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Substance Abuse Treatment Provider Views of "Culture": Implications for Behavioral Health Care in Rural Settings

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Mandates for culturally competent substance abuse and mental health services call for behavioral health providers to recognize and engage cultural issues. These efforts to incorporate culture typically focus on client culture, but provider views of culture can also influence the provision of services. Analysis of 42 semistructured interviews with behavioral health providers suggests that culture is considered by many to be an obstacle to help seeking and treatment of substance-abusing youth. Although some providers do not highlight cultural issues, others conceptualize culture in terms of (a) generalized Hispanic cultural attributes, (b) male-dominant gender roles, and (c) the culture of poverty. Recommendations for provider training on cultural issues focus on ways they might critically consider their ideas about culture.

Keywords: *adolescent; cultural competence; rural, substance abuse treatment*

Across the United States federal and state governments are mandating the provision of culturally competent services in a variety of care settings, including substance abuse and mental health treatment. Two documents are emblematic of this development on the federal level. In 2001, the surgeon general released the supplemental report *Mental Health: Culture, Race and Ethnicity*, which outlines strategies to reduce the disproportionate burden of unmet behavioral health care needs that racial and ethnic minorities bear (Public Health Service Office of the Surgeon General [Surgeon General], 2001). A central tenet of this report is that to address these disparities, cultural issues must be accounted for in the design, adaptation, and implementation of treatment services and systems.

This report was followed in 2002 with the president's New Freedom Commission on Mental Health, a group of policy makers, practitioners, and administrators charged to conduct a comprehensive study of the behavioral health service delivery system in the United States and to advise on methods to improve it. The commission's final report, like its predecessor, emphasized the important role of culturally competent services in addressing disparities in behavioral health and recommended that both prevention and intervention services be responsive to the language, traditions, beliefs, and values of ethnic minority populations (New Freedom Commission on Mental Health, 2003).

The commission provides a wide range of recommendations that, if fully adopted, would reshape the conduct of clinical practice and likely make a significant impact on the composition and training of the behavioral health provider workforce (New Freedom Commission, 2003). Among the recommendations for realizing culturally competent services is the development of a well-trained workforce that includes members of ethnic, cultural, and linguistic minorities. Ideally, these providers will share and respect the beliefs, norms, values, and patterns of communication of culturally diverse populations. At the same time, the report underscores the importance of developing culturally competent services that encourage providers to partner with individuals with behavioral

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Table 1
Key Demographic Features of the Communities

County	Population in 2000	Persons per Square Mile	Hispanic	White, Non-Hispanic	Percentage Below Poverty (%)
1	3,543	0.5	18.9	77.2	18.9
2	31,002	7.8	48.7	49.0	19.6
3	5,932	1.7	55.9	43.1	23.6
4	25,016	8.4	59.6	38.1	26.2

Source: U.S. Census Bureau (2000).

health problems to design individualized plans of care that include attention to the cultural aspects of delivering and receiving services.

In general terms, these initiatives call for providers to develop knowledge and understanding that allow them to recognize and engage cultural issues in therapeutic settings more effectively (New Freedom Commission, 2003). Invariably this involves a process whereby the provider learns how "culture" and "cultural factors" operate in clinical encounters in a more or less systematic way and then integrates these understandings into practice (Ramirez, Wassef, Paniagua, Linskey, & O'Boyle, 1994). However, in the behavioral health professions, culture traditionally has been portrayed in static terms, as a coherent phenomenon that is divisible into discrete and measurable elements, such as language, values, beliefs, and traditions (Guarnaccia & Rodriguez, 1996). These conceptualizations of culture might hinder consideration of the multivariate ways in which culture intersects with daily life. A growing literature aims to problematize such portrayals of culture (Kumanyika, 2003), yet in practice, these elements might still be conceived as enduring and consistent within a population.

Although a great deal of attention has been focused on the purported aspects of patient cultures that are relevant to treatment (Guarnaccia & Rodriguez, 1996; Santiago-Irizarry, 2001), there has been much less consideration given to provider views of culture and the implications that these conceptions might have for the provision of services. In this article, we present the more prominent ideas that a regionally based group of behavioral health care providers shared regarding the impact of culture on help-seeking processes in rural behavioral health care settings and suggest the relevance of these ideas for clinical practice. Culture was often expressed as a barrier to the help seeking and treatment of substance-abusing youth. This leads us to consider how culture is perceived in multicultural behavioral health settings and in relation to U.S. society at large.

We conclude with a series of critical recommendations for provider training on cultural issues. We caution against simplistic treatments of culture—checklists and traits—and suggest that providers consider culture as a dynamic process in which beliefs and everyday practices are influenced by social transformation, social conflicts, and power relationships (Guarnaccia & Rodriguez, 1996). We also argue that providers tend to conflate cultural traits with structural impediments and by doing so might mistakenly attribute Hispanic help-seeking behaviors to collective values and worldviews rather than framing these practices as a result of political economy and historical racism. Most important, we suggest that providers begin their engagements with cultural difference with a reflexive assessment of their own notions of culture.

Method

The data presented here derive from a larger qualitative study of drug use and pathways to behavioral health care for Hispanic (or Latino) and White (non-Hispanic, or "Anglo") adolescents living in four adjacent counties in rural southern New Mexico (two of which border the Republic of Mexico). These counties comprise the most rural regions of New Mexico, with high percentages of persons living in poverty and some of the highest unemployment rates in the country (see Table 1). The project's overall objective is to provide "on the ground" information to support the development of culturally relevant, quality care for rural adolescent populations that presently have limited access to behavioral health services.

We interviewed 42 providers of behavioral health–related services over a 3-month period in 2005. We used a purposive sampling procedure to identify these participants. This type of selection process is based on the idea of theoretical representativeness, whereby the investigator chooses participants from segments of a social

system that are meaningful in terms of the investigator's theories or research interests (Johnson, 1990). This is a form of judgment sampling in which participants are "selected for a specific reason or purpose" (p. 28). The goal of such a sampling strategy is to get "information-rich cases" (Patton, 2002, p. 169) for in-depth study, individuals that are experts in a particular cultural domain. Research on special populations, like drug users, often relies on judgment sampling (Bernard, 1994).

We identified experts to interview in consultation with our community research work group, which was made up of local stakeholders with interests in youth substance abuse. Through this collaboration we compiled an initial list of 30 interview participants that included drug and alcohol counselors, mental health therapists, nurses and physicians, and prevention specialists; individuals with less than 2 years of regional work experience were excluded. Because there was a strong presence of White providers who had immigrated into the region within this sample, we conducted 12 additional interviews with Hispanic participants who were long-term residents. Recruited via purposive sampling methods, these participants were largely of nonprofessional, nonlicensed status (i.e., *curandero/as*, volunteer coordinators, and juvenile probation officials) but had extensive experience working with substance-abusing youth. The final sample included 10 (24%) men and 32 (76%) women. Two (5%) individuals self-identified as African American, 1 (2%) as Asian American, 16 (38%) as Hispanic, 1 (2%) as Hispanic and White, and 22 (52%) as White.

Together these individuals represented virtually every professional and paraprofessional provider involved in youth substance abuse treatment in the four counties covered in this study. As a result, we are confident that the findings presented here are an accurate and comprehensive representation of how providers in this region conceptualize Hispanic culture and its relation to substance abuse help-seeking processes. In addition, anthropological researchers investigating cultural domains have noted that interviews with 15 to 30 respondents can provide adequate coverage of major core cultural beliefs, knowledge, and information (Romney, Weller, & Batchelder, 1986; Trotter, Needle, Goosby, Bates, & Singer, 2001).

Developed with input from the community research work group and patterned after the seminal explanatory model of illness approach in anthropology as well as more recent sociological models of health care utilization (Kleinman, 1981; Pescosolido & Boyer, 1999), our semistructured interview protocol consisted of 34 questions and covered several domains, including general background and work history; adolescent substance abuse and mental health; risk and protective factors; help-seeking processes; prevention and treatment; the organizational, policy, and regulatory context of behavioral health care; and recommendations to improve the treatment system. Structured questions included attention to respondent gender and ethnic identification. More open-ended questions were also developed to assess provider perceptions of different ethnic populations and the role cultural factors play in youth substance abuse and help seeking (e.g., What are the culturally oriented help-seeking behaviors that you have noticed among Latino adolescents?).

The interview took approximately 90 minutes to complete. Each participant signed a written informed consent document approved by the Southwest Institutional Review Board. The document explained the parameters of their participation in the study, including assurances of anonymity, ability to withdraw from the study, and compensation of $40 per interview event.

Responses were tape-recorded, transcribed, and then coded using NVivo. In line with the exploratory nature of this study, no a priori theoretical models structured our preliminary analysis of the interview data. Instead, analysis followed an approach whereby a descriptive coding scheme was developed from transcripts based on the specific questions and broader domains that made up the interview. Analysis then proceeded to the development of pattern codes. As described by Miles and Huberman (1994), pattern codes are more inferential and explanatory and allow the analyst to index data that illustrate emergent themes and categories. In the context of the research presented here, pattern coding was employed to highlight examples of themes relevant to provider views of how culture influences help seeking for behavioral health problems by adolescents in rural environments. The authors regularly reviewed both descriptive and pattern codes during project research team meetings, at which time themes and categories were critically discussed. Coding proceeded in an iterative fashion with each author coding sets of transcripts and then passing their work to the other authors for review. Discrepancies or conflicts in coding were identified during this review process and resolved in team meetings. Through this hermeneutic process of coding and research team consultation, concepts of culture emerged as a significant theme in interview texts, and in-depth NVivo analysis of these concepts produced the following results.

Table 2
Major Themes Regarding Provider Views of Hispanic Culture

Theme	Perceived Impact on Substance Abuse and Help-Seeking Behaviors
Family	Individuals are suspicious of providers from outside social groups and attempt to deal with issues internally. Families conceal conditions to avoid social stigma associated with mental illness. Values of self-reliance compel families to address issues on their own. Families socialize adolescents in ways that both contribute to and protect against substance abuse.
Religion and spirituality	Hispanics are seen as more likely to use religion and clergy in order to address mental health issues. Clergy lack referral networks to link families to available professional services.
Gender	Stereotypical gender roles create situations where women's health care is deemphasized. Men are culturally prescribed to be self-reliant and avoid the image of vulnerability associated with help seeking.
Socioeconomic factors	Poverty and lack of opportunity create a context where lack of future orientation and goals predominate and are passed on from generation to generation.

Results

Below we present the dominant themes about culture derived from our analysis, focusing on provider perceptions of cultural factors that influence behavioral health and help-seeking behavior among rural youth (summarized in Table 2). Even though the population of the four-county region is roughly half Hispanic and half non-Hispanic White, perceptions of culture typically focused on dominant societal notions about Hispanic people. These notions centered on family, religiousness, and male-dominant gender roles, and in many ways paralleled the prevailing literature on cultural assessment among Hispanic populations (Antshel, 2002; Cuadrado & Lieberman, 2002; Freeman, Lewis, & Colón, 2002; Vega, 1990). Providers also expressed ideas that linked specific cultural attributes to poverty and thereby seemed to conflate cultural barriers to substance abuse treatment with the many structural factors that create reluctance among Hispanic people to use available health and human services in rural New Mexico. In many instances, these ideas reflected broader beliefs that Hispanic "culture" presented obstacles for youth in need of help for substance abuse issues. Finally, the providers we interviewed were generally reluctant to discuss how cultural differences within clinical settings challenged their own professional practice.

The Hispanic Family

The most widely shared ideas about culture focused on cultural attributes of Hispanic families that set these social units apart from other groups. Providers commonly noted that Hispanic families were more circumspect about seeking behavioral health services because of distrust of Anglo providers, the wish to avoid stigma associated with mental illness and substance abuse, and the need to demonstrate self-reliance. One provider explained, "The Latino culture tends to be family determined. There's less going outside and more dealing with it inside. That's cultural. And with Anglos it's the other way around."

Families were seen as important participants in the therapeutic process and crucial to adolescent success in dealing with substance abuse and mental health issues. One provider equated culture with "family values":

> I would say family values have a lot to do with it. Those that have a close family—with parents who talk to their kids more and are there more for their kids—tend to overcome it [adolescent substance abuse issues].

There was also recognition that the larger cultural context was not necessarily conducive to fostering the development of strong, cohesive family social units. A provider remarked,

> We don't integrate kids into our families. There's no concept of a family unit being a team. We keep them in this protected space and give them what they want. In past cultures, those kids would have been integrated into the working unit of the family by the age of three. So they don't get this connected lifestyle, they get this totally disconnected thing.

Although comments like these indeed reference broader social processes, this lack of cultural integration within family units was generally perceived as an essential etiological agent in adolescent substance abuse and mental health issues.

Providers commonly highlighted family dynamics and behavior patterns associated with substance abuse in rural communities. Although families were sometimes portrayed as a positive force in adolescent lives, providers more often recognized that these social units

contributed to the transmission of substance abuse. One provider explained, "There's the culture of drinking. This is what my family does when we get together, we all drink." These kinds of family observations enabled some providers to substantiate their own socially acquired views on culture. One provider characterized this local culture in the following way:

> It is in the Hispanic culture that they get their children to drink at a very young age. I know this because you see it in my family. My in-laws all allow this and they are Hispanic. They have all kinds of problems. My [White] family never tolerated that.

Families were conceptualized as social units characterized by values of permissiveness that were conducive to the development of adolescent substance abuse problems. One provider stated, "They're kind of permissive in that way, letting the kids do this [consume alcohol or drugs]." In a similar way, social relationships in small rural communities often meant that legal infractions involving alcohol and other substance use by young people were overlooked or downplayed. A provider summarized, "There's this culture frequently with the local law enforcement not to give kids tickets for underage drinking or driving and drinking because often they're relatives or friends."

In summary, the Hispanic family was subjected to conflicting ideas about risk factors related to youth substance abuse. Lack of integration into the family unit was put forth as an etiologic factor in adolescent substance abuse. However, at the same time, the values of the Hispanic families or communities were typically deemed dangerous to youth.

Religion and Spirituality

Religion and spirituality were other aspects of culture commonly recognized as exerting an important influence on help-seeking processes. Providers reported that Hispanics were more likely to use religious resources when confronted by behavioral health issues. One provider commented,

> I think some of the Hispanic families are more spiritual. They go to the priest first or go to the pastor and talk to him about the problems they're having, and then after that go to a provider. But I think first in these families I've noticed it's God, seeking God first.

A second provider, however, was concerned that members of the clergy and other religious officials did not make referrals to professionals in the community and often lacked the training to address specific issues related to substance abuse.

> They're helpful in the way that they can give them advice. I don't know if some of the churches have been trained to bring in other agencies to help with problems and things like that or if they've had any special training in how to deal with kids getting up in drug [use].

Denial, morality, and even self-protection were reasons providers offered for why some Christian clergy appeared reticent to explicitly address issues pertaining to youth substance abuse. Even though folk-Catholic *curanderismo* is still practiced in the area, relatively few Christian faith-based and professional providers viewed it as a viable treatment option for the region's youth. A tense respect between local Christian faith-based providers and professionally trained substance abuse treatment providers existed, with each group regarding the other's treatment orientation with measured skepticism.

Gender Roles

Other dynamics associated with gender in traditional Hispanic culture were also thought to exert a negative impact on help-seeking processes. The gender status of women in Hispanic societies meant that they were sometimes not afforded the attention and care they might otherwise gain as men. A provider summarized,

> The female in the Hispanic culture does not have as much value as the female in the Anglo culture. The male has the upper hand and is the most important. The Hispanic male is put on a pedestal and they get all of the attention.

Such statements occasionally bordered on the stereotypical. Another provider asserted, "The women often learn to be subservient and the boys learn to be more domineering. They're controlling of their women and their women's actions." This passive role of Hispanic women complemented the stereotype of Hispanic male youth as aggressive and prone to violence. That most youth clients were mandated by the courts to see providers, and that these clients were largely Hispanic boys and young men, might have reinforced these stereotypes about Hispanic gender norms.

The assessment of the role of gender in help seeking, however, was not univocal. Other providers noted that traditional male cultural roles and expectations, in conjunction with cultural ethos of self-reliance, placed

barriers to help seeking and produced negative health outcomes. One provider explained,

> Men are trained to take care of themselves and to think that they don't need help. That's a huge cultural problem. We have trained our males to be self-sufficient and to not ask for help and it's become a detriment to them. And I think that's why we have more of the male population commit suicide.

It is important to note that some Hispanic providers contested these negative stereotypes of Hispanic gender roles. When probed about the roles she thought *machismo* played in her work with victims of violence, this same provider explained,

> I always have . . . a real strong aversion to how people think about [*machismo*], or what they think that means, and how it's defined because it has lots of negative connotations about Latino culture; and you know I want to always be someone who can speak to the gifts of men in our community.

Socioeconomic Factors

Socioeconomic factors were also regarded as important considerations when evaluating cultural barriers to help seeking. The region in which we conducted this research has undergone a substantial change in economic opportunity as the main industries in the area, mining, ranching, and logging, have diminished in importance. Compounding these circumstances are local attitudes toward education, future goal orientation, and opportunity. One provider commented,

> There doesn't seem to be a vision or a goal and I don't know if that's the culture's mentality or because we're poor—people don't have the imagination to look forward to the future. And kids here just don't really seem to see education as a vehicle to get them what they want or to move them down the road.

Nearly all providers concurred that there was "nothing for youth to do" in the region, emphasizing the dearth of youth-focused entertainment venues (i.e., movie theatres, skating rinks, pool halls and arcades, and dances). The general perception was that in the absence of such activities, youth turned to alcohol, drugs, and sexual activity. Risk factors typically associated with poverty, such as single-parent households, lack of education, teen pregnancy and early parenting, sexual and domestic violence, and criminality were commonly mentioned by providers in relation to the problems experienced by adolescents in the region. The attitudes underlying these behaviors were construed as phenomena that were passed on to younger generations through families and shared by others in the larger community. In this way, broader socioeconomic processes were reduced to cultural factors in explanations of youth substance abuse and a number of other issues.

Denial of Cultural Issues

Several providers did not emphasize the importance of cultural factors in shaping the youth help-seeking process. Instead, these individuals noted that adolescents from different cultural groups were more alike than different as a result of their involvement with substance abuse and the related treatment issues they faced. A provider summarized, "By the time they get to me there is not much difference. They're presenting with pretty much the same stuff."

Finally, some providers had apparently never considered how cultural factors might influence the help-seeking patterns of the people they worked with, and they were thus unable to provide an answer when asked about this topic. Some providers struggled to articulate ethnic or cultural attributes of peoples in the region, and one provider simply admitted, "I don't know the answer to that." In fact, most providers claimed having no problems with cultural differences between themselves and their clients, except those of related language. However, in those cases where providers were required to communicate with Spanish-speaking relatives and were unable to, the majority of providers felt that they could rely upon a bilingual staff member or the youth to reliably translate. Although this reluctance to engage in critical discussion might reveal some discomfort with reporting negative assessments of personal or institutional competence in the interview context, the absence of speech was telling in itself. Silence on this issue might reflect providers' adherence to greater sociocultural pressures, namely the "politically correct" avoidance of articulations of culture as linked to race (Del Vecchio Good, Good, & Becker, 2003; Gordon & Newfield, 1994).

Discussion

Substance abuse treatment providers practicing in southern New Mexico have a limited conception of culture that uncritically promulgates stereotypical

views of the Hispanic family and gender roles even as it conflates cultural barriers to treatment with structural ones. Current national initiatives call for incorporating cultural considerations into treatment plans and interactions with patients and their families (New Freedom Commission, 2003; Surgeon General, 2001), but this research suggests that frontline service providers might already hold perceptions of "culture" that influence how they work with clients. The integration of culture into treatment represents a positive shift, but it is essential to not lose sight of the ideas providers already possess about their patients' culture and how these ideas influence their interactions with clients and determine the issues they directly address (or not) in treatment and prevention settings.

At issue are shifts in the dominant U.S. society regarding the notion of culture itself and an associated tendency to avoid articulations of cultural differences because "we are all the same" (Frankenberg, 1993; Gordon & Newfield, 1994; Willging, Salvador, & Kano, 2006). The fact that some providers experienced conceptual or moral difficulty in describing cultural or ethnic attributes was not surprising. In recent decades, the term *ethnicity* has replaced *race* to depict how culture is linked to one's descent (Balibar & Wallerstein, 1988; Hall, 1992). The replacement of race is, in part, the result of a historical process whereby this term has been misused to ascribe cultural attributes to particular groups as inherited features. Ethnicity, however, more accurately describes how patterned beliefs, attitudes, and behaviors are transmitted over time through shared cultural and social processes. Although the move to disconnect ideals about culture from racial concepts is a welcome one, the shift is incomplete. Terms like ethnicity still allow for the conflation of cultural variables with the biological determinism underlying racial classifications and associated attributes (Gilroy, 2000; Harrison, 1995).[1]

It is worth clarifying that some providers, when asked about ethnic or cultural differences among their clients, responded with versions of "all families are prone to substance abuse problems." These providers also expressed a color-blind approach to service delivery, asserting that neither race nor ethnicity should influence access to treatment. Although these efforts to avoid bias demonstrate providers' good intentions, they might also indicate a denial of the role that racism and cultural variation play in shaping differential patterns of help seeking and access to treatment as well as the experience and outcome of these processes. As we discuss below, confronting these issues, as uncomfortable as it might be, can reveal how and why families might be culturally disoriented in the face of services offered.

Although some providers were hesitant to link ethnicity or race to culture explicitly, they more easily discussed how culture related to poverty. Moreover, when discussing such dynamics, providers often articulated versions of the "culture of poverty" theory dominant in the 1970s and since criticized in the social sciences for its racist implications (Goode & Eames, 1996; Jones & Luo, 1999; Leacock, 1971). As conceptualized by its originator, Lewis (1966), a sense of hopeless acceptance of poverty is passed down from parent to child within certain social groups, and some ethnic groups, including African Americans, Puerto Ricans, and urban Mexicans, manifest this culture more than others. According to the logic of this theory, the inherited culture of the impoverished is to blame not only for substance abuse but also for the reluctance of some to use available health and human services appropriately to address this issue. Such causal reasoning omits consideration of the many structural and historical factors that might better explain local patterns of poverty as well as service use. In the setting of southern New Mexico, this logic is reproduced through the notion that Hispanic families are especially prone to substance abuse and more resistant to treatment in spite of the commonplace assumption among providers that services are free or readily available to them.

A politically correct avoidance of discussion of difference, the application of stereotyped cultural roles in an ethnically marked context, and the erasure of local and national relations of power are some of the ways in which the experiences of Hispanic and other peoples are simplified within the dominant U.S. society. In contrast to this unitary vision of Hispanic experience, other research clearly indicates diversity associated with national origins, socioeconomic class, and generational status (cf. Raffaelli, Carlo, Carranza, & Gonzalez-Kruger, 2005). Factors such as geography, gender, sexuality, and age have a differential effect on how people from the same "ethnic group" or even from the same community experience substance abuse and access help to address it (Quimby, 2006).

The classification of Hispanic people as a homogeneous cultural group represents a failure to recognize and address this diversity and has been shown to generate problems in a number of different domains ranging from research methodology and treatment (Asencio, 1999; Vega, Gil, & Kolody, 2002) to politics and community action (De Genova & Ramos-Zayas, 2003).

Within this cultural heterogeneity, however, U.S. Hispanic people as a whole are subjected to discrimination and stereotyping, and for particular populations the stresses related to these processes are shown to have negative behavioral health outcomes (Araújo & Borell, 2006). Many study participants rejected the notion that Hispanic people in southern New Mexico were discriminated against, drawing on the commonly held local belief that Hispanic culture prevails. Indeed, Hispanic peoples are now the largest minority in the United States, and New Mexico is a "majority–minority" state, with a 43% Hispanic population (Bernstein, 2004). Historically, however, the majority of the power holders in this nation, and even in this area, have not been Hispanic. This holds true for the ethnic composition of the contemporary behavioral health care workforce as well.

It is important to note that systems of meaning that blur culture and ethnicity give providers a conceptual means to associate Hispanic culture with youth substance abuse and lack of treatment usage. However, reluctance to participate in treatment, the importance of family and religion, and the experience of living in poverty are factors that are more aptly analyzed in terms of features associated with rural contexts and structural barriers (Elliott & Larson, 2004) rather than being characterized as collective cultural attributes shared by Hispanic people as a whole. It is possible that some providers, trained and brought up in urban areas far from southern New Mexico, might not be prepared for managing these cultural concerns with their otherwise well-equipped clinical tool set. Considering cultural issues as an ethnic "deficit" in substance-abusing youth and their families or challenging deeply held feelings of ethnic pride or identity understandably leads to conflict and alienation among clients.

Several research participants shared other challenges that face youth. In this rural region, vast distances between residence and treatment facilities and the lack of public transportation pose serious challenges for youth in need of substance abuse treatment services. Rural social dynamics led to processes whereby some youth are labeled as "bad" and to family apprehension that gossip might arise concerning an adolescent's participation in treatment. Compounding these barriers to help seeking is the notion that youth and their family members might lack appropriate immigration documentation and fear deportation on discovery in treatment contexts. Furthermore, the new sources of employment in southern New Mexico, which are replacing historical forms of livelihood that are in decline, typically lack basic benefits, such as insurance, that would otherwise increase access to treatment.

Implications for Provider Training

In line with a recent review of behavioral health services issues in rural settings (Heflinger & Christens, 2006), we suggest that improvements that are simply directed at increasing the quantity of providers and therapeutic services in rural settings will not necessarily improve the quality of care available. This is particularly true where outdated and static notions of culture adversely affect well-intentioned efforts to integrate cultural factors into prevention and treatment models, resulting in simplistic responses to the complex social, political, and economic realities that create health disparities among ethnic minority populations (Willging, Helitzer, & Thompson, 2006). The research reported here suggests several important implications for carrying forward mandates for culturally competent treatment, particularly for practitioners in both rural and Hispanic settings.

First, it is essential that providers become familiar with the historical forms of marginalization that result in present day access barriers to substance abuse treatment services for people of color in New Mexico. As suggested by the providers we interviewed, perceptions of the Hispanic family are fundamental to local understandings of culture. Yet, providers commonly assigned to Hispanic families the qualities of closed, reticent, and unwilling to seek help from outsiders for substance abuse and mental health problems. Although more generally held social stigmas associated with behavioral health problems and concepts of self-reliance no doubt influence how some Hispanic families seek help (Ortega & Alegría, 2002), it is also important to note the role that a history of discrimination and racism plays in such processes. Providers in the southwestern United States work within the context of a colonial legacy of emotionally charged interactions and processes through which specific cultural groups have been exploited, misrepresented, and stereotyped. This has resulted in a climate where many New Mexican American Indian and Hispanic communities look on mainstream health and human service institutions with suspicion (Horton, 2004). These perceptions might be more the result of shared experiences of a specific sociostructural system of racism than a shared system of cultural values or beliefs. Attributing Hispanic help-seeking behaviors to "culture" in this situation obscures these relationships

and directs change attempts at Hispanic "beliefs" rather than at the social structures that have historically shaped the development of these sentiments.

Second, the prominence of the family as the initial site for illness management and the locus of resiliency points to the need for policy makers and providers to collaborate on strategies to more effectively engage families. At present, efforts to include families in treatment typically occur within the context of law enforcement interventions. For example, the families of adolescents taking part in court drug programs are often mandated to participate in treatment alongside their kin. Although many find such participation extremely beneficial, others resent the implicit criminalization of the overall family unit and blame adolescent members for the unwanted scrutiny from law enforcement and behavioral health professionals.

Data from our larger study suggest that family members who have been required to participate in youth substance abuse treatment claim a certain degree of disorientation with the language of treatment, whether it be in English and where a professional translator is not available, or when concepts foreign to them are invoked, such as those employed in Alcoholics Anonymous or Narcotics Anonymous programs. These family members claim to dutifully complete mandated requirements, including participation in 12-step meetings and group counseling and regular drug tests, sometimes to the detriment of their job security, all in the interest of helping a son, daughter, grandchild, or niece or nephew. "Helping" youth means fulfilling these program requirements. That family-oriented treatment pedagogy gets lost in translation suggests that supporting family resiliency in these populations might mean addressing the more difficult challenge of providing not only appropriate Spanish language services but also educational and employment opportunities for youth and families, even for those lacking residency documentation.

Third, in contexts where access to behavioral health care services is limited and individuals might use less formal, culturally endorsed forms of help, it is important for behavioral health professionals to establish and maintain referral networks that include family and community leaders, elders, and clergy. Because religiosity and spirituality do play important roles in the help-seeking processes of families in the four-county region, it is imperative that professional providers seek to forge working alliances with interested clergy to ensure that as many points of access to substance abuse treatment are open to area youth as possible.

Fourth, the beliefs, practices, and language of non-White peoples are best approached as a resiliency factor rather than a risk factor or as a "deficit" (Flores et al., 2002). Some providers, when pressed, mentioned the closeness and value of family, the tendency to look to elders for support, and the importance of spirituality and respect as strengths that Hispanic culture could offer substance-abusing youth. However, these depictions slid easily into how these same factors placed children at risk. There were several silences in response to direct probes about the strengths that Hispanic ethnicity offered youth. Questions about cultural differences among client populations seemed to be interpreted as euphemistic queries for racism or rejection of dominant (White) values or treatment culture. That providers rarely considered Hispanic cultural heritage or values as a strength to people in need of behavioral health services but saw them as obstacles to general well-being suggests a belief that culture is a trait to be treated and changed, if not simply rendered irrelevant in the face of other etiological agents. Simplistic readings of a return to a precolonial or "traditional" culture to inform behavioral health work enable this understanding of culture as something to be treated (Brady, 1995).

Fifth, providers make it clear that socioeconomic status, not just culture, is important in determining the social context of illness, help seeking, and recovery. It is well documented that people suffering from substance abuse problems report self-medicating to address the depression of unemployment, alienation, or school problems or to labor more hours or get through the workday, or engage in drug trafficking to support themselves (Corcoran & Corcoran, 2001; Finch, Catalano, Novaco, & Vega, 2003; Harris & Edlund, 2005; Trujillo, 2006; Willging, Trujillo, & La Luz, 2004). These are strong factors not to be overlooked, especially in a rural context of severe economic decline and absence of livelihood opportunities. To conceptually embed poverty into culture via commonplace culture of poverty arguments, however, disables understanding of the means by which both cultural values and economic status are constructed through historical processes and events. By foregrounding culture in the absence of economic considerations, those interested in addressing substance abuse issues might miss out on some rather clear-cut factors shaping adolescent substance abuse and its treatment.

Sixth, providers' lack of awareness regarding the influence of cultural factors on substance abuse help seeking is troubling and might indicate a need for more explicit, extended training. Such training should first

encourage providers to think reflexively about their own value systems and the status and privilege (often based on race) that they bring to clinical encounters with patients of varying cultural, ethnic, and class backgrounds. For example, some Anglo female providers made critical commentaries about Hispanic gender roles as marked by masculine privilege, or *machismo*, a system of values that apparently allowed for permissiveness toward boys and a lack of attention to girls. This vision resonates with the Third World feminists' critique of how northern feminists have mobilized to address the mistreatment of marginalized women by their family members while extracting these "well-meaning" women's privileged agency in power dynamics and structures that contribute to both women's and men's oppression (Burton, 1990; Frankenburg, 1993; Mohanty, 1988). A few Hispanic providers revealed their discomfort with discussing *machismo*, referring in different ways to how this construct has been used by social scientists and others to pathologize Hispanic society in general (Guttman, 1996; Paredes, 1971). Indeed, none of the White providers made mention of such histories of *machismo*'s representation.

The process of confronting one's role in status hierarchies is often uncomfortable and conflict ridden, especially in locations where "well-intentioned" people are serving the "less fortunate" (Del Vecchio Good et al., 2003), including contexts of rural poverty or racial marginalization. In multicultural environments, minority perspectives and knowledge can diverge from the beliefs and practices of White or Anglo peoples, whose value systems generally rest safely within the order of dominant society, as well as in the order of dominant biomedical practices and pedagogy. It can be troubling and quite challenging to consider how the same ideologies that shape one's values as "doing good" also sustain racial, economic, and geographic privilege and exclusion. Thus, such training should foreground reflection on how providers also live and work in multiple cultures of their own and that racism is best understood not as a quality of individual actors but as a historical process of both marginalization and privilege that affects all (Frankenberg, 1993). By calling into question perceptions of culture as a problem that the provider rather than the client must overcome, such trainings can then demonstrate how different experiences, knowledges, and values cannot just be acknowledged but must be integrated and appreciated. The need for further research to structure the content of such training and for subsequent evaluation remains great (Flores et al., 2002) despite the national emphasis recently placed on cultural competency.

Finally, workforce development might provide important inroads into the establishment of community-responsive substance abuse services. Nationally, Hispanic people are significantly underrepresented in the health and behavioral professions (Flores et al., 2002). That there were few native, Hispanic, or long-term professional behavioral health providers in the four-county region suggests greater possibilities for cultural dissonance with adolescents and their families and those treating them. State and local governments might wish to consider mechanisms that encourage the training, hiring, and licensing of local behavioral health professionals who represent the cultural background of the communities in which they serve. State and local government agencies can develop relationships with local and state institutions of higher education to provide training opportunities and internships to behavioral health professionals in exchange for service. A developing body of research suggests that "matching" backgrounds of providers with young clients results in beneficial behavioral health treatment outcomes (Halliday-Boykins, Schoenwald, & Letourneau, 2005; Jerrell, 1998). Nevertheless, although clearly important, recruiting ethnic minority professionals does not ensure that services will be culturally appropriate, as providers might be far different from their patient population (Shaw, 2005; Willging, Helitzer, et al., 2006).

Conclusion

If they are to develop and implement culturally competent substance abuse treatment services for rural adolescents and their families, it is imperative that providers consider their own views of culture and how such views influence their interactions with clients. At the same time, it is essential to recognize the constraints under which most providers practice and the fact that broader supports might be needed to ensure the delivery of culturally competent care. The ability of rural providers to address the diverse range of factors that influence the involvement of an adolescent and family in substance abuse is a substantial task and hardly possible with substance abuse counseling or inpatient treatment alone. Providers often are overwhelmed with the basic problems-in-living and complex behavioral health issues that many of their young clients and families face on a daily basis,

including larger processes of poverty that they cannot address single-handedly. Providers also maintain contradictory ideas about the Hispanic family, with some providers emphasizing "deficits" and others recognizing "strengths." Although some providers view Hispanic heritage as a community strength to be tapped for prevention and treatment purpose, the dominant notion that "race does not matter" limits how providers can draw upon cultural values descriptive of, but not necessarily specific or limited to, Hispanic peoples.

Note

1. In critical race and cultural racism theories, the beleaguered term *race* has been vindicated as a means to articulate contexts where peoples have been subjected to processes of historical racism. We use the term *race* in the context of related discussion as "Hispanics" have been subjected to a constellation of racializing ideologies that determine them inferior to the dominant group, Anglos or Whites. We use the limited term *Hispanic* in reference to how most research participants described people of Latin-American or Spanish-speaking heritage. Although *Latino* might be preferred for an academic audience, use of this term alone is not ideal, especially in this context where people use other terms in this diverse cultural environment to identify their cultural heritage.

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