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Ethnic and cultural considerations treating addictive disorders in a therapeutic group setting, which explores the evolution of race and ethnicity in our society and how these prevailing attitudes express themselves in the therapeutic group process.¹

ARTICLE

Introduction

Ethnic and Cultural Considerations Treating Addictive Disorders in a therapeutic group setting explores the evolution of race and ethnicity in our society and how these prevailing attitudes express themselves in the therapeutic group process. Mixed race therapy in a therapeutic group setting is reviewed to see its impact on the effectiveness of the group. The importance of cultural diversity in a therapeutic group setting is evaluated as it enhances the group process and promotes treatment goals. The importance of cultural competence by the therapist is also assessed as it relates to the success of the therapeutic group process. Culture, race, and attitudes of the therapist are also explored to measure their impact on the client. Clients and therapists participating in group therapy are shown to benefit from a culturally diverse therapeutic group experience.

Addiction therapy has evolved as a white, middle-class phenomenon primarily in North America (Sue, 1998). At a time when immigrants and visible minorities constitute an increasing number of the population, it is important to contemplate adjustments and modifications to the theories and techniques of addiction therapy when dealing with non-majority group members. Available evidence indicates that minority patients are underrepresented in addiction therapy and have higher dropout rates than Caucasians. The reasons for this are manifold: cultural biases; language barriers; cost of treatment; and lack of information to name a few (Sue, 1998). We must learn more about the way of life of these potential group therapy clients and be open to adapt some of our norms and expectations to meet their needs. In this way addiction therapists may establish services that are more responsive to ethnic patients, and addiction group therapy can become a more attractive, acceptable and effective addiction treatment modality for this segment of society (2001).

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Cultural Diversity

Background

Over the past few decades the demographic composition of many industrialized countries has changed significantly. More liberal immigration rules in the main recipient countries (US, Canada and Australia), which stopped the past immigration of potential immigrants of non-Caucasian origin, has been a major contributing factor (Salvendy, 1999). In addition the existence of long, easily crossed borders (between the US and Mexico, and the US and Canada), and the easing of restrictions for entry by most countries of the world has increased the opportunities for many people to immigrate legally and illegally into the United States. Last but not least, the numerous armed conflicts and civil wars have led to repeated mass exodus of refugees and the politically, ethnically or religiously persecuted (Silverstein, 1999).

As the traditional European immigration was drying up (due to that continent's economic recovery after the Second World War) it was replaced by people from the developing regions of the world migrating into the United States. These migrants are not only visibly different from the local majority population but they bring with them a gamut of disparate cultural properties such as language, religion, social attitudes, dress, cuisine and music, among others (Salvendy, 1999). The apparent transformation of our societies through this process of infusing different looking and sounding people, which is most visible in the big cities, has left an indelible impact on both the original and the immigrant populations (White, 1999).

Learning and understanding each other's culture contributes to the process of integration and harmony (Zane, 1998). However, this process has become much more complex than in the past, due to the diversity of the new minorities. Thus for the longest period, in the United States it was sufficient to understand the difference between the Caucasian and Afro-American cultures (Jenkins, 1998). With the influx of Hispanic, Asian, African and Polynesian immigrants that relatively simple equation has changed. This increase in a portion of the population, which appears distinct and dissimilar, poses a significant challenge to Addiction Therapists treating clients with addictive disorders (Addison, 2001).

Evolution of Concepts

Race and Ethnicity have been and still are topics that evoke discomfort and anxiety in social and clinical settings and are often treated as a taboo. Talking about race and ethnicity can arouse powerful feelings related to the problems of difference, wishes for recognition and desires for domination and control (Leary, 2002).

The sensitivity related to discussions about this topic is due to a history of prejudice, and severe discrimination, on grounds of race and ethnicity in North America and elsewhere (Curry, 2001). The persecution of the Native Indians of the Americas, of Afro-Americans, of the Jews in Europe and the horrors of the latest ethnic cleansing in Iraq have all contributed to this sense of uneasiness when the issue of race and ethnicity comes up. The subject is further compounded by widespread prejudices and stereotyping of others (Leary, 2002).

Therapists conducting addiction group therapy have not been immune to the prevailing socio-political views and that partially explains the scarcity of literature dealing with the impact of

race and ethnicity on the theories and practices in the field of addictions. The other reason for less clinical attention being directed to racial issues is that patients and therapists of non-Caucasian origin are themselves under-represented in the population offering and receiving treatment for addictive disorders (Silverstein, 1999). As a result, the dynamics of race and ethnicity remain unarticulated because most therapists are unfamiliar with the many issues that such patients present (Leary 2002).

Therapists belonging to a particular race or ethnic group (European-Americans) contributed a good portion of what has been established by those who are confronted daily with this issue (Sue, 1998). Gordon (2004) put it this way "Until our society recognizes and finds a remedy for the fact that the most fundamental aspect of racism is simply the advantage that comes with white skin, we will not effectively deal with the other, more visible issues." Addiction therapists conducting group counseling sessions formulated much of the earlier views on race and ethnicity for clients in treatment for addictive disorders. Generally, race was perceived as a hindrance to the client's treatment process (Salvendy, 1999). Thus an Afro-American patient's culture as well as the potentially prejudicial attitude of the white therapist was viewed as an obstacle to successful treatment (Curry, 2001). For example, Curry (2001) felt that black patients, from the very beginning, entered treatment fearing and distrusting Caucasian therapists because of specific previous life experience.

Further difficulties arose from the formulation of the role of race in the addiction treatment process. In the early literature the impact of race and ethnicity was often narrowly focused on the inquiry concerning the influence of racism on personality development and interpersonal dynamics (Holmes 1998). This led to a frequent stereotyping of a particular race or ethnic group. As a result, for example, some authors (Jenkins, 1998) described a "Negro personality" which developed due to segregation and discrimination and was believed to be characterized by low self esteem, apathy, fears of relatedness, mistrust, problems with the control of aggression and orientation to pleasure in the moment.

The major shortcoming of this approach is that the cultural practices of patients belonging to a non-Caucasian race and their personal experience did not have a meaning of their own apart from reflecting personality defects that were supposedly common to all members of that racial or ethnic group (Curry, 2001). With the increased racial acceptance in the United States and widespread integration in the past ten years, the focus has shifted to encourage and acknowledge the patient's communication about the therapist's (different) race and not equate racial responses automatically with transference (White, 1999).

Zane (1998) pointed out the major shortcomings of the stereotyped assumption; rather than seeing racial differences as limiting he maintained that paying attention to racial and ethnic issues could have a positive effect and stimulate the therapeutic group process. Later Addison (2001) argued that in mixed-race addiction group therapy situations, exploring the patient and therapist's expectations about race and ethnicity could enhance the entire therapeutic group process.

Contemporary thinking on mixed-race addiction group therapy situations assumes that attention directed toward the realities and fantasies associated with race or ethnicity may facilitate therapeutic work or even be a precondition for its success (White, 1999). Some clinicians, primarily of non-Caucasian background, have suggested that, for example, Afro-American patients would be better served through the provision of culturally specific addiction

therapy, which would be consistent with the cultural practices and beliefs of Afro-Americans (Jenkins, 1998).

The risks in this approach, which could apply to other ethnic groups and cultures as well, is that it establishes specific norms of behavior for a whole race or ethnic group. This also sets new stereotypes and thus resembles the early psychodynamic writing on race and ethnicity (Sue, 1998). Furthermore it would likely lead to more separation between the various races and ethnic groups as its premise supports the notion that race and ethnicity cannot be discussed in a social therapeutic group setting. This attitude also negates the view that people with a variety of racial or ethnic backgrounds may have different views about themselves and others but can still establish meaningful understanding in ways that maintain the personal integrity of each (Zane, 1998). Current addiction theories emphasize the importance of the client-therapist relationship and the importance of open client interaction in the therapeutic group process, these two methods are both likely to be more conducive to the therapeutic needs of minority patients participating in addiction group therapy (Zastrow, 2001).

Socio-Cultural Observations

Afro-Americans born in the United States differ vastly from their African brethren or from their Caribbean counterparts (Jenkins, 1998). In fact, there are distinct differences even among blacks hailing from various islands in the Caribbean. Also the degree of acculturation within the same ethnic groups may differ markedly (Addison, 2001). Thus second generation Chinese may be quite westernized compared to recent immigrants from China (Chen, 1999). Conformity is sanctioned by society, and when a segment is seen as not conforming in appearance, attitude or behavior, prejudice may be the result (Chen, 1999). Ethnicity is sometimes correlated with social factors such as poverty and/or single parent families, which contribute to stress, anxiety and a restricted or non-adaptive social life. Each culture also brings with it its own, often-unusual perception of power, authority, interpersonal boundaries and family dynamics (Chen, 1999).

For many ethnic populations who are relatively recent immigrants, group therapy is even less acceptable than individual counseling due to the loss of face of having their weaknesses witnessed by other non-professionals (Zane, 1998). Therefore first generation immigrants are even more under-represented in group therapy than in individual therapy, and they also tend to be hampered by language barriers; an immigrant may be able to communicate with a health care professional but will often be at a loss to follow a fast flowing group dialogue (Zane, 1998).

All individuals manifest varying levels of ethnic or racial bias. However, therapist and patient awareness of their own prejudices can minimize resistance and promote treatment goals (Addison, 2001). Therapists who are knowledgeable about minority cultures and sensitive to their needs may attract members of such communities which otherwise could not be accessible to treatment. Furthermore, they are likely to encounter a much lower percentage of dropouts than would be otherwise the case (Sue, 1998).

Cultural Competence

In its broadest context, cultural competence is the ability to effectively treat addictive disorders in a therapeutic group setting cross-culturally. According to Cross (1998), it is a set of behaviors, attitudes, and policies that come together to enable a therapist to lead group therapy

effectively in cross-cultural situations. Cultural competence is an ideal goal toward which a therapist must thrive. It is a developmental process that depends on the continual acquisition of knowledge, development of skills, and continual self-evaluation (Cross, 1998). Cultural competence in treating addictive disorders rests on a unifying set of values about how treatment is provided to minority clients in a group therapy setting. These values stress that being different is positive, that group therapy must be responsive to specific cultural needs, and that addiction therapy is delivered in a way that empowers the minority client (Cross, 1998). According to Cross (1998) the culturally competent therapist: respects the needs of minority clients; acknowledges culture as a force in shaping client's lives; recognizes the value of family and community; understands the dignity of a client is linked to the dignity of his/her culture; acknowledges cultural diversity and how it affects group therapy; recognizes how personal thought patterns are different from those of minority clients; acknowledges that when working with minority clients, process is as important as product; and understands when values of minority clients are in conflict with the values of the dominant culture. Taken together, these assumptions provide the backbone of a truly cross-cultural model of group therapy. This includes the impact of cultural differences on addictive disorders, the family, and community as a starting point for cross-cultural group therapy.

Discussion

Assumptions and Limitations

The group process elicits feelings about one's own ethnic group with greater intensity than individual therapy. This is due to the individual facing others who are different from him or herself including the therapist (Corey, 2000). All group members experience an intense pressure to conform to the majority view, regardless of how scary or foreign it may appear to them (Zastrow, 2001). At the same time European-American group norms are generally not receptive to minority values. This often leads to splits among group members due to stereotyping, projection, misinformation and fear (Zastrow, 2001). Due to different values, self-consciousness and a feeling of representing their whole ethnic group, patients of a different racial or cultural group may often feel ill at ease in the group therapy process (White, 1999). Ethnic and visible minorities experience additional problems relating to the group, due to dissimilar value systems and at times split loyalties. The latter situation arises when the price of the desired change in the group is the alienation or disapproval from one's own cultural community (Chen, 1999).

Racial and ethnic differences can significantly affect a person's diagnosis, assignment to a particular mode of therapy, transference, and the client-therapist relationship. Thus a minority group patient may get a more severe diagnostic label and may be referred to a group because the interviewer did not want to see the person in individual therapy (White, 1999). Minority clients may have a strong authority transference to their therapist, while the therapist may respond to such a group member in a negative fashion or an over-protective positive fashion, depending on their counter-transference with their client (White, 1999).

Ethnic and cultural differences can lead to increased resistance, especially when sensitivities specific to a particular race are overlooked (Diller, 2004). Distinguishing between cultural and personal distrust and animosity is particularly relevant in ethnically heterogeneous groups. Many minority members are too inhibited to self disclose, fearing stereotyping and negative implications for their ethnic group (Leary, 2002). They perceive themselves in the group not just

as individuals but also as representatives of their ethnic group. Therefore, an Afro-American man in an all Caucasian group, who in his individual assessment complained about his mother abandoning him at the age of ten, came to her defense when the event was later discussed in his group (Jenkins, 1998). Self-disclosure for minority members is more difficult unless trust has been established and patients feel that the group will relate fairly to their personal backgrounds (Corey, 2000).

Heterogeneous Groups

The degree of racial harmony or polarization in the community is likely to impact significantly on the group's composition, dynamics and outcome (Salvendy, 1999). It is therefore more feasible to have a racially heterogeneous group set up where members of different ethnic groups having ongoing contact at school, work, and socially than when they exist in parallel societies (Silverstein, 1999).

The commonest defense mechanisms in ethnically heterogeneous groups are denial, intellectualization, projection and polarization (Addison, 2001). The members may not want to discuss their biases and differing views, pretending that all is harmonious, or may make-up stories to explain their differences. They may also project their fears and prejudices of each other or focus on real or imaginary differences to keep the group from working (Leary, 2002). Therapists should also be aware that a minority member might use the reality of racial discrimination in the service of resistance (Ivey, 1998). Issues of common racism may also mask hidden but unresolved issues; thus parental rejection could be presented in the group as racial discrimination (Addison, 2001).

It is also likely that more of the therapist's authentic feelings will be elicited more in the group therapy process than in individual therapy, as group therapy resembles real life much more individual therapy (Gordon, 2004). In group therapy not all the negative reactions to the therapist are due to transference, some may be in response to insinuations by the therapist. The racial or ethnic differences between the patients and the therapist are among the most avoided areas in treatment usually with negative results for the patient (Addison, 2001). Cultural sensitivity practiced in group therapy can help to impart information about an understanding of the clients and therapists way of life.

Familial Influence

Family structure and dynamics are completely different for Asians, Afro-Americans, South Asians or Middle Easterners than they are for the European-American (Chen, 1999). Social pressures to conform to a particular culture's norms can wield enormous influence upon an individual group member, and if not recognized by the group can lead to injurious results (Sue, 1998). Thus the intrusiveness of some Italian parents or the major role of in-laws in the (East) Indian culture has to be seen in its perspective. It is also noteworthy that in some culture's, Asian for example, conflict cannot be directly expressed and is often internalized (Sue, 1998).

When working with Asian group members who are first generation immigrants, one may note their acceptance of authority and authoritarianism as norms, and face-saving as being of utmost importance (Chen, 1999). Such group members will be more deferential to their parents and the therapist, more reserved in their emotional expressions and may feel more reluctant to criticize members of their families. They may also have a much more pragmatic view of life and

of interpersonal relationships (Chen, 1999). Therefore, some Asian group members may be at times confused and feel anxious about the group's emphasis on verbalization, confrontation, individuation and autonomy (Chen, 1999).

Therapist Competence

The therapist's aim in the group is to improve the ability of minority members to relate to the group and thus increase the effectiveness of their group therapy treatment. Therefore, authenticity and independence should be fostered along with the ability to resist pressure (Corey, 2000). An effort should be made by the therapist not to impose European American standards to the detriment of the ethnic group members (Salvendy, 1999). Thus a group containing a single widowed or divorced traditional Moslem or orthodox Jewish woman needs to adjust its expectations (the group leader should facilitate this adjustment) and norms to what is acceptable to these minority women when dating or premarital sex is being discussed (Sue, 1998).

A therapist should perform a thoroughly informative assessment of a minority group candidate; this is needed to understand their concerns prior to starting them in group therapy. Such an initial assessment is essential to ensure the settling and thriving of a minority person in the group therapy process (Addison, 2001). During the preparatory assessment a minority client's expectations and goals should be clarified, the client should be informed what to expect with respect to their different ethnicity, and how the therapist plans to deal with the many issues arising out of this situation (Jenkins, 1998). Such an assessment should also touch on the different ethnic backgrounds of the candidate and the therapist, and allow for an open discussion of the feelings and approaches involved (Diller, 2004). Therefore, therapists who have strong negative reactions to certain or all minority group members should not treat such patients, as the results are likely to be less than optimal (White, 1999). In fact therapists in addiction therapy who have strong negative reactions to certain minority groups should find another line of work.

Therapists and their group members are often ignorant about minority cultures or harbor misperceptions that are best attended to early (Diller, 2004). In ethnically heterogeneous groups the leader should aim to establish a broader set of norms, which take cultural variables into account (Curry, 2001). Beyond the simple knowledge of behavioral differences the therapist and group members should strive to understand both the real and the symbolic meaning of the many socio-cultural factors involved in ethnically heterogeneous group therapy (Zane, 1998). Thus a therapeutic group setting that includes assertiveness, challenging and confrontation may be viewed as very dysfunctional by an Asian group member whose own family disapproves of such behavior (Chen, 1999).

Stereotypes, misinformation and projection often result in fear that disconnects people who are different (Vega and Gill, 1998). When therapists and/or group members consider the minority member as a representative of that ethnic group by focusing on stereotypes they risk devaluing that member's individual life experience and may inflict on them psychological damage (Ivey, 1998). Therapists on the other hand are available as models by containing anxiety and anger, standing firm in the face of perfunctory glossing over, accepting individual differences and by demonstrating a willingness to integrate a variety of cultural experiences (Ivey, 1998).

Effective therapists acknowledge and validate the unique life experience arising out of the relationship between the majority and minority cultures in a therapeutic group experience (Zane, 1998). Therapists and group members should be educated about the norms and life-styles of the minority group member in order to discern which behaviors are symptomatic of personal psychopathology and which are attributable to cultural influences (Curry, 2001). Therapists can help the group to move from concrete discussions to those of a culturally sensitive nature, by focusing on the universal affective responses to experiences such as physical or emotional deprivation, a variety of losses, separation and family conflict as they are manifested in different cultural contexts (Chen, 1999).

Therapeutic Focus

Trust must be fostered not only between the minority member and the therapist but also among all the fellow participants (Corey, 2000). The successful integration of ethnic members cannot be based solely on the imparting of information by the therapist, unless this information is accompanied by a corrective emotional experience that will make this group process truly therapeutic (Holmes, 1998).

A therapeutic focus that includes ethnicity can help individuals resolve identity conflicts. It allows visible minorities and second generation immigrants to integrate enough of the mainstream culture to be functional socially at home and at work without having to deny the importance and meaning of their own culture to their sense of well being and integrity (Addison, 2001). If the therapist acknowledges in group therapy the positive aspects of a particular culture, this will allow clients of that culture to feel more comfortable and important (Zastrow, 2001). For example, Latino families emphasize strong family bonds, strong moral values and well organized social, cultural and community activities; by emphasizing these facts a Latino client will feel more like a part of the group.

If there is a perceived imbalance of power between majority and minority group members it needs to be addressed immediately by the therapist for group therapy to be effective (Corey, 2000). In some groups it may be a more pronounced problem than in others. In some cases the risk also exists that majority members overcompensate and invest the minority member with special powers not available to anyone else (Corey, 2000). Thus in a newly formed therapeutic group the only Afro-American woman kept coming considerably late to several early sessions, giving rather flimsy explanations for her tardiness. The rest of the group ignored these occurrences until the therapist confronted them with it several sessions later, and only when they perceived his approval; the late-coming patient was finally challenged (Curry, 2001). Due to the intense nature of the group proceedings all parties are prone to misinterpretation, and therefore the clarification of communication in ethnically heterogeneous groups is particularly important. This is even more imperative if some members of the group are immigrants and may not have a full command of the language or are difficult to understand due to their accents (Chen, 1999).

It is helpful to have minority patients first attend individual therapy, where trust, rapport and credibility are established, and then transfer them to a group with the same therapist, often keeping the option of some parallel individual sessions open (Corey, 2000). This will facilitate their adjustment and cause them less anxiety once they enter group therapy. One should also be aware that the minority members' adjustment to the group majority's cultural norms might not serve them well in their own communities (Leary, 2002). The group leader has to gauge how

much change in a particular direction is adaptive outside the group for minority members who may spend most of their time within their own communities (Leary, 2002).

Therapists are not immune to biases towards minorities, and being alert to their own stereotypes will allow them to have less counter-transference feelings that may show itself in a number of forms (Holmes, 1998). To compensate for feelings of guilt related to their own prejudices, therapists may not confront minority patients or may grant them special privileges (Gordon, 2004). At the other extreme, due to their feelings of hostility therapists may exhibit aggression and be too confrontational. If the therapist is overly curious regarding the minority member's culture it may impede therapeutic work in the group, as the patient's personal dynamics are likely to get lost (White, 1999). In this case the therapist should schedule some individual sessions with the client to ask questions about the clients culture.

Therapists should watch for signs of negative transference and mistrust by a group member of a different racial background. As ethnicity and race are emotionally loaded issues therapists may repress their own personal stereotypes and fall short of working through them (White, 1999). When the therapist notices clues in either of the above situations they are best addressed early before the therapeutic efficacy suffers (White, 1999). At the same time therapists should be able to perceive to what extent the minority members behavior or attitude is deviant or conforming not just to European-American standards but also to the values of their own ethnic group (Jenkins, 1998).

Summary

Treating addictive disorders in a therapeutic group setting that is conducted with the knowledge and acceptance of other ethnic groups and cultures and sensitivity to their values enables visible and ethnic minorities to relate better to others, improve their own self esteem and retain a sense of self respect and autonomy (Holmes, 1998). Group therapy has an inherent change-oriented focus, when setting individual goals for clients; their particular view of the world has to be appreciated so that they can safeguard their principles (Silverstein 1999). Therefore, different cultural, social and religious imperatives have to be assessed in their proper context and should not be overridden by a white, secular, Judeo-Christian middle class gold standard (Silverstein, 1999).

The cohesiveness and effectiveness of multi-ethnic group therapy treating addictive disorders can be measured by the degree that its members feel free to discuss their feelings about the group and its members, including the member's tendency to stereotype (Ivey, 1998). Another way to measure the effectiveness of group therapy treating addictive disorders is to measure what extent members feel free to express criticism or caring for each other (Corey, 2000). There is increasing evidence that interracial and/or interethnic group therapy treating addictive disorders can be effective if the minority members satisfy themselves that the therapist is sensitive to their socio-cultural and personal situation (Jenkins 1998). These types of ethnically heterogeneous groups operate successfully when the therapist manages to create a common bond for the participants despite diversity. The above observations and considerations highlight the pivotal role assumed by therapists who work with ethnically heterogeneous patients (Ivey, 1998). It is therefore crucial that therapists dealing with such a clientele educate and sensitize themselves to the particular cultures they are dealing with (Holmes, 1998).

It may not be possible for a single therapist to master a whole gamut of different cultures (cultural competence) but one should be open to learning about different cultures by asking new minority clients appropriate questions. As no therapist is likely to be completely free of bias, one should be able to recognize personal bias and watch out for its manifestations (White, 1999). When therapists manage to treat minority members more competently through modifications of attitude and technique it helps to lessen social tensions and increase racial harmony (Ivey, 1998). When a therapist is culturally sensitive and educated; treating addictive disorders in a therapeutic group setting is much more effective and positive process.

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