There have been numerous definitions of culture. Dwight Heath offers a simple definition: "It is a system of patterns of belief and behavior that shape the worldview of the member of a society. As such, it serves as a guide for action, a cognitive map, and a grammar for behavior."

Substance abuse refers to the abuse of alcohol and other drugs, primarily illicit drugs, but what is considered "illicit" is often culturally determined and can vary between social groups. Most culturally distinct groups have used and abused alcohol and other drugs throughout the ages, and they have established codes of behavior in their approach to drugs and alcohol.

This article begins with a brief overview of the historical background and context for the use and abuse of substances. A review of the effect of culture on the initiation, use, and abuse of substances follows. Finally, some guidelines on culturally informed assessment and treatment are provided. Rather than being all-inclusive, this article focuses on North American cultural groups.

**Historical roots, fruits, and plants**

Alcohol and many other drugs have been used for thousands of years. Alcoholic beverages have been fermented from an array of plants and fruits since at least 4000 BC. Both wine and beer were first made at about the same time in what are now Iraq and Iran. Some of the earliest references to the use of alcohol are found in ancient Sumerian clay tablets that contain recipes for the use of wine as a solvent for medications. There is little mention of alcohol use in North America before the arrival of whites. However, there are some isolated reports of alcohol use by the Aztec in Mexico, by the Pima/Papago in the Southwest United States, and by the Aleuts from as far north as Alaska. Alcoholic beverages were introduced in larger quantities during colonial times.

At about the same time that some groups were fermenting alcoholic beverages, the Sumerians were cultivating the opium poppy, which they named "hul gil," the plant of joy. The opium poppy was used for its medicinal properties to relieve pain and diarrhea and for its mental properties to provide sedation and euphoria. Its presence in the United States, in the form of opium, was noted among early Chinese immigrants, and later heroin was introduced to urban minority groups, such as blacks and Hispanics.

Marijuana is thought to have its origins more than 4000 years ago in China and later in India. Before its psychoactive use, marijuana (hemp) was used as a fiber, and traces of its use for cloth date back more than 10,000 years in China. Hemp was grown by George Washington at Mount Vernon and was the second largest crop--after cotton--grown in the South before the US Civil War. After World War I, Mexican laborers introduced Americans to smoking marijuana for its psychoactive properties. Most of the world's psychoactive plants originated in the Americas--in all, more than 1500 compounds. Included among these mind-altering drugs are hallucinogens, stimulants (cocaine), and tobacco. Cocaine was produced in the Andes of South America and became a major drug of abuse in the United States in the past 30 years. Tobacco was used in the New World in approximately 5000 bc. When Christopher Columbus landed in the Caribbean, he discovered the natives using tobacco for a number of ailments. Within the next 150 years, the use of tobacco rapidly spread around the world. Peyote was used in religious ceremonies in northern Mexico and later spread to southwestern Native American tribes.

**The role of culture in substance use and abuse**

Sociocultural beliefs can shape the approach to and behavior regarding substance use and abuse. Culture plays a central role in forming the expectations of individuals about potential problems they may face with drug use. For many social groups, this may provide a protective factor. An example is
the use of alcohol by the ancient Aztecs before any contact with white settlers. Their use of alcohol was heavily regulated and was only for ceremonial purposes. Non-ceremonial use of alcohol was strictly forbidden under penalty of death. Another example is the development of the peyote cult in northern Mexico. Peyote was used in a ceremonial setting to treat chronic alcohol addiction. This use later became a central part of the Native American church, which provided important spiritual treatment for chronic alcoholism.

Initiation into excessive substance use may occur during periods of rapid social change, often among cultural groups who have had little exposure to a drug and have not developed protective normative behavior. Anomie, or loss of a healthy ethnic or cultural identity, may occur among native populations whose cultures have been devastated by the extensive and sudden influx of outside influence.

Because of its low availability, few North American Indians had any exposure to alcohol before the arrival of whites. On the western frontier, potent distilled alchoholic beverages became widely available, and the only model Native Americans had was the drunken comportment of the frontiersman.

Acculturation, the degree to which an individual identifies with his or her native culture, is thought to be related to substance use and abuse. Native American elders believe that many substance abuse problems are related to the loss of traditional culture. Higher rates of substance use have been found in persons who closely identify with non-Native American values and the lowest rates are found in bicultural individuals who are comfortable with both sets of cultural values.

A related situation is that of the immigrant who has moved from his homeland to a new country. Immigrants leave the protective environment of their family behind and are faced with a new set of cultural norms and values. This has been seen in Hispanics who have moved to the United States. Sensitivity to changes in the degree of acculturation has been described in Cuban American, Puerto Rican, and Mexican American women. These women may often assume the drinking behavior of the dominant society and, as a result, they increase their use of alcohol.

A recent study from Washington State demonstrated the accelerated abuse of alcohol and use of illegal drugs in acculturated Hispanics. Illegal drug use in the previous month and increased alcohol use were reported by 7.2% compared with less than 1% of nonacculturated Hispanics and 6.4% of whites. Nonacculturated Hispanics (recent immigrants) were more family oriented and had lower rates of drug and alcohol use. Apparently, indigenous cultural values have a protective effect.

**Assessment and screening**

With the population of the United States becoming increasingly diverse, it is important to consider a person's cultural background when assessing for substance abuse or dependence. The publication of DSM-IV was an important turning point in the application of cultural psychiatry principles because it provided an outline for cultural formulation including:

- A discussion of the cultural variations in currently recognized DSM disorders.
- A glossary of culture-bound syndromes.
- An outline for a culturally relevant case formulation based on 5 major areas: cultural identity, cultural explanation of the illness, cultural factors related to psychosocial environment and levels of functioning, cultural elements of the relationship between the individual and the clinician, and overall cultural assessment for diagnosis and care.

The things that should be included in considering a patient's cultural identity are cultural reference groups, involvement with culture of origin, language, and cultural factors of development. For example, for Native Americans it is important to note the tribe the individual is part of and what tribe or ethnic group the person identifies with. Another factor that should be considered is whether the person speaks his native language and what his first language was. Often, individuals can feel alienated from their host culture if they do not speak their native language fluently or at all. This can be a barrier to those wishing to seek care from traditional healers. It is also important to note what involvement a person has had with his host culture and to what degree his family is involved with their culture.

An example of cultural alienation was seen in previous generations of Native American children who were sent to boarding schools. The children were often hundreds of miles away from their families and would not see their families for months or even years. Their behavior was shaped primarily through punishment, and emotional and physical abuse was common. The schools' punitive model was perpetuated when these children became adults and had children of their own. This eventually led to an accelerated weakening of the culture that had previously guided Native American communities. Many Native Americans believe that this loss of culture is the primary cause of their existing social problems, which includes those associated with alcohol. However, more research is
Screening can be done either routinely by asking patients about their alcohol and drug use in the past year or by using a screening test, such as the Alcohol and Use Disorders Identification Test (AUDIT) to ascertain the amount of alcohol use, or the Michigan Alcohol Screening Test (MAST), which has been modified to include the use of drugs. It should be emphasized that these screens are just that, screens--they should not replace a thorough medical and cultural history from the patient and collateral information from family and friends. One study that used the short version MAST found that it may have produced a high number of false positives when using the cutoff score of 3 or higher. Therefore, when using screening instruments, it is prudent not to use them as diagnostic tools.

**Treatment**

Treatment access, like access to drugs, requires more than availability in the community. One study found that a particular ethnic group did not seek alcohol or drug treatment from a local program because the program did not have staff that included members of the same ethnic group. Staff composition is critical in developing treatment programs, particularly with treatment initiation and retention. Hiring qualified staff of the same ethnic background may dramatically increase patient access and initiation into treatment. In addition, if the treatment provider is not of the same ethnic background, it is best that he or she take on an inquisitive role and not make any ethnocentric assumptions based on his own cultural heritage. The goal of the clinician should be to uncover sociocultural issues that will affect acceptance, retention, and ultimately, treatment outcome. Access to treatment is facilitated by locating treatment facilities in easily accessible geographic areas. Patients should have access to facilities and counselors in their own community rather than in remote treatment locations. One caveat is that in small rural communities, ease of access may reduce the ability to keep treatment confidential. This is largely dependent on whether the individual who provides treatment lives within the local community or outside of it.

One aspect of recovery that is often overlooked is that of cultural recovery. Cultural recovery involves regaining a viable ethnic identity and acquiring a functional social network committed to the person's recovery; making a religious, spiritual, or moral recommitment; re-engaging in recreational or vocational activities; and gaining a social role in the recovering community, society at large, or both. Those individuals who fail to make a satisfactory cultural recovery are at risk for re-addiction. Family involvement is an important focus in working with Hispanic and Native American communities. Both the patient's immediate family and extended family are significant and should be involved in the intervention process because alcohol and drug abuse can erode important family and social ties, and restorative efforts to repair an individual's familial and social network can buffer the effects of alcohol or drug abuse.

Finally, the community must re-establish a culturally integrated fabric, only part of which may be related to drug and alcohol use. Efforts to re-establish a culturally integrated community must precede, or at least parallel, the development of a meaningful intervention; efforts must combine basic community cultural values with the most recent advances in treatment intervention. For example, the Alkali Lake community in British Columbia achieved a reduction of alcoholism from 95% to 5% over 10 years through the revitalization of tradition and the establishment of a community atmosphere that no longer tolerated alcoholism. As Chief Andy Chelsey simply put it "The community is the treatment center."

**Conclusion**

The problems that drugs and alcohol bring to communities are multidimensional. Treatment interventions should be designed with input from the community. It is in this task of community healing that hope is rekindled, and it is this hope that initiates and drives the healing process. Tribal groups, families, traditional healers, religious entities, legal authorities, and local health care providers should all be involved in the healing and recovery process.

**Evidence-Based Reference:**


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**References:**


Links:
[1] [http://www.psychiatrictimes.com/addiction](http://www.psychiatrictimes.com/addiction)