available public and senior transportation schedule.

- Help train representatives of health agencies so they can identify older women with substance abuse problems and refer clients to the treatment program for services.

- Ensure that the facility (both its entrances and furnishings) is accessible to older clients, including those with physical disabilities and/or sensory losses. For example, deep seats that are low to the ground are difficult for some older people to use.

- The physical condition of some older people must be kept in mind. Frail older people bruise easily, their bones may be fragile, and their sense of touch may be diminished. Many older women have osteoporosis and generalized bone loss. For example, what might be a therapeutic hug to a young person could bruise or break the bones of some older women. Hearing and vision problems should also be diagnosed and recognized during individual and group therapy. Because thermoregulation does not occur quickly for some women who are much older, it may be appropriate to encourage some older women to wear sweaters during therapy and education sessions.

- For homebound older women, regular telephone therapy groups facilitated by a substance abuse counselor may be an appropriate approach. On a specific day of the week, at a specific time of day, the counselor makes a conference call that may include, for example, three clients and the counselor/facilitator. The phone group should be closed, have specific discussion topics, and be of a set duration. Assignments to be completed between sessions need to be developed for each of the members. The group members can decide at the end of the formal, facilitated sessions (eight to 10) whether they wish to exchange telephone numbers and maintain informal telephone contacts. This approach can be extremely valuable: sensitive subjects can be discussed openly, given the degree of anonymity that the telephone

offers. The telephone therapy group should be followed up with regular telephone contact between the counselor and the individual group members. These individual calls are also scheduled for a set length of time.

5.4.2 Ethnic and Racial Populations

Designing and implementing successful treatment strategies requires racial, ethnic, and cultural knowledge; competency; and sensitivity concerning diverse issues. However, in attempting to describe cultural factors, it is important not to fall into the trap of unintentionally perpetuating stereotypes of ethnic and racial populations. It is also critical to understand that diversity exists within a racial or ethnic group as well as among groups: women of all races and ethnic groups vary by personality, geographic origin, socioeconomic class, religious upbringing, and other factors, all of which play a role in their individual "cultures."

Moreover, many of the cultural differences attributed to one population may apply generally—if somewhat differently—to many racial and ethnic groups. For example, communication styles vary considerably in terms of preferred space (physical distance) between the conversants; the degree to which contact (touching) is appropriate; eye contact (which is value-laden in most societies); and language styles (formal or "street" or other). Differences in communication style also can vary by personality type, socioeconomic class, and religious upbringing. An example of the latter is the "call and response" communication attributes applied by some to African Americans who are religious. They are equally applicable to Roman Catholics irrespective of their race or ethnicity. Therefore it is important for the counselor to assess each individual's cultural orientation carefully. The counselor should not presume the degree to which the various "cultural" factors—not only ethnic or racial background—are predeterminant.

Counselors and staff should be trained to recognize and confront their own biases toward clients of other ethnic, racial, and cultural groups; this helps them to be aware of their own nonverbal communication. They particularly need to be cognizant of nonverbal communication that is rejecting, insincere, or judgmental. If these messages, however unintended, are communicated to the client, her response whether verbal or nonverbal, may be inappropriately labeled as defensive or hostile. As with other judgements regarding the client's behavior, counselors and other staff need to be aware that such labeling can unfortunately become a diagnosis that may follow the woman throughout her treatment and severely impede her recovery.

Counselors and staff should be trained to recognize and confront their own biases toward clients of other ethnic, racial, and cultural groups.

For recent immigrants of any origin, at some point early in the treatment process, the counselor should question clients about citizenship status, degree of acculturation, country of origin, circumstances of move to the United States, country with which they identify, language abilities, literacy level in native and other languages, spiritual/religious base, educational level, housing, and legal issues. However, given laws of deportation, the staff must be very sensitive when asking these questions.

African American Women

- As with other ethnic groups, there are regional cultural differences in the behaviors of African American women that have often been shaped by or formed in response to the dominant culture. For example, some African American women may be more inclined to avoid maintaining eye contact because it has been perceived as showing disrespect or as defying authority—a carryover from segregation. In contrast, other African American women may have rejected behaviors that indicate deference to authority and may be perceived by some program staff as defensive or hostile. Staff need to be clear about the particular viewpoint of the

individual client and be cautious about judging behavioral clues.

- "Touching" during conversation to convey empathy is typically welcomed and accepted by most African Americans only between those who are close and by intimate friends. However, if touching is secondary to an insult or an act of disrespect that the care provider is attempting to redress, it may be considered intrusive and insincere. It may not be appropriate for a therapist to touch the client unless there is an established level of trust and rapport that merits such intimacy. Touching should not be viewed as a therapeutic approach to gaining trust.

- African American women are often reluctant to engage in conversations with and seek assistance from health care professionals, particularly those who are not African Americans, because of negative and demeaning experiences that they have heard about or experienced. African Americans may perceive questions related to finances or sexual behavior as intrusive and as indicative of stereotypical thinking. Because some African American women are reluctant to "put their business on the street," staff should be aware that it may take some time before clients disclose information that the program requires or believes necessary for treatment.

American Indian Women

- The American Indian woman often experiences feelings of isolation from the rest of the American Indian community while in treatment. These feelings can be minimized by integrating traditional healers or other community leaders into treatment programs, if so desired by the client. This should be done early in the treatment process when making decisions about treatment placement (i.e., outpatient versus inpatient) and the length of stay. Include the family and/or tribal decision makers in planning the treatment and continuing care program if applicable.

- Culturally appropriate and community-specific conceptual processes, including an awareness of historical and contemporary factors influencing substance use and abuse, are critical. Also important is an awareness of the cultural concepts and definitions of health, illness, and substance abuse held by American Indians and how these beliefs can be used as the foundation for treatment. If possible, services in American Indian languages should be provided for those women not conversant in English. If the treatment agency is not nearby, the agency should make arrangements for providing transportation for clients and their families, if appropriate. Program staff members must acknowledge and promote clients' religious beliefs, values, and practices as a significant part of their empowerment and validation. Collaborating with American Indian health care programs and allowing for culturally relevant adaptation of treatment modalities (e.g., sweats, dances, and Talking Circles) are important ways to show respect for American Indian cultures. The Swinomish Mental Health Program manual suggests ways to develop appropriate services for American Indian women.

- American Indian female clients should, if possible, be referred to American Indian agencies, educational programs, and vocational training programs when outside resources are used.

Asian/Pacific Islanders

- It is essential for treatment providers to be aware that various Asian/Pacific Islander (API) groups have traditional methods and values for physical and emotional healing. Although some of these perspectives may seem contrary to mainstream recovery practices, they can help the API client. For example, the use of Chinese acupuncture and herbs are accepted by some as a viable means to help with detoxification symptoms, cravings, and physical imbalances. These healing approaches have, in fact, shown very favorable results in the early stages of recovery.

The value of spirituality as a source of strength and healing should not be overlooked.

- Recognizing the historical significance of spirituality and religion will help counselors understand the API client. Many API cultures have integrated Western religion with their indigenous beliefs and rituals. The value of spirituality as a source of strength and healing should not be overlooked. For example, some Native Hawaiians use healers and respected elders called "Kahunas" to provide and promote emotional and spiritual guidance and healing.

- The case manager should be responsible for locating culturally specific services that have bilingual/bicultural staff, or identify appropriate staff in mainstream service agencies.

Hispanic/Latina Women

- If the target population is predominantly Spanish-speaking, all materials should be printed in Spanish, including intake and assessments forms, treatment plan forms, discharge forms, and other documents. The program should also have available educational materials in Spanish. At least some clinical staff (part time or full time) members should be Spanish-speaking.

- Programs should establish a library of books and tapes in Spanish that present the stories of Hispanic/Latina women who have addressed (and overcome) similar problems and who can act as role models for women entering substance abuse treatment.

- It is recommended that the program host or arrange for referral to AA, Al-Anon, or other 12-Step meetings in Spanish for women only.

- Networking with programs and agencies serving Hispanic/Latina women and their families to arrange for cross-training is extremely helpful. Through this method, the program staff can explore how they handle substance abuse issues, share program information, and formalize communication.

- By providing access for Hispanic/Latina women to groups that address women's concerns or general concerns of their cultural community, clients can build confidence as women in roles other than those of addicted persons or mothers. Such groups can include, for example, those relating to expanding women's roles in the economic development of the community, generating housing opportunities, and helping to increase access to health care services.

- One avenue which may serve as an incentive for Hispanic women to enter treatment is to invite Hispanic/Latina women from the community to visit the program and explore services for themselves, their children, or other relatives.

5.4.3 Other Specific Groups of Women

Women in the Criminal Justice System

- Treatment staff should acknowledge and address the additional stigma that incarcerated women or women with criminal records face; this will be particularly useful during follow-up and continuing care.

- Criminal justice and treatment personnel should work together to ensure that each conveys similar messages to female clients, regarding the importance of ensuring that they access substance abuse treatment and determining the appropriate modality for each woman.

- It is important to involve women from different ethnic and socioeconomic backgrounds who have "graduated" from the criminal justice system as role models for those in treatment. Such involvement may include their participation in discussion groups at the program, having available written personal histories, or arranging for videotapes in which their personal histories are presented.

- The program should develop a referral system to provide legal assistance for such issues as custody and parole.

Women with HIV/AIDS

- Substance abuse treatment programs should provide an ongoing HIV/AIDS education, prevention, and treatment component that is fully integrated into the overall treatment system. Programs that are part of a medical center will likely have the appropriate resources to provide medical care to their clients who are HIV-positive or who have AIDS. Most programs will provide services through referrals to outside sources. The treatment program should have formal referral agreements with such sources, which should include case management to ensure that the treatment program is aware of services provided, their outcome, and the on-going health status of the client. In addition to the comprehensive services described previously in this chapter, the special parenting issues, self-care techniques, symptom management, medical needs, and the needs of family members and significant others should be addressed.

- Legal assistance should be provided to women with AIDS who may need help drawing up a living will or addressing other legal (or legal/financial) issues such as access to Social Security benefits and life insurance.

- The program should also offer appropriate psychiatric and psychological assessments and psychological support for women infected with HIV/AIDS to address the issues of death and dying and custody and care of children when it becomes necessary.

- The program should establish liaison with the many support groups that address parenting, general or sexual health, and other issues for HIV-positive and AIDS clients.

- Personnel must be prepared to help the women with AIDS and their families deal with the issue of medication for easing pain in the terminal phases of AIDS.

Women with Disabilities

- To serve women with disabilities, it is critical that information, policies, programs, and facilities are accessible to them. Providing accessible transportation, particularly in communities where transportation options are limited, is also essential. Women with disabilities who are staff members of the treatment program can facilitate the process of engaging women with disabilities in treatment for substance abuse problems.

- Staff members need to be careful not to view a client's disability as *the* cause of substance abuse, or even as a cause. Sometimes the disability may be the result of substance abuse. For example, a woman's disability could have been the result of an accident that occurred when she was driving while intoxicated. Sometimes the disability may be a minor or irrelevant factor. Counselors may find it helpful to obtain information on the extent, nature, cause, and age of onset of the disability, as well as the woman's assessment of the role of her disability status in her substance abuse problem. This information can be obtained as part of the intake process, but it should not be the first item on the intake agenda.

- Counselors should assess women with disabilities in the same manner that they assess women who are not disabled. They need to cover the same topics and issues during intake and avoid making limiting assumptions about the woman's sexuality or lifestyle. For example, sexuality should not be overlooked in the treatment of women with disabilities. It is also important to consider women with disabilities as the experts on their own disabilities.[15] They should be key participants in determining what types of accommodations and help they need to participate in the treatment program.

It is also important to consider women with disabilities as the experts on their own disabilities.

- The language of disability is rapidly changing. In general, the term "disability" is preferred to "handicapped," and "woman with a disability" is preferred to "disabled woman,"

since the woman comes first, before her disability. Language that suggests victimization and suffering should be avoided; for example, avoid the terms "suffers from cerebral palsy," "victim of polio," or "confined to a wheelchair." New terms such as "differently able" or "physically challenged" or "mentally challenged" have been rejected by disability rights activists as euphemisms. However, some people with disabilities may disagree. Thus, when in doubt, ask the woman what terminology she prefers.