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REVIEW ARTICLE

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Recovery Assessment: Culture, Ethnicity, and Spiritual Dysfunction

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ABSTRACT

Religion and Spirituality are essential pieces to an individual's or group's identity and are present on the spectrum of multicultural diversity. Human service practitioners cannot overlook how individuals conceptualize their relationship with the Sacred. Knowledge of spiritual beliefs and practices creates the basic cultural competence of the practitioner. It enriches the relationship between the practitioner and the person receiving service and makes room for powerful spiritual healing. There needs to be a professional nonsectarian change toward a holistic model of recovery and resilience that embraces the spiritual dimension. This dimension must include traditional and non-traditional belief systems not just as part of the self-help movement but as part of an integrated psychological and spiritual health model that complements people's biological and genetic foundation. This integrated model must focus on: (1) the elimination of stress in the overall community; (2) being attentive toward environmental factors such as divorce, death, and Illness; and (3) supporting and providing opportunities for better housing, increased employment opportunities and positive family activities. Effective treatment services must embrace a holistic approach that integrates well into a comprehensive social support network perspective.

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Introduction

A clinical assessment is to identify areas of disruption in an individual's life that have an inhibitory impact on current healthy behaviors and lifestyles. A risk in this perspective is that the clinician will fail to consider cultural and spiritual factors that influence one's behavior. The need for a more comprehensive, sensitive classification system must acknowledge the role that culture and spirituality play in dysfunctional behavior. When taken out of their cultural context, certain behaviors could be viewed as deviant or abnormal but culturally and spiritually congruent [1,2]. There is increasing pressure for clinicians to become more knowledgeable, professionally comfortable, and skilled in working with individuals from different races, ethnic backgrounds, sexual and religious/spiritual orientations, and other populations not bound by contemporary Western standards. The DSM-5 assessment protocols discuss no distinct cultural and ethnic patterns that could influence the diagnostic/assessment process and, in many ways, bias an evaluator from pursuing cultural and spiritual practices of influence. At best, the DSM-5 states.

Different cultures and communities exhibit or explain symptoms in various ways. Clinicians need to be aware of relevant contextual information stemming from a patient's culture, race, ethnicity, religion, or geographical origin [3].

The DSM-5 does not effectively express cultural variations in the expression of maladaptive behavior, even though the culture and ethnic background of the individual does influence symptoms and etiology of many disorders. Cory (2001) cautions clinicians about misdiagnosis:

Diagnostic assessment can be complex when one ethnic or cultural group uses the DSM classification to evaluate an individual from a different ethnic or cultural group. A practitioner unfamiliar with an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, belief, or experience particular to the individual's culture [4].

The DSM-5 in the Section III chapter "*Cultural Formulation*" requests that clinicians and researchers provide further data on the usefulness of various cultural assessment measures, including the CFI. For the reader's information, the Cultural Formulation Interview (CFI) is a set of sixteen (16) questions that clinicians use to obtain mental health information for evaluation. The medical critique is a kind of cultural critique. Ecks, states that

what is presented as "culture" in the DSM-V is too focused on meaning and not enough practice. Its culture sections are based on anthropological theory's hermeneutic, meaning-centered

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tradition. This approach deals with ideas, but it is terrible at grasping material, nonhuman things that co-constitute everything that humans experience [5].

Culture and Ethnicity in Assessment

Jungian analysts believe that culture permeates all life domains; therefore, you treat the individual when you treat the culture [6]. For those who have not experienced sociocultural change, cultural issues might come to the fore in interactions with individuals who do not share the same culture of origin. These encounters prompt the realization that different cultures view the world differently. One-way to bridge those differences is by acquiring knowledge about other cultures. Cultural knowledge enhances understanding diverse worldviews and provides insight into the optimum approach to problem-solving strategies [7]. Cultural competence is a set of interpersonal and intellectual skills that allow individuals to appreciate and understand cultural differences and similarities within, among, and between groups [8]. A culturally competent assessment demonstrates sensitivity and understanding of cultural differences in treatment and program design, implementation, and evaluation [9]. Within a recovery and resilience-oriented setting, cultural competence is a fundamental ingredient that helps develop trust and an understanding of the way members of different cultural groups define health, Illness, healing, and health care [10]. A culturally competent model of recovery/ resilience acknowledges the person's artistic strengths, values, and experiences while encouraging behavioral and attitudinal change.

Social scientists believe that ethnicity is a significant cultural variable that impacts a person's s concept and sense of belonging with other members of a subgroup and defines the individual's relationship to the dominant culture. Studies have found that a strong ethnic identity is correlated with better psychological well-being and higher self-esteem. Ethnic identity develops in early adolescence through young adulthood [11]. The concept of "*ethnicity*" is sometimes used interchangeably with "*race*," even though they are distinctions between the two. Ethnicity refers to a person's social identity and belonging that defines a group of people through common historical or family origins, beliefs, and standards of behavior. For example, the White Anglo- Saxon Protestant peoples of England and Northern Europe have different cultural attributes and very different histories in the United States than the Mediterranean peoples of Southern Europe, e.g., Italians, Greeks, etc. [1].

At present, there appears to be insufficient research on the relationship of ethnic and cultural differences and their effect, positive or negative, on the assessment, diagnosis, and treatment of dysfunctional behavior. In some respects, members of minority groups may view and react to the world just like all other people; in others, they may feel differently, believing their problems result from exposure to racism and poverty. Research on maladaptive behavior has increased about similarities and differences and the impact on individuals living in different communities [12,13]. Cross-cultural research indicates that different ethnicities have varying personality traits brought about by the influence of their respective societies. These can be inaccurately over- pathologized due to flawed evaluation tools [14]. These differences become relevant in that practitioners must be knowledgeable about the world views of their clients and attempt to understand these views without negative judgments [15,16]. Unless clinicians consider their client's social and cultural context, it is almost impossible to understand a given client's struggle. For example, research on cross-cultural comparisons of emotional disturbance and its expression has shown that depression often has different meanings and forms in different societies. For example, cases of depression worldwide are experienced and expressed in bodily terms of back pain, headaches, fatigue, and other somatic symptoms that lead many individuals to regard this condition as a physical problem. In contemporary Western societies, depression is seen principally as an intrapsychic experience [17]. Clinicians need to take account of cultural factors about cultural variations in emotional expression, body language, and religious beliefs and rituals within societies such as the United States. This cultural susceptibility must also show a sensitivity to the client's culture and the clinician's own cultural biases that they both work and live on before effectively evaluating other individuals. It is not necessarily important that the counselor is in recovery or a member of a minority group to help an individual. More important is that the clinician be receptive to similar feelings and struggles. Sometimes our differences are as significant as our similarities. Delgado and Delgado [18,19], reflecting on culture and the healing process, reported four necessary resources that constitute a natural community-based support network that embraces.

- The use of extended family, which will enhance the social and emotional support network.
- The use of folk healers, who utilize culturally specific methods, facilitates healing emotional, spiritual, and physical ailments.
- The use of faith/religious institutions, which offer additional social and psychological support services, emergency assistance in a crisis, and spiritual advice.
- The use of merchants and social/civic clubs, which traditionally are neighborhood-based, could provide a wide variety of social activities and support.

It should be noted that "*recovery*" has become a civic, political, and medical challenge for many. The social recovery model is, to many, a manifestation of a consumer empowerment model of care. Many practitioners A growing body of knowledge in the health care field believes recovery should be more of a philosophy than a specific model [20].

Corey (2000) established some practical guidelines for working effectively with diverse client populations:

- Learn more about your own culture and how it has influenced your behavior and thoughts about others.
- Identify for yourself basic 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 applying techniques that benefit different cultures [4].

Social Determinants of Health

There is a growing realization among clinicians and healthcare researchers that a focus on health care disparities (social

determinants) is essential for improving healthcare outcomes. Activities toward improvement must bring together many sociocultural elements of our healthcare delivery system. The American Society of Addiction Medicine (ASAM) standards were developed through a multi-causal strength-based assessment, which addresses an individual's needs, various obstacles, liabilities, strengths, assets, resources, and social support structure [21].

This multidimensional model encapsulates both public health and population health concerns. The public health model of assessment includes a medical examination, drug use history, psychosocial evaluation, and where warranted, a psychiatric evaluation, as well as a review of socioeconomic factors and eligibility for public health, welfare, employment, and educational assistance programs. The inclusion and expansion of individual and community health must embrace both the traditional public health bio-medical factors as well as the social and community population health concerns of disparities such as health care, poor housing, etc [22].

Generally, populations that have customarily been underserved in the American health care system include African Americans, Latinos, Native Americans, and Asian Americans [23-25]. Many researchers have suggested that race/culture/ethnicity significantly influences how individuals manage adverse circumstances [26-29]. As mentioned earlier in this paper, studies on multicultural theory noted that people's worldviews are primarily influenced by their cultural background, affecting their ability to adapt to the environment successfully. According to Sue and Sue (2003), worldviews are "*composed of our attitudes, values, opinions, and concepts and affect how we think, define events, make decisions, and behave*" [30]. Members of minority groups often perceive and experience their lives differently based on their cultural upbringing and different worldviews. European Americans tend to assume members of all other cultures share their worldview. However, many members of other cultural groups do not share those same values, which can cause them to view their world differently. Reducing health care disparities is essential for better health care outcomes and lowering healthcare costs [22].

Spiritual Dysfunction in Recovery

Historically, the field of counseling and psychotherapy struggles with the psychospiritual approach. The teachings of Jesus and the early Christians and their instant cures through the power of faith or spiritual guidance led to the first psychotherapeutic spiritual interventions [31]. For many centuries, the church "*diagnosed*" and treated the "*mentally ill*" who was "*possessed*," in trance states or under some "*satanic*" influence. Due to increasing pressure, the Church ceased practicing this healing art and abrogated it to the physicians' new "*priests*" or "*shamans*" of modern medicine. Descartes's assertion that the mind and body were separate entities fostered the development of physical explanations for all emotional difficulties. By the end of the 19th century, biomedical science took histories, searched the biochemical and structural parts of the body, and reduced signs and symptoms of illnesses to single diagnostic categories [32]. It took almost ninety years and the evolution of modern Psychiatry to produce the first Diagnostic and Statistical Manual of Mental Disorders (DSM-I) in1952 and the DSM-5 in 2013. It is important to note that labeling individual behaviors into symptoms complexes known as diagnostic groups reflects two of the three explanatory paradigms: (1) the Biomedical and (2) the Psychosocial.

The third paradigm, Spirituality, can help humanize the recovery process, motivate change, and counter the adverse effects of certain beliefs about behavioral health challenges.

The Biomedical Model

It relates to one's physical body and the connections and communications between nerves, bones, muscles, and the rest of one's physical presentation. Much of Western medicine and, to a large extent American Psychiatry is grounded in this model, being represented primarily by allopathic medicine (M.D's) and, to a lesser extent, by osteopathic medicine (D.O's). The acceptance of Chiropractic healing, the younger relative to osteopathy, appears to be the most radical of the traditional Western practices. Even Psychiatry is considered more "*mainstream*" than the natural principles of chiropractic healing, which finds much comfort in the recovery process. The holistic approach to chiropractic healing indicates that a balanced diet and regular exercise foster the human body's innate healing potential. That pharmaceutical suppression of symptoms can compromise the body's ability to heal itself and those natural non- pharmaceutical measures should be the approach of first resort, not last [31]. This approach appears to make sense when one views "*pathology*" from a broader ecosystem perspective.

For the reader's information, the one Eastern or Chinese medical practice that appears to compliment the Western biomedical approach to health is Acupuncture, which analyses the physical body through meridians or pathways. The energy that flows through the material body is called "*Chi.*" The objective of Acupuncture is to allow unimpeded energy to flow through the body, its organs, and the channel pathways, therefore, producing a balanced state of health. According to Eastern medicine, Illness usually results from an interruption or imbalance in the flow of "*Chi.*" Acupuncture is employed to remove the obstructions [33].

The Exploratory Model

This model includes much of the psychosocial domain of counselors and is often referred to as the mind, body, emotion relationship. Western medicine is rooted in traditional psychiatric practice or non-medical psychological therapies. Historically, the Freud/Jung schism was more of a reflection of the times and had more to do with the identification of Psychiatry as a branch of modern medicine with little or no association with thehistorical, religious or spiritual traditions. Jung's constant interjection of theological and archetypal explanations of psychic phenomena threatened the new marriage between psychoanalysis and modern medicine [34]. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is primarily an outgrowth of the biomedical model of sickness, discomfort, or malfunction. Although non-medical practitioners (psychologists, clinical social workers, etc.) have inappropriately identified with the medical model, one hopes that the non-medical mental health community will continue to view problems in living as more than medical and psychosocial.

When one only looks at the biological reasons for behavioral

health challenges, the assumption is that getting well and overcoming deficiencies is a function of the individual rather than the system of care. This kind of narrow perspective has contributed to a behavioral health delivery system that continually struggles to provide an integrated care model [35].

The Spirituality Model

Most individuals in substance abuse treatment usually have some religious and spiritual beliefs [36,37]. Spiritual and religious activity has confirmed that people who participate in spiritual/religious activities are less likely to abuse substances [36]. Also, religious practices and beliefs (at least those from established religions) seem to affect physical health by improving coping, reducing emotional distress, improving attitude and mood, increasing social support, and reducing problem behaviors [37]. Due to the influence of 12-Step groups like Alcoholics Anonymous, spiritual beliefs play an essential role in many substance abuse treatment programs. Many individuals find that spiritual and religious beliefs play a crucial role in their recovery. Therefore, counselors should be prepared to discuss these beliefs with clients if they choose. In behavioral health settings, a client's religious or spiritual beliefs can motivate change and, sometimes, counter adverse effects of specific cultural ideas about sexuality and substance use. For example, a client who believes that not drinking will jeopardize his masculinity and status among his peers may better reconcile his decision to maintain abstinence as a culturally appropriate one if supported by a priest or clergyman. Faith can also help recovering clients as they reenter their communities; support from a church, synagogue, mosque, or other faith-based institution can improve their chances of recovery and reduce the odds of relapse [38]. Although substances, such as wine or peyote, may be used in some religious rituals, all major religions have adaptations for individuals with substance use disorders, enabling them to participate in the faith without partaking in those substances. Behavioral health services providers should become familiar with their clients' spiritual beliefs, practices, and experiences just as they learn about their occupations, families, habits, and mental health. Defining and distinguishing the difference between Religion and Spirituality is helpful since some individuals view themselves as spiritual but not necessarily religious. Religion is organized, with each religion having its own "*theology, doctrine, creeds, and liturgical practices, all of which are intended to enhance each member's spirituality*" [39].

On the other hand, Spirituality is a personal matter involving the individual's search for meaning, and it does not require affiliation with any religion. People can have spiritual experiences or develop their Spirituality regardless of the presence or absence of any religious connection [39]. In recovery from substance use and dependency, focusing on Spirituality rather than religion can help some people accept the need for a higher power or a power greater than themselves.

One hopes that the influence of Spirituality in therapy will transcend the physical body of our clients and reach out to more transpersonal relationships with their Illness. Indeed, mental conditions require diagnosis and medical and psychosocial interventions. Indeed, to survive in the "*behavioral health field*," we must know and contribute to the diagnostically driven payment system of health care. However, clinicians must never lose sight of their primary mission, which is physical, psychosocial, and spiritual. To ignore any of these systems is to splinter an individual's reality. The presentation of the DSM-5 has value in completing insurance forms, communicating with clients or other practitioners about common symptoms, and assigning meaning to an experience that helps others explain a general healthcare course of action. By its very nature, this labeling denies the existence of multiple realities, with credit only given to scientific fact. All clients should have a comprehensive medical and social assessment conducted over multiple sessions. The total evaluation should include, but not be limited to, the individual's recollections of and attitudes about previous substance abuse treatment, explanations, and motivations for treatment, levels of support for a substance-free lifestyle, as well as a history of physical or sexual abuse and traumatic life events. The individual's cultural, religious, and spiritual basis should incorporate values and assumptions that might affect treatment. This information should be included in an integrated summary in which the client's strengths and weaknesses are noted. All treatment plans should match each client to appropriate healthcare services.

In a therapeutic relationship of mutual respect and tolerance, differences between counselor and client in spiritual beliefs need not become problematic. A clinician can serve as an orchestrator of resources for a client's religious or spiritual beliefs [36]. Just as the clinician or other appropriate staff can help clients get the physical services they need (e.g., housing, medical care), they can also help clients meet their spiritual needs. These spiritual needs can be accomplished by arranging visits with spiritual advisors or clergy and providing access to faith- based services during treatment. Clinicians must refer clients to spiritual advisors from many different faiths (reflecting the clinician's population). This "*Spirituality of ordinary people*" refers to willing involvement in socially desirable activities or processes that are beyond the immediate details of daily life and personal self-interest. Attention to the ethics of behavior, consideration for the interests of others, community involvement, helping others, and participating in organized religious activities are expressions of Spirituality. A client's Spirituality can be an essential treatment resource, and persons recovering from addiction often experience increased interest in the spiritual aspects of their lives. A study by Flynn and colleagues (2003) of four hundred and thirty-two patients admitted to eighteen treatment programs found that those who remained in recovery for five years credited religion or Spirituality as one factor in this outcome [40]. It is incumbent that staff assess a clients' connections with religious or spiritual institutions because they often provide a valuable sense of belonging in the rehabilitative process. Miller found a lack of research exploring the association between spirituality and addiction recovery but concluded that spiritual engagement or re-engagement appeared associated with recovery [41]. Individuals with a high degree of spiritual motivation to recover reported that treatment programs that included spiritual guidance or counseling were more likely to produce positive outcomes than programs that did not [42]. There is a real need for all treatment programs to assess spiritual resources adequately.

As significant as this issue is for clients, it appears more important for counselors and other mental health professionals to be trained in client spirituality [29].

Humanizing the recovery process can be found in the faith and spiritual communities. For example, Buddhist practice encourages individuals to turn to a more ecologically balanced way of preserving their natural resources, sustaining the entire population, and engaging in the community as a supportive human experience. Doctrine from all the major religious faiths urges 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 (www.hinduism.iscon.com). A basic tenet of Christianity is to give relief to the needy and comfort others' suffering. All the above practices may pay homage to one's faith. Still, the act is also a form of building and strengthening one's community, recognizing that the human condition is a shared cultural and collective experience and honors the mutual relationship between individuals, families, and communities [43]. Beyond the search for an explanation of suffering, human beings have always searched for a path to transcend physical calamity, disease, and death of the body. 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. Traditions and rituals that constituted religious practices empowered believers gave them a structure for creating meaning out of their suffering, and offered a path to healing.

In conclusion, the healing process not only helps a person develop a better sense of their conscious identity, but it also helps one explore the deeper meaning of existence. The more one feels their values, beliefs, and thoughts originate outside of oneself; the more one gives those activities the power to control their life. The objective in life is to balance one's mythology (inner Self) and ego complexes (outer Self) so that the soul/spirit can take command of one's life rather than the heart always being a stepchild to reality. With a sense of purpose in life and a belief in hope and transcendence, this balance finds common ground in Wilber's four-quadrant theory of human experience. The teleological shift from personal needs and feelings (Western psychotherapy) to a focus on cosmic/communal space that surrounds our private world (Eastern traditions) [44,45]. Effective treatment services must embrace a holistic approach that integrates well into a comprehensive social support network perspective.

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