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### **Islam**

In 2008, roughly 1.3 million people identified as Muslims in the United States, making it the third most common religion (Kosmin and Keysar 2009). Many Americans assume that all Arabs are Muslim, but the majority of Arab Americans are Christian; Muslims can come from any ethnic background (Abudabbeh and Hamid 2001). Islam is the most ethnically diverse religion in America, with a membership that is 15 percent White, 27 percent Black, 34 percent Asian, and 10 percent Latino (Kosmin et al. 2001).

Attitudes of Muslims toward mental illness and seeking formal mental health services are likely to be affected by cultural and religious beliefs about mental health problems, knowledge and familiarity with formal services, perceived societal prejudice, and the use of informal indigenous resources (Aloud 2004). Attitudes toward substance use, abuse, and treatment will likely be shaped by Islam's prohibition of the use of alcohol and other intoxicants. Many Muslim countries have harsh penalties for the use of alcohol and other drugs. For these reasons, Muslims

appear to have low rates of substance use disorders. Despite there being no current data regarding levels of alcohol and other substance use among Muslim immigrants in the United States, Cochrane and Bal (1990) found that, in a comparison of Sikh, Hindu, Muslim, and White (probably Christian) men in a British community, Muslims by far drank the least, yet those Muslims who consumed the most alcohol experienced a greater number of alcohol-related problems on average. High levels of alcohol consumption among Muslims who do drink could be related to feelings of guilt and shame about their behavior, thus potentially leading to further abuse and avoidance of seeking substance abuse treatment when problems arise (Abudabbeh and Hamid 2001).

### **Buddhism**

In 2008, about 1.2 million Buddhists were living in the United States (Kosmin and Keysar 2009). In 2001, according to Kosmin et al (2001), the majority of Buddhists were Asian Americans (61 percent), but a significant number of White Americans have embraced the religion (they make up 32 percent of Buddhists in the United States), as have African Americans (4 percent) and Latinos (2 percent). In China and Japan, Buddhism is often combined with other religious traditions, such as Taoism or Shintoism, and some immigrants from those countries combine the beliefs and practices of those religions with Buddhism.

Buddhists believe that the choices made in each life create karma that influences the next life and can affect behavior (McLaughlin and Braun 1998). The Fifth Precept of Buddhism is not to use intoxicating substances, and thus, the expectation for devout believers is that they will not use alcohol or other substances of abuse (Assanangkornchai et al. 2002). In the United States, no specific substance abuse treatment programs specialize in treating

Buddhist clients. Buddhist substance abuse and mental health treatment programs do exist in other countries (e.g., Thailand) and report high outcome rates (70 percent) using culturally specific practices (e.g., herbal saunas) and religious practices (Barrett 1997).

## As You Proceed

This chapter has established the foundation and rationale of this TIP; reviewed the core concepts, models, and terminology of cultural competence; and provided an overview of factors that are common among diverse racial, ethnic, and cultural groups. As you proceed, be aware that diversity occurs not only across racially and ethnically diverse groups, but

within each group as well—there are cultures within cultures. Clinicians and organizations need to develop skills to create an environment that is responsive to the unique attributes and experiences of each client, as outlined earlier in this chapter in the “What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture?” section. As you read this TIP, remember that many cross-cutting factors influence the counselor–client relationship, the client’s presentation and identification of problems, the selection and interpretation of screening and assessment tools, the client’s responsiveness to specific clinical services, and the effectiveness of program delivery and organizational structure and planning.





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