



Transcript:

Integrating Cultural Competency & EPB's When Treating African Americans With Substance Use Disorder (M.2)

Presenter: Mark Sanders

MAUREEN FITZGERALD: For today's presentation, Integrating Culturally Competent Practice with Evidence-Based Practices with African-Americans with Substance Use Disorders. Our presenter today is Mark Sanders, LCSW, CADC. This presentation is hosted by the Great Lakes Addiction Technology Transfer Center, the Great Lakes Mental Health Technology Transfer Center, and the Great Lakes Prevention Technology Transfer Center. We are funded by the Substance Abuse and Mental Health Services Administration. And we're funded through the following cooperative grants.

We'd like to let everyone know that, at the time of this presentation, Dr. Elinore F. McCance-Katz is Assistant Secretary of SAMHSA. The opinions expressed in this presentation are the views of the speaker and do not reflect the official position of the Department of Health and Human Services or SAMHSA. This presentation is part of an online series. If you'd like more information, please contact the Great Lakes ATTC.

Our presenter, Mark Sanders, LCSW, CADC, is the author of five books focused on behavioral health. Recent writings include Slipping Through the Cracks-- Intervention Strategies for Clients with Multiple Addictions and Disorders, Recovery Management, and Relationship Detox-- Helping Clients Develop Healthy Relationships in Recovery. He has had two stories published in The New York Times best-selling book series, Chicken Soup for the Soul.

Mark's numerous awards include a Lifetime Achievement Award from the Illinois Addiction Counselor Certification Board. His 30-year career and behavioral health includes teaching at the University of Chicago, the Illinois State University, the Illinois School of Professional Psychology, and Loyola University of Chicago School of Social Work. Mark also created and curates the online museum of African-American Addictions, Treatment, and Recovery.

Today's presentation will cover the following topics-- defining cultural competence, cultural humility, understanding feedback informed treatment, using motivational incentives, and applying culturally competent practices in group therapy. And now I'd like to turn the presentation over to Mark Sanders.



MARK SANDERS: Thank you, Maureen. And I'd like to ask everybody listening to the webinar to join me in giving the Great Lakes ATTC a virtual round of applause for sponsoring this webinar series. And I'd like to start with one of my favorite quotes. "The flap of a butterfly's wings In Brazil can cause an earthquake in Texas. The flap of a butterfly wings in Brazil can cause an earthquake in Texas." And I'd like to take a moment to explain that quote using a story.

So on March of 1986, I was sitting in my office in downtown Chicago. And the phone rang at 9 o'clock on a Monday morning. It was an African-American male who called. And he was in tears. He was crying. He said, I need to see a counselor today.

I looked in the appointment book, and I said, I can see you in one hour. He said it will take eight hours. He lived on 103rd Street South. My office was located downtown Chicago on Jackson and State Street. He walked 103 blocks to meet with me. Was he motivated?

He had gotten paid that Friday and spent his whole paycheck on drugs. So he called me at 9 o'clock on a Monday morning. He showed up exhausted and filled with remorse. And I knew that if I were to talk to him for a whole hour, his tears might have dried up, and he might not have felt like getting help. I've discovered in my 36 years as a drug counselor that, sometimes, you can talk to someone so long that you can actually talk them out of getting help.

So 15 minutes into the conversation, I asked, are you ready to get help? He says, I'm ready. I said, if you leave my office, and you go and stand on the corner of Jackson and State Street, a bus will appear. Take the bus to the end of the line. At the end of the line, you'll find a drug treatment center. And he said, I don't have bus fare.

And I was about to reach into my pocket to give him bus fare. Then one of my professor's voices came into my head. We're not about charity. We're about helping people help themselves. Give a man a fish, he eats for a day. Teach a man to fish, he eats for a lifetime. I reached into my pocket, then gave him bus fare. He walked 103 blocks.

I left my desk, and I waited for the bus. And I said to him, as I was paying his bus fare, at the end of the line, there's a drug treatment center. He came back a year to the day that I gave him that bus fare and gave it back and said that he was grateful for his recovery.

What I've learned in my 36 years as a drug counselor is that once you've helped someone with their recovery, eventually, gratitude sets in. And once they become grateful, they start doing good things in the world. Then the people that they helped start doing really good things in the world. And out of gratitude, those that they helped start doing great things in the world.



So it basically means that your good work never ends. So it really is true that the flap of a butterfly's wings in Brazil can cause an earthquake in Texas, that every bit of good that you do to promote recovery will be magnified.

Today's webinar is entitled Integrating Culturally Competent Practice with Evidence-Based Practices with African-Americans with Substance Use Disorders. And we'd like to start with a definition of key terms. And the first definition is a definition of cultural competence. It reads the ability to substantially understand, communicate, and interact effectively with people from different cultures.

Now, I've been doing these trainings on cultural competence for 25 years. And while I think that's not a bad goal to aim for, there's a part of me that believes that it's virtually impossible to be completely culturally competent. In fact, if you look at this definition, it suggests that once you have a certain amount of information, you have arrived. There are many experts who believe that you could read 300 books on Chinese culture, and there will still be some things about Chinese culture that you simply would not understand.

The next definition is of cultural humility. It reads, a lifelong process in which one first learns to increase self-awareness of their own biases, assumptions, and stereotypes-- now, I can tell you that I've been doing these trainings on cultural competence for decades, and I still have lots of biases, I make assumptions and stereotypes-- and the ability to challenge their own beliefs when they interact with others. Cultural humility involves the ability to acknowledge gaps in one's own knowledge of various cultures and an openness to learn new ideas and contradictory information.

So cultural humility really requires us to literally be humble and acknowledge that we do not know everything about our own culture or the culture of other people that we serve. And it challenges us to keep learning more. And the backdrop of this workshop is the belief that cultural humility is a much more realistic goal than cultural competence.

So the first premise of this webinar is that in this era of evidence-based practices, few, if any, models have been intentional about integrating or incorporating cultural competence into the model. I want you to take a moment to think about whether or not you know of any evidence-based practices that have been intentional about incorporating cultural competence into the model. And I often ask this question at live seminars, for people to raise their hand if they know of any evidence-based practice that incorporate culture intentionally, and never have I ever seen one hand go up.

"Each evidence-based practice introduces techniques. Techniques alone have no therapeutic value." Many of you have gone to school for years, spent thousands of dollars to learn techniques. And yet, the evidence indicates that not one technique in and of itself has therapeutic value. "They are only



valuable if the client finds it credible, influenced by the therapeutic relationship."

So I want you to think about the fact that there can often be tension, particularly in cross-cultural relationships-- counseling relationship-- between the counselor and the African-American client. And unless that tension is addressed, it doesn't matter whether or not you are a master in 10 evidence-based practices and you have a hundred techniques. It won't be effective until you're able to address the tension that may exist between you and the client.

So I pose some questions for you to look at a later date to examine your experiences and how they might impact your relationship with the African-American client with substance use disorders. You can begin that process by asking yourself questions like, what is your ethnicity, what has it meant for you to be a member of your own cultural group? What traumatic experiences have your ethnic or cultural group endured?

I want to take a moment and talk about the reason that question is very important. Well, you'll find that at the core of addiction for so many clients in general, and African-Americans specifically, is a history of trauma, both historical trauma and current trauma. And some clinicians might find themselves saying, well, I don't really relate to the client because I have never experienced trauma.

And in live seminars, I often point out that almost every member of every audience I've ever presented to is a trauma survivor. Some of you listening to this call will may be the descendants of former Africans who were enslaved. Some of you on this call may be the descendants of indentured servants. And these were individuals who were allowed to leave the prisons in Europe a few hundred years ago and work off their prison sentences through slave labor.

Some of you on this call may be Native Americans, coming from a group that has hundreds of years of massacre, trauma, and land taken away. Some of you listening may be refugees, coming to America, not seeking, necessarily, but escaping some horrible situations that you faced at home. Some of you on this call might be descendants of European immigrants who came to America several hundred years ago via Ellis Island.

In my live seminars, I often ask participants to raise their hand if they actually come from a family that migrated to the United States several hundred years ago from Europe via Ellis Island. And they raise their hand, and I ask, well, what's the reason they came? And my most common answers that I received include things like, my family came to America escaping World War II or escaping World War I or escaping Hitler or escaping religious persecution, poverty, or famine.



And I point out that these were all traumatic experiences. And so you are, really, descendants of trauma survivors. Now, how does that help? When we're in touch with our own trauma, it makes it easier for us to empathize with clients that we serve who also have histories of trauma.

As a member of your ethnic or cultural group, what are you most proud of? When did you first become aware of differences? When you were growing up, how did your community view members of other ethnic groups that did not reside in the community-- admiration, fear, hate, et cetera? And where and how did you learn biases, assumptions, and stereotypes?

So that final question, I want you to think about any biases, assumptions, and stereotypes that you may hold or have held in the past regarding African-Americans and to really just think about how you learned those. Because minus an examination of these areas, it's easy to bring those biases, assumptions, and stereotypes into our work.

So we're going to talk about the integration of culturally competent practice into evidence-based practices with African-Americans with substance use disorders. And we will use three evidence-based practices as case studies. So I often ask participants if they are aware of the differences between evidence-based practice and practice-based evidence. And almost every audience member has heard of evidence-based practices, but few have heard of practice-based evidence. So let me share with you what audience members have told me.

An evidence-based practice is a practice developed by a researcher or clinician, most often male. You know, so many of my current students have told me that most evidence-based practice they've studied, they have been models developed mostly by men. And in many instances, the individuals who develop the study hired their own researchers.

In fact, one of my colleagues, Dr. Jo Rosenfeld, said, when you are examining an evidence-based practice, you should first ask, who developed the practice, and who did the research? Because sometimes the person who developed the practice actually hired the researchers to prove that it was evidence-based. Others have taken it a step further, and they actually hire outside research firms to say, yes, this is truly evidence-based.

The primary difference between evidence-based practice and practice-based evidence, with an evidence-based practice, all the evidence comes from the model's developer's research. With practice-based evidence, all the evidence as to whether or not the approach is effective comes directly from feedback from clients.

Doctor Scott Miller said that feedback from clients, ultimately, is more important than even feedback from your immediate supervisor, as important



as that is. Because your immediate supervisor can watch you working with clients through a one-way mirror, conclude that you walk on clinical air, and if your clients do not return for the next session, it doesn't matter how good your supervisor thinks you are. That feedback from clients directly is of the utmost importance.

The developers of feedback or practice-based evidence actually changed the name of the approach to feedback-informed treatment. And feedback-informed treatment is included in the SAMHSA Registry of Evidence-Based Practices.

You can learn more about this model in a book written by Barry Duncan and Scott Miller called *The Heroic Client*. And through their research-- they did a mega-study, a 50-year study, on what helps counselors engage clients in counseling. And what they learned is that client engagement comes down to four factors.

The first factor is the model that's used, and every model has a name, like motivational interviewing and cognitive behavioral therapy and dialectical behavioral therapy. The second factor that helps us to engage clients in counseling is counselor hopefulness. In other words, there are many clients who come into substance use disorders treatment lacking hope. And as an addictions professional, you're very hopeful, and clients can borrow some of your hope.

The third factor that helps us to engage clients in counseling is the relationship that we establish with clients. And then, the fourth factor includes what we call client factors. And that will be the things that lie within the client. But I want you to think about what percentage of the client engagement process do each of these four factors account for. And as you think about that, we want you to put some percentages on that factor. And your ultimate number should add up to 100%.

So you could easily say that each of these four factors account for 25% of the engagement process, and that would be 100%. But it would be the wrong answer because some of these factors are more important than others. So here's the answer. Now, the clinical model that we use accounts for 15% of the engagement process. What the research suggests is that clinical models are about equal in their effectiveness, but every counselor using that model is not equal in their effectiveness.

Here's an idea, or an example. I have a colleague that works in Detroit, Michigan with African-American clients returning home from prison. And they are using a model called cognitive behavioral therapy, which is really smart because-- very smart-- because, for many individuals, continuous crime is about how you think, and cognitive behavioral therapy helps with thinking.



He told me that one of his counselors trained in cognitive behavioral therapy has one client no-show per month. Only one client misses the session per month. And another counselor trained in the same approach has three client no-shows per day, leading Scott Miller to conclude that instead of talking as much as we do about evidence-based therapies, we should talk more about evidence-based therapists, that some therapists are better evidence-based than others.

Counselor hopefulness accounts for 15% of the engagement process. Once, I presented those numbers in Las Vegas at a conference, and there was a woman who stood up and said, nonsense. Hope is 100%. And I said, let me tell you why hope is not 100%.

You're working with a client, an African-American male, who's been incarcerated from age 15 to age 45-- for 30 years, mostly in prison the whole time. He leaves prison, and he goes to a halfway house. The executive director of the halfway house hands him a piece of paper and says, you need to do a resume. You have 30 days to get a job, or you have to leave this halfway house.

He starts his resume off perfectly-- he spells his name correctly. Then it's all downhill from there. The only address he can put on the resume is the address of the halfway house, which happens to be located in a neighborhood where even the zip code is stigmatized. Under education, he puts eighth grade. In the section called work history, he puts a question mark. We think hope alone is only going to carry that guy so far. He needs some skills along with our hope.

The therapeutic relationship accounts for 30% of the engagement process. Now, I know you're thinking that that's inaccurate, that it accounts for 30% of the engagement process. That means that the most important factor in our ability to engage a client, at 40%, are things that lie within the client.

One way you know that might be true is that, in spite of all of your skills, the only way you can engage someone is if they allow you to engage them. This is critical, leading the authors of *The Heroic Client* to conclude that client engagement might be the number one evidence-based practice.

Let's talk about client factors. It includes things like success prior to the presenting problem. It's no military secret that the founders of Alcoholics Anonymous were quite successful. Dr. Bob was a surgeon, and Bill W. was a stockbroker. Doctors have an 85% recovery rate.

Another therapeutic factor that clients can bring to bear on their own recovery include things like individual and family resilience, cultural strength and pride, and love. I tell stories, so sometimes people stay at the end of my seminars, and they tell me stories.



So a woman told me the following story. She and her husband had a baby, and she asked her husband to go home to bring her some clean clothes so that she could wear clean clothes home from the hospital. She told me that her husband was gone for two days.

She said his sister showed up and said that when her husband went home, there were men robbing the house. And he went and got the family gun and held them at gunpoint and called the police. And when the police showed up and saw her husband holding a gun-- he was an African-American man-- they accidentally shot and killed her husband. She told me that she was to receive the largest settlement that anybody has ever received in Illinois history-- wrongful death-- police killing her husband.

She said, Mark, I was in the courtroom, when the judge opened his mouth. And the judge said, you will receive. She said right before the judge finished his sentence, there was a woman in the back of the courtroom who stood up and said, wait a minute, your honor. He's not her husband. I married him first. We never divorced. The second woman received a settlement.

Now, the woman who told me this story was a probation officer-- a very good one, I was told. Before she received this news of betrayal from her husband, approximately 35% of her caseload went back to prison. The national average is half. But when she received this news of betrayal, she was so bitter in her heart that her numbers swelled from 35% going back to prison to approximately 65%. Now, I imagine a number of you on this webinar can have some experiences that, if we don't work through them, they can impact our heart because of bitterness and impact our work.

She told me that, one day, she was at home feeling bitter and there was a ringing at her doorbell. And she said there was a 13-year-old girl standing there. And the girl said the woman who won the settlement is my mother, and the man who you married is my father. The girl told her before her mother received a settlement check, the state came and did a background check and found out her mother had been receiving public assistance forever, illegally, a felony in all 50 states.

The girl said, they put my mother in prison. When she was released from prison, she started using drugs. She neglected me. I haven't been going to school. I've been smoking marijuana. Can I live with you? Can I live with you? She told me that, against the recommendation of her family and friends, she told the girl, yes, you can live with me.

She said, Mark, I mothered this girl. Love brought me back, and it brought her back, too. She's now a college student. Love is the most important ingredient in all of recovery. Some clients, in spite of everything they've gone through, there are lots of people who love them, and they can bring that to bear on their recovery.



Employability, a good education, vocational skills, hope for the future, leadership qualities, faith, spirituality, someone's praying for them. Now, I've done lots of work with African-American adolescents with substance use disorders who've experienced their fair share of trauma. And I asked them what got them through all the things they endured. And the most common answer, I had a mother, or I had a grandmother, who prayed for me.

Extended family orientation. As you know, African-American culture is one of extended family orientation. My father died smoking crack cocaine, May 29, 1986. And a few months later, my uncle went in front of a judge and said, your honor, I don't want to go to prison this time. I want to go to drug treatment.

And the judge said, why should we put you in treatment? You've been committing crimes since you were a juvenile. My uncle said, your honor, my father died of alcoholism-- he was my grandfather-- my brother-in-law died smoking crack cocaine. Your honor, I don't want to die. I want to live.

And they put my uncle in treatment. He was the first person in the family to ever go to drug treatment. They called my uncle's 13 siblings to participate in family night. And none of them liked him because he had stolen from all of them during their addiction. So they said, we're not coming to family night. The counselor called back and said, we have food. My family said, we'll be there.

So my 13 aunts and uncles participated in my uncle's family night. And then they invited the nieces and nephews, and 26 of us attended. So 39 family members participated in family night at my uncle's treatment. And he got sober.

And he was the first person in the family to get sober. And we count 30 people in our family who've entered recovery since my uncle began his recovery journey. And he says to me that the bottom line was that I thought if I got my family back that I'd have a good reason to maintain my recovery.

So everything that I've said is true thus far about client factors and things that clients bring to bear on their own recovery. This suggests that in our work with African-American clients with substance use disorders, our first goal should be to establish an egalitarian relationship that is a relationship of equals, making sure that the client has a voice in their treatment plan.

So with feedback-informed treatment, an important tool is the session rating scale. And at the end of each session, the counselor gives the client a piece of paper called the session rating scale. And they're asked to rate the quality of that session today.

The reason that's significant is because too many counselors wait too long to get client feedback. Some counselors tell me they get feedback every 90



days. Others will say they receive feedback at the end of 30-day residential treatment. The problem that so many clients will drop out of addictions treatment by the second session.

So they recommend that we get feedback at the end of each session by giving clients the session rating scale, where they're asked to draw a vertical line through the horizontal line-- how satisfied are they with the session today? We have a lowest end and a highest end. So let's say a client places their vertical line as far left as possible. What you would ask them is, what would it take for you to move your rating of the quality of these sessions just a quarter of an inch further to the right? Whatever the client says, you do.

The research indicates that some client-- many clients-- who rate the early sessions at the highest level are often less likely to return to counseling than the ones who rate the early sessions lower. One reason being is that, often, when clients rate the sessions lower, it means they trust the process enough, and their connection with you, to be honest and tell the truth.

There are other ways of getting feedback from clients-- asking questions like, how was the session today? What worked? What did not work? And what would you like to see different in the next session? I have a colleague named Matthew Selekman, who asks other questions to get client feedback, such as, what questions do you think I have avoided asking you that are important for me to ask you? What do I need to know that would make you believe that we were on the same page and have more faith in my ability to help you? And what do you think I am missing that would make a big difference in your situation?

So I also want you to know that when you are working with African-American clients, there are some additional questions that you can ask them to get feedback, such as, from your perspective as an African-American, how do you view the problem? From your perspective as an African-American, what do you view as the cause of this problem? And from your perspective as an African-American, how do you believe the problem should be addressed?

I remember, years ago, working with a client, an African-American male. And the psychiatrist believed that his diagnosis was schizophrenia and alcohol use disorder. So the psychologist's recommendation for treatment included medication, psychotherapy, case management, and attendance to Alcoholics Anonymous meetings.

And from the family's cultural lens, their religious perspective, they believed the client-- their relative-- was demon-possessed, and they believed that the treatment should be a prayer and the laying of hands. What I observed is that the psychiatrist and the family listened to each other. And the psychiatrist listened to the client.



And ultimately, the treatment plan included psychotherapy, case management, medication, attendance at AA meetings, prayer, and the laying of hands. They were able to establish the type of relationship that I called earlier egalitarian. And they made sure that the client had a voice in the process.

I want to take a moment to talk with you about another evidence-based practice included in the SAMHSA Registry of Evidence-Based Practices called motivational incentives. I'm going to explain how this approach works and then I'm going to talk about how to tailor the approach to your work with African-American clients with substance use disorders.

I first want to ask you to take a moment and visualize the following scenario. Pretend that you are stranded on a desert island. And while on this island, you can have one piece of candy while you waited for them to rescue you. If you were stranded on a desert island, and you could have one piece of candy, what would it be? You know, the most common answer I get are Snickers candy bars and Reese's peanut butter cups. Oh, as I'm talking to you on this webinar, I can see how big your eyes are getting if you think about candy.

There was a doctor who worked with heroin users. And he offered his clients a piece of candy at the end of each session. And what he discovered is that if you offer the client a piece of candy at the end of a session, they were more likely to come back to the next session. So he wondered what would happen if he offered every other client who was addicted to heroin their favorite piece of candy. And what he discovered was that those clients who received the candy were more likely to come back to the next session than those who did not.

The doctor wrote an article about his findings, and they received a call from the National Institute of Drug Abuse. They invited him to do a study, the use of motivational incentives, which involves offering rewards to clients for achieving their goals. They simply invited him to offer every other client a piece of candy-- their favorite piece-- at the end of each session. And those who received the candy were more likely to come back than the rest.

Years ago, I was invited to do an educational group in the public housing development in Gary, Indiana with a group of African-American women who were living in public housing. My task was to provide an educational session every Friday. The first Friday I attended the program to do the workshop, one of the clients, one of the women, reached for a bottle of water. And the staff member frowned and said, we don't give clients bottles of water. And that really bothered me.

So I took matters into my own hands. Near my home in Chicago, there was a grocery store and a Duncan Donuts. So every Friday, on my way to Gary, Indiana, I would stop at the grocery store, and I would buy the women orange juice. Then I would go to Duncan Donuts, and I would buy them donuts.



Attendance tripled on Fridays-- it tripled. Some of the women came to the group and said, I don't know why, but when I go to bed, when I go to sleep on Thursday nights, I find myself dreaming about donuts.

One of my colleagues heard about a program based in principles of motivational incentives called the fishbowl technique. She's working with clients that I consider to be culturally-- what do you call it?-- quadruple challenged. She's working with an African-American population, and each of them are HIV positive. That's one challenge. Each of them has a psychiatric diagnosis-- number two.

Three, each of them have a substance use disorder. And all of them are threatening homelessness because, if they buy drugs one day, with their only source of income being social security, they may struggle to pay their rent that month. So all HIV positive, all her clients living with substance use disorders, all have a psychiatric diagnosis, and all threatening homelessness.

You're probably thinking it's a challenge for her to motivate her clients to come to groups. Well, she heard about an evidence-based practice called the use of motivational incentives. So in her group room is a fishbowl, one that's only small enough for one, say, goldfish to fit in the bowl. And in the fish bowl are raffle tickets. There are 250 raffle tickets in the fishbowl. And each time a client comes to group, they get to draw a raffle ticket from the bowl, where they can win various prizes-- incentives.

So what's written on 125 of those raffle tickets is, congratulations for coming to the group today. Keep up the good work. It basically means there is a 50% chance that a client will not win anything that day. However, the clients in her group that draw that raffle ticket, they receive round of applause from other group members. Why is that significant? Because her clients carry so much stigma, some of them have had no one clap for them for years. So she's found that even a round of applause is significant.

50 raffle tickets read, congratulations for coming to the group today. You win a small prize. The value of a small prize is \$5. 50 raffle tickets read, congratulations for coming to group today. You win a medium prize. The value of the medium prize is \$10. 24 raffle tickets read, congratulations for coming to the group today. You win a large prize. The value is \$15 to \$20.

And then, one raffle ticket reads-- out of 250-- congratulations for coming to the group today. You win the grand prize. And the grand prize is a flat screen TV. And all of the prizes sit in the group room on the table, meaning that you could win immediately. So just like drugs work immediately, these incentives also work immediately.

If you're wondering what the attendance is like in her groups-- standing room only. They are showing up to win the prizes, and she's able to help them



maintain their recovery while they do that. So there's a 1 in 250 chance that you can actually win the flat screen TV.

And one day, the funders visited her program to observe the fishbowl. And the day they observed it, a man with cocaine dependence-- stimulant use disorder-- won the flat screen TV. He won it, with the cameras rolling. People wanted to know what did he do with the flat screen? When I asked that question at seminars, people tend to say, he sold it for crack cocaine.

The answer is that he did not sell it for crack cocaine. He donated it back to the program. He had been sober for one year. What the research suggests is when these prizes are most valued are the first 90 days after the last time a person has gotten high. But when you are sober for a year or longer, a new incentive kicks in called gratitude. He just wanted to give back to the program that he said saved his life.

So I became curious. What would happen if I introduced a fishbowl technique to a group of adolescent African-American female clients and a group of adolescent African-American male clients? What would happen if we introduced it? And what would we need to do different than working with an adult population?

So what we discovered was that all we needed to do was to make sure that the prizes that were offered, the incentives, reflected some of what the clients were interested in. So on the male campus, we had things like Yankee caps and anything with Nike-- a logo-- Chicago Cubs hats and jerseys. And that was really important a few years ago when the Cubs were World Series champions. The youth really value anything with Cubs names on it.

We have Michael Jordan jerseys, a very valued prize. And we have \$5 gift cards to Target department store and 7-Eleven. Why? Because the agency where we provided the services-- the groups-- were right across the street from a Target and a 7-Eleven. And they could go immediately to the store after group.

All the typical resistance that you would see in groups with adolescents, none of it were there in these group because they were coming for the prizes. And so they could easily say, I don't have a substance use problem, but I want these prizes. And while they were there, we taught them strategies to maintain their recovery.

Let's take a moment to talk about the grand prize. On the girls' campus, the grand prize was a \$100 gift certificate to a woman's department store called Forever 21. And the young women in that program really valued that prize. And on the male campus, the grand prize, actually, was \$100 gift certificate to NikeTown.



And on both campuses, both the men and the women, we offered as an alternative grand prize a \$100 Visa card. And the last time I led the group, a young man won the grand prize, a \$100 Visa card. And his counselor called me, and she asked, what do you think he did with that card?

And I know what some of you on this webinar are thinking. Some of you are thinking he used it to get high. But what she told me is that, did you know that his mother was homeless? She said he used that Visa card to buy his mother some clothes. We're calling you to ask you if we could give him another Visa card. And I, of course, said yes.

So some of you are thinking that I'm not going to pay clients to do what they should be doing, anyway. Except in my state, Illinois, it costs \$90,000 to incarcerate an adolescent for a year. And some of these incentives-- actually, with both the adults and the adolescents, all the incentives were donated. So with the adult program, the incentives were donated by Walmart, Kmart, Sears, and church groups. And with the adolescent program, so many people donated these prizes.

But even if we paid for them, it costs \$90,000 to incarcerate an adolescent in Illinois for a year. What does it cost in your state? But we could spend a few hundred dollars on incentives and have a lot of adolescents attend these groups where they can learn how to achieve recovery.

We want to take a moment to talk about group psychotherapy. Of all the modalities that we utilize in substance use disorders treatment, group psychotherapy is our most common modality. And there was a man by the name of Irvin Yalom that did research on group psychotherapy. And in his research, he talked about the importance of cohesive groups. He said that cohesive groups, members make more progress than they do in groups that are not cohesive.

And he talked about those factors that are most important to building group cohesion in the early stages of group, in the middle stages of group therapy, and in the later stages of group therapy. What his research indicated is that early on in a group's development, the most important factors include universality-- that is, the feeling that I'm not alone. As you know, addiction leads to isolation. And people come to groups, and they start to hear the stories of the other people in the group, and they quickly discover that I'm not alone, that there are people who can relate to me.

The second factor, early in development of a group, is what's called installation of hope, that many clients with substance use disorders come to group feeling a sense of hopelessness. And they hear the stories of other group members, particularly those who have longer periods of sobriety than them, and they begin to feel a sense of hope.



This hope comes by way of story, and the stories that have the greatest ability to impact hope are called the hero's journey. And there are three parts to the hero's journey. The hero takes a journey is the first part. And there are two types of journey the hero can take. The first kind is called a voluntary journey. The hero volunteers to go away to college. The hero volunteers to join the military. The hero volunteers to join a street gang.

The second type of journey the hero can take is an involuntary journey, like Dorothy in The Wizard of Oz, sleeping in her bed next to her dog named Toto, and a tornado occurs, lifts Dorothy and Toto off the ground, and they wind up in a strange land called Oz. The hero is drafted into the military. The hero is robbed at gunpoint. We're talking about involuntary journeys. The second part of the hero's journey story is a point where all hope seems lost. If you have a pen, I'd like to ask you to underline that-- a point where all hope seems lost.

Here's my question. What would happen if you led a therapy group, a substance use disorders group, and every story the clients told ended with a point where all hope seems lost? Yes, you'd have very few clients motivated to show up for group. And yet, in order for a story to be inspiring, that second point is really important.

How many of you would be inspired by this story-- she was born, she succeeded, she died? No one would be inspired by that story. But how about the story told to me by one of my clients. When he was about eight years old, he saw the FBI raid his house and arrest his father on drug possession. Shortly after that, the family became homeless. And on and off through high school, they had bouts of homelessness.

He told me that he and his family spent his junior and senior year in high school living out of the family's car. That was the point where all hope seemed lost. But every morning, the school would allow him to show up at 7:30 AM, before his classmates, and take a shower at school. He graduated from high school on time, and he was the first person in his family to ever go to college.

That is the third part of the story-- the hero has a victory. If you think about recovery leads, you will see all features of that in the story, where the person nearly died, and then, ultimately, they got into recovery. And that's an inspirational story.

There's a term brought to us by a famous psychiatrist by the name of Carl Jung. It's called the collective unconscious. And according to Dr. Jung, that human beings are connected unconsciously by the stories that they tell. The famous poet Maya Angelou tells a story in her book called I Understand Why the Caged Bird Sings. And the reason the caged bird sings is because it yearns to be free.



When Maya Angelou was young, she visited her relatives in St. Louis. And she spoke to a man, and he sexually assaulted her. She told her uncles what happened to her, and the man who assaulted her disappeared. And Maya Angelou stopped talking.

And later in her memoir, she said I learned that if I spoke to someone, something bad would happen to me. Then if I told what happened to me, somebody might disappear. So she stopped talking for years. And when she began talking, ultimately she became one of the world's greatest /

Her book, *I Understand Why the Caged Bird Sings*, has been translated into languages all over the world. She once asked, why would someone from China, Japan, Australia, want to read my book? It is because her story represents the story of every young girl all over the world who was assaulted and ultimately achieved a great deal of success. Stories are really important in group therapy.

In the middle stages of group therapy, according to the research of Irvin Yalom, the factor most important in that phase is group cohesion. Incredible story about this boy named Mike. He played Little League Baseball on a team known as the Cougars. And Mike came down with a rare illness requiring him to have chemotherapy radiation treatment. He lost his hair.

And he was embarrassed to go to the next Cougars baseball game because, at the beginning of each game, the team would line up along the third base line and take off their hats and place them over their heart and sing the national anthem. And he feared that his teammates would laugh at him when they saw that he had no hair.

His father talked him into going to the next Cougars baseball game, and they lined up along the third base line. And right before he took off his hat, all 25 of his teammates took off their hats first. And he saw that they all shaved off their hair. They looked at him and they said, once a Cougar, always a Cougar. And that story suggests to me that, once a person is connected to a cohesive team, it's amazing what they can accomplish.

The way a group achieves cohesion is, ultimately, through the stories that they share with each other during the first phases of group. Cohesion is really important. That closeness is important for clients to get to the third part, for those factors most important in the third part of group therapy, and that includes a deeper catharsis. They now trust each other, so they can share more of their deeper secrets with each other.

And interpersonal learning. What we mean by that is that ways in which clients distance himself from other people. So they learn things like how my behavior distances me from others, how my behavior impact others, how



others see me, hidden talents that others can see that I can't see, and, of course, some of my blind spots.

So what do you do in situations where you have African-American clients in a group, along with other group members from various cultural groups, and you experience some cross-cultural tension in that group based upon differences? And so I stumbled upon the work of a social worker named Larry Davis. And he talks about developing group cohesion when you have groups with multicultural membership.

And in his writings, he introduces four important terms. And if you have a pen, work along with me. These are the four subgroups of group members that we commonly see. The first subgroup we see are members of what we call the actual minority. By actual minority, we mean the ethnic or cultural group that has the least number of members present. The next term is the actual majority, and that will be the cultural group that has the most members present.

Now these definitions will become interesting. The third subgroup of members includes the psychological minority. And that would be the cultural group that feels the least comfort based upon their numbers in the group. They feel the least comfort based upon their numbers in the group. Then, the final subgroup includes the psychological majority. And that would be the group that experiences the most comfort based upon their numbers in the group.

So the research says that the subgroup of members most likely to drop out of the group prematurely are those in the psychological minority because they feel the least comfort. And those who are most likely to stay in the group longer are those in the psychological majority. Larry Davis's research indicates that minority groups and majority groups have a different conceptualization of when a group is racially balanced.

Research says that minority group members are more likely to feel that a group is racially balanced when it's numerically even. Therefore, a substance use disorders group of 10, if there were five members of a minority group and five members of a majority group present, then the minority group members would say, I'm comfortable. This is balanced.

Research says the majority group members are more likely to consider a group to be balanced when the percentage of the minority in the group and the percentage of majority in the group mirrors the percentage of minority and majority in that town, city, state, or province. So therefore, if there were a community, and 80% of people living in that neighborhood or community, if 80% of people living in that community were majority, and 20% were minority, then the majority would say, I'm comfortable.



And your question is, what's the reason that majority members and minority members have a different conceptualization of when a group is balanced? It's because minority group members have more experiences going into environments where they are in the minority. And where there is experience, there is increased comfort.

So armed with this research, I led groups with White and African-American clients. What I noted was that if there were eight white clients in the group and two African-American clients in the group that the white clients would do most of the talking in the group.

And then, when two of the white clients would get discharged from the group and two or three more African-American clients were added to the group, then the white clients would do less talking, and the African-American clients would do more talking. And I started noticing how group members' comfort with talking would shift based upon their numbers in the group. This is something that we ought to pay attention to-- balance in our groups.

In the meantime, there are some things that you can do as a counselor, and working with African-American clients in groups with multicultural membership, to help ensure that the clients are more comfortable in groups. Number one, you are the bridge, initially, as a group facilitator. Sometimes clients are uncomfortable talking with each other based upon differences. But it's important for you to be a bridge for all of them and available to all.

Often, clients expect us to side with, or pay more attention to, clients of our same ethnicity. For example, as an African-American man, some clients might expect me to pay more attention to my African-American clients. Truly, to build cohesion in these groups, we have to be available to all, helping those in the psychological minority feel more comfortable. And all that involves sometimes is an occasional smile, a glance, a head-nod to let them know, you may not have the numbers in terms of balance, but I'm here for you, I'm supporting you.

Try to avoid tokenism-- one African-American in a group with 10 others who are non African-American. Be aware of how issues occurring in the larger society can impact group process. Years ago, I led a group, and there was mostly white men and black men in this group. It was a recovery group. And they would sit integrated. And I remember leading that group after the Rodney King verdict came in, the following group. The black men were sitting on one side of the room, and the white men, in a group, were sitting on the other side of the room.

I remember leading a group years ago after the OJ Simpson verdict was read. White clients were sitting on one side of the group. The black clients were sitting on the other side of the group. And in both instances, what I learned is all we had to do was talk about those verdicts and how those verdicts



impacted our group process. And by simply talking about it, we were able to work together effectively again.

As we speak,

A couple of years ago, I was leading a group with African-American teenagers. And they said that we cannot talk about our substance use until we talk about what just happened to Laquan McDonald. Some of you might remember that, a few years ago, there was an African-American adolescent named Laquan McDonald that was walking in the middle of the street in Chicago and was shot 16 times by a police officer. We want to pay attention to events happening in the larger community, in the media, and pay attention to how it impacts clients in general and African-American clients specifically, and to be willing to talk about it if it's impacting group process.

So renowned psychiatrist Dr. Carl Bell was asked if psychoanalysis developed by Sigmund Freud in Vienna was culturally competent. And Dr. Carl Bell said that all clinical models are culturally competent in the hands of culturally competent therapists. So one suggestion here in our work with African-Americans with substance use disorders is that we continue to develop our cultural competence. And the more competent we become, the better helper we become.

So I want to share with you a resource. And it is the Online Museum of African-American Addiction, Treatment, and Recovery. I am the curator of the online museum. The link is below on that slide. I invite you to visit the link. And you will find a ton of counseling articles on how to counsel African-Americans with substance use disorders, webinars, leadership institutes, lots of music and videos, and there is a blog where we post frequently on issues that would help you in your work with African-Americans with substance use disorders.

I imagine that many of you have seen the movie *The Color Purple*. And I can suggest to you there was so much drinking in the movie *The Color Purple* that they could have used your services in the movie-- lots of domestic violence and childhood abuse.

And towards the middle of the movie, a singer showed up named Shug Avery. And Shug Avery was from Memphis, Tennessee, and she was a breath of fresh air. And towards the end of the movie, Shug Avery was going back to Memphis to sing. So in true Southern tradition, they held a dinner for her before she went back to Memphis. And as they were leaving, her husband tipped his hat and said to those remaining in the dining room, you are the salt of the earth.

Now, I imagine that most of you have heard that term. So I went on the internet. I wanted to know that the origin of the term, the salt of the earth.



What I discover is that that word, that term, that phrase, has been with us for a long time. The phrase, the salt of the earth, is in the Bible.

I learned that, years ago, people were not paid in dollars and cents. They were paid in salt. You've probably heard the phrase, he's not worth his weight in salt. And I learned that, in America, before we had refrigeration, salt was used to preserve food.

Salt was used to preserve food, so it was considered precious and sacred, which is exactly how I see you, individuals who've dedicated your life to helping others with their recovery. You truly are the salt of the earth. Thank you so very much for listening to me. And that concludes our webinar.

MAUREEN FITZGERALD: Thank you so much, Mark. That was a great presentation, and we so appreciate you coming here and giving it with us today.

MARK SANDERS: Thank you.