

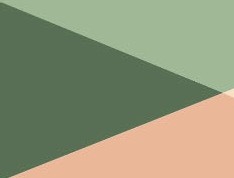
A TREATMENT IMPROVEMENT PROTOCOL

**Improving Cultural Competence**

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**Improving Cultural Competence**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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Improving Cultural Competence

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## What Is a TIP?

Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). TIPs are best practice guidelines for the treatment of substance use disorders.

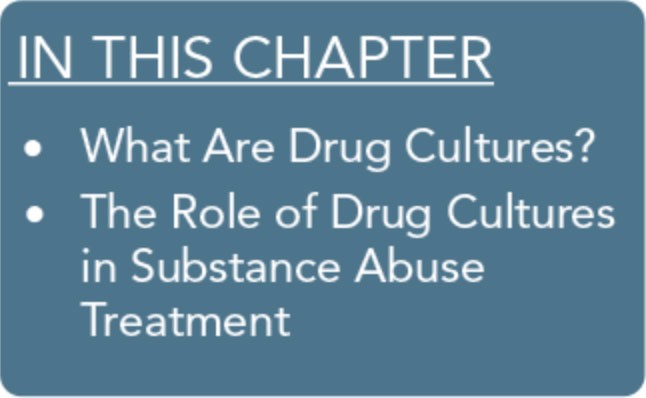
TIPs draw on the experience and knowledge of clinical, research, and administrative experts to evaluate the quality and appropriateness of various forms of treatment. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that the field of substance abuse treatment is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey front-line information quickly but responsibly. If research supports a particular approach, citations are provided.

XI

## Drug Cultures and the Culture of Recovery

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Lisa is a 19-year-old White college student living in San Diego, CA, who was sent to treatment by her parents after failing her college classes and being placed on academic probation. While home on break earlier that year, her parents found pills in her room but let her return to school after she promised to stop using. The academic probation is only part of the reason her parents sent her to treatment. They were also concerned about her recent weight loss, as her older sister had previously struggled with bulimia.

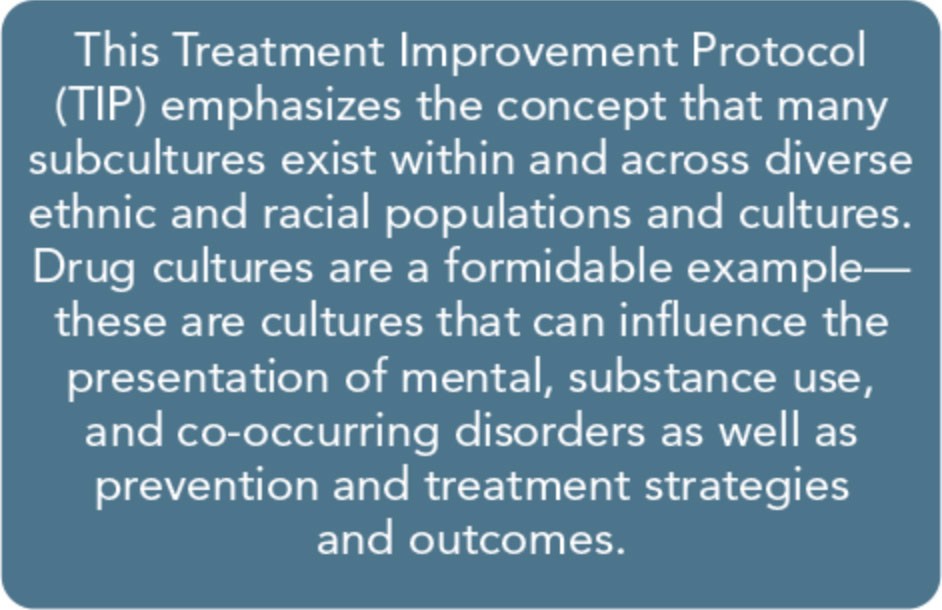
Lisa began using marijuana at age 15 with a cousin. In her first year of high school, she had difficulty fitting in. However, the next year, she became friendly with an electronic dance music clique that helped her define an identity for herself and introduced her to ecsta­ sy (3,4-methylenedioxymethamphetamine, or MDMA), metham­ phetamine, and various hallucinogens, along with new ideas about politics, music, and art. She has since found similar friends at college and keeps in touch with several members of her high school clique.

In treatment, Lisa tells her counselor that she has long felt neglect­ ed by her parents, who are too interested in material things. She sees her drug use and that of her friends as a rebellion against the materialistic attitudes of their parents. She also dismisses her fami­ ly's cultural heritage, insisting that her parents only identify as Americans even though they are first-generation Americans with European backgrounds. She talks at length about ways to acquire and prepare relatively unknown hallucinogens, the best music to listen to while using, and how to evaluate the quality of marijuana.

Lisa says that she doesn't believe she has a problem. She thinks that her failing grades reflect her lack of interest in college, which she says she is attending only because people expect it of her. When asked what she would rather be doing, she says she does not have any clearly defined goals and just wants to do "something with art

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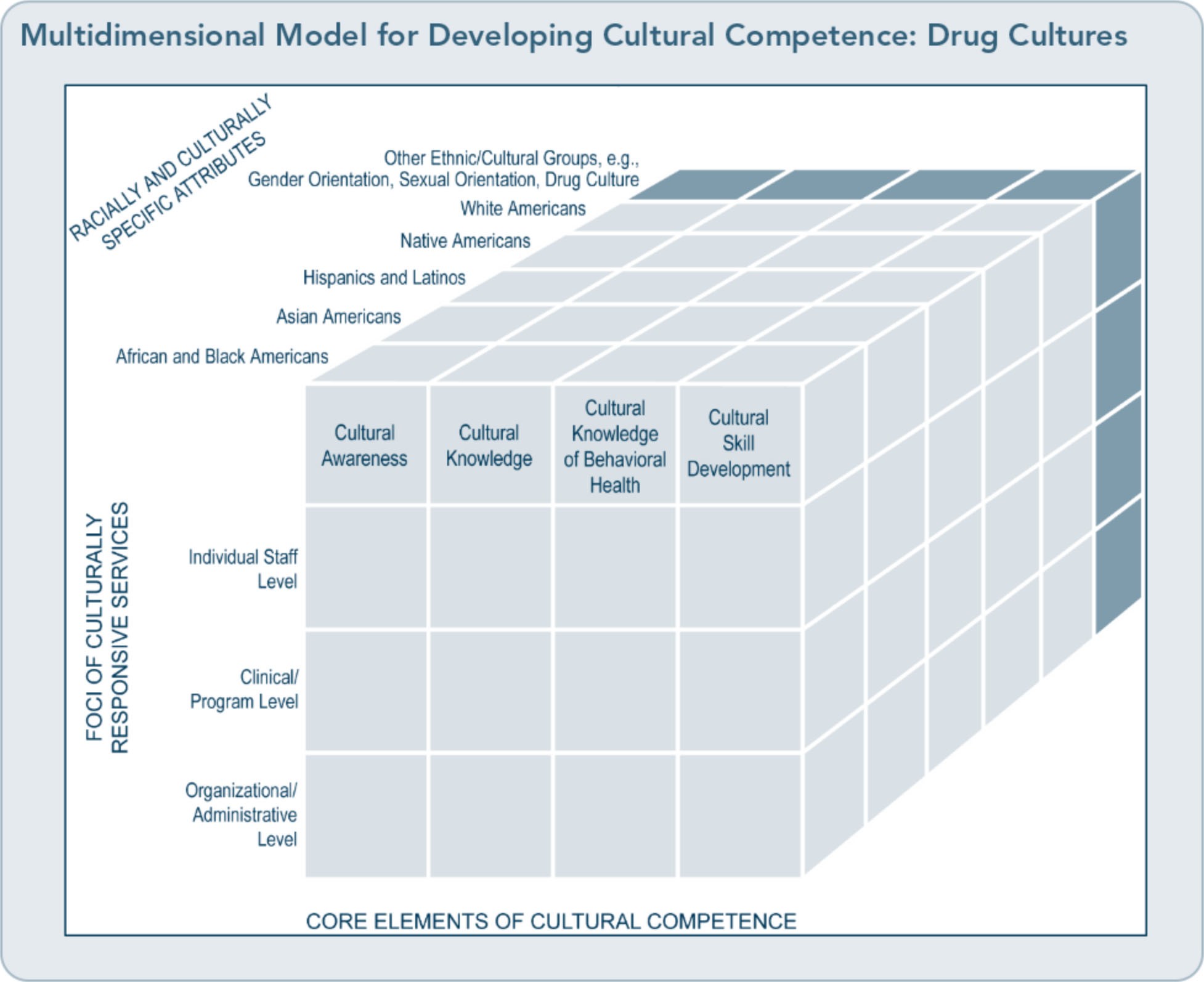
Improving Cultural Competence



or music." Lisa points out that, unlike most of her classmates, she doesn't drink and has stopped doing addictive drugs like ecstasy and methamphetamine, which were responsible for her weight loss. She is convinced that she can continue to smoke pot and *Salvia divinorum,*

which she notes "isn't even illegal," and take other botanical hallucinogens. She is adamant about keeping her friends, who she says have been supportive of her and are not materialis­ tic "sellouts" like her parents.

Her counselor places a priority on connecting Lisa with other people her age who are in recovery. She asks a client who graduated from the program and is only a year older than Lisa to accompany her to Narcotics Anonymous **(NA)** meetings attended mostly by younger people in recovery. The counselor also encour­ ages Lisa's friendships with other young peo­ ple in the program. When Lisa complains about her parents' materialism and the materi­ alism of mainstream culture, her counselor brings up the spiritual elements of mutual­ help recovery groups and how they provide an



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alternative model for interacting with others. The counselor begins to help Lisa explore how her drug use may be an attempt to fill her unmet emotional and social needs and may hinder the development of her own interests, identity, and goals.

Treatment providers should consider how cultural aspects of substance use reinforce substance use, substance use disorders, and relapses. Factors to note include clients' possi­ ble self-medication of psychological distress or mental disorders. Beyond specific biopsycho­ social issues that contribute to the risk of substance-related disorders and the initiation and progression of use, counselors and treat­ ment organizations must continually acquire knowledge about the ever-changing, diverse drug cultures in which client populations may participate and which reinforce the use of drugs and alcohol. Moreover, behavioral health service providers and program administrators need to translate this knowledge into clinical and administrative practices that address and counter the influence of these cultures within the treatment environment (e.g., by instituting policies that ban styles of dress that indicate affiliation with a particular drug culture).

Adopting Sue's multidimensional model (2001) for developing cultural competence, this chap­ ter identifies drug cultures as a domain that requires proficiency in clinical skills, program­ matic development, and administrative practic­ es. It explores the concept of drug cultures, the relationship between drug cultures and main­ stream culture, the values and rituals of drug cultures, and how and why people value their participation in drug cultures. This chapter describes how counselors can determine a client's level of involvement in a drug culture,

how they can help clients identify and develop alternatives to the drug cultures in which they participate, and the importance of assisting clients in developing a culture of recovery.

### What Are Drug Cultures?

Up to this point, this TIP has focused on cultures based on ethnicity, race, language, and national origin. The TIP looks primarily at those cultural groups because they are the major cultural forces that shape an individual's life and worldview. However, there are other types of cultural groups (sometimes referred to as subcultures) that are also organized around shared values, beliefs, customs, and traditions; these cultural groups can have, as their core organizing theme, such factors as sexuality, musical styles, political ideologies, and so on. For most clients in treatment for substance use disorders (including those who have a co­ occurring mental disorder), the drug subcul­ ture will likely have affected their substance use and can affect their recovery; that is the primary rationale for the development of this unique chapter. Research literature in this topic area is considerably limited.

Some people question whether a given drug culture is in fact a subculture, but many seem to have all the elements ascribed to a culture (see Chapter 1). A drug culture has its own history (pertaining to drug use) that is usually orally transmitted. It has certain shared values, beliefs, customs, and traditions, and it has its own rituals and behaviors that evolve over time. Members of a drug culture often share similar ways of dressing, socialization patterns, language, and style of communication. Some even develop a social hierarchy that gives different status to different members of the culture based on their roles within that culture (Jenkot 2008). As with other cultures, drug cultures are localized to some extent. For exam­ ple, people who use methamphetamines in Hawaii and Missouri could share certain atti­ tudes, but they will also exhibit regional differ­ ences. The text boxes in this chapter offer examples of the distinct values, languages,

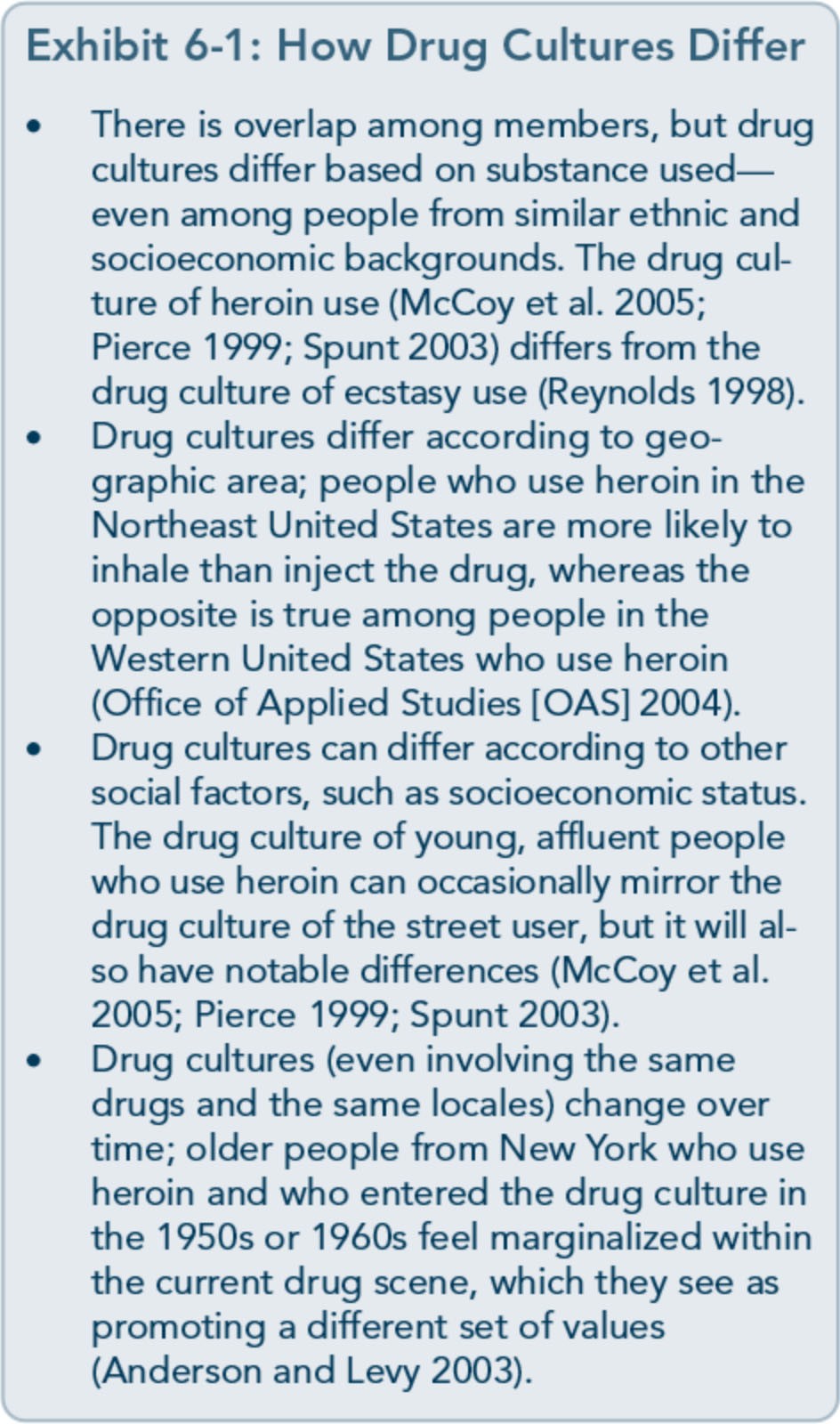
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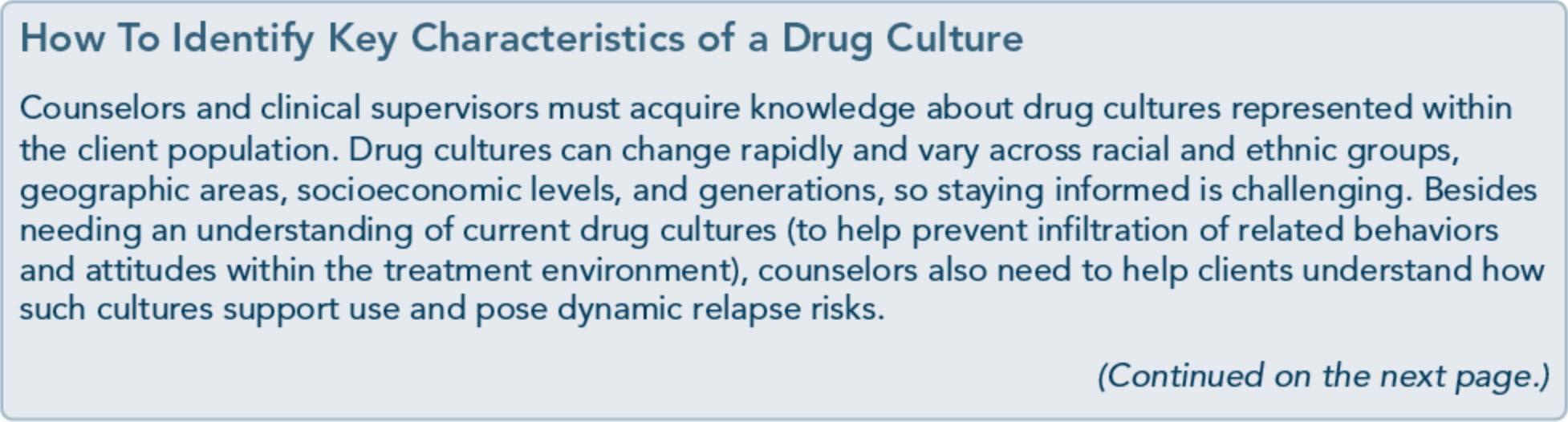
rituals, and types of artistic expression associ­ ated with particular drug cultures.

Many subcultures exist outside mainstream society and thus are prone to fragmentation. A single subculture can split into three or four related subcultures over time. This is especially true of drug cultures, in which people use different substances, are from different locales, or have different socioeconomic statuses; they may also have very different cultural attitudes related to the use of substances. Bourgois and Schonberg (2007) described how ethnic and racial differences can affect the drug cultures of users of the same drugs to the point that even such things as injection practices can differ between Black and White heroin users in the same city. Exhibit 6-1 lists of some of the ways in which drug cultures can differ from one another.

Differences in the physiological and psycho­ logical effects of drugs account for some dif­ ferences among drug cultures. For example, the drug culture of people who use heroin is typically less frenetic than the drug culture involving methamphetamine use. However, other differences seem to be more clearly related to the historical development of the culture itself or to the effects oflarger social forces. Cultural and socioeconomic compo­ nents contributed to the rise in methamphet­ amine use among gay men on the West Coast (Reback 1997) and among Whites of lower socioeconomic status in rural Missouri (Topolski and Anderson-Harper 2004). How­ ever, in these two cases, the details of those



change factors are quite different. In Missouri, the low cost and easy production of the drug influenced development of a methampheta­ mine drug culture. Missouri leads the nation in the number of methamphetamine labs seized by police; a disproportionately large number of seizures occur in rural areas (Carbone-Lopez et al. 2012; Topolski and Anderson-Harper 2004). The popularity of the drug among



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Chapter 6-Drug Cultures and the Culture of Recovery

**How To Identify and Discuss Key Characteristics of a Drug Culture {continued)**

Counselors can use this exercise to begin to educate clients about the influence of drug cultures and help them identify the specific behaviors, values, and attitudes that constitute their experience of using alcohol and drugs. It can be a helpful tool in improving clients' understanding of the reinforcing as­ pects of alcohol and drug use beyond physiological effects. In addition, this exercise can be used as a training tool in clinical supervision to help counselors understand the influence and potential reinforc­ ing qualities of a drug culture among clients and within the treatment milieu.

**Materials needed:** Diagram handout and pencils.

**Instructions:**

* Determine whether this exercise is more appropriate as an individual or group exercise. Assess the newness and variability of recovery within the group constellation. If several group members support recovery-related behavior, conducting this exercise may be a beneficial educational tool and means of intervention with clients who continue to identify mainly with their drug culture. Conversely, if most group members are new or have had difficulty accepting treatment or treatment guidelines, this exercise may be more aptly used as an individual tool.
* Attention: In group settings, strict parameters need to be established at the beginning of the session to ensure that the discussion remains centered on attitudes, values, and behaviors sur­ rounding drug and alcohol use-not onspecific techniques or procedures for using drugs or rit­ uals surrounding intake or injection.
* Start the discussion by first presenting the idea that drug cultures exist-describing the main elements that constitute culture (refer to Chapter 1 or the categories identified in the "Drug Culture" diagram below). Next, provide examples of how drug culture can support continued use and relapse. Keep in mind that not all clients are engaged in a drug culture.
* Following the general introduction, review each block in the diagram and ask clients to provide examples related to their own use and involvement with drugs and alcohol. After discussing their examples, ask them to identify the most significant behaviors, attitudes, and values that re­ inforce their use (e.g., a feeling of acceptance or camaraderie).
* Counselors can redirect this general discussion to related topics-for example, by identifying behaviors, values, and attitudes likely to support recovery or by shifting from discussion to role­ plays that will help clients address relapse risks associated with their drug culture and practice coping skills (e.g., assertiveness or refusal skills to counter the influence of others once they are discharged from the program or to address situations that arise during the course of treatment).

Drug Culture

|  |  |  |
| --- | --- | --- |
| Establishing Trust and Credibility  *How do* you go about establishing *credibility?* | Socialization  *How were* you *introduced* to *the culture?* | **Values**  *What values are upheld or devalued* in *the group?* |
| **Status**  *In what* ways can you *obtain*  status *or be* seen as a success? | **Rules**  *Are there* spoken *and* unspoken rules *or* norms? | **Gender Roles and Relationships**  *What gender* expectations  exist *surrounding drug* use? |
| **Concepts of Sanction, Punishment, and** Conflict **Mediation**  *How* does *the group deal with in-group conflicts?* | **Symbols and Images**  *Are there* symbols *that* represent a *particular* association *with* a *group or* substance? | **Dress**  *Are there* specific ways to dress *that* show *allegiance* to a specific substance *or group?* |
| **View of Past, Present, and Future**  *Are there* specific *beliefs about*  *the* past, present, *and/or future?* | **Language** & **Communication** *Are there* special *verbal or nonverbal* ways to communicate *about* substance­  *related* activities? | **Attitudes**  *What are* common *attitudes toward others (nonusers, police, etc.)?* |

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Whites could be linked to the historical de­ velopment of the methamphetamine trade by White motorcycle gangs (Morgan and Beck 1997). On the other hand, most gay men who use the drug report having first used it at parties with the expectation of involvement in sexual activity (Hunt et al. 2006). In studies of gay men who used methamphetamine, the main reason for use was to heighten sexual experience (Halkitis et al. 2005; Kurtz 2005; Reback 1997). Morgan and Beck (1997) found that increased sexual activity was one reason why certain women and heterosexual

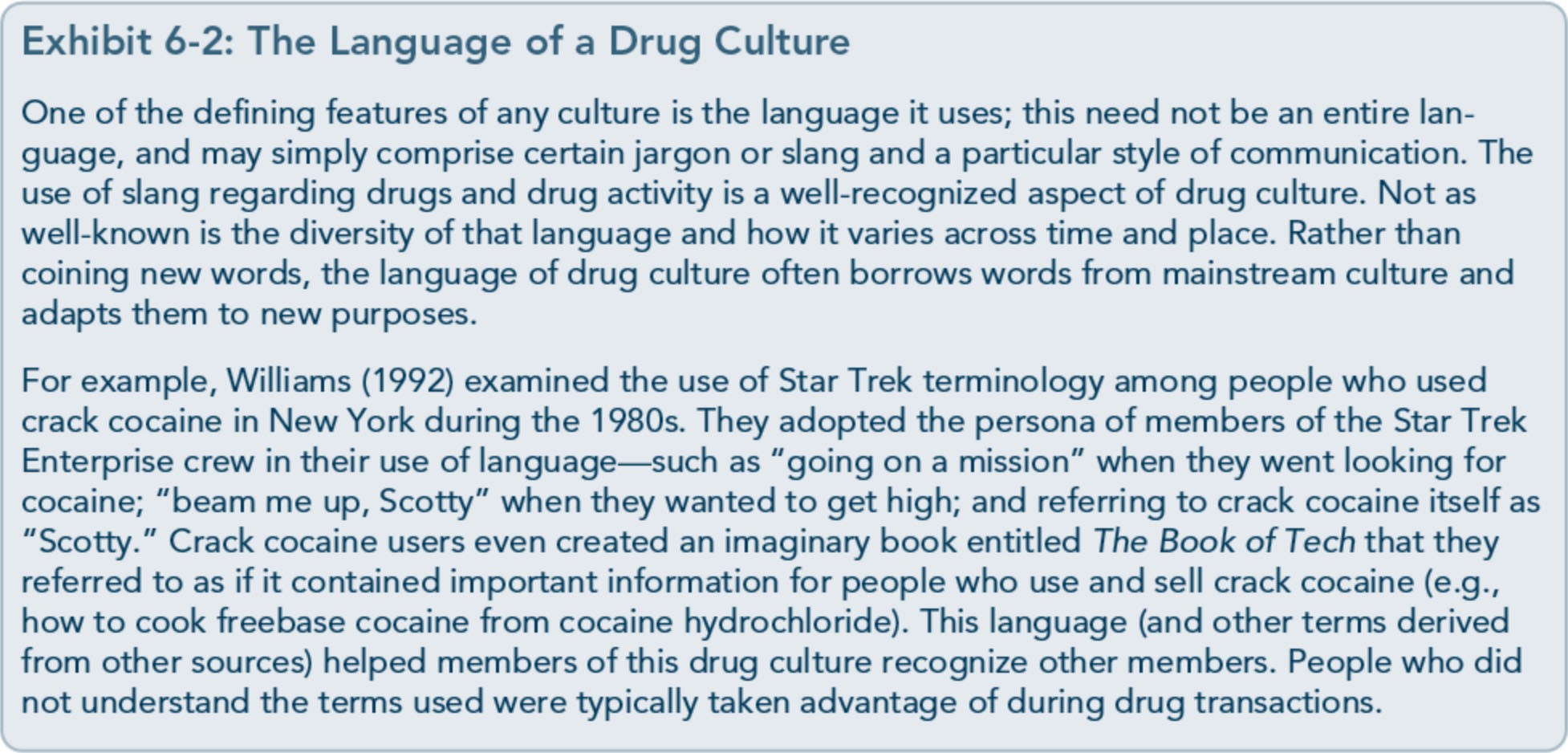
men used methamphetamine, but it was not as important a reason as it was for gay men.

This chapter aims to explain that people who use drugs participate in a drug culture, and further, that they value this participation.

However, not all people who abuse substances are part of a drug culture. White (1996) draws attention to a set of individuals whom he calls "acultural addicts." These people initiate and sustain their substance use in relative isolation from other people who use drugs. Examples of acultural addicts include the medical profes­ sional who does not have to use illegal drug networks to abuse prescription medication, or the older, middle-class individual who "pill

shops" from multiple doctors and procures drugs for misuse from pharmacies. Although drug cultures typically play a greater role in the lives of people who use illicit drugs, people who use legal substances-such as alcohol­ are also likely to participate in such a culture (Gordon et al. 2012). Drinking cultures can develop among heavy drinkers at a bar or a college fraternity or sorority house that works to encourage new people to use, supports high levels of continued or binge use, reinforces denial, and develops rituals and customary behaviors surrounding drinking. In this chap­ ter, drug culture refers to cultures that evolve from drug and alcohol use.

**The Relationship Between Drug Cultures and Mainstream Culture** To some extent, subcultures define themselves in opposition to the mainstream culture. Sub­ cultures may reject some, if not all, of the values and beliefs of the mainstream culture in favor of their own, and they will often adapt some elements of that culture in ways quite different from those originally intended (Hebdige 1991; Issitt 2009; Exhibit 6-2). Individuals often identify with subcultures-such as drug cul­ tures-because they feel excluded from or



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unable to participate in mainstream society. The subculture provides an alternative source of social support and cultural activities, but those activities can run counter to the best interests of the individual. Many subcultures are neither harmful nor antisocial, but their focus is on the substance(s) of abuse, not on the people who participate in the culture or their well-being.

Mainstream culture in the United States has historically frowned on most substance use and certainly substance abuse (Corrigan et al. 2009; White 1979, 1998). This can extend to legal substances such as alcohol or tobacco (including, in recent years, the increased pro­ hibition against cigarette smoking in public spaces and its growing social unacceptability in private spaces). As a result, mainstream culture does not-for themost part-have an accepted role for most types of substance use, unlike many older cultures, which may accept use, for example, as part of specific religious rituals. Thus, people who experiment with drugs in the United States usually do so in highly marginalized social settings, which can contribute to the development of substance use disorders (Wilcox 1998). Individuals who are curious about substance use, particularly young people, are therefore more likely to become involved in a drug culture that en­ courages excessive use and experimentation with other, often stronger, substances (for a review of intervention strategies to reduce discrimination related to substance use disor­ ders, see Livingston et al. 2012).

When people who abuse substances are mar­ ginalized, they tend not to seek access to mainstream institutions that typically provide sociocultural support (Myers et al. 2009). This can result in even stronger bonding with the drug culture. A marginalized person's behavior is seen as abnormal even if he or she attempts to act differently, thus further reducing the

chances of any attempt to change behavior (Cohen 1992). The drug culture enables its members to view substance use disorders as normal or even as status symbols. The disorder becomes a source of pride, and people may celebrate their drug-related identity with other members of the culture (Pearson and Bourgois 1995; White 1996). Social stigma also aids in the formation of oppositional values and beliefs that can promote unity among mem­ bers of the drug culture (Exhibit 6-3).

When people with substance use disorders experience discrimination, they are likely to delay entering treatment and can have less positive treatment outcomes (Fortney et al. 2004; Link et al. 1997; Semple et al. 2005). Discrimination can also increase denial and step up the individual's attempts to hide sub­ stance use (Mateu-Gelabert et al. 2005). The immorality that mainstream society attaches

to substance use and abuse can unintentionally serve to strengthen individuals' ties with the drug culture and decrease the likelihood that they will seek treatment.

The relationship between the drug and main­ stream cultures is not unidirectional. Since the beginning of a definable drug culture, that culture has had an effect on mainstream cul­ tural institutions, particularly through music (Exhibit 6-4), art, and literature. These con­ nections can add significantly to the attraction a drug culture holds for some individuals (especially the young and those who pride themselves on being nonconformists) and create a greater risk for substance use escalat­ ing to abuse and relapse.

#### Understanding Why People Are Attracted to Drug Cultures

To understand what an individual gains from participating in a drug culture, it is important first to examine some of the factors involved

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###### Exhibit 6-3: The Values and Beliefs of a Heroin Culture

Many core values of illicit drug cultures involve rejecting mainstream society and its cultural values. Stephens (1991) analyzed value statements from people addicted to heroin and extracted the core tenets of this drug culture's value system. They are:

* Antisocial viewpoint-Members of this drug culture share a viewpoint that sees all people as basically dishonest and egocentric; they are especially distrustful of those who do not use heroin.
* Rejection of middle-class values-Members denigrate values such as the need for hard work, security, and honesty.
* Excitement/hedonism-Members value immediate gratification and the intense pursuit of pleas­ ure over more stable and lasting values.
* Importance of outward appearances-As much as members of the drug culture may complain

about the mainstream culture's shallowness, they strongly believe in conspicuous consumption and the importance of owning things that give an image of prosperity.

* Valence of street addict subcultures-Members of this drug culture value the continued partici­ pation of others in the culture, even to the point of expecting individuals who have stopped us­ ing to continue to participate in the culture.
* Emotional detachment-People involved in this drug culture value emotional aloofness and see emotional involvement with others as a weakness.

These core values (initially examined by Stephens et al. 1976) were taken from a specific drug culture (heroin), but they can be found in many other drug cultures that center on the use of illicit drugs.

However, these same values will not be upheld in every drug culture. For instance, the drug culture of people who use **MDMA** does not appear to value emotional aloofness, but rather to appreciate the drug's ability to create a feeling of emotional intimacy among those who use it (Gourley 2004; Reynolds 1998). Drug cultures involving legal substances (notably alcohol) are less likely to reject the core values of mainstream society and are less likely to be rejected by that society. They will, howev­ er, still value excitement/hedonism and the participation of others in the subculture.

###### Exhibit 6-4: Music and Drug Cultures

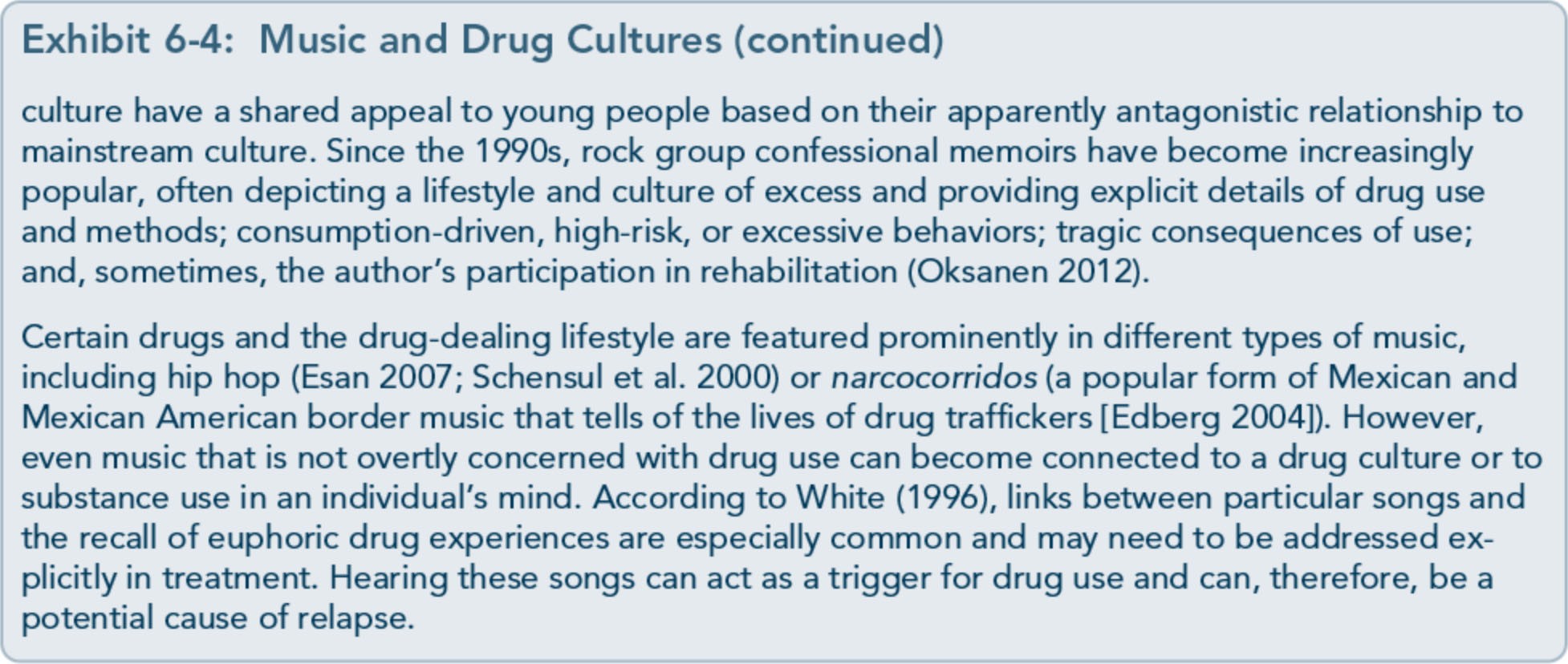
Since the 1920s, when marijuana use became associated with jazz musicians, there has been a con­ nection between certain music subcultures and particular types of substance use (Blake 2007; Gahlinger 2001). As Blackman (1996) notes, "Before the emergence of post-war youth culture, there was a direct connection between the development of the popular music-jazz-and the useof illicit drugs in terms of musicians who used drugs, including heroin, cocaine, and cannabis and their narra­ tives about these drugs through songs" (p. 137). Early Federal legislation criminalizing marijuana was motivated, in part, by use of the drug by jazz musicians and fear that their example would influence youth (Whitebread 1995).

In recent years, the link between drug culture and music has been exemplified by the importance of **MDMA** in the rave music scene (Kotarba 2007; Murguia et al. 2007). Reynolds (1998) credits the development of rave music to **MDMA's** ability to create a feeling of intimacy among relative strangers and the way in which people who use it respond to repetitive, up-tempo music. Con­ versely, Adlaf and Smart (1997) found that adolescents in Canada typically became involved in the rave music scene after starting to use **MDMA** and other drugs. Regardless of how the relationship developed, **MDMA** and rave music are so closely linked that it is hard to tell where the music culture ends and the drug culture begins.

Blackman (1996) states that drug use has become an essential element of youth culture mainly through its association with musical artists. Similarly, Knutagard (1996) observes how different youth cultures, each defined in part by its members' choices in music and substance use, have made some types of substance use acceptable to many young people. Esan (2007) notes that urban music and drug

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in substance use and the development of substance use disorders. Despite having differ­ ing theories about the root causes of substance use disorders, most researchers would agree that substance abuse is, to some extent, a learned behavior. Beginning with Becker's (1953) seminal work, research has shown that many commonly abused substances are not automatically experienced as pleasurable by people who use them for the first time (Fekjaer 1994). For instance, many people find the taste of alcoholic beverages disagreeable during their first experience with them, and they only learn to experience these effects as pleasurable over time. Expectations can also be important among people who use drugs; those who have greater expectancies of pleasure typically have a more intense and pleasurable experience. These expectancies may play a part in the development of substance use disorders (Fekjaer 1994; Leventhal and Schmitz 2006).

Additionally, drug-seeking and other behav­ iors associated with substance use have a reinforcing effect beyond that of the actual drugs. Activities such as rituals of use (Exhibit 6-5), which make up part of the drug culture, provide a focus for those who use drugs when the drugs themselves are unavailable and help them shift attention away from problems they might otherwise need to face (Lende 2005).

Drug cultures serve as an initiating force as well as a sustaining force for substance use and abuse (White 1996). As an initiating force, the culture provides a way for people new to drug use to learn what to expect and how to appre­ ciate the experience of getting high. As White (1996) notes, the drug culture teaches the new user "how to recognize and enjoy drug effects" (p. 46).There are also practical matters involved in using substances (e.g., how much to take, how to ingest the substance for strongest effect) that people new to drug use may not know when they first begin to experiment with drugs. The skills needed to use some drugs can be quite complicated, as shown in Exhibit 6-6.

The drug culture has an appeal all its own that promotes initiation into drug use. Stephens (1991) uses examples from a number of ethno­ graphic studies to show how people can be as taken by the excitement of the drug culture as they are by the drug itsel£ Media portrayals, along with singer or music group autobiog­ raphies, that glamorize the drug lifestyle may increase its lure (Manning 2007; Oksanen 2012). In buying (and perhaps selling) drugs, individuals can find excitement that is missing in their lives. They can likewise find a sense of purpose they otherwise lack in the daily need to seek out and acquire drugs. In successfully navigating the difficulties ofliving as a person

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###### Exhibit 6-5: The Rituals of Drug Cultures

Several authors have noted that illicit drug use and alcohol use typically involve ritualized behaviors (Alverson 2005; Carlson 2006; Carnes et al. 2004; Grund 1993; White 1996). The rituals of substance use affect where, when, and how substances are used. Substance-related rituals serve both instru­ mental and social functions. Instrumental functions include maximizing drug effects, minimizing negative effects of drug use, and preventing secondary problems. Socially, the rituals display one's affiliation with the drug culture to other people and help create a sense of community within the culture. Obviously, the social function is more central to group activities than to solitary rituals.

Most drug-related social rituals involve sharing substances or sharing the experience of intoxication. Some drug cultures (e.g., marijuana) encourage the sharing of substances, but even when they are not shared, drugs are often used with other people who use, such as in crack houses and shooting galleries (Bourgois 1998; Grund 1993; Williams 1992). Rituals involving shared substance use and public substance use strengthen the bonds between members of a drug culture and sustain the drug culture. Some social rituals are so important to members of the drug culture that they participate in them even when they have no drugs, such as when marijuana smokers smoke an inert substance (e.g., horse manure, banana peels) together when they have no marijuana (White 1996). Drug use can also be incorporated into other ritualized behaviors, such as sexual activity (Carnes et al. 2004).

Individuals develop their own drug-related rituals through the influence of other members of the culture and also through trial and error. This allows them to determine what works best for them to maximize the drug's effect and minimize related problems. For example, Grund (1993) found, through observing the rituals surrounding the injection of cocaine and heroin among people in the Netherlands, that specific rituals governed the timing and administration of the drugs so that heroin lessened the unpleasant side effects of the cocaine. Other recent examples are the combination of energy drinks with alcohol to delay the normal onset of sleepiness (Howland and Rohsenow 2013; Substance Abuse and Mental Health Services Administration [SAMHSA] 2013c) and the combination of methylphenidate with alcohol to intensify euphoric effects (for review of central nervous system stimulant use and emergency room information, see SAMHSA 2013b).

**Exhibit 6-6: Questions Regarding Knowledge and Skill Demands of Heroin Use**

* If first use is by snorting, how is it done (assuming the person has never taken a drug intranasal­ ly)? Is there a special technique for using heroin this way?
* If first use is by injection, is it best to inject the drug under the skin (skin-popping) or into a vein?
* What equipment is required? If one doesn't have a hypodermic syringe, what other equipment can be substituted to make up a set of "works" or an "outfit"?
* How is heroin prepared (cooked) for injection?
* What techniques or procedures are used to inject the drug?
* What does one do if the needle clogs?
* Is there any way to test the purity of the drug?
* How much of the drug constitutes a desirable dose?
* If more than one person is using and an outfit is being shared, who uses it first?
* If sharing, how can the works be cleaned to prevent the transmission of disease?
* How does one know if he or she has injected too much?
* Are there any unpleasant side effects one should anticipate?
* How long will the effects of the drug last?
* Is there any way to maximize the drug's effects?
* Is there anything one should not do while high on the drug?
* How much time must pass before the drug can be used again?
* If a bruise or an abscess develops at the injection site, how can it be hidden and treated (without seeing a physician)?

*Source: White 1996.*

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who uses drugs, they can gain approval from peers who use drugs and a feeling that they are successful at something.

In some communities, participation in the drug trade-an aspect of a drug culture-is simply one of the few economic opportunities available and is a means of gaining the admi­ ration and respect of peers (Bourgois 2003; Simon and Burns 1997). However, drug deal­ ing as a source of status is not limited to eco­ nomically deprived communities. In studying drug dealing among relatively affluent college students at a private college, Mohamed and Fritsvold (2006) found that the most im­ portant motives for dealing were ego gratifica­ tion, status, and the desire to assume an outlaw image.

Marginalized adolescents and young adults find drug cultures particularly appealing.

Many individual, family, and social risk factors associated with adolescent substance abuse are also risk factors for youth involvement with a drug culture. Individual factors-such as feelings of alienation from society and a strong rejection of authority-can cause youth to look outside the traditional cultural institu­ tions available to them (family, church, school, etc.) and instead seek acceptance in a subcul­ ture, such as a drug culture (Hebdige 1991; Moshier et al. 2012). Individual traits like sensation-seeking and poor impulse control, which can interfere with functioning in main­ stream society, are often tolerated or can be freely expressed in a drug culture. Family involvement with drugs is a significant risk factor due to additional exposure to the drug lifestyle, as well as early learning of the values and behaviors (e.g., lying to cover for parents' illicit activities) associated with it (Haight et al. 2005). Social risk factors (e.g., rejection by peers, poverty, failure in school) can also in­ crease young people's alienation from tradi­ tional cultural institutions. The need for social

acceptance is a major reason many young people begin to use drugs, as social acceptance can be found with less effort within the drug culture.

In addition to helping initiate drug use, drug cultures serve as sustaining forces. They sup­ port continued use and reinforce denial that a problem with alcohol or drugs exists. The importance of the drug culture to the person using drugs often increases with time as the person's association with it deepens (Moshier et al. 2012). White (1996) notes that as a person progresses from experimentation to abuse and/or dependence, he or she develops a more intense need to "seek for supports to sustain the drug relationship" (p. 9). In addi­ tion to gaining social sanction for their sub­ stance use, participants in the drug culture learn many skills that can help them avoid the pitfalls of the substance-abusing lifestyle and thus continue their use. They learn how to avoid arrest, how to get money to support their habit, and how to find a new supplier when necessary.

The more an individual's needs are met within a drug culture, the harder it will be to leave that culture behind. White (1996) gives an example of a person who was initially attracted in youth to a drug culture because of a desire for social acceptance and then grew up within that culture. Through involvement in the drug culture, he was able to gain a measure of self­ esteem, change his family dynamic, explore his sexuality, develop lasting friendships, and find a career path (albeit a criminal one). For this individual, who had so much of his life invest­ ed in the drug culture, it was as difficult to conceive of leaving that culture as it was to conceive of stopping his substance use.

#### Online Drug Cultures

One major change that has occurred in drug cultures in recent years is the development of

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##### How To Lead an Exercise Examining Benefits, Losses, and the Future

Counselors and clinical supervisors can help clients identify reinforcing aspects (besides physiologi­ cal effects) of their drug and alcohol use and the losses associated with use, including unmet goals and dreams. The physiological, social, and emotional gains and losses that have transpired during their use (whether or not they associate these losses with their use) can serve as risks for relapse.

This exercise works well as an interactive psychoeducational lecture for clients, as a training tool for counselors, and as a group counseling exercise. It can also be adapted for individual sessions.

**Materials needed:** Group room with sufficient space to move around.

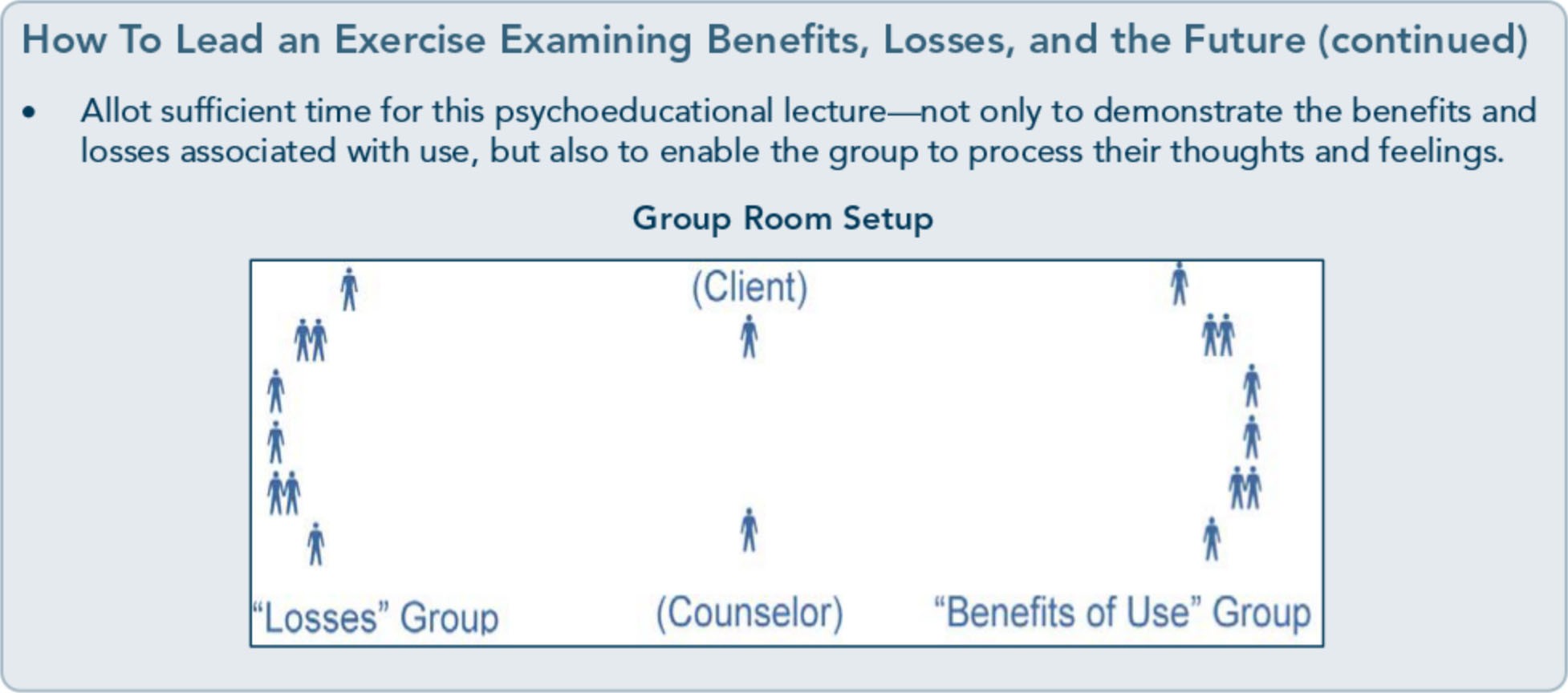
**Instructions:**

* Select an amenable client aware of the losses and consequences associated with his/her use. Later in the exercise, select other clients to give other group members a more direct experience.
* Divide the group in two. For large groups, select only 6 to 8 people for each side. Have each subgroup stand on opposite sides of the room facing each other. One group will represent the benefits of use; the other, losses associated with use (see diagram for room set-up).
* Rather than using the client's personal benefits and losses (at least initially), ask group members to brainstorm about their experiences that represent each side. Begin with the side of the room that represents "benefits of use" and ask everyone in the room to name some benefits. Then, assign a specific benefit to each person in the "benefits of use" group and create a one-line message for each (a first-person statement describing the benefit), asking the representative cli­ ent to remember the line. For example, if the group named a benefit of use as immediate ac­ ceptance from others who use, assign this benefit to one person and create a message to capture it: "I make you feel like you belong," or "We are family now." Continue brainstorming until you have assigned six or more benefits.
* Next, go to the opposite group that represents the losses associated with use and begin to solicit losses from everyone in the room. Assign a loss to each person in the "loss" group, create a one-line message that coincides with each loss, and then ask an individual to remember each loss message (e.g., "I am the loss of your children," "I am the loss of your self-respect," "I am the loss of your health"). In addition, ask the group to name future goals and plans that were curtailed because of use. Assign these losses as well, following the same format (e.g., "I am the loss of a college degree," "I am the loss of intimate relationships," "I am the loss of belief in the future"). Note: If you run out of people, you can assign two roles to one person.
* At this point, the exercise can already be a powerful experience for many clients. Now, have the person who was originally selected as the client stand facing the "benefits of use" group. Have the client process what it is like to see the benefits of use. You can also have each person in the "benefits of use" group state his or her one-line message to help facilitate this process. Stand with the client as he or she moves to the "loss" group. Again, have the client stand and face this group while asking him or her what it is like to see the losses, including the losses related to goals and the future. Note: It is not important as an exercise to have benefits or losses specific only to this client. It is far better to gain a sample from the entire group so that everyone is in­ volved and to maximize the exercise's effectiveness as a psychoeducational tool.
* After the client has stood in front of both groups, ask him or her to move back and forth be­ tween each group several times to see what emotional changes occur in experiencing each group. It is important to process this experience as a group. You can invite other members to switch out of their roles and stand in as clients to experience this exercise more directly. Clients are likely to see how seductive the "benefits of use" group can be and how this attraction can lead back to relapse. This exercise may also help clients connect with the losses associated with their use. At times, clients may gain awareness that the very losses associated with their use can also serve as a trigger for use as a means of self-medicating feelings.

*(Continued* on *the* next *page.)*

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Internet communities organized around drug use (Gatson 2007*a;* Murguia et al. 2007) and drug use facilitation, including information on use, production, and sales (Bowker 2011; U.S. Department of Justice 2002). Such communi­ ties develop around Web sites or discussion boards where individuals can describe their drug-related experiences, find information on acquiring and using drugs, and discuss related issues ranging from musical interests to legal problems. Many of the Web sites where these online communities develop are originally created to lessen the negative consequences of substance use by informing people about vari­ ous related legal and medical issues (Gatson 2007*b;* Murguia et al. 2007). As in other drug cultures, users of these Web sites and discus­ sion boards develop their own language and values relating to drug use. Club drugs and hallucinogenics are the most often-discussed types of drugs, but online communities involve the discussion of all types oflicit and illicit substances, including stimulants and opioids (Gatson *2007a;* Murguia et al. 2007; Tackett­ Gibson 2007).

Murguia et al. (2007) reported on a survey of adult (ages 18 and older) participants in one online community. The self-selected survey sample included 1,038 respondents, 80 percent

of whom were from the United States. Re­ spondents were likely to be young (90 percent were under 30), male (76 percent), White (92 percent), relatively affluent (58 percent had household incomes of $45,000 or more), employed (41 percent were employed full time; another 28 percent, part time), and/or in school (57 percent were attending school full or part time). According to the 2011 National Survey on Drug Use and Health, approxi­ mately 0.3 percent of individuals 12 years of age or older purchase prescription drugs through the Internet (SAMHSA, 2012b).

### The Role of Drug Cultures in Substance Abuse Treatment

Most people seek some kind of social affilia­ tion; it is one aspect oflife that gives meaning to day-to-day existence. Behavioral health service providers can better understand and help their clients if they have an understand­ ing of the culture(s) with which they identify. This understanding can be even more im­ portant when addressing the role of drug culture in a client's life because, of all cultural affiliations, it is likely to be the one most intimately connected with his or her substance

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abuse. The drug culture is likely to have had a considerable influence on the client's behav­ iors related to substance use.

#### Drug Cultures in Assessment and Engagement

The first step in understanding the role a drug culture plays in a client's life is to assess which drug culture(s) the client has been involved with and his or her level of involvement. There are no textbooks that can inform providers about the drug cultures in their areas, but counselors probably know quite a bit about them already, as they learn much about drug cultures through talking with their clients.

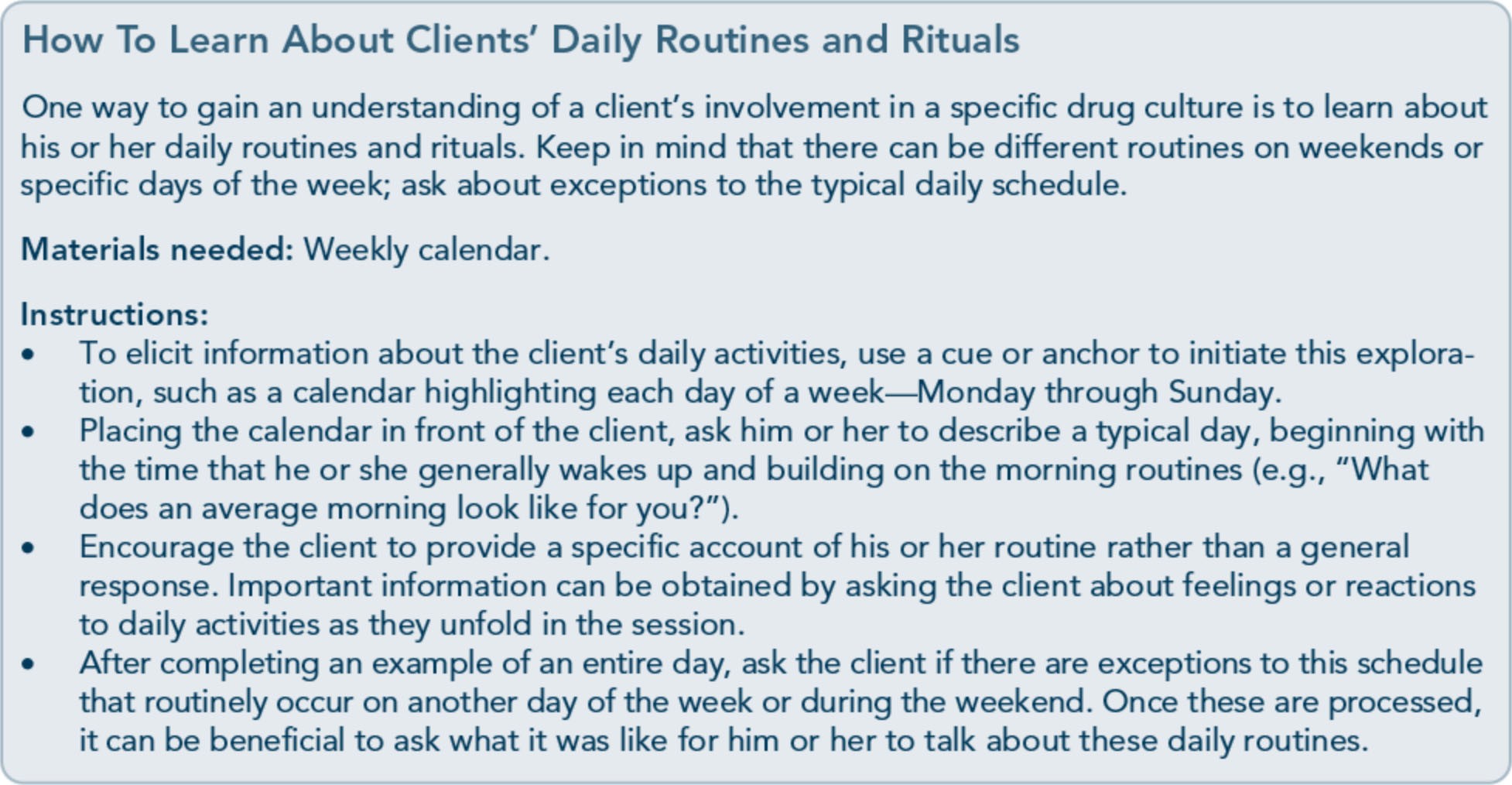
Counselors who are themselves in recovery may be familiar with some clients' substance­ using lifestyles and social environments or will have insight into how to explore the issue with clients. They can also educate their colleagues.

Providers who have never personally abused substances can learn from recovered counse­ lors as well as from their clients. However, asking a client point-blank about his or her involvement in a drug culture is likely to be answered with a blank stare. Instead, talking to

clients about their relationships, daily activities and habits relating to substance use, values, and views of other people and the world can allow providers to develop a good sense of the meanings drug cultures hold for clients.

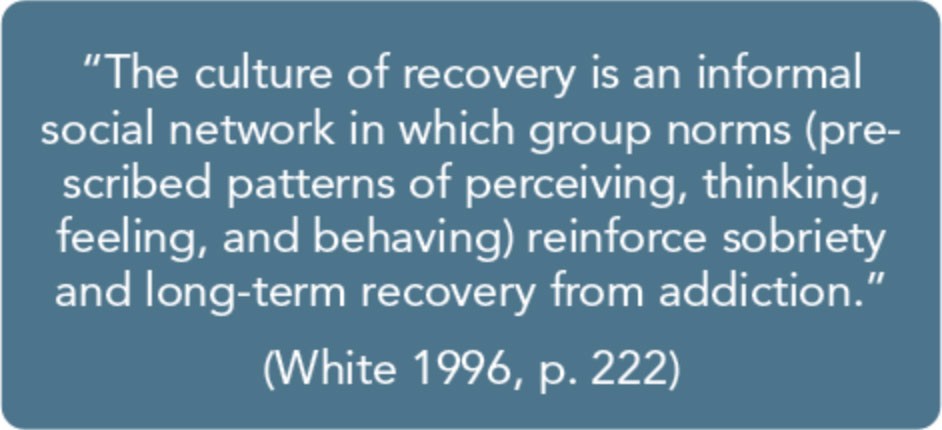
To engage a client in treatment, understanding his or her relationship with a drug culture may be as important as understanding elements of that client's racial or ethnic identity. Clients are unlikely to self-identify as members of the drug culture in the same way that they would identify as an African American or Asian American, for example, but they can still be offended or distrustful if they think the provid­ er or program does not understand how their lifestyle relates to their substance use. Affilia­ tion with a drug culture is a source of client identity; the client's place in the drug culture can be important to his or her self-esteem.

After the assessment and engagement stage, the provider's attitude toward the client's participation in a drug culture will be signifi­ cantly different from his or her attitude to­ ward the client's other cultural affiliations. As most providers already know (even if they do not use the term drug culture), if a client



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continues to be closely affiliated with the

drug-using life, then he or she is more likely to relapse. The people, places, things, thoughts, and attitudes related to drug and/or alcohol use act as triggers to resume use of substances. Behavioral health service providers need to help their clients weaken and eventually elim­ inate their connections to the drug culture.

White (1996) identifies an important issue to address during transition from engagement to treatment-in the process of engaging clients, providers help them identify how their con­ nections to the drug culture prevent them from reaching their goals and how the loss of these connections would affect them if they chose to cut ties with the drug culture.

#### Finding Alternatives to Drug Cultures

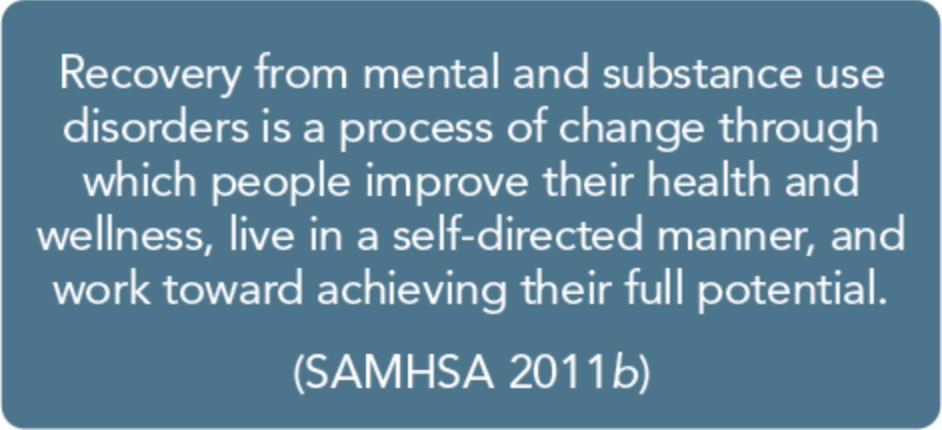
A client can meet the psychosocial needs previ­ ously satisfied by the drug culture in a number of ways. Strengthening cultural identity can be a positive action for the client; in some cases, the client's family or cultural peers can serve as a replacement for involvement in the drug culture. This option is particularly helpful when the client's connection to a drug culture is relatively weak and his or her traditional culture is relatively strong. However, when this option is unavailable or insufficient, clinicians must focus on replacing the client's ties with the drug culture (or the culture of addiction) with new ties to a culture of recovery.

To help clients break ties with drug cultures, programs need to challenge clients' continued involvement with elements of those cultures

(e.g., style of dress, music, language, or com­ munication patterns). This can occur through two basic processes: replacing the element with something new that is positively associat­ ed with a culture of recovery (e.g., replacing a marijuana leafkeychain with an NA key­ chain), and reframing something so that it is no longer associated with drug use or the drug culture (e.g., listening to music that was asso­ ciated with the drug culture at a sober dance with others in recovery; White 1996). The process will depend on the nature of the cul­ tural element.

**Developing a Culture of Recovery** Just as people who are actively using or abus­ ing substances bond over that common experi­ ence to create a drug culture that supports their continued substance use, people in recov­ ery can participate in activities with others who are having similar experiences to build a culture of recovery. There is no single drug culture; likewise, there is no single culture of recovery. However, large international mutual­ help organizations like Alcoholics Anonymous (AA) do represent the culture of recovery for many individuals (Exhibit 6-7). Even within such organizations, though, there is some cultural diversity; regional differences exist, for example, in meeting-related rituals or attitudes toward certain issues (e.g., use of prescribed psychotropic medication, approaches to spirituality).

The planned TIP, *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e),* provides more information on using mutual-help groups in



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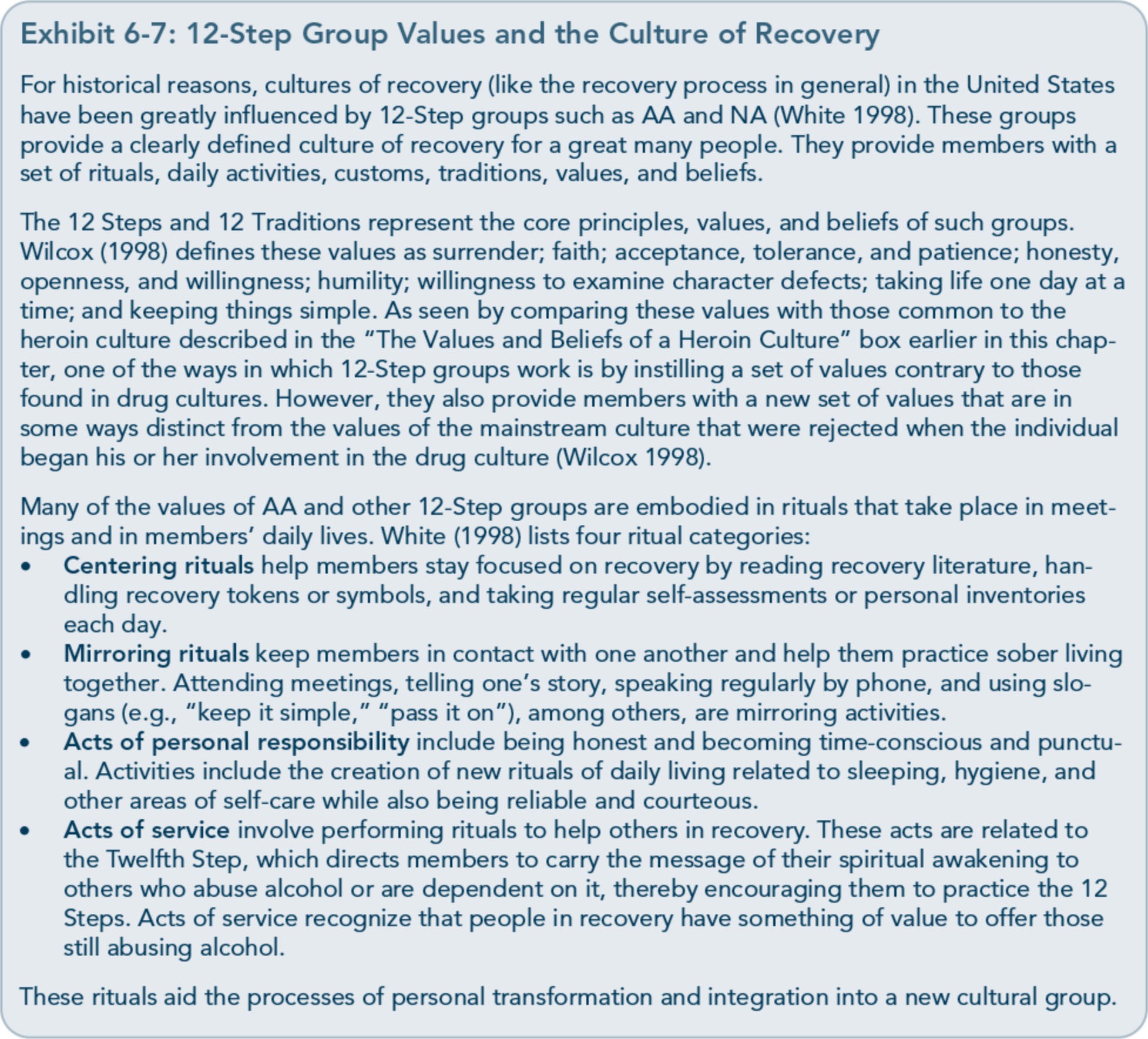
treatment settings and in long-term recovery. It contains detailed information about poten­ tial recovery supports that behavioral health programs can use to foster cultures of recovery among clients and program graduates.

Most treatment programs try to foster a culture of recovery for their clients. Some modalities, with therapeutic communities being the lead example, focus on this issue as a primary treat­ ment strategy. Even one-on-one outpatient treatment programs typically encourage attend­ ance at mutual-help groups, such as AA, to meet sociocultural recovery needs. Most pro­ viders also recognize that clients need to

replace the activities, beliefs, people, places, and things associated with substance abuse with new recovery-related associations-the central purpose of creating a culture of recovery.

Even programs that already recognize the need to create a culture of recovery for their clients can make doing so more of a focus in treatment. White (1996) explores ways to do this, including:

* Teaching clients about the existence of drug cultures and their potential influence in clients' lives.
* Teaching clients about cultures of recovery and discussing how elements of the drug



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culture can be replaced by elements of a culture of recovery.

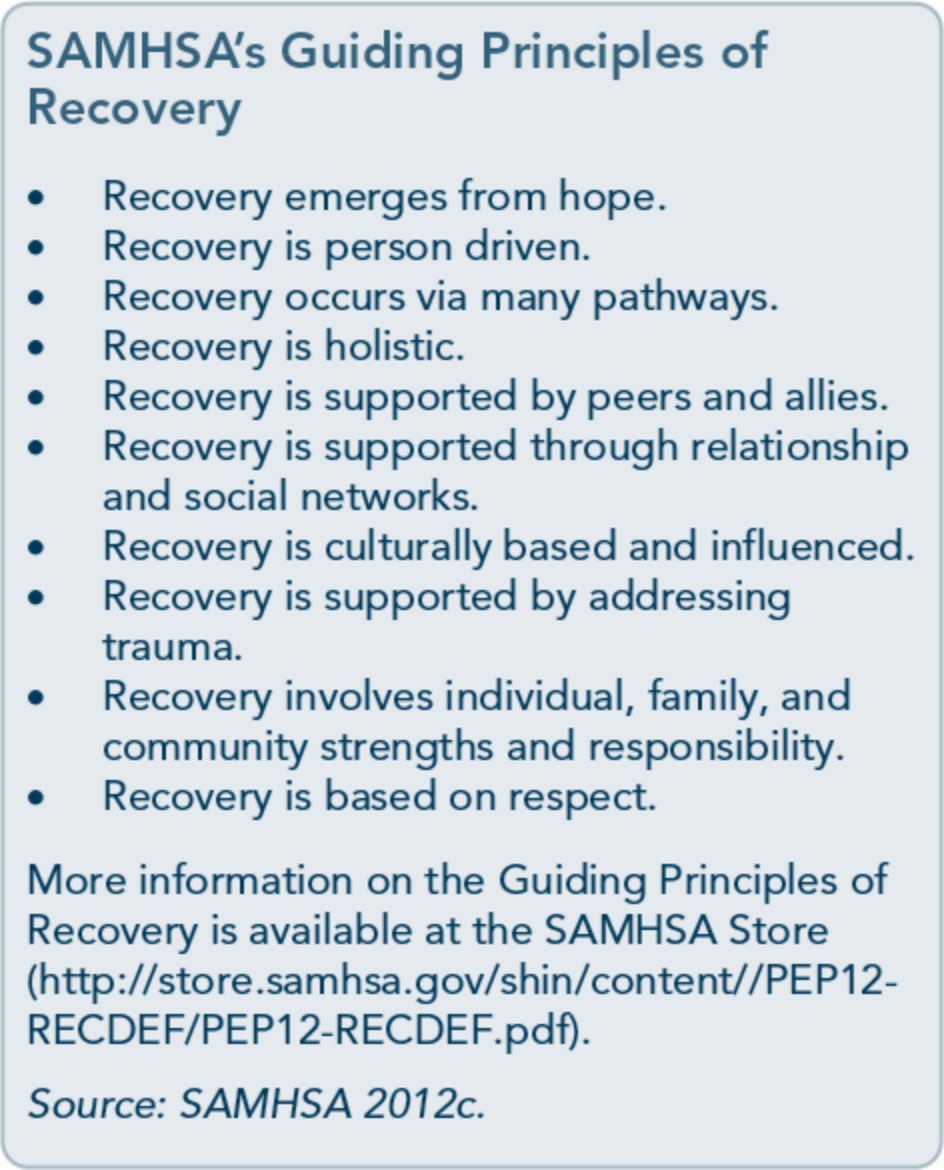
* Establishing clear boundaries for appro­ priate behavior (e.g., behavior that does not reflect drug cultures) in the program and consistently correcting behaviors that violate boundaries (e.g., wearing shirts de­ picting pot leaves; displaying gang­ affiliated symbols, gestures, and tattoos).
* Working to shape a peer culture within the program so that longer-term clients and staff members can socialize new clients to a culture of recovery.
* Having regular assessments of clients and the entire program in which staff members and clients determine areas where work is needed to minimize cultural attitudes that can undermine treatment.
* Involving clients' families (when appropri­ ate) in the treatment process so they can support clients' recovery as well as partici­ pate in their own healing process.

White (1996) suggests that programs build linkages with mutual-help groups; include mutual-help meetings in their programs or provide access to community mutual-help meetings; and include mutual-help rituals, symbols, language, and values in treatment processes.

Other activities that can improve integration into a recovery culture include SAMHSA's Recovery Community Services Program (<http://www.samhsa.gov/grants/2011/ti_l1_0> 04.aspx), which was developed to provide and evaluate peer-based recovery support services, and Recovery Community Centers, which provide space for recovering people to social­ ize, organize, and develop a recovery culture (White and Kurtz 2006). Developing a culture

of recovery involves connecting individuals back to the larger community and to their cultures of origin (Davidson et al. 2008). This can require efforts to educate the community about recovery as well (e.g., by promoting a recovery month in the community, hosting recovery walks or similar events, or offering outreach to community groups, such as churches or fraternal/benevolent societies).

Programs that do not have a plan for creating a culture of recovery among clients risk their clients returning to the drug culture or hold­ ing on to elements of that culture because it meets their basic and social needs. In the worst case scenario, clients will recreate a drug cul­ ture among themselves within the program. In the best case, staff members will have a plan for creating a culture of recovery within their treatment population.



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