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Spirituality, Culture, and the Process of Assessment in Recovery

Pascal Scoles*

Abstract

Background: The narrow perspective of the medical/psychiatric model of care doesn't adequately consider advocacy groups in its concept of community health care. The central issue to positive mental health, and the resolution of life problems, such as alcohol or other drug challenges, gambling, abuse, etc., is partly vested in a robust recovery management system that is sensitive to the spiritual and cultural needs of consumers. The continued indifference in clinical assessment protocols of ethnic and cultural identity is a significant variable that impacts a person's concept of belonging and further defines a person's relationship to the dominant cultural standards of health. The mental health professions appear reluctant to embrace a program of healing that includes people with the "disease" who believe that long term recovery from their "disorder" is not just biological and psychological but also communal and spiritual. This historical neglect of recovery-oriented supportive communities is one of the helping professional's greatest weakness.

Keywords

Psychiatric model; Community health; Alcohol; Substance use; Gambling

Introduction

Professionals working in the field of substance use and abuse are engaged in a movement away from the conventional disease-treatment model of care, with its emphasis on diagnosis and subsequent treatment, to a more holistic approach to recovery resilience and transformation. This approach addresses the mind/body/spirit in its entirety and reflects an understanding of the power that faith, spirituality, personal empowerment, and community have on the healing process [1]. However, as revolutionary as this model may be for many practitioners within the helping professions, this holistic approach to healing human suffering traces its practices throughout the religions of Judaism, Christianity, Islam, Hinduism, Buddhism, Taoism, and the first Earth-Based religions [2-4].

While there are still theologians who preach that natural disasters are God's wrath against human frailties, many present-day faith leaders have adopted a more complex view of behavioral health challenges.

Religion and spiritual leaders in the post-modern era emphasize a human race fallen out of harmony with the natural earth and living in isolation from family and community. Through the excessive and careless misuse of resources, humans have set the globe on an unsustainable course. Technological advances have empowered humans to travel, explore space, or communicate via the internet with colleagues anywhere in the world. This empowering communication has not stopped the pace of human experience from being more isolated or dehumanized as a people or a nation [5].

Faith and Spiritual Communities as a Form of Healing

Part of humanizing the above technological advances can be found in the faith and spiritual communities. Buddhist practice encourages a return to a more ecologically balanced way of being in the world to preserve our natural resources, sustain the entire population, and engage in the community as a sacred experience. Doctrines from all the major religious faiths urge the act of giving to others. The Third Pillar of Islam is almsgiving. Buddhist practice underscores giving to those in need as the beginning of the path to Nirvana. Judaism teaches the act of doing a good deed for another as a path of the book of life. In Hinduism, Vedic theology promotes the sharing of personal wealth with neighbors in one's community who are less fortunate. A basic tenet of Christianity is to give relief to the needy and bring comfort to others who are suffering. These deeds may pay homage to one's faith, but the act itself is also a form of building and strengthening one's community. These deeds are a recognition that the human condition is a shared cultural and collective experience and honors the mutual relationship between individuals, families, and their communities [6,7].

While human pain and the human condition, in general, predisposes us to existential crisis and feelings of disempowerment at both the individual and communal level, the practice of rites, rituals, and ceremonies traditionally acted as a path to recovery, resilience, and transformation. Rites and rituals that constituted religious practices, empowered believers, gave them a structure for creating meaning out of their suffering and offered a path to spiritual healing. A Cree Indian word, *Oenikika*, translated as the breath of life, was the traditional purification ceremony practiced by First Nation people in the Americas. A sweat lodge was built from branches, covered with tarps and blankets, and contained lava rocks and fire to emit steam. Specific ceremonies varied from tribe to tribe. Still, for all Native people, who use this tradition, the ceremonial lodge was constructed for sacred space, time for prayer, transformation, and healing of the spirit [8].

Historically, these practices of religion through rites, rituals, and ceremonies not only created meaning to human existence, but they also fostered a culture of community and group cohesion and identity, as opposed to a more isolated and dehumanizing sense of identity. For example, during the *Oenikika* Ceremony, as many as thirty tribal members sit in a circle at one time offering prayers of thanks and praise for the Great Spirit. After worship, the participants bring in food and gifts for the medicine man or woman leading *Oenikika*; this practice of gathering together for thanksgiving, prayer, and healing solidified social values and strong communal bonds [8].

***Corresponding author:** Scoles P, Community College of Philadelphia, Behavioral Health and Human Services, Philadelphia, USA, Tel: 6103892096; E-mail: pscoles@ccp.edu

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The historical shift of one's collective identity, which had solidified social and communal bonds, at least for Native and African people who endured holocausts, the destruction of kinship models, the tearing of the fabric of their very cultures was not a simple matter of free choice. Humans experience the self in isolation rather than in the community, where the immediacy of human contact once gave accurate feedback on how people connect. Instead, community and cultural experiences were defined by mass media and technologically based social networks. Large portions of society prefer to tune into reality television shows such as Survivor to watch human beings creating a false community. Internet-based social networks such as Facebook and Twitter have become the alternative meeting places for connecting with friends, family, and acquaintances. These artificial constructs, reality TV, Facebook, Twitter, etc. continue to create what Fromm (1941) described as a discrepancy between one's *"authentic self"* and creates a *"psychic dissonance"* that erodes emotional health [9].

Categorization and Assessment of Mental Health Challenges

The isolation of the human experience in conjunction with the biomedical perspective (as opposed to the psychosocial or spiritual) of psychoanalytic theory helped the emerging behavioral health professions join the mainstream of "medical science." To be recognized by the nineteenth-century medical community, the science of mental health had to develop a system in which complex psychic phenomena were explained in terms of more straightforward, physically measurable data that followed scientific laws and were reasonably predictable. Historically, if the above science did not develop, the study of mental health would be reduced to non-scientific or mystical explanations. In turn, it would negate the evolution of the assessment and treatment of mental health issues and have a significant impact on the legitimacy of the evolving profession of psychiatry and, to some extent, psychology [10].

Historically, Sigmund Freud's break with Carl Jung was more about the mundane effort to separate behavioral health challenges from religion and spirituality to join the mainstream scientific medical community. The need for diagnostic labels, which attempt to explain life in a singular dimension, primarily physical and mechanical, with little consideration to one's culture or spirituality, was a necessity if the emerging profession of psychiatry was to establish itself as a part of medicine. Although psychiatry has tried to merge biomedical, psychosocial perspectives and, to some extent, spirituality in the diagnosis of behavioral health issues, the language does not sufficiently disguise its biomedical bias. Surely psychiatric labels do help one converse with professional colleagues and comply with managed care requirements (reimbursement agents). Still, the person in front of the therapist is more than a label and higher than modern science [11].

The Community Mental Health Movement

In 1961 a national mental health study was published titled "Action for Mental Health." The study attempted to shift the care for "psychiatric patients" from the state mental health hospitals to community- based facilities. The Community Mental Health Act of 1963 established mental health centers, consultation, and prevention, and to provide services to as many people as possible from all different cultural perspectives. These new Community Mental Health Centers (CMHC's) were intended to change society overall and solve various social problems. While this new "community psychiatry" approach extended an atmosphere of hope and optimism in the community-based psychiatric field of practice, it fell short of its goals.

The initial intent was to deinstitutionalize the warehousing of people in long-term care psychiatric hospitals in which most physicians believed that treatment was the exception rather than the rule. Partly based on the ignorance of the medical perspective and the new wave of psychotropic medications in the 1950s and early '60s, people were being released into the community with a "bag of medicine" with no integrated aftercare plan. The 1963 report, "Action for Mental Health," promised a psychiatric revolution of care and treatment that would shift to the home environment of people receiving services. The enormous amounts of money that would be saved because people receiving psychiatric care would no longer be hospitalized would be redirected to the entire community through community psychiatry. As we know today, the state hospital population was dramatically reduced, but only a small fraction of the money followed the patient into the community [12].

Almost sixty years later, the medical model of care that put individuals into the asylums was primarily responsible for moving the mental health problem out of the dark ages of the state hospitals and into the dark ages of community psychiatry. Practitioners in the field changed their name and shifted the place of practice to health care but, overall, continued to oppress and relegate people receiving services to second-class citizenship. The inability to abandon traditional medical models of care by many psychiatrists, and to lesser degree psychologists and clinical social workers, significantly contributed to the failure of the community mental health movement. The minimal success of psychosocial rehabilitation approaches stands in direct contrast to the continuing community health disaster of people living with serious mental health issues who share with their peers living with addictions and those who had formally committed crimes a sense of helplessness and despair. Without reinventing asylums or discovering a magic bullet to cure serious mental health challenges, the field of behavioral health continued to rely on mental health policies, practices, and services without adequate financial support for community care [13].

The community mental health movement has mainly failed because it was unable to deal with the community, its culture, its definition of deviance, its stresses, and its supports. Furthermore, it has given no more than lip service to the community prevention of mental disorders (health issues). Psychiatry is quickly withdrawing from the community and returning to the hospital before the failure becomes too apparent [14].

Culture and Ethnicity

Generally, culture is expressed as a shared, learned, system of values, beliefs, and attitudes that shape and influence perception and behavior. Culture is expressed through traditions, customs, art, folklore, history, norms, and institutions of a given people. Ethnicity (at times referred to as minority membership) is an integral part of one's culture and must become an essential part of one's behavioral health recovery. At present, there is insufficient research on the relationship between ethnic and cultural differences and their effect on the assessment, diagnosis, and treatment of dysfunctional behavior. Research on personality and maladaptive behavior has increased about similarities and differences and the impact these differences have on individuals

living in different communities [15,16]. Differences become relevant in that clinicians must understand and be comfortable in their world views, be knowledgeable about the world views of the people receiving services and attempt to understand these views without making negative judgments [17,18]. Unless counselors consider the social, cultural, and community context of an individual, it is almost impossible to understand that person's struggle. For example, research on cross- cultural comparisons of emotional disturbance and its expression has shown that depression often has very different meanings and interpretations in different societies. Most cases of depression worldwide are experienced and expressed in real terms of aching backs, headaches, fatigue, and a wide assortment of other somatic symptoms that lead individuals to regard this condition as a physical problem. Only in contemporary Western societies is depression seen principally as an intrapsychic experience [19].

Clinicians need to take account of cultural factors concerning cultural variations in emotional expression, body language, and religious/spiritual beliefs and rituals within societies such as the United States.

To transform health care delivery, stakeholders in the behavioral health community had to re-evaluate the way they assess individuals while being sensitive to an individual's culture and ethnicity regarding diagnosis and treatment. The purpose of diagnosis is to identify areas of disruption in an individual's life that harm current behavior and lifestyle. The danger in this restrictive perspective is that the clinician will often fail to consider ethnic and other cultural and community factors that influence behavior. The need for a more environmentally sensitive classification system, one that acknowledges the role that cultural and community factors play in behavioral health issues, and clinical judgments about them, is a topic of much debate. Historically, this cultural insensitivity has led to labeling (stigmatizing) individuals with inappropriate disorders. Certain behaviors and personality styles, when taken out of their ethnic or cultural context, could be viewed as deviant or dysfunctional when, in fact, they were culturally congruent. There is increasing pressure for practitioners to become more knowledgeable, comfortable, and skilled in working with individuals from different cultures, ethnic backgrounds, sexual orientations, genders, gender identities, and religious/spiritual orientations. A multicultural strength-based concept focuses on what the person is already doing that is successful [20].

The strength-based perspective of direct multicultural engagement is a paradigm shift away from the historical treatment emphasis on psychopathology, disease, and disorder. It attends not to personal deficits but accents resilience, strengths, gifts, and capacities. The strengths perspective is primarily a philosophy or way of interpreting information about our body, mind, and spirit that reinterprets self- defeating behavior, guilt, feelings, and dysfunctional relationships. The strengths approach is a more positive framework in which an individual's life struggles are viewed as healthy, intelligent, and emotional responses to life events that might involve unwelcome incarceration, psychiatric hospitalizations, ethnicity/nationality, cultural differences, etc. The goal of all human interactions is to assist with the identification and augmentation of an individual's strengths and resources. There is an expectation that resources exist both in the person and in their broader environment. It is assumed that the individual and the individual's supporters know best how to utilize these resources [21].

The strength-based perspective allows one to view *"pathology"* from a broader wellness transformative function. This perspective is particularly relevant to behavioral health challenges and the development of resilience and protective factors in children and adolescents because it helps people recognize the more expansive worldview that one must create and make a part of their new reality [22]. This new worldview system brings a different perspective to an otherwise blind life during mental health or alcohol and other drug challenges [23].

Assessment

The Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association discusses no real distinct cultural or ethnic patterns that could influence the diagnostic process and, in turn, bias an evaluator from pursuing a strength-based plan. The DSM does not deal with cultural variations in the expression of maladaptive behavior. Even though culture and ethnic background do influence symptoms and etiology of many disorders. Cory cautions the clinician about misdiagnosis [24].

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM classification to evaluate an individual from a different ethnic or cultural group. A clinician that is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience that are particular to the individual's culture.

Many social scientists believe that ethnic identity is a significant cultural variable that impacts a person's concept of belonging with other members of a subgroup and defines the individual's relationship to the dominant culture. These shared influences can affect a person's willingness to seek help concerning mental health challenges. Additionally, a person's cultural perspective impacts how he/she may describe his/her problems to a professional worker [25]. Concerning shared experiences, the counselor doesn't need to be in recovery or a survivor of trauma to help an individual. What is more important is that the helper possesses or is receptive to a similar set of feelings and struggles. Sometimes our differences are as significant as our similarities. If an evaluator is oblivious, apathetic, and unskilled regarding a person's values, beliefs, and customs, his/her culture, ethnicity, or recovery has little if any bearing on the individual's competence. Insensitive Euro-Americans (Whites) are just as problematic as insensitive African Americans, Asian Americans, Latinos, or Native Americans. Cory in discussing culture in clinical practice, established some practical guidelines for working effectively with people from diverse populations [24]:

- Learn more about your own culture and how it has influenced your behavior and thoughts about others
- Identify for yourself underlying assumptions about culture, race, ethnicity, gender, etc
- Expand your knowledge and experience with other cultural groups
- Learn to find your common ground with people of diverse backgrounds
- Recognize the importance of being flexible in the application of techniques that benefit different cultures

Two factors need to be emphasized concerning the above guidelines:

- Many Euro-Americans (Whites) have limited experiences with communities of color, their cultures, and their concerns and often labor under the belief that the ways of the dominant culture are preferred. Generally, Americans continue to go to different schools, live in non-integrated neighborhoods, attend segregated churches, and socialize in different parts of the community. Social scientists, as well as many others, believe that groups who live separately have difficulty understanding each other, trusting one another and generally, know very little about the social and cultural realities of individuals with different world views. Book knowledge about culture is not the same as living with and experiencing different cultures. Too often, individuals enter the healing professions with no meaningful contact or exposure to other cultures
- The interpersonal relationship or the development of effective therapeutic relationships foster the kind of respect, professional courtesy, and competence that helps experienced, skilled practitioners work effectively with culturally dissimilar people. Expertise in assessment and treatment requires that the counselor have enough breadth and depth in (1) cultural awareness and sensitivity, (2) a body of multicultural knowledge and experience, as well as, (3) a specific set of practice skills [26]

If culture and ethics represent the vehicle in which we travel through life, the interpersonal relationship is the fuel that moves us through our life process. How the body, mind, and spirit become acquainted with one another is through our ability to interact with the environment and community. That interaction between conscious and unconscious activity balances the arrogant and insensitive, reads the non-verbal gestures, facial expressions, etc. and it helps shape the social encounter, leading to self-management and social competence. Without the interpersonal experience, there could be no journey, and without the tour, there could be no path to recovery. Counselors of various therapeutic orientations widely accept that human interaction is an essential part of the helping relationship. The core social interaction skills needed to help people develop better-coping behaviors focus on Empathy (accurate understanding), Respect (positive regard), and Genuineness (congruence). Through empathy, genuineness, and unconditional positive regard, helpers create the foundation for services that promote recovery and resilience in people experiencing behavioral health challenges [27-29].

Conclusion

A comprehensive view of recovery from drugs and alcohol must be sensitive to an individual's culture, ethnicity, and encompass an individual's whole life, including mind, body, spirit, and community. The assessment should holistic and includes addressing self-care practices, family, housing, employment, transportation, and education, clinical treatment for behavioral challenges such as primary healthcare, dental care, complementary and alternative services, faith, spirituality, social support networks, and community participation. The array of services and supports available should be integrated and coordinated.

References

1. Mark Salzer, Sable M Menkir, Jeff Shair, Richard Drain, LaKeetra McClaine (2006) Collaborative jointly developed the Community Integration resource packet on Community Integration and the Department of Behavioral Health and Intellectual disability Services (DBHIDS), City of Philadelphia.
2. Matthews W (2013) World Religions, 7th Edition. Cengage Learning, p: 464.
3. Crowley V (2000) Jung: A journey of transformation: Exploring his life and experiencing his ideas. Wheaton Illinois: Quest Books.
4. Jung C (1964) Man and his symbols. New York: Anchor Books, pp: 1-322.
5. Schramme T, Edwards S (2017) Handbook of the philosophy of medicine. Springer Press.
6. Gitterman A , Germain CB (2008) The life model of social work practice: Advances in knowledge and practice (3rd edition). New York, NY: Columbia University Press. p: 632.
7. Scoles P (2020) Faith, spirituality, and resilience in recovery. Kindle Publication.
8. Null G (1998) Secrets of the sacred white buffalo: Native American healing remedies, rites and rituals, paramus, NJ: Prentice-Hall, pp: 350.
9. Fromm E (1941) Escape from Freedom New York: Rinehart and Co.
10. Scoles P (2019) Assessment and service planning in recovery. CA: Cengage Learning.
11. Epstein M (1995) Thoughts without a thinker. New York: Basic Books, p: 272.
12. Sharfstein S (2000) Whatever happened to community mental health? Psychiatr Serv 51: 616-620.
13. Geller JL (2000) The last half-century of psychiatric services, as reflected in psychiatric services. Psychiatr Serv 51: 41-67.
14. Murray JE (1975) Failure of the community mental health movement. Am J Nurs 75: 2034-2036.
15. Jackson J (1991) Life in black America. Newbury Park, CA: Sage.
16. Uba L (1994) Asian Americans: personality patterns, identity, and mental health. New York: Guilford Press. Nurturing young black males. Washington, DC: Urban Institute.
17. Jeff M (1994) Afrocentrism and Afro-American male youths. In R. Mincy (Ed). Nurturing Young black males. Washington, DC: Urban Institute Press. pp: 99-118.
18. Moore Q (1994) The whole new world of diversity. J Intergroup Relations 20: 28-40.
19. Jenkins JH, Kleinman A, Good BJ (1991) Cross-cultural studies of depression. In J Becker and A Kleinman edition, Psychosocial aspects of depression. Lawrence Erlbaum Associates Inc, pp: 67-99.
20. Meyer O, Zane N (2013) The influence of race and ethnicity in clients' experiences of mental health treatment. J Community Psychol 41: 884-901.
21. Saleeby D (1997) The strengths perspective in social work. (2nd edition). Boston: Allyn and Bacon.
22. Scoles P (2020) Health and the healing process of recovery. J Addict Recovery 3: 1018.
23. Singer J (1994) Boundaries of the Soul. New York: Doubleday Publishing.
24. Cory G (2013) Theory and practice of counseling and psychotherapy. New York: Brooks/Cole Publishing Co.
25. Olandi M (1992) Defining cultural competence: An organizing framework. In: M. Olandi (Ed) Cultural Competence for Evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities. Rockville, MD: U.S. Department of HHS.
26. Leong FTL, Kim HHW (1991) Going beyond cultural sensitivity on the road to multiculturalism: using the intercultural sensitizer as a counselor training tool. J Counsel Develop.
27. Sommers-Flanagan J, Sommers-Flanagan R (2018) Counseling and psychotherapy theories in context and practice: Skills, strategies, and techniques. John Wiley and Sons, pp: 592.

28. Scoles P, DiRosa F (2018) Social determinants of health and behavioral health challenges. Counselor 19.
29. Scoles P (2020) Building recovery resilience through culture, community, and spirituality. J Behav Health 9: 1-5..

Author Affiliations

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