitive not only to school obligations, but to extracurricular and social activities as well. Such flexibility is an important attribute for any therapist working with adolescents. When teens are not willing to engage in therapy/treatment, parents may be encouraged to attend therapy to examine ways of working with their troubled teen.

Gender also may have implications in family groupings for therapy sessions, particularly in families where abuse has occurred. There may be cases where father/son or mother/daughter sessions will be helpful.

For more information on substance abuse treatment with adolescents, see TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT 1999*c*) and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT 1999*e*).

Older Adults

Background issues

Although definitions of "older adults" vary, they typically refer to individuals age 60 and older. Up to 17 percent of older adults are estimated to have problems with alcohol or prescription drugs. Older men are much more likely than older women to abuse alcohol (Atkinson et al. 1990; Bucholz et al. 1995; Myers et al. 1984); women typically experience later onset of problem drinking than do men (Gomberg 1995; Hurt et al. 1988; Moos et al. 1991). For both men and women, substance abuse can lead to social isolation and loneliness, reduced self-esteem, family conflict, sensory losses, cognitive impairment, reduced coping skills, decreased economic status, and the necessity to move out of one's home and into a more supervised setting (CSAT 1998*d*).

There are two patterns of substance abuse among older adults. The first includes those for whom drug or alcohol abuse has been a chronic, lifelong pattern leading to significant impairment by the time they are older. The second includes older adults who have recently begun misusing alcohol or drugs in response to life transition issues, such as the death of a spouse. Through reduced tolerance and the decrease in the amount of body water (associated with aging) in which to dilute alcohol (Dufour and Fuller 1995; Kalant 1998), alcohol use considered moderate and nonproblematic through a person's middle years can cause intoxication and dysfunction in an older person. In general, treatment is more effective and the prognosis more optimistic for people with later-onset substance disorders.

Diagnosis can be difficult in this age group (and misdiagnosis is more likely) because symptoms easily can be confused with age-related organic brain disorders or effects and interactions of prescribed medications. Depression or bone fractures from falls may be incorrectly attributed to the natural aging process. Family members may hide the older person's substance abuse. A retired person will not have problems at work related to substance abuse, and the behavior of those living alone often will go unobserved. Moreover, although older people often have many contacts with the health care system, they are not routinely screened for substance abuse (CSAT 1998*d*).

Ageism also contributes to the underdetection of substance abuse and mental disorders (e.g., depression) in older people. One study found that different expectations of younger and older people contributed to minimizing problems of older adults. Substance abuse and other problems were perceived as more significant when they were experienced by younger people (Ivey et al. 2000).

Prescription drug misuse and abuse are higher among older adults than any other age category. For some individuals, the misuse may be unintentional, because of confusion and the sheer amount of medicines they must manage. Some studies estimate that more than 80 percent of those over 65 take at least one prescription drug (Ray et al. 1993) and nearly one-third take eight or more prescription drugs daily (Sheahan et al. 1989). Older adults also take a disproportionately large amount of psychoactive mood-changing drugs (such as antidepressants, tranquilizers, and hypnotics). Moreover, they typically take these drugs longer than younger adults (Sheahan et al. 1995; Woods and Winger 1995). The cost of medication also is a factor related to compliance for older adults.

Application to family therapy

While the efficacy of family therapy to treat older adults has not been extensively examined, some indications suggest it is an effective method to draw even the older person who lives alone back into a family context and reduce feelings of isolation. Although family ties can be beneficial at any stage of life, some older adults may regard involvement of their long-grown children in their lives as intrusive and threatening to their independence (Sluzki 2000). The therapist must respect the elder's autonomy and privacy, and obtain specific permission from the client to contact family members and communicate with them about substance abuse problems. The therapist also should be aware that adult children may have their own substance use problems and screen them carefully.

Therapists must be sensitive to the possibility of elder abuse, which is pervasive, though often overlooked. In some States, it is mandatory for all helping professionals to report elder abuse. Such reports of physical, psychological, financial, or emotional mistreatment or neglect have increased dramatically in the past 15 years, yet only a fraction of cases are ever reported. While a common perception is that elder abuse is a nursing home-related phenomenon, the fact is that perpetrators are most often the victims' family members (Brandl and Horan 2002).

Even when abuse is not a factor, older adults sometimes are infantilized and trivialized within the family. Likewise, family therapists must be cognizant of their own tendencies to infantilize the elderly (Sluzki 2000). It is helpful to refrain from framing the substance abuse in pejorative terms, such as *heavy* and *problem drinking.* Instead, a less stigmatizing classification system may refer to a person as *at-risk.* Linking at-risk use to existing or potential medical conditions also places the problem in a medical framework and identifies it as a danger to health.

The family therapist working with older adults may also find it helpful to make extensive use of home visits. It is important to respect clients and their life experiences. Older people, especially those who feel isolated, may have a need to tell their stories (for example, growing up during the Great Depression), and the therapist needs to listen attentively. Telling stories is important and a developmentally appropriate behavior.

Other accommodations that are helpful for many older clients include

- Involving the older adult's physician and/or nursing staff.
- Recognizing and addressing barriers to treatment, such as ageism, lack of awareness, comorbidity of physical or mental disorders, transportation problems, client's time constraints, lack of staff expertise, and economic limitations.
- Addressing issues of loss, grief, death, and dying.
- Addressing concomitant substance use, including tobacco.
- Using supportive, nonconfrontational intervention approaches. Motivational interviewing is appropriate for some older adults.
- Acknowledging the cultural expectations regarding use to better understand the older client's perceptions of his or her own using.

For more information about substance abuse treatment and older adults, see TIP 26, *Substance Abuse Among Older Adults* (CSAT 1998*d*).

Women

Background Issues

According to data from the 2002 National Household Survey on Drug Abuse (OAS 2003*a*), 6.4 percent of American women reported using an illicit drug in the month preceding the survey, while 9.9 percent of women reported binge drinking in the same timeframe. In 2002, men continued to have higher rates of illicit drug use than women—10.3 percent of men compared to 6.4 percent of women (OAS 2003*a*).

Despite the significant number of women who abuse substances, the substance abuse treatment and research fields have been grounded historically in the needs and experiences of middle-aged, white males with alcoholism. Recent studies suggest that the causes, consequences, and costs of women's substance abuse are in many ways different from men's. For example, the onset of substance abuse among women is more likely to be tied to specific events, such as divorce or the death of a loved one. Women also tend to enter treatment at later stages than men, and women continue to encounter many gender-related barriers to treatment (Brady and Randall 1999; Chaney and White 1992). Moreover, in addition to the risks shared with men (i.e., hepatitis, HIV infection, malnutrition, unemployment, criminal acts, and arrests), women have been found to develop more severe alcohol-related medical problems while consuming smaller amounts of alcohol than men. Sexual, physical, or emotional abuse of women can increase their risk of substance abuse (Covington 2002).

In some respects, the psychological burden of women's substance abuse is likely to be greater than for men. One of the biggest psychosocial differentials between men and women who abuse substances is stigma. For a man, especially in certain cultures, drinking may be part of manhood. Women with substance use disorders often are referred to in derogatory and sexually charged terms. A mother with a substance abuse problem quickly is regarded as unfit and may be confronted with losing her children. Although 9 out of 10 women stay with male partners who abuse substances, men are more likely to leave relationships with a woman who abuses substances (Hudak et al. 1999).

A recurring theme in the lives of women with substance use disorders is a lack of healthy relationships (Covington 2002). Brown et al. (1995) found that when women were drinking, they often lacked social support, particularly from their partners, and that their families often were opposed to their getting treatment. For more information, see the forthcoming TIP *Substance Abuse Treatment and Trauma* (CSAT in development *i*) and TIP 36, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* (CSAT 2000*b*).

An important distinction in women's substance abuse has to do with their traditional roles as caretakers of children. Even before children are born, women who abuse illicit drugs and alcohol experience a variety of gynecological problems that can make birth control and pregnancy detection difficult, adding to the probability of infertility and problem pregnancies and births. Many studies of substance use and pregnancy have found poor pregnancy outcomes such as preterm delivery, fetal distress, and hemorrhage, whether the drug is alcohol, cocaine, opioids, marijuana, or nicotine (Brady and Randall 1999; Bry 1983).

A variety of other ills may influence the children of mothers who abuse substances, including increased risk for depression, anxiety, and conduct disorders (Brady and Randall 1999; Merikangas and Dierker 1998), higher rates of lifetime suicidal ideation (Pfeffer et al. 1998), and more frequent periods of living outside the nuclear family during childhood (Goldberg et al. 1996). Child abuse and neglect are also often associated with women's drug and alcohol abuse (Bijur et al. 1992; Casado-Flores et al. 1990; Famularo et al. 1986, 1992; Murphy et al. 1991).

Bays (1990) suggests a number of factors associated with drug abuse that put parents who abuse substances at greater risk of abusing or neglecting their children. These include diverting family resources from meeting the needs of the children to supporting the substance abuse, criminal activity to support a substance use disorder, mental and physical illness, poor parenting skills, side effects of drugs, and family violence. In addition, the effects of prenatal drug exposure may produce characteristics in the children that interfere with attachment and put them at greater risk for abuse (Cook et al. 1990) and the development of substance abuse problems later in life (Merikangas and Dierker 1998; Muetzell 1995; Su et al. 1997). For further information about women's issues in substance abuse treatment, see the forthcoming TIP *Substance Abuse Treatment: Addressing the Specific Needs of Women* (CSAT in development *e*).

Application to Family Therapy

Family therapy for women with substance use disorders is appropriate except in cases in which there is ongoing partner abuse. Safety should always be the primary consideration. This could mean that the abusive partner progresses through treatment directed at impulse control or a batterers' program before any family or couples therapy is initiated to address the woman's substance abuse problem. This decision should be made after careful consultation with the professional staff overseeing the abusive partner's treatment. While the abusive partner's treatment is ongoing, it may be helpful for the client who has been victimized to participate in individual therapy or some type of group therapy focused on her experience with abuse.

Covington (2002) notes that substance abuse treatment is more effective for women when it addresses women's specific needs and understands their daily realities. Finkelstein (1994) likewise emphasizes the need for a holistic approach to achieve successful outcomes. Far-reaching changes, she points out, are needed in many areas of a woman's life, including employment, housing, health care, child care, children's services, family supports, legal rights, and division of labor within the family. To be responsive to a woman's needs, family therapy should address these broad areas. Amaro and Hardy-Fanta (1995), Covington (2002), and Finkelstein (1996), among other researchers and clinicians who work with female clients, also stress the importance of relationships in a woman's life and the need for a model to meet these needs. Family therapy, with its focus on the family unit and the relationships therein, can clearly help address these needs for women and help them improve their relationships.

Particular treatment issues relevant to women include shame, stigma, trauma, and control over her life. Women tend to hide their drinking and substance abuse because of the shame that is associated with it. It is important that women feel they are being treated with respect and dignity in treatment (Covington 2002; Hudak et al. 1999). Because of the high rates of victimization in women's lives, it is critical that the therapist addresses trauma in women's therapy in order for it to be successful. Substance abuse recovery and trauma recovery should occur together, and safety must be ensured in therapy (Covington 2002). Related is the issue of control in the woman's life in areas such as sex, money, food, and religion. Some control problems for women are internal and manifested in self-abusive behaviors, such as eating disorders or self-cutting.

Women who have lost custody of their children may need help to regain it once stable recovery has been achieved. In fact, working to get their children back may be a strong treatment motivator for women. Finally, childcare is one of the most important accommodations necessary for women in treatment. Children must be allowed to come to therapy sessions, or when such attendance is not appropriate, to be placed in suitable childcare.

Race and Ethnicity

Although a great deal of research exists on both family therapy and culture and ethnicity, little research has concentrated on how culture and ethnicity influence the core family and clinical processes (Santisteban et al. 2002). Rigorous investigations are needed to explore the dynamic interplay between "ethnicity, family functioning, and family intervention" (Santisteban et al. 2002, p. 331).

One important requirement is to move beyond ethnic labels and consider a host of factors—values, beliefs, and behaviors—that are associated with ethnic identity. Among major life experiences that must be factored into treating families touched by substance abuse is the complex challenge of determining how acculturation and ethnic identity influence the treatment process. Other influential elements include the effects of immigration on family life and the circumstances that motivated emigration (migration due to war or famine is a far more stressful process than voluntary migration to pursue upward mobility), and the sociopolitical status of the ethnically distinct family, in particular how the host culture judges people of the family's ethnicity (Santisteban et al. 2002).

Generalizations about barriers to treatment for racially and ethnically diverse men and women should be made with caution. Nevertheless, some barriers to treatment, particularly among African Americans and Hispanics/Latinos, have been investigated. They include problem recognition or perceptions of problem severity (for example, the belief that one's alcohol use is not a problem, or not a severe one, and that those affected can handle the problem on their own), costs associated with seeking treatment, as well as doubt about the efficacy of treatment (Kline 1996). Other barriers to treatment for these groups include inaccurate perceptions about the cost or availability of treatment (especially for people who lack insurance), a

cultural need to maintain dignity, negative beliefs about treatment (such as harsh rules in residential programs), and structural problems (such as too little treatment for people with no or inadequate insurance, inadequate detoxification facilities, and bureaucratic red tape) (Kline 1996). For more information about cultural competency, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *b*).

African Americans

Background issues

Many African Americans were able to overcome the destabilizing trauma of slavery by relying on the support of affectional ties, extended kinship ties, and multigenerational networks, among other strengths (Wilkinson 1993). Kinship bonds continue to provide support in coping with the difficulties of a discriminating society (Sue and Sue 1999). Paniagua (1998) states that family therapy is recommended with African-American families, and should specifically include emphasis on assigning tasks to be completed at home as well as role-playing scenarios to develop intrafamilial communication.

To work effectively with African-American families, family therapists must become familiar with the complex interactions, strengths, and problems of extended families (Boyd-Franklin 1989). Many extended African-American families incorporate various related people into a network that provides emotional and economic support. Numerous adults and older children participate in raising younger children, often interchanging family functions and roles (Hines and Boyd-Franklin 1996). The practice of exchanging assistance, or reciprocity, is an essential part of extended family life. Such reciprocity may take the form of caring for another's child, knowing that the favor will be returned when necessary, or providing and receiving emotional support (Wright 2001). Many extended families also take in secondary members, such as cousins, siblings of the parents, elders of the parents, or grandchildren. In other cases, families take in children who are not biologically related. Approximately 1.4 percent of African-American children live in homes where they are unrelated to the head of the household (U.S. Census Bureau 2001*b*).

Application to family therapy

As with all individuals, African-American clients are sensitive to whether they are being treated with respect. Cultural information should be considered hypotheses rather than knowledge. Techniques shown to be effective with African Americans will be rendered ineffective if the therapist assumes an attitude that is alienating to clients.

People of African ancestry are widely divergent. Therapies effective for African Americans may be inappropriate for immigrants from the Caribbean or Africa (see below). The personal connection between family and therapist is the single most important element in working with African-American families. Without rapport, treatment techniques are worthless and the family will likely terminate therapy early (Wright 2001).

Within-Group Diversity: Caribbean Black Populations

Interventions deemed appropriate and effective with African Americans born and raised in the United States may be inappropriate for other groups. For example, single-family therapy may not be effective with Caribbean Black populations. Because this culture values privacy so keenly, families may not discuss problems at all, even among themselves (Harris-Hastick 2001). In order to minimize the discomfort of West Indian clients, Harris-Hastick (2001) recommends offering an educational orientation about treatment, alcohol, and other drugs, scheduling individual sessions until clients can comfortably talk about themselves or be assigned to groups with other Caribbean members.

African-American families also are sensitive to a patronizing approach that Boyd-Franklin (1989) refers to as missionary racism. Therapists should be sensitive to the ways in which this message may be conveyed. Clinicians must be aware of any biases or attitudes regarding their African-American clients. To address this issue effectively, therapists may need assistance from supervisors or colleagues or training in cross-cultural situations (Wright 2001).

Santisteban et al. (1997) found that single-family therapy improved family relationships and reduced behavioral problems in African-American youngsters. African Americans also function very successfully in multiple family therapy. For many African-American Christians, the Bible is a longstanding source of truth and solace that helps them make sense of life (Reid 2000). Because of the church's centrality to their lives, a Bible-related recovery program has been found to be effective for African-American Christian families (Reid 2000).

African-American women

Mothers in African-American communities often are characterized in terms of their strength and devotion to family (Hines and Boyd-Franklin 1996). This role often proves stressful and destructive for African-American women with substance use disorders because they are committed to an exceptionally high level of responsibility. Perhaps as an additional result, they exhibit a high level of denial regarding their substance abuse.

Reid (2000) maintains that in African-American families where the mother has a substance use disorder, the family may react by persecuting her because of her failure to uphold the role as mother. Most often, however, the family will act to protect the mother's image, becoming her caretakers, keeping her substance abuse secret, and taking care of her children. This assistance may ultimately enable the mother's denial to become so strong that she considers treatment to be a violation of her self-respect and obligation to her family. In this scenario, a mother's loyalty to the family may eventually lead to a crisis, when the pressure of presenting a functional front becomes too great (Reid 2000).

Because the mythical role of the African-American superwoman prevents many mothers from seeking help, therapy must address these expectations. Addressing shame and guilt, and giving African-American women permission to acknowledge their personal needs, are essential points for recovery (Reid 2000).

Parenting issues

Therapists often take exception to the strict parental discipline meted out in some African-American families. Sue and Sue (1999) warn against therapists' imposing their own beliefs and values on these parents; they say that "physical discipline should not be seen as necessarily indicative of a lack of parental warmth or negativity" (p. 241).

Many African-American families are headed by women. Functional single-parent African-American families are characterized by certainty about who is in charge, precise understanding of roles and responsibilities, clear and flexible boundaries, children having access to the parent, children being cared for and having their needs met, and parents and children feeling free to seek and provide nurturance and communicate their needs. Some functional single-parent families have a parental child who helps the mother take care of other children, particularly while the mother is working. The existence of a parental child does not necessarily indicate dysfunction. These families may operate successfully as long as the child has access to activities with peers and the parent does not abandon responsibilities or inappropriately burden the child (Boyd-Franklin 1989).

Other factors

Such factors as AIDS, violence, and disrupted families have had a profoundly negative effect on the African-American community. To counter this, effective substance abuse treatment should be life-affirming and emphasize an acquisition of power that moves the person with a substance use disorder, the family, and the community toward increased self-determination (Rowe and Grills 1993). Effective substance abuse treatment and recovery should "emphasize the positive potential of human behavior based on a value system and sense of order committed to the greater good of humankind" (Rowe and Grills 1993, pp. 26–27).

Counselors should also be aware of how racism impacts the family. Boyd-Franklin (1989) notes that even middle-class African Americans may experience diminished self-esteem and anxiety about maintaining their position. Some middle-class African-American families experience particularly intense pressure to maintain appearances (Boyd-Franklin 1989). These families often place a strong emphasis on respectability where causing shame for the family is considered to be particularly reprehensible and damaging.

Hispanics/Latinos

Tremendous demographic and cultural heterogeneity exists within the Hispanic/Latino population. Indeed, even within a specific subgroup, there will be substantial variation based on regional, social, economic, and acculturation-related differences. "Most analyses have treated Hispanics as a single group, despite the fact that traditional alcohol use patterns vary among Hispanics with different countries of origin. In addition, studies among Hispanics typically have focused on male drinking patterns" (Caetano et al. 1998, p. 234).

An understanding of Hispanic/Latino subgroups must begin with knowledge of their families' immigration history. Some people leave their home country voluntarily in order to pursue adventure or escape poverty. Refugees, on the other hand, may flee persecution, fear for their safety, and have much more pain and anger associated with their migration. Those who come from war-torn countries may show symptoms of posttraumatic stress disorder and other associated trauma.

Substance use in Hispanic/Latino communities

Substance use and abuse varies between Hispanic and Latino communities. Level of acculturation has a strong positive association with substance use. Specifically, more acculturated individuals report greater use of alcohol and other substances. Cuadrado and Lieberman (1998) assert that English-speaking Mexican Americans are eight times more likely to use marijuana than their Spanish-speaking peers, and among Puerto Ricans the same circumstances effect a fivefold increase.

The role of acculturation in family functioning

In attempting to navigate their new environment, many immigrants experience a loss in confidence, as well as shame, anger, and confusion. These emotional reactions generally result from poverty, unemployment, social isolation, discrimination, lack of resources, sociopolitical marginality, and cultural shock (Hernandez and McGoldrick 1999). Any of these factors may contribute to substance abuse and impact family functioning.

Cultural characteristics that impact family therapy

Perhaps the most widely acknowledged common thread among Hispanics/Latinos is the importance placed on family unity, the family's well-being, and the use of family as a support network. Familialism or *familismo* are terms that refer to a core construct among Hispanic and other ethnic-minority cultures. It has three components: (1) perceived obligations toward helping family members, (2) reliance on support from family members, and (3) the use of family members as behavioral and attitudinal referents (Marín and Marín 1991).

Generally, the typical nuclear family is embedded in an extended family with flexible and open boundaries. Hispanics/Latinos place a strong emphasis on extended family and clustering (Kaufman and Borders 1988), and there tend to be fluid boundaries between family members such as cousins, aunts, uncles, and grandparents. "The family is usually an extended system that encompasses not only those related by blood and marriage, but also *compadres* (godparents) and *hijos de crianza* (adopted children, whose adoption is not necessarily legal)" (Garcia-Preto 1996, p. 151).

Extended family members perform parental duties and functions, providing the children with the adult attention that is hard to come by in a large family (Falicov 1998). Relationships between siblings and cousins are strong and it is not uncommon to have few peer friendships outside the sibling subgroup. Godparents are practically an additional set of parents, acting as guardians or sponsors of the godchildren and maintaining a strong relationship with the natural parents (Falicov 1998).

Application to family therapy

Despite substantial research documenting the underutilization of services by Hispanic/Latino families, single-family therapy can be used effectively with troubled Hispanic/Latino children and adolescents and their families. Santisteban et al. (1997) showed that family therapy could be effective in reducing behavior problems and improving family functioning in Hispanic/Latino children who were at high risk for drug abuse. Santisteban et al. (1996) and Szapocznik et al. (1988) demonstrated that single-family therapy using specialized engagement strategies could successfully engage reluctant families into treatment. Family therapy is consistent with the family orientation of Hispanics/Latinos, who welcome the involvement of all family members. Paniagua (1998) believes that family therapy "should be considered as the first therapeutic approach with all Hispanic clients" because it fits well with Hispanics' "view of familismo and extended family" (p. 51).

To the non-Hispanic family therapist, extended family relationships may at times appear enmeshed and over-involved. Therapists must understand the intensive emotional involvement among extended families (Guiao and Esparza 1997). Everyone who is relevant to the extended family network (i.e., whoever is central to the family's day-to-day functioning) should be involved within the family therapy session. Conducting multiple family therapy may meet with more success through focusing on the broader issues of strong relevance to Hispanic/Latino families that may be contributing to presenting problems. For example, these issues may include the powerful intrafamilial stresses due to acculturation and immigration (Santisteban et al. 2002). However, when bringing Hispanic families together, the family therapist must address confidentiality to enhance a sense of trust and privacy, particularly in small communities.

Respeto and conflict

The *respeto* (respect) that Hispanic/Latino parents command from children has a different internal meaning and set of expectations than the more egalitarian Anglo-American notion of "respect" (Falicov 1996). The extent to which parents prefer markedly hierarchical family relations has powerful implications for families and family therapy. When parents view good family functioning as consisting of marked levels of authority (nonegalitarian), they can perceive any type of open disagreements between parents and adolescents as disrespectful and unacceptable.

This view may clash with traditional Western models of family therapy in which full conflict emergence with resolution is valued, and in which both negative and positive emotions tend to be more easily expressed and tolerated. Hispanics/Latinos may perceive therapy interventions as incompetent or misguided if they openly encourage young people to speak their mind or tell parents what they really think. Care must be taken to ensure that children, who are generally encouraged to speak openly during sessions, do not violate the family's disciplines and thereby prompt premature termination (Santisteban et al. 2002). The therapist should ask the family how it resolves conflict.

Although Hispanic/Latina women generally are accorded a great deal of respect, Hispanic society is more concerned with the needs of the social group as a whole than the needs of the individual. As a result, Hispanic/Latina women may be more strongly invested in others, as opposed to self-invested, a concept that grows out of the more individualistic goals of dominant-culture therapy (Trepper et al. 1997).

Communication styles

Because open disagreement and demands for clarification are viewed as rude and insensitive, indirect communication is sometimes viewed as preferable. The use of impersonal third-person pronouns is one method of indirect communication. Sometimes Hispanic/Latino culture's emphasis on smooth relationships may become excessive, leading to concealment and lies (Falicov 1998). Family therapists must gauge the extent to which communication patterns present such a hindrance.

Falicov (1998) urges family therapists to adopt a tone of acceptance and eschew direct confrontation and demands for extensive disclosure throughout treatment. Therapists can ease the confrontational nature of therapy by employing humor, allusions, and diminutives. Disclosure is made easier when the family therapist takes a philosophical approach through storytelling, anecdotes, and metaphors. Other culturally harmonic tools include analogies, proverbs, popular songs, and unexpected statements that convey a sense of the absurdity of life (Falicov 1998). However, direct communication can and should be used when seeking informed consent or when an emergency situation exists.

Counseling strategies

Family therapists should have a working knowledge of how substance abuse is defined in the families' country of origin. Many countries of origin, such as Mexico, have a culture that is more permissive toward substance use. Immigration and acculturation into the U.S. may alter family members' attitudes toward substance use. Any such changes must be addressed, given their immediate impact on family relations.

Clinicians should also explore family members' experiences of migration, cultural transition, and ethnic-minority status. Holding an open discussion about these experiences allows therapists to analyze family stories and leads directly to issues affecting substance abuse. For instance, a discussion concerning how family members reconcile their culture of origin and American culture will reveal differing acculturation levels within the family. Therapists may also explore the issue through the simple exercise of having family members rate how close they feel to their culture of origin on a scale from 1 to 10. Naturally, in all cases, therapists must make arrangements so that language does not impede a family member's participation.

Therapists who plan to work with Latino families who have migrated from Mexico should be familiar with spiritual healers, the *curandero* or *curandera* (i.e., folk healer). These healers can help resolve intrapsychic and interpersonal problems. Curanderismo, or the art of folk healing, is a particular treatment modality used primarily in Latino/Southwestern rural communities, although it is also prevalent in metropolitan areas with a large Latino population. Curanderos earn their trust from the community; the community validates their "practice." This modality contains a mix of psychological, spiritual, and personal belief factors. Since the curanderos are considered to be holy, they invoke God's and the Saints' blessings on people seeking their help.

Other considerations include the following:

- A businesslike approach to treatment will not appeal to Hispanic/Latino families. A personable tack will yield much more effective results.
- Hispanic/Latino family members will be much more forthcoming when the therapist solicits their feelings through subtle and indirect means. Encouraging clients to speak forcefully and directly may have the unintended effect of inhibiting their participation (Paniagua 1998).
- The establishment of behavioral contracts may be an overly task-oriented approach for this population. Scheduling time ahead to resolve intimate issues may also not be acceptable to clients. Falicov (1998) recommends making homework assignments conditional because it is more collaborative, less presumptive, and more in keeping with a cultural affinity for spontaneity.
- Hernandez (2000) recommends that family therapists adopt a broader perspective than the disease model, to incorporate the impact of a toxic social environment and the effects of oppression as factors contributing to substance dependency. While still holding people with substance use disorders accountable for their actions, this approach helps to frame substance abuse as a communal problem and spur family members into learning more about the effects of oppression.
- Using fundamental spiritual precepts can inspire hope and patience. The endurance of suffering, the practice of forgiveness, and the importance of repentance may be fertile values to use in working with families with substance abuse. This strategy should only be used when it is in harmony with the spiritual views of the individual family or family member (Hernandez 2000).

Asian Americans

Background issues

Asians are culturally diverse, with great variations of language, history, religion, and values. Caution should be used when addressing any of these groups as a whole.

Asians comprise more than 45 distinct subgroups (Barnes and Bennett 2002; Grieco 2001), speaking more than 60 languages (New York State Education Department 1997). The tremendous cultural differences between these groups make generalizations difficult. This complexity is increased by key variables such as reasons for migration, degree of acculturation, English-speaking capacity, family composition and intactness, education, and adherence to religious beliefs. Despite this diversity, Asian immigrants and refugees share many traits, including

- Deference to authority
- Emotional inhibition
- Adherence to specified roles
- Hierarchical families
- Gender-specific roles
- Extended family involvement (Sue and Sue 1999)

Asian family structure

Filial piety is highly valued in Asian cultures (Fang and Wark 1998; Herrick and Brown 1998). However, "filial piety can be a source of great anxiety when family obligations conflict with individual interests" (Fang and Wark 1998, p. 67). In Asian families, women tend to have fewer decisionmaking abilities than their Western counterparts. Families are patriarchal, with the eldest son having decisionmaking powers when parents reach old age. Elders are seen as wise, and as such are revered (Herrick and Brown 1998). However, the more acculturated an Asian-American family is, the more Western intrafamily relationships may become (Fang and Wark 1998).

Rates of substance abuse in Asian communities

Substance use within individual Asian communities has received scant attention with most studies placing Asians into a single ethnic category rather than as separate ethnic groups (Uehara et al. 1994) or categorizing Asians as "others."

As seen with most immigrant communities, second- and third-generation Asian Americans, born in the United States, are at higher risk to begin using substances (Mercado 2000). As individuals become increasingly acculturated, their drinking patterns resemble those of European Americans. This acculturation may lead to intergenerational conflict, which in turn spurs the acculturated family member's substance abuse in order to alleviate the conflict (Bhattacharya 1998; Makimoto 1998).

Application to family therapy

The contemporary image of Asian Americans is of a highly successful minority who experience little or no difficulty in American society. Mercado (2000) states that this "model-minority" myth, Asian Americans' cultural values, and typical underutilization of mental health services have influenced substance abuse therapists into believing that Asian-American families are psychologically healthier and in less need than other ethnic groups. The model-minority myth also prevents Asian-American communities from receiving adequate financial commitment and increases Asian Americans' alienation from other minority groups. Looking beyond this myth can help family therapists to better understand the Asian experience in America.

Asians may be hesitant to admit to having a substance use disorder, believing that to do so is an imposition and risks shaming the family. Family members are disinclined to confront people with substance use disorders preferring to minimize, deny, reject, or even ostracize the offending individual (Chang 2000). Inevitably, the result is a cycle of enabling that perpetuates the addictive process and leads to advanced stages before coming to outside attention (Chang 2000). Unfortunately, for many Asian Americans with substance use disorders, this is the point at which treatment often commences. The opportunity for the IP to "save face" is a critical element in making therapy an acceptable part of healing.

Because Asian cultures are so intensively family-centered, the responsibility of maintaining filial obligations is perhaps the dominant concern in the life of most Asians (Herrick and Brown 1998). Given the central importance of family in Asian cultures, it is critical to assess the family's part when treating Asian Americans with substance use disorders. The psychological influence of the family, particularly the older members, is considerable even when key members are missing as a result of loss, nonmigration, or emotional estrangement (Chang 2000). Family therapy with Asian Americans is least likely to include older generations. The primary reason for this absence, younger family members say, is that they hope to spare their elders any discomfort.

Working delicately and tactfully with elders is of foremost importance. When treating unresolved issues among older generations, therapists must demonstrate respect, reveal genuine empathy, and above all, avoid embarrassing older family members. Often family members, particularly the person with the substance use problem, will try to shield older family members from shame. Family therapists must be cognizant not to rush into exploration of sensitive areas. One method is to initially join with the family at a broad experiential level—sharing their salient traumatic incident—without prying for embarrassing or threatening details (Chang 2000).

Opinions vary on whether family therapy is an appropriate vehicle with which to counsel Asian Americans with substance use disorders. Paniagua (1998) states that family therapy is effective because the family is more important than the individual in Asian families and the act of withholding information from family members is unfamiliar to many Asians. May Lai (2001) urges therapists to work with the client's family, but to use individual counseling rather than family therapy. Debates on the efficacy of involving Asian families in treating substance abuse often revolve around the

presumed skill level of the therapist, not the fundamental importance of the client's relationship to his or her family. Clearly, counseling Asian-American families requires skill, delicacy, and knowledge of cultural factors.

Issues of acculturation

As is common among immigrants, Asian-American families present widely varying levels of acculturation within the nuclear and extended family. The process of acculturation varies with each of the Asian groups, depending on their reasons for immigrating (e.g., for political or economic reasons) (Inouye 1999). Acculturation places traditional values and customs out of context (Chang 2000). It results in intensified isolation, removal of social supports, and a sense of alienation from the dominant culture. Asian immigrants may be psychologically maladjusted, despite the perception of their being part of a "model-minority" (May Lai 2001). The loss of family, and of the traditional conception of family, engenders a further loss of identity and place in the world.

The presence of the family will help the family therapist determine the individual's and the family's degree of adherence to traditional values and to assess the family conflicts that result from differential acculturation patterns between family members. Effective pretreatment assessment that includes key questions of acculturation must also include Asian Americans' most significant psychological unit, the family (see for example Huff and Kline 1999).

Factors attributable to acculturation that cause conflict within Asian families are women receiving increased status, children no longer demonstrating the highest regard for their elders, and older family members losing their preeminence as the keepers of tradition. Additionally, Asian fathers' traditional emotional distance from the family can become a detriment in the United States, where family systems experience different demands.

Communication styles

Western-style therapy often requires a frank and open discussion of feelings and problems to be effective. For Asians, directness risks confrontation and rudely ignores one's obligation to help maintain face. On the other hand, to be indirect enables one to convey meaning without challenging or insulting another. To underscore this point, Asian languages tend to be more metaphoric, while English words tend to have precise meanings (Chang 2000).

Furthermore, Asian culture places a high value on "saving face." A family striving to avoid the shame of a family member with a substance use disorder will likely perceive that member as a tremendous liability to the family's structure. Discussing such an issue in therapy with a nonfamily member (no matter how professional) can be interpreted as a sign of weakness for many Asian families (Lee 1996; Paniagua 1998).

For Asians, discussing one's inner feelings is often unfamiliar and culturally unacceptable. It is overly confrontational to seek open discussion of personal issues prior to establishing trust (Sue and Sue 1999). Intervention models that stress direct and explicit exchange between family members or client and therapist are likely to be either ineffective or harmful (Chang 2000). For example, traditional substance abuse therapy often teaches families to detriangulate by challenging one another directly (Mercado 2000). Asian Americans view such behavior, particularly across generations, as disrespectful.

Because traditional Asian families are grounded on a hierarchical structure, they negotiate differences through mediation. This hierarchy requires the counselor to function as a negotiator and follow the family structure when doing so (Sue and Sue 1999). The father, as head of the family, should be spoken to first in order to gather his insight into the family's problem.

It is important for therapists to focus most heavily on specifics when working with Asian families. Rather than discussing feelings, it is more effective to be problem focused and goal oriented (Paniagua 1998).

Engagement

Attempts to underscore the influence of family dynamics as a key contributor to the family member's substance abuse may be received with disapproval and possible termination. Kim (1985) recommends an approach to pace the family's cultural expectations and limitations in relation to traditional Western psychotherapy, in an effort to continue engagement with the family.

The first step is to assert that the IP's *ailment* is indeed the problem—by implication not the client him- or herself. Complaining about physical ailments is an accepted means of communicating psychological stress. Rather than discussing anxiety and depression, Asians may complain about headaches, fatigue, restlessness, or disturbances in sleep and appetite (Sue 1997; Toarmino and Chun 1997). Taking the patient's blood pressure, ordering vitamins, or advising on minor physical ailments will increase the Asian patient's trust in the treatment facility (May Lai 2001). Sue and Sue (1999) also recommend acknowledging and treating physical problems before moving on to possible emotional factors. For example, focusing on the physical symptoms of the person with a substance use disorder (such as high liver enzyme) rather than substance abuse is more culturally acceptable for Asian Americans. In addition, therapists should respect the client's need to use culturally relevant health care such as acupuncture and herbal medicines.

The second step in the engagement process is to acknowledge and strengthen the family's wishes to assist the family member in changing his or her behavior. Treatment planning for Asians with substance use disorders should consider the family's role as early as possible. Although involving the family adds complexity to the therapist's task, its integral importance cannot be overstated. It is critical to assess the individual's substance abuse in regard to the family's level of functioning (Chang 2000). Given cultural mandates to show deference to authority figures, Asian families may present as particularly compliant in treatment.

The third step is for the therapist to stress that each family member's contribution is vital to helping the family member, and that without each family member's participation the problem will persist or worsen, further exacerbating the family's difficulties.

Other considerations in engaging Asian families are noted below:

- Family therapists should be careful that therapy does not breach proscribed gender roles or boundaries between generations. The first appointment should be made with the decisionmaker of the family, who will most likely be the father (Lee 1996).
- Asian clients respond best to credible experts who provide specific suggestions for alleviating distress (Lee 1996).
- Sensitivity to clients' privacy is just as important at a macro level. Because different Asian-American clients may live in the same tight-knit community, therapists should assure them of confidentiality and avoid sharing information regarding one client with another (May Lai 2001).
- Family therapists should not presume that therapy sessions will move forward on a regular basis. Counselors must choose between making the most of the first or initial sessions and scheduling ongoing regular sessions. Many Asians are unfamiliar with Western treatment models and will adopt a more infrequent, crisis-oriented approach to therapy (Lee 1996).
- Clients may feel slighted if the therapist spends limited time with the family without providing a thorough explanation of his or her plan for treatment.
- Lee (1996) recommends the therapist proceed on the assumption that the first session with the entire family will likely be the last, scheduling ample time beyond 1 hour to gather important family history and information.
- It may be effective to leverage the family's willingness and arrange a rapid follow-up (sooner than 1 week) to strengthen the budding therapeutic relationship.

In itself, successfully engaging the family of an Asian person with a substance use disorder goes a long way toward alleviating the IP's profound shame (Chang 2000). For the therapist, the challenge is successfully facilitating the engagement of family members while stretching them to improve their methods of interrelating.

American Indians

Background issues

There are 2.5 million American Indians living in the United States and an additional 1.6 million people who reported being American Indian and at least one other race (Ogunwole 2002). American Indians and Alaska Natives are an exceptionally heterogeneous group. The Federal government recognizes 562 distinct tribes in the United States (*Indian Entities Recognized* 2002), and each has its own culture.

For many American Indians, spirituality is a way of life rather than a part of life. American Indians differentiate between spirituality and religion. However, because Christian missionaries have been working in American-Indian communities for years, there is also a great deal of blended spiritual belief and modern religion (Coyhis 2000). Mixing spirituality and religion enables American Indians to pull from both sources for recovery (Coyhis 2000).

It is difficult to discuss specific values given the overwhelming diversity of American Indians. Sue and Sue (1999) offer a generalized description of American-Indian values:

- *Sharing*. Honor and respect are both gained by sharing and giving. When sufficient money is accumulated, some American Indians may stop working and spend time and energy in ceremonial activities. Refusing to share drinks or substances with a member of the same tribe may be considered an insult.
- *Cooperation*. Many American Indians value the tribe and family more than the individual. Instead of going to an appointment, some may instead assist a family member needing help. In a counseling setting, though they may agree with the counselor, they often will not follow through with the suggestions.
- *Noninterference*. Generally, American Indians do not like to interfere with others and prefer to observe rather than react impulsively. Rights of others are respected. They are often seen as permissive in child rearing.
- *Time orientation.* American Indians are often present-oriented. Punctuality or planning for the future may be de-emphasized. Tasks are completed according to a rational order and not according to deadlines.
- *Extended family orientation*. Interrelationships between relatives are important, and there is a strong respect for elders and their wisdom and knowledge.

- *Harmony with nature.* Rather than seeking to control the environment, many American Indians accept things as they are (Sue and Sue 1999).

Substance abuse patterns

American Indians and Alaska Natives report more illicit drug use and more binge and heavy alcohol use than any other ethnic group (OAS 2002*d*). During the period 1994–1999, 70 percent of American-Indian men and 59 percent of American-Indian women who entered treatment entered because of alcohol abuse. Marijuana was the illicit substance with the most admissions—13 percent of male admissions and 11 percent of female admissions (OAS 2001*b*). Peyote and other intoxicants traditionally used for American-Indian ceremonies continue to be used specifically for these sacred purposes (Weaver 2001).

American Indians are significantly more likely to die of alcohol-related causes than the general population (Penn et al. 1995). From 1994 to 1996, the alcoholism death rate of American Indians was 7 times the rate of all races in the United States (Indian Health Service 2002).

Other relevant issues

American Indians have experienced 500 years of historical trauma including the purposeful disruption of the multigenerational family process and loss of land, language, culture, and identity (Duran and Duran 1995). When family therapists understand this historical oppression and validate in therapy the dysfunction that it has imposed on the multigenerational processes of American Indians, it may create an atmosphere of increased honesty and empower families to understand that some of their difficulties stem from external forces (Duran and Duran 1995).

Although many American Indians practice abstinence from alcohol and drugs, substance abuse remains a tremendous problem with this population. Nearly one third of people of childbearing age report heavy drinking, a major factor in the development of fetal alcohol syndrome (Sue and Sue 1999).

Application to family therapy

In general, the structure of the traditional American-Indian family focuses on all living generations and members of the extended family. Since children are highly valued in this ethnic group, the entire extended family ensures that they are provided guidance, discipline, and control (Attneave 1982). The primary tasks of the executive subsystem are shared responsibilities delegated among aunts, uncles, grandparents, and parents. The high level of involvement of the non-parent adults frees up the natural parents to have a more relaxed and spontaneous relationship with their children. Often, the emotional bond created between grandparents and grandchildren is a deep and long-lasting one (Attneave 1982).

There are numerous tribal differences among American-Indian families, with the phenomenon of the trigenerational extended family being the most fundamental and important constant. Families may be matriarchal or patriarchal in structure. No matter how this complex family organization varies, there is usually an older man or woman who holds a key administrative role (McGoldrick 1982). The usual family therapy intervention of separating the generations would not necessarily be the most appropriate intervention for this ethnic family group (McGoldrick 1982). It should be noted, too, that owing to the private nature of American-Indian families, multiple family involvement is likely not beneficial, and best confined to psychosocial education.

Many tribes do not make any distinction between the nuclear family and grandparents, uncles, aunts, and cousins (Brucker and Perry 1998; Napoliello and Sweet 1992). Many tribes characterize great uncles, great aunts, godparents, and biological grandparents as grandparents (Brucker and Perry 1998). Sometimes the family includes medicine people and nonrelated people (Brucker and Perry 1998).

Within Indian culture, families work together to address problems. Family therapy's emphasis on systems and relationships is in particular cultural harmony with American Indians (Sutton and Broken Nose 1996). Sutton and Broken Nose (1996) emphasize the preferred use of culturally appropriate, nondirective approaches involving "storytelling, metaphor, and paradoxical interventions" (p. 33). Networking and ritual approaches are preferable to strategic or brief interventions (Sutton and Broken Nose 1996).

In certain cases a family member must go into inpatient treatment for substance abuse before family therapy can make any real impact. It is always possible, however, to continue to work with the family in preparation for the return of the family member to the home, with the goal of modifying family relations that may have contributed to the maintenance of the problem. The historical trauma experienced by American Indians combined with the usual considerations of codependency and enabling, for example, make family therapy for substance abuse treatment a challenging endeavor (Duran and Duran 1996).

Acculturation

Acculturation should be determined on an individual basis, as the problems, process, and goals for traditional and more acculturated American Indians may be quite different (Sue and Sue 1999). "More than 50 percent of American Indians and Alaska Natives reside in large metropolitan areas" (Hodge and Fredericks 1999, p. 279). There are urban Indians who may never have been to a reservation or do not know their tribal language. As a result,

American Indians who are isolated from reservations or other areas of traditional living may experience a breakdown of social support systems (Hodge and Fredericks 1999).

Sue and Sue (1999) recommend that therapists delve into the ethnic differences between the family and the therapist in an indirect manner. Therapists should also explore the family's value structure and examine any potential cultural or identity conflicts. Initial questions may ascertain whether the family lives on or near a reservation, and whether being connected to the tribe is of importance. Sue and Sue (1999) assert that mainstream therapies may well fit more acculturated Indian families. More traditional families, however, will first have to navigate trust issues.

Communication styles

Gaining an individual's trust is essential. Many American Indians have experienced poor treatment, including racism, and will have a tendency to withdraw. Coyhis (2000) emphasizes that gaining an American Indian's trust involves aligning one's "spirit and intent" in such a manner that one's words and feelings are internally congruent or truthful (p. 86). Speaking with an American Indian as a human being, rather than as an "Indian," will help to build trust.

American Indians place greater emphasis on listening and observation than verbal exchange. Therapists should understand that clients "will communicate feelings and emotions through clues with their bodies, eyes, and tone of voice" (Paniagua 1998, p. 82). Direct eye contact can be a sign of disrespect for many American Indians (Paniagua 1998). Because of this communication style, it is important to be patient when working with American Indians. When a therapist asks an American Indian a question, she should wait for the answer before asking another question. American Indians listen carefully to the person to whom they are speaking, and sometimes enough time will pass after the therapist has asked a question that she may mistakenly believe the individual is nonresponsive. Paniagua (1998) suggests that therapists not take notes at the beginning of therapy as it can be taken as a sign that they are not listening.

Historically, the therapeutic relationship between American Indians and non-Indian therapists has been marked by racism (Sutton and Broken Nose 1996). Placed in this context, it is then clear that most American Indians will not discuss sensitive matters until trust has developed.

Culturally competent approaches

Therapists working with American-Indian families must be aware of how Western values conflict with traditional Indian culture. For example, while Western culture values an adolescent's steadily increasing independence from his or her parents, traditional Native culture does not. For traditional American Indians the goal for an adolescent may be precisely the opposite: increasing interdependence with the extended family (Sue and Sue 1999).

American Indians may require a greater degree of guidance than is usually provided in client-centered approaches (Sue and Sue 1999). Many American Indians arrive in treatment hoping for a culturally sensitive therapist who can offer practical and specific advice about their problems (Sutton and Broken Nose 1996).

While overly directive interventions may be seen as disrespectful and intrusive, therapists who combine family therapy with substance abuse treatment must be somewhat directive. Often, they are being forced to follow the mandates of the judicial system. So therapists must be very skillful, balancing cultural needs for an indirect approach with external needs demanding a more direct approach.

Just as people in the dominant culture may seek the guidance of a counselor, American Indians will turn to an elder. It is also useful to find out whether the IP has an elder who will support him in the recovery process (Coyhis 2000).

The more traditional an American Indian is, the more difficulty he or she will have with Alcoholics Anonymous (AA) concepts (Coyhis 2000). For many American Indians, the source of difficulty with AA is that the concepts derive from a European, Christian mindset (Duran and Duran 1995). White Bison is one example of an American-Indian alternative to the traditional AA approach that "integrates the medicine wheel with the twelve-step teachings of AA to adapt substance abuse recovery to Native American culture" (Krestan 2000, p. 36).

Paniagua (1998) suggests the following guidelines for therapists working with American-Indian clients:

- The therapist should involve all nuclear and extended family members, including tribal leaders and traditional healers.
- The therapist should present suggestions in a slow and calm manner, indicating attention to clients' time-oriented approach.
- The therapist should determine whether all family members belong to the same tribe. Intertribal issues could be a source of conflict.
- The therapist should allow family members to be involved in directing the process of therapy.

Sexual Orientation

Background Issues

The therapist can help the veteran locate services, including benefits to which they are entitled. Therapists need to know where local veteran centers are. If treatment is difficult to access, it may be hard to get families involved.

A psychological issue that many veterans must address is survivor guilt—having lived while their comrades perished. The issue of abandoned children may also be difficult for veterans. A number of veterans fathered children while in the service. For example, American military men in Vietnam fathered many offspring. These lost families often need to be addressed in family therapy. Therapy sessions with veterans can become graphic and horrifying. The therapist must be able to work with high levels of intensity.

Veterans' wives, particularly, may need support, and support groups can be helpful. Children may face a number of issues related to a parent's veteran status. Therapists have observed, for example, that as the children of Vietnam veterans approach the age their fathers were when they went to Vietnam (usually late teens), the fathers begin pressuring them to learn to be tough.

Chapter 5 Summary Points From a Family Counselor Point of View

- Children and adolescents can represent a number of challenging concerns and might require referral, especially for concerns about inhalant abuse or abuse and neglect.
- Older adults may require referral to distinguish organic mental disorders that are substance-related from other organic brain disorders.
- The complex roles and demands that can be placed on women within some families requires special attention, including enhanced assessment processes and possible ancillary services.
- Diversity, disability, and co-occurring disorders often require administrative, clinical, and supervisory sensitivity.

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