4.2.3 Ethnic and Racial Populations

Successful identification and outreach to women with substance abuse problems requires racial, ethnic, and cultural knowledge, competency, and sensitivity. When staff members engage in outreach to women, they should understand the issues confronted by diverse ethnic and racial minority populations and recognize that there is diversity within racial and ethnic groups. For example, the culture and experience of an African American woman whose family has lived in an urban area in the Midwest for generations may be significantly different from an African American woman who lives in a rural community in the South. Their experiences will be different from a woman of primarily African descent who recently immigrated from Jamaica. The culture and experience of a Laotian woman who recently immigrated to the United States will differ significantly from a third generation woman of Japanese descent. Cultural values and norms vary across ethnic groups of Caucasian women as well, particularly among those who are recent immigrants or first-generation Americans.

When staff members engage in outreach to women, they should understand the issues confronted by diverse ethnic and racial minority populations.

African American Women. Having survived a historical experience that demanded extraordinary courage and inner strength, traditionally African American women are seen as strong and as not needing anyone or anything to cope with life and its challenges. This perception is perpetuated by continuing socioeconomic conditions that require African American women to maintain a predominant role in caring for their families. If an African American woman believes she should be strong, regardless of her circumstances, she might feel that admitting she needs help is a sign of personal failure and that she has failed her family. This can result in low self-esteem and feelings of shame that could keep her from admitting to herself or others that she has a substance abuse problem.

African American women are most likely to rely on other African American women or their place of worship for assistance with crises.

African American women are most likely to rely on other African American women or their place of worship for assistance with crises. For

example, African American women often establish sisterhood relationships to help each other with proactive listening, counseling, and emotional support. Informal neighborhood groups (card playing groups), formal clubs (social and charity), church groups and to a lesser degree, sororities have been important sources of networking for African American women. Recently three of the largest sororities (Zeta Phi Beta, Delta Sigma Theta, and Alpha Kappa Alpha) have developed substance abuse prevention programs. These sororities differ from the mainstream sororities in that their dominant focus is on community action and social service.

To facilitate the African American woman's acceptance of treatment, it is important for a program to establish relationships with respected African American individuals and organizations in the community. Religious institutions and community organizations that serve African American women can be vital resources for a successful outreach program.

American Indian Women. American Indian populations consist of approximately 450 different tribes with varying customs and some 250 languages. For American Indian women, barriers to treatment include the following:

- the disproportionate number of unemployed American Indian women, which hinders early detection and referral in the workplace;
- the lack of education in cross-cultural issues among physicians, nurses, social workers, and other health care providers may result in a lack of sensitivity to the values, beliefs, and practices of American Indian women; the use of stereotypes, although unconsciously by health care providers, can be a basis for assessment and diagnosis;
- geographic isolation, which limits access to substance abuse treatment; the lack of funding in the Indian Health Service

for needed programs; and the disproportionate poverty among American Indian women, further limiting financial access to treatment; and

- cultural differences among American Indian women in the relative value placed on the use of different substances (some of which they do not consider addictive), may preclude the women from accepting or seeking help for their abuse of other substances.

Developing a relationship of trust with American Indian women is critical in the outreach phase.

Because of a long history of a lack of trust in the United States federal government (because of broken treaties, outlawing of American Indian languages and religious practices, and inadequate services provided through the government), American Indians often mistrust health care programs run by government agencies, including substance abuse programs. Developing a relationship of trust with American Indian women is, therefore, critical in the outreach phase.

A simple, cost-effective strategy to identify high-risk American Indian women is for treatment programs to establish relationships with existing American Indian programs, such as cultural centers, Indian Health Boards, and Indian healers.

However, it should be noted that a little less than half of all American Indians live in rural and/or reservation communities. The remaining population lives in urban locations scattered among other racial/cultural groups rather than in cohesive communities. This poses another barrier in identifying American Indian women who are at risk.

Asian/Pacific Islander women who are immigrants and refugees confront many stressors that exacerbate already severe challenges in their daily ability to cope and function.

Asian and Pacific Islander Women. To design an outreach program for Asian/Pacific Islander women, it is important to understand the complexity of the historical, social, economic, political, and cultural factors that underscore the Asian/Pacific Islander experience in the United States and the diversity of the population itself. Sue has suggested that for Asian

American populations (as would be true for other recent immigrant populations), it is important to consider the specific ethnic group, place of birth, generational status, and degree of acculturation.[12]

Asian/Pacific Islander women who are immigrants and refugees confront many stressors that exacerbate already severe challenges in their daily ability to cope and function. These challenges may include language barriers (which can make it difficult to obtain basic resources such as health care), racism, social isolation, changes in traditional family roles, economic distress, and family disintegration. Mainstream services are often underutilized by Asian/Pacific Islander women because the services are inaccessible, too expensive, culturally irrelevant, and/or unavailable in their native language.

Sun has suggested the following as useful strategies to intervene with Asian American women:[13]

- have bilingual and bicultural professionals available who can engage and be involved in the treatment process for newly arrived immigrants - the program might gain access to volunteer professionals through Asian American organizations in their community;
- eliminate terms such as "mental illness" or "psychiatric dysfunction," which Asian Americans tend to be more sensitive to than Westerners; and
- include information that reflects cultural sensitivity, including recognition of the Asian woman's traditional role, ethnic, and cultural identity(ies) and the importance of intergenerational relationships in outreach material.

Hispanic/Latina Women. The Hispanic population in the United States is heterogenous, representing different cultures and ethnic groups.

Many communities are inhabited by multiple Hispanic groups where generational differences exist within each group. Treatment programs conducting outreach to Hispanic women should become familiar with the diversity, origins, dynamics, cultures, and problems of the different Hispanic groups living in the community. Treatment providers should not assume that one approach will work for all Hispanic groups or that all Hispanic women exhibit the same pattern or type of substance abuse problem.

Many substance abuse treatment programs do not have staff who can communicate in Spanish. Hispanic women, therefore, tend to view these programs as less than "user-friendly." If possible, programs serving Spanish-speaking women should have treatment staff who can speak Spanish. Also, educational materials on substance abuse and treatment often assume high levels of reading ability. This presents an obstacle for those who are not proficient in the English language. Thus, materials should be available in Spanish.

Outreach to Hispanic women requires a genuine respect for the women and their family culture.

Outreach to Hispanic women requires a genuine respect for the women and their family culture. The families of Hispanic women can be important resources to help these women get treatment for substance abuse problems. However, if family members feel that a woman's participation in treatment threatens the status quo or legal standing of the family, they can work against a woman who is responding to outreach efforts. Disclosure may be a particular problem for undocumented Hispanic women who fear that this may result in their deportation; they may also fear that undocumented family members (and friends) will be discovered and deported if they enter the "system" in any way.

4.2.4 Other Specific Groups of Women

Many women are not aware of their HIV status until they are symptomatic with AIDS and/or have been diagnosed through the health care system, often through prenatal testing.

Women with HIV/AIDS. During the second decade of the AIDS epidemic, the number of women with HIV/AIDS has increased dramatically. In recognition of the differences in disease progression and types of opportunistic infections of HIV/AIDS in women, the CDC recently revised the diagnostic categories used to define an individual as having AIDS. (Chapter 2 presented more detailed epidemiologic data on women and HIV/AIDS.) The increase in the number of reported AIDS cases may, in part, be because of this expanded definition.

Outreach and identification of HIV-infected women often occurs at their point of need, such as through primary or acute health care, public assistance, or other social service agencies. However, it is important to note that many women are not aware of their HIV status until they are symptomatic with AIDS and/or have been diagnosed through the health care system, often through prenatal testing.

HIV-positive women from lower socioeconomic groups often lack the resources to meet their most basic needs for food, housing, and transportation. As a result, they may delay seeking care for their substance abuse problems or for their HIV status until they become symptomatic or until their basic needs, or those of their children, have been met. HIV-positive women who are addicted to illicit drugs may fear interacting with the health care system, for fear of being placed in the criminal justice system. They may choose not to seek treatment until they have established a trusting relationship with a case worker or health care professional or until there is a medical crisis.

Specific outreach strategies include the following:

- work with local AIDS prevention and advocacy groups, including street outreach programs, to promote the program's services for women at high risk for or with HIV/AIDS; and

- encourage staff members to appear on local radio and television talk shows to discuss the needs of substance using women with HIV/AIDS and how the treatment program tries to address those needs.

Women Residing in Rural Areas. A shortage of primary care physicians exists in poor urban neighborhoods and in rural areas. Families who must travel from rural areas to urban clinics for health care may have no place to stay in the city. Few have the energy to make multiple visits to different institutions at different times (often waiting for a long time to receive services) to obtain care for themselves and their families. Because it may be difficult to find lodging when traveling long distances for services, many women delay seeking treatment until a crisis develops. Helping women from rural areas to use health and social services is important. This may require providing or helping the women to access transportation. Also important are methods of "getting the word out" about women-specific services across large, often sparsely-populated geographic areas.

Specific outreach strategies include the following:

- work with staff of rural hospitals and health clinics to identify women who need services and make home visits, where appropriate, with health care or social services personnel; and

- advertise program services on local radio stations and in local county newspapers.

Many homeless women are substance-abusing, psychiatrically impaired, and physically ill individuals.

Homeless Women. Homeless women are vulnerable to a variety of risky behaviors, diseases, and disorders. Many homeless women are substance-abusing, psychiatrically impaired, and physically ill individuals. The stigma attached to being "homeless" impedes many women from seeking assistance. Some homeless women who have children fear that they will lose their children and/or their places in homeless shelters if they admit to having substance abuse problems. Homeless women may be frightened, distrustful, and/or unfamiliar with systems of care and treatment. Some women who are homeless and who have few dependents will move from one shelter to another. It is critical to note here that all homeless women are not in shelters: some may be in living arrangements with family or friends. Also, some women may be in a battering relationship and may be abusing alcohol or other drugs as a result of the stressors caused by this relationship. Such women may live temporarily with relatives or friends, and their residential status may be difficult to discern.

Because homeless women are outside the mainstream networks of referrals and intervention, those who require acute medical attention or who are being detained for alleged civil or criminal violations often come to the attention of police and emergency room personnel more frequently than they do to substance abuse treatment professionals. The primary routes of intervention, therefore, must be through street outreach, medical clinics, law enforcement, emergency rooms, public housing communities (for those women still in housing), and jails or detention centers.

Lesbians. Lesbians, unlike many other minority groups, cannot be readily identified based on appearance, language, or socioeconomic criteria. The lesbian category embraces women of all ages (including adolescents and older women), races, ethnicities, religions, socioeconomic groups, and physical abilities. Since determining the percentage of lesbians in our society depends on self-reporting, and knowing that many lesbians will not identify themselves because of society's stigmatization of homosexuality,

the number of lesbians in any community is likely to be grossly underestimated. Adolescent lesbians (an extremely high-risk group with a very high suicide rate) and lesbians who are parents (approximately one-third of lesbians) are underserved by substance abuse treatment providers. Treatment programs may not have staff who are sensitive to the needs of lesbians, and in fact, the staff may even be hostile. These factors create barriers to outreach, treatment, and continuing care because a lesbian would not want to enter a program with an insensitive or hostile environment.

Women of color who are lesbians face an even greater potential for discrimination than Caucasian women. Many of these women may be more difficult to identify and serve effectively than their Caucasian counterparts. Very few programs are designed for lesbians of color. Outreach strategies developed for this population must be detailed, consistent, and use appropriate language and events. Above all, the outreach strategies must be safe. As noted by Kanuha, lesbians of color face a variety of challenges because of the prejudices inherent in both the heterosexual and lesbian communities. Racism in the lesbian community is reinforced by the relative lack of presence of women of color in the mainstream lesbian culture. For lesbians of color to benefit from therapy, clinicians must understand the dynamics of being both a woman of color and a lesbian.[14]

The overriding emotion that drives almost all of the individual barriers to outreach for lesbians is fear.

The overriding emotion that drives almost all of the individual barriers to outreach for lesbians is fear. Lesbians fear losing anonymity or acknowledging homosexuality in a setting outside the lesbian community or an immediate circle of friends. A lesbian may fear that revealing her sexual orientation could result in losing a job or being separated from valuable relationships.

Lesbians are cautious about obtaining help if they feel that their partners or significant others will not be treated with respect. Very often, programs are not willing or prepared to integrate same-sex partners into

groups of couples or family therapy sessions. In addition, many lesbians who are mothers hesitate to seek services because they fear they will lose custody of their children.

Outreach to lesbians must be specific to the population, must be community-based, and safe. Resources for lesbians in rural settings will, as a rule, be more difficult to develop because lesbians may be more difficult to reach (i.e., be less open about their sexual orientation) than those living in urban areas. Programs that seek to serve lesbians must be prepared to advocate on their behalf for health and social services, to anticipate the possibility of receiving criticism from the heterosexual population, and to invest time developing credibility within the lesbian community.

Specific outreach strategies include the following:

- develop relationships with gay/lesbian bookstores, offering them, for example, space to sell books at program events in return for their distributing program materials at gay/lesbian bookstores;
- support lesbian-specific community events, and provide staff and/or assistance with advertising and distributing announcements;
- advertise programs and activities in publications created specifically for the lesbian community;
- have an information booth at lesbian and gay events;
- use language in program materials to indicate that services are available for partners of women, rather than for husbands or spouses only; and
- sponsor alcohol and drug-free social and sports events for lesbians.