

PRINCIPLES OF MULTICULTURAL PSYCHIATRIC REHABILITATION SERVICES

Background Information

PRA recognizes the striking disparities in mental health care found for racial and ethnic minorities in the USA and endorses these ten principles as the foundation for providing effective multicultural psychiatric rehabilitation (PSR) services.

Background for PRA Multicultural Principles

This paper, prepared by the Multicultural Committee of the Psychiatric Rehabilitation Association (PRA), is designed as a global overview of issues related to culture. Like many aspects of psychiatric rehabilitation and mental health service delivery, components of this paper are likely to become out-of-date as research and experience provide new lessons; therefore, readers should treat this document as an open door to begin a journey of exploration into culture and cultural competence, not as a complete or definitive review. As with the earlier version of the *Multicultural Principles* (1996), this paper is a work-in-progress, so comments, suggestions, and help with the next revision are always welcome.

Disparities in mental health care

In the USA, and most likely in other countries around the world, due to bias, prejudice and discrimination, people of different groups have different rates of access to and success with health care services, including mental health care (USDHHS, 2001). Mental health service providers, like most people in the USA, assess and treat people differently based on “racial” characteristics such as skin color (Atkinson et al., 1996; USDHHS, 2001).

A culture-centered approach to recovery recognizes and understands that both the philosophy and practice of mental health services in the USA, and the contemporary theories and practices of psychiatric rehabilitation, medicine, psychology, social work, nursing, and other disciplines in the healing arts, are derived from a specific Eurocentric cultural context. A culture-centered approach **is integral to** psychiatric rehabilitation and must be based on the cultural context of the individual person who is using PSR services. Culture-centered practitioners begin this process by first seeking to understand the strengths and limitations of these theories and practices by understanding the Eurocentric scientific and empirical context in which they arose. The next step for practitioners is to expand their cultural competence by learning how to reformulate these interventions in relation to the cultural backgrounds and contexts of the persons whom they serve. Competent practitioners also are committed to the acquisition and implementation of new theories and practices as they become available, including those based on both qualitative and quantitative research methodology.

Understanding culture

The term “culture” often is used to describe ethnic heritage or to refer to a group with some common characteristics. A more useful description is to conceptualize culture as a blend of history, perspective, and beliefs that is shared with other people in a defined group. This view recognizes that culture can encompass such diverse categories as sex (meaning biological makeup), gender identity and gender expression, age cohort, sexual orientation, and health status, while continuing to include ethnicity, national origin, regional identification, and the physical characteristics implied by the term “race.” Race is a social construct, an idea that is created by political, emotional, and social situations, and that creates divisions, dissension, bias, and prejudice among groups of people (Sotnik & Jezewski, 2005). The commonly accepted “racial” categories are not biologically exclusive (USDHHS, 2001), and genetic

contributions to physical appearance are not significantly correlated to other characteristics such as intelligence. Rather, racial labels, often based on skin color (Atkinson, Brown, Parham, Matthews, Landrum-Brown, & Kim, 1996) have been used historically for purposes of inclusion and exclusion. The effect on an individual of his or her “race” needs to take into account his or her experiences with prejudice, discrimination, and oppression.

Culture includes customs, values, traditions, and celebrations that have evolved to help people cope with the challenges that life brings. Culture resides in memories, shared experiences, food, art, music, dance, literature, and family heritage (Pernell-Arnold, What you can 1991) - all of which come together to shape how a person views the world. PRA supports the full inclusion of each individual with his or her cultural differences, recognizing that appreciating differences between people can expand the range of solutions available to solve problems.

At the foundation of the PRA Multicultural Principles is the recognition that all behavior occurs within a cultural context. Culture is complex and multi-faceted, meaning that even two people who share part of their cultural backgrounds are likely to differ in some significant ways. Every encounter between two people, therefore, can be considered a cross-cultural encounter (Pedersen, 2000; Sue, D.W. et al. 1992; Sue, D.W. et al. 1982; Sue, D.W., Ivey, & Pedersen, 1996).

Culture and identity

Everyone has multiple identities and experiences related to culture (see “Aspects of Diversity” below), and each person weighs those cultural variables differently. Although knowledge (real or assumed) about a person’s culture(s) can be used to facilitate understanding of that person, the major source of information about a person’s culture(s) and cultural identity is that person’s description. The person’s family and community are additional valid sources of information. Since every human being is born into a particular culture, every culture provides a context for individual growth and development. In doing so, each culture functions to provide a sense of self, identity, and belonging to its members through shared values, beliefs, customs, and perceptions (Basso and Selby, 1976). A person’s world view is a rich and often untapped source of recovery potential, a container for values, beliefs and perceptions, many of which have been handed down from generation to generation through socialization and enculturation processes. Individual attributes therefore have their roots in cultural heritage through traditions and practices. As a person learns to locate and mobilize resources from his or her cultural backgrounds, and to respect the backgrounds of others, a process of reciprocal empowerment takes place (Prillentski, 1985; Trickett, Birman, & Watts, 1993) that serves as a catalyst for healing and recovery.

ASPECTS OF DIVERSITY

Acculturation	degree to which a person can function in the mainstream culture
Discrimination	barriers to opportunity based on prejudice
Economic status	earnings, income, and financial resources
Education	how much and what type of schooling you had
Ethnicity	your ancestry and heritage
Experience	specific events in your life that influenced your worldview
Gender Identity	whether you consider yourself male, female, neither, or something else individually and/or culturally defined.
Illness/disability	your current condition and past medical/psychiatric history
Immigration/migration status	personal and family history of location and/or relocation



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National origin	where you were born (what you consider your original country/home)
Nuclear family	usually you, your parents, and your siblings
Primary language	the language you spoke at home growing up
Race*	usually refers to physical characteristics, such as skin color
Religion	your affiliation with an organized, spiritually-oriented group
Sex	refers to your biological, physiological, and anatomical composition (male, female, intersex, e.g.)
Sexual orientation	feelings of attraction towards any given gender category or categories of persons
Social kinship network	all people you consider family, may include close friends
Traditions/rituals	practices and routines handed down in your family and/or culture

Cultural identity evolves and changes over time. Some experts (e.g., Helms & Cook, 1999; Kerwin & Ponterotto, 1995) suggest that racial or ethnic identity ranges along a continuum from a lack of awareness of oneself as a cultural being and of one's attitudes towards other cultures to a mature or healthy identity that involves understanding oneself as a cultural, racial, or ethnic being while fully appreciating others' group identities and cultural values.

Cultural variables do not have a fixed importance or salience within a person's identity (McKimmin, 2007). At any given point in the process of rehabilitation and recovery, a cultural variable such as age can change dramatically in its relevance and importance to defining a person's identity. Such changes might have profound implications for the direction in which a person's recovery evolves or may not have any effect at all. Culture, rehabilitation, and recovery interact in complex ways, underscoring the necessity for an approach that not only honors culture, but places it in context with other influential factors, while seeking to understand how these many factors interact in a complex and dynamic fashion.

A cultural identity gives a sense of belongingness to a group and can be a source of pride and support. Similarly, disparagement of one's culture or one's group can be experienced by an individual as a personal attack. Respect for everyone and an appreciation and valuing of difference is essential, as the dignity of a person is not guaranteed unless the dignity of his/her people is preserved (Finley & Pernell- Arnold, 1992).

Initial assumptions about a person's behavior need to be suspended in favor of active exploration of that person's own interpretation of that behavior within his/her cultural contexts. The perspectives of family members, friends, and involved community members may be beneficial in developing a full understanding of an individual's actions and reactions.

Culture, family, and community

Natural systems, such as family, community, church, or healers are primary mechanisms of support for many people. "Family" may be defined differently by different cultures and should be considered the primary and preferred point of interventions, where family involvement is desired by the person receiving services. Families from some cultures perceive separation from the family as a major source of problems for the person, family, and/or the community.

Culture-blindness

Many people, especially people from a position of privilege in a society (Hays, 2001), see their own perspectives as “normal” or “ordinary.” Other perspectives seem “alien” or “wrong,” unless one has a full appreciation of the validity of diverse views. Lack of awareness of one’s own culture, or “culture-blindness,” can result in ignoring the possibility that the mainstream culture in one society may be considered “odd” in another society.

Psychological theories and mental health practices are often specific to a mainstream US or European worldview (Sue, 1992; USDHHS, 2001) but are mistakenly applied as universally beneficial. Psychiatric rehabilitation practitioners must be aware of such biases and must work to modify and tailor interventions to maximize compatibility with the worldview, values, beliefs, and expectations of the individuals using their services. Even program models or interventions that have been demonstrated to be effective and are considered to be “evidence-based practices,” may be of limited benefit to people from cultural groups that differ from those in the original studies; (Atkinson, Bui, & Mori, 2001).

One aspect of culture-blindness is a lack of awareness of the degree to which members of privileged groups within the majority culture benefit by their status (Hays, 2001). This lack of awareness then makes it difficult for individuals who benefit from privilege to fully understand the ways in which members of other groups may experience bias/discrimination. The unacknowledged discrepancy in benefits ultimately allows prejudice, discrimination, and oppression to continue.

Discrimination and prejudice

Many people, if not all people, have experienced some form of discrimination (Finley & Pernell-Arnold, 1996; PRIME, 2006). PSR practitioners need to be committed to learning about problems and issues that adversely and disproportionately affect the various cultural groups with whom they work (PRIME, 2006). Experiences with prejudice and discrimination, both personal experiences and historical events against a person’s cultural group, affect a person’s development and relationships. Other social forces, such as poverty and political oppression, affect a person as well (Hays, 2001; Locke, 1992). The conditions of prejudice, rejection, and discrimination need to be addressed as rights violations as well as barriers to recovery (Finley & Pernell-Arnold, 1996). Discrimination is experienced as stress. The skills for handling this type of stress are not generally available in families or through institutions; consequently, most discriminatory experiences are not resolved or healed. Unresolved discriminatory experiences can produce residual effects such as negative emotions, behaviors, beliefs, and attitudes that interfere with self-esteem, relationships, and achievement. The effects of discrimination are issues in treatment, rehabilitation, and recovery. A thorough understanding of the experience of discrimination will reduce the risk that, in the liberation of one group, another group could be victimized. PSR practitioners need to have the skills needed to help people share these experiences, to prevent isolation, to teach coping strategies, to heal, and prevent the internalization of the negative messages and long-term impacts of discrimination. Psychiatric rehabilitation practitioners have a role and responsibility to eliminate, or at least mitigate the effects of all “isms,” such as racism, age-ism, able-ism, and heterosexism, and to advocate for access to opportunities and resources. Practitioners also are responsible for actively promoting positive intergroup relations, particularly between program participants and the larger community.

Universal building blocks of culture

Cultures can be described through certain themes that appear to be universal (Hays, 2001). These include history, worldview, traditions and celebrations, beliefs and values, communication style, kinship and social support/status patterns, achievement orientation, and beliefs about health, illness, mental

health, and disability. Psychiatric rehabilitation practitioners can use this framework of themes to understand a previously unfamiliar culture.

For example, worldview encompasses the ways that someone makes sense out of the world, including such basic notions as the meaning of time, space (including personal space and the relationship between humans and the natural world), the role of luck or fate in how events unfold, and the definition of “me” (e.g., as an independent individual or as one interconnected component of a family or community). Each worldview is valid and influences how a person perceives and defines problems, perceives and judges the nature of help, assesses the viability of various possible solutions, and conceptualizes the desirability of various possible outcomes. Psychiatric rehabilitation practitioners show respect by accepting cultural preferences that value process or product, harmony or achievement within one’s life, and interdependent relationships or individuation and independence.

Culture specific factors

Many cultural competence training programs, and much of the literature on culture, provide background on specific cultural groups. In the USA, the most frequently described groups of color are Asian Americans, Hispanic or Latino Americans, African Americans, and Native Americans. These divisions may provide a useful starting point for learning about different cultures, but such broad dividing lines mask the extensive differences found within cultures. Information on communication styles, cultural identity development, learning styles, gender roles, definitions and patterns of family, and many other culture-specific factors must be studied to understand how they interact to influence how each person and family becomes a specific representation of their culture.

A culturally competent education or training program provides information on universal factors and includes specific information about all of the cultures present amongst the learners in the group, as well as about the ethnic and cultural groups present amongst local practitioners and persons being served by local mental health programs, about their families, and about local communities. Most importantly, training needs to emphasize that the culture of the United States of America has evolved from European cultures, and US culture needs to be explored as the dominant culture with which all other cultures are interacting.

The PSR practitioner’s goal in learning about culture is to understand how to use questions and constructive narrative to help each person tell the story of his or her culture, values, and beliefs. The next step is to help the person incorporate these into choices, goals, and coping strategies.

Acculturation and change

Belonging to one cultural group implies that there are views and values about what it means to belong to that group, and that these views and values form the basis for decisions made, consciously or unconsciously, about the role and importance of that culture in one’s life. A person may choose to reject his or her culture of origin, in whole or in part; to selectively adopt aspects of another culture (perhaps the mainstream culture); or to become bicultural, accepting and integrating divergent views and values. A demand to assimilate or acculturate, regardless of the source of that demand, can create stress and compromise a person’s mental health and recovery.

Acculturation involves choices and changes in behavior that increase similarity to the dominant culture and/or decrease similarity to one’s culture of origin (Landrine & Klonoff, 2004; Wolfe, Yang, Wong, & Atkinson, 2001). For members of a non-mainstream or minority group, success in the mainstream culture may require adopting some behaviors and beliefs of the dominant culture (biculturality). Any person from a non-mainstream cultural/ethnic group has to be bicultural to succeed in the mainstream culture, and

PSR practitioners recognize that this bicultural stance, along with demands to acculturate, creates its own set of mental health issues and identity conflicts. Relationship to the person's reference group, personal satisfaction, goals, and comfort are issues to be considered when a person is making choices between mono-, bi-, or multi-cultural identities.

At times, one culture's values and norms will conflict with those of other groups, or a culture may have practices that are not consistent with US law. PSR practitioners need to recognize that such conflicts exist, to help individuals deal with such clashes of beliefs and norms, and to foster acceptance and tolerance of diversity. In general, PSR programs and practitioners need to be welcoming of differing perspectives, while ensuring that acceptance of any one practice or point of view does not serve to oppress people with differing views or practices.

Culture and psychiatric disabilities

Views vary about health, illness, "mental" vs. "physical" conditions, and what constitutes an acceptable form of "treatment." While the mainstream culture in the USA values scientific explanations of illnesses (e.g., "schizophrenia is a brain disease"), this view is not universal. Cultural definitions of illness are dependent on the group worldview and belief system - illness might be seen as emanating from the violation of a taboo, separation from the family, violation of a death bed promise, violation of a spiritual or religious covenant, angering the spirits, a curse, or "fixing" (poisoning) the food. Practitioners need the skills to recognize and respect these beliefs. In addition, alliances are needed with folk medicine and alternative treatment practitioners in order to prevent harm, coordinate interventions, and provide services that are compatible with the person's culture.

The process of rehabilitation and recovery often involves a radical change from that of a person with an illness/disability to that of a person in recovery from an illness/disability (McKimmin, 2007). A person experiencing this change may need to seek out and develop resources to help manage the "culture shock" (Pedersen, 1996) that accompanies this journey and the resulting personal transformation.

A culture-centered approach (McKimmon, 2007) recognizes and acknowledges the unique cultural context and background of the person in recovery and of all participants in the recovery process. Because culture is **the** context for recovery, recovery comes to be re-interpreted as a change in one's sense of self, a profound change in one's cultural identity. A culture-centered approach to recovery begins with the client's current cultural context, including family, friends, and support system. It extends to include both client cultures and professional cultures from which the person in recovery draws support and develops skills in the course of their recovery. This includes all clients as well as professional persons assisting recovery—practitioners, and system administrative and support staff—who are supportive and helpful to the person in recovery. A culture-centered approach to recovery acknowledges that every participant in recovery may function as a "cultural teacher" or "cultural" (Pipher, 2002) in supporting the person in recovery's journey.

A culture-centered approach to recovery also recognizes that recovery itself is a multidimensional phenomenon. The personal transformation described as "recovery" has been described as the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993). Recovery has a second dimension, that of growing beyond the catastrophic effects of having a mental illness, and possibly co-occurring substance and/or alcohol abuse. In addition, all persons in recovery are confronted with growing beyond the oppressive effects of stigma, privilege, and the "isms," including, but not limited to, classism, racism, sexism, and heterosexism. When recovery is seen as involving these critical dimensions, the task of creating a "culture of recovery" that encompasses persons, systems, and society itself becomes paramount. To be truly transformative in

nature, culture-centered recovery (McKimmin, 2007) needs to begin with effective outreach and prevention efforts, enhance competency in interventions and recovery practices, and promote research and outcomes that improve the opportunities for a durable recovery.

Culture and communication

If every interaction between two people is a cross-cultural interaction, then every communication runs the risk of being derailed due to cross-cultural misunderstandings. For example, communication patterns are affected by language; by worldview (e.g., perspectives on time); and by beliefs about status, gender, and respect. Cultures may vary in their communication styles (Sue & Sue, 1999), and a lack of awareness of these cultural differences can leave PSR practitioners misinterpreting cues and messages, or perhaps unable to get their own messages across.

Cultural competence: Psychiatric rehabilitation practitioners

Practitioners who are culturally competent have studied their own cultures and identities. They have learned to accept the personal meaning of their heritage while viewing it objectively. They have become aware of their own biases, stereotypes, and prejudices, and can recognize such biases in others. They know that interpersonal encounters can never be objective or fully value-free, and that mental health services and interventions grow from practitioner beliefs, values, and positions in society (Ballou & Gabalac, 1985; Morell, 1987). Through study and experience, the culturally competent practitioner has developed an appreciation and understanding of other cultures and can overcome his or her own limited perspectives and biases to develop a positive working relationship with someone from a different background. Each of us lives in a cultural bubble; a culturally competent practitioner can enter another person's bubble without bursting it (Pernell-Arnold, 1995).

A culture-centered approach to recovery (McKimmin, 2007) expects that people who use and deliver PSR services are aware of and knowledgeable about the problems posed by ethnocentrism and cultural encapsulation (Wrenn, 1962) and are prepared to acquire the skills necessary to eliminate or delimit their negative influences. This awareness begins with one's own worldview, including culturally learned assumptions and biases that are embedded in that world view.

From a culture-centered perspective, culture is understood as a learned phenomenon. Cultural competence requires un-learning the beliefs and opinions that act as barriers to effective and culturally appropriate service delivery, while learning new values and beliefs that can assist in the recovery process, and while learning about problems and issues that adversely affect historically disadvantaged populations. Because prejudice, discrimination, privilege, and oppression exist within society, culturally competent individuals acknowledge their responsibility to mitigate the effects of these societal "isms," and to advocate for access to opportunities and resources for all.

The term "cultural competence" as used here implies a life-long process, rather than an expected outcome, and does not presume that any practitioner can achieve the state of being fully cultural competent. Cultural competence is a unified set of behaviors, attitudes, and policies that come together in a system, agency, or group of professionals that enable working effectively in cross-cultural settings (Cross et al., 1989). Becoming accepting of and responsive to diversity challenges service providers to become flexible and person centered.

Traditionally, cultural competence training has focused on knowledge of specific groups, which risks implying that people can be fit neatly into categories and may lead practitioners to perceive individuals as representatives of a particular cultural group, rather than as unique individuals. One can never know all

there is to know about the many diverse cultures in the world. Even if that were possible, within-culture diversity makes understanding any individual a complex challenge.

Cultural competence: Psychiatric rehabilitation programs and mental health systems

As currently formulated, many of the core concepts of psychiatric rehabilitation - choice, empowerment, hope - have their origin in relation to the notion of an individual or Western concept of selfhood. Using interventions that have been derived almost exclusively from a Western view of the self runs the risk of making rehabilitation and recovery programs and systems irrelevant to persons who belong to or grew up in a more collectivist context, as well as those who may have rejected assimilation into mainstream US cultural life. Not everyone in the USA sees “choice” as something that they, and they alone, have the power to enact or realize. Any intervention that is solely Eurocentric in its understanding and practice neglects to take into account the mediating variable of acculturation, making it potentially irrelevant for many individuals. Programs and practices need to be tailored to meet the unique cultural needs of every person in recovery in order to avoid the danger of sacrificing individualization, which is a key value of psychiatric rehabilitation (McKimmin, 2007).

In order for practitioners to be effective at the direct service level, institutions, organizations, and agencies must also be culturally competent. This is accomplished by:

- assessing the level of competence of the agency and its practitioners
- assessing the presence and needs of underserved population
- involving cultural experts, people who use the agency’s services, families, and community leaders in the development of culturally compatible services
- the development of regulations, policies and procedures that permit the flexible responses to cultural differences

For example, people from some cultures will not go to a mental health facility, and might need, for instance, home based services, Saturday services, or services based in a church, temple, or mosque. Explanations of diagnosis and interventions need to be given in the context of the person’s understanding of what is causing the problem. Accommodations need to be made to render services compatible with the person’s culture, such as creating a vocational placement in the family’s place of business.

People who use and deliver PSR services can benefit from an individual cultural competence plan. This plan might include the competencies that enable more effective interaction with others perceived as different, as well as advocacy and action in personal, professional, and political spheres to combat prejudice and discrimination. Similar plans might be developed for every service component of the mental health system of care and for the system itself.

A culturally competent organization is one in which the mission, policies, procedures, and organization culture create a multicultural environment in which cultural responsiveness regularly occurs. The organizational atmosphere is welcoming and supportive of diversity. A process exists for the assessment and development of multicultural organizational competence. All levels in the organization are representative of the cultural, racial, and ethnic groups in the organization’s service area. Strong linkages exist between the organization and cultural, racial, and ethnic groups in the community, including family involvement in services and programs. Prejudice and discrimination are not tolerated; there are established processes and procedures to address and eliminate discrimination. Practices exist for ferreting out covert and overt practices of prejudice, ethnic slurs, jokes, destructive assumptions, stereotypes, and stigma towards any group, including people with mental illness.

Within the culturally competent organization, mechanisms and guidelines exist for settling disputes and

disagreements, and are consistent with multicultural values and practices. Evidence exists that these mechanisms and guidelines do lead (or have led) to problem resolution. Services, programs, activities, and physical spaces encourage and reflect the expression of cultural, racial, and ethnic differences, through worldview, the arts, communication, and learning styles. Services and organization management practices are designed to meet the needs of and be congruent with various cultural, racial, and ethnic groups. Services are culturally and linguistically accommodating. Staff and administration have the skills and competencies needed to implement culturally competent services. Regular evaluation and training facilitate ongoing development of multicultural competencies. The organization quality assurance program and any evaluation of program outcomes are consistent with multicultural values.

Training to increase cultural competence

Cultural competence requires expanding resourcefulness; exploring diverse recovery options, including indigenous healing traditions, as appropriate to a person's individual needs and preferences; and offering hope of a more complete and durable recovery. A culture-centered approach to rehabilitation and recovery combines interdisciplinary perspectives on illness and wellness. It does so to provide a balanced and comprehensive interpretation of human behavior in terms of the context in which it was learned and how it is displayed (Pederson, 1996). A culture centered approach to recovery requires moving beyond the "comfort zone" of one's professional discipline, and to seek out knowledge and skills that augment existing competencies.

Training is required to develop cultural competence. The attitudes, beliefs, and behaviors that negatively influence the practitioner's ability to develop effective cross-cultural relationships are often deeply embedded, and need to be discovered before mature cognitive processes are available. Effective cultural competence training is a complex combination of knowledge from many disciplines, such as anthropology, history, psychology, and sociology. Education and training methods need to be designed to enable practitioners to learn to examine their own biases, learn to be comfortable with difference, how to explore the effect the practitioner's culture has on the cultures of others, how to understand the meaning of life and health in various cultural contexts, and how to apply this knowledge to the process of making services compatible with the cultures of persons receiving services.

PSR practitioners need to be committed to learning about problems and issues that adversely and disproportionately affect the various cultural groups with whom they work (PRIME, 2006). Becoming accepting of and responsive to diversity challenges PSR practitioners to become flexible and person centered, rather than to perceive individuals as representative of their culture. Rather than focusing on providing stereotyped information about a pre-defined list of ethnic groups, effective cultural competence training is systematically designed, taking into account existing research and theory on cultural competence (Pope-Davis & Coleman, 1997; Smith, Constantine, et al., 2006).

The Ethical Mandate

A culture-centered approach to rehabilitation and recovery recognizes that embracing cultural differences requires nothing less than one's own personal transformation. It presupposes the creation and development of an ethical foundation that will support the quest of "openness to the other" (Flowers & Davidov, 2006; McKimmin, 2007). A culture-centered approach recognizes and accepts that encountering and embracing cultural differences will have a profound impact on one's own worldview and cultural identity. Character strengths and virtues needed for such a transformation represent the basic principles that form the foundation for ethical practice honesty, courage, and justice. In the quest to develop full "openness to the other," it is essential to seek out cultural brokers (Pipher, 2002), teachers, mentors, and guides who will help develop and sustain these necessary character strengths. These supports will also

assist in the personal development of an ethical foundation that supports the personal transformation implicit in a culture-centered approach to rehabilitation and recovery.

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