

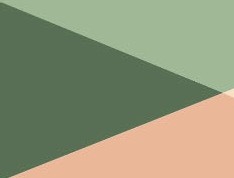
A TREATMENT IMPROVEMENT PROTOCOL

**Improving Cultural Competence**

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**Improving Cultural Competence**

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**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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Improving Cultural Competence

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II

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**Contents**

[Consensus Panel. vii](#_TOC_250009)

[KAP Expert Panel and Federal Government Participants ix](#_TOC_250008)

[What Is aTIP? xi](#_TOC_250007)

Foreword xiii

Executive Summary xv

Chapter 1-Introduction to Cultural Competence 1

Purpose and Objectives of the TIP 2

Core Assumptions 4

What Is Cultural Competence? 5

Why Is Cultural Competence Important? 7

How Is Cultural Competence Achieved? 9

What Is Culture? 11

What Is Race? 13

What Is Ethnicity? 15

What Is Cultural Identity? 16

What Are the Cross-Cutting Factors in Race, Ethnicity, and Culture? 16

As You Proceed 33

Chapter 2-Core Competencies for Counselors and Other Clinical Staff 35

Core Counselor Competencies 36

Self-Assessment for Individual Cultural Competence 55

Chapter 3-Culturally Responsive Evaluation and Treatment Planning 57

Step 1: Engage Clients 59

Step 2: Familiarize Clients and Their Families With Treatment and Evaluation Processes. 59 Step 3: Endorse Collaboration in Interviews, Assessments, and Treatment Planning 60

Step 4: Integrate Culturally Relevant Information and Themes 61

Step 5: Gather Culturally Relevant Collateral Information 64

Step 6: Select Culturally Appropriate Screening and Assessment Tools 65

Step 7: Determine Readiness and Motivation for Change 69

Step 8: Provide Culturally Responsive Case Management 70

Step 9: Integrate Cultural Factors Into Treatment Planning 71

Ill

Improving Cultural Competence

Chapter4-Pursuing Organizational Cultural Competence 73

Cultural Competence at the Organizational Level 74

Organizational Values 76

Governance 78

Planning 80

Evaluation and Monitoring 84

Language Services 88

Workforce and Staff Development 90

Organizational Infrastructure 96

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups 101

[Introduction 102](#_TOC_250006)

[Counseling for African and Black Americans 103](#_TOC_250005)

[Counseling for Asian Americans, Native Hawaiians, and Other Pacific Islanders 116](#_TOC_250004)

[Counseling for Hispanics and Latinos 128](#_TOC_250003)

[Counseling for Native Americans 138](#_TOC_250002)

[Counseling for White Americans 150](#_TOC_250001)

Chapter 6-Drug Cultures and the Culture of Recovery 159

What Are Drug Cultures? 161

The Role of Drug Cultures in Substance Abuse Treatment 171

[Appendix A: Bibliography 177](#_TOC_250000)

Appendix B: Instruments To Measure Identity and Acculturation 253

Appendix C:Tools for Assessing Cultural Competence 259

AppendixD: ScreeningandAssessment Instruments 277

Appendix E: Cultural Formulation in Diagnosis and Cultural Concepts ofDistress 283

Appendix F: Cultural Resources 287

Appendix G: Glossary 295

Appendix H: Resource Panel 299

Appendix I: Cultural Competence and Diversity Network Participants 301

Appendix]: Field Reviewers 303

Appendix K: Acknowledgments 307

**List of Exhibits**

Exhibit 1-1: Multidimensional Model for Developing Cultural Competence 6

Exhibit 1-2: The Continuum of Cultural Competence 10

Exhibit 1-3: Common Characteristics of Culture 12

Exhibit 1-4: Education and Culture 22

IV

Contents

Exhibit 1-5: Cultural Identification and Cultural Change Terminology 24

Exhibit 1-6: Five Levels of Acculturation 25

Exhibit 1-7: Measuring Acculturation 27

Exhibit 2-1: Stages of Racial and Cultural Identity Development 40

Exhibit 2-2: Counselor Worldview 43

Exhibit 2-3: ACA Counselor Competencies: Counselors' Awareness of Their

Own Cultural Values and Biases 46

Exhibit 2-4: ACA Counselor Competencies: Awareness of Clients' Worldviews 47

Exhibit 2-5: Attitudes and Behaviors of Culturally Competent Counselors 49

Exhibit 2-6: ACA Counselor Competencies: Culturally Appropriate Intervention

Strategies 56

Exhibit 3-1: Client-Counselor Matching 71

Exhibit 4-1: Requirements for Organizational Cultural Competence 75

Exhibit 4-2: Creating Culturally Responsive Treatment Environments 75

Exhibit 4-3: Hands Across Cultures Mission Statement 78

Exhibit 4-4: Critical Treatment Issues To Consider in Providing Culturally Responsive Services 80

Exhibit 4-5: Qyalities of Effective Cultural Competence Training 92

Exhibit 4-6: OMH Staff Education and Training Guidelines 94

Exhibit 4-7: Cultural Competence Initiative Across Time in One Organization 99

Exhibit 5-1: Core Culturally Responsive Principles in Counseling African Americans 110

Exhibit 5-2: Lifetime Prevalence of Substance Use Disorders According to Ethnic

Subgroup and Immigration Status 130

Exhibit 5-3: Native Americans and Community 143

Exhibit 5-4: The Lakota Version of the 12 Steps 147

Exhibit 6-1: How Drug Cultures Differ 162

Exhibit 6-2: The Language of a Drug Culture 164

Exhibit 6-3: The Values and Beliefs of a Heroin Culture 166

Exhibit 6-4: Music and Drug Cultures 166

Exhibit 6-5: The Rituals of Drug Cultures 168

Exhibit 6-6: Qyestions Regarding Knowledge and Skill Demands of Heroin Use 168

Exhibit 6-7: 12-Step Group Values and the Culture of Recovery 174

V

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## What Is a TIP?

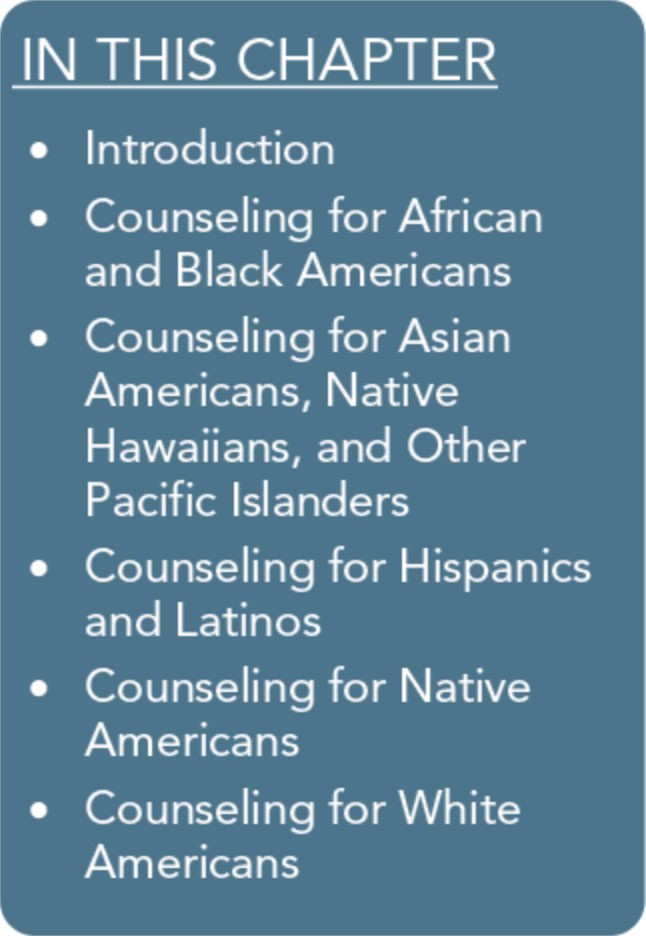
Treatment Improvement Protocols (TIPs) are developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (HHS). TIPs are best practice guidelines for the treatment of substance use disorders.

TIPs draw on the experience and knowledge of clinical, research, and administrative experts to evaluate the quality and appropriateness of various forms of treatment. TIPs are distributed to facilities and individuals across the country. Published TIPs can be accessed via the Internet at [http://store.samhsa.gov.](http://store.samhsa.gov/)

Although each TIP strives to include an evidence base for the practices it recommends, SAMHSA recognizes that the field of substance abuse treatment is continually evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey front-line information quickly but responsibly. If research supports a particular approach, citations are provided.

XI

## Behavioral Health Treatment for Major Racial and Ethnic Groups

John, 27, is an American Indian from a Northern Plains Tribe. He recently entered an outpatient treatment program in a midsized Midwestern city to get help with his drinking and subsequent low mood. John moved to the city 2 years ago and has mixed feelings about living there, but he does not want to return to the reserva­ tion because ofits lack of job opportunities. Both John and his counselor are concerned that (with the exception of his girlfriend, Sandy, and a few neighbors) most of his current friends and coworkers are "drinking buddies." John says his friends and family on the reservation would support his recovery-including an uncle and a best friend from school who are both in recovery-but his contact with them is infrequent.

John says he entered treatment mostly because his drinking was interfering with his job as a bus mechanic and with his relationship with his girlfriend. When the counselor asks new group members to tell a story about what has brought them to treatment, John explains the specific event that had motivated him. He describes having been at a party with some friends from work and watching one of his coworkers give a bowl of beer to his dog. The dog kept drinking until he had a seizure, and John was disgusted when peo­ ple laughed. He says this event was "like a vision;" it showed him that he was being treated in a similar fashion and that alcohol was a poison. When he first began drinking, it was to deal with bore­ dom and to rebel against strict parents whose Pentecostal Christian beliefs forbade alcohol. However, he says this vision showed him that drinking was controlling him for the benefit of others.

Later, in a one-on-one session, John tells his counselor that he is afraid treatment won't help him. He knows plenty of people back

101

Improving Cultural Competence

home who have been through treatment and still drink or use drugs. Even though he doesn't consider himself particularly tradition­ al, he is especially concerned that there is nothing "Indian'' about the program; he dis­ likes that his treatment plan focuses more on changing his thinking than addressing his spiritual needs or the fact that drinking has been a poison for his whole community.

John's counselor recognizes the importance of connecting John to his community and, if possible, to a source of traditional healing.

After much research, his counselor is able to locate and contact an Indian service organiza­ tion in a larger city nearby. The agency puts him in touch with an older woman from John's Tribe who resides in that city. She, in turn, puts the counselor in touch with another member of the Tribe who is in recovery and had been staying at her house. This man agrees to be John's sponsor at local 12-Step meetings. With John's permission, the counse­ lor arranges an initial family therapy session that includes his new sponsor, the woman who serves as a local "clan mother,"John's girl­ friend, and, via telephone,John's uncle in recovery, mother, and brother. With John's permission and the assistance of his new sponsor, the counselor arranges for John and some other members of his treatment group to attend a sweat lodge, which proves valuable in helping John find some inner peace as well as giving his fellow group members some insight into John and his culture.

To provide culturally responsive treatment, counselors and organizations must be commit­ ted to gaining cultural knowledge and clinical skills that are appropriate for the specific racial and ethnic groups they serve. Treatment pro­ viders need to learn how a client's identifica­ tion with one or more cultural groups influences the client's identity, patterns of substance use, beliefs surrounding health and

healing, help-seeking behavior, and treatment expectations and preferences. Adopting Sue's (2001) multidimensional model in developing cultural competence, this chapter identifies cultural knowledge and its relationship to treatment as a domain that requires proficien­ cy in clinical skills, programmatic develop­ ment, and administrative practices. This chapter focuses on patterns of substance use and co-occurring disorders (CODs), beliefs about and traditions involving substance use, beliefs and attitudes about behavioral health treatment, assessment and treatment consider­ ations, and theoretical approaches and treat­ ment interventions across the major racial and ethnic groups in the United States.

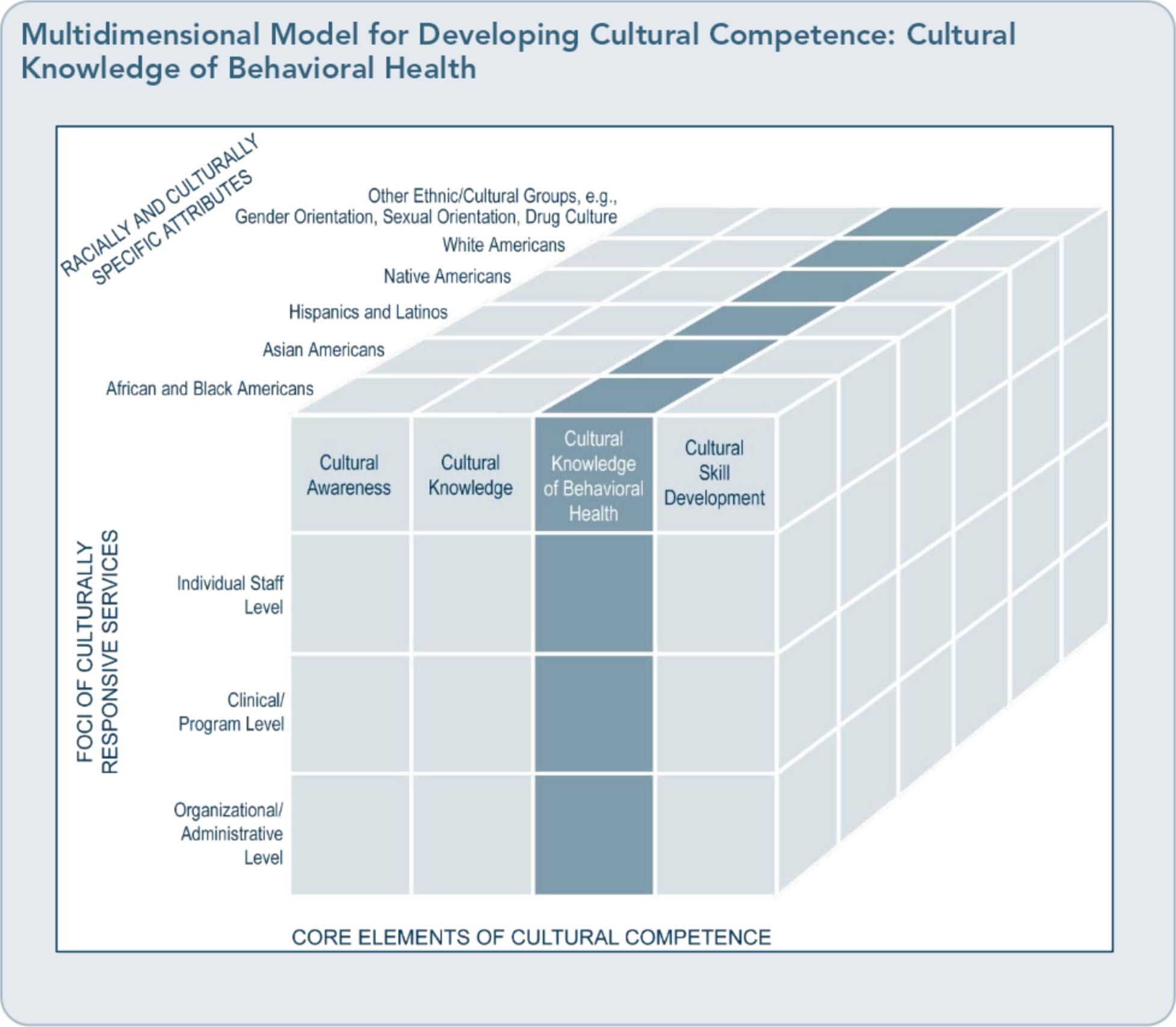
### Introduction

Culture is a primary force in the creation of a person's identity. Counselors who are culturally competent are better able to understand and respect their clients' identities and related cultural ways of life. This chapter proposes strategies to engage clients of diverse racial and ethnic groups (who can have very differ­ ent life experiences, values, and traditions) in treatment. The major racial and ethnic groups in the United States covered in this chapter are African Americans, Asian Americans (including Native Hawaiians and other Pacific Islanders), Latinos, Native Americans (i.e., Alaska Natives and American Indians), and White Americans. In addition to providing epidemiological data on each group, the chap­ ter discusses salient aspects of treatment for these racial/ethnic groups, drawing on clinical and research literature. This information is only a starting point in gaining cultural knowledge as it relates to behavioral health.

Understanding the diversity within a specific culture, race, or ethnicity is essential; not all information presented in this chapter will apply to all individuals. The material in this chapter has a scientific basis, yet cultural beliefs,

102

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups



traditions, and practices change with time and are not static factors to consider in providing services for clients, families, or communities.

Although these broad racial/ethnic categories are often used to describe diverse cultural groups, the differences between two members of the same racial/ethnic group can be greater than the differences between two people from

different racial/ethnic groups (Lamont and Small 2008; Zuckerman 1998). It is not possi­ ble to capture every aspect of diversity within each cultural group. Behavioral health workers should acknowledge that there will be many individual variations in how people interact

with their environments, as well as in how

environmental context affects behavioral health. However, to provide a framework for understanding many diverse cultural groups, some generalizations are necessary; thus, broad categories are used to organize information in this chapter. Counselors are encouraged to learn as much as possible about the specific populations they serve. Sources listed in Appendix F provide additional information.

### Counseling for African and Black Americans

According to the 2010 U.S. Census definition, African Americans or Blacks are people whose

103

Improving Cultural Competence

origins are "in any of the black racial groups of Africa" (Humes et al. 2011, p. 3). The term includes descendants of African slaves brought to this country against their will and more recent immigrants from Africa, the Caribbean, and South or Central America (many individ­ uals from these latter regions, if they come from Spanish-speaking cultural groups, iden­ tify or are identified primarily as Latino). The term "Black'' is often used interchangeably with African American, although sometimes the term "African American'' is used specifi­ cally to describe people whose families have been in this country since at least the 19th century and thus have developed distinct African American cultural groups. "Black'' can be a more inclusive term describing African Americans as well as more recent immigrants with distinct cultural backgrounds.

##### Beliefs About and Traditions Involving Substance Use

In most African American communities, significant alcohol or drug use may be socially unacceptable or seen as a sign of weakness (Wright 2001), even in communities with limited resources, where the sale of such sub­ stances may be more acceptable. Overall, African Americans are more likely to believe that drinking and drug use are activities for which one is personally responsible; thus, they may have difficulty accepting alcohol abuse/dependence as a disease (Durant 2005).

##### Substance Use and Substance Use Disorders

To date, there has not been much research analyzing differences in patterns of substance use and abuse among different groups of Blacks, but there are indications that some gender differences exist. For example, alcohol consumption among African American wom­ en increases as they grow older, but Caribbean Black women report consistently low alcohol

consumption as they grow older (Center for Substance Abuse Treatment [CSAT] *1999a;* Galvan and Caetano 2003). Rates of overall substance use among African Americans vary significantly by age. Several researchers have observed that despite Black youth being less likely than White American youth to use substances, as African Americans get older, they tend to use at rates comparable with those ofWhite Americans (Watt 2008). This increase in substance use with age among Blacks is often referred to as a crossover effect.

However, Watt (2008), in her analysis of 4 years of National Survey on Drug Use and Health (NSDUH) data (1999-2002), found that when controlling for factors such as drug exposure, marriage, employment, education, income, and family/social support, the cross­ over effect disappeared for Blacks ages 35 and older; patterns for drug and heavy alcohol use among Black and White American adults remained the same as for Black and White American adolescents (i.e., White Americans were significantly more likely to use substanc­ es). Watt concludes that systemic issues, such as lower incomes and education levels, and other factors, such as lower marriage rates, contribute to substance use among Black adults. Additional research also suggests that exposure to discrimination increases willing­ ness to use substances in African American youth and their parents (Gibbons et al. 2010).

When comparing African Americans with other racial and ethnic groups, NSDUH data from 2012 suggest that they are somewhat more likely than White Americans to use illicit drugs and less likely than White Americans to use alcohol. They also appear to have an inci­ dence of alcohol and drug use disorders simi­ lar to that seen in White Americans (Substance Abuse and Mental Health Services Administration [SAMHSA] *2013d).* Crack cocaine use is more prevalent among Blacks

104

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

than White Americans or Latinos, whereas rates of abuse of methamphetamine, inhalants, most hallucinogens, and prescription drugs are lower **(SAMHSA** *2011a).* Phencyclidine use also appears to be a more serious problem, albeit affecting a relatively small group, among African Americans than among members of other racial/ethnic groups.

There appear to be some other differences in how African Americans use substances com­ pared with members of other racial/ethnic groups. For example, Bourgois and Schonberg (2007) observed that among people who inject­ ed heroin in San Francisco, White Americans tended to administer the drug quickly whether or not they could find a vein, which led them to inject into fat or muscle tissue and resulted in a higher rate of abscesses. However, African Americans who injected heroin were more methodical and took the time to find a vein, even if it took multiple attempts. This, in turn, often resulted in using syringes that were already bloodied and increased their chances of contracting HIV/AIDS and other blood­ borne diseases. African Americans who inject­ ed heroin were significantly more likely to also use crack cocaine than were White Americans who injected heroin (Bourgois et al. 2006).

African American patterns of substance use have changed over time and will likely contin­ ue to do so. Based on treatment admission data, admissions of African Americans who injected heroin declined by 44 percent during a 12-year period, whereas admissions declined by only 14 percent among White Americans (Broz and Ouellet 2008). Additionally, during this period, the peak age for African Americans who injected heroin increased by 10 years, yet it decreased by 10 years for White Americans. This suggests that the decrease in injectable heroin use among African Americans was largely due to decreased use among younger individuals.

Some preliminary evidence suggests that African Americans are less likely to develop drug use disorders following initiation of use (Falck et al. 2008), yet more research is needed to identify variables that influence the devel­ opment of drug use disorders. Even though African Americans seem less likely than White Americans to develop alcohol use disorders, a number of older studies have found that they more frequently experience liver cirrhosis and other alcohol-related health problems (Caetano 2003; Polednak 2008). In tracking 25 years of data, Polednak (2008) found that the magnitude of difference has decreased over time; nonetheless, health dispar­ ities continue to exist for African Americans in terms of access to and quality of care, which can affect a number of health problems (Agency for Healthcare Research and Qyality 2009; Smedley et al. 2003).

##### Mental and Co-Occurring Disorders

A number of studies have found biases that result in African Americans being overdiag­ nosed for some disorders and underdiagnosed for others. African Americans are less likely than White Americans to receive treatment for anxiety and mood disorders, but they are more likely to receive treatment for drug use disorders (Hatzenbuehler et al. 2008). In one study evaluating posttraumatic stress disorder **(PTSD)** among African Americans in an outpatient mental health clinic, only 11 per­ cent of clients had documentation referring to **PTSD,** even though 43 percent of the clients showed symptoms of PTSD (Schwartz et al. 2005). Black immigrants are less likely to be diagnosed with mental disorders than are Blacks born in the United States (Burgess et al. 2008; Miranda et al. *2005b).*

African Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with affective disorders than

105

Improving Cultural Competence

White Americans, even though multiple studies have found that rates of both disorders among these populations are comparable (Baker and Bell 1999; Bresnahan et al. 2000; Griffith and Baker 1993; Stockdale et al. 2008; Strakowski et al. 2003). African Americans are about twice as likely to be diagnosed with a psychotic disorder as White Americans and more than three times as likely to be hospital­ ized for such disorders. These differences in diagnosis are likely the result of clinician bias in evaluating symptoms (Bao et al. 2008; Trierweiler et al. 2000; Trierweiler et al.

2006). Clinicians should be aware of bias in assessment with African Americans and with other racial/ethnic groups and should consid­ er ways to increase diagnostic accuracy by reducing biases. For an overview of mental health across populations, refer to *Mental Health United States, 2010* (SAMHSA *2012a).*

In some African American communities, incidence and prevalence of trauma exposure and PTSD are high, and substance use ap­ pears to increase trauma exposure even further (Alim et al. 2006; Breslau et al. 1995; Curtis­ Boles and Jenkins-Monroe 2000; Rich and Grey 2005). Black women who abuse sub­ stances report high rates of sexual abuse

(Ross-Durow and Boyd 2000). Trauma histo­ ries can also have a greater effect on relapse for African American clients than for clients from other ethnic/racial groups (Farley et al. 2004). There are few integrated approaches to trau­ ma and substance abuse that have been evalu­ ated with African American clients, and although some have been found effective at reducing trauma symptoms and substance use, the extent of that effectiveness is not necessarily as great as it is for White Americans (Amaro et al. 2007; Hien et al.

2004; SAMHSA 2006).

African Americans are less likely than White Americans to report lifetime CO Ds (Mericle et al. 2012). However, limited research indi­ cates that, as with other racial groups, there are differences across African American groups in the screening and symptomatology of CODs. Seventy-four percent of African Americans who had a past-year major depressive episode were identified as also having both alcohol and marijuana use disorders (Pacek et al. 2012).

Miranda et al. *(2005b)* found that American­ born Black women were more than twice as likely to be screened as possibly having depres­ sion than African- or Caribbean-born Black women, but this could reflect, in part, differ­ ences in acculturation (see Chapter 1). How­ ever, research findings strongly suggest that cultural responses to some disorders, and possibly the rates of those disorders, do vary among different groups of Blacks. Differences do not appear to be simply reflections of differences in acculturation (Joe et al. 2006).

For a review of African American health, see Hampton et al. (2010).

##### Treatment Patterns

African Americans may be less likely to re­ ceive mental health services than White Americans. In the Baltimore Epidemiologic Catchment Services Area study conducted during the 1980s, African Americans were less likely than White Americans to receive mental health services. However, at follow-up in the early 1990s, African American respondents were as likely as White Americans to receive such services, but they were much more likely to receive those services from general practi­ tioners than from mental health specialists (Cooper-Patrick et al. 1999). Stockdale et al. (2008) analyzed 10 years of data from the National Ambulatory Medical Care Survey; they found significant improvements in diag­ nosis and care for mental disorders among African Americans in psychiatric settings

106

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

between 1995 and 2005, but they also found that disparities persisted in the diagnosis and treatment of mental disorders in primary care settings. Fortuna et al. (2010) suggest that persistent problems exist in the delivery of behavioral health services, as evidenced by lower retention rates for treating depression.

Even among people who enter substance abuse treatment, African Americans are less likely to receive services for CODs. A study of administrative records from substance abuse and mental health treatment providers in New Jersey found that African Americans were significantly more likely than White Americans to have an undetected co-occurring mental disorder, and, if detected, they were signifi­ cantly less likely than White Americans or Latinos to receive treatment for that disorder (Hu et al. 2006). Among persons with sub­ stance use disorders and co-occurring mood or anxiety disorders, African Americans are significantly less likely than White Americans to receive services (Hatzenbuehler et al. 2008). African Americans who do receive services for CODs are more likely to obtain them through substance abuse treatment programs than mental health programs (Alvidrez and

Havassy 2005).

According to the Treatment Episode Data Sets (TEDS) from 2001 to 2011, African American clients entering substance abuse treatment most often reported alcohol as their primary substance of abuse, followed by mari­ juana. However, gender differences are evident, indicating that women report a broader range of substances as their primary substance of abuse than men do **(SAMHSA,** Center for Behavioral Health Statistics and O!iality [CBHSQJ, 2013). Most recent research sug­ gests that African Americans are about as likely to seek and eventually receive substance abuse treatment as are White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009;

SAMHSA, CBHSQ2011; Schmidt et al. 2006). Data analyzed by Perron et al. (2009) indicate that among African Americans with lifetime diagnoses of drug use disorders, 20.8 percent had received some type of treatment, as defined broadly to include resources such as pastoral counseling and mutual-help group attendance. This made them more likely to have received treatment than White Ameri­ cans (15.5 percent of whom received treat­ ment) or Latinos (17.3 percent of whom received treatment). Although data indicate that African Americans were less likely to receive services from private providers, they also indicate that African Americans were more likely to use more informal services (e.g., pastoral counseling, mutual help).

Although most major studies have found that race is not a significant factor in receiving treatment, African Americans report lengthier waiting periods, less initiation of treatment, more barriers to treatment participation (e.g., lack of childcare, lack of insurance, lack of knowledge about available services), and shorter lengths of stay in treatment than do White Americans (Acevedo et al. 2012; Brower and Carey 2003; Feidler et al. 2001; Grant 1997; Hatzenbuehler et al. 2008; Marsh et al. 2009; SAMHSA 201*lc;* Schmidt et al.

2006). In SAMHSA's 2010 NSDUH, 33.5

percent of African Americans who had a need for substance abuse treatment but did not receive it in the prior year reported that they lacked money or the insurance coverage to pay for it (SAMHSA, CBHSQ2011). Economic disadvantage does leave many Africans Amer­ icans uninsured; approximately 16.1 percent of non-Latino Blacks had no coverage in 2004 (Schiller et al. 2005).

Likewise, some researchers have found that African Americans are less likely than White Americans to receive needed services or an appropriate level of service (Alegria et al.

107

Improving Cultural Competence

2011; Bluthenthal et al. 2007; Marsh et al. 2009). For example, African Americans and Latinos are less likely than White Americans to receive residential treatment and are more likely to receive outpatient treatment, even when they present with more serious substance use problems (Bluthenthal et al. 2007). Other studies have found that African Americans with severe substance use or CODs were less likely to enter or receive treatment than White Americans with equally severe disorders (Schmidt et al. 2006, 2007).

African Americans are overrepresented among people who are incarcerated in prisons and jails (for review, see Fellner 2009), and a sub­ stantial number of those who are incarcerated (64.1 percent of jail inmates in 2002) have substance use disorders (Karberg and James 2005) and mental health problems (SAMHSA *2012a).* However, according to Karberg and (James 2005), African Americans with sub­ stance dependence disorders who were in jail in 2002 were less likely than White Americans or Latinos to participate in substance abuse treatment while under correctional supervision (32 percent of African Americans participated compared with 37 percent of Latinos and *45* percent ofWhite Americans). In the 2010 TEDS survey, African Americans entering treatment were also less likely than Asian Americans, White Americans, Latinos, Native Hawaiians/Pacific Islanders, or American Indians in the same situation to be referred to treatment through the criminal justice system (SAMHSA, CBHSQ2012). Notwithstand­ ing, African Americans are more likely to be referred to treatment from criminal justice settings rather than self-referred or referred by other sources (Delphin-Rittmon et al. 2012)

Beyond issues related to diagnosis and care that can prevent African Americans from accessing mental health services, research suggests that a lack of familiarity with the

value and use of specialized behavioral health services among some African Americans may limit service use. Hines-Martin et al. (2004) found a positive relationship between famili­ arity and use of mental health services among African Americans. Additionally, factors such as social and familial prejudices (Ayalon and Alvidrez 2007; Mishra et al. 2009; Nadeem et al. 2007) and fears relating to past abuses of African Americans within the mental health system (Jackson 2003) can contribute to the lack of acceptance and subsequent use of these services. An essential step in decreasing dis­ parity in behavioral health services among African Americans involves conducting cul­ turally appropriate mental health screenings and using culturally sensitive instruments and evaluation tools (Baker and Bell 1999).

##### Beliefs and Attitudes About Treatment

According to 2011 NSDUH data, African Americans were, next to Asian Americans, the least likely of all major ethnic and racial groups to state a need for specialized sub­ stance abuse treatment (SAMHSA, CBHSQ *2013a).* Still, logistical barriers may pose a greater challenge for African Americans than for members of other major racial and ethnic groups. For example, 2010 **NSDUH** data regarding individuals who expressed a need for substance abuse treatment but did not receive it in the prior year indicate that African Americans were more likely than members of other major ethnic/racial groups to state that they lacked transportation to the program or that their insurance did not cover the cost of such treatment **(SAMHSA** *2011a).* African Americans experience several challenges in accessing behavioral health treatment, including fears about the therapist or therapeutic process and concerns about discrimination and costs (Holden et al. 2012;

108

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

Holden and Xanthos 2009; Williams et al. 2012).

Longstanding suspicions regarding established healthcare institutions can also affect African Americans' participation in, attitudes toward, and outcomes after treatment (for review, see Pieterse et al. 2012). Historically, the mental health system has shown bias against African Americans, having been used in times past to control and punish them (Boyd-Franklin and Karger 2012;Jackson 2003). After controlling for socioeconomic factors, African Americans are significantly more likely to perceive the healthcare system as poor or fair and signifi­ cantly more likely to believe that they have been discriminated against in healthcare settings (Blendon et al. 2007). Attitudes to­ ward psychological services appear to become more negative as psychological distress in­ creases (Obasi and Leong 2009). In many African American communities, there is a persistent belief that social and treatment services try to impose White American values, adding to their distrust of the treatment sys­ tem (Larkin 2003; Solomon 1990).

African Americans, even when receiving the same amount of services as White Americans are less likely to be satisfied with those services (Tonigan 2003). However, recent evidence suggests that, once engaged, African American clients are at least as likely to continue partici­ pation as members of other ethnic/racial groups (Harris et al. 2006). Because distrust of the healthcare system can make it more diffi­ cult to engage African American clients ini­ tially in treatment, Longshore and Grills (2000) recommend culturally congruent moti­ vational enhancement strategies to address African American clients' ambivalence about treatment services. Providers also need to craft culturally responsive health-related messages for African Americans to improve treatment engagement and effectiveness (Larkin 2003).

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Most importantly, providers need to demon­ strate multicultural experience. In a study comparing outcomes among Black and White clients at community mental health centers, the only clinician factor that predicted more favorable outcomes was clinicians' general experiences and relationships with people from racial/ethnic and cultural groups other than their own (Larrison et al. 2011).

##### Treatment Issues and Considerations

African American clients generally respond better to an egalitarian and authentic relation­ ship with counselors (Sue 2001). Paniagua (1998) suggests that in the initial sessions with African American clients, counselors should develop a collaborative client-counselor rela­ tionship. Counselors should request personal information gradually rather than attempting to gain information as quickly as possible, avoid information-gathering methods that clients could perceive as an interrogation, pace the session, and not force a data-gathering agenda (Paniagua 1998; Wright 2001). Coun­ selors must also establish credibility with clients (Boyd-Franklin 2003).

Next, counselors should establish trust. Self­ disclosure can be very difficult for some clients because of their histories of experiencing racism and discrimination.These issues can be exacerbated in African American men whose experience of racism has been more severe or who have had fewer positive relationships with White Americans (Reid 2000; Sue 2001).

Counselors, therefore, need to be willing to address the issue of race and to validate African American clients' experiences of racism and its reality in their lives, even if it differs from their own experiences (Boyd-Franklin 2003; Kelly and Parsons 2008). Moreover, racism and discrimination can lead to feelings of anger, anxiety, or depression. Often, these feelings are not specific to any given event;

**109**

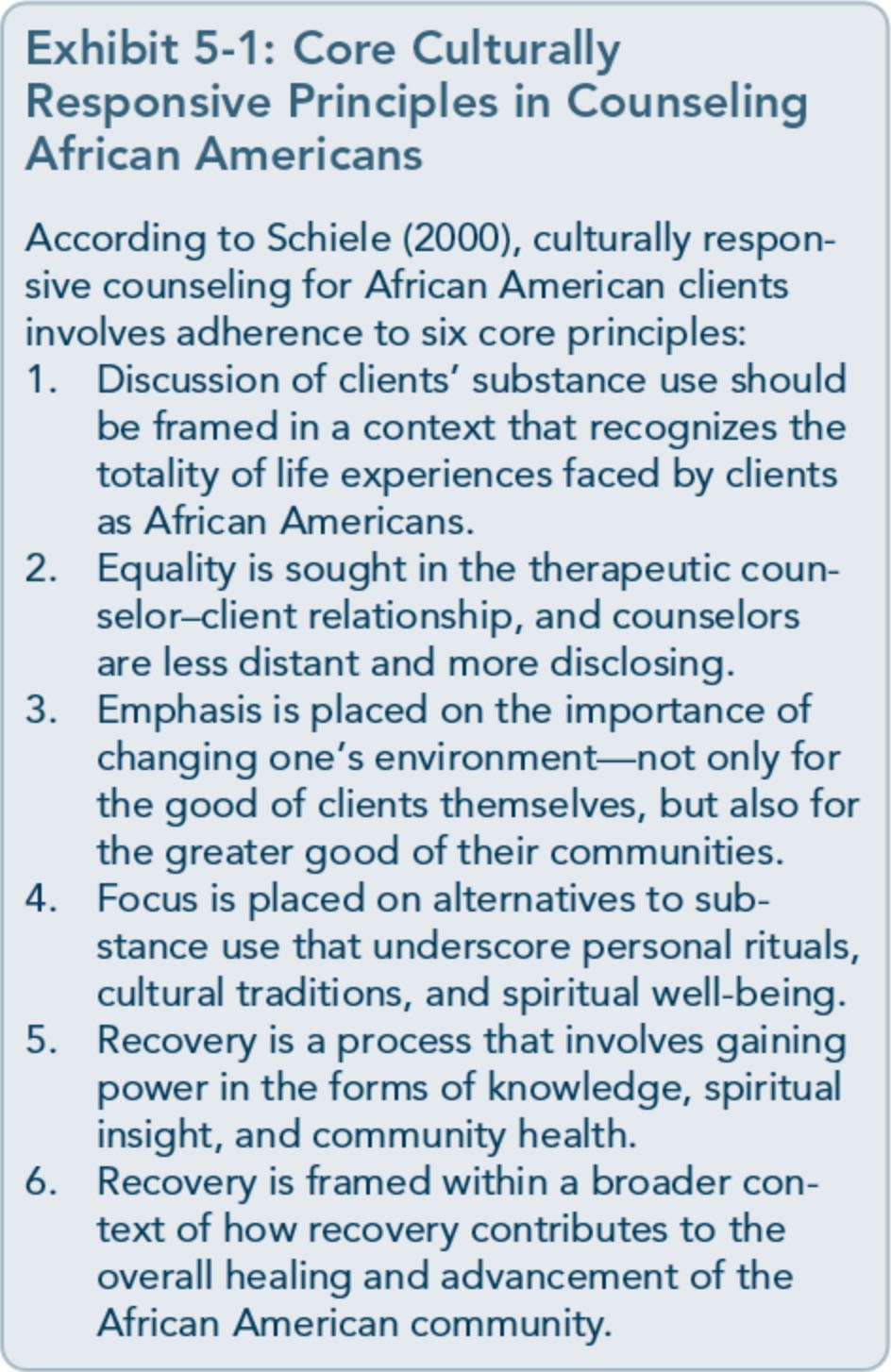
Improving Cultural Competence

110

rather, they are pervasive (Boyd-Franklin et al. 2008). Counselors should explore with clients the psychological effects of racism and develop approaches to challenge internal negative messages that have been received or generated through discrimination and prejudice (Good­ ing 2002).

Additional methods that may enhance en­ gagement and promote participation include peer-supported interventions and strategies that promote empowerment by emphasizing strengths rather than deficits (Paniagua 1998; Tondora et al. 2010; Wright 2001). It is important to explore with clients the strengths that have brought them this far.

What personal, community, or family strengths have helped them through difficult times? What strengths will support their recovery efforts? Exhibit 5-1 gives an



overview of core guiding principles in work­ ing with African American clients.

##### Theoretical Approaches and Treatment Interventions

Research suggests that culturally congruent interventions are effective in treating African Americans (Longshore and Grills 2000; Longshore et al. 1998a; Longshore et al.

1998b; 1999). Although there are conflicting results on the effectiveness of motivational interviewing among African American clients (Montgomery et al. 2011), some motivational interventions have been found to reduce sub­ stance use among African Americans (Bernstein et al. *2005;* Longshore and Grills 2000). Longshore and Grills (2000) describe a culturally specific motivational intervention for African Americans involving both peer and professional counseling that makes use of the core African American value of commu­ nalism by addressing the ways in which the individual's substance abuse affects his or her whole community. The motivational program affirms "the heritage, rights, and responsibili­ ties of African Americans ... using interaction styles, symbols and values shared by members of the group" (Longshore et al. 1998b, p. 319). So too, African American music, artwork, and food can help programs create a welcoming and familiar atmosphere, as is the case for other racial and ethnic groups when familiar cultural symbols appear in the clinical setting.

Many of the interventions developed for substance abuse treatment services in general have been evaluated with populations that were at least partly composed of African Americans; many of these interventions are as effective for African Americans as they are for White Americans (Milligan et al. 2004; To­ nigan 2003). One intervention that appears to work better for African American (and Latino) clients than for White American clients­ perhaps because it focuses on improving

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

client-counselor communication-is node­ link mapping (visual representation using information diagrams, fill-in-the-blank graph­ ic tools, and client-generated diagrams or visual maps). This approach was associated with lower rates of substance use, better treat­ ment attendance, and better counselor ratings of motivation and confidence among African Americans than among White Americans (Dansereau et al. 1996; Dansereau and Simpson 2009).

In addition, cognitive-behavioral therapy **(CBT)** has certain distinct advantages for African American clients; it fosters a collabo­ rative relationship and recognizes that clients are experts on their own problems (Kelly and Parsons 2008). Maude-Griffin et al. (1998) compared CBT and 12-Step facilitation for a group of mostly African American (80 per­ cent) men who were homeless and found that CBT achieved significantly better abstinence outcomes, except among those who considered themselves very religious (these individuals

had better outcomes with 12-Step facilitation).

Other interventions that use CBT principles have also been effective with African American populations. For example, a number of studies have evaluated contingency management approaches with predominantly African American client populations, finding that this model was effective at reducing cocaine and illicit opioid use, improving employment outcomes for clients in methadone mainte­ nance (Silverman et al. 2002; Silverman et al.

2007), reducing substance use during and after treatment, and improving self-reported quality oflife (Petry et al. 2004; Petry et al. *2005;* Petry et al. 2007). The Living in the Balance inter­ vention, which uses psychoeducation and CBT techniques, has also been evaluated with a mostly African American sample and has been shown to improve treatment retention and reduce substance use (Hoffman et al. 1996).

Another therapy that has been evaluated with African American clients and found effective is supportive-expressive psychotherapy, which reduces substance use and improves psycho­ logical functioning for individuals in metha­ done maintenance (Woody et al.1987; Woody et al. 1995). Medications for substance abuse can also work well with African American clients. In one large study, African Americans were more likely than Latinos or White Americans to indicate that they found metha­ done helpful (Gerstein et al. 1997), and in another study, they reported greater perceived quality of life as a result of participation in a methadone program (Geisz 2007). Schroeder et al. (2005) also reported that African Americans in a methadone program had significantly fewer adverse medical events (e.g., infections, gastrointestinal complaints) than did White American participants. African Americans who were being treated for cocaine depend­ ence remained in treatment significantly longer than did other African Americans if they received disulfiram (Milligan et al. 2004).

A review of cultural adaptations of evidence­ based practices is given by Bernal and Domenech Rodriguez (2012). For an over­ view of gender-specific treatment considera­ tions for mental and substance use disorders among African American men and women, see Shorter-Gooden (2009).

#### *Family therapy*

African American clients appear more likely to stay connected with their families through­ out the course of their addiction. For instance, Bourgois et al. (2006) reported that in compar­ ing African American and White American individuals who injected heroin, African Americans appeared to be more likely to maintain contact with their extended families. Some research also suggests that African Americans with substance use disorders are more likely to have family members with

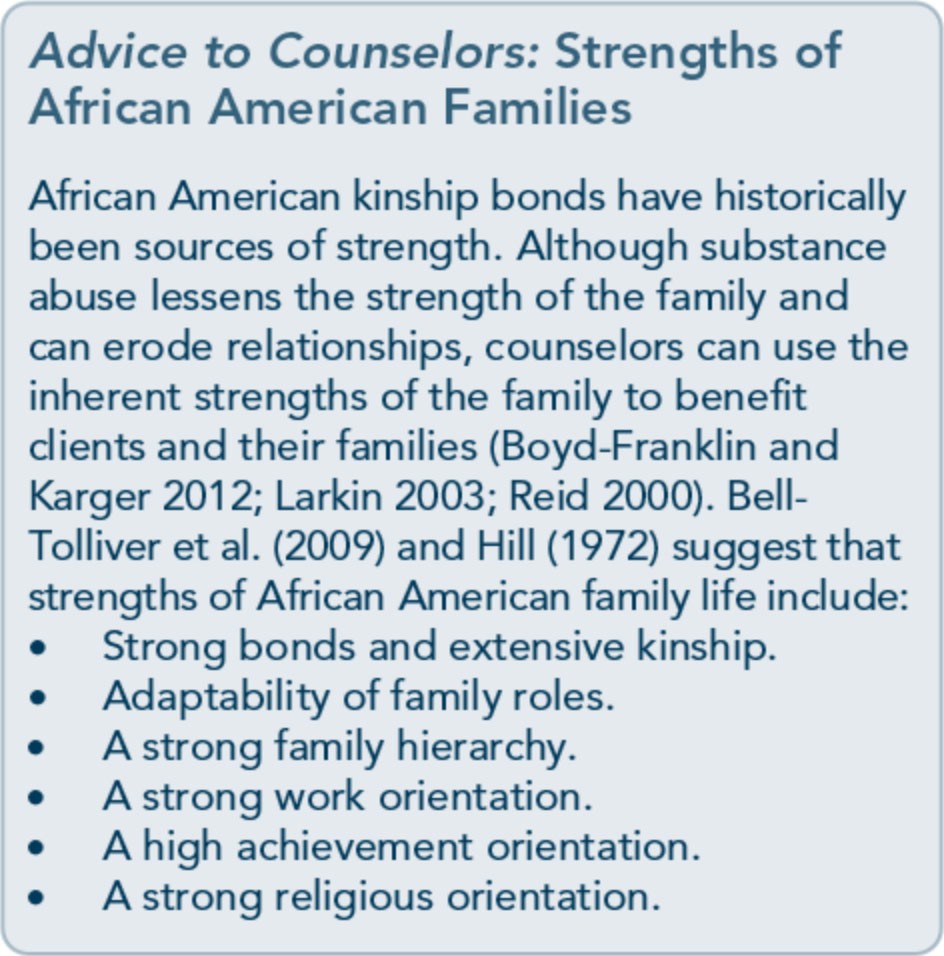
**111**

Improving Cultural Competence

histories of substance abuse, suggesting an even greater need to address substance abuse within the family (Brower and Carey 2003).

Strong family bonds are important in African American cultural groups. African American families are embedded in a complex kinship network of biologically related and unrelated persons. Hence, counselors should be willing to expand the definition of family to a more extended kinship system (Boyd-Franklin 2003; Hines and Boyd-Franklin 2005). Clients need to be asked how they define family, whom they would identify as family or "like family," who resides with them in their homes, and whom they rely on for help. Hines and Boyd-Franklin (2005) discuss the importance of both blood and nonblood kinship networks for African American families. To build a support network for African American clients, counselors should start by asking clients to identify people (whether biological kin or not) who would be willing and able to support their recovery and then ask clients for permis­ sion to contact those people and include them in the treatment process.

Family therapy is often a productive approach to treatment with African Americans (Boyd­ Franklin 2003; Hines and Boyd-Franklin *2005;* Larkin 2003). However, the extended family can be large and have many ties with other families in a community; therefore, the family therapist sometimes needs to take on other roles to assist with case management or other activities, including involvement in community-wide interventions (Sue 2001). In reviewing specific family therapy approaches for African Americans, Boyd-Franklin (2003) discusses the use of a multisystem family therapy approach, which incorporates an extended network of relationships that play a part in clients' lives. Using this model, social service and other community agencies can be considered a significant part of the family



system. Network therapy, which involves clients' extended social networks, has also been found to improve substance use outcomes for African American clients when added to standard treatment (Keller and Galanter 1999). Likewise, the family team conference model can be a useful approach, given that it also engages both families and communities in the helping process by attempting to stimulate extensive mobilization of activity in the formal and informal relationships in and around cli­ ents' families (State of New Jersey Department of Human Services 2004).

Brief structural family therapy and strategic family therapy reduce substance use as well, but research has primarily focused on African American youth (Santisteban et al. 1997; Santisteban et al. 2003; Szapocznik and Williams 2000). Multidimensional family therapy has increased abstinence from sub­ stance use among African American adoles­ cents and produced more lasting effects than CBT, but it also has not been evaluated with adult clients (Liddle et al. 2008). In reviewing specific family programs, Larkin (2003) reports promising preliminary data on a family therapy intervention among African Americans in public housing that addresses substance abuse.

**112**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

The program initially engages families via psychoeducation on substance abuse and its effects on the family, followed by a strength­ based family therapy intervention. Despite the small sample size, all 10 families admitted to the program completed treatment, and 7 of 10 family members with substance abuse prob­ lems entered recovery and continuing care.

Participant surveys indicated that 60 percent of families preferred multiple-family therapy over single-family therapy, and 80 percent preferred services delivered in the housing project community center to other venues.

Engaging Moms is another family-oriented program and intervention developed specifi­ cally for African American mothers that has been shown to significantly improve treatment engagement (Dakof et al. 2003). The interven­ tion is designed for women who have children and have been identified as cocaine users. The program focuses on mobilizing family members who would be likely to motivate the mothers to enroll and remain in substance abuse treatment. Research has shown no long-term impact, yet women who received the intervention were significantly more likely to enter treatment (88 percent of women involved in the program versus 46 percent of the control group) and remain for at least 2 weeks.

#### *Group therapy*

Because of the communal, cooperative values held by many African Americans, group ther­ apy can be a particularly valuable component of the treatment process (Sue and Sue 2013b). A strong oral tradition is one of many forms of continuity with African tradition main­ tained in the African American experience; therefore, speaking in groups is generally acceptable to African American clients. How­ ever, Bibb and Casimer (2000) note that Black Caribbean Americans can be less comfortable with the group process, particularly the re­ quirement that they self-disclose personal

problems to people who are relative strangers. African Americans seem less likely to self­ disclose about the past in group settings that include non-Hispanic Whites (Johnson et al. 2011; Richardson and Williams 1990). Con­ sequently, groups composed only of African Americans can be more beneficial. Homoge­ nous African American groups can also be good venues for clients to deal with systemic problems, such as racism and lack of economic opportunities in the African American com­ munity (Jones et al. 2000).

#### *Mutual-help groups*

A variety of mutual-help groups are available for African Americans entering recovery from substance use and mental disorders. However, most of the literature focuses on 12-Step groups, including Alcoholics Anonymous (AA) and Narcotics Anonymous. Some find that the 12-Step approach warrants careful consideration with African Americans, who can find the concept of powerlessness over substances of abuse to be too similar to experi­ ences of powerlessness via discrimination.

Additionally, the disease concept of addiction presented in 12-Step meetings can be difficult for many African Americans (Durant 2005). In some instances, the Black community has changed the mutual-help model for substance use and mental health to make it more em­ powering and relevant to African American participants. For additional information on the 12 Steps for African Americans, visit Alcohol­ ics Anonymous World Services (AAWS), AA for the Black and African American Alcoholic, available online (<http://www.aa.org/> pdf/products/p-51\_CanAAHelpMeToo.pd£).

Despite their emphasis on the concept of powerlessness, 12-Step programs are significant support systems for many African Americans. In Ms 2011 membership survey, 4 percent of members identified their race as Black (AAWS 2012). Analysis of 2006-2007

113

Improving Cultural Competence

NSDUH data showed that African Americans were less likely to use mutual-help groups in the past year for substance use (about 11 percent did) than White Americans (about 67 percent did) or Latinos (about 16 percent did; SAMHSA *2013d).* However, the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) survey did find that African Americans who had a lifetime drug use disorder diagnosis and had sought help were more than three times as likely to have attended mutual-help meetings as were White Americans or Latinos (Perron et al. 2009).

Several other surveys suggest that African Americans with alcohol-related problems are at least as likely to participate in AA as White Americans and that greater problem severity is associated with increased likelihood of partici­ pation (Kingree and Sullivan 2002). Of the participants who attended mutual-help group sessions for mental health in the past year, approximately 10 percent were Black or Afri­ can American, 75 percent were White Ameri­ can, and 11.4 percent were Latino (SAMHSA 2010).

Durant (2005) observes that African American 12-Step participants tend to participate differ­ ently in meetings where participants are most­ ly White Americans than in meetings where most participants are African American. In some areas, there are 12-Step meetings that are largely or entirely composed of African American members, and some African American clients feel more comfortable par­ ticipating in these meetings. Mutual-help groups can be particularly helpful for African Americans who consider themselves religious. Maude-Griffin et al. (1998) found that indi­ viduals who identified as highly religious did significantly better when receiving 12-Step facilitation than when receiving CBT, but that pattern was reversed for those who did not consider themselves highly religious. Other studies have found that African Americans

express a greater degree of comfort with shar­ ing in meetings, and they are more likely to engage in AA services and state that they had a spiritual awakening as a result of AA partic­ ipation (Bibb and Casimer 2000; Kaskutas et al. 1999; Kingree 1997).

Research suggests that African Americans who attend 12-Step programs have higher levels of affiliation than White Americans in the same programs (Kingree and Sullivan 2002). However, they are less likely to have a sponsor or to read program materials (Kaskutas et al. 1999), and their abstinence appears to be less affected by meeting attendance (Timko et al. 2006). Other research has found that African Americans who participate in 12-Step groups report an increase in the number of people within their social networks who sup­ port their recovery efforts (Flynn et al. 2006). Other mutual-help groups for African Americans are available, particularly faith­ based programs to support recovery from mental illness and substance use disorders and to aid individuals in the process of transition­ ing from correctional institutions. For exam­ ple, the Nation of Islam has been involved in successful substance abuse recovery efforts, especially for incarcerated persons (Sanders 2002; White and Sanders 2004).

***Traditional healing and complementary methods***

In general, African Americans are less likely to make use of popular alternative or comple­ mentary healing methods than White Ameri­ cans or Latinos (Graham et al. 2005).

However, the African American culture and history is steeped in healing traditions passed down through generations, including herbal remedies, root medicines, and so forth (Lynch and Hanson 2011). The acceptance of tradi­ tional practices by African American clients and their families does not necessarily indicate that they oppose or reject the use of modern

**114**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

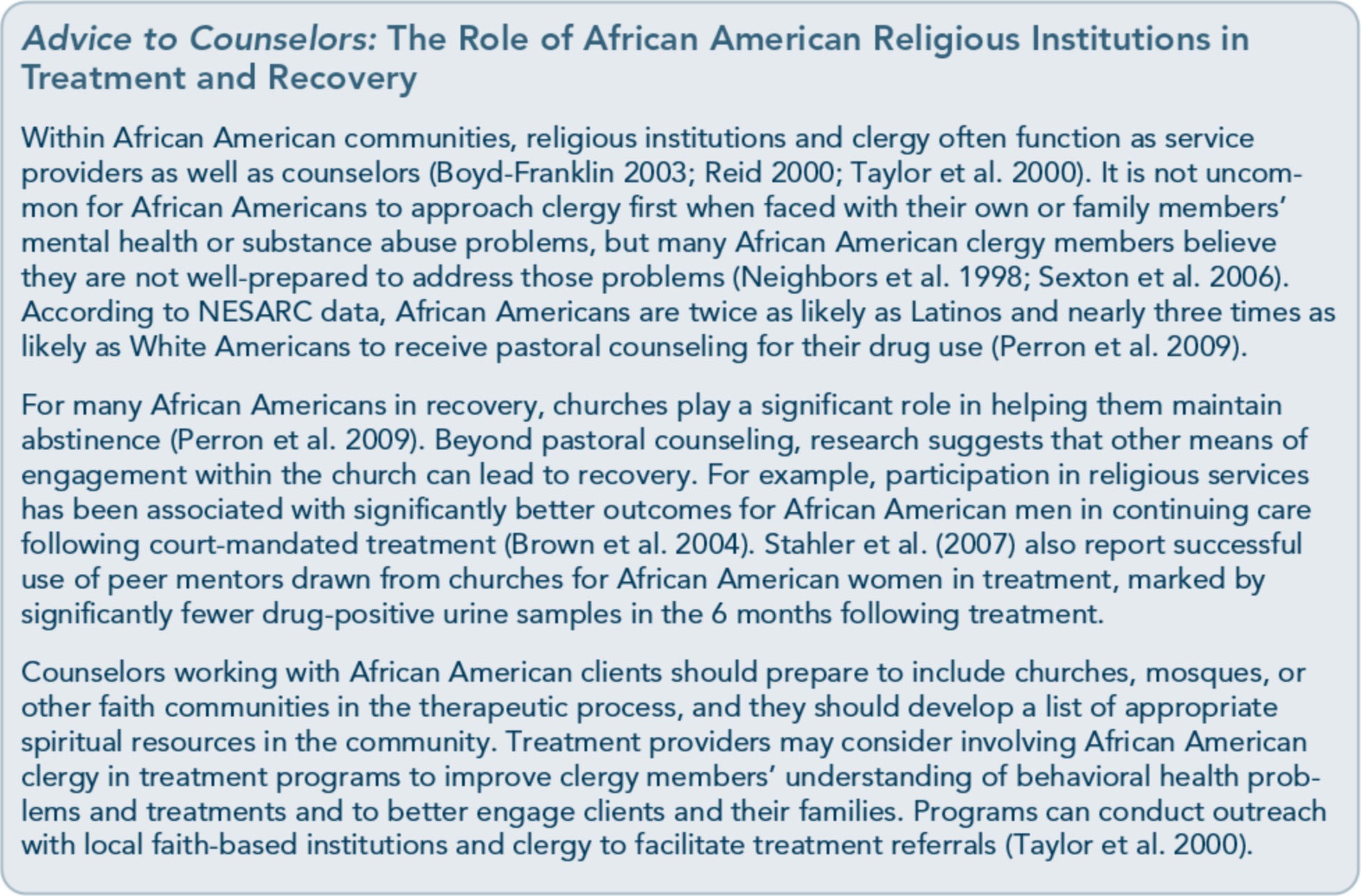
therapeutic approaches or other alternative approaches. They can accept and use all forms of treatment selectively, depending on the perceived nature of their health problems.

That said, psychological and substance abuse problems can be seen as having spiritual causes that need to be addressed by traditional heal­ ers or religious practices (Boyd-Franklin 2003). Moreover, African Americans are much more likely to use religion or spirituality as a response to physical or psychological problems (Cooper et al. 2003; Dessio et al. 2004; Graham et al. 2005; Nadeem et al. 2008).

African American cultural and religious insti­ tutions (see advice box below) play an im­ portant role in treatment and recovery, and African Americans who use spirituality or religion to cope with health problems are nearly twice as likely as other African Americans to also make use of complementary or alterna­ tive medicine (Dessio et al. 2004). Likewise, African American churches and mosques play

a central role in education, politics, recreation, and social welfare in African American com­ munities. To date, African Americans report the highest percentage (87 percent) of reli­ gious affiliation of any major racial/ethnic group (Kosmin and Keysar 2009; Pew Forum on Religion and Public Life 2008). Even though most are committed to various Christian denominations (with the Baptist and African Methodist Episcopal churches ac­ counting for the largest percentages), a growing number of African Americans are converts to Islam, and many recent immigrants from Africa to the United States are also Muslims (Boyd-Franklin 2003; Pew Forum on Religion and Public Life 2008).

***Relapse prevention and recovery*** African Americans appear to be responsive to continuing care participation and recovery activities associated with substance use and mental disorders, yet research is very limited. According to **NESARC** data (Dawson et al.



**115**

Improving Cultural Competence

2005), African Americans in recovery from alcohol dependence were more than twice as likely as White Americans to maintain absti­ nence rather than just limiting alcohol con­ sumption or changing drinking patterns. In another study analyzing the use of continuing care following residential treatment in the U.S. Department of Veterans Affairs care system, African American men were significantly more likely than White Americans to partici­ pate in continuing care (Harris et al. 2006).

Other research evaluating continuing care for African American men who had been man­ dated to outpatient treatment by a parole or probation office found that participants as­ signed to a continuing care intervention were almost three times as likely to be abstinent and five times less likely to be using any drugs on a weekly basis during the 6-month follow-up period compared with those who did not receive continuing care (Brown et al. 2004).

In evaluating appropriate relapse prevention strategies for African American clients, Walton et al. (2001) found that African American clients leaving substance abuse treatment reported fewer cravings, greater use of coping strategies, and a greater belief in their self-efficacy. However, they also expected to be involved in fewer sober leisure activities, to be exposed to greater amounts of substance use, and to have a greater need for continuing care services (e.g., housing, medical care, assistance with employment). Walton notes that these findings could reflect a tendency of African American clients to underestimate the difficulties they will face after treatment; they report a greater need for resources and greater exposure to substance use, but they still have a greater belief in their ability to remain free of substances. Although an individual's belief in coping can have a positive effect on initially managing high-risk situations, it also can lead to a failure to recognize the level of risk in a given situation, anticipate the consequences,

secure resources and appropriate support when needed, or engage in coping behaviors condu­ cive to maintaining recovery. Counselors can help clients practice coping skills by role­ playing, even if clients are confident that they can manage difficult or high-risk situations.

### Counseling for Asian Americans, Native Hawaiians, and Other Pacific Islanders

Asian Americans, per the U.S. Census Bureau definition, are people whose origins are in the Far East, Southeast Asia, or the Indian sub­ continent (Humes et al. 2011). The term in­ cludes East Asians (e.g., Chinese,Japanese, and Korean Americans), Southeast Asians (e.g., Cambodian, Laotian, and Vietnamese Americans), Filipinos, Asian Indians, and Central Asians (e.g., Mongolian and Uzbek Americans). In the 2010 Census, people who identified solely as Asian American made up

4.8 percent of the population, and those who identified as Asian American along with one or more other races made up an additional 0.9 percent. Census data includes specific infor­ mation on people who identify as Asian Indian, Chinese, Filipino,Japanese, Korean, Vietnamese, and "other Asians."The largest Asian populations in the United States are Chinese Americans, Filipino Americans, Asian Indian Americans, Korean Americans, and Vietnamese Americans. Asian Americans overwhelmingly live in urban areas, and more than half (51 percent) live in just three states (NY, CA, and HI; Hoeffel et al. 2012).

Not all people with origins in Asia belong to what is commonly conceived of as the Asian race. Some Asian Indians, for example, self­ identify as White American. For this reason, among others, counselors should be careful to learn from their Asian American clients how

**116**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

they identify themselves and which national heritages they claim. Counselors should rec­ ognize that clients who appear to be Asian may not necessarily think of themselves pri­ marily as persons of Asian ancestry or have a deep awareness of the traditions and values of their countries of origin. For example, Asian orphans who have been adopted in the United States and raised as Americans in White American families may have very little con­ nection with the cultural groups of their bio­ logical parents (St. Martin 2005). Counselors should not make generalizations across Asian cultures; each culture is quite distinct.

Little literature on substance use and mental disorders, rates of co-occurrence, and treatment among Asian Americans focuses on behavioral health treatment for Native Hawaiians and Pacific Islanders; thus, a text box at the end of this section summarizes available information.

##### Beliefs About and Traditions Involving Substance Use

Within many Asian societies, the use of intox­ icants is tolerated within specific contexts. For example, in some Asian cultural groups, alco­ hol is believed to have curative, ceremonial, or beneficial value. Among pregnant Cambodian women, small amounts of herbal medicines with an alcohol base are sometimes used to ensure an easier delivery. Following childbirth, similar medicines are generally used to in­ crease blood circulation (Amodeo et al. 1997). Some Chinese people believe that alcohol restores the flow of *qi* (i.e., the life force). The written Chinese character for "doctor" con­ tains the character for alcohol, which implies the use of alcohol for medicinal purposes.

Some Asian American cultural groups make allowances for the use of other substances.

Marijuana, for instance, has been used medici­ nally in parts of Southeast Asia for many years

(Iversen 2000; Martin 1975). However, some Asian Americans tend to view illicit substance use and abuse as a serious breach of acceptable behavior that cannot readily be discussed.

Nonetheless, there are broad differences in Asian cultures' perspectives on substance use, thus requiring counselors to obtain more specific information during intake and subse­ quent encounters.

Acknowledging a substance abuse problem often leads to shame for Asian American clients and their families. Families may deny the problem and inadvertently, or even inten­ tionally, isolate members who abuse substances (Chang 2000). For example, some Cambodian and Korean Americans perceive alcohol abuse and dependence as the result of moral weak­ ness, which brings shame to the family (Amodeo et al. 2004; Kwon-Ahn 2001).

##### Substance Use and Substance Use Disorders

According to the 2012 **NSDUH,** Asian Americans use alcohol, cigarettes, and illicit substances less frequently and less heavily than members of any other major racial/ethnic group **(SAMHSA** *2013d).* However, large surveys may undercount Asian American substance use and abuse, as they are typically conducted in English and Spanish only (Wong et al. 2007*b).* Despite the limitations of research, data suggest that although Asian Americans use illicit substances and alcohol less frequently than other Americans, sub­ stance abuse problems have been increasing among Asian Americans. The longer Asian Americans reside in the United States, the more their substance use resembles that of other Americans. Excessive alcohol use, intox­ ication, and substance use disorders are more prevalent among Asians born in the United States than among foreign-born Asians living in the United States (Szaflarski et al. 2011).

**117**

Improving Cultural Competence

Among Asian Americans who entered sub­ stance abuse treatment between 2000 and 2010, methamphetamine and marijuana were the most commonly reported illicit drugs (SAMHSA, CBHSQ2012). Methampheta­ mine abuse among Asian Americans is partic­ ularly high in Hawaii and on the West Coast (OAS *2005a).* As with other racial and ethnic groups, numerous factors-such as age, birth country, immigration history, acculturation, employment, geographic location, and in­ come-add complexity to any conclusions about prevalence among specific Asian cultur­ al groups. Asian Americans who are recent immigrants, highly acculturated, unemployed, or living in Western states are generally more likely than other Asian Americans to abuse drugs or alcohol (Makimoto 1998). For exam­ ple, according to the National Latino and Asian American Study **(NLAAS),** Asians who are more acculturated are at greater risk for prescription drug abuse (Watkins and Ford 2011).

There are variations among particular groups of Asians; some Asian cultural groups have different attitudes toward substance use than others, and these differences tend to be ob­ scured in large-scale surveys. Researchers have found that Korean American college students drank more frequently and drank greater quantities than did Chinese American stu­ dents at the same schools and were more likely to consider drinking socially acceptable (Chang et al. 2008). Another study in the District of Columbia and surrounding metro­ politan area compared substance use among different groups of Southeast Asians (i.e., Cambodian, Laotian, and Vietnamese Americans); Vietnamese Americans had the highest rates of alcohol use, but Cambodian Americans had the highest rates of illicit drug use (Wong et al. 2007*b).* Research in San Francisco found Chinese Americans to be less likely than Vietnamese or Filipino Americans

to use illicit drugs, whereas Filipino Americans had the highest rate of illicit drug use (Nemoto et al. 1999). ln that same study, Filipino American immigrants were also significantly more likely to have begun using substances prior to immigrating than were Chinese or Vietnamese immigrants. Other studies have found that Filipino Americans are more likely to use illicit drugs and to inject drugs than other Asian American populations (see review in Nemoto et al. 2002).

To date, the largest national study to assess substance use and mental disorders across Asian American groups is the **NLAAS** (Takeuchi et al. 2007). This study found that Filipino American men were 2.38 times more likely to have a lifetime substance use disorder than were Chinese American men, whereas the differences among women of diverse Asian ethnicities were much smaller. Other research suggests that Korean Americans are more likely to have family histories of alcohol de­ pendence than are Chinese Americans (Ebberhart et al. 2003).

Besides the variations across different cultures, substance use and abuse among Asian Ameri­ cans is also influenced by age. Substance abuse appears higher for young Asian Americans than for those who are older (possibly reflect­ ing differences in acculturation). A study conducted in New York City showed that Asian American junior and senior high school students had the lowest percentage of heavy drinkers of any ethnic group, but those who were heavy drinkers drank twice as much daily as those who did not drink heavily (Makimoto 1998). Asian American youth, especially im­ migrants, tend to start using substances at a later age than members of other ethnic groups, which could be a factor in the lower levels of abuse seen among Asian Americans.

Despite rates of substance use disorders among Asian Americans having increased over

118

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

time, research has regularly found that, of all major racial/ethnic groups in United States, Asian Americans have the lowest rates of alcohol use disorders (Grant et al. 2004; **SAMHSA** 2012b). This phenomenon has typically been explained in part by the fact that some Asians lack the enzyme aldehyde dehydrogenase, which chemically breaks down alcohol (McKim 2003). Thus, high levels of acetaldehyde, a byproduct of alcohol metabo­ lism, accumulate and cause an unpleasant flushing response (Yang 2002). The alcohol flushing response primarily manifests as flush­ ing of the neck and face but can also include nausea, headaches, dizziness, and other symptoms.

Additional factors that could play a part in increasing the likelihood of substance use disorders among Asian Americans include experiences of racism and the absence of ethnic identification. Compared with Asian Americans who do not have alcohol use disor­ ders, Asian Americans who have alcohol use disorders are more than five times as likely to report unfair treatment because of their race and are more than twice as likely to deny strong ethnic identification (Chae et al. 2008). Compared with other racial and ethnic groups, Asian Americans who drink heavily are more likely to have friends or peers who also drink heavily (Chi et al. 1989).

##### Mental and Co-Occurring Disorders

Overall, health and mental health are not seen as two distinct entities by Asian Ameri­ can cultural groups. Most Asian American views focus on the importance of virtue, maturity, and self-control and find full emo­ tional expression indicative of a lack of ma­ turity and self-discipline (Cheung 2009).

Given the potential shame they often associate with mental disorders and their typically holistic worldview of health and illness, Asian

Americans are more likely to present with somatic complaints and less likely to present with symptoms of psychological distress and impairment (Hsu and Folstein 1997; Kim et al. 2004; Room et al. 2001; U.S. Department of Health and Human Services [HHS] 2001; Zhang et al. 1998), even though mental illness appears to be nearly as common among Asian Americans as it is in other ethnic/racial groups. In 2009, approximately 15.5 percent of Asians reported a mental illness in the past year, but only 2 percent reported past-year occurrence of serious mental illness (SAMHSA *2012a).* Asian Americans have a lower inci­ dence of CODs than other racial/ethnic groups because the prevalence of substance use disor­ ders in this population is lower. In the 2012 NSDUH, 0.3 percent of Asian Americans indicated co-occurring serious psychological distress and substance use disorders, and 1.1 percent had some symptoms of mental distress along with a substance use disorder-the low­ est rates of any major racial/ethnic group in the survey **(SAMHSA** *2013c).*

Considerable variation in the types of mental disorders diagnosed among diverse Asian American communities is evident, although it is unclear to what extent this reflects diagnostic and/or self-selection biases. For example, Barreto and Segal (2005) found that Southeast Asians were more likely to be treated for major depression than other Asians or mem­ bers of other ethnic/racial groups; East Asians were the most likely of all Asian American groups to be treated for schizophrenia (nearly twice as likely as White Americans). Traumat­ ic experiences and PTSD can be particularly difficult to uncover in some Asian American clients. Although Asian Americans are as likely to experience traumatic events (e.g., wars experienced by first-generation immi­ grants from countries such as Vietnam and Cambodia) in their lives, their cultural respons­ es to trauma can conceal its psychological

**119**

Improving Cultural Competence

effects. For instance, some Asian cultural groups believe that stoic acceptance is the most appropriate response to adversity (Lee and Mock *2005a,b).*

##### Treatment Patterns

Treatment-seeking rates for mental illness are low among most Asian populations, with rates varying by specific ethnic/cultural heritage and, possibly, level of acculturation (Abe-Kim et al. 2007; Barreto and Segal 2005; Lee and Mock *2005a,b).* Asian Americans who seek help for psychological problems will most likely consult family members, clergy, or tradi­ tional healers before mental health profession­ als, in part because of a lack of culturally and linguistically appropriate mental health ser­ vices available to them (HHS 2001; Spencer and Chen 2004). However, among those Asian Americans who seek behavioral health treat­ ment, the amount of services used is relatively high (Barreto and Segal 2005).

Asian Americans tend to enter treatment with less severe substance abuse problems than members of other ethnic/racial groups and have more stable living situations and fewer criminal justice problems upon leaving treat­ ment (Niv et al. 2007). However, for Asian Americans involved in the criminal justice system, there is a more pronounced relation­ ship between crime and drug abuse than for other ethnic and racial groups. In the early 1990s, an estimated 95 percent of Asian Americans in California prisons were there because of drug-related crimes (Kuramoto 1994). According to SAMHSA's 2010 TEDS data, 48.5 percent of Asian Americans in treatment were referred by the criminal justice system in that year, compared with 36.4 per­ cent of African Americans and 36.6 percent of White Americans (SAMHSA, CBHSQ 2012). According to 2010 NSDUH data regarding individuals who reported a need for treatment but did not receive it in the prior

year, Asian Americans were also the most likely of all major racial/ethnic groups to report that they could not afford or had no insurance coverage for substance abuse treat­ ment (SAMHSA, CBHSQ2011).

##### Beliefs and Attitudes About Treatment

Compared with the general population, Asian Americans are less likely to have confidence in their medical practitioners, feel respected by their doctors, or believe that they are involved in healthcare decisions. Many also believe that their doctors do not have a sufficient under­ standing of their backgrounds and values; this is particularly true for Korean Americans (Hughes 2002). Even so, Asian Americans, especially more recent immigrants, seem more likely to seek help for mental and substance use disorders from general medical providers than from specialized treatment providers

(Abe-Kim et al. 2007). Many Asian American immigrants underuse healthcare services due to confusion about eligibility and fears of jeopard­ izing their residency status (HHS 2001).

As with other groups, discrimination, accul­ turation stress, and immigration and genera­ tional status, along with language needs, have a large influence on behavioral health and treatment-seeking for Asian Americans (Meyer et al. 2012; Miller et al. 2011). The NLAAS found that although rates of behavioral health service use were lower for Asian Americans who immigrated recently than for the general population, those rates increased significantly for U.S.-born Asian Americans; third­ generation U.S.-born individuals' rates of ser­ vice use also were relatively high (Abe-Kim et al. 2007). Of those Asian Americans who had any mental disorder diagnosis in the prior year,

62.6 percent of third-generation Americans sought help for it in the prior year compared with 30.4 percent of first-generation Americans.

120

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

Overall, Asian Americans place less value on substance abuse treatment than other popula­ tion groups and are less likely to use such services (Yu and Warner 2012). Niv et al. (2007) found that Asian and Pacific Islanders entering substance abuse treatment programs in California expressed significantly more negative attitudes toward treatment and rated it as significantly less important than did others entering treatment. Seeking help for substance abuse can be seen, in some Asian American cultural groups, as an admission of weakness that is shameful in itself or as an interference with family obligations (Masson et al. 2013). Among 2010 NSDUH respond­ ents who stated a need for substance abuse treatment in the prior year but did not receive it, Asian Americans were more likely than members of all other major racial/ethnic groups to say that they could handle the prob­ lem without treatment or that they did not believe treatment would help (SAMHSA 2011c). Combining NSDUH data from 2003 to 2011 NSDUH, Asian Americans who needed but did not receive treatment in the past year were the least likely of all major ethnic/racial groups to express a need for such treatment (SAMHSA, CBHSQ2013c).

##### Treatment Issues and Considerations

It is important for counselors to approach presenting problems through clients' culturally based explanations of their own issues rather than imposing views that could alter their acceptance of treatment. In Asian cultural groups, the physical and emotional aspects of an individual's life are undifferentiated (e.g., the physical rather than emotional or psycho­ logical aspect of a problem can be the focus for many Asian Americans); thus, problems as well as remedies are typically handled holisti­ cally. Some Asian Americans with traditional backgrounds do not readily accept Western

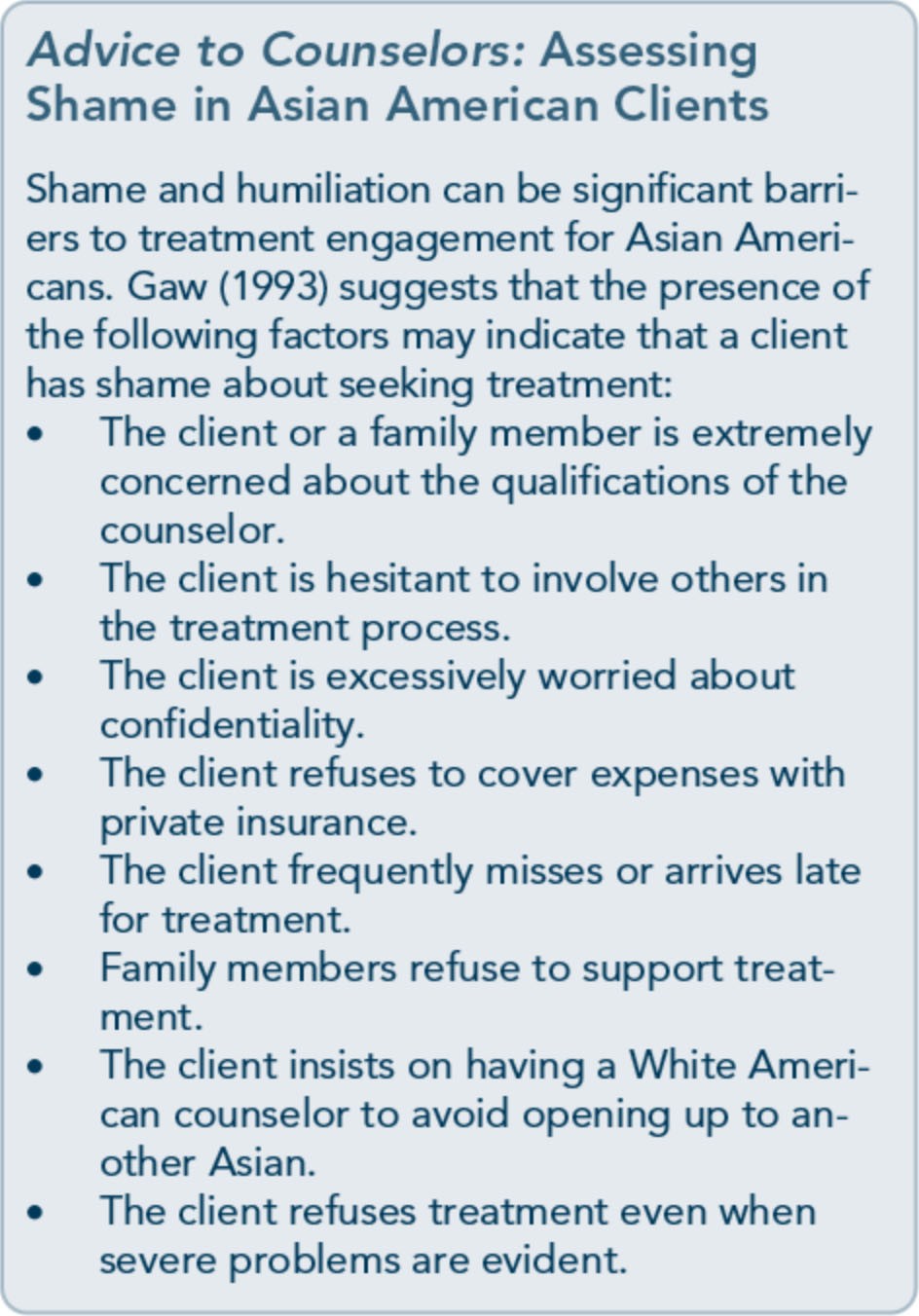
biopsychosocial explanations for substance use and mental disorders. Counselors should promote discussions focused on clients' under­ standing of their presenting problems as well as any approaches the clients have used to address them. Subsequently, presenting prob­ lems need to be reconceptualized in language that embraces the clients' perspectives (e.g., an imbalance in *yin* and *yang,* a disruption in *chi;* Lee and Mock *2005a,b).* It is advisable to educate Asian American clients on the role of the counselor/therapist, the purpose of thera­ peutic interventions, and how particular aspects of the treatment process (e.g., assessment) can help clients with their presenting problems (Lee and Mock *2005a,b;* Sue 2001). Asian American clients who receive such education participate in treatment longer and express greater satisfaction with it (Wong et al. 2007*a).*

As with other racial/ethnic groups, Asian American clients are responsive to a warm and empathic approach. Counselors should realize, though, that building a strong, trusting rela­ tionship takes time. Among Asian American clients, humiliation and shame can permeate the treatment process and derail engagement with services. Thus, it is essential to assess and discuss client beliefs about shame (see the "Assessing Shame in Asian American Clients" advice box on the next page). In some cases, self-disclosure can be helpful, but the counse­ lor should be careful not to self-disclose in a way that will threaten his or her position of respect with Asian American clients.

Asian American clients may look to counse­ lors for expertise and authority. Counselors should attempt to build client confidence in the first session by introducing themselves by title, displaying diplomas, and mentioning his or her experience with other clients who have similar problems (Kim 1985; Lee and Mock *2005a,b).* Asian American clients may expect and be most comfortable with formalism on

121

Improving Cultural Competence



the part of counselors, especially at the begin­ ning of treatment and prior to assessment of clients' needs (Paniagua 1998). Many Asian American clients expect counselors to be directive (Leong and Lee 2008). Passivity on the part of the counselor can be misinterpret­ ed as a lack of concern or confidence.

Counselors who are unaccustomed to working with Asian populations will likely encounter conflict between their theoretical worldview of counseling and the deference to authority and avoidance of confrontation that is common among more traditional Asian American clients. Some clients can be hesitant to con­ tradict the counselor or even to voice their own opinions. Confrontation can be seen as something to avoid whenever possible. Fur­ thermore, many Asian cultural groups have high-context styles of communication, mean­ ing that members often place greater im­ portance on nonverbal cues and the context of

verbal messages than on the explicit content of messages (Hall 1976). Asian Americans often use indirect communication, relying on subtle gestures, expressions, or word choices to con­ vey meaning without being openly confronta­ tional. Counselors must not only be observant of nuances in meaning, but also learn about verbal and nonverbal communication styles specific to Asian cultural groups (for a review of guidelines to use when working with Asian Americans, see Gallardo et al. 2012).

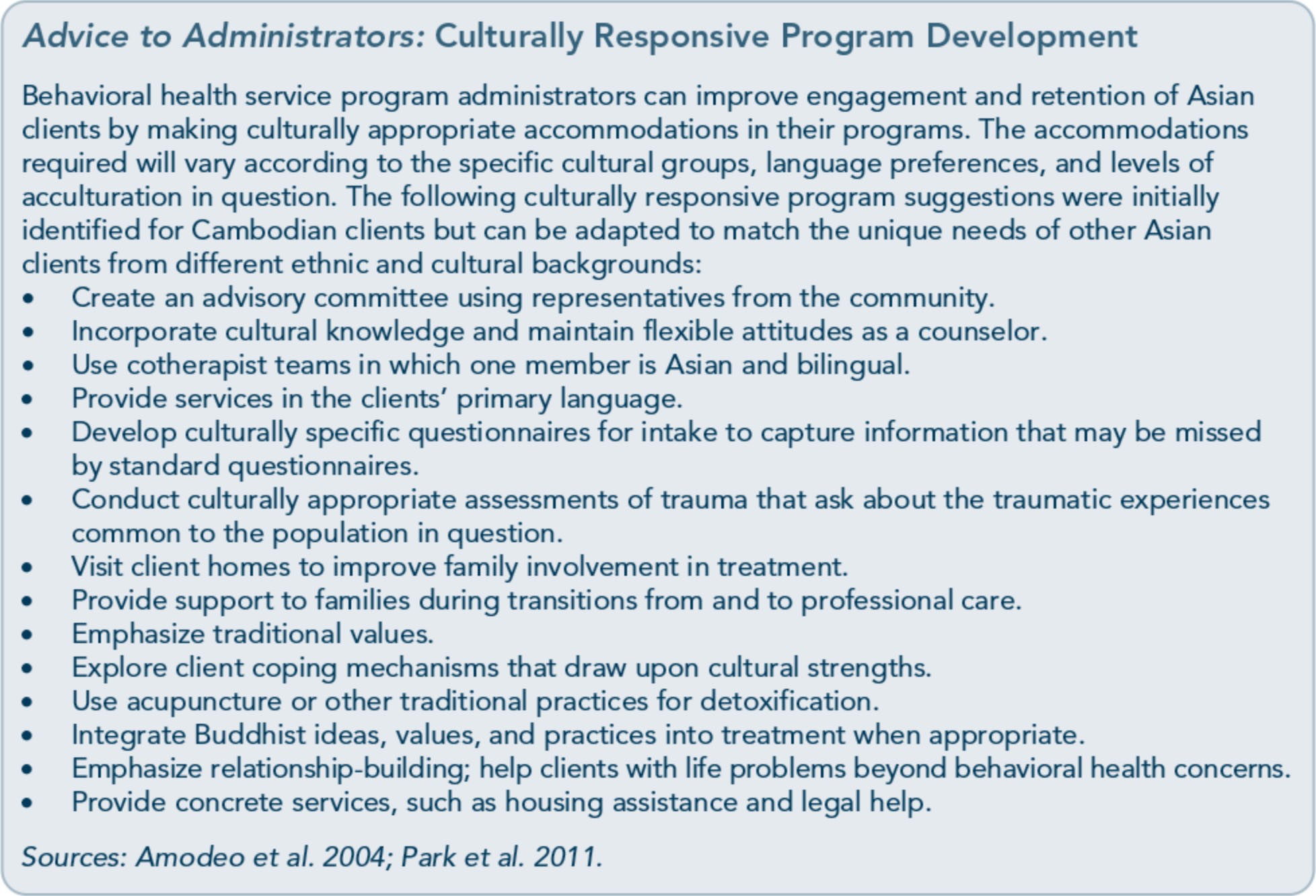
Asian American clients appear to respond more favorably to treatment in programs that provide services to other Asian clients.

Takeuchi et al. (1995) found that Asian Americans were much more likely to return to mental health clinics where most clients were Asian American than to programs where that was not the case (98 percent and 64 percent returned, respectively). When demographic differences were controlled for, those who attended programs that had predominantly Asian clients were 15 times more likely to return after the initial visit. Asian Americans were also more likely to stay in treatment when matched with an Asian American coun­ selor regardless of the type of program they attended. Sue et al. (1991) also found that Asian American clients attended significantly more treatment sessions if matched with an Asian American counselor.

Among Asian American women, crucial strategies include reducing the shame of sub­ stance abuse and focusing on the promotion of overall health rather than just addressing substance abuse. Such strategies reduce the chance of a woman and her family seeing substance abuse as an individual flaw. Home visits, when agreed in advance with the client, can be appropriate in some cases as a way to gain the trust of, and show respect for, Asian American women. Asian American women may not be as successful in mixed-gender

**122**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups



groups if strict gender roles exist whereby communication is constricted within and out­ side the family; women will likely remain silent or defer to the men in the group (Chang 2000). For more information on treating women, see Treatment Improvement Protocol **(TIP)** 51, *Substance Abuse Treatment: Addressing the Specific Needs of Women* **(CSAT** 2009c).

##### Theoretical Approaches and Treatment Interventions

Some Asian cultural groups emphasize cogni­ tions. For instance, Asian cultural groups that have a Buddhist tradition, such as the Chinese, view behavior as controlled by thought. Thus, they accept that addressing cognitive patterns will affect behaviors (Chen 1995). Some Asian cultural groups encourage a stoic attitude toward problems, teaching emotional suppres­ sion as a coping response to strong feelings (Amodeo et al. 2004; Castro et al. *1999b;* Lee and Mock *2005a,b;* Sue 2001). Treatment can

be more effective if providers avoid approaches that target emotional responses and instead use strategies that are more indirect in discuss­ ing feelings (e.g., saying "that might make some people feel angry" rather than asking directly what the client is feeling; Sue 2001).

Asian Americans often prefer a solution­ focused approach to treatment that provides them with concrete strategies for addressing specific problems (Sue 2001). Even though little research is available in evaluating specific interventions with Asian Americans, clinicians tend to recommend cognitive-behavioral, solution-focused, family, and acceptance commitment therapies (Chang 2000; Hall et al. 2011; Iwamasa et al. 2006; Rastogi and Wadhwa 2006; Sue 2001). Asian American clients are likely to expect that their counselors take an active role in structuring the therapy session and provide clear guidelines about what they expect from clients. CBT has the

123

Improving Cultural Competence

**124**

advantages of being problem focused and time limited, which will likely increase its appeal for many Asian Americans who might see other types of therapy as failing to achieve real goals (Iwamasa et al. 2006). Although specific data on the effectiveness of CBT among Asian Americans is not available, there is some research indicating that CBT is effective for treating depressive symptoms in Asians (Dai et al. 1999; Fujisawa et al. 2010). In China, a Chinese Taoist version of CBT has been developed to treat anxiety disorders and was found to be effective, especially in conjunction with medication (Zhang et al. 2002).

***Family therapy***

Some Asian Americans, particularly those who are less acculturated, prefer individual therapy to group or family interventions be­ cause it better enables them to save face and keep their privacy (Kuramoto 1994). Some clients may wish to enter treatment secretly so that they can keep their families and friends from knowing about their problems. Once treatment is initiated, counselors should strongly reinforce the wisdom of seeking help through statements such as "you show concern for your husband by seeking help" or "you are obviously a caring father to seek this help."

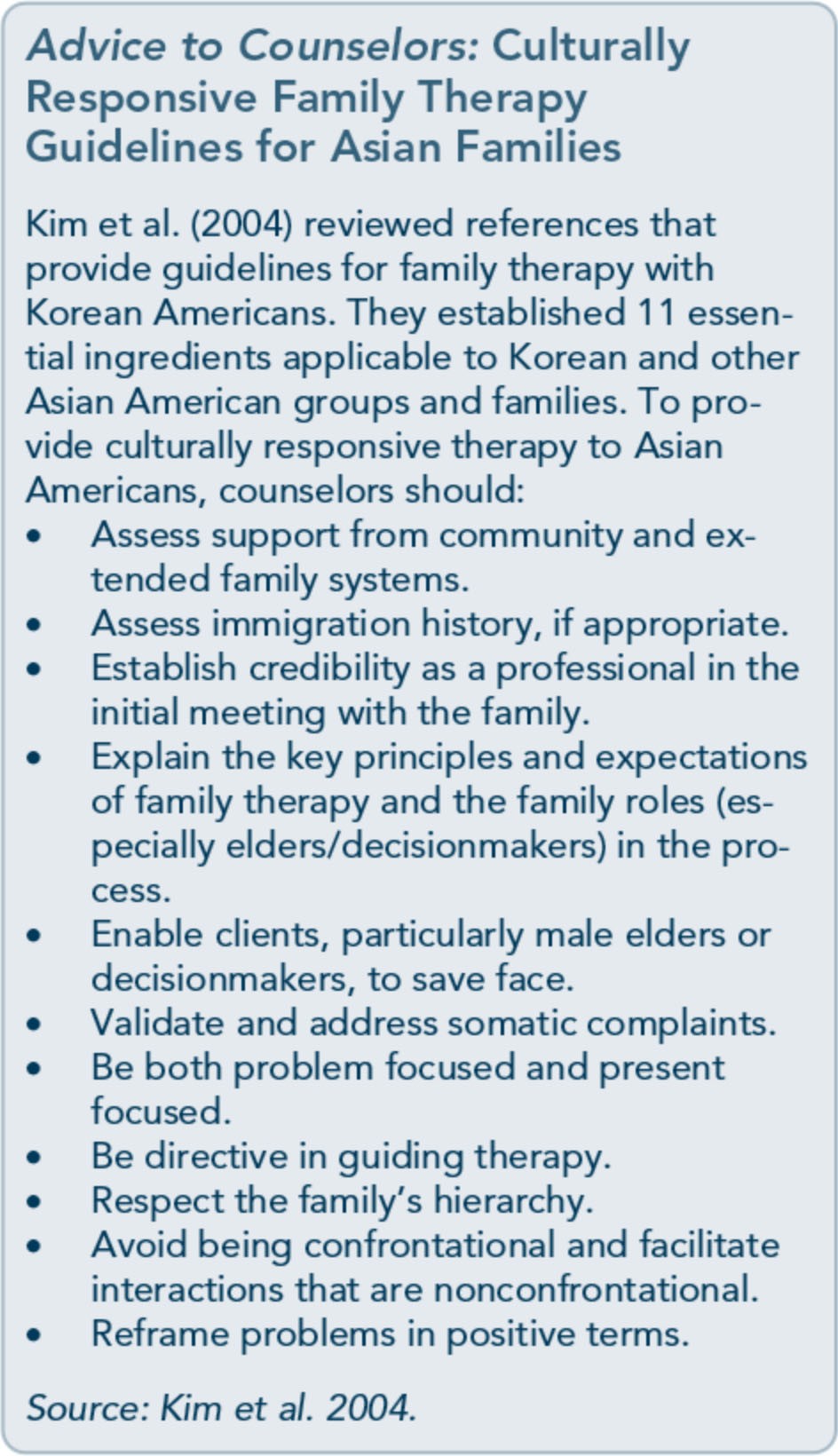
The norm in Asian families is that "all prob­ lems (including physical and mental problems) must be shared only among family members"; sharing with others can cause shame and guilt, exacerbating problems (Paniagua 1998, pp.

59-60). Counselors should expect to take

more time than usual to learn about clients' situations, anticipate client needs for reassur­ ance in divulging sensitive information, and frame discussions in a culturally competent way. For example, counselors can assure cli­ ents that discussing problems is a step toward resuming their full share of responsibility in their families and removing some of the stress their families have been feeling.

For most Asian Americans, particularly those who are less acculturated, successful treatment involves the client's family (Chang 2000; Kim et al. 2004; Rastogi and Wadhwa 2006). Even in individual treatment, it is important to understand the client's family and his or her relationship with its members, the dynamics and style of the family, and the family's role in the client's substance abuse (Meyer et al.

2012). Particularly among Asian American women, family involvement can be essential due to the client's concern about being re­ sponsive to her family's needs. Nonetheless, involving the family can be quite difficult, as both male and female clients may wish to conceal their substance abuse from their fami­ lies because of the shame that it brings.



Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

To engage family members in the client's treatment, the counselor first needs to be familiar with the way the family functions. Different acculturation levels among individu­ al family members and across generations can affect how the family functions, producing significant stress and internal conflict. Also, the counselor must be aware of how gender roles and generational status influence the communication patterns and rules within each family (e.g., expectations of how a child ad­ dresses a parent, the potential relegation of authority among female family members).

Even more than for other clients, it is critical for Asian Americans to "avoid embarrassing the family members in front of each other.

The counselor should always protect the dignity and self-respect of the client and his or her family" (Paniagua 1998, p. 71).

#### *Group therapy*

Group therapy may not be a good choice for Asian Americans, as many prefer individual therapy (Lai 2001; Sandhu and Malik 2001). Paniagua (1998, p. 73) suggests that "group therapy... would be appropriate in those cases in which the client's support system (relatives and close friends) is not available and an alternative support system is quickly needed." Some Asian Americans participating in group therapy will find it difficult to be assertive in a group setting, preferring to let others talk.

They can also abide by more traditional roles in this context; men might not want to divulge their problems in front of women, women can feel uncomfortable speaking in front of men, and both men and women might avoid con­ tradicting another person in group (especially an older person). It may not make sense to Asian American clients to hear about the problems of strangers who are not part of their community.

Asian Americans are likely to be motivated to work for the good of the group; presenting

group goals in this framework can garner active participation. Still, in group settings and in other instances, Asian American clients may expect a fair amount of direction from the group leader. Chen (1995) described leader­ ship of a culturally specific therapy group for Chinese Americans, noting that clients expect a group leader to act with authority and give more credence to his or her expertise than to other group members. If members of the group belong to the same Asian American community, the issue of confidentiality will loom large, because the community is often small. Asian cultural groups generally appreci­ ate education in more formal settings, so psychoeducation groups can work well for Asian Americans. It is possible for a psy­ choeducational group with Asian American participants to evolve comfortably into group therapy.

#### *Mutual-help groups*

According to 2012 NSDUH data, Asian Americans were less likely than other racial and ethnic groups to report the use of mutual­ help groups in the past year (SAMHSA *2013d).* Mutual-help groups can be challeng­ ing for Asian Americans who find it difficult and shaming to self-disclose publicly. The degree of emotion and candor within these groups can further alienate traditional Asian American clients. Furthermore, linguistically appropriate mutual-help groups are not always available for people who do not speak English. Highly acculturated Asian Americans may perceive participation in mutual-help groups as less of a problem, but nevertheless, Asian Americans can benefit from culture-specific mutual-help groups where norms of interper­ sonal interaction are shared. Asian American 12-Step groups are available in some locales. It is important for counselors to assess client attitudes toward mutual-help participation and find alternative strategies and resources,

125

Improving Cultural Competence

including encouragement to attend without sharing (Sandhu and Malik 2001).

Although they are not mutual-help groups in the traditional sense, mutual aid societies and associations are important in some Asian American communities. Some mutual aid societies have long histories and have provided assistance ranging from financial loans to help with childcare and funerals. The Chinese have family associations for people with the same last name who share celebrations and offer each other help.Japanese, Chinese, and South Asians have specific associations for people from the same province or village. For some Asian American groups, such as Koreans, churches are the primary organizational vehi­ cles for assistance. These social support groups can be important resources for Asian American clients, their families, and the behavioral health agencies that provide services to them.

***Traditional healing and complementary methods***

Asian Americans are twice as likely as other Americans to report making use of acupunc­ ture and traditional healers. Even though there is considerable variation in their use of com­ plementary and traditional medicine (Hughes 2002), many Asian Americans highly regard traditional healers, herbal preparations, and other culturally specific interventions as a means of restoring harmony and balance.

However, Asian American clients do not always readily disclose the use of traditional medicine to Western treatment providers. Ahn et al. (2006) found that about two-thirds of Chinese and Vietnamese Americans who spoke no or limited English had used tradi­ tional medicine, but only 7.6 percent had discussed the use of these therapies with their Western medical providers.

Traditional treatment to restore physical and emotional balance for Asian Americans occurs

through a variety of culture-specific interven­ tions. For example, some Southeast Asian cultural groups practice *cao* gio---massaging the skin with ointment and hot coins (Chan and Chen 2011). The Chinese have developed enormously complex systems of medical treatment over centuries of pragmatic experi­ mentation. Traditional herbal medicine com­ bines plant substances according to precise formulas to have the desired influence on the affected organs of the body. Acupuncture techniques involve regulating the flow of energy *(qi)* through the body by inserting needles at precise locations called acupuncture points.In traditional Chinese medicine, which has influenced traditional medical practices in other Asian cultural groups, illness is seen as an imbalance of *yin* and *yang;,* a return to physical wellness can require introducing elements such as herbs to increase *yin* or *yang* as needed (Torsch and Ma 2000).

Among less acculturated Asian Americans, Western medicine, including Western behav­ ioral health services, can be insufficient to deal with a problem such as substance abuse and its effects on clients and their families. For exam­ ple, all health problems for the Hmong (whether physical or psychological) are con­ sidered spiritual in nature; if providers ignore the clients' understanding of their problems as spiritual maladies, they are unlikely to effect positive change (Fadiman 1997). Even for more acculturated Asian Americans, the use of traditional healing methods and spirituality can be a very important aspect of treatment (see Chan and Chen 2011 for an overview of health beliefs and practices). Such use can provide a spiritual connection that helps man­ age feelings that are especially difficult to express to others. Many practices associated with meditation, yoga, and Eastern religious traditions can help disperse the stress and anxiety experienced during treatment and recovery. In the United States, there are few

**126**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

**Behavioral Health Counseling for Native Hawaiians and Other Pacific Islanders**

The ancestors of Native Hawaiians and other Pacific Islanders were the original inhabitants of Hawaii, Guam, Samoa, and other Pacific islands. The population of Native Hawaiians and other Pacific Islanders grew more than three times faster than the total U.S. population from 2000 to 2010. More than half of Native Hawaiian and other Pacific Islanders live in Hawaii and California. The largest Pacific Islander populations in the United States comprise Hawaiians, Samoans, and Chamorros-the indigenous people of the Mariana Islands, of which Guam is the largest (Hixson et al. 2012).

Native Hawaiians and other Pacific Islanders make up a relatively small proportion of the total United States population. In the 2010 Census, 540,000 people, or 0.2 percent ofthe population, reported their race as Native Hawaiian or other Pacific Islander, and another 685,000 people (0.2 percent of the population) stated that they were Native Hawaiian or other Pacific Islander in addition to one or more other races (Hixson et al. 2012). The largest concentration of Native Hawaiians and other Pacific Islanders is in Hawaii, where individuals with at least some of this ancestry made up 23.3 percent of the population.

In 2012, according to NSDUH data, 5.4 percent of Native Hawaiians and other Pacific Islanders interviewed had a substance use disorder in the prior year, and 7.8 percent engaged in current illicit drug use **(SAMHSA** 2013d). Binge and heavy drinking appear to be relatively high, especially among Native Hawaiian/Pacific Islander women. Data from the 2001-2011 TEDS surveys indicate that the most common primary substances of abuse among Native Hawaiians and other Pacific Islanders entering substance abuse treatment are alcohol, cannabis, and methamphetamine **(SAMHSA** 2013c). Because of its relatively small size, many studies have either ignored or been unable to make conclu­ sions about substance use and abuse in this population; other research has grouped Native Hawaiians and other Pacific Islanders together with Asians (more for the sake of convenience than for underlying cultural similarities).

According to NSDUH data, 1.8 percent of adult Native Hawaiians and other Pacific Islanders report­ ed serious mental illness. Insufficient data were available to analyze past-year mental illness rates **(SAMHSA** 2013c). Similar to substance use data, specific mental health data are limited across national studies, primarily because the population has been grouped with Asians. However, the evidence that is available suggests that Native Hawaiians are less likely than other racial/ethnic groups in Hawaii to access treatment services even though they experience higher rates of mental health problems (for a review of health beliefs and practices, see Mokuau and Tauili'ili 2011).

A few examples of culturally specific interventions for Native Hawaiians have been presented in the literature. For example, the Rural Hawai'i Behavioral Health Program, which provides substance abuse and mental health services to Native Hawaiians living in rural areas, incorporates Native Hawaiian beliefs and practices into all areas of the program, emphasizing the value of *'ohana* (family) relations, including the importance of respecting and honoring ancestors and elders and passing on cultural ways to the next generation. Program staff members are trained in Native Hawaiian culture and beliefs, including spirituality and the essential value of graciousness, the honoring of mana (life energy), healing rituals such as *pule* (prayer), the use of healing herbs, and Native Hawaiian beliefs about the causes of illness, such as wrongdoing and physical disruption (Oliveira et al. 2006).

*Ho'oponopono* is a form of group therapy used by Native Hawaiians; it involves family members and is facilitated by a *Ki.ipuna* (elder). A qualitative study by Morelli and Fong (2000) of *Ho'oponopono* with pregnant or postpartum women with substance use disorders (primarily methamphetamine abuse) reported high client satisfaction and positive outcomes (80 percent were abstinent 2 years after treatment). The Na Wahine Makalapua Project, sponsored by the Hawaii Department of Health's Alcohol and Drug Abuse Division and SAMHSA's Center for Substance Abuse Prevention, uses elements of Hawaiian culture to treat women with substance use disorders, such as by having *Ki.ipuna* counsel younger generations.

127

Improving Cultural Competence

examples of culturally specific treatment pro­ grams that focus on Asian religious or spiritual treatment; however, there are programs over­ seas, such as the Thai Buddhist treatment center described by Barrett (1997).

Asian Americans are much more likely than members of other racial/ethnic groups to label themselves as secular, agnostic, or atheist (Kosmin and Keysar 2009; Pew Forum on Religion and Public Life 2008). That said, a substantial number of Asian Americans still have religious affiliations. About *45* percent are Protestant; 17 percent, Catholic; 14 per­ cent, Hindu; 9 percent, Buddhist; and 4 per­ cent, Muslim (Pew Forum on Religion and Public Life 2008). More acculturated Asian Americans are likely to enter treatment through medical settings and to be comforta­ ble with a medical model for treatment, but those who are less acculturated or are foreign­

born can prefer the use of traditional healing and/or religious traditions and beliefs as part of their treatment (Ja and Yuen 1997). Reli­ gious institutions can play an important part in the treatment of some groups of Asian Americans. For example, Kwon-Ahn (2001)

notes that many Korean Americans, particu­ larly more recent immigrants, turn to Chris­ tian clergy or church groups for assistance with family and personal problems, such as substance abuse, before seeking professional help. Amodeo et al. (2004) suggest that, in working with Cambodian immigrants, provid­ ers integrate Buddhist philosophy and practic­ es into treatment, and, if possible, partner with Buddhist temples to facilitate treatment entry or to provide services for clients who choose to reside in Buddhist temples.

***Relapse prevention and recovery*** Little research has evaluated relapse preven­ tion and recovery promotion strategies specifi­ cally for Asian Americans. However, issues involving shame can make the adjustment to

abstinence difficult for Asian clients. Counse­ lors should take this into account and address difficulties that can arise for clients with fami­ lies who have shame about mental illness or substance use disorders. To date, there are no indications that standard approaches are un­ suitable for Asian American clients. For more information on these approaches, see the planned **TIP,** *Relapse Prevention and Recovery Promotion in Behavioral Health Services* (SAMHSA planned *e).*

### Counseling for Hispanics and Latinos

The terms "Hispanic" and "Latino" refer to people whose cultural origins are in Spain and Portugal or the countries of the Western Hemisphere whose culture is significantly influenced by Spanish or Portuguese coloniza­ tion. Technically, a distinction can be drawn between Hispanic (literally meaning people from Spain or its former colonies) and Latino (which refers to persons from countries ranging from Mexico to Central and South America and the Caribbean that were colonized by Spain, and also including Portugal and its former colonies); this TIP uses the more inclusive term (Latino), except when research specifically indicates the other. The term "Latina" refers to a woman of Latino descent.

Latinos are an ethnic rather than a racial group; Latinos can be of any race. According to 2010 Census data, Latinos made up 16 percent of the total United States population; they are its fastest growing ethnic group (Ennis et al. 2011). Latinos include more than 30 national and cultural subgroups that vary by national origin, race, generational status in the United States, and socioeconomic status (Padilla and Salgado de Snyder 1992; Rodriguez-Andrew 1998). According to Ennis et al. (2011), of Latinos currently living in the United States (excluding Puerto Rico and

128

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

other territories), Mexican Americans are the largest group (63 percent), followed by Central and South Americans (13.4 percent), Puerto Ricans (9.2 percent), and Cubans (3.5 percent).

##### Beliefs About and Traditions Involving Substance Use

Attitudes toward substance use vary among Latino cultural groups, but Latinos are more likely to see substance use in negative terms than are White Americans. Marin (1998) found that Mexican Americans were signifi­ cantly more likely to expect negative conse­ quences and less likely to expect positive outcomes as a result of drinking than were White Americans. Similarly, Hadjicostandi and Cheurprakobkit (2002) note that most Latinos believe that prescription drug abuse could have dangerous effects (85.7 percent), that individuals who abuse substances cause their whole families to suffer (81.4 percent), and that people who use illicit drugs will participate in violent crime (74.9 percent) and act violently toward family members (78.9 percent). Driving under the influence of alco­ hol is one of the most serious substance use problems in the Latino community.

Other research suggests that some Latinos hold different alcohol expectancies. When comparing drinking patterns and alcohol expectancies among college students, Velez­ Blasini (1997) found that Puerto Rican partic­ ipants were more likely than other students to see increased sociability as a positive expectan­ cy related to drinking and sexual impairment as a negative expectancy. Puerto Rican partici­ pants were also significantly more likely to report abstinence from alcohol. In another study comparing Puerto Ricans and Irish Americans, Puerto Rican participants who expected a loss of control when drinking had fewer alcohol-related problems, whereas Irish Americans who expected a loss of control had a greater number of such problems (Johnson

and Glassman 1999). The authors concluded that "losing control" has a different cultural meaning for these two groups, which in turn affects how they use alcohol.

For many Latino men, drinking alcohol is a part of social occasions and celebrations. By contrast, solitary drinking is discouraged and seen as deviant. Social norms for Latinas are often quite different, and those who have substance abuse problems are judged much more harshly than men. Women can be per­ ceived as promiscuous or delinquent in meet­ ing their family duties because of their substance use (Hernandez 2000). Amaro and Aguiar (1995) note that the heavy emphasis on the idealization of motherhood contributes to the level of denial about the prevalence of substance use among Latinas. Women who use injection drugs feel the need to maintain their roles as daughters, mothers, partners, and community members by separating their drug use from the rest of their lives (Andrade and Estrada 2003), yet research suggests that substance abuse among women does not go unrecognized within the Latino community (Hadjicostandi and Cheurprakobkit 2002).

Among families, Latino adults generally show strong disapproval of alcohol use in adoles­ cents of either gender (Flores-Ortiz 1994).

Adults of both genders generally disapprove of the initiation of alcohol use for youth 16 years of age and under (Rodriguez-Andrew 1998). Long (1990) also found that even among Latino families in which there has been multi­ generational drug abuse, young people were rarely initiated into drug abuse by family members. However, evidence regarding paren­ tal substance use and its influence on youth has been mixed; most studies show some correlation between parental attitudes toward alcohol use and youth drinking (Rodriguez­ Andrew 1998). For instance, research with college students found that family influences

129

Improving Cultural Competence

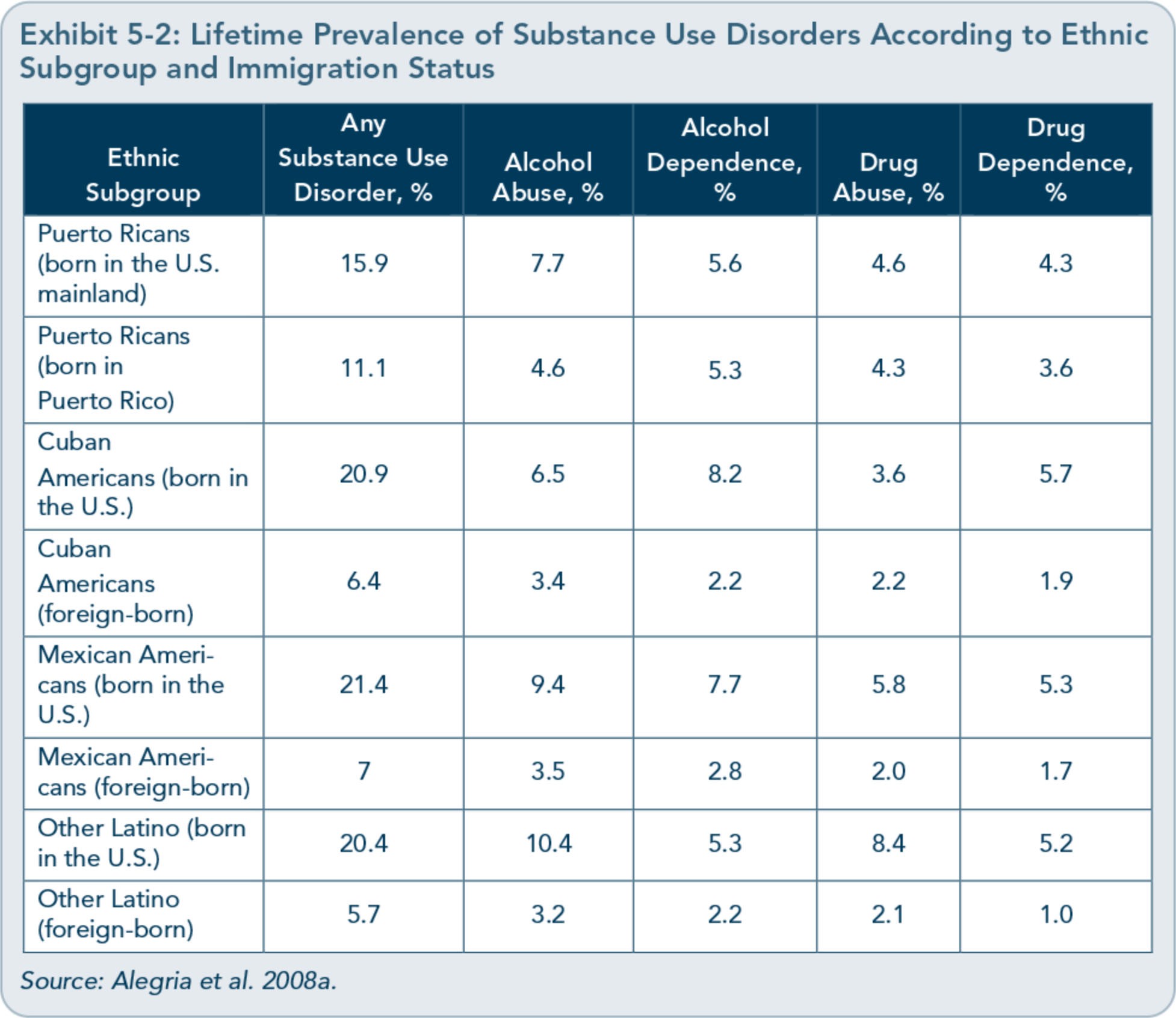
had a significant effect on drinking in Latinos but not White Americans; the magnitude of this effect was greater for Latinas than for Latino men (Corbin et al. 2008).

##### Substance Use and Substance Use Disorders

According to 2012 NSDUH data, rates of past-month illicit substance use, heavy drink­ ing, and binge drinking among Latinos were lower than for White Americans, Blacks, and Native Americans, but not significantly so (SAMHSA *2013d).* The same data showed that 8.3 percent of Latinos reported past­ month illicit drug use compared with 9.2 percent of White Americans and 11.3 percent of African Americans.

Although data are available from a number of studies regarding Latino drinking and drug use patterns, more targeted research efforts are needed to unravel the complexities of sub­ stance use and the many factors that affect use, abuse, and dependence among subgroups of Latino origin (Rodriguez-Andrew 1998). For example, some studies show that Latino men are more likely to have an alcohol use disorder than are White American men (Caetano

2003), whereas others have found the reverse to be true (Schmidt et al. 2007). Disparities in survey results may reflect varying efforts to develop culturally responsive criteria (Carle 2009; Hasin et al. 2007). The table in Exhibit 5-2 shows lifetime prevalence of substance use disorders among Latinos based on



130

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

immigration status and ethnic subgroup (Alegria et al. 2008a).

Among diverse Latino cultural groups, differ­ ent patterns of alcohol use exist. For example, some older research suggests that Mexican American men are more likely to engage in binge drinking (having five or more drinks at one time; drinking less frequently, but in higher quantities) than other Latinos but use alcohol less frequently (Caetano and Clark 1998). There are also differences regarding the abuse of other substances. Among Latinos entering substance abuse treatment in 2006, heroin and methamphetamine use were espe­ cially high among Puerto Ricans and Mexican Americans, respectively. Other research has found that Puerto Ricans are more likely to inject drugs and tend to inject more often during the course of a day than do other Latinos (Singer 1999).

Patterns of substance use are also linked to gender, age, socioeconomic status, and accul­ turation in complex ways (Castro et al. *1999a;* Wahl and Eide 2010). For instance, increased frequency of drinking is associated with great­ er acculturation for Latino men and women, yet the drinking patterns of Latinas are affect­ ed significantly more than those of Latino men (Markides et al. 2012; Zemore 2005).

Age appears to influence Latino drinking patterns somewhat differently than it does for other racial/ethnic groups. Research indicates that White Americans often "age out" of heavy drinking after frequent and heavy alco­ hol use in their 20s, but for many Latinos, drinking peaks between the ages 30 and 39.

Latinos in this age range have the lowest abstention rates and the highest proportions of frequent and heavy drinkers of any age group (Caetano and Clark 1998). In the same study, Latino men between 40 and 60 years of age had higher rates of substance use disorders

than men in the same age group across other racial/ethnic populations.

Latino youth appear to start using illicit drugs at an earlier age than do members of other major ethnic/racial groups. Cumulative data from 28 years of the Monitoring the Future Study show Latino eighth graders as having higher rates of heavy drinking, marijuana use, cocaine use, and heroin use than African or White Americans in the same grade. Among youth in grade 12, the rates of use among Latino and White American students are more similar, but Latinos still had the highest rates of crack cocaine and injected heroin use (Johnston et al. 2003).

Patterns of substance use and abuse vary based on Latinos' specific cultural backgrounds.

Among Latinos, rates of past-year alcohol dependence were higher among Puerto Rican and Mexican American men (15.3 percent and

15.1 percent, respectively) than among South/Central American or Cuban American men (9 percent and 5.3 percent, respectively). Among Latinas, past-year alcohol dependence rates were significantly higher for Puerto Rican women (6.4 percent) than for Mexican American (2.1 percent), Cuban American (1.6 percent), or South/Central American (0.8 percent) women (Caetano et al. 2008).

##### Mental and Co-Occurring Disorders

As with other populations, it is important to address CODs in Latino clients, as CODs have been associated with higher rates of treatment dropout (Amodeo et al. 2008).

There are also reports of diagnostic bias, sug­ gesting that some disorders are underreported and others are overreported. Minsky et al. (2003) found that, at one large mental health treatment site in New Jersey, major depression was overdiagnosed among Latinos, especially Latinas, whereas psychotic symptoms were

131

Improving Cultural Competence

sometimes ignored. Among Latinos with CODs, other mental disorders preceded the development of a substance use disorder 70 percent of the time (Vega et al. 2009).

Overall, research indicates fewer mental disor­ ders and CODs among Latinos than among White Americans (Alegria et al. 2008a; Vega et al. 2009). However, data from the 2012 NSDUH indicate that the magnitude of the difference may be decreasing; 1.2 percent of Latinos had both serious mental illness and substance use disorders in the prior year, as did White Americans, similar to the rate seen among African Americans (0.9 percent; SAMHSA 2013c). When any mental disorder symptoms co-occurring with a substance use disorder diagnosis were evaluated, Latinos had a slightly higher rate of co-occurrence (3.4 percent) than did African Americans (3.3 percent; SAMHSA 2013c). Rates of mental disorders and CODs also vary by Latino subgroup (Alegria et al. 2008a), and accultura­ tion can play a confounding, but inconsistent, role in the identification and development of CODs in Latino populations (Alegria et al.

2008a; Vega et al. 2009).

##### Treatment Patterns

Barriers to treatment entry for Latinos in­ clude, but are not limited to, lack of Spanish­ speaking service providers, limited English proficiency, financial constraints, lack of cul­ turally responsive services, fears about immi­ gration status and losing custody of children while in treatment, negative attitudes toward providers, and discrimination (Alegria et al.

2012; Mora 2002). Among all ethnic/racial groups included in the 2010 NSDUH, Lati­ nos were the most likely to report that they had a need for treatment but did not receive it because they could not find a program with the appropriate type of treatment or because there were no openings in programs that they wished to attend, which may reflect a lack of

linguistically and/or culturally appropriate services **(SAMHSA** 2011c). They were about twice as likely to state the former and four times as likely to state the latter as members of the group that was the next most likely to make such statements.

A significant problem prohibiting participa­ tion in substance abuse treatment among Latinos is the lack of insurance coverage to pay for treatment. In SAMHSA's 2010 **NSDUH,** 32 percent of Latinos who needed but did not receive substance abuse treatment in the past year reported that they lacked mon­ ey or insurance coverage to pay for it compared with 29*.5* percent of White Americans and

33.5 percent of African Americans (SAMHSA 2011c). Other national surveys also found that Latinos with self-identified drinking problems were significantly more likely than either White Americans or African Americans to indicate that they did not seek treatment because of logistical barriers, such as a lack of funds or being unable to obtain childcare (Schmidt et al. 2007).

Latinos with substance use disorders are about as likely to enter substance abuse treatment programs as White Americans (Hser et al.

1998; Perron et al. 2009; Schmidt et al. 2006).

Latinos tend to enter treatment at a younger age than either African Americans or White Americans (Marsh et al. 2009). There are also significant differences in treatment-seeking patterns among Latino cultural groups. For example, Puerto Ricans who inject heroin are much more likely to participate in methadone main-tenance and less likely to enter other less-effective detoxification programs than are Dominicans, Central Americans, and other Latinos (Reynoso-Vallejo et al. 2008). The researchers note, however, that this could be due partially to the fact that Puerto Ricans, compared with other Latinos, have a greater awareness of treatment options.

132

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

##### Beliefs and Attitudes About Treatment

In general, Latino attitudes toward health care are shaped by a lack of access to regular quality care, including inability to afford it (see review of health beliefs and help-seeking behaviors among Mexican Americans and Mexicans dwelling in the United States in Rogers 2010). DeNavas-Walt et al. (2006) found that Lati­ nos are less likely to have health insurance (32.7 percent were uninsured in 2005) than either non-Latino White Americans (11.3 percent were uninsured) or African Americans (19.6 percent were uninsured). They are also less likely to have had a regular place to go for conventional medical care (Schiller et al.

2005). Lack of knowledge about available services can be a major obstacle to seeking services (Vega et al. 2001). In their review, Murguia et al. (2000) identified several factors that influence the use of medical services including cultural health beliefs, demographic barriers, level of acculturation, English profi­ ciency, accessibility of service providers, and flexibility of intake procedures; they found that many Latinos only seek medical care for serious illnesses.

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Research on substance abuse indicates that Latinos who use illicit drugs appear to have relatively unfavorable attitudes toward treat­ ment and perceive less need for treatment than do illicit drug users among every other major ethnic and racial group but Native Americans (Brower and Carey 2003). However, in the 2011 NSDUH, Latinos were more likely than White Americans, African Americans, or Asian Americans to indicate that they had a need for substance abuse treatment in the prior year but did not receive it (SAMHSA *2012b).* Other studies have found that Latinos with substance use disorders are about as likely to enter substance abuse treatment programs as other racial and ethnic groups (Hser et al.

1998; Perron et al. 2009; Schmidt et al. 2006). Latinos who receive substance abuse treatment also report less satisfaction with the services they receive than White or African Americans (Wells et al. 2001). Even when receiving a level of substance abuse treatment services comparable to those received by White and African Americans, Latinos are more likely to be dissatisfied with treatment (Tonigan 2003).

##### Treatment Issues and Considerations

Latino clients' responsiveness to therapy is influenced not only by counselor and program characteristics, but also by individual charac­ teristics, including worldview, degree of accul­ turation, gender orientation, religious beliefs, and personality traits. As with other cultural groups, efforts to establish clear communica­ tion and a strong therapeutic alliance are essential to positive treatment outcomes among Latino clients. Foremost, counselors should recognize the importance of-and integrate into their counseling style and ap­ proach-expressions of concern, interest in clients' families, and personal warmth *(person­ alismo;* Ishikawa et al. 2010).

Counselors and clinical supervisors need to be educated about culturally specific attributes that can influence participation and clinical interpretation of client behavior in treatment. For instance, some Latino cultural groups view time as more flexible and less structured· thus rather than negatively interpreting the client's behavior regarding the keeping of strict schedules or appointment times, counselors should adopt scheduling strategies that pro­ vide more flexibility (Alvarez and Ruiz 2001; Sue 2001). However, counselors should also advise Latino clients of the need to take rele­ vant actions with the aim of arriving on time for each appointment or group session. Coun­ selors should try to avoid framing noncompli­ ance in Latino clients as resistance or anger. It

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133

Improving Cultural Competence

is often, instead, a *pelea nonga* (relaxed fight) showing both a sense of being misunderstood and *respeto* (respect that also encompasses a sense of duty) for the counselor's authority (Baron 2000; Medina 2001).

Unfortunately, many providers who work with Latino cultural groups continue to have mis­ perceptions and can even see culture as a hindrance to effective treatment rather than as a source of potential strength (Qyintero et al. 2007). For instance, in treating the alcohol problems of Latinas, many counselors believe that they should not incorporate endorsement of traditional and possibly harmful cultural patterns into the services they provide (Mora 2002). However, other counselors note that the transformative value of the most positive aspects of Latino cultural groups can be em­ phasized: strength, perseverance, flexibility, and an ability to survive (Gloria and Peregoy 1996). Respecting women's choices can mean supporting empowerment to pursue new roles and make new choices free of alcohol, guilt, and discrimination (Mora 2002). For others, it can mean reinvigorating the positivity of Latina culture to promote abstinence while respecting and maintaining traditional family roles for women (Gloria and Peregoy 1996).

Because some research has found that Latinos have higher rates of treatment dropout than other populations (Amaro et al. 2006), pro­ grams working with this population should consider ways to improve retention and out­ comes. Treatment retention issues for Latinos can be similar to those found for other popu­ lations (Amodeo et al. 2008), but culturally specific treatment has been associated with better retention for Latinos (Hohman and Galt 2001). Research evaluating ethnic match­ ing with brief motivational interventions also found more favorable substance abuse treat­ ment outcomes at 12-month follow-up when clients and providers were ethnically matched

(Field and Caetano 2010). Available literature and research highlight four main themes sur­ rounding general counseling issues and pro­ grammatic strategies for Latinos, as follows.

**Socializing the client to treatment:** Latino clients are likely to benefit from orientation sessions that review treatment and counseling processes, treatment goals and expectations, and other components of services (Organista 2006).

**Reassurance of confidentiality:** Regardless of the particular mode of therapy, counselors should explain confidentiality. Many Latinos, especially undocumented workers or recent immigrants, are fearful of being discovered by authorities like the United States Citizenship and Immigration Services and subsequently deported back to their countries of origin (Ramos-Sanchez 2009).

**Client-counselor matching based on gen­ der:** To date, research does not provide con­ sistent findings on client-counselor matching based on similarity of Latino ethnicity. How­ ever, client-counselor matching based on gender alone appears to have a greater effect on improving engagement and abstinence among Latinos than it does for clients of other ethnicities (Fiorentine and Hillhouse 1999).

**Client-program matching:** Matching clients to ethnicity-specific programs appears to improve outcomes for Latinos. Takeuchi et al. (1995) found that only 68 percent of Mexican American clients in programs that had a majority of White American clients returned after the first session compared with 97 per­ cent in those programs where the majority of clients were Mexican American.

##### Theoretical Approaches and Treatment Interventions

Overall, research evaluating cultural adoption of promising or evidence-based practices in

134

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

treatment specifically for Latinos is scarce (Carvajal and Young 2009). For instance, empirical literature evaluating CBT specifical­ ly for substance abuse and substance use dis­ orders in Latinos is quite limited. Still, a number of authors recommend CBT for Latinos in mental health and substance abuse treatment settings because it is action oriented, problem focused, and didactic (Alvarez and Ruiz 2001; Organista 2006; Organista and Munoz 1998). CBT's didactic component can educate Latinos about disorders and frame therapy as an educational (and hence less shameful) experience. However, Organista's (2006) review of available research on CBT

for mental disorders among Latinos suggests that this approach is not always as effective with Latinos as it is with other populations.

Other effective interventions include contin­ gency management and motivational inter­ viewing; see the review by Amaro et al. (2006) for more on these interventions. Methadone maintenance, too, has been associated with long-term reductions in the use of alcohol as well as heroin and other illicit drugs among Mexican Americans with opioid use disorders, although 33 percent of the original cohort died before the 22-year longitudinal study concluded (Goldstein and Herrera 1995).

Another therapeutic intervention that can improve outcomes for Latino clients is node­ link mapping (visual representation using information diagrams, fill-in-the blank graph­ ic tools, and client-generated diagrams or visual maps), which has been associated with lower levels of opioid and cocaine use, better treatment attendance, and higher counselor ratings of motivation and confidence for Latinos in methadone maintenance treatment (Dansereau et al. 1996; Dansereau and Simp­ son 2009). For a review of Latino outcome studies in health, substance abuse, and mental health in social work, refer to Jani and col­ leagues (2009).

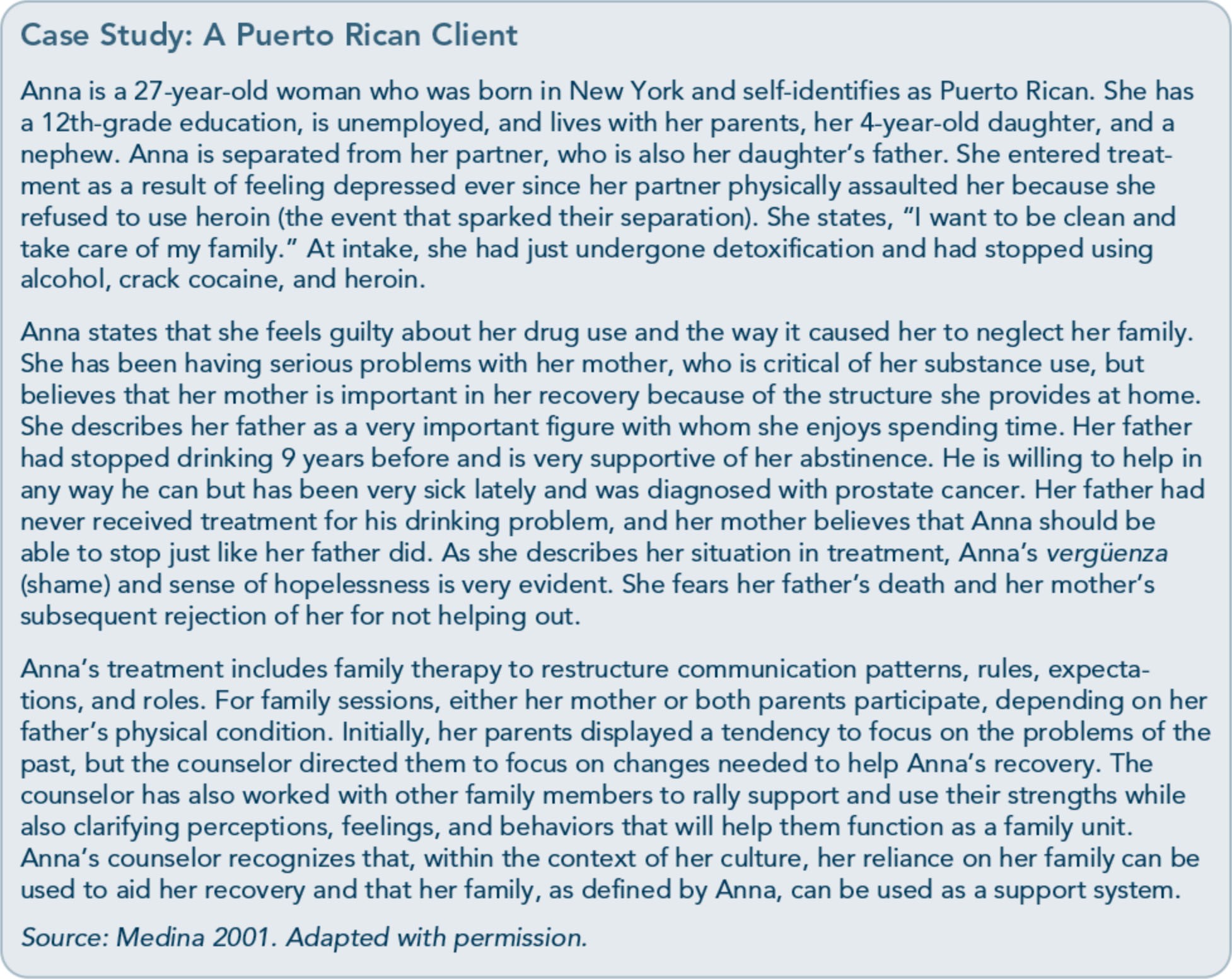
#### *Family therapy*

Family therapy is often recommended for treating Latinos with substance use disorders (Amaro et al. 2006; Baron 2000; Hernandez 2000). Although there is little research evalu­ ating the effectiveness of family therapy for adults, both multidimensional family therapy (Liddle 2010) and brief strategic family thera­ py (Santisteban et al. 1997; Santisteban et al. 2003; Szapocznik and Williams 2000) have been found to reduce substance use and im­ prove psychological functioning among Latino youth. The term *familismo* refers to the cen­ trality of the family in Latino culture and can include valuing and protecting children, re­ specting the elderly, preserving the family name, and consulting with one another before making important decisions. As highlighted in the case study of a Puerto Rican client on the next page, counselors must consider the poten­ tially pivotal roles families can play in support­ ing treatment and recovery. Latino families are likely to have a strong sense of obligation and commitment to helping their members, in­ cluding those who have substance use disor­ ders. Even so, the level of family support for people who have substance use or mental disorders varies among Latinos depending on country of origin, level of acculturation, degree of family cohesion, socioeconomic status, and factors related to substance use (Alegria et al. 2012). For example, Reynoso-Vallejo et al. (2008) concluded that significantly higher rates of homelessness found among people from Central American countries who inject­ ed heroin compared with other Latinos could stem from lower levels of tolerance for injec­ tion drug use among their families.

For counselors who lack cultural understand­ ing, it can be easy to simply label and judge families' behavior as enabling or codependent. Instead, counselors should move away from labeling the behavior and focus more on help­ ing families recognize how their behavior can

135

Improving Cultural Competence



affect one member's substance abuse and how best to handle it. The advice box on the next page provides general therapeutic guidelines for working with Latino families.

#### *Group therapy*

Little information is available concerning Latinos' preferences in behavioral health services, but a study evaluating mental health treatment preferences for women in the Unit­ ed States found that Latinas were significantly more likely to prefer group treatment (Nadeem et al. 2008). According to Paniagua (1998), the use of group therapy with Latino clients should emphasize a problem-focused approach. Group leaders should allow mem­ bers to learn from each other and resist func­ tioning as a content expert or a representative

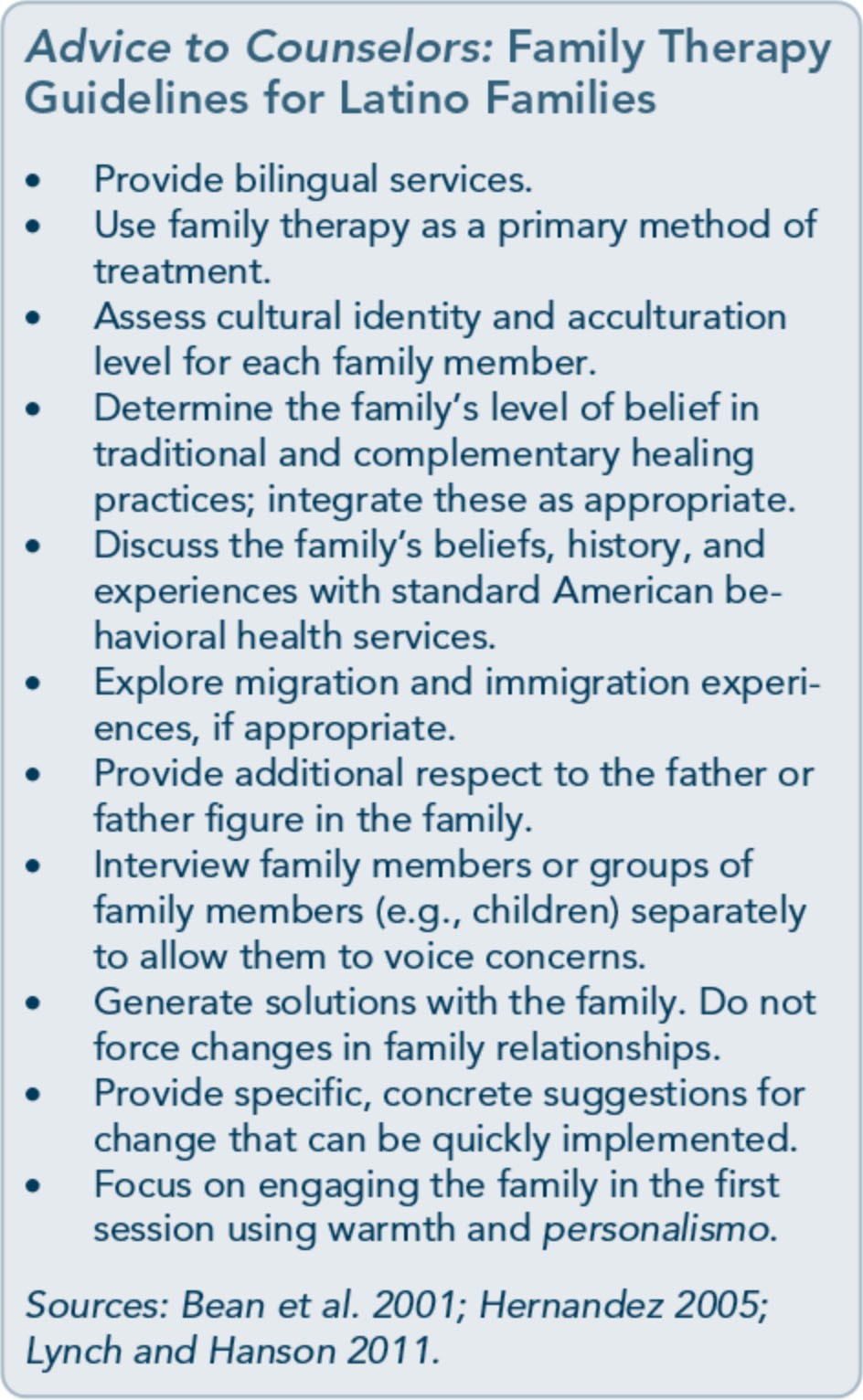
of the rules of the system. Otherwise, mem­ bers could see group therapy as oppressive. Facilitators in groups consisting mostly of Latino clients must establish trust, responsibil­ ity, and loyalty among members. In addition, acculturation levels and language preferences should be assessed when forming groups so that culturally specific or Spanish-speaking groups can be made available if needed.

#### *Mutual-help groups*

Findings on the usefulness of 12-Step groups for Latino clients are inconsistent. Member­ ship surveys of AA indicate that Latinos comprise about 5 percent of AA membership (AAWS 2012). Latinos who received inpatient treatment were less likely to attend AA than White Americans (Arroyo et al. 1998). Rates

136

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups



of mutual-help participation among people with drug use disorders are also lower for Latinos (Perron et al. 2009). Language can present a barrier to mutual-help group partici­ pation for Spanish-speaking Latinos; however, Spanish-language meetings are held in some locations. Counselors should consider the appropriateness of 12-Step participation on a case-by-case basis (Alvarez and Ruiz 2001).

For example, Mexican American men who identify with attitudes of *machismo* can feel uncomfortable with the 12-Step approach. Concern about divulging family issues in public can cause hesitation to address substance­ related problems in public meetings.

For Latinos who do participate in 12-Step programs, findings suggest higher rates of abstinence, degree of commitment, and level

of engagement than for White American participants (Hoffman 1994; Tonigan et al. 1998). For some Latinos, 12-Step groups can appeal to religious and spiritual beliefs. Her­ nandez (2000) suggests that mutual-help groups composed solely of Latinos make it easier for participants to address the cultural context of substance abuse. Some Latino 12- Step groups do not hold that substance abuse is a biopsychosocial problem, instead concep­ tualizing the disorder as a weakness of charac­ ter that must be corrected. Hoffman (1994) studied Latino 12-Step groups in Los Angeles and observed that, in addition to a more traditional form of AA, there were groups that practiced *terapia dura* (i.e., rough therapy), which often uses a confrontational approach and endorses family values related to *machismo* (e.g., by reinforcing that overcoming substance abuse rather than drinking is manly). Howev­ er, these groups were not overly welcoming of female members and gay men. In such cases, gay Latino men and Latinas can benefit from attending 12-Step groups that are not cultur­ ally specific or that do not use *terapia dura.*

***Traditional healing and complementary methods***

In a study of the use of alternative and com­ plementary medical therapies, Latinos were less likely to use medical alternatives than were White Americans (Graham et al. 2005). However, those who did use such approaches were more likely to do so because they could not afford standard medical care (Alegria et al. 2012). As in other areas, the use of comple­ mentary and traditional medicine likely varies according to acculturation level and country of origin. For instance, the use of faith and reli­ gious practices to cope with mental and emo­ tional problems is significantly more common among foreign-born Latinos than among

those born in the United States (Nadeem et al. 2008; Vega et al. 2001).

137

Improving Cultural Competence

Many Latinos place great importance on the practice of Roman Catholicism. Yamamoto and Acosta (1982) describe the central tenets of Latino Catholicism as sacrifice, charity, and forgiveness. These beliefs can hinder assertive­ ness in some Latinos, but they can also be a source of strength and recovery. Traditionally, Latinos have been Catholic, although several Protestant and evangelical groups have con­ verted millions of Latinos to their religions since the 1970s. Some Latinos also believe in syncretistic religions (e.g., Santeria or Curanderismo) or practices derived from them and make use of a variety of traditional heal­ ing practices and rituals to heal mental and spiritual ailments (Lefley et al. 1998; Sandoval 1979). Among Puerto Ricans, *espiritismo* (spiritualism) is a popular traditional healing system successfully used to address mental health issues (Lynch and Hanson 2011; Moli­ na 2001). Some Mexican Americans rely on *curanderos,* folk healers who address problems that might be framed as psychological (Falicov 2005, 2012). For a review of culturally respon­ sive interventions with Latinos, refer to Gallardo and Curry (2009).

***Relapse prevention and recovery*** There are no substantial studies evaluating the use of relapse prevention and recovery promo­ tion with Latinos, yet literature suggests that they would be appropriate and effective for this population (Blume et al. 2005; Castro et al. 2007). Overall, Latinos can face somewhat different triggers for relapse relating to accul­ turative stress or the need to uphold particular cultural values *(e.g.,personalismo, machismo;* Castro et al. 2007), which can lead to higher rates of relapse among some Latino clients.

For example, in a study of relapse patterns among White American and Latino individu­ als who used methamphetamine, Brecht et al. (2000) found that Latino participants relapsed more quickly than White American participants.

Data are lacking on long-term recovery for Latinos. Given the many obstacles that block accessibility to treatment for Latinos, continu­ ing care planning can benefit from greater use of informal or peer supports. For example, White and Sanders (2004) recommend the use of a recovery management approach with Latinos. They point to an early example of the East Harlem Protestant Parish's work, which helped Puerto Rican individuals recovering from heroin dependence connect to social clubs and religious communities that sup­ ported recovery. Latinos use community and family support in addition to spirituality to address mental disorders (Lynch and Hanson 2011; Molina 2001). Castro et al. (2007) also note that family support systems can be espe­ cially important for Latinos in recovery.

### Counseling for Native Americans

There are 566 federally recognized American Indian Tribes, and their members speak more than 150 languages (U.S. Department of the Interior, Indian Affairs *2013a);* there are numerous other Tribes recognized only by states and others that still go unrecognized by government agencies of any sort. According to the 2010 U.S. Census (Norris et al. 2012), the majority (78 percent) of people who identified as American Indian or Alaska Native, either alone or in combination with one or more other races, lived outside of American Indian and Alaska Native areas. Approximately 60 percent of the 5.2 million people who identi­ fied as American Indian or Alaska Native, alone or in combination with one or more other races, reside in urban areas (Norris et al. 2012). The category of Alaska Natives in­ cludes four recognized Tribal groups­ Alaskan Athabascan, Aleut, Eskimo, and Tingit-Haida-along with many other inde­ pendent communities (Ogunwole 2006).

138

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

Native Americans who belong to federally recognized Tribes and communities are mem­ bers of sovereign Indian nations that exist within the United States. On lands belonging to these Tribes and communities, Native Americans are able to govern themselves to a large extent and are not subject to most state laws-only to federal legislation that is specif­ ically designated as applying to them (Henson 2008). Although health care (including sub­ stance abuse treatment) is provided to many Native Americans by Indian Health Services **(IHS),** Tribal governments do have the option of taking over those services. Counselors working with these populations should re­ member that Native Americans, by virtue of their membership in sovereign Tribal entities, have rights that are different from those of other Americans; this distinguishes them from members of other ethnic/racial groups.

American Indians live in all *50* states; the states with the largest populations of Ameri­ can Indians are Oklahoma, California, and Arizona. The 2000 Census allowed people to identify, for the first time, as a member of more than one race. Of persons who checked two or more races, nearly one in five indicated that they were part American Indian or Alaska Native (U.S. Census Bureau *200la,b).*

Behavioral health service providers should recognize that Native American Tribes repre­ sent a wide variety of cultural groups that differ from one another in many ways (Duran et al. 2007). Alaska Natives who live in coastal areas have very different customs from those inhabiting interior areas (Attneave 1982). The diversity of Native American Tribes notwith­ standing, they also share a common bond of respect for their cultural heritages, histories, and spiritual beliefs, which are different from those of mainstream American culture. For more information on the treatment and pre­ vention of substance abuse and mental illness

among Native Americans, see the planned TIP, *Behavioral Health Services far American Indians and Alaska Natives* (SAMHSA planned *a).*

##### Beliefs About and Traditions Involving Substance Use

Few American Indian Tribes and no Alaska Natives consumed alcoholic beverages prior to contact with non-Native people, and those who did used alcohol primarily for special occasions and ceremonies. Most Tribes first encountered the use of alcohol when they encountered European settlers and traders.

Because of this lack of experience with alco­ hol, few Native Americans had a context for drinking besides what they learned from these non-Natives, who at the time drank in large quantities and often engaged in binge drink­ ing. Although patterns of alcohol consump­ tion in the mainstream population of the United States changed over time, they re­ mained relatively the same in the more isolat­ ed Native American communities. According to an NSDUH report on American Indian and Alaska Native adults, binge drinking continues to be a significant problem for these populations. Both binge drinking and illicit drug use is higher among Native Americans than the national average (30.2 percent versus

23 percent and 12.7 percent versus 9.2 percent, respectively; SAMHSA 2013d).

American Indian drinking patterns vary a great deal by Tribe. Tribal attitudes toward alcohol influence consumption in complicated ways. For example, in Navajo communities, excessive drinking was acceptable if done in a group or during a social activity. However, solitary drinking (even in lesser amounts) was considered to be deviant (Kunitz et al. 1994). Kunitz et al. (1994) observed that during the 1960s, binge drinking was acceptable among the Navajo during public celebrations, whereas any drinking was considered unacceptable among the neighboring Hopi population,

139

Improving Cultural Competence

wherein regular drinkers were shunned or, in some cases, expelled from the community.

Hopi individuals who did drink tended to do so alone or moved off the reservation to bor­ der towns where heavy alcohol use was com­ mon. The ostracism of Hopi drinkers seemed to lead to even greater levels of abuse, given that there were much higher death rates from alcoholic cirrhosis among the Hopi than among the Navajo.

Native American recovery movements have often viewed substance abuse as a result of cultural conflict between Native and Western cultures, seeing substances of abuse as weapons that have caused further loss of traditions (Coyhis and White 2006). To best treat this population, substance abuse treatment provid­ ers need to expand their perspectives regarding substance abuse and dependence and must embrace a broader view that explores the spiritual, cultural, and social ramifications of substance abuse (Brady 1995; Duran 2006;

Jilek 1994).

##### Substance Use and Substance Use Disorders

According to 2012 NSDUH data, American Indian and Alaska Native peoples have the highest rates of substance use disorders and binge drinking (SAMHSA *2013d).* Although rates of substance abuse are high among Native Americans, so too are rates of absti­ nence. American Indians and Alaska Natives are more likely to report no alcohol use in the past year than are members of all other major racial and ethnic groups **(OAS** 2007). The American Indian Services Utilization and Psychiatric Epidemiology Risk and Protective Factors Project (AI-SUPER PFP) also found that rates oflifetime abstinence from alcohol for American Indians in the study were signif­

icantly higher than lifetime abstinence rates among the general population (Beals et al. 2003). Data on alcohol consumption also

show that Alaska Natives are significantly more likely to abstain than are other Alaskans (Wells 2004).

The most common pattern of abusive drink­ ing among American Indians appears to be binge drinking followed by long periods of abstinence (French 2000; May and Gossage 2001). A similar pattern is seen among Alaska Natives (Seale et al. 2006; Wells 2004). As an example, the Urban Indian Health Institute (2008) found that binge drinking was signifi­ cantly more common among the Native American population (with 21.3 percent engaging in binge drinking in the prior 30 days compared with 15.8 percent of non­ Native Americans) and that, among those who drank, 40.7 percent of Native American par­ ticipants engaged in binge drinking compared with 26.9 percent of non-Natives.

There are a number of historical reasons for the development of binge drinking among Native Americans. The existence of dry reser­ vations (which can limit the times when indi­ viduals are able to get alcohol), high levels of poverty, lack of availability (e.g., in remote Alaska Native villages), a history of trauma, and the loss of cultural traditions can all con­ tribute to the development and continuation of this pattern of drinking. Native Americans are also more likely than members of other major racial/ethnic groups to have had their first drink before the age of 21 or before the age of 16, which also may shape drinking patterns (SAMHSA 2011c).

However, data on heavy and binge drinking do not reflect the same pattern of alcohol con­ sumption for all Native American Tribes. One analysis of alcohol dependence among mem­ bers of seven different Tribes found rates of dependence varying from *56* percent of men and 30 percent of women in one Tribe to 1 percent of men and 2 percent of women in another (Koss et al. 2003). Other research

140

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

confirms significant differences in alcohol use among diverse Native American communities (O'Connell et al. 2005; Whitesell et al. 2006).

In addition to alcohol, methamphetamine and inhalant abuse are major concerns for a num­ ber of Native American communities. None­ theless, there are considerable regional differences in patterns and prevalence of drug use (Miller et al. 2012). According to the National Congress of American Indians (2006), 74 percent ofTribal police forces ranked methamphetamine as the drug causing the most problems in their communities.

Methamphetamine abuse can be even more serious for Native Americans living in rural areas than for those in urban areas, but it is also a serious problem for growing numbers of American Indians, especially women, entering treatment in urban areas (Spear et al. 2007).

American Indians and Alaska Natives are more likely to report having used inhalants at some time during their lives, but use tends to peak in 8th grade and then decrease (Miller et al. 2012). In some Native American communi­ ties (e.g., on the Kickapoo reservation in Tex­ as), inhalants have been a major drug of abuse for adults as well as youth. During the early 1990s, about 46 percent of the adult popula­ tion on that reservation were thought to abuse inhalants (Fredlund 1994). Although more recent data are not available, reports from the area suggest that inhalant abuse remains a significant problem (Morning Star 2005).

Rates of substance use disorders appear to be higher in individuals who consider themselves exclusively Native American than for those who identify as more than one race/ethnicity, but even when surveys ask whether people are of mixed race, those who report themselves to be partially Native American still have high rates of substance use disorders (OAS 2007).

Native Americans are about 1.4 times more likely than White Americans to have a lifetime

diagnosis of an alcohol use disorder (Gilman et al. 2008). Illicit drug use is also more com­ mon for Native Americans than for members of other major racial/ethnic groups.

Among Native Americans entering treatment in 2010, alcohol use disorders alone or in conjunction with drug use disorders were the most pressing substance-related problem, with cannabis and opioids other than heroin being the next most common primary substances of abuse. One of the largest studies on American Indian substance use and abuse to date, the AI-SUPER PFP, found that 31.2 percent of American Indians met criteria for a lifetime

diagnosis of a substance use disorder, and 13.4 percent met criteria for a past-year diagnosis (Beals et al. 2003). The study found that rates of alcohol use disorders were high among men from the three Tribes represented but varied to a greater degree among women across Tribes (Mitchell et al. 2003).

American Indians have high rates of certain diseases and conditions. In particular, the incidence of diabetes is increasing among Native Americans, and approximately 38 percent of elder Native Americans have diabe­ tes (Moulton et al 2005). Diabetes is also associated with both substance use disorders and depression in this population (Tann et al. 2007). Other health problems associated with alcohol use include fetal alcohol syndrome, cirrhosis, and depression.

##### Mental and Co-Occurring Disorders

According to the 2012 NSDUH, 28.3 percent of American Indians and Alaska Natives report having a mental illness, with approxi­ mately 8.5 percent indicating serious mental illness in the past year (SAMHSA *2013c).*

Native Americans were nearly twice as likely to have serious thoughts of suicide as members of other racial/ethnic populations, and more

141

Improving Cultural Competence

than 10 percent reported a major depressive episode in the past year. Common disorders include depression, anxiety, and substance use.

As with other groups, substance use disorders among Native Americans have been associated with increased rates of a variety of different mental disorders (Beals et al. 2002; Tann et al. 2007; Westermeyer 2001). The 2012 **NSDUH** revealed that 14 percent of Native Americans reported both past-year substance use disor­ ders and mental illness. Among those who

reported mental illness, nearly *5* percent re­

ported several mental illnesses co-occurring with substance use disorders (SAMHSA 2013c).

Native American communities have experi­ enced severe historical trauma and discrimina­ tion (Brave Heart and DeBruyn 1998; Burgess et al. 2008). Studies suggest that many Native Americans suffer from elevated exposure to specific traumas (Beals et al. *2005;* Ehlers et al. 2006; Manson 1996; Manson et al. 2005), and they may be more likely to develop PTSD as a result of this exposure than members of other ethnic/racial groups. PTSD comparison rates taken from the AI-SUPER PFP study and

the National Comorbidity Study show that

12.8 percent of the Southwest Tribe sample and 11.5 percent of the Northern Plains Tribe sample met criteria for a lifetime diagnosis of PTSD compared with 4.3 percent of the general population (Beals et al. 2005). Trauma histories and PTSD are so prevalent among Native Americans in substance abuse treat­ ment that Edwards (2003) recommends that assessment and treatment of trauma should be a standard procedure for behavioral health programs serving this population. For exam­ ple, Native American veterans with substance use disorders are significantly more likely to have co-occurring PTSD than the general population of veterans with substance use disorders (Friedman et al. 1997).

##### Treatment Patterns

Despite a number of potential barriers to treatment (Venner et al. 2012), Native Ameri­ cans are about as likely as members of other racial/ethnic groups to enter behavioral health programs. According to data from the 2003 and 2011 NSDUH (SAMHSA, CBHSQ

2012), Native Americans were more likely to have received substance use treatment in the past year than persons from other racial/ethnic groups (15.0 percent versus 10.2 percent).

Other studies indicate that about one-third of Native Americans with a current substance use disorder had received treatment in the prior year (Beals et al. 2006; Herman-Stahl and Chong 2002). The 2012 NSDUH reported that approximately 15 percent of Native Americans received mental health treatment (SAMHSA 2013c).

Native Americans were least likely of all major ethnic/racial groups to state that they could not find the type of program they needed and were the next least likely after Native Hawaiians and other Pacific Islanders to state that they did not know where to go or that their insurance did not cover needed treatment. Among Native Americans who identified a need for treat­ ment in the prior year but did not enter treat­ ment, the most commonly cited reasons for not attending were lack of transportation, lack of time, and concerns about what one's neigh­ bors might think (SAMHSA 2011c).

Many Native Americans, especially those residing on reservations or other Tribal lands, seek mental health and substance abuse treat­ ment through Tribal service providers or **IHS** Gones-Saumty 2002; McFarland et al. 2006). However, an analysis using multiple sources found that 67 percent of Native Americans entering substance abuse treatment over the course of a year did so in urban areas, and the majority of those urban-based programs were not operated by IHS (McFarland et al. 2006).

142

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

The same research also found that Native Americans were somewhat more likely than the general treatment-seeking population to enter residential programs.

Native Americans were more likely to enter treatment as a result of criminal justice refer­ rals than were White Americans or African Americans: 47.9 percent of American Indians and Alaska Natives entering public treatment programs in 2010 were court-ordered to treatment compared with 36.6 percent of White Americans and 36.4 percent of African Americans (SAMHSA, CBHSQ2012). The lack of recognition of special needs and knowledge of Native American cultures within behavioral health programs may be the main reasons for low treatment retention and un­ deruse of help-seeking behaviors among Native Americans (LaFromboise 1993; Sue and Sue *2013e).*

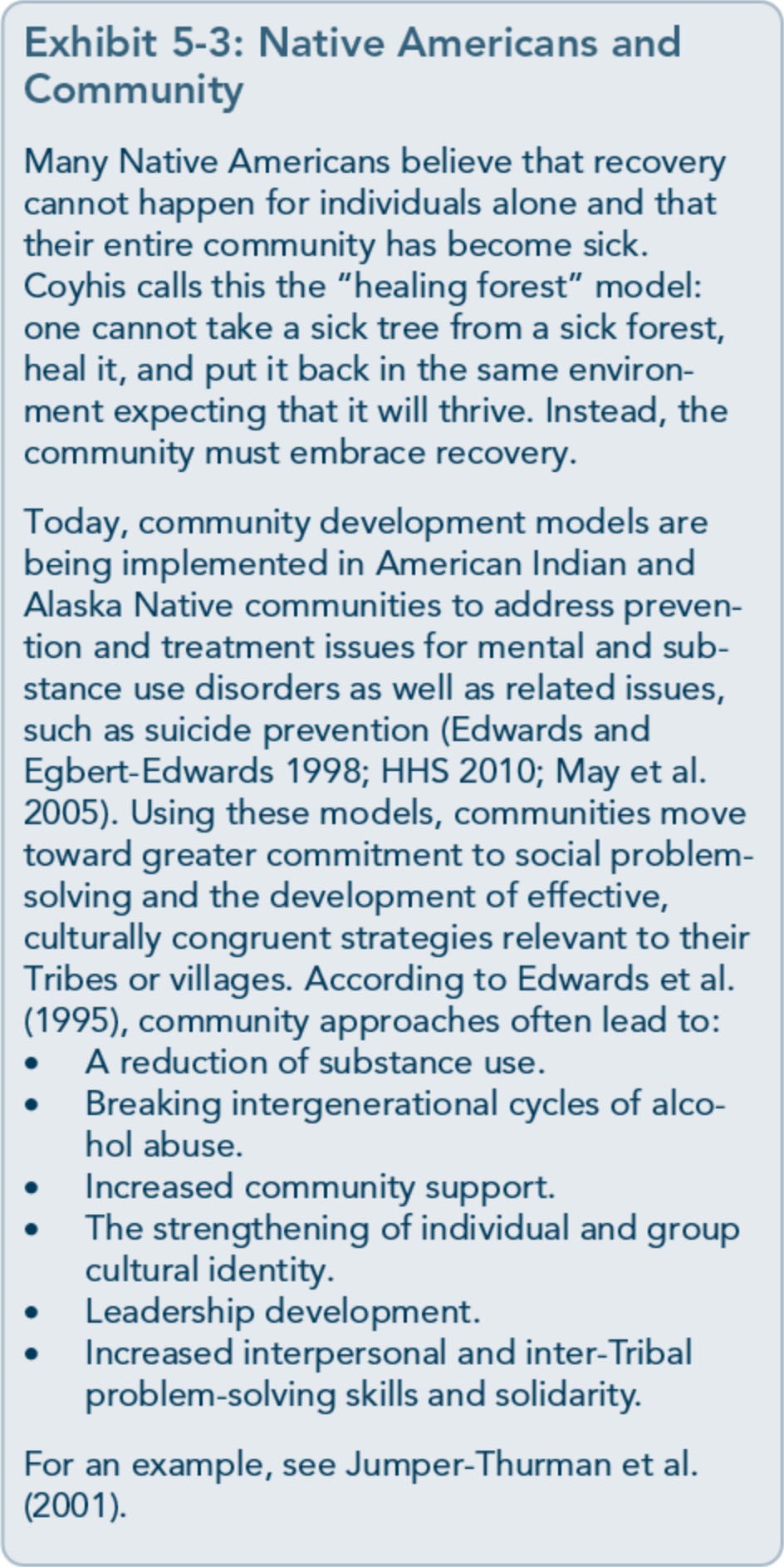
##### Beliefs and Attitudes About Treatment

Duran et al. (2005) evaluated obstacles to treatment entry among American Indians on three different reservations; most frequently mentioned were the perception that good­ quality or suitable services were unavailable and the perceived need for individuals to be self-reliant. They also found social relation­ ships to be extremely important in overcoming these barriers.Jumper-Thurman and Plested (1998) reported that focus groups of American Indian women listed mistrust as one of the primary barriers for seeking treatment. This is due, in part, to the women's belief that they would encounter people they knew among treatment agency staff; they also doubted the confidentiality of the treatment program.

##### Treatment Issues and Considerations

Each Tribe and community will likely have different customs, healing traditions, and

beliefs about treatment providers that can influence not only willingness to participate in treatment services, but also the level of trust clients have for providers. Counselors and other behavioral health workers must develop ongoing relationships within local Native American communities to gain knowledge of the unique attributes of each community, to show investment in the community, and to learn about community resources (Exhibit 5- 3). Identifying and developing resources with­ in Native communities can help promote culturally congruent relationships.



**143**

Improving Cultural Competence

To provide culturally responsive treatment, providers need to understand the Native American client's Tribe; its history, traditions, worldview, and beliefs; the dimensions of its substance abuse problem and other communi­ ty problems; the incidence of trauma and abuse among its members; its traditional healing practices; and its intrinsic strengths.

Providers who work with Native Americans but do not have an understanding of their cultural identity and acculturation patterns are at a distinct disadvantage (Ponterotto et al.

2000). Before beginning any treatment, pro­ viders should routinely seek consultation with knowledgeable professionals who are experi­ enced in working with the specific Tribal group in question (Duran 2006; Edwards and Egbert-Edwards 1998; Straits et al. 2012) and should conduct thorough client assessments that evaluate cultural identity (see Appendix F and Chapter 2 for resources). Some Native American persons have a strong connection to their cultures and others do not; some identify with a blend of American Indian cultural groups called pan-lndianism or inter-Tribal identity. Still others are comfortable with a dual identity that embraces both Native and non-Native cultural groups.

Native Americans often approach the begin­ ning of a relationship in a calm, unhurried manner, and they may need more time to develop trust with providers. Concerns about confidentiality can be an important issue to address with Native American clients, espe­ cially for those in small, tightly-knit commu­ nities. For providers, it is very important to make clear to clients that what they say to the counselor will be held in confidence, except when there is an ethical duty to report.

Native American cultural groups generally believe that health is nurtured through balance and living in harmony with nature and the community (Duran 2006; Garrett et al. 2012).

They also, for the most part, have a holistic view of health that incorporates physical, emotional, and spiritual elements (Calabrese 2008), individual and community healing (Duran 2006; McDonald and Gonzalez 2006), and prevention and treatment activities Q"ohnston 2002). For many, culture is the path to prevention and treatment.

However, not all Native Americans have a need to develop stronger connections to their communities and cultural groups. As Brady (1995) cautions, culture is complex and chang­ ing, and a return to the values of a traditional culture is not always desired. An initial inquiry into each client's connection with his or her culture, cultural identity, and desire to incor­ porate cultural beliefs and practices into treatment is an essential step in culturally competent practice. When appropriate, pro­ viders can help facilitate the client's reconnec­ tion with his or her community and cultural values as an integral part of the treatment plan. In addition, treatment providers need to adapt services to be culturally responsive. In doing so, outcomes are likely to improve not only for Native American clients, but for all clients within the program. Fisher et al. (1996) modified a therapeutic community in Alaska to incorporate Alaska Native spiritual and cultural practices and found that retention rates improved for White and African Ameri­ can clients as well as Alaska Native clients participating in the program.

In working with Native American clients, providers should be prepared to address spirit­ uality and to help clients access traditional healing practices. Culturally responsive treat­ ment should involve community events, group activities, and the ability to participate in ceremonies to help clients achieve balance and find new insight (Calabrese 2008). Stronger attachment to Native American cultural groups protects against substance use and

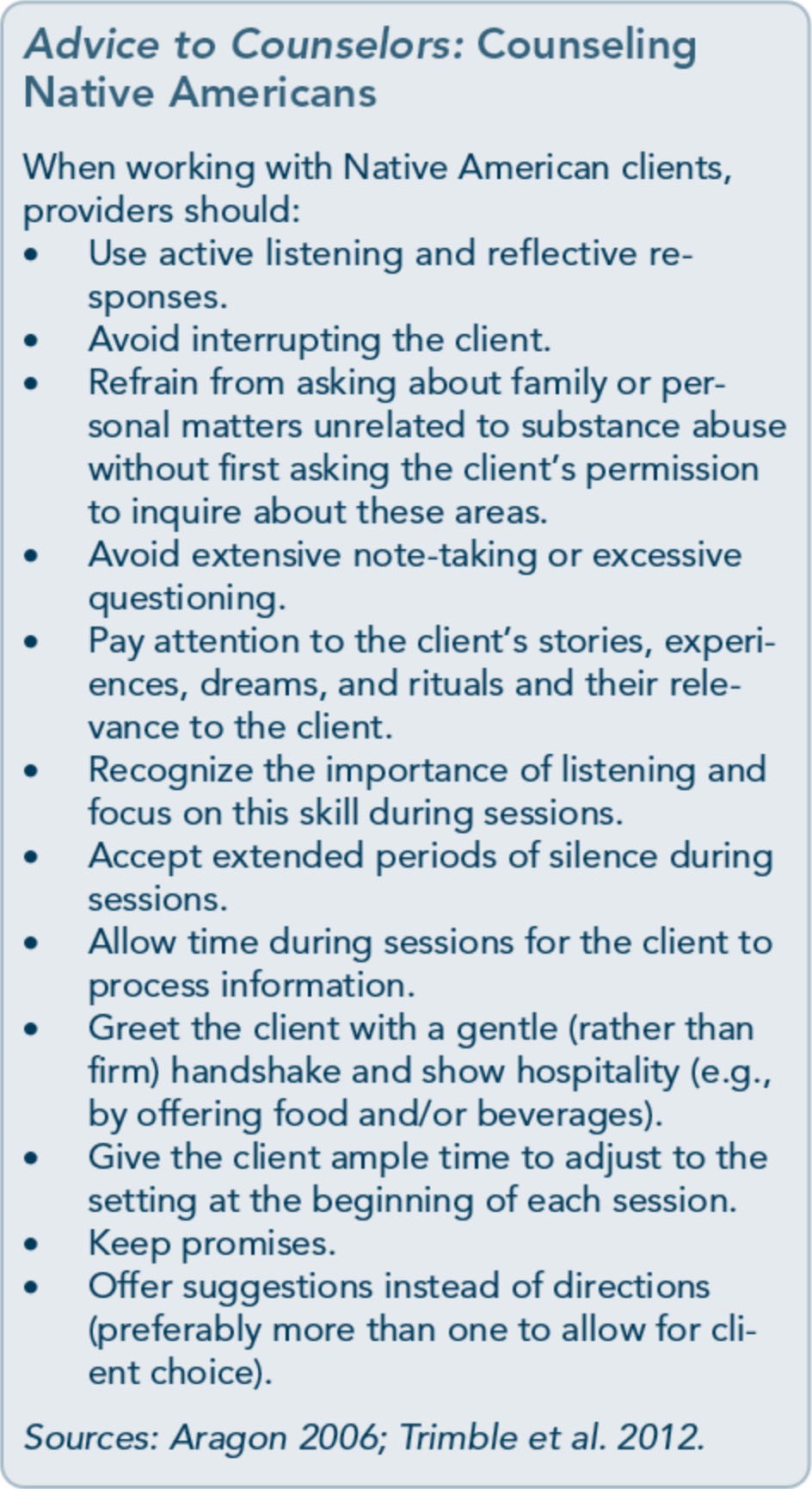
**144**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

abuse; therefore, strengthening this connection is important in substance abuse treatment (Duran 2006; Moss et al. 2003; Spicer 2001; Stone et al. 2006).

##### Theoretical Approaches and Treatment Interventions

Some clinicians caution that a model of coun­ seling that requires self-disclosure to relative strangers can be counterproductive with Native American clients. Other authors recommend CBT and social learning approaches for Native American clients, as such approaches typically have less cultural bias, focus on prob­ lem-solving and skill development, emphasize



client strengths and empowerment, recognize the need to accept personal responsibility for change, and make use oflearning styles that many Native Americans find culturally ap­ propriate (Heilbron and Guttman 2000; McDonald and Gonzalez 2006). Motivational interviewing is also recommended for Native American clients. In a small study, Villanueva et al. (2007) found that all treatment modali­ ties resulted in improvements at 15-month follow-up, but clients who received motiva­ tional enhancement therapy reported signifi­ cantly fewer drinks per drinking day during the 10- to 15-month posttreatment follow-up period. Venner et al. (2006) wrote a manual for motivational interviewing with Native American clients.

#### *Family therapy*

Family involvement in treatment leads to better outcomes for Native Americans at the time of discharge from treatment (Chong and Lopez 2005). Research also suggests that family and community support can have a significant effect on recovery from substance use disorders for this population (Jones­ Saumty 2002; Paniagua 1998). Family therapy can be quite helpful and perhaps even essential for American Indian clients (Coyhis 2000), especially when other social supports are lacking (Jones-Saumty 2002).

American Indians place high value on family and extended family networks; restoring or healing family bonds can be therapeutic for clients with substance use disorders. Moreo­ ver, Native American clients are sometimes less motivated to engage in "talk therapy" and more willing to participate in therapeutic activities that involve social and family rela­ tionships (Joe and Malach 2011). Treatment approaches should remain flexible and in­ clude clients' families when appropriate.

Counselors should be able to recognize what constitutes family, family constellations, and

**145**

Improving Cultural Competence

family characteristics.The Native American concept of family can include elders, others from the same clan, or individuals who are not biologically related. In many Tribes, all mem­ bers are considered relatives. Families can be matrilineal (i.e., kinship is traced through the female line) and/or matrilocal (i.e., married couples live with wife's parents).

When families do enter treatment, they may initially prefer to focus on a concrete problem, but not necessarily on the most significant family issue. Discussion of a clearly defined presenting problem enables families to assess the therapeutic process and better understand what is expected of them in treatment. Provid­ ers should be aware that the entire clan and/or Tribe could know about a given client's treat­ ment and progress. Family therapy models such as network therapy, which makes use of support structures outside the immediate family and which were originally developed for Native American families living in urban communities, can be particularly effective with Native clients, especially when they have been cut off from their home communities because of substance abuse or other issues. For more information on network therapy and similar approaches, see TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT *2004b).*

#### *Group therapy*

Although researchers and providers once viewed group therapy as ineffective for Ameri­ can Indian clients (Paniagua 1998), opinion has shifted to recognize that, when appropri­ ately structured, group therapy can be a pow­ erful treatment component (Garrett 2004; Garrett et al. 2001; Trimble andJumper­ Thurman 2002). Garrett (2004) notes that many Native American Tribes have traditional healing practices that involve groups; for many of these cultural groups, healing needs to occur within the context of the group or community (e.g., in talking circles). Thus, if properly

adapted, group therapy can be very beneficial and culturally congruent. It is important, however, to determine Native American clients' level of acculturation before recommending Western models of group therapy, as less acculturated Native clients are likely to be less comfortable with group talk therapy (Mail and

Shelton 2002). Group therapy for Alaska Natives should also be nonconfrontational and focus on clients' strengths.

Group therapy can incorporate Native American traditions and rituals to make it more culturally suitable. For example, the talking circle is a Native tradition easily adapted for behavioral health treatment. In this tradition, the members of the group sit in a circle. An eagle feather, stone, or other sym­ bolic item is passed around, and each person speaks when he or she is handed the item.

Based on a review of the literature, Paniagua (1998) recommends that providers using group therapy with Native American clients:

* Earn support or permission from Tribal authorities before organizing group therapy.
* Consult with Native professionals.
* If group members consent, invite respected Tribal members (e.g., traditional healers or elders) to participate in sessions.

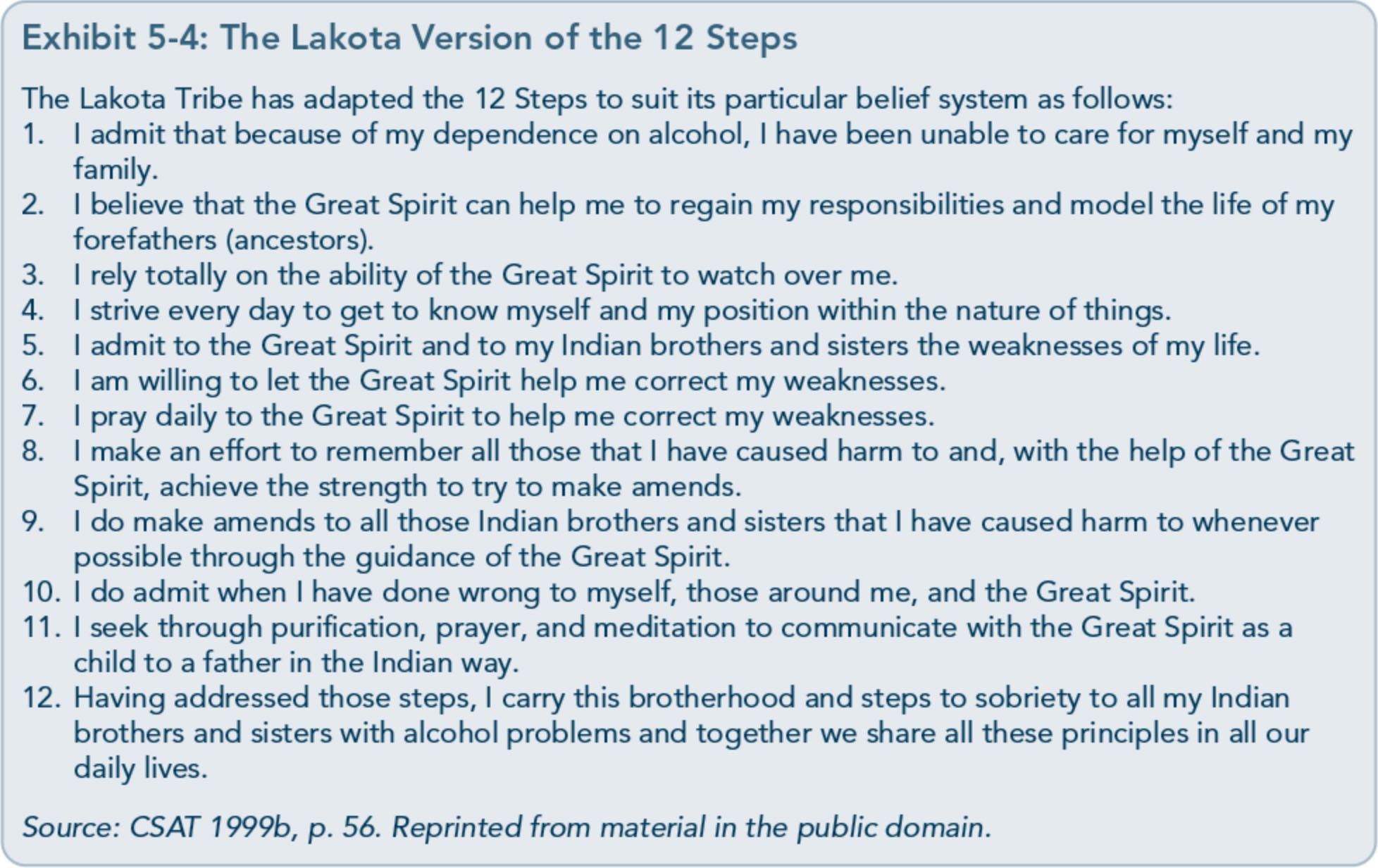
#### *Mutual-help groups*

Native American peoples have a long history ofinvolvement in mutual-help activities that predates the 12-Step movement (Coyhis and White 2006). Depending on acculturation, availability of a community support network, and the nature of their presenting problems, Native American clients may be more likely to solicit help from significant others, extended family members, and community members.

Contemporary manifestations of Native American mutual-help efforts include adapta­ tions of the 12 Steps (Exhibit 5-4) and of 12- Step meeting rituals and practices (Coyhis and White 2006). Another modified element of

146

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups



the 12 Steps is use of a circular, rather than a linear, path to healing. The circle is important to American Indian philosophy, which sees the great forces of life and nature as circular (Coyhis 2000). In addition, staff members of the White Bison program have also rewritten the AA "Big Book'' from a Native American perspective (Coyhis and Simonelli 2005). The principles of the 12 Steps, which involve using the group or community to provide support and motivation while emphasizing spiritual reconnection, appeal to many Native Ameri­ cans who see treatment as social in nature and who view addiction as a spiritual problem.

The Native American Wellbriety movement is a modern, indigenous mutual-help program that has its roots in 12-Step groups but incor­ porates Native American spiritual beliefs and cultural practices (Coyhis and Simonelli 2005; Coyhis and White 2006; White Bison, Inc.

2002; also see http://www.whitebison.org). Although the Wellbriety movement is popular with many Native Americans in recovery, a

considerable number also continue to partici­ pate in traditional 12-Step groups. In the AI­ SUPER-PFP, 47 percent of Northern Plains Tribe respondents and 28.8 percent of South­ west Tribe respondents with a past-year sub­ stance use disorder reported 12-Step group attendance in the prior year (Beals et al. 2006). Mohatt et al. (2008b) found that more Alaska Natives in recovery reported participation in 12-Step groups than in substance abuse treat­ ment. In Venner and Feldstein's (2006) re­ search with American Indians in recovery, 84 percent of respondents had attended some mutual-help meetings.

***Traditional healing and complementary methods***

Native American peoples have a range of be­ liefs about health care-from traditional beliefs to strong support for modern science-and may use a number of strategies when address­ ing health problems. Traditional healing prac­ tices are often used in conjunction with modern medicine. For example, American Indians

**147**

Improving Cultural Competence

148

traditionally view all things as deeply inter­ connected. Disruption of the physical, mental, spiritual, or emotional sides of a person can result in illness. A Native American client may consult a medical doctor to address part of the problem and a traditional healer to help regain balance and harmony.

The use of traditional healing for substance abuse and mental health problems is fairly common among Native Americans (Herman­ Stahl and Chong 2002; Herman-Stahl et al. 2003). For example, among Native American individuals who reported a substance use disorder in the past year, *57.4* percent of those from a Southwest Tribe and 31.7 percent from a Northern Plains Tribe used traditional heal­ ers or healing practices (Beals et al. 2006). In a survey of American Indians from three differ­ ent Arizona Tribes, 27.4 percent stated that they had used traditional healers and/or heal­ ing practices to help with mental health prob­ lems (Herman-Stahl and Chong 2002).

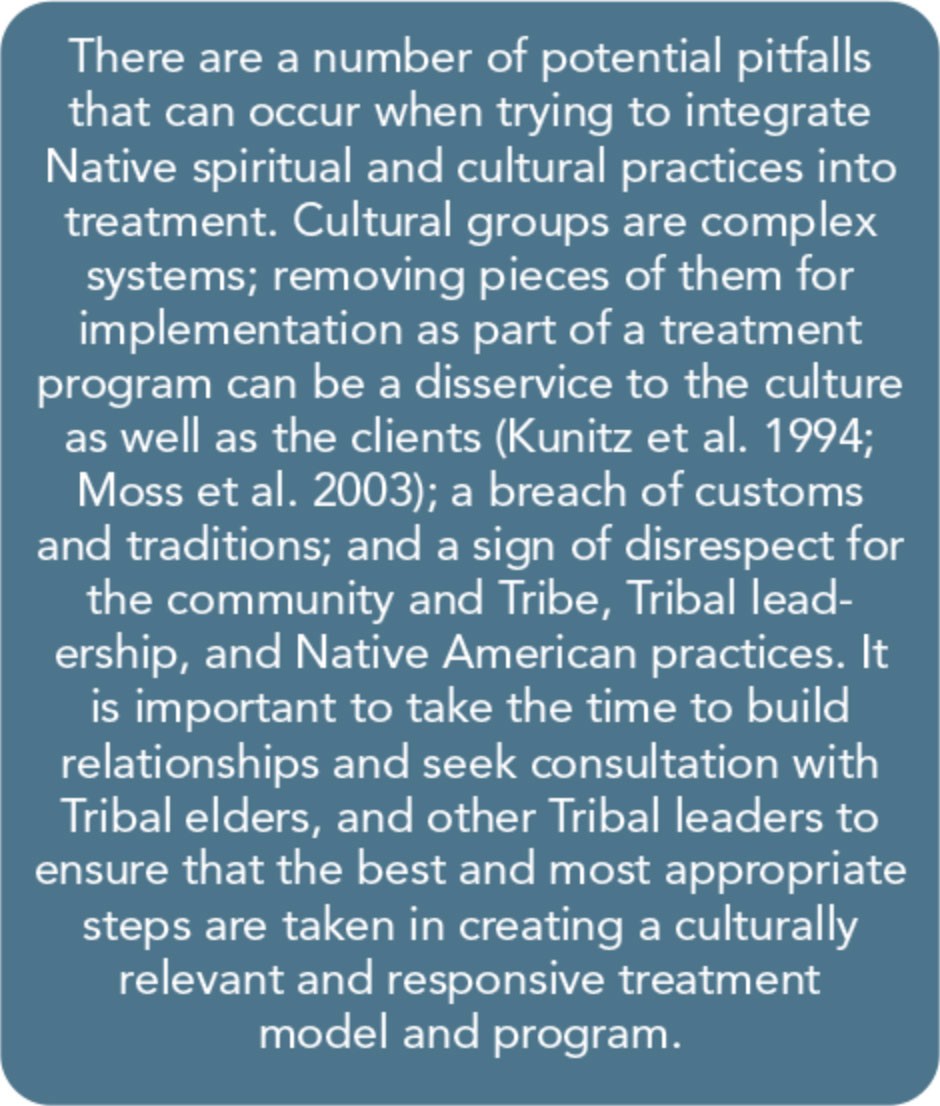
Overall, many Native Americans believe that culture is the primary avenue of healing and that connecting with one's culture is not only a means of prevention, but also a healing treat­ ment (Bassett et al. 2012)

Each Native American culture has its own specific healing practices, and not all of those practices are necessarily appropriate to adapt to behavioral health treatment settings. How­ ever, many traditional healing activities and ceremonies have been made accessible during treatment or effectively integrated into treat­ ment settings (Castro et al. *1999b;* Coyhis 2000; Coyhis and White 2006; Mail and Shelton 2002; Sue 2001; White 2000). These practices include sacred dances (such as the Plains Indians' sun dance and the Kiowa's gourd dance), the four circles (a model for conceptualizing a harmonious life), the talking circle, sweat lodges, and other purification practices (Cohen 2003; Mail and Shelton

2002; White 2000). The sweat lodge, in par­ ticular, is frequently used in substance abuse treatment settings (Bezdek and Spicer 2006; Schiff and Moore 2006).

Alaskan behavioral health programs have developed recovery camps to provide a treat­ ment setting that incorporates Native beliefs and seasonal practices (e.g., Old Minto Family Recovery Camp: <http://www.tananachiefs.org/>health- services/old-minto-family-recovery-camp­ new/). Recovery camps are based on the mod­ el of traditional Native Alaskan fishing camps and provide a context in which clients can learn about traditional practices, such as suste­ nance activities. Another program, the Village Sobriety Project, incorporates traditional Yup'ik and Cup'ik Eskimo traditions of hunt­ ing, chopping wood, berry picking, and taking tundra walks (Mills 2003). See Niven (2010) for a review of client-centered, culturally responsive behavioral health techniques for use with Alaska Natives.

It is difficult to measure the effectiveness of Native American healing practices using



Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

Western standards and practices. Limited or inconsistent funding, migration patterns, culturally incompetent or incongruent evalua­ tion practices, and abuses incurred during or after data collection are major confounding variables that have limited knowledge on the effectiveness of incorporating traditional practices into Western approaches to the treatment of substance abuse and mental illness. Nonetheless, Mail and Shelton (2002) reviewed earlier literature on the use of "indig­ enous therapeutic interventions" for alcohol abuse and dependence and suggest that a number of these interventions have been of value to Native Americans with substance use disorders. Other authors have concurred (Coyhis and White 2006; Sabin et al. 2004).

Regardless of whether a program adapts spe­ cific Native American healing practices, pro­ viders working with this population should recognize that spirituality is central to its values and is perceived as an integral part of life itself It is through spiritual experiences that Native Americans believe they will find meaning in life. Some Native languages have words that refer to spirituality as "walking around" or "living the path." In many cases, the spiritual traditions of Native Americans are not (and have never been) conceived of as a religion, but rather as a set of beliefs and practices that pervades every aspect of daily life (Deloria 1973).

Despite religion and spirituality often playing important roles in recovery from mental and substance use disorders for Native Americans, providers should not assume that only indige­ nous spirituality is relevant. The majority of Native Americans do not practice their tradi­ tional spirituality exclusively, and Christian religious institutions like the Native American Church and Pentecostal churches have been instrumental in helping many Native Ameri­ cans overcome substance use disorders

(Garrity 2000). In 2001, roughly 20 percent of American Indians identified as Baptist, 17 percent as Catholic, 17 percent as having no religious preference, and 3 percent as following a Tribal religion (Kosmin et al. 2001).

The relative importance of religion can also vary among diverse Native American commu­ nities. Before pursuing traditional methods, assessment of clients' spiritual orientation is important. Spirituality is a personal issue that treatment providers must respect; clients should choose which spiritual and cultural methods to incorporate into treatment. Pro­ viders should also be wary of an obsession with their clients' cultural activities, which may be considered intrusive (LaFromboise et al.

1993). Checking with community resources on the subject and asking the client "What feels right for you?" are appropriate steps to take in identifying whether traditional healing practices will have therapeutic value. Providers should consult with Native healers or Tribal leaders about the appropriateness of using a particular practice as part of behavioral health services. Rather than using traditional healing methods themselves, counselors may wish to refer clients to a Native American healer in the community or in the treatment program.

***Relapse prevention and recovery*** Despite limited data on long-term recovery for Native Americans who have substance use disorders, a few studies have found high rates of relapse following substance abuse treatment (see review in Chong and Herman-Stahl 2003). White and Sanders (2004) recommend that long-term recovery plans for Native Americans make use of a recovery manage­ ment rather than a traditional continuing care approach. Such an approach emphasizes the use of informal recovery communities and traditional healing approaches to provide extended monitoring and support for Native Americans leaving treatment.

**149**

Improving Cultural Competence

Researchers have conducted interviews with both American Indians (Bezdek and Spicer 2006) and Alaska Natives (Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004) who have achieved extended periods of recovery. Bezdek and Spicer (2 06) identified two key tasks for American Indians entering recovery. First, they need to learn how to respond to family and friends who drank with them and to those who supported their recovery. Next, they have to find new ways to deal with boredom and negative feelings. By accomplishing these tasks, Native clients can build new social support systems, develop effective coping strategies for negative feelings, and achieve long-term recovery. The People Awakening Project found that, among Alaska Natives who had a substantial period of recov­ ery, the development of active, culturally ap­ propriate coping strategies was essential (e.g., distancing themselves from friends or family who drank heavily, getting involved in church, doing community service, praying; Hazel and Mohatt 2001; Mohatt et al. 2008; People Awakening Project 2004).

### Counseling for White Americans

According to the 2010 U.S. Census definition, White Americans are people whose ancestors are among those ethnic groups believed to be the original peoples of Europe, the Middle East, or North Africa (Humes et al. 2011).

The racial category of White Americans includes people of various ethnicities, such as Arab Americans, Italian Americans, Polish Americans, and Anglo Americans (i.e., people with origins in England), among others. Many Latinos will also identify racially (if not ethni­ cally) as White American. Non-Latino White Americans constitute the largest racial group in the United States (making up 63.7 percent

of the population in the 2010 Census; Mather et al. 2011).

White Americans, like other large ethnic and cultural groups, are extremely heterogeneous in historical, social, economic, and personal features, with many (often subtle) distinctions among subgroups. Perhaps because White Americans have been the majority in the United States, it is sometimes forgotten how historically important certain distinctions between diverse White American ethnic heritages have been (and continue to be, for some). Conversely, many White American people prefer not to see themselves a: such. and instead identify according to their specific ethnic background (e.g., as Irish American).

For similar reasons, certain cross-cutting cultural issues (see Chapter 1) like geographic location, sexual orientation, and religious affiliation are important in defining the cul­ tural orientations of many White Americans.

**Beliefs About and Traditions Involving Substance Use** Historically, use of alcohol was accepted among White/European cultural groups because it provided an easy way to preserve fruit and grains and did not contain bacteria that might be found in water. Over time, the production and consumption of alcohol b -. came an often-integral part of cultural activi­

ties, which can be seen in the way some White cultural groups take particular pride in nation­ al brands of alcoholic beverages (e.g., Scotch whisky, French wine; Abbott 2001; Hudak 2000). A number of European cultural groups (e.g., French, Italian) traditionally believed that daily alcohol use was healthy for both mind and body (Abbott 2001; Marinangeli 2001), and for others (e.g., English, Irish), the bar or pub was the traditional center of com­ munity life (O'Dwyer 2001). Despite some variations in cultural attitudes toward appro­ priate drinking practices, alcohol has been and

150

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

remains the primary recreational substance for Whites in the United States. Predominant attitudes toward drinking in the United States more closely reflect those of Northern Europe; alcohol use is generally accepted during cele­ brations and recreational events, and, at such times, excessive consumption is more likely to be acceptable.

Typically, White European cultural groups accept alcohol use as long as it does not inter­ fere with responsibilities, such as work or family, or result in public drunkenness (Hamid 1998). However, among certain groups of White Americans (usually defined by religious beliefs), the use of alcohol or any other intoxi­ cant is considered immoral (van Wormer 2001). These religious beliefs, combined with concerns about the effects of problematic drinking patterns (especially among men in the frontier; White 1998), became the impetus for the early 19th-century creation of the Temperance Movement and culminated in the passing of the 18th Amendment to the United States Constitution, which enacted Prohibition. Although the Temperance Movement is no longer a major political force, belief in the moral and social value of abstinence continues to be strong among some segments of the White American population.

Illicit drug use, on the other hand, has histori­ cally been demonized by White American cultural groups and seen as an activity engaged in by people of color or undesirable subcul­ tures (Bonnie and Whitebread 1970; Hamid 1998; Whitebread 1995). For example, White Americans typically link drug use to per­ ceived threat of crime-particularly crimes perpetrated by people of color (Hamid 1998; Whitebread 1995). Attitudes have changed over time, but White American cultural groups continue to enforce strong cultural prohibitions against most types of illicit drug use. At the same time, White Americans are

often more accepting of prescription medica­ tion abuse and less likely to perceive prescrip­ tion medications as potentially harmful (Hadjicostandi and Cheurprakobkit 2002).

Despite illicit drug use now being as common among White Americans as people of color, White Americans still tend to perceive drug use as an activity that occurs outside their families and communities. In a 2001 survey, only 54 percent of White Americans ex­ pressed concern that someone in their family might develop a drug abuse problem compared with 81 percent of African Americans (Pew Research Center for the People and the Press 2001). In the same survey, White Americans expressed less concern about drug abuse in their neighborhoods than did other racial and ethnic groups. However, in terms of seeing drugs as a national problem, White Americans and other racial and ethnic groups are in closer agreement. Perhaps as a result of this misper­ ception about the prevalence of drug use in their homes and communities, White American parents are less likely to convey disapproval of drug use to their children than African American parents (National Center on Addiction and Substance Abuse 2005) and much more likely than Latino or African American parents to think that their children have enough information about drugs (Pew Research Center for the People and the Press 2001).

There are also differences in how White Amer­ icans, Latinos, and African Americans perceive drug and alcohol addictions. White Americans are less likely than African Americans, but more likely than Latinos, to state that they believe a person can recover fully from addic­ tion (Office of Communications 2008). How­ ever, White Americans are more likely than African Americans to indicate that substance use disorders should be treated as diseases (Durant 2005).

151

Improving Cultural Competence

##### Substance Use and Substance Use Disorders

According to 2012 NSDUH data, rates of past-year substance use disorders were higher for White Americans than for Native Hawaiians, other Pacific Islanders, and Asian Americans; rates of current alcohol use were higher than for every other major ethnic/racial group (SAMHSA *2013d).* Alcohol has tradi­ tionally been the drug of choice among White Americans of European descent; however, not all European cultural groups have the same drinking patterns. Researchers typically con­ trast a Northern/Eastern European pattern, in which alcohol is consumed mostly on week­ ends or during celebrations, with that of Southern Europe, in which alcohol is con­ sumed daily or almost daily but in smaller quantities and almost always with food. The Southern European pattern involves more regular use of alcohol, but it is also associated with less alcohol-related harm overall (after controlling for total consumption; Room et al. 2003). The pattern of White Americans typi­ cally follows that of Northern and Eastern Europe, but individuals from some ethnic groups maintain the Southern European pattern.

White Americans, on average, begin drinking and develop alcohol use disorders at a younger age than African Americans and Latinos (Reardon and Buka 2002). White Americans are more likely to have their first drink before the age of 21 and to have their first drink before the age of 16 than members of any other major racial/ethnic group except Native Americans (SAMHSA 2011c). Some data suggest that White Americans begin using illicit drugs at an earlier age than African Americans (Watt 2008) and that the mean age for White Americans who inject heroin has decreased (Broz and Ouellet 2008).

White Americans who use heroin are less likely than people who use heroin from all other major racial/ethnic groups except African Americans to have injected the drug (SAMHSA 2011c). White Americans are also more likely than members of other major racial/ethnic groups, except Native Hawaiians and other Pacific Islanders (for whom esti­ mates may not be accurate), to have tried ecstasy. Except for Native Americans (some of whom may use the hallucinogen peyote for religious purposes), they are also more likely than other racial/ethnic groups to have tried hallucinogens **(SAMHSA** 2011c). Research confirms that prescription drug misuse is more common among White Americans than African Americans or Latinos (Ford and Arrastia 2008; SAMHSA 2011c), and they are more likely to have used prescription opioids in the past year and to use them on a regular basis.

Comparative studies indicate that White Americans are more likely than all other major racial/ethnic groups except Native Americans to have an alcohol use disorder (Hasin et al.

2007; Perron et al. 2009; Schmidt et al. 2007). White Americans are at a greater risk of having severe alcohol withdrawal symptoms (such as delirium tremens) than are African Americans or Latinos with alcohol use disorders (Chan et al. 2009). So too, White Americans are more likely than African Americans or Latinos to meet diagnostic criteria for a drug use disorder at some point during their lives (Perron et al. 2009). Overall, substance use disorders vary considerably across and within non-European White American cultural groups. For example, rates of substance abuse treatment admissions in Michigan from *2005* suggest that substance use disorders may be considerably lower for Arab Americans than other White Americans (Arfken et al. 2007).

152

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

##### Mental and Co-Occurring Disorders

About 20 percent of White Americans report­ ed some form of mental illness in the past year, and they were more likely to have past-year serious psychological distress than other popu­ lation groups excluding Native Americans (SAMHSA *2012a).*

White Americans appear to be more likely than Latinos or Asian Americans to have CODs (Alegria et al. 2008a; Vega et al. 2009) and more likely to have concurrent serious psychological distress and substance use disor­ ders (SAMHSA 2011c). White Americans with CODs are also more likely to receive treatment for both their substance use and mental disorders than are African Americans with CODs (Alvidrez and Havassy *2005;* Hatzenbuehler et al. 2008), but they are per­ haps less likely to receive treatment for their substance use disorder alone (Alvidrez and Havassy 2005). White Americans are more likely to receive family counseling and mental health services while in substance abuse treat­ ment and less likely to have unmet treatment needs (Marsh et al. 2009; Wells et al. 2001). In addition, White Americans are significantly less likely than Latinos or African Americans to believe that antidepressants are addictive (Cooper et al. 2003).

The most common mental disorders among White Americans are mood disorders (par­ ticularly major depression and bipolar I disor­ der) and anxiety disorders (specifically phobias, including social phobia, and general­ ized anxiety disorder; Grant et al. *2004b).*

Among White Americans, these disorders are more prevalent than in any other ethnic/racial groups save Native Americans (Grant et al.

*2005;* Hasin et al. 2005). For example, rates of a lifetime diagnosis of generalized anxiety disor­ der are about 40 percent lower for African Americans and Latinos than for White

Americans and about 60 percent lower for Asian Americans (Grant et al. 2005). A simi­ lar pattern exists for major depressive disorder (Hasin et al. 2005).

##### Treatment Patterns

White Americans are more likely to receive mental health treatment or counseling than other racial/ethnic groups (SAMHSA *2012b).* White Americans are more likely than African Americans to receive substance abuse treat­ ment services from a private physician or

other behavioral health or primary care profes­ sional (Perron et al. 2009). Among White American clients entering substance abuse treatment programs in 2010, alcohol (alone or in conjunction with illicit drugs) was most often the primary substance of abuse, followed by heroin and cannabis. However, findings are inconsistent concerning the relative frequency with which White Americans enter substance abuse treatment. Some studies have found that White Americans are more likely to receive needed behavioral health services than both African Americans and Latinos (Marsh et al. 2009; Wells et al. 2001). In contrast, other studies have found that African Americans with an identified need are somewhat more likely to enter treatment for drug use disorders and about as likely to receive treatment for alcohol use disorders when compared with White Americans (Hatzenbuehler et al. 2008; Perron et al. 2009; SAMHSA, CBHSQ2012;

Schmidt et al. 2006).

##### Beliefs and Attitudes About Treatment

White Americans appear to be generally accepting of behavioral health services. They have better access to health care and are more likely to use services than people of color, but this varies widely based on socioeconomic status and cultural affiliation. Most treatment services have historically been developed for

153

Improving Cultural Competence

White American populations, so it is not surprising that White Americans are more likely than other racial/ethnic groups to be satisfied with treatment services (Tonigan 2003).

Still, attitudes differ among certain cultural subgroups of White Americans. For example, Russian immigrants from the former Soviet Union have a longstanding distrust of mental health systems and hence may avoid substance abuse treatment (Kagan and Shafer 2001).

Other groups who have a strong family orien­ tation, such as Italian Americans or Scotch­ Irish Americans, might avoid treatment that asks them to reveal family secrets (Giordano and McGoldrick *2005;* Hudak 2000).

According to 2010 **NSDUH** data regarding people who recognized a need for substance abuse treatment in the prior year but did not receive it, White Americans were more likely than members of other major racial/ethnic groups to state that it was because they had no time for treatment, that they were concerned what their neighbors might think, that they did not want others to know, and/or that they were concerned about how it might affect their jobs (SAMHSA 2011c). Other research confirms that White Americans are significant­ ly more likely to avoid treatment due to fear of what others might think or because they are in denial (Grant 1997). White Americans may also have different attitudes toward recovery, at least regarding alcohol use disorders, than do members of other ethnic/racial groups. Ac­ cording to NESARC data on people who

met criteria for a diagnosis of alcohol de­ pendence at some point during their lives, White Americans were more likely than African Americans, Latinos, or other non­ Latinos to have achieved remission from that disorder but were also less likely than African Americans or other non-Latinos (but not Latinos) to currently abstain from drinking, as

opposed to being in partial remission or drink­ ing without symptoms of alcohol dependence (Dawson et al. 2005).

##### Treatment Issues and Considerations

Most major treatment interventions have been evaluated with a population that is largely or entirely White American, although the role of White American cultural groups is rarely considered in evaluating those interventions. For example, as Straussner (2001) notes, "the paradox of writing about substance abusers of European background is that they are a group that is believed to be the group for whom the traditional alcohol and other drug treatment models have been developed, and yet they are a group whose unique treatment needs and treatment approaches have rarely been ex­ plored" (p. 165). Very few evaluations of treatment strategies and interventions (wheth­ er based on research or clinical observation) have taken into account ethnic and cultural differences among White American clients, and therefore it is generally not possible to make culturally responsive recommendations for specific subgroups of White Americans.

Culturally responsive treatment for many White Americans will involve helping them rediscover their cultural backgrounds, which sometimes have been lost through acculturation and can be an important part of their long­ term recovery. Giordano and McGoldrick (2005) note that ethnic identity and culture can be more important for some White Americans "in times of stress or personal crisis," when they may want to "return to familiar sources of comfort and help, which may differ from the dominant society's norms" (p. 503). Appendix **B** provides information on instruments for assessing cultural identifica­ tion. For an overview of challenges in main­ taining mental health, access to health care,

**154**

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

and help-seeking among White Americans, see Downey and D'Andrea (2012).

##### Theoretical Approaches and Treatment Interventions

Overall, the optimum treatment approach with White Americans is a comprehensive one; the more tools in the toolkit, the greater the chance of success (McCaul et al. 2001). Within-group differences arise regarding education level, socioeconomic status, gender, and other factors, which must be considered.

Providers can, however, assume that most

well-accepted treatment approaches and inter­ ventions (e.g., CBT, motivational interviewing, 12-Step facilitation, contingency management, pharmacotherapies) have been tested and evaluated with White American clients.

Still, treatment is not uniformly appropriate even for White Americans. Approaches may need modification to suit class, ethnic, reli­ gious, and other client traits. Providers should establish not only the client's ethnic back­ ground, but also how strongly the person identifies with that background. Few clinicians have made observations on best therapeutic approaches for members of particular White American cultural/ethnic subgroups.

#### *Family therapy*

In White American families, individuals are generally expected to be independent and self­ reliant; as a result, families in therapy can have trouble adjusting to work that focuses more on communication processes than specific prob­ lems or content (McGill and Pearce 2005).

Van Wormer (2001) notes that many White Americans need help addressing communica­ tion issues. In family therapy, useful approach­ es include those that encourage open, direct, and nonthreatening communication.

There is no singular description that fits White American families within or across

ethnic heritages, and there is no approach that is effective for all White Americans in family therapy (Hanson 2011). Hierarchical families, such as German American families, may expect the counselor to be authoritative, at least in the initial sessions (Winawer and Wetzel 2005), although a more egalitarian German American family might not respond well to such imperatives. In the same vein, one client of French background could readily accept direct and clear therapeutic assign­ ments that contain measurable goals (Abbot 2001), whereas another French American client may value counseling that is more pro­ cess oriented. Thus, it is imperative to assess the cultural identification of clients and their families, along with the treatment needs that best match their cultural worldviews.

In some White American families, there is a longstanding culture of drinking. Attempts at abstinence can be perceived by family mem­ bers as culturally inappropriate.In other fami­ lies, there is deep denial about alcohol abuse or dependence, especially when talking about substance use to those outside the family. For example, some Polish American families can be resistant to the idea that drinking is the cause of family problems (Folwarski and Smolinski 2005) and sometimes believe that to admit an alcohol problem, especially to someone outside the family, signals weakness.

#### *Group therapy*

Standard group therapies developed for men­ tal health and substance abuse treatment programs have generally been used and evalu­ ated with White American populations. For details on group therapy in substance abuse treatment, see TIP 41, *Substance Abuse Treat­ ment: Group Therapy* (CSAT *2005c).*

#### *Mutual-help groups*

Mutual-help groups, of which AA is the most prevalent, have a largely White American

155

Improving Cultural Competence

membership (AAWS 2008; Atkins and Hawdon 2007). In a 2011 survey, 87 percent of AA members indicated their race as White (AAWS 2012). In research with largely White populations, AA participation has been found to be an effective strategy for promoting recovery from alcohol use disorders (Dawson et al. 2006; McCrady et al. 2004; Moos and Moos 2006; Ritsher et al. 2002; Weisner et al. 2003). Other mutual-help groups, such as

Self-Management and Recovery Training, Secular Organizations for Sobriety/Save Our Selves, and Women for Sobriety, also have predominately White American membership and are based on Western ideas drawn from psychology (Atkins and Hawdon 2007; White 1998).

The appeal of mutual-help groups among White Americans rests on the historical ori­ gins of this model. The 12-Step model was originally developed by White Americans based on European ideas of spirituality, faith, and group interaction. Although the model has been adopted worldwide by different cultural groups (White 1998), the 12-Step model works especially well for White ethnic groups, including Irish Americans, Polish Americans, French Americans, and Scotch­ Irish Americans, because it incorporates Western cultural traditions involving spiritual practice, public confession, and the use of anonymity to protect against humiliation (Abbott 2001; Gilbert and Langrod 2001; Hudak 2000; McGoldrick et al. *2005;* Taggart 2005).

In addition to mutual-help groups for sub­ stance abuse, numerous recovery support groups, Internet resources, Web-based com­ munities, and peer support programs are available to promote mental health recovery. Many resources are available through the National Alliance on Mental Illness (http://www.nami.org).

***Traditional healing and complementary methods***

Only 12 percent of White Americans consider themselves atheist, agnostic, or secular without a religious affiliation, meaning that, as a group, White Americans are more religious than Asian Americans but less so than Latinos or African Americans (Pew Forum on Religion and Public Life 2008). As with other groups, White Americans belong to many different religions, although the vast majority belong to various Christian denominations, with approx­ imately *57* percent identifying as Protestant and *25.*9 percent as Catholic (National Center on Addiction and Substance Abuse, 2001).

White Americans also make up 91 percent of practitioners ofJudaism in the United States, 14 percent of followers oflslam, and 32 per­ cent of the American Buddhist population (Kosmin et al. 2001). For more religious White Americans, pastoral counseling or prayer can be useful aids in the treatment of substance use disorders. However, White Americans are significantly less likely to use prayer as a method of coping (Graham et al. 2005). White Americans are more likely than members of other major racial/ethnic groups to use complementary or alternative medical therapies, such as herbal medicine, acupunc­ ture, chiropractors, massage therapy, yoga, and special diets (Graham et al. 2005).

***Relapse prevention and recovery*** Factors that promote recovery for White Americans include the learning and use of coping skills (Litt et al. 2003; Litt et al. *2005;* Maisto et al. 2006). Even though some research suggests that White Americans are less likely to use coping skills than African Americans (Walton 2001) and have lower levels of self­ efficacy upon leaving treatment (Warren et al. 2007), the development of these skills and of self-efficacy is important in managing relapse risks and in maintaining recovery. Counselors

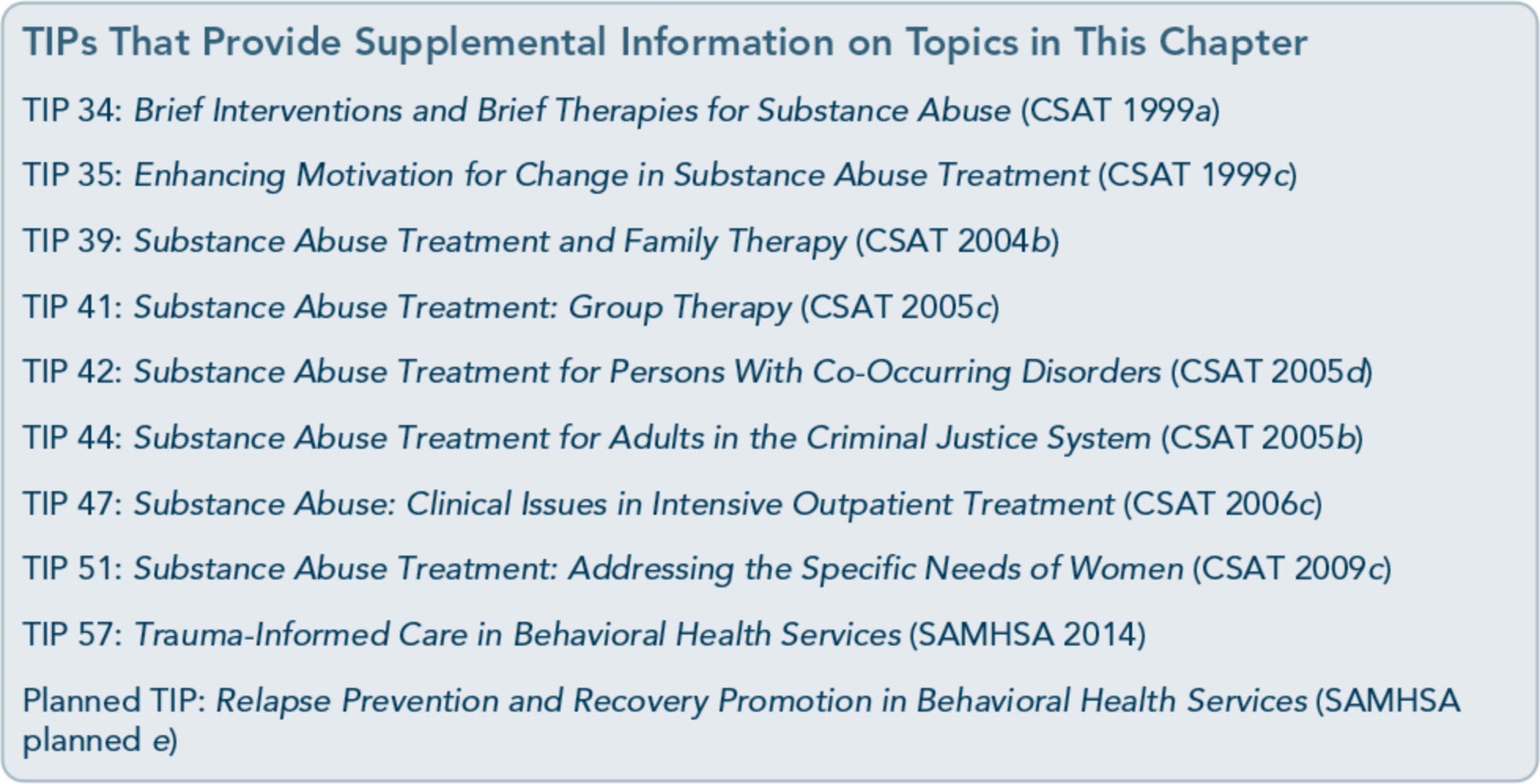
156

Chapter 5-Behavioral Health Treatment for Major Racial and Ethnic Groups

may offer psychoeducation on the value of coping strategies, specific skills to manage stressful situations or environments, and op­ portunities to practice these skills during treatment. Some coping skills or strategies may be more important than others in manag­ ing high-risk situations, but research suggests that greater use of a variety of coping strate­ gies is more important than the use of any one specific skill (Gossop et al. 2002).

Social and family supports are also important in maintaining recovery and preventing re­ lapse among White Americans (Laudet et al.

2002; McIntosh and McKeganey 2000; Rumpf et al. 2002). Other important factors include continuing care, the development of substitute behaviors (i.e., reliance on healthy or positive activities in lieu of substance use), the creation of new caring relationships that do not involve substance use, and increased spirituality (Valliant 1983). Valliant (1983) and others (e.g., Laudet et al. 2002; McCrady et al. 2004; Moos and Moos 2006) conclude, based on research with mostly White partici­ pants, that mutual-help groups often play an important role in maintaining recovery.



157

# Appendix A-Bibliography

Abbott, A.A. Substance abuse treatment with clients of French background. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 180-198). New York: Guil­ ford Press, 2001.

Abbott, P.J. Traditional and western healing practices for alcoholism in American Indians and Alaska Natives. *Substance Use* & *Misuse* 33(13):2605-2646, 1998.

Abe,]. A community ecology approach to cultural competence in mental health service delivery: The case of Asian *Americans.Asian American journal of Psychology* 3(3):168-180, 2012.

Abe-Kim,]., Takeuchi, D.T., Hong, S., Zane, N., Sue, S., Spencer, M.S., Appel, H., Nicdao, E., and Alegria, M. Use of mental health-related services among immigrant and US-born Asian

Americans: Results from the National Latino and Asian American *study.American journal of*

*Public Health* 97(1):91-98, 2007.

Abdel-Khalek, A.M. lnternal consistency of an Arabic adaptation of the Beck Depression Inven­ tory in four Arab countries. *Psychological Reports* 82:264-266, 1998.

Abudabbeh, N., and Hamid, A. Substance use among Arabs and Arab Americans. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 275-290). New York: Guil­ ford Press, 2001.

Abueg, F.R., and Chun, K.M. Traumatization stress among Asians and Asian Americans. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 283-294). New York: Routledge, 1998.

Acevedo, A., Garnick, D.W., Lee, M.T., Horgan, C.M., Ritter, G., Panas, L., Davis, S., Leeper, T., Moore, R., and Reynolds, M. Racial and ethnic differences in substance abuse treatment ini­

tiation and engagement.journal *of Ethnicity in Substance Abuse* 11(1):1-21, 2012.

Acevedo-Polakovich, I.D., Reynaga-Abiko, G., Garriott, P.O., Derefinko, K.J., Wimsatt, M.K., Gudonis, L.C., and Brown, T.L. Beyond instrument selection: Cultural considerations in the psychological assessment of U.S. Latinas/as. *Professional Psychology: Research and Practice* 38(4):375-384, 2007.

Ackerman, S.J., and Hilsenroth, M.J. A review of therapist characteristics and techniques posi­ tively impacting the therapeutic alliance. *Clinical Psychology Review* 23(1):1-33, 2003.

Adewuya, A.O. Validation of the Alcohol Use Disorders Identification Test (AUDIT) as a screening tool for alcohol-related problems among Nigerian university *students.Alcohol and Alcoholism* 40:575-577, 2005.

177

Improving Cultural Competence

Addiction Technology Transfer Center. *The Change Book: A Blueprint for Technology Tranifer.* 2nd ed. Kansas City, MO: Addiction Technology Transfer Center, 2004.

Adlaf, E.M., and Smart, R.G. Party subculture or dens of doom? An epidemiological study of rave attendance and drug use patterns among adolescent *students.journal of Psychoactive Drugs* 29(2):193-198, 1997.

African immigrants in the United States are the nation's most highly educated *group.journal of*

*Blacks in Higher Education* 26:60-61, 2000.

Agency for Healthcare Research and Qyality. *National Healthcare Disparities Report 2008.* Rock­ ville, MD: Agency for Healthcare Research and Qyality, 2009.

Agency for Healthcare Research and Qyality. *National Healthcare Disparities Report 2011.* Rock­ ville, MD: Agency for Healthcare Research and Qyality, 2012.

Aguilar-Gaxiola, S., Loera, G., Mendez, L., Sala, M., Latino Mental Health Concilio, and Nakamoto,]. *Community-Defined Solutions for Latino Mental Health Care Disparities: Califor­ nia Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report.* Sac­ ramento, CA: UC Davis, 2012.

Ahmad, S., and Bhugra, D. Sex and culture. In: Bhattacharya, R., Cross, S., and Bhugra, D., eds. *Clinical Topics in Cultural Psychiatry* (pp. 196-208). London: Royal College of Psychiatrists, 2010.

Ahn, A.C., Ngo-Metzger, Q, Legedza, A.T.R., Massagli, M.P., Clarridge, B.R., and Phillips,

R.S. Complementary and alternative medical therapy use among Chinese and Vietnamese Americans: Prevalence, associated factors, and effects of patient-clinician communication.

*American journal of Public Health* 96(4):647-653, 2006.

Akbar, N. Cultural expressions of the African-American child. *Black Child journal* 2(2):6-16, 1981.

Alansari, B.M. Gender differences in depression among undergraduates from seventeen Islamic countries. *Social Behavior and Personality* 34:729-738. 2006.

Al-Ansari, E.A., and Negrete,J.C. Screening for alcoholism among alcohol users in a traditional Arab Muslim *society.Acta Psychiatrica Scandinavica* 83(3):217-222, 1990.

Alarcon, **R.D.** Culture, cultural factors and psychiatric diagnosis: Review and projections. *World Psychiatry* 8(3):131-139, 2009.

Alcoholics Anonymous World Services, *Inc.A.A.for the Black and African American Alcoholic.*

New York: Alcoholics Anonymous World Services, 2001.

Alcoholic Anonymous World Services, *Inc.Alcoholics Anonymous 2007 Membership Survey.* New York: Alcoholics Anonymous World Services, 2008.

Alcoholics Anonymous World Services, *Inc.Alcoholics Anonymous 2011 Membership Survey.* New York: Alcoholics Anonymous World Services, 2012.

Alderete, E., Vega, W. A., Kolody, B., and Aguilar-Gaxiola, S. Lifetime prevalence of and risk

factors for psychiatric disorders among Mexican migrant farmworkers in *California.American journal of Public Health* 90(4):608-614, 2000.

178

Appendix A-Bibliography

Alegria, M., Canino, G., Shrout, P.E., Woo, M., Duan, N., Vila, D., Torres, M., Chen, C.N., and Meng, X.L. Prevalence of mental illness in immigrant and non-immigrant U.S. Latino

groups. *The American journal of Psychiatry* 165(3):359-369, *2008a.*

Alegria, M., Canino, G., Stinson, F.S., and Grant, B.F. Nativity and DSM-IV psychiatric disor­ ders among Puerto Ricans, Cuban Americans, and Non-Latino Whites in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *The*

*journal of Clinical Psychiatry* 67(1):56-65, 2006.

Alegria, M., Carson, N.J., Goncalves, M., and Keefe, K. Disparities in treatment for substance use disorders and co-occurring disorders for ethnic/racial minority *youth.journal of the American Academy of Child and Adolescent Psychiatry* 50(1):22-31, 2011.

Alegria, **M.,** Chatterji, **P.,** Wells, **K.,** Cao, Z., Chen, **C.N.,** Takeuchi, D.,Jackson,J., and Meng,

**X.L.** Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services* 59(11):1264-1272, *2008b.*

Alegria, M., Mulvaney-Day, N., Woo, M., and Viruell-Fuentes, E.A. Psychology of Latino adults: Challenges and an agenda for action. In: Chang, E.C., ed. *Handbook of Race and De­*

*velopment in Mental Health* (pp. 279-306). New York: Springer Science+ Business Media, 2012.

Alim, T.N., Graves, E., Mellman, T.A., Aigbogun, N., Gray, E., Lawson, W., and Charney, D.S.

Trauma exposure, posttraumatic stress disorder and depression in an African-American pri­ mary care *population.journal of the National Medical Association* 98(10):1630-1636, 2006.

Allen,J.P., Litten, **R.Z.,** Fertig,J.B., and Babor, T. A review of research on the Alcohol Use Dis­ orders Identification Test *(AUDIT).Alcoholism: Clinical and Experimental Research* 21:613- 619, 1997.

Almeida, R. Asian Indian families: An overview. In: McGoldrick, M., Giordano,]., and Garcia­ Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 377-394). New York: Guilford Press, 2005.

Aloud, N. *Factors Affecting Attitudes Toward Seeking and Using Formal Mental Health and Psycho­ logical Services Among Arab-Muslims Population* [Doctoral dissertation]. Columbus, OH: Ohio State University, 2004.

Alvarez, L.R., and Ruiz, P. Substance abuse in the Mexican American population. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 111-136). New York: Guil­ ford Press, 2001.

Alverson, H. *Students' Social Life at Dartmouth College: Reflections in Their Looking Glass.* Dart­ mouth, NH: Dartmouth College, 2005.

Alvidrez,]., and Havassy, B.E. Racial distribution of dual-diagnosis clients in public sector men­ tal health and drug treatment *settings.journal of Health Care far the Poor and Underserved* 16(1):53-62, 2005.

179

Improving Cultural Competence

Amaro, H., and Aguiar, M. Programa Mama/Mom's Project: A community-based outreach model for addicted women. In: Szapocznik,J., Orlandi, M.A., and Epstein, L.G., eds.A *His­ panic/Latino Family Approach to Substance Abuse Prevention* (pp. 125-153). CSAP Cultural Competence Series 2. HHS Publication No. (SMA) 95-3034. Rockville, MD: Center for Substance Abuse Prevention, 1995.

Amaro, H., Arevalo, S., Gonzalez, G., Szapocznik,J., and Iguchi, M.Y. Needs and scientific opportunities for research on substance abuse treatment among Hispanic adults. *Drug and Alcohol Dependence* 84(Suppl 1):S64-S75, 2006.

Amaro, H., Dai,]., Arevalo, S., Acevedo, A., Matsumoto, A., Nieves, R., and Prado, G. Effects of

integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse *treatment.Journal of Urban Health* 84(4):508-522,

2007.

American Evaluation Association. *Public Statement on Cultural Competence in Evaluation.* Fairha­ ven, MA: American Evaluation Association, 2011.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 4th Text Revision ed. Washington, **DC:** American Psychiatric Association, 2000.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed.

Washington, DC: American Psychiatric Association, 2013.

American Psychological Association. *APA Guidelines for Providers of Psychological Services to Eth­ nic, Linguistic, and Culturally Diverse Populations.* Washington, DC: American Psychological Association, 1990.

American Psychological Association. *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists.* Washington, **DC:** American Psychologi­ cal Association, 2002.

American Psychological Association. *Resilience and Recovery After War: Refugee Children and Families in the United States.* Washington, **DC:** American Psychological Association, 2010.

American Psychological Association. *Crossroads: The Psychology of Immigration in the New Centu­ ry.*Washington, **DC:** American Psychological Association, 2012.

American Translators Association. *Interpreting: Getting it Right: A Guide to Buying Interpreting Services.* Alexandria, VA: American Translators Association, 2011.

Amodeo, M., Chassler, D., Oettinger, C., Labiosa, W., and Lundgren, L.M. Client retention in residential drug treatment for Latinos. *Evaluation and Program Planning* 31(1):102-112, 2008.

Amodeo, M., and Jones, L.K. Viewing alcohol and other drug use cross culturally: A cultural framework for clinical practice. *Families in Society* 78(3):240-254, 1997.

Amodeo, M., Peou, S., Grigg-Saito, D., Berke, H., Pin-Riebe, S., and Jones, L.K. Providing

culturally specific substance abuse services in refugee and immigrant communities: Lessons from a Cambodian treatment and demonstration *project.journal of Social Work Practice in the Addictions* 4(3):23-46, 2004.

180

Appendix A-Bibliography

Amodeo, M., Robb, N., Peou, S., and Tran, H. Alcohol and other drug problems among South­ east Asians: Patterns of use and approaches to assessment and *intervention.Alcoholism Treat­ ment Quarterly* 15(3):63-77, 1997.

Amorim, P., Lecrubier, Y., Weiller, E., Hergueta, T., and Sheehan, D. DSM-III-R psychotic disorders: Procedural validity of the Mini International Neuropsychiatric Interview (MINI): Concordance and causes for discordance with the CIDI. *European Psychiatry* 13:26-34, 1998.

Anderson,]., Moeschberger, M., Chen, M.S. Jr., Kunn, P., Wewers, M.E., and Guthrie, R. An acculturation scale for Southeast Asians. *Social Psychiatry and Psychiatric Epidemiology* 28:134-141, 1993.

Anderson, L.M., Scrimshaw, S.C., Fullilove, M.T., Fielding,J.E., and Normand,]. Culturally competent healthcare systems. A systematic *review.American journal of Preventive Medicine* 24(3 Suppl):68-79, 2003.

Anderson, T.L., and Levy,J.A. Marginality among older injectors in today's illicit drug culture: Assessing the impact of aging. *Addiction* 98(6):761-770, 2003.

Andrade, R., and Estrada, A.L. Are Hispana ID Us tecatas?: Reconsidering gender and culture in Hispana injection drug use. *Substance Use* & *Misuse* 38(8):1133-1158, 2003.

Aragon, A.M. A clinical understanding of urban American Indians. In: Witko, T.M., ed. *Mental Health Care far Urban Indians: Clinical Insights From Native Practitioners* (pp. 19-31). Wash­ ington, DC: American Psychological Association, 2006.

Arciniega, G.M., Anderson, T.C., Tovar-Blank, Z.G., and Tracey, T.J.G. Toward a fuller concep­ tion of Machismo: Development of a traditional Machismo and Caballerismo *Scale.journal*

*of Counseling Psychology* 55(1):19-33, 2008.

Arfken, C.L., Kubiak, S.P., and Koch, A.L. Health issues in the Arab American community: Arab Americans in publicly financed substance abuse treatment. *Ethnicity and Disease* 17(2 Suppl 3):S3, 2007.

Arfken, C.L., Said, M., and Owens, D. Racial and ethnic differences in reported criminal justice referral at treatment *admission.journal of Psychoactive Drugs* 44(5):428-433, 2012.

Arias, E. United States life tables by Hispanic origin. *Vital and Health Statistics* 2(152). National Center for Health Statistics, 2010.

Arndt, S., Acion, L., and White, K. How the states stack up: Disparities in substance abuse out­ patient treatment completion rates for minorities. *Drug and Alcohol Dependence* 132(3):547- 554, 2013.

Arroyo,J.A., Westerberg, V.S., and Tonigan,J.S. Comparison of treatment utilization and out­ come for Hispanics and non-Hispanic *Whites.journalof Studies onAlcohol* 59(3):286-291, 1998.

Assanangkornchai, S., Conigrave, K.M., and Saunders,J.B. Religious beliefs and practice, and alcohol use in Thai *men.Alcohol andAlcoholism* 37(2):193-197,2002.

Association for Assessment in Counseling and Education. *Standards far Multicultural Assessment.*

4th ed. Alexandria, VA: Association for Assessment in Counseling and Education, 2012.

181

Improving Cultural Competence

Atkins, R.G.Jr., and Hawdon,J.E. Religiosity and participation in mutual-aid support groups for

*addiction.journal of Substance Abuse Treatment* 33(3):321-331, 2007.

Attneave, C. American Indians and Alaska Native families: Emigrants in their own homeland. In: McGoldrick, M., Pearce,J.K., and Giordano,]., eds. *Ethnicity and Family Therapy* (pp. *55-* 83). New York: Guilford Press, 1982.

Ayalon, L., and Alvidrez,]. The experience of Black consumers in the mental health system­ Identifying barriers to and facilitators of mental health treatment using the consumers' per­ spective. *Issues in Mental Health Nursing* 28(12):1323-1340, 2007.

Ayalon, L. and Young, M.A. Using the SCL-90-R to Assess distress in African Americans and Caucasian *Americans.journal of Black Studies* 39:420-433, 2009.

Azevedo, K., and Bogue, H.O. Health and occupational risks of Latinos living in rural America.

In: Aguirre-Molina, M., Molina, C., and Zambrana, R.E., eds. *Health Issues in the Latino Community* (pp. 359-380). San Francisco: Jossey-Bass, 2001.

Azocar, F., Arean, P., Miranda,]., and Munoz, R.F. Differential item functioning in a Spanish translation of the Beck Depression *Inventory.journal of Clinical Psychology* 57:355-365, 2001.

Babor, T.F., de la Fuente,J.R., Saunders,]., and Grant, *M.AUDIT: The Alcohol Use Disorders Identification Test. Guidelines far Use in Primary Health Care.* Geneva: World Health Organi­ zation, 1992.

Baicker, K., Chandra, A., and Skinner,J.S. Geographic variation in health care and the problem of measuring racial disparities. *Perspectives in Biology and Medicine,* 48:S42-S53, 2005.

Bail, K.M., Foster,]., Dalmida, S.G., Kelly, U., Howett, M., Ferranti, E.P., and Wald,]. Theim­ pact of invisibility on the health of migrant farmworkers in the southeastern United States: A case study from Georgia. *Nursing Research and Practice,* 2012.

Bainwol, S., and Gressard, C.F. The incidence of Jewish alcoholism: A review of the literature.

*journal of Drug Education* 15(3):217-224, 1985.

Baker, F.M., and Bell, C.C. Issues in the psychiatric treatment of African Americans. *Psychiatric Services* 50(3):362-368, 1999.

Baldwin,J.A., and Bell, Y.R. The African self-consciousness scale: An Africentric personality questionnaire. *The Westernjournalof Black Studies* 9(2):61-68, 1985.

Balsam, K.F., Huang, B., Fieland, K.C., Simoni,J.M., and Walters, K.L. Culture, trauma, and wellness: A comparison of heterosexual and lesbian, gay, bisexual, and two-spirit Native Americans. *Cultural Diversity* & *Ethnic Minority Psychology* 10(3):287-301, 2004.

Bao, Y., Fisher,]., and Studnicki,]. Racial differences in behavioral inpatient diagnosis: Examin­ ing the mechanisms using the 2004 Florida inpatient discharge data. *The journal of Behavior Health Services Research* 35(3):347-357, 2008.

Barbujani, G., Magagni, A., Minch, E., and Cavalli-Sforza, L.L. An apportionment of human DNA diversity. *Proceedings of the National Academy of Sciences of the United States of America* 94(9):4516-4519, 1997.

182

Appendix A-Bibliography

Bardwell, W.A., and Dimsdale,J.E. The impact of ethnicity and response bias on the self-report of negative *affect.journalof Applied Biobehavioral Research* 6:27-38, 2001.

Baron, M. Addiction treatment for Mexican American families. In: Krestan,J.A., ed. *Bridges to Recovery:Addiction, Family Therapy, and Multicultural Treatment* (pp. 219-252). New York: The Free Press, 2000.

Barr, D.A. *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health.* Balti­ more: Johns Hopkins University Press, 2008.

Barreto, **R.M.,** and Segal, **S.P.** Use of mental health services by Asian Americans. *Psychiatric Services* 56(6):746-748, *2005.*

Barrett, M.E. Wat Thamkrabok: A Buddhist drug rehabilitation program in Thailand. *Substance Use* & *Misuse* 32(4):435-459, 1997.

Barry, D.T. Development of a new scale for measuring acculturation: The East Asian Accultura­ tion Measure (EAAM) *.journal of Immigrant Health* 3:193-197, 2001.

Bassett, D., Tsosie, U., and Nannauck, S. "Our culture is medicine": Perspectives of Native healers on posttrauma recovery among American Indian and Alaska Native patients. *The Permanente journal,* 16(1):19-27, 2012.

Batistoni, S.S., Neri, A.L., and Cupertino, A.P. Validity of the Center for Epidemiological Stud­ ies Depression Scale among Brazilian elderly. *Revista de Saude Publica* 41:598-605, 2007.

Bazron, B., and Scallet, L. *The Impact of Culturally and Linguistically Appropriate Services on Access To Care in a Managed Behavioral Health Care Environment.* Working Draft. Falls Church, VA: The Lewin Group, 1998.

Beach, M.C., Gary, T.L., Price, E.G., Robinson, K., Gozu, A., Palacio, A., Smarth, C.,Jenckes, M., Feuerstein, C., Bass, E.B., Powe, N.R., and Cooper, L.A. Improving health care quality for racial/ethnic minorities: A systematic review of the best evidence regarding provider and organization interventions. *BMC Public Health* 6:104, 2006.

Beals,]., Manson, S.M., Shore,J.H., Friedman, M.J., Ashcraft, M., Fairbank,J.A., and Schlenger,

W.E. The prevalence of posttraumatic stress disorder among American Indian Vietnam vet­ erans: Disparities and *context.journal ofTraumatic Stress* 15(2):89-97, 2002.

Beals,]., Manson, S.M., Whitesell, N.R., Spicer, P., Novins, D.K., and Mitchell, C.M. Prevalence of DSM-IV disorders and attendant help-seeking in two American Indian reservation popu­ *lations.Archives of General Psychiatry* 62(1):99-108, *2005.*

Beals,]., Novins, D.K., Spicer, P., Whitesell, N.R., Mitchell, C.M., and Manson, S.M. Help seeking for substance use problems in two American Indian reservation populations. *Psychiat­ ric Services* 57(4):512-520, 2006.

183

Improving Cultural Competence

Beals,]., Spicer, P., Mitchell, C.M., Novins, D.K., Manson, S.M., and the American Indian Ser­ vice Utilization Psychiatric Epidemiology Risk and Protective Factors Project Team: Big Crow, C.K., Buchwald, D., Chambers, B., Christensen, M.L., Dillard, D.A., DuBray, K., Es­ pinoza, P.A., Fleming, C.M., Frederick, A.W., Gurley, D.,Jervis L.L.,Jim, S.M., Kaufman, C.E., Keane, E.M., Klein, S.A., Lee, D., McNulty, M.C., Middlebrook, D.L., Moore, L.A.,

Nez, T.D., Norton, I.M., Orton, H.D., Randall, C.J., Sam, A., Shore,J.H., Simpson, S.G.,

and Yazzie, L.L. Racial disparities in alcohol use: Comparison of two American Indian reser­ vation populations with national *data.American journal of Public Health* 93(10):1683-1685,

2003.

Bean, R.A., Perry, B.J., and Bedell, T.M. Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic *families.journal of Marital* & *Family Thera­ py* 27(1):43-54, 2001.

Beauvais, F., Wayman,J.C.,Jumper-Thurman, P., Plested, B., and Helm, H. Inhalant abuse

among American Indian, Mexican American, and non-Latino white adolescents. *The Ameri­ can journal of Drug and Alcohol Abuse* 28(1):171-187, 2002.

Beck, A.T., and Steer, R.A. *BAI, Beck Anxiety Inventory Manual.* San Antonio, TX: The Psycho­ logical Corporation, 1990.

Beck, A.T., Steer, R.A., and Brown, G.K. *Beck Depression Inventory* - *II Manual.* San Antonio, TX: The Psychological Corporation, 1996.

Becker, H.S. Becoming a marihuana *user.American journal of Sociology* 59(3):235, 1953. Bedregal, L.E., Sobell, L.C., Sobell, M.B., and Simco, E. Psychometric characteristics of a Span­

ish version of the DAST-10 and the RAGS. *Addictive Behaviors* 31:309-319, 2006.

Bell-Tolliver, L., Burgess, R., and Brock, L.J. African American therapists working with African American families: An exploration of the strengths perspective in *treatment.journal of Mari­*

*tal and Family Therapy* 35(3):293-307, 2009.

Bennett, L.A., and Cook, P.W. Alcohol and drug studies. In: Sargent, C.F., and Johnson, T.M., eds. *Handbook ofMedical Anthropology: Contemporary Theory and Method.* Revised ed. (pp.

235-251). Portsmouth, NH: Greenwood Publishing Group, 1996.

Benuto, L.T. *Guide to Psychological Assessment With Hispanics.* New York: Springer, 2012.

Berger, L. K., Zane, N., and Hwang, W-C. Therapist ethnicity and treatment orientation differ­ ences in multicultural counseling competencies. Asian American Journal of Psychology 5(1): 53-65, 2014.

Bergmark, K.H., and Kuendig, H. Pleasures of drinking: A cross-cultural *perspective.journal of*

*Ethnicity in Substance Abuse* 7(2):131-153, 2008.

Berlin, E.A., and Fowkes, W.C.,Jr. A teaching framework for cross-cultural health care. Applica­ tion in family practice. *The Western journal of Medicine* 139(6):934-938, 1983.

Bernal, G., and Domenech Rodriguez, M.M. *Cultural Adaptations: Tools for Evidence-Based Prac­ tice with Diverse Populations.* Washington, D.C: American Psychological Association, 2012.

184

Appendix A-Bibliography

Bernstein,]., Bernstein, E., Tassiopoulos, K., Heeren, T., Levenson, S., and Hingson, R. Brief motivational intervention at a clinic visit reduces cocaine and heroin use. *Drug and Alcohol Dependence* 77(1):49-59, 2005.

Berry,J.W. Acculturative stress. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 117-122). New York: Routledge, 1998.

Bezdek, M., and Spicer, P. Maintaining abstinence in a northern plains tribe. *Medical Anthropolo­ gy Quarterly* 20(2):160-181, 2006.

Bhugra, D., and Becker, M.A. Migration, cultural bereavement and cultural identity. *World Psy­ chiatry* 4(1):18-24, 2005.

Bhugra, D., and Gupta, S. Culture and its influence on diagnosis and management. In: Morgan, C., ed. *Principles of Social Psychiatry.* 2nd ed. (pp. 117-131). Hoboken, NJ: Wiley-Blackwell, 2010.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., and Bhugra, D. Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research* 7:15, 2007.

Bibb, A., and Casimer, G.J. Addiction recovery among West Indians. In: Krestan,J.A., ed. *Bridges to Recovery:Addiction, Family Therapy, and Multicultural Treatment* (pp.173-191). New York: The Free Press, 2000.

Bigby,]., and American College of Physicians. *Cross-Cultural Medicine.* Philadelphia: American College of Physicians, 2003.

Black, **D.W.,** Arndt, S., Hale, N., and Rogerson, **R.** Use of the Mini International Neuropsychiat­ ric Interview **(MINI)** as a screening tool in prisons: Results of a preliminary *study.journal of the American Academy of Psychiatry and the Law* 32:158-162, 2004.

Blackman, S.J. Has drug culture become an inevitable part of youth culture? A critical assessment of drug education. *Educational Review* 48(2):131-142, 1996.

Blake, A. Drugs and popular music in the modern age. In: Manning, P., ed. *Drugs and Popular Culture: Drugs, Media and Identity in Contemporary Society* (pp. 103-116). Devon, United Kingdom: Willan Publishing, 2007.

Bland, I.J., and Kraft, I. The therapeutic alliance across cultures. In: Okpaku, S.O., ed. *Clinical Methods in Transcultural Psychiatry* (pp. 266-278). Washington, DC: American Psychiatric Press, 1998.

Blendon, R.J., Buhr, T., Cassidy, E.F., Perez, *D.].,* Hunt, K.A., Fleischfresser, C., Benson,J.M., and Herrmann, M.J. Disparities in health: Perspectives of a multi-ethnic, multi-racial Ameri­ ca. *Health Affairs (Project Hope)* 26(5):1437-1447, 2007.

Bloomfield, K., Gmel, G., and Wilsnack, S. lntroduction to special issue: Gender, culture and alcohol problems: A multi-national study. *Alcohol and Alcoholism Supplement* 41(1):i3-i7, 2006.

Blume, A.W., Morera, O.F., and de la Cruz, B.G. Assessment of addictive behaviors in ethnic­ minority cultures. In: Donovan, D.M., and Marlatt, G.A., *eds.Assessment of Addictive Behav­ iors.* 2nd ed. (pp. 49-70). New York: Guilford Press, 2005.

185

Improving Cultural Competence

Bluthenthal, R.N.,Jacobson,J.O., and Robinson, P.L. Are racial disparities in alcohol treatment completion associated with racial differences in treatment modality entry? Comparison of outpatient treatment and residential treatment in Los Angeles County, 1998 to *2000.Alcohol­ ism: Clinical* & *Experimental Research* 31 (11 ):1920-1926, 2007.

Bonilla,]., Bernal, G., Santos, A., and Santos, D. A revised Spanish version of the Beck Depres­ sion Inventory: Psychometric properties with a Puerto Rican sample of college students.

*journal of Clinical Psychology* 60:119-130, 2004.

Bonnie, R.J., and Whitebread, C.H. The forbidden fruit and the tree of knowledge: An inquiry into the legal history of American marijuana prohibition. *Virginia Law Review* 56(6):971, 1970.

Borges, G., and Cherpitel, C.J. Selection of screening items for alcohol abuse and alcohol de­ pendence among Mexicans and Mexican Americans in the emergency *department.journal of Studies onAlcohol* 62:277-285, 2001.

Bourgois, P. *In Search of Respect: Selling Crack in El Barrio.* 2nd ed. New York: Cambridge Univer­ sity Press, 2003.

Bourgois, P.Just another night in a shooting gallery. *Theory, Culture* & *Society* 15(2):37-66, 1998. Bourgois, P., and Schonberg,]. Intimate apartheid: Ethnic dimensions ofhabitus among home­

less heroin injectors. *Ethnography* 8(1):7-31, 2007.

Bourgois, P., Martinez, A., Kral, A., Edlin, B.R., Schonberg,]., and Ciccarone, D. Reinterpreting ethnic patterns among White and African American men who inject heroin: A social science of medicine approach. *PLoS Medicine* 3:0001-0011, 2006.

Bowker, A. The 21st Century substance abuser: Cyberspace intersecting with the drug culture.

Scituate, MA: *Corrections Connection,* 2011.

Boyd-Franklin, N. *Black Families in Therapy: Understanding the African American Experience.* 2nd ed. New York: Guilford Press, 2003.

Boyd-Franklin, N., and Karger, M. Intersections of race, class, and poverty: Challenges and resili­ ence in African American families. In: *Normal Family Processes: Growing Diversity and Com­ plexity.* 4th ed. (pp. 273-296). New York: Guilford Press, 2012.

Boyd-Franklin, N., Kelly, S., and Durham,]. African-American couples in therapy. In: Gurman, A.S., ed. *Clinical Handbook of Couple Therapy* (pp. 681-697). New York: Guilford Press, 2008.

Brach, C., and Fraser, I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review* 57(Suppl 1):181-217, 2000.

Brady, M. Culture in treatment, culture as treatment: A critical appraisal of developments in addictions programs for indigenous North Americans and Australians. *Social Science* & *Medi­ cine* 41(11):1487-1498, 1995.

Brave Heart, M.Y.H. Gender differences in the historical trauma response among the Lakota.

*journal of Health* & *Social Policy* 10(4):1-20, 1999.

186

Appendix A-Bibliography

Brave Heart, M.Y.H. Culturally and historically congruent clinical social work assessment with native clients. In Fong, R., and Furuta, S. eds. *Cultural Competent Practice: Skills, Interventions, and Evaluation* (pp. 163-177). Reading, MA: Longman Publishers, 2001.

Brave Heart, M.Y.H., Chase,]., Elkins,]., and Altschul, D.B. Historical trauma among Indige­ nous peoples of the Americas: Concepts, research, and clinical considerations.journal*of Psy­ choactive Drugs* 43(4):282-290, 2011.

Brave Heart, M.Y.H., and Debruyn, L.M. The American Indian Holocaust: Healing historical unresolved *grief.American Indian and Alaska Native Mental Health Research,* 8(2):56-78, 1998.

Brecht, M.L., von Mayrhauser, C., and Anglin, M.D. Predictors of relapse after treatment for methamphetamine *use.journal of Psychoactive Drugs* 32(2):211-220, 2000.

Breslau, N., Davis, G.C., and Andreski, P. Risk factors for PTSD-related traumatic events: A prospective analysis. *The American journal of Psychiatry* 152(4):529-535, 1995.

Bresnahan, M., Begg, M.D., Brown, A., Schaefer, C., Sahler, N., Insel, B., Vella, L., and Susser, E. Race and risk of schizophrenia in a US birth cohort: Another example of health disparity?

*International journal of Epidemiology* 36:751-758, 2000.

Brisbane, F.L. Introduction: Diversity among African Americans. In: Brisbane, F.L., Epstein, L.G., Pacheco, G., and Qyinlan,J.W., eds. *Cultural Competence far Health Care Professionals Working With African-American Communities: Theory and Practice.* **CSAP** Cultural Compe­ tence Series 7 (pp. 1-8). Rockville, **MD:** Center for Substance Abuse Prevention, 1998.

Broekman, B.F.P., Nyunt, S.Z., Niti, M.,Jin, A.Z., Ko, S. M., Kumar, R. Fones C.S, and Ng, T.P. Differential item functioning of the Geriatric Depression Scale in an Asian population.jour­

*nal of Affective Disorders* 108:285-290, 2008.

Brower, K.J., and Carey, T.L. Racially related health disparities and alcoholism treatment out­ comes. *Alcoholism: Clinical* & *Experimental Research* 27(8):1365-1367,2003.

Brown, B.S., O'Grady, K., Battjes, R.J., and Farrell, E.V. Factors associated with treatment out­ comes in an aftercare population. *The American journal of Addiction* 13(5):447-460, 2004.

Broz, D., and Ouellet, L.J. Racial and ethnic changes in heroin injection in the United States: Implications for the HIV/AIDS epidemic. *Drug and Alcohol Dependence* 94(1-3):221-233, 2008.

Burgess, D.J., Ding, Y., Hargreaves, M., van Ryn, M., and Phelan, S. The association between

perceived discrimination and underutilization of needed medical and mental health care in a multi-ethnic community *sample.journal of Health Care far the Poor and Underserved* 19(3):894-911, 2008.

Butcher,J.N., Dahlstrom, **W.G.,** Graham,J.R., Tellegen, A., and Kaemmer, **B.** *The Minnesota Multiphasic Personality Inventory-2 (MMPI-2): Manual far Administration and Scoring.* Min­ neapolis, **MN:** University of Minnesota Press, 1989.

Butler, S.F., Redondo,J.P., Fernandez, K.C., and Villapiano, A. (2009). Validation of the Spanish Addiction Severity Index Multimedia Version (S-ASI-MV). *Drug and Alcohol Dependence* 99:18-27, 2009.

187

Improving Cultural Competence

Caetano, R. Alcohol-related health disparities and treatment-related epidemiological findings among Whites, Blacks, and Hispanics in the United *States.Alcoholism: Clinical* & *Experi­ mental Research* 27(8):1337-1339, 2003.

Caetano, R., and Clark, C.L. Trends in alcohol-related problems among Whites, Blacks, and Hispanics: *1984-1995.Alcoholism: Clinical and Experimental Research* 22(2):534-538, 1998.

Caetano, R., Ramisetty-Mikler, S., and Rodriguez, L.A. The Hispanic Americans baseline alco­

hol survey (HABLAS): Rates and predictors of alcohol abuse and dependence across His­ panic national *groups.journal of Studies on Alcohol and Drugs* 69(3):441-448, 2008.

Caetano, R., and Schafer,]. DSM-IV alcohol dependence in a treatment sample ofWhite, Black, and Mexican-American *men.Alcoholism: Clinical and Experimental Research* 20(2):384-390, 1996.

Calabrese,J.D. Clinical paradigm clashes: Ethnocentric and political barriers to Native American efforts at self-healing. *ETHOS* 36(3):334-353, 2008.

Calsyn, D.A., Saxon, A.J., and Daisy, F. Validity of the MCMI Drug Abuse Scale varies as a function of drug choice, race, and Axis II *subtypes.American journal of Drug and Alcohol Abuse* 17:153-159, 1991.

Campinha-Bacote,J., Claymore-Cuny, D., Cora-Bramble, D., Gilbert,]., Husbands, R.M., Like, R.C., Llerena-Qyinn, R., Lu, F.G., Soto-Greene, M.L., Stubblefield-Tave, B., and Tang, G.

*Transforming the Face of Health Professions Through Cultural and Linguistic Competence Educa­ tion: The Role of the HRSA Centers of Excellence.* Washington, DC: Health Resources and Ser­

vices Administration, 2005.

Canady, R.B., Stammel, M., and Holzman, C. Measurement properties of the centers for epide­ miological studies depression scale (CES-D) in a sample of African American and non­

Hispanic White pregnant *women.journal of Nursing Measurement* 17:91-104, 2009.

Canino, G. Alcohol use and misuse among Hispanic women: Selected factors, processes, and studies. *The International journal of the Addictions* 29(9):1083-1100, 1994.

Canino, G., Bravo, M., Ramirez, R., Febo, V.E., Rubio-Stipec, M., Fernandez, R.L., and Hasin,

D. The Spanish Alcohol Use Disorder and Associated Disabilities Interview Schedule (AUDADIS): Reliability and concordance with clinical diagnoses in a Hispanic population.

*journal of Studies onAlcohol* 60:790-799, 1999.

Canino, G., Vega, W.A., Sribney, W.M., Warner, L.A., and Alegria, M. Social relationships, social assimilation, and substance use disorders among adult Latinos in the United *States.journal of Drug Issues* 38(1):69-101, 2008.

Carbone-Lopez, K., Owens,J.G., and Miller,]. Women's "storylines" of methamphetamine ini­ tiation in the *Midwest.journal of Drug Issues* 42(3):226-246, 2012.

Cardemil, E.V., Moreno, 0., and Sanchez, M. One size does not fit all: Cultural considerations in evidence-based practice for depression. In: Springer, D.W., Rubin, A., and Beevers, C.G., eds.

*Treatment of Depression in Adolescents and Adults* (pp. 221-243). Hoboken, NJ: John Wiley &

Sons,2011.

188

Appendix A-Bibliography

Carise, D., and McLellan, A.T. *Increasing Cultural Sensitivity of the Addiction Severity Index (ASI): An example With Native Americans in North Dakota. Special Report.* Rockville, **MD:** Center for Substance Abuse Treatment, 1999.

Carle, A. Assessing the adequacy of self-reported alcohol abuse measurement across time and ethnicity: Cross-cultural equivalence across Hispanics and Caucasians in 1992, non­ equivalence in 2001-2002. *BMC Public Health* 9(1):60, 2009.

Carlson, R.G. Ethnography and applied substance misuse research: Anthropological and cross­ cultural factors. In: Miller, W.R., and Carroll, K.M., eds. *Rethinking Substance Abuse: What the Science Shows and What Ure Should Do About It* (pp. 201-219). New York: Guilford Press, 2006.

Carmody, D.P. Psychometric characteristics of the Beck Depression Inventory-II with college students of diverse ethnicity. *International journal of Psychiatry in Clinical Practice* 9:22-28, 2005.

Carnes, P.J., Murray, R.E., and Charpentier, L. Addiction interaction disorder. In: Coombs, R.H., ed. *Handbook of Addictive Disorders: A Practical Guide to Diagnosis and Treatment* (pp. 31-60). Hoboken, NJ: John Wiley & Sons, 2004.

Carpenter-Song, E., Whitley, R., Lawson, W., O!Jimby, E., and Drake, R.E. Reducing disparities in mental health care: Suggestions from the Dartmouth-Howard collaboration. *Community Mental Health journal* 47(1):1-13, 2011.

Carvajal, S.C., and Young, R.S. Culturally based substance abuse treatment for American Indi­ ans/Alaska natives and *Latinos.journal of Ethnicity in Substance Abuse* 8(3):207-222, 2009.

Case Management Society of America. *Standards of Practice far Case Management.* Little Rock, AR: Case Management Society of America, 2010.

Casswell, S., Pledger, M., and Hooper, R. Socioeconomic status and drinking patterns in young

*adults.Addiction* 98(5):601-610, 2003.

Castro, F.G. Cultural competence training in clinical psychology: Assessment, clinical interven­ tion, and research. In: Bellack, A.S., and Hersen, M., eds. *Comprehensive Clinical Psychology: Sociocultural and Individual Differences,* Vol. 10 (pp. 127-140). Oxford: Pergamon, 1998.

Castro, F.G., Cota, M.K., and Vega, S. Health promotion in Latino populations: Program plan­ ning, development, and evaluation. In: Huff, R.M., and Kline, M.V., eds. *Promoting Health in Multicultural Populations: A Handbook far Practitioners* (pp. 137-168). Thousand Oaks, CA: Sage Publications, *1999a.*

Castro, F.G., and Gutierres, S. (1997). Drug and alcohol use among rural Mexican Americans. In: Robertson, E.B., and National Institute on Drug Abuse, eds. *Rural Substance Abuse: State Of Knowledge and Issues* (pp. 498-530). Rockville, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, 1997.

Castro, F.G., and Murray, K.E. Cultural adaptation and resilience: Controversies, issues, and emerging models. In: Reich,J.W., Zautra, A.J., and Hall,J.S., eds. *Handbook of Adult Resilience* (pp. 375-403). New York: Guilford Press, 2010.

189

Improving Cultural Competence

Castro, F.G., Nichols, E., and Kater, K. Relapse prevention with Hispanic and other racial/ethnic populations: Can cultural resilience promote relapse prevention? In: Witkiewitz, K.A., and Marlatt, G.A., eds. *Therapist's Guide to Evidence-Based Relapse Prevention: Practical Resources for the Mental Health Professional* (pp. 259-292). Boston: Elsevier Academic Press, 2007.

Castro, F.G., Proescholdbell, R.J., Abeita, L., and Rodriguez, D. Ethnic and cultural minority groups. In: McCrady, B.S., and Epstein, E.E., *eds.Addictions:A Comprehensive Guidebook* (pp. 499-526). New York: Oxford University Press, *1999b.*

Castro, Y., Gordon, K.H., Brown,J.S., Anestis,J. C., and Joiner,]. Examination of racial differ­ ences on the MMPI-2 clinical and restructured clinical scales in an outpatient sample.As­ *sessment* 15:277-286, 2008.

Celenk, 0., and Van de Vijver, F. Assessment of acculturation: Issues and overview of measures.

*Online Readings in Psychology and Culture* 8(1), 2011.

Center for Substance Abuse Prevention. *Following Specific Guidelines Will Help You Assess Cultural Competence in Program Design, Application, and Management.* Technical Assistance Bulletin:1-

4. Rockville, MD: Center for Substance Abuse Prevention, 1994.

Center for Substance Abuse Prevention. *CSAP Implementation Guide: Hispanic/Latino Natural Support Systems.* HHS publication No. (SMA) 95-3033. Washington, DC: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Ser­ vices, 1995.

Center for Substance Abuse Treatment. *Improving Treatment for Drug-Exposed Infants.* Treat­ ment Improvement Protocol (TIP) Series *5.* HHS Publication No. (SMA) 95-3057. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, *1993a.*

Center for Substance Abuse Treatment. *Pregnant, Substance-Using Ulomen.* Treatment Improve­ ment Protocol (TIP) Series 2. HHS Publication No. (SMA) 93-1998. Rockville,MD: Sub­ stance Abuse and Mental Health Services Administration, *1993b.*

Center for Substance Abuse Treatment. *Screeningfor Infectious Diseases Among Substance Abusers.*

Treatment Improvement Protocol (TIP) Series 6. HHS Publication No. (SMA) 95-3060. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1993c.

Center for Substance Abuse Treatment. *Practical Approaches in the Treatment of Ulomen Who Abuse Alcohol and Other Drugs.* HHS Publication No. (SMA) 94-3006. Washington, DC: U.S. Gov­ ernment Printing Office, *1994a.*

Center for Substance Abuse Treatment. *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases.* Treatment Improvement Protocol (TIP) Series 11. HHS Publication No. (SMA) 94-2094. Rockville, MD: Substance Abuse and Mental Health Services Administration, *1994b.*

Center for Substance Abuse Treatment. *Alcohol and Other Drug Screening of Hospitalized Trauma Patients.* Treatment Improvement Protocol (TIP) Series 16. HHS Publication No. (SMA) 95-3041. Rockville, MD: Substance Abuse and Mental Health Services Administration, *1995a.*

190

Appendix A-Bibliography

Center for Substance Abuse Treatment. *Combining Alcohol and Other Drug Treatment with Diver­ sion far juveniles in the justice System.* Treatment Improvement Protocol (TIP) Series 21. HHS Publication No. (SMA) 95-3051. Rockville, MD: Substance Abuse and Mental Health Ser­ vices Administration, *1995b.*

Center for Substance Abuse Treatment. *Developing State Outcomes Monitoring Systems far Alcohol and Other Drug Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 14. HHS Publication No. (SMA) 95-3031. Rockville, MD: Substance Abuse and Mental Health Ser­ vices Administration, 1995*c.*

Center for Substance Abuse Treatment. *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 13.

HHS Publication No. (SMA) 95-3021. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1995*d.*

Center for Substance Abuse Treatment. *The Tuberculosis Epidemic: Legal and Ethical Issues far Alcohol and Other Drug Abuse Treatment Providers.* Treatment Improvement Protocol (TIP) Series 18. HHS Publication No. (SMA) 95-3047. Rockville, MD: Substance Abuse and Mental Health Services Administration, *1995e.*

Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing.* Treatment Improvement Protocol (TIP) Series 23. HHS Publication No. (SMA) 96-3113. Rockville,MD: Substance Abuse and Mental Health Services Administration, 1996.

Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services far Primary Care Clinicians.* Treatment Improvement Protocol (TIP) Series 24. HHS Publication No. (SMA) 97-3139. Rockville, MD: Substance Abuse and Mental Health Services Administration, *1997a.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Domestic Violence.* Treat­ ment Improvement Protocol (TIP) Series 25. HHS Publication No. (SMA) 97-3163. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, 1997*b.*

Center for Substance Abuse Treatment. *Comprehensive Case Management far Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 27. HHS Publication No. (SMA) 98-3222. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998a.

Center for Substance Abuse Treatment. *Continuity of Offender Treatment far Substance Use Disor­ ders From Institution to Community.* Treatment Improvement Protocol (TIP) Series 30. HHS Publication No. (SMA) 98-3245. Rockville, MD: Substance Abuse and Mental Health Ser­ vices Administration, 1998b.

Center for Substance Abuse Treatment. *Naltrexone and Alcoholism Treatment.* Treatment Im­ provement Protocol (TIP) Series 28. HHS Publication No. (SMA) 98-3206. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998c.

Center for Substance Abuse Treatment. *Substance Abuse Among Older Adults.* Treatment Im­ provement Protocol (TIP) Series 26. HHS Publication No. (SMA) 98-3179. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998d.

191

Improving Cultural Competence

Center for Substance Abuse Treatment. *Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities.* Treatment Improvement Protocol (TIP) Series 29. HHS Publica­ tion No. (SMA) 98-3249. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1998e.

Center for Substance Abuse Treatment. *Brief Interventions and Brief Therapies for Substance Abuse.*

Treatment Improvement Protocol (TIP) Series 34. HHS Publication No. (SMA) 99-3353.

Rockville, MD: Substance Abuse and Mental Health Services Administration, *1999a.*

Center for Substance Abuse Treatment. *Cultural Issues in Substance Abuse Treatment.* HHS Publi­ cation No. (SMA) 99-3278. Rockville, MD: Center for Substance Abuse Treatment, *1999b.*

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 35. HHS Publication No. (SMA) 99-3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999c.

Center for Substance Abuse Treatment. *Screening and Assessing Adolescents for Substance Use Disor­ ders.* Treatment Improvement Protocol (TIP) Series 31. HHS Publication No. (SMA) 99- 3282. Rockville, MD: Substance Abuse and Mental Health Services Administration, *1999d.*

Center for Substance Abuse Treatment. *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series 32. HHS Publication No. (SMA) 99-3283. Rockville, MD: Substance Abuse and Mental Health Services Administration, l *999e.*

Center for Substance Abuse Treatment. *Treatment for Stimulant Use Disorders.* Treatment Im­ provement Protocol (TIP) Series 33. HHS Publication No. (SMA) 99-3296. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999/

Center for Substance Abuse Treatment. *Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series 38. HHS Publication No. (SMA) 00-3470. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2000a.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues.* Treatment Improvement Protocol (TIP) Series 36. HHS Publication No. (SMA) 00-3357. Rockville, MD: Substance Abuse and Mental Health Services Administra­ tion, *2000b.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series 37. HHS Publication No. (SMA) 00-3459. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2000c.*

Center for Substance Abuse Treatment. *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, And Transgender Individuals.* HHS Publication No. (SMA) 01-3498. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2001.

Center for Substance Abuse Treatment. *Patterns of Substance Use Among Minority Youth and Adults in the United States:An Overview and Synthesis of National Survey Findings.* **NEDS** Analytic Summary Series #29, February 2002.

**192**

Appendix A-Bibliography

Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction.* Treatment Improvement Protocol (TIP) Series 40. HHS Pub­

lication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2004a.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Family Therapy.* Treat­ ment Improvement Protocol (TIP) Series 39. HHS Publication No. (SMA) 04-3957. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, *2004b.*

Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publi­ cation No. SMA 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2005a.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Adults in the Criminal justice System.* Treatment Improvement Protocol (TIP) Series 44. HHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administra­ tion, *2005b.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Group Therapy.* Treatment Improvement Protocol (TIP) Series 41. HHS Publication No. SMA 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2005c.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons with Co-Occurring Disorders.* Treatment Improvement Protocol (TIP) Series 42. HHS Publication No. SMA 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2005d.*

Center for Substance Abuse Treatment. *Detoxification and Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 45. HHS Publication No. SMA 06-4131. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2006a.*

Center for Substance Abuse Treatment. *Substance Abuse: Administrative Issues in Intensive Outpa­ tient Treatment.* Treatment Improvement Protocol (TIP) Series 46. HHS Publication No.

SMA 06-4151. Rockville, MD: Substance Abuse and Mental Health Services Administra­ tion, *2006b.*

Center for Substance Abuse Treatment. *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.* Treatment Improvement Protocol (TIP) Series 47. HHS Publication No. 06- 4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2006c.*

Center for Substance Abuse Treatment. *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery.* Treatment Improvement Protocol (TIP) Series 48. HHS Publication No. SMA 08-4353 Rockville, MD: Substance Abuse and Mental Health Services Admin­ istration, 2008.

Center for Substance Abuse Treatment. *Addressing Suicidal Thoughts and Behaviors With Clients in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series 50. HHS Publica­ tion No. SMA 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Ad­ ministration, *2009a.*

193

Improving Cultural Competence

Center for Substance Abuse Treatment. *Incorporating Alcohol Pharmacotherapies Into Medical Practice.* Treatment Improvement Protocol (TIP) Series 49. HHS Publication No. SMA 09- 4380. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2009b.*

Center for Substance Abuse Treatment. *Substance Abuse Treatment: Addressing the Specific Needs of Women.* Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. SMA 09- 4426 Rockville, MD: Substance Abuse and Mental Health Services Administration, *2009c.*

Center for Substance Abuse Treatment. *Supervision and the Professional Development of the Sub­ stance Abuse Counselor.* Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. SMA 09-4435. Rockville, MD: Substance Abuse and Mental Health Services Admin­ istration, *2009d.*

Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report­ United States, 2011. *Morbidity and Mortality lifleekly Report* 60(Suppl):1-109, 2011.

Chae, D.H., Takeuchi, D.T., Barbeau, E.M., Bennett, G.G., Lindsey,J.C., Stoddard, A.M., and Krieger, N. Alcohol disorders among Asian Americans: Associations with unfair treatment, racial/ethnic discrimination, and ethnic identification (the National Latino and Asian Ameri­ cans study, 2002-2003) *.journal of Epidemiology and Community Health* 62(11):973-979, 2008.

Chan, G.M., Hoffman, R.S., Gold,J.A., Whiteman, P.J., Goldfrank, L.R., and Nelson, L.S. Racial variations in the incidence of severe alcohol *withdrawal.journal of Medical Toxicology* 5(1):8-14, 2009.

Chan, S., and Chen, D. Families with Asian roots. In: Lynch, E.W., and Hanson, M.J., eds. *De­ veloping Cross-Cultural Competence: A Guide for Working With Children and Their Families.* 4th ed. (pp. 234-318). Baltimore: Paul H. Brookes Publishing, 2011.

Chang,]., Shrake, E., and Rhee, S. Patterns of alcohol use and attitudes toward drinking among Chinese and Korean American college *students.journal of Ethnicity in Substance Abuse* 7(3):341-356, 2008.

Chang, P. Treating Asian/Pacific American addicts and their families. In: Krestan,J.A., ed. *Bridg­ es to Recovery:Addiction, Family Therapy, and Multicultural Treatment* (pp. 192-218). New York: Free Press, 2000.

Chao, P.J., Steffen,].]., and Heiby, E.M. The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health journal* 48(1):91-97, 2012.

Chapleski, E.E., Lamphere,J.K., Kaczynski, R., Lichtenberg, P.A., and Dwyer,J.W. Structure of a depression measure among American Indian elders: Confirmatory factor analysis of the CES-D Scale. *Research on Aging* 19:462-485, 1997.

Chapman, L.K., Williams, S. R., Mast, E.T., and Woodruff-Borden,]. A confirmatory factor analysis of the Beck Anxiety Inventory in African American and European American young *adults.journalof Anxiety Disorders* 23:387-392, 2009.

Chappel, J.N. Spiritual components of the recovery process. In: Graham, A.W., and Wilford, B.B., eds. *Principles of Addiction Medicine.* 2nd ed. (pp. 725-728). Chevy Chase, MD: Ameri­ can Society of Addiction Medicine, 1998.

194

Appendix A-Bibliography

Charon,J.M. *Ten Questions: A Sociological Perspective.* 5th ed. Belmont, CA: Wadsworth, 2004.

Chatterji, S., Saunders,J.B., Vrasti, R., Grant, B.F., Hasin, D., and Mager, D. Reliability of the alcohol and drug modules of the Alcohol Use Disorder and Associated Disabilities Interview Schedule-Alcohol/Drug-Revised (AUDADIS-ADR): An international comparison. *Drug and Alcohol Dependence* 47:171-185, 1997.

Chavez, A.F., and Guido-DiBrito, F. Racial and ethnic identity and development. *New Directions for Adult and Continuing Education* 84:39-4 7, 1999.

Chen, C.P. Group counseling in a different cultural context: Several primary issues in dealing with Chinese clients. *Group* 19(1):45-55, 1995.

Cheng, T.C., and Robinson, M.A. Factors leading African Americans and Black Caribbeans to use social work services for treating mental and substance use disorders. Health & Social Work 38(2):99-109, 2013.

Cheng, A.T., Tien, A.Y., Chang, C.J., Brugha, T.S., Cooper,]. E., Lee, C.S. Compton, W., Liu,

C.Y., Yu, W.Y., and Chen, H.M. Cross-cultural implementation of a Chinese version of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) in Taiwan. *British journal of*

*Psychiatry* 178:567-572, 2001.

Cherpitel, C.J. Screening for alcohol problems in the emergency *department.Annals of Emergency Medicine* 26:158-166, 1995.

Cherpitel, C. J. Comparison of screening instruments for alcohol problems between Black and White emergency room patients from two regions of the country. *Alcoholism: Clinical and Ex­ perimental Research* 21:1391-1397. 1997.

Cherpitel, C.J. Emergency room and primary care services utilization and associated alcohol and drug use in the United States general *population.Alcohol and Alcoholism* 34:581-589, 1999.

Cherpitel, C.J. A brief screening instrument for problem drinking in the emergency room: The RAPS4.Journal of Studies on Alcohol 61:447-449, 2000.

Cherpitel, C.J. Screening for alcohol problems in the U.S. general population: Comparison of the CAGE, RAPS4, and RAPS4-Qf by gender, ethnicity, and service *utilization.Alcoholism: Clinical and Experimental Research* 26:1686-1691, 2002.

Cherpitel, C.J., and Bazargan, S. Screening for alcohol problems: Comparison of the audit, RAPS4 and RAPS4-Qf among African American and Hispanic patients in an inner city emergency department. *Drug and Alcohol Dependence* 71:275-280, 2003.

Cherpitel, C.J., and Borges, G. Performance of screening instruments for alcohol problems in the ER: A comparison of Mexican-Americans and Mexicans in *Mexico.American journal of*

*Drug and Alcohol Abuse* 26:683-702, 2000.

Cherpitel, C.J., Robertson, M., Ye, Y., Borges, G., Bautista, C.F., Lown, A., Greenfield, T., and Bond,]. Comorbidity for alcohol use disorders and drug use in Mexican-origin groups: Comparison of data from national alcohol surveys in the U.S. and Mexico. *Substance Use* & *Misuse* 42(11):1685-1703, 2007.

195

Improving Cultural Competence

Cherpitel, C.J., Ye, Y., Moskalewicz,J., and Swiatkiewicz, G. Screening for alcohol problems in two emergency service samples in Poland: Comparison of the RAPS4, CAGE and AUDIT. *Drug and Alcohol Dependence* 80:201-207, 2005.

Cheung, S. Asian American immigrant mental health: Current status and future directions. In: Chin.J.L., ed. *Diversity in Mind and in Action, Vol 1: Multiple Faces of Identity* (pp. 87-104). Santa Barbara, CA: Praeger/ABC-CLIO, 2009.

Chi, I., Lubben,J.E., and Kitano, H.H. Differences in drinking behavior among three Asian­ American *groups.journalof Studies onAlcohol* 50(1):15-23, 1989.

Chaney, S.K., Berryhill-Paapke, E., and Robbins, R.R. The acculturation of American Indians:

Developing frameworks for research and practice. In: Ponterotto,J.G., Casas,J.M., Suzuki, L.A., and Alexander, C.M., eds. *Handbook of Multicultural Counseling* (pp. 73-92). Thousand Oaks, CA: Sage Publications, 1995.

Chong,]., and Herman-Stahl, M. Substance abuse treatment outcomes among American Indians in the telephone aftercare *project.journal of Psychoactive Drugs* 35(1):71-77, 2003.

Chong,]., and Lopez, D. Social networks, support, and psychosocial functioning among Ameri­ can Indian women in treatment. *American Indian and Alaska Native Mental Health Research* 12(1):62-85, 2005.

Chow,J.C.,Jaffee, K., and Snowden, L. Racial/ethnic disparities in the use of mental health services in poverty *areas.American journal of Public Health* 93(5):792-797, 2003.

Cochrane, R., and Bal, S. The drinking habits of Sikh, Hindu, Muslim and White men in the West Midlands: A community survey. *British journal of Addiction* 85(6):759-769, 1990.

Cohen, K. *Honoring the Medicine: The Essential Guide to Native American Healing.* New York: Ballantine Books, 2003.

Cohen, P.Junky elend: Some ways of explaining it and dealing with it. *Wiener Zeitschrift Fur Suchtforschung* 14, 1991(3-4):59-64, 1992.

Cokley, K., and Williams, W. A psychometric examination of the Africentric Scale: Challenges in measuring Afrocentric *values.journal of Black Studies* 35(6):827-843, 2005.

Cole, S.R., Kawachi, I., Maller, S.J., and Berkman, L.F. Test of item-response bias in the CES-D scale: Experience from the New Haven EPESE *Study.journal of Clinical Epidemiology* 53:285-289, 2000.

Colistra, A., and Brown-Rice, K. *When the Rubber Hits the Road· Applying Multicultural Compe­ tencies in Cross-Cultural Supervision.* Alexandria, VA: American Counseling Association, 2011.

Comas-Diaz, L. *Multicultural Care:A Clinician's Guide to Cultural Competence* (pp. 33-56). Wash­ ington, DC: American Psychological Association, 2012.

Congress, E.P. The use of culturagrams to assess and empower culturally diverse families. *Fami­ lies in Society* 75(9):531-540, 1994.

196

Appendix A-Bibliography

Congress, E.P. Cultural and ethical issues in working with culturally diverse patients and their families: The use of the culturagram to promote cultural competent practice in health care settings. *Social Work in Health Care* 39(3-4):249-262, 2004.

Congress, E.P., and Kung, W.W. Using the culturagram to assess and empower culturally diverse families. In: Congress, E.P., and Gonzalez, M.J., eds. *Multicultural Perspectives in Working With Families.* 2nd ed. (pp. 3-21). New York: Springer, 2005.

Constantine, M.G., and Sue, D.W. *Strategies for Building Multicultural Competence in Mental Health and Educational Settings.* Hoboken, NJ: John Wiley & Sons, 2005.

Cook, C.C.H. Addiction and *spirituality.Addiction* 99(5):539-551, 2004.

Cooper, L.A., Brown, C., Vu, H.T., Ford, D.E., and Powe, N.R. How important is intrinsic spir­ ituality in depression care? A comparison ofWhite and African-American primary care pa­

*tients.journal of General Internal Medicine* 16(9):634-638, 2001.

Cooper, L.A., Gonzales,J.J., Gallo,J.J., Rost, K.M., Meredith, L.S., Rubenstein, L.V., Wang, N.Y., and Ford, D.E. The acceptability of treatment for depression among African­ American, Hispanic, and White primary care patients. *Medical Care* 41(4):479-489, 2003.

Cooper-Patrick, L., Gallo,J.J., Powe, N.R., Steinwachs, D.S., Eaton, W.W., and Ford, D.E. Men­ tal health service utilization by African Americans and Whites: The Baltimore epidemiologic catchment area follow-up. *Medical Care* 37(10):1034-1045, 1999.

Corbett, K., Mora,]., and Ames, G. Drinking patterns and drinking-related problems of Mexi­ can-American husbands and *wives.journal of Studies onAlcohol* 52(3):215-223, 1991.

Corbin, W.R., Vaughan, E.L., and Fromme, K. Ethnic differences and the closing of the sex gap in alcohol use among college-bound students. *Psychology of Addictive Behaviors* 22(2):240- 248, 2008.

Cormier, L.S., Nurius, P., and Osborn, C.J. *Interviewing and Change Strategies for Helpers: Fun­ damental Skills and Cognitive Behavioral Interventions.* 6th ed. Belmont, CA: Brooks/Cole, Cengage Learning, 2009.

Cornell, S., and *Kalt,J.P.American Indian Seif-Determination:The Political Economy of a Succesiful Policy.* Cambridge, MA: Harvard University, 2010.

Corrigan, P.W., Kuwabara, S.A., and O'Shaughnessy,J.The public stigma of mental illness and drug addiction: Findings from a stratified random *sample.journal of Social Work* 9(2):139- 147, 2009.

Cortes, D.E., and Rogler, L.H. Biculturality among Puerto Rican adults in the United States.

*American journal of Community Psychology* 22:707-722, 1994.

Cottler, L.B. *Composite International Diagnostic Interview* - *Substance Abuse Module (SAM).* St. Louis, MO: Washington University School of Medicine, Department of Psychiatry, 2000.

Council of National Psychological Associations for the Advancement of Ethnic Minority Inter­ ests. *Psychology Education and Trainingfrom Culture-Specific and Multiracial Perspectives: Critical Issues and Recommendations.* Washington, **DC:** American Psychological Association, 2009.

197

Improving Cultural Competence

Coyhis, D. Culturally specific addiction recovery for Native Americans. In: Krestan,J., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment* (pp. 77-114). New York: The Free Press, 2000.

Coyhis, D., and Simonelli, R. Rebuilding Native American communities. *Child Welfare*

###### 84(2):323-336, 2005.

Coyhis, D.L., and White, W.L. *Alcohol Problems in Native America: The Untold Story of Resistance and Recovery -"The Truth About the Lie."* Colorado Springs, CO: White Bison, Inc., 2006.

Craig, R.J., and O Ison, R. Stability of the MCMI-III in a substance-abusing inpatient sample.

*Psychological Reports* 83(3, Pt 2):1273-1274, 1998.

Cremonte, M., and Cherpitel, C.J. Performance of screening instruments for alcohol use disor­ ders in emergency department patients in Argentina. *Substance Use and Misuse* 43:125-138 2008.

Crissey, S.R. Educational attainment in the United States: 2007. In: *Current Population Reports: US. Census Bureau.* Washington, DC: U.S. Census Bureau, 2009.

Crocker,]., Luhtanen, R., Blaine, B., and Broadnax, S. Collective self-esteem and psychological well-being among White, Black, and Asian college students. *Personality and Social Psychology Bulletin* 20:503-513, 1994.

Cross, **T.L.,** Bazron, **B.J.,** Dennis, **K.W.,** and Isaacs, **M.R.** *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed, Vol. 1.* Washington, DC: Georgetown University Child Development Center,

###### 1989.

Cross, W.E. The psychology of nigrescence: Revising the Cross model. In: Ponterotto,J.G., Casas,J.M., Suzuki, L.A., and Alexander, C.M., eds. *Handbook of Multicultural Counseling* (pp. 93-122). Thousand Oaks, CA: Sage, 1995.

Crum, R.M. The epidemiology of addictive disorders. In: Graham, A.W., Schultz, T.K., Mayo­ Smith, M.F., Ries, R.K., and Wilford, B.B., eds. *Principles of Addiction Medicine* (pp. 17-31). Chevy Chase, MD: American Society of Addiction Medicine, 2003.

Cuellar, I., Arnold, B., and Maldonado, R. Acculturation Rating Scale for Mexican Americans II: A revision of the original ARSMA scale. *Hispanic journal of Behavioral Sciences* 17:275-304, 1995.

Cuellar, I., Harris, L.C., and Jasso, R. An acculturation scale for Mexican American normal and clinical populations. Hispanic Journal of Behavioral Sciences 2:199-217, 1980.

Curtis-Boles, H., and Jenkins-Monroe, V. Substance abuse in African American *women.journal*

*of Black Psychology* 26(4):450-469, 2000.

Daeppen,J.B., Burnand, B., Schnyder, C., and Bonjour, M. Validation of the addiction severity index in French-speaking alcoholic *patients.journal of Studies on Alcohol* 57:585-590, 1996.

Dai, Y., Zhang, S., Yamamoto,]., Ao, M., Belin, T.R., Cheung, F., and Hifumi, S.S. Cognitive behavioral therapy of minor depressive symptoms in elderly Chinese Americans: A pilot study. *Community Mental Health]ournal35(6):537-542,*1999.

198

Appendix A-Bibliography

Dakof, G.A., O!Jille, T.J., Tejeda, M.J., Alberga, L.R., Bandstra, E., and Szapocznik,J. Enrolling and retaining mothers of substance-exposed infants in drug abuse *treatment.journal of Con­ sulting* & *Clinical Psychology* 71(4):764-772, 2003.

Damashek, A., Bard, **D.,** and Hecht, **D.** Provider cultural competency, client satisfaction, and engagement in home-based programs to treat child abuse and neglect. *Child Maltreatment* 17(1):56-66, 2012.

Dana, R.H. *Understanding Cultural Identity in Intervention and Assessment.* Thousand Oaks, CA: Sage Publications, 1998.

D'Andrea, W. Psychology of European American adults: Challenges, advantages, and the push for further growth. In: Downey, C.A., ed. *Handbook of Race and Development in Mental Health* (pp. 223-241). New York: Springer Science+ Business Media, 2012.

Dansereau, D.F., and Simpson, D.D. A picture is worth a thousand words: The case for graphic representations. *Professional Psychology: Research and Practice* 40(1):104-110, 2009.

Dansereau, D.F.,Joe, G.W., Dees, S.M., and Simpson, D.D. Ethnicity and the effects of map­ ping-enhanced drug abuse *counseling.Addictive Behaviors* 21(3):363-376, 1996.

D'Avanzo, C.E., Frye, B., and Froman, R. Culture, stress and substance use in Cambodian refu­ gee *women.journal of Studies on Alcohol* 55(4):420-426, 1994.

Davidson, L., Andres-Hyman, R., Bedregal, L., Tondora,J., Fry,]., and Kirk, T.A. From double

trouble to dual recovery: Integrating models of recovery in addiction and mental *health.jour­ nal of Dual Diagnosis* 9(1):273-290, 2008.

Dawson, D.A., Grant, B.F., Stinson, F.S., and Chou, P.S. Estimating the effect of help-seeking on achieving recovery from alcohol *dependence.Addiction* 101(6):824-834, 2006.

Dawson, D.A., Grant, B.F., Stinson, F.S., Chou, P.S., Huang, B., and Ruan, W.J. Recovery from DSM-IV alcohol dependence: United States, 2001-2002. *Addiction* 100(3):281-292, 2005.

de Korin, E.C., and Petry, S.S.d.C. Brazilian families. In: *Ethnicity and Family Therapy.* 3rd ed. (pp. 166-177). New York: Guilford Press, 2005.

De La Rosa, M. Acculturation and Latino adolescents substance use: A research agenda for the future. *Substance Use* & *Misuse* 37(4):429-456, 2002.

De La Rosa, M., Vega, R., and Radisch, M.A. The role of acculturation in the substance abuse behavior of African-American and Latino adolescents: Advances, issues, and recommenda­

*tions.journal of Psychoactive Drugs* 32(1):33-42, 2000.

Deloria, V. *God Is Red·A Native View of Religion.* New York: Dell Publishing, 1973.

Delphin-Rittmon, M.E., Andres-Hyman, R., Flanagan, E.H., and Davidson, L. Seven essential strategies for promoting and sustaining systemic cultural competence. *Psychiatric Quarterly* 84(1):53-64, *2012a.*

Delphin-Rittmon, M., Andres-Hyman, R., Flanagan, E.H., Ortiz,]., Amer, M.M., and Da­ vidson, L. Racial-ethnic differences in referral source, diagnosis, and length of stay in inpa­ tient substance abuse treatment. *Psychiatric Services* 63(6):612-615, *2012b.*

199

Improving Cultural Competence

DeNavas-Walt, C., Proctor, B.D., and Lee, C.H. *Income, Poverty, and Health Insurance Coverage in the United States: 2005.* (pp. 60-229). Washington, DC: U.S. Government Printing Office, 2006.

Dessio, W., Wade, C., Chao, M., Kronenberg, F., Cushman, L.E., and Kalmuss, D. Religion, spirituality, and healthcare choices of African-American women: Results of a national survey. *Ethnicity and Disease* 14(2):189-197, 2004.

de Torres, L.A., Rebollo, E.M., Ruiz-Moral, R., Fernandez-Garcia,J.A., Vega, R.A., and Palomi­ no, M.M. Diagnostic usefulness of the Alcohol Use Disorders Identification Test (AUDIT) questionnaire for the detection of hazardous drinking and dependence on alcohol among

Spanish patients. *European journal of General Practice* 15:15-21, 2009.

Diwan, S.,Jonnalagadda, **S.S.,** and Gupta, **R.** Differences in the structure of depression among older Asian Indian immigrants in the United *States.journal of Applied Gerontology* 23:370- 384, 2004.

Dixon, M., and Iron, **P.E.** *Strategies far Cultural Competency in Indian Health Care.* Washington,

**DC:** American Public Health Association, 2006.

Dixon, L., Lewis-Fernandez, R., Goldman, H., lnterian, A., Michaels, A., and Kiley, M.C. Ad­ herence disparities in mental health: Opportunities and *challenges.journal of Nervous and Mental Disease* 199(10):815-820, 2011.

Dogra, N., and Karim, K. Diversity training for psychiatrists. In: Bhattacharya, R. Cross, S., and Bhugra, D., eds. *Clinical Topics in Cultural Psychiatry* (pp. 348-365). London: Royal College of Psychiatrists, 2010.

Donisi, V.,Tedeschi, F.,Percudani, M., Fiorillo, A., Confalonieri, L., De Rosa, C., Salazzari, D., Tansella, M., Thornicroft, G., and Amaddeo, F. Prediction of community mental health ser­ vice utilization by individual and ecological level socio-economic factors. *Psychiatry Research* 209(3): 691-698, 2013.

Downey, C.A., and D'Andrea, W. Psychology of European American adults: Challenges, ad­ vantages, and the push for further growth. In: Chang, E.C., and Downey, C.A., eds. *Handbook*

*of Race and Development in Mental Health* (pp. 223-241). New York: Springer Science, 2012.

Drake, R. E., McHugo, G.J., and Biesanz,J. C. The test-retest reliability of standardized instru­ ments among homeless persons with substance use *disorders.journal of Studies on Alcohol* 56:161-167, 1995.

Dreachslin,J.L., Gilbert, **M.J.,** and Malone, **B.** *Diversity and Cultural Competence in Health Care: A Systems Approach.* 1st ed. San Francisco: Jossey-Bass, 2013.

200

Appendix A-Bibliography

Duffy, F.F., West,J.C. Wilk,]. Narrow, W.E., Hales, D., Thompson,]., Regier, D.A., Kohout,].,

Pion, G.M., Wicherski, M.M., Bateman, N., Whitaker, T., Merwin, E.I., Lyon, D., Fox,J.C., Delaney, K.R., Hanrahan, N., Stockton, R., Garbelman,J., Kaladow,J., Clawson, T.W., Smith, S.C., Bergman, D.M., Northey, W.F., Blankertz, L., Thomas, A., Sullivan, L.D., Dwyer, K.P., Fleischer, M.S., Woodruff, C.R., Goldsmith, H.F., Henderson, M.J., Atay,J.J., and Mander­ scheid, R.W. Mental health practitioners and trainees. In: Manderscheid, R.W., and Hender­ son, M.J., eds. *Mental Health, United States, 2002* (pp. 327-368). HHS Publication No. (SMA) 3938. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.

Dugger, K. Social location and gender-role attitudes: A comparison of Black and White women.

In: Lorber,]., and Farrell, S.A., eds. *The Social Construction of Gender* (pp. 38-59). Newbury

Park, CA:Sage Publications, 1991.

Duran, B., Duran, E., and Brave Heart, M.Y.H. Native Americans and trauma of history. In: Thornton, R., ed. *Studying Native America: Problems and Prospects* (pp. 60-76). Madison, WI: University ofWisconsin Press, 1998.

Duran, E.G., Oetzel,]., Lucero,J.,Jiang, Y., Novins, D.K., Manson, S., and Beals,]. Obstacles for rural American Indians seeking alcohol, drug, or mental health *treatment.journal of Consult­ ing and Clinical Psychology* 73(5):819-829, 2005.

Duran, E.G., Wallerstein, N., and Miller, W.R. New approaches to alcohol interventions among American Indian and Latino communities: The experience of the Southwest Addictions Re­ search Group. *Alcoholism Treatment Quarterly* 25(4):1-10, 2007.

Duran, E. *Healing the Soul Wound: Counseling With American Indians and Other Native Peoples (Multicultural Foundations of Psychology and Counseling).* New York: Teachers College Press,

2006.

Durant, A. African-American alcoholics: An interpretive/constructivist model of affiliation with Alcoholics Anonymous *(AA).]ournal of Ethnicity in Substance Abuse* 4(1):5-21, 2005.

Dutton, G. R., Grothe, K. B.,Jones, G. N., Whitehead, D., Kendra, K., and Brantley, P.J. Use of the Beck Depression Inventory-II with African American primary care patients. *General Hospital Psychiatry* 26:437-442, 2004.

Ebberhart, N.C., Luczak, S.E., Avanecy, N., and Wall, T.L. Family history of alcohol dependence in Asian *Americans.journal of Psychoactive Drugs* 35(3):375-377, 2003.

Edberg, M.C. *El Narcotraficante: Narcocorridos and the Construction of a Cultural Persona on the US. Mexican Border.* Austin, TX: University ofTexas Press, 2004.

Edwards, E.D., and Egbert-Edwards, M. Community development with American Indians and Alaska Natives. In: Rivera, F.G., and Erlich,J.L., eds. *Community Organizing in a Diverse So­ ciety.* 3rd ed. (pp. 25-42). Boston: Allyn & Bacon, 1998.

Edwards, E.D., Seaman,J.R., Drews,]., and Edwards, M.E. A community approach for Native American drug and alcohol prevention programs: A logic model *framework.Alcoholism Treatment Quarterly* 13(2):43-62, 1995.

Edwards, Y. Cultural connection and transformation: substance abuse treatment at Friendship

*House.journal of Psychoactive Drugs* 35(1):53-58, 2003.

201

Improving Cultural Competence

Ehlers, C.L., Hurst, S., Phillips, E., Gilder, D.A., Dixon, M., Gross, A., Lau, P., and Yehuda, R. Electrophysiological responses to affective stimuli in American Indians experiencing trauma with and without *PTSD.Annals of the New York Academy of Sciences* 1071:125-136, 2006.

Ennis, S.R., Rios-Vargas, M., and Albert, N.G. *The Hispanic Population: 2010.* Census 2010 Brie£ Washington, DC: U.S. Census Bureau, 2011.

Esan, 0. Echoes of drug culture in urban music. In: Manning, P., ed. *Drugs and Popular Culture: Drugs, Media and Identity in Contemporary Society* (pp. 196-210). Devon, United Kingdom: Willan Publishing, 2007.

Escobar,J.I., and Vega, W.A. Mental health and immigration's AAAs: where are we and where do we go from here? *journal of Nervous and Mental Disease* 188(11):736-740, 2000.

Evans, E., Pierce,]., Li, L., Rawson, R., and Hser, Y.I. More alike than different: Health needs, services utilization, and outcomes of Asian American and Pacific Islander (AAPI) popula­ tions treated for substance use *disorders.journal of Ethnicity in Substance Abuse* 11(4):318- 338, 2012.

Evans-Campbell,T. Historical trauma in American Indian/Native Alaska communities: A multi­ level framework for exploring impacts on individuals, families, and *communities.journal of Interpersonal Violence* 23(3):316-338, 2008.

Ewing,J.A. Detecting alcoholism. The CAGE questionnaire.journal *of the American Medical Association* 252:1905-1907,1984.

Eytan, A., Durieux-Paillard, S., Whitaker-Clinch, B., Loutan, L., and Bovier, P.A. Transcultural validity of a structured diagnostic interview to screen for major depression and posttraumatic stress disorder among *refugees.journal of Nervous and Mental Disease* 195:723-728, 2007.

Fadiman, A. *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision ofTwo Cultures.* 1st ed. New York: Farrar, Straus, and Giroux, 1997.

Falck, R.S., Wang,]., and Carlson, R.G. Among long-term crack smokers, who avoids and who succumbs to cocaine addiction? *Drug and Alcohol Dependence* 98(1-2):24-29, 2008.

Falicov, C.J. Mexican Families. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds.

*Ethnicity and Family Therapy.* 3rd ed. (pp. 229-241). New York: Guilford Press, 2005.

Falicov, CJ Immigrant family processes: A multidimensional framework. In: Walsh, F., ed. *Nor­ mal Family Processes: Growing Diversity and Complexity.* 4th ed. (pp. 297-323). New York: Guilford Press, 2012.

Farley, M., Golding,J.M., Young, G., Mulligan, M., and Minkoff,J.R. Trauma history and relapse probability among patients seeking substance abuse *treatment.journal of Substance Abuse Treatment* 27(2):161-167, 2004.

Farver,J.A., Narang, **S.K.,** and Bhadha, **B.R.** East meets West: Ethnic identity, acculturation, and conflict in Asian Indian *families.journal of Family Psychology* 16(3):338-350, 2002.

Feidler, **K.,** Screen, A., Greenfield, **L.,** and Fountain, **D.** *Analysis of Three Outcome Proxies for Post­ Treatment Substance Use in NTIES.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2001.

202

Appendix A-Bibliography

Fekjaer, H.O. *The Psychology of"Getting High."* Colombo, Sri Lanka: ADIC, 1994.

Felix-Ortiz, M., Newcomb, M.D., and Myers, H. A multidimensional measure of cultural identi­ ty for Latino and Latina adolescents. *Hispanic journal of Behavioral Sciences* 16:99-115, 1994.

Fellner,]. Race, drugs and law enforcement in the United States. *Staeford Law and Policy Review*

20(2):257-292, 2009.

Fernandez-Montalvo,]., Landa, N., Lopez-Goni,J.J., and Lorea, I. Personality disorders in alcoholics: A comparative pilot study between the IPDE and the *MCMI-II.Addictive Behav­ iors* 31:1442-1448, 2006.

Field, C., and Caetano, R. The role of ethnic matching between patient and provider on the effectiveness of brief alcohol interventions with *Hispanics.Alcoholism: Clinical* & *Experi­ mental Research* 34(2):262-271, 2010.

Field, L. D., Chavez-Korell, S., and Domenech Rodriguez, M.M. No hay rosas sin espinas: Con­ ceptualizing Latina-Latina supervision from a multicultural developmental supervisory mod­ el. *Training and Education in Professional Psychology* 4(1):47-54, 2010.

Fiorentine, R., and Hillhouse, M.P. Drug treatment effectiveness and client-counselor empathy: Exploring the effects of gender and ethnic *congruency.journal of Drug Issues* 29(1):59-74, 1999.

Fisher, D.G., Lankford, B.A., and Galea, R.P. Therapeutic community retention among Alaska Natives: Akeela *house.journal of Substance Abuse Treatment* 13(3):265-271, 1996.

Flores-Ortiz, Y.G. The role of cultural and gender values in alcohol use patterns among Chica­ na/Latina high school and university students: Implications for AIDS prevention. *The Inter­ national journal of the Addictions* 29(9):1149-1171, 1994.

Flynn, A.M., Alvarez,J.,Jason, L.A., Olson, B.D., Ferrari,J.R., and Davis, M.I. African Ameri­ can Oxford House residents: Sources of abstinent social *networks.journalof Prevention* & *In­ tervention in the Community* 31(1-2):111-119,2006.

Folwarski,J., and Smolinski,]. Polish Families. In: McGoldrick, M., Giordano,]., and Garcia­ Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 741-755). New York: Guilford Press, 2005.

Fontes, L.A. *Interviewing Clients Across Cultures: A Practitioner's Guide.* New York: Guilford Press, 2008.

Ford,J.A., and Arrastia, M.C. Pill-poppers and dopers: A comparison of non-medical prescrip­ tion drug use and illicit/street drug use among college *students.Addictive Behaviors* 33(7):934-941, 2008.

Fortney,]., Mukherjee, S., Curran, G., Fortney, S., Han, X., and Booth, B.M. Factors associated with perceived stigma for alcohol use and treatment among at-risk drinkers. *The journal of Behavior Health Services* & *Research* 31(4):418-429, 2004.

Fortuna, L.R., Alegria, M., and Gao, S. Retention in depression treatment among ethnic and racial minority groups in the United States. *Depression and Anxiety* 27(5):485-494, 2010.

203

Improving Cultural Competence

Fowler, D.M., Glenwright, B.J., Bhatia, M., and Drapeau, M. Counselling expectations of a sample of East Asian and Caucasian Canadian undergraduates in Canada. *Canadian journal*

*of Counselling and Psychotherapy/Revue Canadienne de Counseling et de Psychotherapie*

45(2):151-167, 2011.

Fragoso,]. M. and Kashubeck, S. Machismo, gender role conflict, and mental health in Mexican American men. *Psychology of Men and Masculinity* 1:87-97, 2000.

Frake, C.O. The diagnosis of disease among the Subanun of *Mindanao.American Anthropologist*

63(1):113-132, 1961.

Frank, D., DeBenedetti, A.F., Volk, R.J., Williams, E.C., Kivlahan, D.R., and Bradley, K.A. Effectiveness of the AUDIT-Casa screening test for alcohol misuse in three race/ethnic

*groups.journal of General Internal Medicine* 23:781-787, 2008.

Frank,J.W., Moore, R.S., and Ames, G.M. Historical and cultural roots of drinking problems among American *Indians.American journal of Public Health* 90(3):344-351, 2000.

Franks, P.H. *Silence/Listening and Intercultural Differences.* Presented at the Twenty-First Annual International Listening Association Convention. March 8, 2000. Virginia Beach, VA, 2000.

Fredlund, E.V. *Volatile Substance Abuse Among the Kickapoo People in the Eagle Pass, Texas Area, 1993.* Research Briefs. Austin, TX: Texas Commission on Alcohol and Drug Abuse (TCADA), 1994.

French, L.A. *Addictions and Native Americans.* Westport, CT: Praeger, 2000.

Friedman, M.J., Ashcraft, M.L., Beals,J.L., Keane, T.M., Manson, S.M., and Marsella, *A.].*

*Matsunaga Vietnam Veterans Project,* Vols. 1 and 2. White River Junction, VT: National Cen­ ter for Posttraumatic Stress Disorder and National Center for American Indian and Alaska Native Mental Health Research, 1997.

Fujisawa, D., Nakagawa, A., Tajima, M., Sado, M., Kikuchi, T., Hanaoka, M., and Ono, Y. Cogni­ tive behavioral therapy for depression among adults in Japanese clinical settings: A single­ group study. *BMC Research Notes* 3:160, 2010.

Fung, K., Lo, H.T., Srivastava, R., and Andermann, L. Organizational cultural competence con­ sultation to a mental health institution. *Transcultural Psychiatry* 49(2):165-184, 2012.

Gache, P., Michaud, P., Landry, U., Accietto, C., Arfaoul, S., Wenger, 0., and Daeppen,J.B. The Alcohol Use Disorders Identification Test (AUDIT) as a screening tool for excessive drink­ ing in primary Care: Reliability and validity of a French *version.Alcoholism: Clinical and Ex­ perimental Research* 29:2001-2007, 2005.

Gahlinger, **P.M.** *The Sagebrush Medical Guide to Illegal Drugs.* 1st ed. Las Vegas, NV: Sagebrush Press, 2001.

Gallardo, M.E., and Curry, S.J. Shifting perspectives: Culturally responsive interventions with Latino substance *abusers.journal of Ethnicity in Substance Abuse* 8(3):314-329, 2009.

Gallardo, M.E., Yeh, C.J., Trimble,J.E., and Parham, T.A. *Culturally Adaptive Counseling Skills: Demonstrations of Evidence-Based Practices.* Thousand Oaks, CA: Sage Publications, 2012.

204

Appendix A-Bibliography

Galvan F.H., and Caetano R. Alcohol use and related problems among ethnic minorities in the United *States.Alcohol Research* & *Health* 27(1):87-94, 2003.

Garcia, M. and Marks, G. Depressive symptomatology among Mexican-American adults: An examination with the CES-D Scale. *Psychiatry Research* 27:137-148, 1989.

Garrett, M.T. Sound of the drum: Group counseling with Native Americans. In: DeLucia­ Waack,J.L., Gerrity, D.A., Kalodner, C.R., and Riva, M.T., eds. *Handbook of Group Counsel­*

*ing and Psychotherapy* (pp. 169-182). Thousand Oaks, CA: Sage Publications, 2004.

Garrett, M.T., Garrett,]., and Brotherton, D. Inner circle/outer circle: A group technique based on Native American healing *circles.journal far Specialists in Group Work* 26:17-30, 2001.

Garrett, M. T. and Pichette, E. F. Red as an apple: Native American acculturation and counseling with or without reservation.journal*of Counseling and Development* 78:3-13, 2000.

Garrett, M.T., Portman, T. A.A., Williams, C., Grayshield, L., Rivera, E.T., and Parrish, M. Native American adult lifespan perspectives: Where power moves. In: Chang, E.C., ed.

*Handbook of Race and Development in Mental Health* (pp. 107-126). New York: Springer Sci­

ence+ Business Media, 2012.

Garrett, M.T., and Wilbur, M.P. Does the worm live in the ground? Reflections on Native Amer­ ican *spirituality.journal of Multicultural Counseling and Development* 27:193-206, 1999.

Garrity,J.F.Jesus, peyote, and the holy people: Alcohol abuse and the ethos of power in Navajo healing. *Medical Anthropology Quarterly* 14(4):521-542, 2000.

Gaston-Johansson, F., Hill-Briggs, F., Oguntomilade, L., Bradley, V., and Mason, P. Patient perspectives on disparities in healthcare from African-American, Asian, Hispanic, and Native American samples including a secondary analysis of the Institute of Medicine focus group

*data.journal of the National Black Nurses Association* 18(2):43-52, 2007.

Gatewood-Colwell, G., Kaczmarek, M., and Ames, M.H. Reliability and validity of the Beck Depression Inventory for a White and Mexican-American gerontic population. *Psychological Reports* 65:1163-1166, 1989.

Gatson, **S.N.** Assessing the likelihood of internet information-seeking leading to offline drug use by youth. In: Murguaia, E., Tackett-Gibson, M., and Lessem, A., eds. *Real Drugs in a Virtual World: Drug Discourse and Community Online* (pp. 99-120.) Lanham, **MD:** Lexington Books, *2007a.*

Gatson, S.N. The body or the body politic? Risk, harm, moral panic and drug use discourse online. In: Murguaia, E., Tackett-Gibson, M., and Lessem, A., eds. *Real Drugs in a Virtual World: Drug Discourse and Community Online* (pp. 23-44). Lanham, MD: Lexington Books, *2007b.*

Gaw, A.C. *Culture, Ethnicity and Mental Illness.* Washington,, DC: American Psychiatric Press, 1993.

Geisz, **M.B.** *Rand Researchers Study Racial Disparities in Substance Abuse Treatment Programs.*

Princeton, **NJ:** Robert Wood Johnson Foundation, 2007.

Gensheimer, **L.** Learning from the experiences of Hmong mental health providers. *Hmong Stud­ ies journal* 7:1-31, 2006.

205

Improving Cultural Competence

Georges, C.A. Advancing diversity in nursing: An interview with Dr. Catherine Alicia Georges, by Theodore Richardeanea. *Policy Politics* & *Nursing Practice* 9(1):22-26, 2008.

Gerson, K. Moral dilemmas, moral strategies, and the transformation of gender: Lessons from two generations of work and family change. *Gender* & *Society* 16(1):8-28, 2002.

Gerstein, D.R., Datta, A.R., lngels,J.S.,Johnson, R.A., Rasinski, K.A., Schildhaus, S., Talley, K., Jordan, K., Phillips, D.B., Anderson, D.W., Condelli, W.G., and Collins,J.S. *The National Treatment Improvement Evaluation Study: Final Report.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1997.

Ghassemzadeh, H., Mojtabai, **R.,** Karamghadiri, N., and Ebrahimkhani, N. Psychometric prop­ erties of a Persian-language version ofThe Beck Depression Inventory-Second Edition: EDI-II-Persian. *Depression and Anxiety* 21:185-192, 2005.

Giang, K.B., Spak, F., Dzung, T.V., and Allebeck, P. The use of audit to assess level of alcohol problems in rural Vietnam. *Alcohol and Alcoholism* 40:578-583, 2005.

Gibbons, F. X., Etcheverry, P. E., Stock, M. L., Gerrard, M., Weng, C. Y., Kiviniemi, M., and O'Hara, R.E. Exploring the link between racial discrimination and substance use: What me­

diates? What buffers? *journal of Personality and Social Psychology* 99(5):785-801, 2010.

Gil, R.M., and Vazquez, C.I. *The Maria Paradox: How Latinas Can Merge Old World Traditions With New World Se!f-Esteem.* New York: G.P. Putnam's Sons, 1996.

Gilbert,]., and Langrod,J. Polish identity and substance abuse. In: Straussner, S.L.A., ed. *Eth­ nocultural Factors in Substance Abuse Treatment* (pp. 234-249). New York: Guilford Press, 2001.

Gilbert, M.J. Alcohol consumption patterns in immigrant and later generation Mexican Ameri­ can women. *Hispanic journal of Behavioral Sciences* 9(3):299-313, 1987.

Gilbert, M.J. Acculturation and changes in drinking patterns among Mexican-American women: Implications for *prevention.Alcohol Health and Research World* 15(3):234-238, 1991.

Gilbert, M.J. *A Manager's Guide to Cultural Competence Education far Health Care Professionals.*

Woodland Hills, CA: The California Endowment, 2003.

Gilman, S.E., Breslau,J., Conron, K.J., Koenen, K.C., Subramanian, S.V., and Zaslavsky, A.M. Education and race-ethnicity differences in the lifetime risk of alcohol *dependence.journal of Epidemiology and Community Health* 62(3):224-230, 2008.

Gim Chung, R.H., Kim, B.S.K., and Abreu,J.M. (2004). Asian American Multidimensional Acculturation Scale: Development, factor analysis, reliability, and validity. *Cultural Diversity and Ethnic Minority Psychology* 10:66-80, 2004.

Giordano, J., and McGoldrick, M. Families of European origin: An overview. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 501- 519). New York: Guilford Press, 2005.

Giordano,]., and McGoldrick, M. Italian families. In: McGoldrick, M., Giordano,]., and Pearce, J.K., eds. *Ethnicity and Family Therapy.* 2nd ed. (pp. 567-582). New York: Guilford Press, 1996.

206

Appendix A-Bibliography

Gloria, A.M., and Peregoy,J.J. Counseling Latino alcohol and other substance users/abusers: Cultural considerations for *counselors.journal of Substance Abuse Treatment* 13(2):119-126, 1996.

Goldstein, A., and Herrera,]. Heroin addicts and methadone treatment in Albuquerque: A 22-

year follow-up. *Drug and Alcohol Dependence* 40(2):139-150, 1995.

Gone,J.P., and Trimble,J.E. American Indian and Alaska Native mental health: Diverse perspec­ tives on enduring disparities.Annual *Review of Clinical Psychology* 8:131-160,2012.

Goode, **T.** *Policy Brief 4: Engaging Communities to Realize the Vision of One Hundred Percent Access and Zero Health Disparities: A Culturally Competent Approach.* Washington, DC: National Center for Cultural Competence, Georgetown University Child Development Center. 2001.

Goode, T.D., Dunne, M.C., and Bronheim, S.M. *The Evidence Base far Cultural and Linguistic Competency in Health Care.* New York: The Commonwealth Fund, 2006.

Gooding, V.A. *Managing Multi-Generational Anger in African American Males.* Jenkintown, PA: Family and Corrections Network, 2002.

Gordon, **R.,** Heim, **D.,** and MacAskill, S. Rethinking drinking cultures: A review of drinking cultures and a reconstructed dimensional approach. *Public Health* 126(1):3-11, 2012.

Gossop, **M.,** Stewart, **D.,** Browne, N., and Marsden,]. Factors associated with abstinence, lapse or relapse to heroin use after residential treatment: Protective effect of coping responses. *Addic­ tion* 97(10):1259-1267, 2002.

Gourley, M. A subcultural study of recreational ecstasy *use.journal of Sociology* 40(1):59-73, 2004.

Graham, R.E., Ahn, A.C., Davis, R.B., O'Connor, B.B., Eisenberg, D.M., and Phillips, R.S. Use

of complementary and alternative medical therapies among racial and ethnic minority adults: Results from the 2002 National Health Interview *Survey.journal of the National Medical As­ sociation* 97(4):535-545, 2005.

Grant, B.F. Barriers to alcoholism treatment: Reasons for not seeking treatment in a general population *sample.journal of Studies on Alcohol* 58(4):365-371, 1997.

Grant, B.F., Dawson, D.A., Stinson, F.S., Chou, S.P., Dufour, M.C., and Pickering, R.P. The 12- month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991-1992 and 2001-2002. *Drug and Alcohol Dependence* 74(3):223-234, *2004a.*

Grant, B.F., Harford, T.C., Dawson, D.A., Chou, P.S., and Pickering, R.P. The Alcohol Use Disorder and Associated Disabilities Interview schedule (AUDADIS): Reliability of alcohol and drug modules in a general population sample. *Drug and Alcohol Dependence* 39:37-44, 1995.

Grant B.F., and Hasin, D.S. (1990). *The Alcohol Use Disorders and Associated Disabilities Interview Schedule (AUDADIS).* Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1990.

Grant, B.F., Hasin, D.S., Stinson, F.S., Dawson, D.A.,June, R.W., Goldstein, R.B., Smith, S.M., Saha, T.D., and Huang, B. Prevalence, correlates, co-morbidity, and comparative disability of DSM-IV generalized anxiety disorder in the USA: Results from the National Epidemiologic Survey on alcohol and related conditions. *Psychological Medicine* 35(12):1747-1759, 2005.

207

Improving Cultural Competence

Grant, B.F., Stinson, F.S., Dawson, D.A., Chou, S.P., Dufour, M.C., Compton, W., Pickering, R P., and Kaplan, K. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol

and Related *Conditions.Archives of General Psychiatry* 61(8):807-816, *2004b.*

Grant, B.F., Stinson, F.S., Hasin, D.S., Dawson, D.A., Chou, S.P., and Anderson, K. Immigration and lifetime prevalence of **DSM-IV** psychiatric disorders among Mexican Americans and

non-Hispanic Whites in the United States: Results from the national epidemiologic survey on alcohol and related *conditions.Archives of General Psychiatry* 61(12):1226-1233, *2004c.*

Greene, **B.** Ethnic minority lesbians and gay men: Mental health and treatment issues. In: Greene, **B.,** ed. *Ethnic and Cultural Diversity Among Lesbians and Gay Men* (pp. 216- 239).Thousand Oaks, CA: Sage Publications, 1997.

Griffith, E.E.H., and Baker, F.M. Psychiatric care of African Americans. In: Gaw, A.C., ed.

*Culture, Ethnicity, and Mental Illness* (pp.147-173). Washington, **DC:** American Psychiatric Press, 1993.

Griffith,J.D.,Joe, **G.W.,** Chatham, **L.R.,** and Simpson, **D.D.** The development and validation of a simpatia scale for Hispanics entering drug treatment. *Hispanic journal of Behavioral Sciences* 20:468-482, 1998.

Griner, D., and Smith, T.B. Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training* 43(4):531-548, 2006.

Grothe, K.B., Dutton, G.R.,Jones, G.N., Bodenlos,J., Ancona, M., and Brantley, P.J. Validation of the Beck Depression Inventory-II in a low-income African American sample of medical outpatients. *Psychological Assessment* 17:110-114, *2005.*

Grund,J.P.C. *Drug Use as a Social Ritual· Functionality, Symbolism and Determinants of Se!f­ Regulation.* Rotterdam, Netherlands: Instituut voor Verslavingsonderzoek, 1993.

Grzywacz,J.G., Qyandt, S.A., Early,]., Tapia,]., Graham, C.N., and Arcury, T.A. Leaving family for work: Ambivalence and mental health among Mexican migrant farmworker *men.journal*

*of Immigrant and Minority Health* 8(1):85-97, 2006.

Guerrero, E.G. Organizational characteristics that foster early adoption of cultural and linguistic competence in outpatient substance abuse treatment in the United States. Evaluation and Program Planning 35(1):9-15, 2012.

Guerrero, E.G., and Kim, A. Organizational structure, leadership and readiness for change and the implementation of organizational cultural competence in addiction health services. Eval­ uation and Program Planning 40:74-81, 2013.

Guerrero, E.G., Marsh,J.C., Duan, L., Oh, C., Perron, B, and Lee, B. Disparities in completion of substance abuse treatment between and within racial and ethnic groups. Health Services Research 48(4):1450-1467, 2013.

Guindon, M.H., and Sobhany, M.S. Toward cultural competency in diagnosis. *International journal far the Advancement of Counselling* 23(4):269-282, 2001.

Gupta, R., Punetha, D., and Diwan, S. The revised CES-D scale for caregivers of the elderly in India. *International journal of Aging and Human Development* 62:61-78, 2006.

208

Appendix A-Bibliography

Hadjicostandi,J., and Cheurprakobkit, S. Drugs and substances: Views from a Latino communi­

*ty.American journal of Drug* & *Alcohol Abuse* 28(4):693-710, 2002.

Haight, W.,Jacobsen, T., Black,]., Kingery, L., Sheridan, K., and Mulder, C. "In these bleak days": Parent methamphetamine abuse and child welfare in the rural Midwest. *Children and Youth Services Review* 27:949-971, 2005.

Halkitis, P.N., Fischgrund, B.N., and Parsons,J.T. Explanations for methamphetamine use among gay and bisexual men in New York City. *Substance Use* & *Misuse* 40(9-10):1331-1345, 2005.

Hall, E.T. *Beyond Culture.* Garden City, NY: Anchor Press, 1976.

Hall, G.C.N., Hong,J.J., Zane, N.W.S., and Meyer, O.L. Culturally competent treatments for Asian Americans: The relevance of mindfulness and acceptance-based psychotherapies.

*Clinical Psychology: Science and Practice* 18(3):215-231, 2011.

Hambleton, R.K., Merenda, P.F., and Spielberger, C.D. *Adapting Educational and Psychological Tests far Cross-Cultural Assessment.* Mahwah, N.J: L. Erlbaum Associates, 2005.

Hamid, A. *Drugs in America: Sociology, Economics, and Politics.* Gaithersburg, MD: Aspen Pub­ lishers, 1998.

Hampton, R.L., Gullotta, T.P., and Crowel, R.L. *Handbook of African American Health.* New York: Guilford Press, 2010.

Hands Across Cultures. *Culture is the Cure: La Cultura Cura.* Retrieved on March 28, 2014, from [http://handsacrosscultures.org](http://handsacrosscultures.org/)

Hanson, M.J. Families with Anglo-European roots. In: Lynch, E.W., and Hanson, M.J., eds.

*Developing Cross-Cultural Competence: A Guide far Working With Children and Their Families.*

4th ed. (pp. 80-102). Baltimore: Paul H. Brookes Publishing, 2011.

Haraguchi, A., Ogai, Y., Senoo, E., Saito, S., Suzuki, Y., Yoshino, A., Ino, A., Yanbe, K., Hasega­ wa, M., Murakami, M., Murayama, M., Ishikawa, T., Higuchi, S., and Ikeda, K. Verification

of the Addiction Severity Index Japanese version (ASI-J) as a treatment-customization, pre­ diction, and comparison tool for alcohol-dependent individuals. *International journal of Envi­ ronmental Research and Public Health* 6:2205-2225, 2009.

Harris, A.H., McKellar,J.D., Moos, R.H., Schaefer,J.A., and Cronkite, R.C. Predictors of en­ gagement in continuing care following residential substance use disorder treatment. *Drug and Alcohol Dependence* 84(1):93-101, 2006.

Hasin, D., Aharonovich, E., Liu, X., Mamman, Z., Matseoane, K., Carr, L.G., and Li, T.K. Alco­ hol dependence symptoms and alcohol dehydrogenase 2 polymorphism: Israeli Ashkenazis, Sephardics, and recent Russian *immigrants.Alcoholism: Clinical* & *Experimental Research* 26(9):1315-1321, 2002.

Hasin, D.S., Goodwin, R.D., Stinson, F.S., and Grant, B.F. Epidemiology of major depressive disorder: Results from the national epidemiologic survey on alcoholism and related condi­

*tions.Archives of General Psychiatry* 62(10):1097-1106, 2005.

209

Improving Cultural Competence

Hasin, D.S., Stinson, F.S., Ogburn, E., and Grant, B.F. Prevalence, correlates, disability, and comorbidity of DSM-IV alcohol abuse and dependence in the United States: Results from

the national epidemiologic survey on alcohol and related *conditions.Archives of General Psy­*

*chiatry* 64(7):830-842, 2007.

Hathaway, S.R., and McK.inley,J.C. *Minnesota Multiphasic Personality Inventory-2.* Minneapolis, MN: National Computer Systems, 1989.

Hatzenbuehler, M.L., Keyes, K.M., Narrow, W.E., Grant, B.F., and Hasin, D.S. Racial/ethnic disparities in service utilization for individuals with co-occurring mental health and substance use disorders in the general population: Results from the national epidemiologic survey on al­

cohol and related conditions. *The journal of Clinical Psychiatry* 69(7):1112-1121, 2008.

Haynes, F.E. Gender and family ideals: An exploratory study of Black middle-class Americans.

*journal of Family Issues* 21(7):811-837, 2000.

Hays, P.A. Sorting things out: Culturally responsive assessment. In: *Addressing Cultural Complexi­ ties in Practice: Assessment, Diagnosis, and Therapy.* 2nd ed. (pp. 105-127). Washington, DC: American Psychological Association, 2008.

Hazel, K.L., and Mohatt, G.V. Cultural and spiritual coping in sobriety: Informing substance abuse prevention for Alaska Native *communities.journal of Community Psychology* 29(5):541-

562, 2001.

Hebdige, D. *Subculture: The Meaning of Style.* New York: Routledge, 1991.

Heilbron, C.L., and Guttman, *M.A.].*Traditional healing methods with First Nations women in group counselling. *Canadian journal of Counselling* 34(1):3-13, 2000.

Helms,J.E. *Black and White Racial Identity: Theory, Research, and Practice.* Westport, CT: Praeger, 1990.

Helms,J.E. An update ofHelms's White and people of color racial identity models. In: Ponterot­ to,J.G., Casas,J.M., Suzuki, L.A., and Alexander, C.M., eds. *Handbook of Multicultural Coun­ seling* (pp. 181-198). Thousand Oaks, CA: Sage Publications, 1995.

Helms,J.E. Racial identity in the social environment. In: Pedersen, P.B., ed. *Multicultural Coun­ seling in Schools:A Practical Handbook.* 2nd ed. (pp. 44-58). Needham Heights, MA: Allyn & Bacon, 2003.

Helms,J.E., and Carter, R.T. Development of the White racial identity inventory. In: Helms, J.E., ed. *Black and White Racial Identity: Theory, Research, and Practice* (pp. 67-80). Westport, CT: Praeger, 1990.

Helms,J.E., and Carter, R.T. Relationships ofWhite and Black racial identity attitudes and demographic similarity to counselor *preferences.journal of Counseling Psychology* 38(4):446- 457, 1991.

Henson, E.C. *The State of the Native Nations Conditions Under US. Policies of Seif-Determination: The Harvard Project on American Indian Economic Development.* New York: Oxford University Press, 2008.

210

Appendix A-Bibliography

Herbeck, D.M., Brecht, M.L., and Pham, A.Z. Racial/ethnic differences in health status and morbidity among adults who use methamphetamine. Psychology, Health, & Medicine 18(3):262-274, 2013.

Herman-Stahl, M., and Chong,]. Substance abuse prevalence and treatment utilization among American Indians residing *on-reservation.American Indian and Alaska Native Mental Health Research* 10(3):1-23, 2002.

Herman-Stahl, M., Spencer, D.L., and Duncan,J.E. The implications of cultural orientation for substance use among American Indians. *American Indian and Alaska Native Mental Health Research* 11(1):46-66, 2003.

Hernandez, M. Puerto Rican families and substance abuse. In: Krestan,J.A., ed. *Bridges to Recov­ ery:Addiction, Family Therapy, and Multicultural Treatment* (pp. 253-283). New York: The Free Press, 2000.

Hernandez, M. Central American families. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 178-191.) New York: Guilford Press, 2005.

Hernandez, M., Nesman, T., Mowery, D., Acevedo-Polakovich, I.D., and Callejas, L.M. Cultural competence: A literature review and conceptual model for mental health services. *Psychiatric Services* 60(8):1046-1050, 2009.

Hien, D.A., Cohen, L.R., Miele, G.M., Litt, L.C., and Capstick, C. Promising treatments for women with comorbid PTSD and substance use disorders. *The American journal of Psychiatry* 161(8):1426-1432, 2004.

Hill, R.B. *The Strengths of Black Families.* New York: Emerson Hall Publishers, 1972.

Hines, P.M., and Boyd-Franklin, N. African American families. In: McGoldrick, M., Giordano, J., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 87-100). New York: Guilford Press, 2005.

Hines-Martin, V.P., Usui, W., Kim, S., and Furr, A. A comparison of influences on attitudes towards mental health service use in an African-American and White *community.Journal of the National Black Nurses Association* 15(2):17-22, 2004.

Hixson, L., Hepler, B.B., and Kim, M.O. *The Native Hawaiian and Other Pacific Islander Popula­ tion: 2010.* Census 2010 Brie£ Washington, DC: U.S. Census Bureau, 2012.

Ho, M.K. Use of Ethnic Sensitive Inventory (ESI) to enhance practitioner skills with minorities.

*journal of Multicultural Social Work* 1:57-67, 1991.

Hoeffel, E.M., Rastogi, S., Kim, M.O., and Shahid, H. *The Asian Population: 2010.* Census 2010 Brie£ Washington, DC: U.S. Census Bureau, 2012.

Hoffman, F. Cultural adaptations of Alcoholics Anonymous to serve Hispanic populations.

*International journal of Addictions* 29(4):445-460, 1994.

Hoffman,J.A., Caudill, B.D., Koman,J.J., III, Luckey,J.W., Flynn, P.M., and Mayo, D.W. Psy­ chosocial treatments for cocaine abuse: 12-month treatment *outcomes.journal of Substance Abuse Treatment* 13(1):3-11, 1996.

211

Improving Cultural Competence

Hoffmann, T., Dana, R.H., and Bolton, B. Measured acculturation and MMPI-168 performance of Native American *adults.journal of Cross-Cultural Psychology* 16(2):243-256, 1985.

Hoge, M.A., Morris,J.A., Daniels, A.S., Stuart, G.W., Huey, L.Y., and Adams, *N.AnAction Plan on Behavioral Health Workforce Development.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Hohman, M.M., and Galt, D.H. Latinas in treatment: Comparisons of residents in a culturally specific recovery home with residents in non-specific recovery *homes.journal of Ethnic* & *Cultural Diversity in Social Work* 9(3-4):93-109, 2001.

Holden, K.B., and Xanthos, C. Disadvantages in mental health care among African Americans.

*journal of Health Care for the Poor and Underserved* 20(2 Suppl):17-23, 2009.

Holden, K.B., McGregor, B.S., Blanks, S.H., and Mahaffey, C. Psychosocial, socio-cultural, and environmental influences on mental health help-seeking among African-American men.

*journal of Men's Health* 9(2):63-69, 2012.

Horton,]., Compton, W., and Cottler, L.B. Reliability of substance use disorder diagnoses among African-Americans and Caucasians. *Drug and Alcohol Dependence* 57:203-209, 2000.

Hovey,J.D. *Migrant Health Issues: Mental Health and Substance Abuse.* Monograph Series. Buda, TX: National Center for Farmworker Health, 2001.

Howard, D.L. Are the treatment goals of culturally competent outpatient substance abuse treat­ ment units congruent with their client profile? *journal of Substance Abuse Treatment* 24(2):103-113, 2003.

Howard, M.O., Walker, RD., Suchinsky, RT., and Anderson, B. Substance-use and psychiatric disorders among American Indian veterans. *Substance Use* & *Misuse* 31(5):581-598, 1996.

Howland,]., and Rohsenow, D.J. Risks of energy drinks mixed with *alcohol.jAA1A: The journal of*

*the American Medical Association* 309(3):245-246, 2013.

Hser, Y.I., Maglione, M., Polinsky, M.L., and Anglin, M.D. Predicting drug treatment entry among treatment-seeking individuals.journal*of Substance Abuse Treatment* 15(3):213-220, 1998.

Hsu, L.K.G., and Folstein, M.F. Somatoform disorders in Caucasian and Chinese Americans.

*journal of Nervous and Mental Disease* 185(6):382-387, 1997.

Hu, H.M., Kline, A., Huang, F.Y., and Ziedonis, D.M. Detection of co-occurring mental illness among adult patients in the New Jersey substance abuse treatment *system.American journal of Public Health* 96(10):1785-1793, 2006.

Hudak,]. Addiction and groups of European origin. In: Krestan,J.A., ed. *Bridges to Recovery: Addiction, Family Therapy, and Multicultural Treatment* (pp. 284-315). New York: Free Press, 2000.

Hughes, D.L. *Quality of Health Care for AsianAmericans:A Fact Sheet.* New York: The Common­ wealth Fund, 2002.

Humes, K.R.,Jones, N.A., and Ramirez, R.R. *Overview of Race and Hispanic Origin: 2010.* Cen­ sus 2010 Brief. Washington, DC: U.S. Census Bureau, 2011.

212

Appendix A-Bibliography

Humeniuk, R., Henry-Edwards, S., Ali, R., Poznyak, V., and Monteiro, M.G. *The Alcohol, Smok­ ing and Substance Involvement Screening Test (ASSIST): Manual far Use in Primary Care.* Ge­ neva, Switzerland: World Health Organization, 2010.

Hunt, D., Kuck, S., and Truitt, L. *Methamphetamine Use: Lessons Learned.* Rockville, MD: Nation­ al Institute of Justice/NCJRS, 2006.

Imel, Z.E., Baldwin, S., Atkins, D. C., Owen,]., Baardseth, T., and Wampold, B.E. Racial/ethnic disparities in therapist effectiveness: A conceptualization and initial study of cultural compe­

*tence.journal of Counseling Psychology* 58(3):290-298, 2011.

lnterian, A., Martinez, I., Rios, L.I., Krejci,]., and Guarnaccia, P.J. Adaptation of a motivational interviewing intervention to improve antidepressant adherence among Latinos. *Cultural Di­ versity* & *Ethnic Minority Psychology* 16(2):215-225, 2010.

Ishikawa, **R.Z.,** Cardemil, E.V., and Falmagne, **R.J.** Help seeking and help receiving for emotion­ al distress among Latino men and women. *Qualitative Health Research* 20(11):1558-1572, 2010.

Issitt, M.L. *Hippies: A Guide to an American Subculture.* Santa Barbara, CA: Greenwood Press/ABC-CLIO, 2009.

Iversen, L.L. *The Science of Marijuana.* New York: Oxford University Press, 2000.

Iwamasa, G.Y., Hsia, C., and Hinton, D. Cognitive behavior therapy with Asian Americans. In: Hays, P.A., and Iwamasa, G., eds. *Culturally Responsive Cognitive-BehavioralTherapy:Assess­ ment, Practice, and Supervision.* 1st ed. Washington, DC: American Psychological Association, 2006.

Ja, D.Y., and Aoki, B. Substance abuse treatment: Cultural barriers in the Asian American com­ munity. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 386-401). New York: Routledge, 1998.

Ja, D., and Yuen, F.K. Substance abuse treatment among Asian Americans. In: Lee, E., ed. *Work­ ing with Asian Americans: A Guide far Clinicians* (pp. 295-308). New York: Guilford Press, 1997.

Jackson, V. *In Our Own Voice:African-American Stories of Oppression, Survival and Recovery in Mental Health Systems* (Part 3 of the "It's About Time: Discovering, Recovering and Cele­ brating Psychiatric Consumer/Survivor History" series.) Rockville, **MD:** Center for Mental Health Studies, 2003.

Jani,J.S., Ortiz, L., and Aranda, M.P. Latino outcome studies in social work: A review of the literature. *Research on Social Work Practice* 19(2):179-194, 2009.

Jenkot, R. Cooks are like gods: Hierarchies in methamphetamine-producing groups. *Deviant Behavior* 29:667-689, 2008.

Jilek, W.G. Traditional healing in the prevention and treatment of alcohol and drug abuse. *Trans­ cultural Psychiatric Research Review* 31(3):219-258, 1994.

Joe,]. R., and Malach, R. S. Families with American Indian roots. In: Lynch, E.W., and Hanson, M.J., eds. *Developing Cross-Cultural Competence: A Guide far Working With Children and Their Families.* 4th ed. (pp. 110-139). Baltimore: Paul H. Brookes Publishing, 2011.

213

Improving Cultural Competence

Joe, S., Baser, R.E., Breeden, G., Neighbors, H.W., and Jackson,J.S. Prevalence of and risk factors for lifetime suicide attempts among Blacks in the United States.JAMA.: *The journal of the American Medical Association* 296(17):2112-2123, 2006.

Joe, S., Woolley, M.E., Brown, G. K., Ghahramanlou-Holloway, M., and Beck, A.T. Psychomet­ ric properties of the Beck Depression Inventory-II in low-income, African American suicide

*attempters.journal of Personality Assessment* 90:521-523, 2008.

Johnson,J.E., Connolly Gibbons, M.B., and Crits-Christoph, P. Gender, race, and group behav­ ior in group drug treatment. *Drug and Alcohol Dependence* 119(3):e39-e45, 2011.

Johnson, **P.B.,** and Glassman, M. The moderating effects of gender and ethnicity on the relation­ ship between effect expectancies and alcohol *problems.journal of Studies onAlcohol* 60(1):64- 69, 1999.

Johnson, **R.C.,** and Nagoshi, *C.T.Asians, Asian-Americans and Alcohol.* Medford, **OR: CNS**

Productions, 2012.

Johnston, **L.D.,** O'Malley, **P.M.,** Bachman,J.G., and Schulenberg,J.E. *Monitoring the Future: National Survey Results on Drug Use, 1975-2003. Volume I- Secondary School Students.* NIH Publication No. 04-5507. Bethesda, MD: National Institute on Drug Abuse, 2003.

Johnston, S.L. Native American traditional and alternative *medicine.Annals of the American Academy of Political and Social Science* 583(1):195-213, 2002.

Jome, L.M., and Moody, M.J. How to develop cultural competence as a White clinician. In: VandeCreek, L., and Jackson, T.L., eds. *Innovations in Clinical Practice:A Source Book,* Vol. 20 (pp. 355-371). Sarasota, FL: Professional Resource Press/Professional Resource Exchange, 2002.

Jones, L., Brazel, D., Peskind, E.R., Morelli, T., and Raskind, M.A. Group therapy program for African-American veterans with posttraumatic stress disorder. *Psychiatric Services* 51(9):1177-1179, 2000.

Jones-Saumty, D. Substance abuse treatment for Native Americans. In: Xueqin Ma, G., and Henderson, G., eds. *Ethnicity and Substance Abuse: Prevention and Intervention* (pp. 270-283). Springfield, IL: Charles C. Thomas Publisher, 2002.

Jones-Webb, R.J., Hsiao, C.Y., and Hannan, P. Relationships between socioeconomic status and drinking problems among black and white men. *Alcoholism: Clinical and Experimental Re­ search* 19(3):623-627, 1995.

Journey Mental Health Center. *Celebrating Fifty-Five Years: Vision* & *Values.* Madison, **WI:** Jour­ ney Mental Health Center, 2004.

Journey Mental Health Center. *Values for Culturally Competent Services.* Madison, **WI:** Journey Mental Health Center, 2013.

Juang, **L.P.,** Syed, **M.,** Cookston,J.T., Wang, Y., and Kim, **S.Y.** Acculturation-based and everyday family conflict in Chinese American families. *New Directions for Child and Adolescent Devel­ opment* 2012(135):13-34, 2012.

Jumper-Thurman, P., and Plested, B. *Health Needs of American Indian Women.* Bethesda, MD: National Institute on Drug Abuse, 1998.

214

Appendix A-Bibliography

Jumper-Thurman, P., Plested, B.A., Edwards, R.W., Helm, H.M., and Oetting, E.R. Using the Community Readiness Model in Native communities. In: Trimble,J.E., Beauvais, F., Epstein, L.G., Pacheco, G., and Johnson, S., eds. *Health Promotion and Substance Abuse Prevention Among American Indian and Alaska Native Communities: Issues in Cultural Competence.* Cultur­ al Competence Series No. 9. HHS Publication No. (SMA) 99-3440. (pp. 129-158). Rock­ ville, MD: Substance Abuse Mental Health Services Administration, 2001.

Kaczorowski,J.A., Williams, A.S., Smith, T.F., Fallah, N., Mendez,J.L., and Nelson-Gray, R. Adapting clinical services to accommodate needs of refugee populations. *Professional Psycholo­ gy: Research and Practice* 42(5):361-367, 2011.

Kagan, H., and Shafer, K.C. Russian-speaking substance abusers in transition: New country, old problems. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 250-271). New York: Guilford Press, 2001.

Karberg,J.C., and James, D.J. *Substance Dependence, Abuse, and Treatment ofJail Inmates, 2002.* Bureau ofJustice Statistics: Special Report. Washington, DC: U.S. Department ofJustice, 2005.

Karriker-Jaffe, K.J., and Zemore, S.E. Associations between acculturation and alcohol consump­ tion of Latino men in the United *States.journal of Studies on Alcohol* 70(l) :27-31, 2009.

Kaskutas, L.A., Weisner, C., Lee, M., and Humphreys, K. Alcoholics anonymous affiliation at treatment intake among White and Black *Americans.journal of Studies onAlcohol* 60(6):810- 816, 1999.

Keller, D.S., and Galanter, M. Technology transfer of network therapy to community-based addictions *counselors.journal of Substance Abuse Treatment* 16(2):183-189, 1999.

Kelly, B.C., and Parsons,J.T. Predictors and comparisons of polydrug and non-polydrug cocaine use in club subcultures. *The American journal of Drug and Alcohol Abuse* 34(6):774-781, 2008.

Kerr, W.C. Categorizing US state drinking practices and consumption trends. *International journal of Environmental Research and Public Health* 7(1):269-283, 2010.

Kim, B.L., and Ryu, E. Korean families. In: *Ethnicity and Family Therapy.* 3rd ed. (pp. 349-362).

New York: Guilford Press, 2005.

Kim, E.Y., Bean, R.A., and Harper,J.M. Do general treatment guidelines for Asian American families have applications to specific ethnic groups? The case of culturally-competent therapy

with Korean *Americans.journal of Marital and Family Therapy* 30(3):359-372, 2004.

Kim, S.C. Family therapy for Asian Americans: A strategic-structural framework. *Psychotherapy*

22(2):342-348, 1985.

Kim, Y.A., Morales, K.H., and Bogner, H.R. Patient ethnicity and the identification of anxiety in elderly primary care *patients.journal of the American Geriatrics Society* 56:1626-1630, 2008.

Kingree,J.B. Measuring affiliation with 12-Step groups. *Substance Use* & *Misuse* 32(2):181-194, 1997.

Kingree,J.B., and Sullivan, B.F. Participation in Alcoholics Anonymous among African­

*Americans.Alcoholism Treatment Quarterly* 20(3/4):175-186, 2002.

215

Improving Cultural Competence

Klonoff, E.A., and Landrine, H. Revising and improving the African American acculturation

*scale.journal of Black Psychology* 26(2):235-261, 2000.

Knutagard, H. New trends in European youth & drug cultures. *Youth Studies Australia* 15(2):37- 42, 1996.

Koltko-Rivera, M.E. The psychology of worldviews. *Review of General Psychology* 8(1):3-58, 2004.

Kopelowicz, A., Zarate, R., Wallace, C.J., Liberman, R.P., Lopez, S.R., and Mintz,]. The ability of multifamily groups to improve treatment adherence in Mexican Americans with schizo­

phrenia. *Archives of General Psychiatry* 69(3):265-273, 2012.

Kosmin, B.A., and Keysar, A. American Religious Identification Survey (ARIS 2008) Summary Report. Hartford, CT: Trinity College, 2009.

Kosmin, B.A., Mayer, E., and Keysar, *A.American Religious Identification Survey.* New York: The Graduate Center of the City University of New York, 2001.

Koss, M.P., Yuan, N.P., Dightman, D., Prince, R.J., Polacca, M., Sanderson, B., and Goldman, D. Adverse childhood exposures and alcohol dependence among seven Native American tribes.

*American journal of Preventive Medicine* 25(3):238-244, 2003.

Kotarba,J.A. Music as a feature of the on-line discussion of illegal drugs. In: Murguaia, E., Tack­ ett-Gibson, M., and Lessem, A., eds. *Real Drugs in a Virtual World· Drug Discourse and Com­ munity Online* (pp. 161-179). Lanham, MD: Lexington Books, 2007.

Krenz, S., Dieckmann, S., Favrat, B., Spagnoli,]., Leutwyler,J.1., Schnyder, C. Daeppen,J.B., and Besson,]. French version of the Addiction Severity Index (5th Edition): Validity and reliabil­ ity among Swiss opiate-dependent patients. *European Addiction Research* 10:173-179, 2004.

Kress, V.E.W., Eriksen, K.P., Rayle,A.D., and Ford, S.].W. The DSM-IV-TR and culture: Con­ siderations for *counselors.journal of Counseling* & *Development,* 83(1):97-104, 2005.

Kunitz, S.J., Levy,J.E., Andrews, T., DuPuy, C., Gabriel, K.R., and Russell, **S.** *Drinking Careers:A Twenty-Five-Year Study of Three Navajo Populations.* New Haven, CT: Yale University Press, 1994.

Kuntsche, S., Gmel, G., Knibbe, R.A., Kuendig, H., Bloomfield, K., Kramer, S., and Grittner, U. Gender and cultural differences in the association between family roles, social stratification, and alcohol use: A European cross-cultural analysis.Alcohol *and Alcoholism. Supplement* 41(1):i37-i46, 2006.

Kuramoto, F.H. Drug abuse prevention research concerns in Asian and Pacific Islander popula­ tions. In: Cazares, A., and Beatty, L.A., eds. *Scientific Methods far Prevention Intervention Re­ search* (pp. 249-272). NIDA Research Monograph 139. Rockville, MD: U.S. Department of Health and Human Services, 1994.

Kurtz, S.P. Post-circuit blues: Motivations and consequences of crystal meth use among gay men in Miami.AIDS *and Behavior* 9(1):63-72, 2005.

Kusnir, D. Salvadoran families. In: *Ethnicity and Family Therapy.* 3rd ed. (pp. 256-265). New York: Guilford Press, 2005.

216

Appendix A-Bibliography

Kwan, K.-L.K., and Sadowsky, G.R. Internal and external ethnic identity and their correlates: A study of Chinese American *immigrants.journal of Multicultural Counseling and Development* 25:51-57, 1997.

Kwon-Ahn, Y.H. Substance abuse among Korean Americans: A sociocultural perspective and framework for intervention. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (418-435). New York: Guilford Press, 2001.

LaFromboise, T. American Indian mental health policy. In: Atkinson, D.R., Morten, G., and Sue, D.W., eds. *Counseling American Minorities: A Cross-Cultural Perspective* (pp. 123-143). Madi­ son, WI: Brown and Benchmark, 1993.

LaFromboise, T., Coleman, H.L.K., and Gerton,]. Psychological impact ofbiculturalism: Evi­ dence and theory. *Psychological Bulletin* 114(3):395-412, 1993.

Lai, T.F.M. Ethnocultural background and substance abuse treatment of Chinese Americans. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 345-367). New York: The Guilford Press, 2001.

Lamont, M., and Small, M.L. How culture matters: Enriching our understanding of poverty. In: Lin, A.C., and Harris, **D.R.,** eds. *The Colors of Poverty: Why Racial and Ethnic Disparities Exist* (pp. 76-102). New York: Russell Sage Foundation, 2008.

Larkin, R. African-Americans in public housing: a traditional social work approach to substance abuse *treatment.journal of Health and Social Policy* 17(2):67-82, 2003.

Larrison, C.R., Schoppelrey, S.L., Hack-Ritzo, S., and Korr, W.S. Clinician factors related to outcome differences between black and white patients at CMHCs. *Psychiatric Services* 62(5):525-531, 2011.

Larsen, L.J. *The Foreign-Born Population in the United States: 2003.* Washington, DC: U.S. Census Bureau, 2004.

Laudet, A.B., Morgen, K., and White, W.L. The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-Step fellowships in quality oflife satisfaction among in­ dividuals in recovery from alcohol and drug problems. *Alcohol Treatment Quarterly* 24(1- 2):33-73, 2006.

Laudet, A.B., Savage, R., and Mahmood, D. Pathways to long-term recovery: A preliminary investigation.journal *of Psychoactive Drugs* 34(3):305-311, 2002.

LaVeist, T.A., Relosa, **R.,** and Sawaya, N. The COA360: A tool for assessing the cultural compe­ tency of healthcare organizations.journal *of Healthcare Management* 53(4):257-266, 2008.

Leavitt, **R.L.** *Cultural Competence:A Lifelong]ourney to Cultural Proficiency.* Thorofare, **NJ:**

SLACK Inc., 2010.

Le Cook, B., and Alegria, M. Racial-ethnic disparities in substance abuse treatment: The role of criminal history and socioeconomic status. *Psychiatric Services* 62(11):1273-1281, 2011.

Lecrubier, Y., Sheehan, D.V., Weiller, E., Amorim, P., Bonora, I., Sheehan, K.H.Janavs,J., and Dunbar, G.C. The Mini International Neuropsychiatric Interview (MINI): A short diagnos­ tic structured interview: Reliability and validity according to the CIDI. *European Psychiatry* 12:224-231, 1997.

217

Improving Cultural Competence

Lee, E. Asian American families: An overview. In: McGoldrick, M., Giordano,]., and Pearce, J.K., eds. *Ethnicity and Family Therapy.* 2nd ed. (pp. 227-248). New York: Guilford Press, 1996.

Lee, E., and Mock, M.R. Asian families: An overview. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 269-289). New York: Guil­ ford Press, *2005a.*

Lee, E., and Mock, M.R. Chinese families. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 302-318). New York: Guilford Press, *2005b.*

Lee,J., and Bean, F.D. America's changing color lines: Immigration, race/ethnicity, and multira­ cial identification. *Annual Review of Sociology* 30(1):221-242, 2004.

Lefley, H.P., Sandoval, M.C., and Charles, C. Traditional healing systems in a multicultural setting. In: Okpaku, S.O., ed. *Clinical Methods in Transcultural Psychiatry* (pp. 88-110). Wash­ ington, DC: American Psychiatric Association, 1998.

Lende, D.H. Wanting and drug use: A biocultural approach to the analysis of addiction. *ETHOS*

33(1):100-124, 2005.

Leong, F.T.L., and Lee, S.H. Chinese Americans: Guidelines for disaster mental health workers. In: Marsella, A.].,Johnson,J.L., Watson, P., and Gryczynski,J., eds. *Ethnocultural Perspectives on Disaster and Trauma: Foundations, Issues, and Applications* (pp. 241-269). New York: Springer Science+ Business Media, 2008.

Leonhard, C., Mulvey, K., Gastfriend, D.R., and Shwartz, M. The Addiction Severity Index: A field study of internal consistency and *validity.Journal of Substance Abuse Treatment* 18:129-

135, 2000.

Leung, S.F. and Arthur, D. Alcohol use disorders identification test (AUDIT): Validation of an instrument for enhancing nursing practice in Hong Kong. *International journal of Nursing Studies* 37:57-64, 2000.

Leventhal, A.M., and Schmitz,J.M. The role of drug use outcome expectancies in substance abuse risk: An interactional-transformational *model.Addictive Behavior* 31(11):2038-2062, 2006.

Lewis, E.W., Duran, E., and Woodis, W. Psychotherapy in the American Indian population.

*Psychiatric Annals* 29(8):477-479, 1999.

Liang, T., Liu, E.W., Zhong, H., Wang, B., Shen, L.M., and Wu, Z.L. Reliability and validity of addiction severity index in drug users with methadone maintenance treatment in Guizhou province, China. *Biomedical and Environmental Sciences* 21:308-313, 2008.

Libby, A.M., Orton, H.D., Beals,]., Buchwald, D., and Manson, S.M. Childhood abuse and later parenting outcomes in two American Indian tribes. *Child Abuse* & *Neglect* 32(2):195-211, 2008.

Liddle, H.A. Multidimensional family therapy: A science-based treatment system. *The Australian and New Zealand]ournal of Family Therapy* 31(2):133-148,2010.

Liddle, H.A., Dakof, G.A., Turner, R.M., Henderson, C.E., and Greenbaum, P.E. Treating ado­ lescent drug abuse: A randomized trial comparing multidimensional family therapy and cog­ nitive behavior *therapy.Addiction* 103(10):1660-1670, 2008.

218

Appendix A-Bibliography

Lie, D. A., Lee-Rey, E., Gomez, A., Bereknyei, S., and Braddock, C.H., 3rd. Does cultural competen­ cy training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future *research.journal of General Internal Medicine* 26(3):317-325, 2011.

Lie, D., Shapiro,]., Cohn, F., and Najm, W. Reflective practice enriches clerkship students' cross­ cultural experiences.journal*of General Internal Medicine* 25(Suppl 2):S119-S125, 2010.

Lima, C.T., Freire, A.C., Silva, A.P., Teixeira, R.M., Farrell, M., and Prince, M. Concurrent and construct validity of the audit in an urban Brazilian sample. *Alcohol and Alcoholism* 40:584- 589, 2005.

Lin, N. Measuring depressive symptomatology in *China.journal of Nervous and Mental Disease*

177:121-131, 1989.

Link, B.G., Struening, E.L., Rahav, M., Phelan,J.C., and Nuttbrock, L. On stigma and its conse­ quences: Evidence from a longitudinal study on men and dual diagnosis of mental illness and substance *abuse.journal of Health and Social Behavior* 38(2):177-190, 1997.

Linkins, K.W., McIntosh, S., Bell,]., and Chong, U. *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile.*

Health Resources and Services Administration, U.S. Department of Health and Human Ser­ vices, 2002.

Litt, **M.D.,** Kadden, **R.M.,** Cooney, **N.L.,** and Kabela, E. Coping skills and treatment outcomes in cognitive-behavioral and interactional group therapy for *alcoholism.journal of Consulting and Clinical Psychology* 71(1):118-128, 2003.

Litt, **M.D.,** Kadden, **R.M.,** and Stephens, **R.S.** Coping and self-efficacy in marijuana treatment: Results from the marijuana treatment *project.journal of Consulting and Clinical Psychology* 73(6):1015-1025, 2005.

Livingston,J.D., Milne,T., Fang, M.L., and Amari, E. The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic *review.Addiction* 107(1):39-50, 2012.

Lobo, S. *American Indian Urban Mobility in the San Francisco Bay Area: Final Report far Bureau of the Census.* Washington, DC: U.S. Census Bureau, 2001.

Lobo, S. Urban clan mothers: Key households in *cities.American Indian Quarterly* 27(3/4):305- 322, 2003.

Long,J.M. Drug use patterns in two Los Angeles barrio gangs. In: Glick, R., and Moore,]., eds. *Drugs in Hispanic Communities* (pp. 155-165). New Brunswick, NJ: Rutgers University Press, 1990.

Longshore, D. Desire for help among drug-using Mexican-American arrestees. *Substance Use* &

*Misuse* 33(6):1387-1406, 1998.

Longshore, D., and Grills, C. Motivating illegal drug use recovery: Evidence for a culturally congruent intervention.journal *of Black Psychology* 26(3):288-301, 2000.

Longshore, D., Grills, C., Anglin, M.D., and Annon, K. Treatment motivation among African American drug-using *arrestees.journal of Black Psychology* 24(2):126-144, 1998a.

219

Improving Cultural Competence

Longshore, D., Grills, C., and Annon, K. Effects of a culturally congruent intervention on cogni­ tive factors related to drug use-recovery. *Substance Use* & *Misuse* 34(9):1223-1241, 1999.

Longshore, D., Grills, C., Annon, K., and Grady, R. Promoting recovery from drug abuse: An Africentric intervention.journal*of Black Studies* 28(3):319-332, 1998b.

Lopez-Class, M., Castro, F.G., and Ramirez, A.G. Conceptions of acculturation: A review and statement of critical issues. *Social Science and Medicine* 72(9):1555-1562, 2011.

Lynch, E.W., and Hanson, M.J. Steps in the right direction: Implications for service providers. In: Lynch, E.W., and Hanson, M.J., eds. *Developing Cross-Cultural Competence: A Guide far Working With Children and Their Families.* 4th ed. (pp. 472-489). Baltimore: Paul H. Brookes Publishing, 2011.

Mail, P.D., and Shelton, C. Treating Indian alcoholics. In: Mail, P.D., Heurtin-Roberts, S., Martin, S.E., and Howard,]., *eds.Alcohol Use Among American Indians and Alaska Natives: Multiple Per­ spectives on a Complex Problem* (pp.141-184). NIH Pub. No. 02-4231. NIAAA Research Mono­ graph 37. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, 2002.

Maisto, S.A., Zywiak, W.H., and Connors, G.J. Course of functioning 1 year following admission for treatment of alcohol use *disorders.Addictive Behaviors* 31(1):69-79, 2006.

Makambi, K.H., Williams, C.D., Taylor, T.R., Rosenberg, L., and Adams-Campbell, L.L. An assessment of the CES-D scale factor structure in Black women: The Black Women's Health Study. *Psychiatry Research* 168:163-170, 2009.

Makimoto, K. Drinking patterns and drinking problems among Asian-Americans and Pacific Islanders.Alcohol *Health and Research World* 22(4):270-275, 1998.

Manning, P. *Drugs and Popular Culture: Drugs, Media and Identity in Contemporary Society.* Devon, United Kingdom: Willan Publishing, 2007.

Manson, S.M. The wounded spirit: A cultural formulation of post-traumatic stress disorder.

*Culture, Medicine* & *Psychiatry* 20(4):489-498, 1996.

Manson, S.M., Beals,]., Klein, S.A., Croy, C.D., and the American Indian Service Utilization Psychiatric Epidemiology Risk and Protective Factors Project Team: Big Crow, C.K., Buch­ wald, D., Chambers, B., Christensen, M.L., Dillard, D.A., DuBray, K., Espinoza, P.A., Flem­ ing, C.M., Frederick, A.W., Gurley, D.,Jervis L.L.,Jim, S.M., Kaufman, C.E., Keane, E.M.,

Klein, S.A., Lee, D., McNulty, M.C., Middlebrook, D.L., Moore, L.A., Nez, T.D., Norton,

I.M., Orton, H.D., Randall, C.J., Sam, A., Shore,J.H., Simpson, S.G., and Yazzie, L.L. Social epidemiology of trauma among 2 American Indian reservation *populations.American journal*

*of Public Health* 95(5):851-859, 2005.

Marin, G. Expectancies for drinking and excessive drinking among Mexican Americans and

non-Hispanic Whites. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Eth­ nic Psychology* (pp. 204-221). New York: Routledge, 1998.

Marin, G., and Gamba, R.J. A new measurement of acculturation for Hispanics: The bidimensional acculturation scale for Hispanics (BAS). *Hispanic journal of Behavioral Sciences* 18:297-317, 1996.

Marin, G., Sabogal, F., Marin, B. V., Otero-Sabogal, R., and Perez-Stable, E.J. Development of a short acculturation scale for Hispanics. *Hispanic journal of Behavioral Sciences* 9:183-205, 1987.

220

Appendix A-Bibliography

Marinangeli, P. Italian culture and its impact on addiction. In: Straussner, S.L.A., ed. *Ethnocultur­ al Factors in Substance Abuse Treatment* (pp. 216-233). New York: Guilford Press, 2001.

Markides, K.S., Al Snih, S., Walsh, T., Cutchin, M.,Ju, H., and Goodwin,J.S. Problem drinking

among Mexican-Americans: The influence of nativity and neighborhood context? *American journal of Health Promotion* 26:225-229, 2012.

Markides, K.S., Ray, L.A., Stroup-Benham, C.A., and Trevino, F.M. Acculturation and alcohol

consumption in the Mexican American population of the southwestern United States: Findings from HHANES *1982-84.Americanjournal of Public Health* 80(Supplement):42-46,1990.

Marsh,J.C., Cao, D., Guerrero, E., and Shin, H.C. Need-service matching in substance abuse treatment: Racial/ethnic differences. *Evaluation and Program Planning* 32(1):43-51, 2009.

Martin, M.A. Ethnobotanical aspects of cannabis in Southeast Asia. In: Rubin, V., ed. *Cannabis and Culture* (pp. 63-76). Paris: Mouton Publishers, 1975.

Martinez, C. Hispanic psychiatric issues. In: Wilkinson, C.B., ed. *Ethnic Psychiatry* (pp. 61-87).

New York: Plenum, 1986.

Martinez, L.C. DSM-IV-TR cultural formulation of psychiatric cases: Two proposals for clini­ cians. *Transcultural Psychiatry, 46,* 506-523, 2009.

Martinez, S., Stillerman, L., and Waldo, M. Reliability and validity of the SCL-90- R with His­ panic college students. *Hispanic journal of Behavioral Sciences* 27:254-264, 2005.

Masson, C.L., Shopshire, M.S., Sen, S., Hoffman, K.A., Hengl, N.S., Bartolome,]., McCarty, D., Sorensen,J.L., and Iguchi, M.Y. Possible barriers to enrollment in substance abuse treatment among a diverse sample of Asian Americans and Pacific Islanders: Opinions of treatment cli­

*ents.journal of Substance Abuse Treatment* 44(3):309-315, 2013.

Mateu-Gelabert, P., Maslow, C., Flom, P.L., Sandoval, M., Bolyard, M., and Friedman, S.R. Keep­ ing it together: Stigma, response, and perception of risk in relationships between drug injectors and crack smokers, and other community residents. *AIDS Care* 17(7):802-813, 2005.

Mather, M., Pollard, K., and Jacobsen, L.A. *First Results From the 2010 Census.* Washington, DC: Population Reference Bureau, 2011.

Matsuoka,J.K., Breaux, C., and Ryujin, D.H. National utilization of mental health services by Asian Americans/Pacific Islanders.journal*of Community Psychology* 25(2):141-145, 1997.

Maude-Griffin, P.M., Hohenstein,J.M., Humfleet, G.L., Reilly, P.M., Tusel, D.J., and Hall, S.M.

Superior efficacy of cognitive-behavioral therapy for urban crack cocaine abusers: Main and matching *effects.journal of Consulting and Clinical Psychology* 66(5):832-837, 1998.

May, P.A., and Gossage, P. New data on the epidemiology of adult drinking and substance use among American Indians of the Northern States: Male and female data on prevalence, patterns, and *consequences.American Indian and Alaska Native Mental Health Research* 10(2):1-26, 2001.

May, P.A., Serna, P., Hurt, L., and DeBruyn, L.M. Outcome evaluation of a public health ap­ proach to suicide prevention in an American Indian tribal *nation.American journal of Public Health* 95(7):1238-1244, 2005.

221

Improving Cultural Competence

Mayfield, D., McLeod, G., and Hall, P. The CAGE questionnaire: Validation of a new alcohol­ ism screening instrument. *American journal of Psychiatry* 131:1121-1123, 1974.

Mays, V.M., Yancey, A.K., Cochran, S.D., Weber, M., and Fielding,J.E. Heterogeneity of health

disparities among African American, Hispanic, and Asian American women: Unrecognized influences of sexual *orientation.American journal of Public Health* 92(4):632-639, 2002.

McCaul, M.E., Svikis, D.S., and Moore, R.D. Predictors of outpatient treatment retention: Pa­ tient versus substance use characteristics. *Drug and Alcohol Dependence* 62(1):9-17, 2001.

McCoy, K., McGuire,]., Curtis, R., and Spunt, B. White chicks on dope: Heroin and identity dynamics in New York in the *1990's.journal of Drug Issues* 35(4):817-842, 2005.

McCrady, B.S., Epstein, E.E., and Kahler, C.W. Alcoholics Anonymous and relapse prevention as maintenance strategies after conjoint behavioral alcohol treatment for men: 18-month out­

*comes.journal of Consulting and Clinical Psychology* 72(5):870-878, 2004.

McDonald,J.D., and Gonzales,]. Cognitive behavior therapy with American Indians. In: Hays, **P.A.,** and Iwamasa, **G.,** eds. *Culturally Responsive Cognitive-BehavioralTherapy:Assessment, Practice, and Supervision.* 1st ed. (pp. 23-45) Washington, DC: American Psychological Asso­ ciation, 2006.

McFarland, B.H., Gabriel, R.M., Bigelow, D.A., and Walker, R.D. Organization and financing of alcohol and substance abuse programs for American Indians and Alaska *Natives.American*

*journal of Public Health* 96(8):1469-1477, 2006.

McGill, D.W., and Pearce,J.K. American families with English ancestors from the colonial era: Anglo Americans. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 520-533). New York: Guilford Press, 2005.

McGoldrick, M. Normal families: An ethnic perspective. In: Walsh, F., ed. *Normal Family Pro­ cesses* (pp. 399-424). New York: Guilford Press, 1982.

McGoldrick, M., Giordano,]., and Garcia-Preto, N. Overview: Ethnicity and family therapy. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 1-40). New York: Guilford Press, 2005.

McGrath,]., Saha, S., Welham,J., Saadi, O.E., MacCauley, C., and Chant, D. A systematic re­ view of the incidence of schizophrenia: The distribution of rates and the influence of sex, ur­ banicity, migrant status and methodology. *BMC Medicine* 2:13, 2004.

McIntosh, J., and McKeganey, N. The recovery from dependent drug use: Addicts' strategies for reducing the risk of relapse. *Drugs: Education, Prevention* & *Policy* 7(2):179-192, 2000.

McKee-Ryan, F., Song, Z., Wanberg, C.R., and Kinicki, A.J. Psychological and physical well­ being during unemployment: A meta-analytic *study.journal of Applied Psychology* 90(1):53- 76, 2005.

McKim, W.A. *Drugs and Behavior: An Introduction to Behavioral Pharmacology.* 5th ed. Upper Saddle River, NJ: Prentice Hall, 2003.

McKinney, C.M., Chartier, K.G., Caetano, R., and Harris, T.R. Alcohol availability and neigh­ borhood poverty and their relationship to binge drinking and related problems among drink­

ers in committed relationships.journal*of Interpersonal Violence* 27(13):2703-2727, 2012.

222

Appendix A-Bibliography

McLaughlin, L.A., and Braun, K.L. Asian and Pacific Islander cultural values: Considerations for health care decision making. *Health and Social Work* 23(2):116-126, 1998.

McLellan, A.T., Luborsky, L., Cacciola,]., Griffith,]., Evans, F., Barr, H.L., and O'Brien, C.P. New data from the Addiction Severity Index: Reliability and validity in three *centers.journal*

*of Nervous and Mental Disease* 173:412-423, 1985.

McLellan, A.T., Luborsky, L., Woody, G.E., and O'Brien, C. P. An improved diagnostic evalua­ tion instrument for substance abuse patients: The Addiction Severity *Index.journal of Nerv­ ous and Mental Disease* 168:26-33, 1980.

McNulty,J.L., Forbey,J.D., Graham,J.R., Ben-Porath, Y.S., Black, M.S., Anderson, S.V., and Burlew, A.K. MMPI-2 validity scale characteristics in a correctional sample. *Assessment* 10:288-298, 2003.

Medina, C. Toward an understanding of Puerto Rican ethnicity and substance abuse. In: Strauss­ ner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 137-163). New York: Guilford Press, 2001.

Medina-Mora, E., Carreno, S., and de la Fuente,J.R. Experience with the alcohol use disorders identification test (AUDIT) in Mexico. *Recent Developments in Alcoholism* 14:383-396, 1998.

Mendoza, **R.H.** (1989). An empirical scale to measure type and degree of acculturation in Mexi­ can-American adolescents and *adults.journal of Cross-Cultural Psychology* 20:372-385, 1989.

Mericle, A.A., Ta Park, V.M., Holck, P., and Arria, A.M. Prevalence, patterns, and correlates of co-occurring substance use and mental disorders in the United States: Variations by race/ethnicity. *Comprehensive Psychiatry* 53(6):657-665, 2012.

Meyer, O.L., Dhindsa, M., and Zane, N. Psychology of Asian American adults: Challenges and strengths. In: Chang, E.C., ed. *Handbook of Race and Development in Mental Health* (pp. 169- 187). New York: Springer Science + Business Media, 2012.

Mezzich,J.E., and Caracci, G., eds. *Cultural Formulation: A Reader for Psychiatric Diagnosis.*

Lanham, MD: Jason Aronson, Inc., 2008.

Mezzich,J.E., Caracci, G., Fabrega, H.,Jr., and Kirmayer, L.J. Cultural formulation guidelines.

*Transcultural Psychiatry* 46(3):383-405, 2009.

Miller, K.A., Stanley, L.R., & Beauvais, F. Regional differences in drug use rates among Ameri­ can Indian youth. *Drug and Alcohol Dependence* 126:35-41, 2012.

Miller, R. and Mason, S.E. (2011). *Diagnosis: Schizophrenia: A Comprehensive Resource for Con­ sumers, Families, and Helping Professionals.* 2nd ed. New York: Columbia University Press, 2011.

Miller, **W.R.,** Hendrickson, **S.M.L.,** Venner, **K.,** Bisono, A., Daugherty, M., and Yahne, C.E. Cross-cultural training in motivational interviewing.journal *of Teaching in the Addictions* 7(1):4-15, 2008.

Miller, **W.R.,** and Rollnick, S. *Motivational Interviewing: Preparing People for Change.* 2nd ed.

New York: Guilford Press, 2002.

223

Improving Cultural Competence

Miller, W.R., and Rollnick, S. *Motivational Interviewing: Helping People Change,.3rd* ed. New York: Guilford Press, 2013.

Milligan, C. 0., Nich, C., and Carroll, K. M. (2004). Ethnic differences in substance abuse treatment retention, compliance, and outcome from two clinical trials. *Psychiatric Service* 55:167-173, 2004.

Millon, **T.,** Davis, **R.,** Millon, C., and Grossman, **S.** *The Millon Clinical Multiaxial Inventory-Ill Third Edition (MCMI-III) (2009) With New Norms and Updated Scoring.* San Antonio, TX: Pearson, 2009.

Mills, P.A. Incorporating Yup'ik and Cup'ik Eskimo traditions into behavioral health treatment.

*journal of Psychoactive Drugs* 35:85-88, 2003.

Minnesota Department of Human Services. *Guidelines far Culturally Competent Organizations.* St.

Paul, MN: Minnesota Department of Human Services, 2004.

Minsky, S., Vega, W., Miskimen, T., Gara, M., and Escobar,]. Diagnostic patterns in Latino, African American, and European American psychiatric *patients.Archives of General Psychiatry* 60(6):637-644, 2003.

Miranda,]., Bernal, G., Lau, A., Kohn, L., Hwang, W.C., and LaFromboise, T. State of the sci­ ence on psychosocial interventions for ethnic minorities.Annual *Review of Clinical Psychology* 1(1):113-142, *2005a.*

Miranda,]., Siddique,]., Belin, T.R., and Kohn-Wood, L.P. Depression prevalence in disadvan­ taged young black women: African and Caribbean immigrants compared to U.S.-born Afri­ can Americans. *Social Psychiatry and Psychiatric Epidemiology* 40(4):253-258, *2005b.*

Mishra, S.I., Lucksted, A., Gioia, D., Barnet, B., and Baquet, C.R. Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health journal* 45(2):117-126, 2009.

Mitchell, C.M., Beals,]., Novins, D.K., and Spicer, P. Drug use among two American Indian populations: Prevalence oflifetime use and DSM-IV substance use disorders. *Drug and Alco­ hol Dependence* 69:29-41, 2003.

Miville, M.L., Rosa, D., and Constantine, M.G. Building multicultural competence in clinical supervision. In: *Strategies far Building Multicultural Competence in Mental Health and Educa­ tional Settings* (pp.192-211). Hoboken, NJ:John Wiley & Sons Inc, 2005.

Mohamed, A.R., and Fritsvold, E. Damn, it feels good to be a gangsta: The social organization of the illicit drug trade servicing a private college campus. *Deviant Behavior* 27(1):97-125, 2006.

Mohatt, G.V., Allen,]., and Thomas, L.R. Drug and alcohol abuse in cross-cultural counseling. In: Pedersen, P.B., Draguns,J.G., Lonner, W.J., and Trimble,J.E., eds. *Counseling Across Cul­ tures.* 6th ed. (pp. 395-413). Thousand Oaks, CA: Sage Publications, 2008a.

Mohatt, G.V., Rasmus, S.M., Thomas, L., Allen,]., Hazel, K., and Marlatt, G.A. Risk, resilience, and natural recovery: A model of recovery from alcohol abuse for Alaska *Natives.Addiction* 103(2):205-215, 2008b.

224

Appendix A-Bibliography

Mokuau, N. Reality and vision: A cultural perspective in addressing alcohol and drug abuse among Pacific Islanders. In: Mokuau, N., Epstein, L.G., Pacheco, G., and Qyinlan,J.W., eds. *Responding to Pacific Islanders: Culturally Competent Perspectives far Substance Abuse Prevention* (pp. 25-47). CSAP Cultural Competence Series 8. HHS Publication No. (SMA) 98-3195. Rockville, MD: Center for Substance Abuse Prevention, 1998.

Mokuau, N., and Tauili'ili, P. Families with Native Hawaiian and Samoan roots. In: Lynch, E.W., and Hanson, M.J., eds. *Developing Cross-Cultural Competence: A Guide far Working with Chil­ dren and Their Families.* 4th ed. (pp. 365-391). Baltimore: Paul H. Brookes Publishing, 2011.

Molina, M.A.N. Community healing among Puerto Ricans: Espiritismo as a therapy for the soul. In: Olmos, M.F., and Paravisini-Gebert, L., eds. *Healing Cultures: Art and Religion as Curative Practices in the Caribbean and Its Diaspora* (pp. 115-130). New York: Palgrave, 2001.

Monnot, M.J., Qyirk, S.W., Hoerger, M., and Brewer, L. Racial bias in personality assessment: using the MMPI-2 to predict psychiatric diagnoses of African American and Caucasian chemical dependency inpatients. *Psychological Assessment* 21:137-151, 2009.

Montgomery, G.T. Comfort with acculturation status among students from south Texas. *Hispanic journal of Behavioral Sciences* 14:201-223, 1992.

Montgomery, L., Burlew, A.K., Kosinski, A.S., and Forcehimes, A.A. Motivational enhancement therapy for African American substance users: A randomized clinical trial. *Cultural Diversity and Ethnic Minority Psychology* 17(4):357-365, 2011.

Moos, **R.H.** Addictive disorders in context: Principles and puzzles of effective treatment and recovery. *Psychology of Addictive Behaviors* 17(1):3-12, 2003.

Moos, **R.H.,** and Moos, **B.S.** Rates and predictors of relapse after natural and treated remission from alcohol use *disorders.Addiction* 101(2):212-222, 2006.

Mora,]. Latinas in cultural transition: Addiction, treatment and recovery. In: Straussner, S.L.A., and Brown, S., eds. *The Handbook of Addiction Treatment far Women: Theory and Practice* (pp. 323-347). San Francisco: Jossey Bass, 2002.

Morales, R. *Alcohol Abuse and the Asian American.* Presentation at the NIDA National Conference on Drug Abuse Research and Practice,January 21, 1991, Washington, DC. 1991.

Morelli, P.T., and Fong, R. The role of Hawaiian elders in substance abuse treatment among Asian/Pacific Island *women.journal of Family Social Work* 4(4):33-44, 2000.

Morgan, P., and Beck,J.E. The legacy and the paradox: Hidden contexts of methamphetamine use in the United States. In: Klee, H., *ed.Amphetamine Misuse: International Perspectives on Current Trends* (pp. 135-162). The Netherlands: Harwood Academic Publishers, 1997.

Morning Star, L. *Chronic Volatile Substance Abuse Among the Adult Kickapoo Traditional Tribe of Texas: Disease and Disability Profiles, Neuropsychosocial Consequences, and Social Implications far Treatment* [Doctoral dissertation]. Houston, TX: The University of Texas Health Sciences Center at Houston School of Public Health, 2005.

Moshier, S.J., McHugh, R.K., Calkins, A.W., Hearon, B.A., Rosellini, *A.].,*Weitzman, M.L., and Otto, M.W. The role of perceived belongingness to a drug subculture among opioid­ dependent patients. *Psychology of Addictive Behaviors* 6(4):812-820, 2012.

225

Improving Cultural Competence

Moss, R.K., Taylor, T., and May, P.A. *Robert Wood Johnson Foundation Healthy Nations Initiative Evaluation: The Stories and Lessons of Fighting Substance Abuse in Native American Communi­ ties.* Anchorage, AK: Institute of Social and Economic Research, University of Alaska, An­ chorage, 2003.

Mouanoutoua, V.L., Brown, L.G., Cappelletty, G.G., and Levine, R.V. A Hmong adaptation of the Beck Depression *Inventory.journal of Personality Assessment* 57:309-322, 1991.

Moulton, P., McDonald, L., Muus, K., Knudson, A., Wakefield, M., and Ludtke, R. *Prevalence of Chronic Disease Among American Indian and Alaska Native Elders.* Grand Forks, ND: Univer­ sity of North Dakota, School of Medicine & Health Sciences, Center for Rural Health, 2005.

Mulia, N., Ye, Y., Zemore, S.E., and Greenfield, T.K. Social disadvantage, stress, and alcohol use among Black, Hispanic, and White Americans: Findings from the 2005 U.S. national alcohol *survey.journal of Studies on Alcohol and Drugs* 69(6):824-833, 2008.

Murali, V., and Oyebode, F. Poverty, social inequality and mental health. In: Bhattacharya, R., Cross, S., and Bhugra, D., eds. *Clinical Topics in Cultural Psychiatry* (pp. 84-99). London: Royal College of Psychiatrists, 2010.

Murguia, A., Zea, M.C., Reisen, C.A., and Peterson, R.A. The development of the cultural health attributions questionnaire (CHAQ.2. *Cultural Diversity* & *Ethnic Minority Psychology* 6(3):268-283, 2000.

Murguia, E., Tackett-Gibson, M., and Willard, R. Club drugs, online communities, and harm reduction websites on the internet. In: Murguaia, E., Tackett-Gibson, M., and Lessem, A., eds. *Real Drugs in a Virtual World: Drug Discourse and Community Online* (pp. 5-22). Lanham, MD: Lexington Books, 2007.

Murray, C.J., Kulkarni, S.C., Michaud, C., Tomijima, N., Bulzacchelli, M.T., Iandiorio, T.J., and Ezzati, M. Eight Americas: Investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Medicine* 3(9):e260, 2006.

Myers, B., Fakier, N., and Louw,J. Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African journal of Psychiatry* 12(3):218-222, 2009.

Nadeem, E., Lange,J.M., Edge, D., Fongwa, M., Belin, T., and Miranda,]. Does stigma keep poor young immigrant and U.S.-born Black and Latina women from seeking mental health care? *Psychiatric Services* 58(12):1547-1554, 2007.

Nadeem, E., Lange,J.M., and Miranda,]. Mental health care preferences among low-income and minority *women.Archives of Women's Mental Health* 11(2):93-102, 2008.

Nanakorn, S., Fukuda, K., Ogimoto, I., Tangseree, **T.,** and Treethiptikhun, S. Validation of the Short Michigan Alcoholism Screening Test Thai version in northeastern Thailand. *Southeast Asian journal ofTropical Medicine and Public Health* 31:780-786, 2000.

National Asian Pacific American Families Against Substance *Abuse.Alcohol, Tobacco, and Other Drug Use Among Vietnamese American High School Students in California: Findings From a 1995 Survey.* Los Angeles: NAPAFASA, 2000.

National Association of Social Workers. *NASW Standards far Cultural Competence in Social Work Practice.* Washington, DC: National Association of Social Workers, 2001.

226

Appendix A-Bibliography

National Center for Cultural Competence. *Rationale for Seif-Assessment.*Washington, DC: Georgetown University, Center for Child and Human Development, 2013.

National Center for Health Statistics. *Health, United States, 2011: With Special Feature on Socioec­ onomic Status and Health.* Hyattsville, MD: Centers for Disease Control and Prevention, Na­ tional Center for Health Statistics, 2012.

National Center on Addiction and Substance Abuse. *Family Matters: Substance Abuse and the American Family:A CASA. White Paper.* New York: Columbia University, 2005.

National Congress of American Indians **(NCAI).** *Methamphetamines in Indian Country:An American Problem Uniquely Affecting Indian Country.* Washington, DC: The National Con­ gress of American Indians, 2006.

National Institutes of Health. *Biennial Report of the Director, National Institutes of Health Fiscal Years 2008* & *2009.* Bethesda, MD: National Institutes of Health, 2012.

Neighbors, H.W., Musick, M.A., and Williams, D.R. The African American minister as a source of help for serious personal crises: Bridge or barrier to mental health care? *Health Education* & *Behavior* 25(6):759-777, 1998.

Nemoto, T., Aoki, B., Huang, K., Morris, A., Nguyen, H., and Wong, W. Drug use behaviors among Asian drug users in San *Francisco.Addictive Behaviors* 24(6):823-838, 1999.

Nemoto, T., Operario, D., and Soma, T. Risk behaviors of Filipino methamphetamine users in San Francisco: Implications for prevention and treatment of drug use and HIV. *Public Health Reports* 117(Suppl 1):S30-S38, 2002.

Nguyen, H.T., Kitner-Triolo, M., Evans, M.K., and Zonderman, A.B. Factorial invariance of the CES-D in low socioeconomic status African Americans compared with a nationally repre­ sentative sample. *Psychiatry Research* 126:177-187, 2004.

Niv, N., Wong, E.C., and Hser, Y.I. Asian Americans in community-based substance abuse treatment: service needs, utilization, and *outcomes.journal of Substance Abuse Treatment* 33(3):313-319, 2007.

Niven,J.A. Client-centered, culture-friendly behavioral health care techniques for work with Alaska natives in the Bering Strait Region. *Social Work in Mental Health* 8(4):398-420, 2010.

Norris, A.E., Ford, K., and Bova, C.A. Psychometrics of a brief acculturation scale for Hispanics in a probability sample of urban Hispanic adolescents and young adults. *Hispanic journal of Behavioral Sciences* 18:29-38, 1996.

Norris, T., Vines, P.L., and Hoeffel, E.M. *The American Indian and Alaska Native Population: 2010.* Census 2010 Brie£ Washington, DC: U.S. Census Bureau, 2012.

Novy, D.M., Stanley, M.A., Averill, P., and Daza, P. Psychometric comparability of English- and Spanish-language measures of anxiety and related affective symptoms. *Psychological Assessment* 13:347-355, 2001.

Nyunt, M.S.Z., Fones, C., Niti, M., and Ng, T.P. Criterion-based validity and reliability of the Geriatric Depression Screening Scale (GDS-15) in a large validation sample of community­ living Asian older *adults.Aging and Mental Health* 13:376-382, 2009.

227

Improving Cultural Competence

Obasi, E.M., and Leong, F.T.L. Psychological distress, acculturation, and mental health-seeking attitudes among people of African descent in the United States: A preliminary investigation.

*journal of Counseling Psychology* 56(2):227-238, 2009.

O'Connell,J.M., Novins, D.K., Beals,]., and Spicer, P. Disparities in patterns of alcohol use among reservation-based and geographically dispersed American Indian *populations.Alcohol­ ism: Clinical and Experimental Research* 29(1):107-116, 2005.

O'Dwyer, P. The Irish and substance abuse. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 199-215). New York: Guilford Press, 2001.

Oetting, E.R., and Beauvais, F. Orthogonal cultural identification theory: The cultural identifica­ tion of minority adolescents. *The International journal of the Addictions* 25(5A-6A):655-685, 1990.

Office of Applied Studies. *2003 National Survey on Drug Use* & *Health: Detailed Tables. Results from the 2003 National Survey on Drug Use and Health: National Findings.* Rockville, **MD:** Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2004.

Office of Applied Studies. *Substance Abuse Treatment Admissions Among Asians and Pacific Is­ landers: 2002.* The Dasis Report June 10. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2005a.*

Office of Applied Studies. *Treatment Admissions in Rural Areas: 2003.* The DASIS Report, Sep­ tember 30, 2005. Rockville, MD: Substance Abuse and Mental Health Services Administra­ tion, *2005b.*

Office of Applied Studies. *Substance Use and Substance Use Disorders Among American Indians and Alaska Natives.* The NSDUH Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007.

Office of Communications. *Summary Report CARAVII.N® Survey for SAMHSA on Addictions and Recovery.* Rockville, MD: Office of Communications, Substance Abuse and Mental Health Services Administration, 2008.

Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. *Social determinants of health. Healthy People 2020.* Rockville, **MD:** Office of Disease Prevention and Health Promotion, 2013.

Office of Minority *Health.Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda.* Rockville, **MD:** Office of Mi­ nority Health, 2000.

Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Ser­ vices in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice.* Washington, DC: Office of Minority Health, 2013.

Office of Minority Health. *What is Cultural Competency?* Washington, DC: Office of Minority Health, 2005.

Ogunwole, S.U. *We the People: American Indians and Alaska Natives in the United States.* Census 2000 Special Reports. Washington, DC: U.S. Census Bureau, 2006.

228

Appendix A-Bibliography

Oksanen, A. To hell and back: Excessive drug use, addiction, and the process of recovery in main­ stream rock autobiographies. *Substance Use* & *Misuse* 47(2):143-154, 2012.

Oliveira,J.M., Austin, A.A., Miyamoto, R.E.S., Kaholokula,J.K., Yano, K.B., and Lunasco, T. The rural Hawai'i behavioral health program: increasing access to primary care behavioral health for Native Hawaiians in rural settings. *Professional Psychology: Research and Practice* 37(2):174-182, 2006.

Organista, K.C. Cognitive-behavioral therapy with Latinos and Latinas. In: Hays, P.A., and Iwamasa, G.Y., eds. *Culturally Responsive Cognitive-BehavioralTherapy:Assessment, Practice, and Supervision* (pp. 73-96). Washington, DC: American Psychological Association, 2006.

Organista, K.C., and Mufi.oz, R.F. Cognitive-behavioral therapy with Latinos. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 353-366). New York: Routledge, 1998.

Organista, P.B., Organista, K.C., and Kurasaki, K. The relationship between acculturation and ethnic minority health. In: Chun, K.M., Balls-Organista, P., and Marin, G., *eds.Acculturation: Advances in Theory, Measurement and Applied Research* (pp. 139-161). Washington, DC: American Psychological Association, 2003.

Ornelas, I.J., and Hong, S. Gender differences in the relationship between discrimination and substance use disorder among Latinos. *Substance Use and Misuse* 47(12):1349-1358, 2012.

Otiniano Verissimo, A.D., Gee, G. C., Ford, C.L., and Iguchi, M.Y. Racial discrimination, gen­ der discrimination, and substance abuse among Latina/os nationwide. *Cultural Diversity and Ethnic Minority Psychology* 20(1): 43-51, 2014.

Otsubo, T., Tanaka, K., Koda, R., Shinoda,]., Sano, N., Tanaka, S., Aoyama, H., Mimura, M., and Kamijima, K. Reliability and validity of Japanese version of the Mini-International Neuro­ psychiatric Interview. *Psychiatry and Clinical Neurosciences* 59:517-526, 2005.

Pacek, L.R., Malcolm, R.J., and Martins, S.S. Race/ethnicity differences between alcohol, mariju­ ana, and co-occurring alcohol and marijuana use disorders and their association with public health and social problems using a national sample. *The American journal on Addictions* 21(5):435-444, 2012.

Pack-Brown, **S.P.,** and Williams, **C.B.** *Ethics in a Multicultural Context: Multicultural Aspects of*

*Counseling Series.* Thousand Oaks, CA: Sage Publications, 2003.

Padilla, A.M. The role of cultural awareness and ethnic loyalty in acculturation. In Padilla, A.M., ed.

*Acculturation: Theory, Models and Some New Findings* (pp. 47-84). Boulder, CO: Westview, 1980.

Padilla, A.M., and Salgado de Snyder, V.N. Hispanics: What the culturally informed evaluator needs to know. In: Orlandi, M.A., Weston, R., and Epstein, L.G ., eds. *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities* (pp. 117-146). OSAP Cultural Competence Series I. HHS Publi­ cation No. (ADM) 92-1884. Rockville, MD: Office for Substance Abuse Prevention, 1992.

Pal, H.R.,Jena, R., and Yadav, D. Validation of the Alcohol Use Disorders Identification Test (AUDIT) in urban community outreach and de-addiction center samples in north India.

*journal of Studies onAlcohol* 65:794-800, 2004.

229

Improving Cultural Competence

Paniagua, F.A. *Assessing and Treating Culturally Diverse Clients: A Practical Guide.* 2nd ed. Thou­ sand Oaks, CA: Sage Publications, 1998.

Park, M., Chesla, C.A., Rehm, R.S., and Chun, K.M. Working with culture: culturally appropriate mental health care for Asian *Americans.journal*ef*Advanced Nursing* 67(11):2373-2382, 2011.

Passel, J.S. *Unauthorized Migrants: Numbers and Characteristics. Background Briefing Prepared far Task Force on Immigration and America's Future.* Washington, DC: Pew Hispanic Center, Pew Research Center, 2005.

Passel,J.S., and Cohn, D. *US. Population Projections: 2005-2050.* Washington, DC: Pew Re­ search Center, 2008.

Passel,J.S., and Cohn, *D.A Portrait if Unauthorized Immigrants in the United States.* Washington, DC: Pew Research Center, 2009.

Pawson, M., and Kelly, B.C. Consumption and community: The subcultural contexts of disparate marijuana practices in jam band and hip-hop scenes. Deviant Behavior 35(5):347-363, 2014.

Peace Corps Information Collection and Exchange. *Culture Matters: The Peace Corps Cross­ Cultural Workbook.* Washington, DC: Peace Corps Information Collection and Exchange, 2012.

Pearson, C., and Bourgois, P. Hope to die a dope fiend. *Cultural Anthropology* 10(4):587-593, 1995. Pena,J.M., Bland, I.J., Shervington, D., Rice,J.C., and Foulks, E.F. Racial identity and its as­

sessment in a sample of African-American men in treatment for cocaine *dependence.Ameri­*

*can journal efDrug and Alcohol Abuse* 26:97-112, 2000.

People Awakening Project. *The People Awakening Project: Discovering Alaska Native Pathways to Sobriety. Final Report 2004.* Fairbanks, AK: University of Alaska Fairbanks, 2004.

Perez, M.A., and Luquis, **R.R.** *Cultural Competence in Health Education and Health Promotion,.lst*

ed. San Francisco: Jossey-Bass, 2008.

Pernell-Arnold, A., Finley, L., Sands, R.G., Bourjolly,]., and Stanhope, V. Training mental health providers in cultural competence: A transformative learning process. American Journal of Psychiatric Rehabilitation 15(4):334-356, 2012.

Perron, B.E., Mowbray, O.P., Glass,J.E., Delva,]., Vaughn, M.G., and Howard, M.O. Differ­ ences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. *Substance Abuse Treatment, Prevention and Policy* 4:3, 2009.

Peters, M.L., Sawyer, C.B., and Guzman, M. Supporting the development of Latino bilingual mental health professionals.journal *if Hispanic Higher Education* 13(1):15-31, 2014.

Petry, **N.M.** A comparison of African American and non-Hispanic Caucasian cocaine-abusing outpatients. *Drug and Alcohol Dependence* 69(1):43-49, 2003.

Petry, **N.M.,** Alessi, **S.M.,** and Hanson, T. Contingency management improves abstinence and quality of life in cocaine *abusers.journal if Consulting and Clinical Psychology* 75(2):307-315, 2007.

Petry, N.M., Alessi, S.M., Marx,]., Austin, M., and Tardif, M. Vouchers versus prizes: Contin­ gency management treatment of substance abusers in community *settings.journal if Consult­ ing and Clinical Psychology* 73(6):1005-1014, 2005.

230

Appendix A-Bibliography

Petry, N.M., Tedford,]., Austin, M., Nich, C., Carroll, K.M., and Rounsaville, B.J. Prize rein­ forcement contingency management for treating cocaine users: How low can we go, and with whom? *Addiction* 99(3):349-360, 2004.

Pew Forum on Religion and Public Life. *U.S. Religious Landscape Survey: Religious Affiliation: Diverse and Dynamic.* Washington, DC: Pew Research Center, 2008.

Pew Research Center for the People & the Press. *Interdiction and Incarceration Still Top Remedies: 74% Say Drug War Being Lost.* Washington, DC: Pew Research Center, 2001.

Pierce, T.G. Gen-Xjunkie: Ethnographic research with young White heroin users in Washing­ ton, DC. *Substance Use* & *Misuse* 34(14):2095-2114, 1999.

Pieterse, A.L., Todd, N.R., Neville, H.A., and Carter, R.T. Perceived racism and mental health among Black American adults: A meta-analytic *review.journal of Counseling Psychology, 59,* 1-9,2012.

Polednak, A.P. Temporal trend in the U.S. Black-White disparity in mortality rates from selected alcohol-related chronic *diseases.journal of Ethnicity in Substance Abuse* 7(2):154-164, 2008.

Ponterotto,J.G., Fuertes,J.N., and Chen, E.C. Models of multicultural counseling. In: Brown, S.D., and Lent, R.W., eds. *Handbook of Counseling Psychology* (pp. 639-669). New York:John Wiley & Sons, 2000. Portes, A., Fernandez-Kelly, P., and Haller, W. Segmented assimilation on the ground: The new second generation in early adulthood. *Ethnic and Racial Studies* 28(6):1000-1040, 2005.

Portes, A., and Rumbaut, R.G. Introduction: The second generation and the children of immi­ grants longitudinal study. *Ethnic and Racial Studies* 28(6):983-999, 2005.

Posner, S.F., Stewart, A.L., Martin, G., and Perez-Stable, E.J. Factor variability of the Center for Epidemiological Studies Depression Scale (CES-D) among urban Latinos. *Ethnicity and Health* 6:137-144, 2001.

Pouget, E.R., Friedman, S.R., Cleland, C.M., Tempalski, B., and Cooper, H.L. Estimates of the population prevalence ofinjection drug users among Hispanic residents oflarge US metro­ politan areas. *journal of Urban Health* 89(3):527-564, 2012.

Prochaska,J.O., and DiClemente, C.C. *The TranstheoreticalApproach: Crossing Traditional Bound­ aries ofTherapy.* Homewood, IL: Dow Jones-Irwin, 1984.

Prochaska,J.O., DiClemente, C.C., and Norcross,J.C. In search of how people change: Applica­ tions to addictive behaviors. *The American Psychologist47(9):1102-1114,* 1992.

Qyintana, M.I., Andreoli, S.B.,Jorge, M.R., Gastal, F.L., and Miranda, C.T. The reliability of the Brazilian version of the composite international diagnostic interview (CIDI 2.1). *Brazilian journal of Medical and Biological Research* 37(11):1739-1745, 2004.

Qyintero, G.A., Lilliott, E., and Willging, C. Substance abuse treatment provider views of"cul­ ture": Implications for behavioral health care in rural settings. *Qualitative Health Research* 17(9):1256-1267, 2007.

Radloff, L.S. The CES-D Scale: A self-report depression scale for research in the general popu­

*lation.Applied Psychological Measurement* 1:385-401, 1977.

231

Improving Cultural Competence

Ramirez, M. *Multicultural Psychotherapy: An Approach to Individual and Cultural Differences.* 2nd ed. Boston: Allyn and Bacon, 1999.

Ramirez, R.R., and de la Cruz, G.P. *The Hispanic Population in the United States: March 2002.*

Current Population Reports. Washington, DC: U.S. Census Bureau, 2003.

Ramos-Sanchez, L. The psychology of undocumented Latinos: Living an invisible existence. In: Chin,J.L., ed. *Diversity in Mind and in Action, Vol 1: Multiple Faces of Identity* (pp. 105-115). Santa Barbara, CA: Praeger/ABC-CLIO, 2009.

Rastogi, M., and Wadhwa, S. Substance abuse among Asian Indians in the United States: A consideration of cultural factors in etiology and treatment. *Substance Use* & *Misuse* 41(9):1239-1249, 2006.

Reardon, S.F., and Buka, S.L. Differences in onset and persistence of substance abuse and de­ pendence among Whites, Blacks, and Hispanics. *Public Health Reports* 117(Suppl 1):S51- S59,2002.

Reback, C.J. *The Social Construction of a Gay Drug: Methamphetamine Use Among Gay and Bisexual Males in Los Angeles.* Los Angeles: City of Los Angeles, AIDS Coordinator, 1997.

Reback, *C.].,* and Shoptaw, S. Development of an evidence-based, gay-specific cognitive behav­ ioral therapy intervention for methamphetamine-abusing gay and bisexual men. *Addictive Be­ haviors* 39(8):1286-1291, 2011.

Reeves, T., and Bennett, C. *The Asian and Pacific Islander Population in the United States: March 2002.* Current Population Reports. Washington, DC: U.S. Census Bureau, 2003.

Reid, D.J. Addiction, African Americans, and a Christian recovery. In: Krestan,J.A., ed. *Bridges to Recovery:Addiction, Family Therapy, and Multicultural Treatment* (pp. 145-172). New York: The Free Press, 2000.

Reinert, D.F. and Allen,J.P. The alcohol use disorders identification test: an update of research findings. *Alcoholism: Clinical and Experimental Research* 31:185-199, 2005.

Reuland, D.S., Cherrington, A., Watkins, G.S., Bradford, D.W., Blanco, R.A., and Gaynes, B.N. Diagnostic accuracy of Spanish language depression-screening instruments. *Annals of Family Medicine* 7:455-462, 2009.

Reyna,J.M., and Cadena, C.H.G. Masculinity, machismo and their relation with some familiar variables. In: Columbus, A.M., *ed.Advances in Psychology Research, Vol. 42* (pp. 123-145).

Hauppauge, NY: Nova Science Publishers, 2007.

Reynolds, S. *Generation Ecstasy: Into the World ofTechno and Rave Culture.* New York: Routledge, 1998.

Reynoso-Vallejo, H., Chassler, D., Witas,J., and Lundgren, L.M. Patterns of drug treatment entry by Latino male injection drug users from different national/geographical backgrounds. *Evaluation and Program Planning* 31(1):92-101, 2008.

Rezentes, W.C. Na Mea Hawaii: A Hawaiian acculturation scale. *Psychological Reports* 73:383- 393, 1993.

232

Appendix A-Bibliography

Rich,J.A., and Grey, C.M. Pathways to recurrent trauma among young Black men: Traumatic stress, substance use, and the "code of the *street".Americanjournalof Public Health* 95(5):816- 824, 2005.

Richardson, T.M., and Williams, B.A. *African-Americans in Treatment: Dealing With Cultural Differences.* Center City, MN: Hazelden, 1990.

Riehman, K.S., Wechsberg, W.M., Zule, W., Lam, W.K., and Levine, B. Gender differences in the impact of social support on crack use among African Americans. *Substance Use* & *Misuse* 43(1):85-104, 2008.

Ring,J.M. *Curriculum far Culturally Responsive Health Care: The Step-by-Step Guide far Cultural Competence Training.* Oxford: Radcliffe Publishing, 2008.

Ritsher,J.B., Moos, R.H., and Finney,J.W. Relationship of treatment orientation and continuing care to remission among substance abuse patients. *Psychiatric Services* 53(5):595-601, 2002.

Roberts, R.E., Rhoades, H.M., and Vernon, S.W. Using the CES-D scale to screen for depres­ sion and anxiety: Effects oflanguage and ethnic status. *Psychiatry Research* 31:69-83, 1990.

Robin, R.W., Saremi, A., Albaugh, B., Hanson, R.L., Williams, D., and Goldman, D. Validity of the SMAST in two American Indian tribal populations. *Substance Use and Misuse* 39:601- 624, 2004.

Rodriguez-Andrew, S. Alcohol use and abuse among Latinos: Issues and examples of culturally competent *services.Alcoholism Treatment Quarterly* 16(1-2):55-70, 1998.

Rogers, A.T. Exploring health beliefs and care-seeking behaviors of older USA-dwelling Mexi­ cans and Mexican-Americans. *Ethnicity* & *Health* 15(6):581-599, 2010.

Room, **R.** Gender roles and interactions in drinking and drug *use.journal of Substance Abuse*

###### 8(2):227-239, 1996.

Room, **R.** Taking account of cultural and societal influences on substance use diagnoses and

*criteria.Addiction* lOl(Suppl 1):31-39, 2006.

Room, **R.,** Graham, K., Rehm,J.,Jernigan, **D.,** and Monteiro, M. Drinking and its burden in a global perspective: Policy considerations and options. *European Addiction Research* 9(4):165- 175, 2003.

Room, R.,Janca, A., Bennett, L.A., Schmidt, L., and Sartorius, N. WHO cross-cultural applica­ bility research on diagnosis and assessment of substance use disorders: An overview of meth­ ods and selected *results.Addiction* 91(2):199-220, 1996.

Room, R., Rehm,]., Trotter, R.T., Paglia, A., and Ustun, T.B. Cross-cultural views on stigma, valuation, parity, and societal values towards disability. In: Ustun, T.B., Chatterji, S., Bicken­ bach,J., Trotter, R.T., II, Room, R., Rehm,]., and Saxena, S., eds. *Disability and Culture: Uni­ versalism and Diversity* (pp. 247-291). Seattle, WA: Published on behalf of the World Health Organization by Hogrefe & Huber Publishers, 2001.

Rose, P.R. *Cultural Competency far Health Administration and Public Health.* Sudbury, MA: Jones and Bartlett, 2011.

233

Improving Cultural Competence

Rosenbaum, S., and Shin, **P.** *Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2005.

Rosenbaum, S., and Teitelbaum,]. *Cultural Competence in Medicaid Managed Care Purchasing: General and Behavioral Health Services for Persons With Mental and Addiction-Related Illnesses and Disorders.* Issue Brief #4. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 1999.

Ross-Durow, P.L., and Boyd, C.J. Sexual abuse, depression, and eating disorders in African Ameri­ can women who smoke *cocaine.journal of Substance Abuse Treatment* 18(1):79-81, 2000.

Rossi, A., Alberio, R., Porta, A., Sandri, M., Tansella, M., and Amaddeo, F. The reliability of the Mini-International Neuropsychiatric Interview-Italian *version.journal of Clinical Psycho­ pharmacology* 24:561-563, 2004.

Roysircar, G. Research in multicultural counseling: Client needs and counselor competencies. In: Lee, C., ed. *Multicultural Issues in Counseling: New Approaches to Diversity.* 3rd ed. (pp. 369- 387). Alexandria, VA: American Counseling Association, 2006.

Ruan, W.J., Goldstein, R.B., Chou, S.P., Smith, S.M., Saha, T.D., Pickering, R.P., Dawson, D.A., Huang, B., Stinson, F.S., and Grant, B.F. The alcohol use disorder and associated disabilities interview schedule-IV (AUDADIS-IV): Reliability of new psychiatric diagnostic modules and risk factors in a general population sample. *Drug and Alcohol Dependence* 92:27-36, 2008.

Ruiz, P. Issues in the psychiatric care of Hispanics. *Psychiatric Services* 48(4):539-540, 1997.

Rumpf, H.J., Bischof, G., Hapke, U., Meyer, C., and John, U. The role of family and partnership in recovery from alcohol dependence: Comparison of individuals remitting with and without formal help. *European Addiction Research* 8(3):122-127, 2002.

Russell, C. *A Report on Cultural Competency Trainingfor Health Care Professionals in Connecticut.*

Hartford, CT: Connecticut Multicultural Health Partnership, 2009.

Russell, L.M. *Reducing Disparities in Life Expectancy: What Factors Matter?* Washington, DC: Institute of Medicine, 2011.

Russell, M. New assessment tools for risk drinking during pregnancy: T-ACE, TWEAK, and

*others.Alcohol Health and Research World* 18:55-61, 1994.

Ryder, A.G., Alden, L.E., and Paulhus, D.L. Is acculturation unidimensional or bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment.jour­ *nal of Personality and Social Psychology* 79:49-65, 2000.

Sabin, C., Benally, H., Bennett, S.K., and Jones, E. *Walking in Beauty on the Red Road·A Holistic Cultural Treatment Model for American Indian* & *Alaska Native Adolescents and Families: Pro­ gram Description and Clinical Manual* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2004.

Sabogal, F., Marin, G., Otero-Sabogal, **R.,** and Marin, B.V. Hispanic familism and acculturation: What changes and what doesn't? *Hispanic journal of Behavioral Sciences* 9:397-412, 1987.

Saitz, R., Lepore, M.F., Sullivan, L.M., Amaro, H., and Samet,J.H. Alcohol abuse and depend­ ence in Latinos living in the United States: Validation of the CAGE (4M) *questions.Archives of Internal Medicine* 159:718-724, 1999.

234

Appendix A-Bibliography

Saldana, D. *Cultural Competency: A Practical Guide for Mental Health Service Providers.* Austin, TX: Hogg Foundation for Mental Health, 2001.

Salgado de Snyder, V.N. Factors associated with acculturative stress and depressive symptomatol­ ogy among married Mexican immigrant women. *Psychology of Women Quarterly* 11(4):475- 488, 1987.

Sanchez, K., Chapa, T., Ybarra, R., and Martinez, O.N. *Enhancing the Delivery of Health Care: Eliminating Health Disparities Through a Culturally* & *Linguistically Centered Integrated Health Care Approach.* Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health, Hogg Foundation for Mental Health, 2012.

Sandberg, S. Cannabis culture: A stable subculture in a changing world. *Criminology* & *Criminal justice:An International journal* 13(1):63-79, 2013.

Sanders, **M.** The response of African American communities to alcohol and other drug prob­ lems: An opportunity for treatment *providers.Alcoholism Treatment Quarterly* 20(3-4):167- 174, 2002.

Sandhu, **D.S.,** and Malik, R. Ethnocultural background and substance abuse treatment of Asian Indian Americans. In: Straussner, **S.L.A.,** ed. *Ethnocultural Factors in Substance Abuse Treat­ ment* (pp. 368-392). New York: Guilford Press, 2001.

Sandi Esquivel, L.E. and Avila, C.K. Validity of the Addiction Severity Index (adapted version) in a Costa Rican population group. *Bulletin of the Pan American Health Organization* 24:70- 76, 1990.

Sandoval, M.C. Santeria as a mental health care system: An historical overview. *Social Science and Medicine: Medical Anthropology* 13B(2):137-151, 1979.

Santisteban, D.A., Coatsworth,J.D., Perez-Vidal, A., Kurtines, W.M., Schwartz, S.J., LaPerriere, A., and Szapocznik,J. Efficacy of brief strategic family therapy in modifying Hispanic adoles­ cent behavior problems and substance *use.journal of Family Psychology* 17(1):121-133, 2003.

Santisteban, D.A., Coatsworth,J.D., Perez-Vidal, A., Mitrani, V.,Jean-Gilles, M., and Szapocz­ nik,J. Brief structural/strategic family therapy with African American and Hispanic high­ risk *youth.journal of Community Psychology* 25(5):453-471, 1997.

Satre, **D.D.,** Campbell, **C.I.,** Gordon, **N .S.,** and Weisner, C. Ethnic disparities in accessing treat­ ment for depression and substance use disorders in an integrated health plan. *International journal of Psychiatry in Medicine* 40(1):57-76, 2010.

Saunders,J.B., Aasland, O.G., Babor, T.F., de la Fuente,J.R., and Grant, M. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol *consumption-II.Addiction* 88:791-804, 1993.

Sayegh, L., and Lasry,J. Immigrants' adaptation in Canada: Assimilation, acculturation, and orthogonal cultural identification. *Canadian Psychology* 34(1):98-109, 1993.

Schensul,J.J., Huebner, C., Singer, M., Snow, M., Feliciano, P., and Broomhall, L. The high, the money, and the fame: The emergent social context of "new marijuana" use among urban youth. *Medical Anthropology* 18(4):389-414, 2000.

Schiele,J.H. *Human Services and the Afrocentric Paradigm.* Binghamton, NY: Haworth Press, 2000.

235

Improving Cultural Competence

Schiff,J.W., and Moore, K. The impact of the sweat lodge ceremony on dimensions of well­

*being.American Indian and Alaska Native Mental Health Research* 13(3):48-69, 2006.

Schiller, J.S., Martinez, M., and Barnes, P. *Early Release of Selected Estimates Based on Data From the 2004 National Health Interview Survey.* Hyattsville, MD: National Center for Health Sta­ tistics, 2005.

Schmidt, L., Greenfield, T., and Mulia, N. Unequal treatment: Racial and ethnic disparities in alcoholism treatment *services.Alcohol Research* & *Health* 29(1):49-54, 2006.

Schmidt, L.A., and Weisner, C.M. Private insurance and the utilization of chemical dependency

*treatment.journal of Substance Abuse Treatment* 28(1):67-7 6, 2005.

Schmidt, L.A., Ye, Y., Greenfield, T.K., and Bond,]. Ethnic disparities in clinical severity and services for alcohol problems: Results from the national alcohol survey. *Alcoholism: Clinical* & *Experimental Research* 31(1):48-56, 2007.

Schoeneberger, M.L., Leukefeld, C.G., Hiller, M.L., and Townsend, M. Substance abuse among rural and very rural drug users at treatment entry. In: *The National Rural Alcohol and Drug Abuse Network Awards far Excellence 2004* (pp. 59-75). Technical Assistance Publication (TAP) 28. HHS Publication No. (SMA) 06-4183. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2006.

Schroeder,J.R., Schmittner,J.P., Epstein, D.H., and Preston, K.L. Adverse events among patients in a behavioral treatment trial for heroin and cocaine dependence: Effects of age, race, and gender. *Drug and Alcohol Dependence* 80(1):45-51, 2005.

Schuster, M.A., Halfon, N., and Wood, D.L. African American mothers in South Central Los Angeles: Their fears for their newborn's future. *Archives of Pediatrics Adolescent Medicine* 152(3):264-268, 1998.

Schwartz, A.C., Bradley, R.L., Sexton, M., Sherry, A., and Ressler, K.J. Posttraumatic stress disorder among African Americans in an inner city mental health clinic. *Psychiatric Services* 56(2):212-215, 2005.

Seale,J.P., Shellenberger, S., and Spence,]. Alcohol problems in Alaska Natives: Lessons from the *Inuit.American Indian and Alaska Native Mental Health Research: The journal of the Na­ tional Center* 13(1):1-31. 2006.

Segal, B., Burgess, D., DeGross, D., Frank, P., Hild, C., and Saylor, B. *Alaska Natives Combating Substance Abuse and Related Violence Through Seif-Healing: A Report far the People.* Anchorage, AK: University of Alaska Anchorage, 1999.

Sellers, R.M., Rowley, S.A.]., Chavous, T.M., Shelton,J.N., and Smith, M.A. Multidimensional Inventory of Black Identity: A preliminary investigation of reliability and constuct validity.

*journal of Personality and Social Psychology* 73:805-815, 1997.

Selzer, M.L., Vinokur, A., and van Rooijen, L. A self-administered Short Michigan Alcoholism Screening Test *(SMAST).journal of Studies onAlcohol* 36:117-126, 1975.

Semple, S.J., Grant, I., and Patterson, T.L. Utilization of drug treatment programs by methamphet­ amine users: The role of social stigma. *The American journal ofAddiction* 14(4):367-380,2005.

236

Appendix A-Bibliography

Sexton, R.L., Carlson, R.G., Siegal, H., Leukefeld, C.G., and Booth, B. The role of African­ American clergy in providing informal services to drug users in the rural South: Preliminary

ethnographic *findings.journal of Ethnicity in Substance Abuse* 5(1):1-21, 2006.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P.,Janavs,J., Weiller, E., Hergueta, T., Baker, R., and Dunbar, G.C. The Mini-International Neuropsychiatric Interview (M.I.N.I): The development and validation of a structured diagnostic psychiatric interview for DSM-IV

and *ICD-10.]ournal of Clinical Psychiatry* 59:22-33, 1998.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H.,Janavs,J., Weiller, E., Keskiner, A., Schinka,J., Knapp, E., Sheehan, M.F., and Dunbar, G.C. The validity of the Mini International Neuro­ psychiatric Interview (MINI) according to the SCID-P and its reliability. *European Psychiatry* 12:232-241, 1997.

Sheikh,]. I. and Yesavage,J. A. Geriatric Depression Scale (GDS): Recent evidence and devel­ opment of a shorter version. *Clinical Gerontologist* 5:165-173, 1986.

Sheu, H. B. and Lent, R. W. Development and initial validation of the Multicultural Counseling Self-Efficacy Scale-Racial Diversity Form. *Psychotherapy: Theory, Research, Practice, Training* 44:30-45, 2007.

Shin, H.B., and Bruno, R. *Language Use and English-Speaking Ability: 2000.* Census 2000 Brief.

Washington, DC: U.S. Census Bureau, 2003.

Shorkey, C., Windsor, L.C., and Spence, R. Assessing culturally competent chemical dependence treatment services for Mexican Americans. *The journal of Behavior Health Services Research* 36(1):61-74, 2009.

Shorter-Gooden, K. Therapy with African American men and women. In: Neville, H.A., Tynes, B.M., and Utsey, S.O., eds. *Handbook of African American Psychology* (pp. 445-458). Thousand Oaks, CA: Sage Publications, 2009.

Silverman, K., Svikis, D., Wong, C.J., Hampton,]., Stitzer, M.L., and Bigelow, G.E. A rein­ forcement-based therapeutic workplace for the treatment of drug abuse: Three-year absti­ nence outcomes. *Experimental and Clinical Psychopharmacology* 10(3):228-240, 2002.

Silverman, K., Wong, C.J., Needham, M., Diemer, K.N., Knealing, T., Crone-Todd, D., Finger­ hood, M., Nuzzo, P., and Kolodner, K. A randomized trial of employment-based reinforce­

ment of cocaine abstinence in injection drug *users.journal of Applied Behavior Analysis*

40(3):387-410, 2007.

Simon, D., and Burns, E. *The Corner: A Year in the Life of an Inner-City Neighborhood.* New York: Broadway Books, 1997.

Singer,J.B. *Visual Assessment Tools: The Culturagram. Interview With Dr. Elaine Congress.* [Audio podcast]. 2007, December 1.

Singer, M. Why do Puerto-Rican injection drug users inject so often? *journal of Anthropology and Medicine* 6(1):31-58, 1999.

Singer, M., Valentin, F., Baer, H., and Jia, Z. Why does Juan Garcia have a drinking problem? The perspective of critical medical anthropology. *Medical Anthropology* 14(1):77-108, 1992.

Skinner, H.A. The Drug Abuse Screening Test. *Addictive Behaviors* 7:363-371, 1982.

237

Improving Cultural Competence

Skinner,J.H. Acculturation: Measures of ethnic accommodation to the dominant American

*culture.journal of Mental Health and Aging* 7:41-51, 2001.

Smedley, B.D., Stith, A.Y., Nelson, A.R., Institute of Medicine, and Committee on Understand­ ing and Eliminating Racial and Ethnic Disparities in Health Care. *Unequal Treatment: Con­ fronting Racial and Ethnic Disparities in Health Care.* Washington, D.C: National Academy Press, 2003.

Smokowski, P.R., Rose, R., and Bacallao, M.L. Acculturation and Latino family processes: How cultural involvement, biculturalism, and acculturation gaps influence family dynamics. *Family Relations* 57(3):295-308, 2008.

Snowden, L.R., and Hines, A.M. A scale to assess African American acculturation.journal *of*

*Black Psychology* 25:36-47, 1999.

Sobralske, M. Machismo sustains health and illness beliefs of Mexican American *men.journal of*

*American Academy of Nurse Practitioners* 18(8):348-350, 2006.

Sadowsky, G. R., and. Wai Ming Lai, E. Asian immigrant variables and structural models of cross-cultural distress. In Booth, A., Crouter, A.C., and Landale, N., eds. *Immigration and the Family: Research and Policy on U.S. Immigrants* (pp. 211-234). Mahwah, NJ: Lawrence Erl­ baum Associates, 1997.

Solomon, B.B. Counseling Black families at inner-city church sites. In: Cheatham, H.E., and Steward,J.B., eds. *Black Families* (pp. 353-371). New Brunswick, NJ: Transaction Publishers, 1990.

Sonn, C., and Walker, R. Working as a culturally competent mental health practitioner. In: Pur­ die, N., Dudgeon, P., and Walker, R., eds. *Working Together: Aboriginal and Torres Strait Is­ lander Mental Health and Wellbeing Principles and Practice* (pp. 157-180). Australian Council for Educational Research, the Kulunga Research Network, and Telethon Institute for Child Health Research, 2010.

Sosulski, M.R., and Woodward, A.T. American women living with mental disorders: Factors associated with helpseeking from professional services and informal supports. Social Work in Public Health 28(7):660-671, 2013.

Sotero, M.A. Conceptual model of historical trauma: Implications for public health practice and

*research.journal of Health Disparities Research and Practice* 1(1):93-108, 2006.

Spear, S., Crevecoeur, D.A., Rawson, R.A., and Clark, R. The rise in methamphetamine use among American Indians in Los Angeles County. *American Indian and Alaska Native Mental Health Research* 14(2):1-15, 2007.

Spencer, M.S., and Chen,]. Effect of discrimination on mental health service utilization among Chinese *Americans.American journal of Public Health* 94(5):809-814, 2004.

Spicer, P. Culture and the restoration of self among former American Indian drinkers. *Social Science and Medicine* 53(2):227-240, 2001.

Spunt, B.The current New York City heroin scene. *Substance Use* & *Misuse* 38(10):1539-1549, 2003.

238

Appendix A-Bibliography

Srivastava, R. Understanding cultural competence in health care. In: Srivastava, R., ed. *The Healthcare Professionals Guide to Clinical Cultural Competence* (pp. 3-27). Toronto, Ontario: Mosby, 2007.

St. Martin, M. *How Important Is Racial/Cultural Identity? Transracial Adoption Part II* Evanston, IL: iParenting.com, 2005.

Stahler, G.J., Kirby, K.C., and Kerwin, M.E. A faith-based intervention for cocaine-dependent Black *women.journal of Psychoactive Drugs* 39(2):183-190, 2007.

State of New Jersey Department of Human Services.A *New Beginning: The Future of Child Wel­ fare in New jersey.* Trenton, NJ: New Jersey Department of Human Services, 2004.

Stephens, R.C. *The Street Addict Role: A Theory of Heroin Addiction.* Albany, NY: State University of New York Press, 1991.

Stephens, R.C., Levine, S., and Ross, W. Street addict values: A factor analytic *study.journal of*

*Social Psychology* 99(2):273-281, 1976.

Stephenson, M. Development and validation of the Stephenson Multigroup Acculturation Scale (SMAS). *Psychological Assessment* 12:77-88, 2000.

Stockdale, S.E., Lagomasino, I.T., Siddique,]., McGuire, T., and Miranda,]. Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and pri­ mary health care visits, 1995-2005. *Medical Care* 46(7):668-677, 2008.

Stone, R.A., Whitbeck, L.B., Chen,X.,Johnson, K., and Olson, D.M. Traditional practices, traditional spirituality, and alcohol cessation among American Indians.journal*of Studies on Alcohol* 67(2):236-244, 2006.

Straits, K.J.E., Bird, D.M., Tsinajinnie, E., Espinoza,]., Goodkind,J., Spencer, 0., Tafoya, N., Willging, C., and the Guiding Principles Workgroup. *Guiding Principles far Engaging in Re­ search with Native American Communities, Version 1.* Albuquerque, NM: UNM Center for Ru­ ral and Community Behavioral Health and Albuquerque Area Southwest Tribal Epidemiology Center, 2012.

Strakowski, S.M., Keck, P.E.,Jr., Arnold, L.M., Collins,]., Wilson, R.M., Fleck, D.E., Corey,

K.B., Amicone,]., and Adebimpe, V.R. Ethnicity and diagnosis in patients with affective dis­ orders. *The journal of Clinical Psychiatry* 64(7):747-754, 2003.

Straussner, S.L.A.Jewish substance abusers: Existing but invisible. In: Straussner, S.L.A., ed. *Eth­ nocultural Factors in Substance Abuse Treatment* (pp. 291-317). New York: Guilford Press, 2001.

Streissguth, A.P., Moon-Jordan, A., and Clarren, S.K. Alcoholism in four patients with fetal alcohol syndrome: Recommendations for *treatment.Alcoholism Treatment Quarterly* 13(2):89- 103, 1995.

Suarez-Morales, L., Martino, S., Bedregal, L., McCabe, B.E., Cuzmar, LY., Paris, M., Feaster D.J., Carroll, K.M., and Szapocznik,J. Do therapist cultural characteristics influence the out­ come of substance abuse treatment for Spanish-speaking adults? *Cultural Diversity* & *Ethnic Minority Psychology* 16(2):199-205, 2010.

239

Improving Cultural Competence

Substance Abuse and Mental Health Services Administration. *Trauma Recovery and Empower­ ment Model (TREM).* Rockville, MD: National Registry of Evidence-Based Programs and Practices (NREPP), 2006.

Substance Abuse and Mental Health Services Administration. *The Recovery Community Services Program (RCSP).* Rockville, MD: U.S. Department of Health and Human Services, Sub­ stance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2008.

Substance Abuse and Mental Health Services Administration. *Results From the 2009 National Survey on Drug Use and Health: Mental Health Findings.* NSDUH Series H-39, HHS Publi­ cation No. (SMA) 10-4609. Rockville, MD: Center for Behavioral Health Statistics and Qyality, 2010.

Substance Abuse and Mental Health Services Administration. *Results From the 2010 National Survey on Drug Use and Health: Summary of National Findings.* NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Ser­ vices Administration, *2011a.*

Substance Abuse and Mental Health Services Administration. *SAMHSA Announces a Working Definition of"Recovery" From Mental Disorders and Substance Use Disorders.* [News Release]. Rockville, MD: SAMHSA Press Office, 201*lb.*

Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) 1999-2009: National Admissions to Substance Abuse Treatment Services.* **DASIS** Series: S-56, HHS Publication No. (SMA) 11-4646. Rockville, MD: substance Abuse and Mental Health Services Administration, *2011c.*

Substance Abuse and Mental Health Services Administration. *Mental Health United States, 2010.* HHS Publication No. (SMA) 12-4681. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2012a.*

Substance Abuse and Mental Health Services Administration. *Results From the 2011 National Survey on Drug Use and Health: Detailed Tables.* NSDUH Series H-44, HHS Publication No. (SMA)

12-4713. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2012b.*

Substance Abuse and Mental Health Services Administration. *Addressing the Specific Behavioral Health Needs of Men.* Treatment Improvement Protocol (TIP) Series 56. HHS Publication No. (SMA) 13-4736. Rockville, MD: Substance Abuse and Mental Health Services Admin­ istration, *2013a.*

Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for People Who Are Homeless.* Treatment Improvement Protocol (TIP) Series 55-R. HHS Publi­ cation No. (SMA) 13-4734. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2013b.*

Substance Abuse and Mental Health Services Administration. *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings.* NSDUH Series H-47, HHS Publi­ cation No. (SMA) 13-4805. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013c.

240

Appendix A-Bibliography

Substance Abuse and Mental Health Services Administration. *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings.* NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Ser­

vices Administration, *2013d.*

Substance Abuse and Mental Health Services Administration. *Trauma-Informed Care in Behav­ ioral Health Services.* Treatment Improvement Protocol (TIP) Series *57.* Rockville, MD: Sub­ stance Abuse and Mental Health Services Administration, 2014.

Substance Abuse and Mental Health Services Administration. *Behavioral Health Services for American Indians and Alaska Natives. Treatment* Improvement Protocol (TIP) Series. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, planned *a.*

Substance Abuse and Mental Health Services Administration. *Building Health, Wellness, and Quality of Life for Sustained Recovery.* Treatment Improvement Protocol (TIP) Series. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, planned *b.*

Substance Abuse and Mental Health Services Administration. *Managing Anxiety Symptoms in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series. Rockville, MD: Substance Abuse and Mental Health Services Administration, planned *c.*

Substance Abuse and Mental Health Services Administration. *Reintegration-Related Behavioral Health Issues in Veterans and Military Families.* Treatment Improvement Protocol (TIP) Series. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, planned *d.*

Substance Abuse and Mental Health Services Administration. *Relapse Prevention and Recovery Promotion in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series.

Rockville, **MD:** Substance Abuse and Mental Health Services Administration, planned *e.*

Substance Abuse and Mental Health Services Administration. *Using Technology-Based Therapeu­ tic Tools in Behavioral Health Services.* Treatment Improvement Protocol (TIP) Series. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, planned *f*

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *The NSDUH Report: Need For and Receipt of Substance Abuse Treatment*

*Among Asian Americans and Pacific Islanders.* Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2005.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *Substance Use Among Asian Adolescents.* The NSDUH Report. Rock­ ville, MD: Substance Abuse and Mental Health Services Administration, 2011.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *Treatment Episode Data Set (TEDS): 2000-2010. National Admissions to Substance Abuse Treatment Services.* DASIS Series: S-61, HHS Publication No. (SMA) 12- 4701. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits.* The DAWN Report. Rockville, MD: Sub­

stance Abuse and Mental Health Services Administration, *2013a.*

241

Improving Cultural Competence

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Sta­ tistics and Qyality. *Need far and Receipt* ef*Substance Use Treatment Among Blacks.* The NSDUH Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, *2013b.*

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *Treatment Episode Data Set (TEDS): 2001-2011. National Admissions to Substance Abuse Treatment Services.* BHSIS Series S-65, HHS Publication No. (SMA) 13- 4772. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2013c.*

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Qyality. *Update on Emergency Department Visits Involving Energy Drinks: A Continuing Public Health Concern.* The DAWN Report. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, *2013d.*

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Partici­ pation in Self-Help Groups far Alcohol and Illicit Drug Use: 2006 and 2007.* The NSDUH Re­ port. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2008.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Mental Health Support and Self-Help Groups.* The NSDUH Report. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *Sub­ stance Use Among American Indian or Alaska Native Adults.* The **NSDUH** Report. Rockville, **MD:** Substance Abuse and Mental Health Services Administration, 2010.

Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *The NSDUH Report: Need For and Receipt* ef*Substance Use Treatment Among American Indians or Alas­ ka Natives.* Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

Sue, D.W. Multidimensional facets of cultural competence. *The Counseling Psychologist*

29(6):790-821, 2001.

Sue, D.W., and Constantine, M.G. Effective multicultural consultation and organizational devel­ opment. In: Constantine, M.G., and Sue, D.W., eds. *Strategies far Building Multicultural Com­ petence in Mental Health and Educational Settings* (pp. 212-226). Hoboken, NJ: John Wiley & Sons Inc., 2005.

Sue, D.W., and Sue, D. *Counseling the Culturally Different: Theory and Practice.* 3rd ed. New York: John Wiley & Sons, *1999a.*

Sue, D.W., and Sue, D. Racial/cultural identity development models (pp. 235-242). In: *Counsel­ ing the Culturally Different: Theory and Practice.* 3rd ed. New York:John Wiley & Sons, *1999b.*

Sue, D.W., and Sue, D. Sociopolitical considerations of trust and mistrust (pp. 63-91). In: *Coun­ seling the Culturally Diverse: Theory and Practice.* 4th ed. New York: John Wiley and Sons, *2003a.*

Sue, D.W., and Sue, D. The politics of counseling and psychotherapy (pp. 33-62). In: *Counseling the Culturally Diverse: Theory and Practice.* 4th ed. New York: John Wiley and Sons, *2003b.*

Sue, D.W., and Sue, D. *Counseling the Culturally Diverse: Theory and Practice.* 5th ed. Hoboken, NJ: John Wiley & Sons, 2008.

242

Appendix A-Bibliography

Sue, D.W., and Sue, D. Communication styles (pp. 160-168). In: *Counseling the Culturally Di­ verse: Theory and Practice.* 6th ed. Hoboken, NJ: John Wiley & Sons, *2013a.*

Sue, D.W., and Sue, D. Counseling African Americans (pp. 365-378). In: *Counseling the Cultur­ ally Diverse: Theory and Practice.* 6th ed. Hoboken, NJ: John Wiley & Sons, *2013b.*

Sue, D.W., and Sue, D. *Counseling the Culturally Diverse: Theory and Practice.* 6th ed. Hoboken, NJ: John Wiley & Sons, *2013c.*

Sue, D.W., and Sue, D. Implications for clinical practice (pp. 205-207). In: *Counseling the Cul­ turally Diverse: Theory and Practice.* 6th ed. Hoboken, NJ: John Wiley & Sons, *2013d.*

Sue, D.W., and Sue, D. The education and training of mental health professionals (pp. 64-70). In: *Counseling the Culturally Diverse: Theory and Practice.* 6th ed. Hoboken, NJ: John Wiley & Sons, *2013e.*

Sue, S., Fujino, D.C., Hu, L.T., Takeuchi, D.T., and Zane, N.W. Community mental health services for ethnic minority groups: A test of the cultural responsiveness *hypothesis.journal of Consulting and Clinical Psychology* 59(4):533-540, 1991.

Suinn, **R.M.,** Ahuna, C., & Khoo, G. The Suinn-Lew Asian Self-Identity Acculturation Scale: Concurrent and factorial validation. *Educational and Psychological Measurement* 52(4):1041- 1046, 1992.

Summers, **N.** *Fundamentals of Case Management Practice Skills far the Human Services.* 4th ed.

Belmont, CA: Brooks/Cole Cengage Learning, 2012.

Sussman, L.K. The role of culture in definitions, interpretations, and management of illness. In: Gielen, U.P., Fish,J.M., and Draguns,J.G., eds. *Handbook of Culture, Therapy, and Healing* (pp. 37-65). Mahwah, NJ: Lawrence Erlbaum Associates Publishers, 2004.

Suzuki, L.A., and Ponterotto, J.G. *Handbook of Multicultural Assessment: Clinical, Psychological, and Educational Applications.* 3rd ed. San Francisco: Jossey-Bass, 2008.

Szaflarski, M., Cubbins, L.A., and Ying,]. Epidemiology of alcohol abuse among US immigrant

*populations.journal of Immigrant and Minority Health* 13(4):647-658, 2011.

Szapocznik,J., Kurtines, W.M., and Fernandez, T. Bicultural involvement and adjustment in Hispanic-American youths. *International journal of Intercultural Relations* 4:353-365, 1980.

Szapocznik,J., Scopetta, M.A., Kurtines, W., and Aranalde, M.D. Theory and measurement of acculturation. *Revista Interamericana de Psicologia* 12:113-130, 1978.

Szapocznik,J., and Williams, R.A. Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review* 3(2):117-134, 2000.

Ta, V.M.,Juon, H.S., Gielen, A.C., Steinwachs, D., and Duggan, A. Disparities in use of mental health and substance abuse services by Asian and Native Hawaiian/other Pacific Islander

women. *The journal of Behavior Health Services Research* 35(1):20-36, 2008.

Tackett-Gibson, M. Scripters and freaks: Knowledge and use of prescription stimulants online. In: Murguaia, E., Tackett-Gibson, M., and Lessem, A., eds. *Real Drugs in a Virtual World: Drug Discourse and Community Online* (pp. 121-134). Lanham, MD: Lexington Books, 2007.

243

Improving Cultural Competence

Taggart, M. Scots-Irish Families. In: McGoldrick, M., Giordano,]., and Garcia-Preto, N., eds.

*Ethnicity and Family Therapy.* 3rd ed. (pp. 654-663). New York: Guilford Press, 2005.

Takeuchi, D.T., Sue, S., and Yeh, M. Return rates and outcomes from ethnicity-specific mental health programs in Los *Angeles.American journal of Public Health* 85(5):638-643, 1995.

Takeuchi, D.T., Zane, N., Hong, S., Chae, D.H., Gong, F., Gee, G.C., Walton, E., Sue, S., and Alegria, M. Immigration-related factors and mental disorders among Asian Americans.

*American journal of Public Health* 97(1):84-90, 2007.

Tang, W.W.H., and Bigby,]. Cultural perspectives on substance abuse. In: Friedman, L., Fleming, N., Roberts, D., and Hyman, S.E., eds. *Source Book of Substance Abuse and Addiction* (pp. 41- 56). Baltimore: Williams & Wilkins, 1996.

Tann, S.S., Yabiku, S.T., Okamoto, S.K., and Yanow,J. TRIADD: The risk for alcohol abuse, depression, and diabetes multimorbidity in the American Indian and Alaska Native popula­ *tion.American Indian and Alaska Native Mental Health Research* 14(1):1-23, 2007.

Taylor, P., Lopez, M.H., Martinez,J.H., and Velasco, G. *When Labels Don't Fit: Hispanics and Their Views of Identity.* Washington, DC: Pew Research Center, 2012.

Taylor, R.J., Ellison, C.G., Chatters, L.M., Levin,J.S., and Lincoln, K.D. Mental health services in faith communities: The role of clergy in Black church. *Social Work* 45(1):73-87, 2000.

Taylor, T. Effective cross-cultural communication in drug abuse intervention among ethnic mi­ nority populations. In: Xueqin Ma, G., and Henderson, G., eds. *Ethnicity and Substance Abuse: Prevention and Intervention* (pp. 19-37). Springfield, **IL:** Charles C. Thomas Publisher, Ltd., 2002.

Telzer, E.H. Expanding the acculturation gap-distress model: An integrative review of research.

*Human Development* 53:313-340, 2010.

The Connecticut Department of Children and Families, Office of Multicultural Affairs. *Develop­ ing a Multiculturally Competent Service System for an Organization or Program.* Hartford, CT: Office of Multicultural Affairs, 2002.

The Joint Commission. *The joint Commission 2008 Requirements Related to the Provision of Cul­ turally and Linguistically Appropriate Health Care.* Oakbrook Terrace, IL: The Joint Commis­ sion, 2009.

The Mental Health Center of Dane County. *Vision* & *Values for Culturally Competent Services.*

Madison, WI: Mental Health Center of Dane County, 2009.

The Office of Nursing Practice and Professional Services, Centre for Addiction and Mental Health & Faculty of Social Work, University of Toronto. *Clinical Supervision Handbook: A Guide for Clinical Supervisors for Addiction and Mental Health.* Toronto, Ontario: Centre for Addiction and Mental Health, 2008.

Thomas, A.J., and Schwarzbaum, S. *Culture* & *Identity: Life Stories for Counselors and Therapists.*

2nd ed. Los Angeles: SAGE, 2011.

Thomas, T.N. Acculturative stress in the adjustment of immigrant *families.journal of Social Dis­ tress and the Homeless* 4(2):131-142, 1995.

244

Appendix A-Bibliography

Tilburt, J., and Geller, G. Viewpoint: The importance of worldviews for medical education.

*Academic Medicine* 82(8):819-822, 2007.

Timble,J.E. Working with North American Indian and Alaska Native clients: Understanding the deep culture within. In: Gallardo, M.E., Yeh, C.J., Timble,J.E., and Parham, T.A., eds. *Cultur­ ally Adaptive Counseling Skills* (pp. 181-200). Thousand Oaks, CA: Sage Publications, 2012.

Timko, C., Billow, R., and Debenedetti,A. Determinants of 12-Step group affiliation and modera­ tors of the affiliation-abstinence relationship. *Drug and Alcohol Dependence* 83(2):111-121, 2006.

Tondora,J., O'Connell, M., Miller, R., Dinzeo, T., Bellamy, C., Andres-Hyman, R., and Da­ vidson, L. A clinical trial of peer-based culturally responsive person-centered care for psycho­ sis for African Americans and Latinos. *Clinical Trials* 7(4):368-379, 2010.

Tonigan,J.S. Project MATCH treatment participation and outcome by self-reported ethnicity.

*Alcoholism: Clinical* & *Experimental Research* 27(8):1340-1344, 2003.

Tonigan,J.S., Connors, G.J., and Miller, **W.R.** Special populations in Alcoholics Anonymous.

*Alcohol Health and Research World* 22(4):281-285, 1998.

Topolski,J.M., and Anderson-Harper, **R.** *Methamphetamine in Missouri 2004.* Jefferson City, MO: Missouri Department of Mental Health, 2004.

Torres,J.B., Solberg, V.S., and Carlstrom, A.H. The myth of sameness among Latino men and their machismo. *The American journal of Orthopsychiatry* 72(2):163-181, 2002.

Torres, L.R., Zayas, L.H., Cabassa, L.J., and Perez, M.C. Diagnosing co-occurring substance­ related disorders: Agreement between SCID, Hispanic clinicians, and non-Hispanic clini­ cians. *The journal of Clinical Psychiatry* 68(11):1655-1662, 2007.

Torres-Rivera, E., Wilbur, M.P., Roberts-Wilbur,]., and Phan, L. Group work with Latino cli­ ents: A psychoeducational *model.journal far Specialists in Group Work* 24(4):383-404, 1999.

Torsch, V.L., and Ma, G.X. Cross-cultural comparison of health perceptions, concerns, and cop­ ing strategies among Asian and Pacific Islander American elders. *Qualitative Health Research* 10(4):471-489, 2000.

Trierweiler, S.J., Neighbors, H.W., Munday, C., Thompson, E.E., Binion, V.J., and Gomez,J.P. Clinician attributions associated with the diagnosis of schizophrenia in African American and non-African American *patients.journal of Consulting* & *Clinical Psychology* 68(1):171- 175, 2000.

Trierweiler, S.J., Neighbors, H.W., Munday, C., Thompson, E.E.,Jackson,J.S., and Binion, V.J. Differences in patterns of symptom attribution in diagnosing schizophrenia between African American and non-African American clinicians. *TheAmericanjournal ofOrthopsychiatry* 76(2):154-160, 2006.

Trimble,J.E., and Jumper Thurman, P. Ethnocultural considerations and strategies for providing counseling services to Native American Indians. In: Pedersen, P.B., Draguns,J.G., Lonner, W.J., and Trimble,J.E., eds. *Counseling Across Cultures* (pp. 53-91). Thousand Oaks, CA: Sage Publications, 2002.

245

Improving Cultural Competence

Trimble,J.E., Scharron-del-Rio, M.R., and Hill,J.S. Ethical considerations in the application of cultural adaptation models with ethnocultural populations. In: Bernal, G., and Domenech Rodriguez, M.M., eds. *Cultural Adaptations: Tools far Evidence-Based Practice With Diverse Populations* (pp. 45-67). Washington, D.C: American Psychological Association, 2012.

Tsai, C.T.L. A reflection on cultural conflicts in women's leisure. *Leisure Sciences* 32:386-390, 2010. Tsai,J.L., Ying, **Y.W.,** and Lee, **P.A.** The meaning of "being Chinese" and "being American'':

Variation among Chinese American young *adults.journal of Cross-Cultural Psychology*

31:302-332, 2000.

Tseng, **W.S.** and Streltzer,J. Introduction: Culture and psychiatry. In Tseng, **W.S.,** and Streltzer,J., eds.

*Cultural Competence in Clinical Psychiatry* (pp. 1-20). American Psychiatric Publishing, 2004.

Tsushima, W.T. and Tsushima, V.G. Comparison ofMMPI-2 validity scales among compensa­ tion-seeking Caucasian and Asian American medical *patients.Assessment* 16:159-164, 2009.

Uba, *L.AsianAmericans: Personality Patterns, Identity, and Mental Health.* New York: Guilford Press, 1994.

U.S. Census Bureau. *Profiles of General Demographic Characteristics 2000.* Washington, DC: 2000 Census of Population and Housing, *2001a.*

U.S. Census Bureau. *Table 1: Population by Race and Hispanic or Latino Origin,far all Ages and far 18 Years and Over,far the United States. 2000.* Washington, DC: U.S. Census Bureau, *2001b.*

U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health:A Report of the Surgeon General* HHS Publication No. (SMA) 01-3613. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2001.

U.S. Department of Health and Human Services. *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations.* HHS Publication No. (SMA) 3828. Rockville, MD: U.S. Department of Health and Human Services, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, *2003a.*

U.S. Department of Health and Human Services. *Eliminating Health Disparities in the American Indian and Alaska Native Community.* Washington, DC: U.S. Department of Health and Human Services, *2003b.*

U.S. Department of Health and Human Services. *To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults.* HHS Publi­ cation No. SMA (10)-4480. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2010.

U.S. Department of Health and Human Services. *Frequently Asked Questions.* Rockville, MD: National Partnership for Action to End Health Disparities, *2011a.*

U.S. Department of Health and Human Services. *HHS Action Plan to Reduce Racial and Ethnic Disparities:A Nation Free of Disparities in Health and Health Care.* Washington, DC: U.S. De­ partment of Health and Human Services, *2011b.*

246

Appendix A-Bibliography

U.S. Department of Health and Human Services, Agency for Healthcare Research and O!Jality. *National Healthcare Disparities Report 2011.* AHRQPublication No. 12-0006. Rockville, MD: Agency for Healthcare Research and O!Jality, 2012.

U.S. Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Center for Behavioral Health Statistics and O!Jality. *2010 Treatment Episode Data Set --Admissions (TEDS-A).* ICPSR33261-vl. Ann Arbor, MI: Inter-university Con­ sortium for Political and Social Research [distributor], 2012.

U.S. Department ofJustice. *Information Bulletin: Drugs, Youth and the Internet.* Johnston, PA: National Drug Intelligence Center, 2002.

U.S. Department of the Interior, Indian Affairs. *Indian Affairs: Who We Are.*Washington, DC: Department of the Interior, *2013a.*

U.S. Department of the Interior, Indian Affairs. *Indian Affairs: What We Do.*Washington, DC: Department of the Interior, *2013b.*

United Nations Office on Drugs and Crime. *World Drug Report 2008.* United Nations publica­ tion Sales No. E.08.:XI.1. Vienna, Austria: United Nations Office on Drugs and Crime, 2008.

United Nations Office on Drugs and Crime. *World Drug Report 2012.* United Nations publica­ tion Sales No. E.12.:XI.1. Vienna, Austria: United Nations Office on Drugs and Crime, 2012.

Urban Indian Health Institute. *Reported Health and Health-Influencing Behaviors Among Urban American Indians and Alaska Natives:AnAnalysis oJData Collected by the Behavioral Risk Factor Surveillance System.* Seattle, WA: Urban Indian Health Institute, 2008.

Ustiin, B., Compton, W., Mager, D., Babor, T., Baiyewu, 0., Chatterji, S., Cottler, L., Gogu , A., Mavreas, V., Peters, L., Pull, C., Saunders,]., Smeets, R., Stipec, M.R., Vrasti, R., Hasin, D., Room, R., Van den Brink, W., Regier, D., Blaine,]., Grant, B.F., and Sartorius, N. WHO study on the reliability and validity of the alcohol and drug use disorder instruments: Over­ view of methods and results. *Drug and Alcohol Dependence* 47:161-169, 1997.

Vaeth, P.A., Caetano, R., and Rodriguez, L.A. The Hispanic Americans Baseline Alcohol Survey (HABLAS): The association between acculturation, birthplace and alcohol consumption across Hispanic national groups. *Addictive Behaviors* 37(9):1029-1037, 2012.

Vaillant, G.E. *The Natural History of Alcoholism.* Cambridge, MA: Harvard University Press, 1983.

van Oers,J.A.M., Bongers, I.M.B., Van de Goar, L.A.M., and Garretsen, H.F.L. Alcohol con­ sumption, alcohol-related problems, problem drinking, and socioeconomic *status.Alcohol* & *Alcoholism* 34(1):78-88, 1999.

van Wormer, K.S. Substance abuse among Americans of British descent. In: Straussner, S.L.A., ed. *Ethnocultural Factors in Substance Abuse Treatment* (pp. 167-179). New York: Guilford Press, 2001.

Vega, W.A., Canino, G., Cao, Z., and Alegria, M. Prevalence and correlates of dual diagnoses in

U.S. Latinos. *Drug and Alcohol Dependence* 100(1-2):32-38, 2009.

Vega, W.A., Kolody, B., and Aguilar-Gaxiola, S. Help seeking for mental health problems among Mexican *Americans.journal of Immigrant Health* 3(3):133-140, 2001.

247

Improving Cultural Competence

Vega, W.A., Sribney, W.M., Aguilar-Gaxiola, S., and Kolody, B. 12-month prevalence of DSM­ III-R psychiatric disorders among Mexican Americans: Nativity, social assimilation, and age

*determinants.journal of Nervous and Mental Disease* 192(8):532-541, 2004.

Vega, W.A., Zimmerman, R.S., Warheit, G.J., Apospori, E., and Gil, A.G. Risk factors for early adolescent drug use in four ethnic and racial groups. In: Organista, P.B., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 178-187). New York: Routledge, 1998.

Velasquez, R.J., Chavira, D.A., Karle, H.R., Callahan, W.J., Garcia,J.A., and Castellanos,]. As­ sessing bilingual and monolingual Latino students with translations of the MMPI-2: Initial data. *Cultural Diversity and Ethnic Minority Psychology* 6:65-72, 2000.

Velez-Blasini, C.J. A cross-cultural comparison of alcohol expectancies in Puerto Rico and the United States. *Psychology of Addictive Behaviors* 11(2):124-141, 1997.

Venner, K.L., and Feldstein, S.W. Natural history of alcohol dependence and remission events for a Native American *sample.journal of Studies onAlcohol* 67(5):675-684, 2006.

Venner, K.L., Feldstein, S.W., and Tafoya, N. *Native American Motivational Interviewing: Weav­ ing Native American and Western Practices. A Manual far Counselors in Native American Com­ munities.* Albuquerque, NM: Center on Alcoholism, Substance Abuse and Addictions (CASAA), 2006.

Venner, K.L., Greenfield, B.L., Vicuna, B., Munoz, R., Bhatt, S., and O'Keefe, V. "I'm not one of them": Barriers to help-seeking among American Indians with alcohol dependence. *Cultural Diversity and Ethnic Minority Psychology* 18(4):352-362, 2012.

Villanueva, **M.,** Tonigan,J.S., and Miller, W.R. Response of Native American clients to three treatment methods for alcohol *dependence.journal of Ethnicity in Substance Abuse* 6(2):41-48, 2007.

Volk, R.J., Steinbauer,J.R., Cantor, S.B., and Holzer, C.E., III The Alcohol Use Disorders Iden­ tification Test (AUDIT) as a screen for at-risk drinking in primary care patients of different racial/ethnic *backgrounds.Addiction* 92:197-206, 1997.

Wahl, A.M.G., and Eitle, T.M. Gender, acculturation and alcohol use among Latina/o adolescents: A multi-ethnic *comparison.journal of Immigrant and Minority Health* 12(2):153-165, 2010.

Wallace, P.M., Pomery, E.A., Latimer, A.E., Martinez,J.L., and Salovey, P. A review of accultura­ tion measures and their utility in studies promoting Latino health. *Hispanic Journal of Behav­ ioral Sciences* 32(1):37-54, 2010.

Walton, M.A., Blow, F.C., and Booth, B.M. Diversity in relapse prevention needs: gender and race comparisons among substance abuse treatment patients. *The American journal of Drug and Alcohol Abuse* 27(2):225-240, 2001.

Ward, C.A. The ABCs of acculturation: Implications for counselors. In: Pedersen, P.B., Draguns, J.G., Lonner, W.J., and Trimble,J.E., eds. *Counseling Across Cultures.* 6th ed. (pp. 291-306).

Thousand Oaks, CA: Sage Publications, 2008.

Warren,J.I., Stein,J.A., and Grella, C.E. Role of social support and self-efficacy in treatment outcomes among clients with co-occurring disorders. *Drug and Alcohol Dependence* 89(2- 3):267-274, 2007.

248

Appendix A-Bibliography

Washington State Department of Social & Health Services. *Cultural Competence Planning Guide: Cultural Competence Workgroup 2011-2014.* Olympia, WA: Department of Social & Health Services, 2011.

Watkins, W.C., and Ford,J.A. Prescription drug misuse among Asian-American adults: Results from a national survey. *Substance Use* & *Misuse* 46(13):1700-1708, 2011.

Watt, T.T. The race/ethnic age crossover effect in drug use and heavy *drinking.journal of Ethnici­ ty in Substance Abuse* 7(1):93-114, 2008.

Weaver, H. The challenges of research in Native American communities: Incorporating princi­ ples of cultural *competence.journal of Social Service Research* 12(3-4):1-29, 1997.

Weisner, C., Delucchi, K., Matzger, H., and Schmidt, L. The role of community services and informal support on five-year drinking trajectories of alcohol dependent and problem drink­

*ers.journal of Studies onAlcohol* 64(6):862-873, 2003.

Weiss, **B.D.** Interpersonal communication (pp. 31-34). In: *Removing Barriers To Better, Safer Care-Health Literacy and Patient Safety: Help Patients Understand. Manual far Clinicians.* Chicago: American Medical Association Foundation, 2007.

Weller, C.E., Ajinkya,J., and Farrell,]. *The State of Communities of Color in the U.S. Economy: Still Feeling the Pain Three Years Into the Recovery.* Washington, **DC:** Center for American Pro­ gress, 2012.

Wells, K., Klap, R., Koike, A., and Sherbourne, C. Ethnic disparities in unmet need for alcohol­ ism, drug abuse, and mental health care. *The American journal of Psychiatry* 158(12):2027-

2032, 2001.

Wells, **R.** *Selected Results From the Behavioral Risk Factor Surveillance System far Alaska Natives 2001-2003.* Anchorage, **AK:** Alaska Native Health Board, 2004.

Westermeyer,J. Alcoholism and co-morbid psychiatric disorders among American Indians.

*American Indian and Alaska Native Mental Health Research* 10(2):27-51, 2001.

Whaley, A.L., and Davis, K.E. Cultural competence and evidence-based practice in mental health services: a complementary perspective. *The American Psychologist* 62(6):563-574, 2007.

Whaley, A.L., and Longoria, R.A. Assessing cultural competence readiness in community mental health centers: A multidimensional scaling analysis. *Psychological Services* 5(2):169-183, 2008.

Whatley, P.R., Allen,]., and Dana, R.H. Racial identity and the MMPI in African American male college students. *Cultural Diversity and Ethnic Minority Psychology* 9:345-353, 2003.

Whealin,J.M., and Ruzek,J. Program evaluation for organizational cultural competence in men­ tal health practices. *Professional Psychology: Research and Practice* 39(3):320-328, 2008.

Whitbeck, **L.B.,** Chen,X., Hoyt, **D.R.,** and Adams, **G.W.** Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among Ameri­

can *Indians.journal of Studies on Alcohol* 65(4):409-418, 2004.

White, **K.,** Clayton, R., and Arndt, S. *Culturally Competent Substance Abuse Treatment Project: Annual Report.* Iowa Department of Public Health (Contract# 5888CP43). Iowa City, IA: Iowa Consortium for Substance Abuse Research and Evaluation, 2009.

249

Improving Cultural Competence

White, W., and Sanders, M. *Recovery Management and People of Color: Redesigning Addiction Treatment far Historically Disempowered Communities.* Chicago: Behavioral Health Recovery Management, 2004.

White, W.A., and Kurtz, E. *Linking Addiction Treatment and Communities of Recovery: A Primer far Addiction Counselors, Recovery Coaches and the Recovery Community.* Pittsburgh, PA: Insti­ tute for Research, Education and Training in Addictions, 2006.

White, W.L. Themes in chemical prohibition. In: *Drugs in Perspective* (pp. 117-182). Rockville, MD: National Institute on Drug Abuse, 1979.

White, W.L. *Pathways: From the Culture of Addiction to the Culture of Recovery. A Travel Guide far Addiction Professionals.* 2nd ed. Center City, MN: Hazelden, 1996.

White, W.L. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America.*

Bloomington, IL: Chestnut Health Systems, 1998.

White, W.L. The history of recovered people as wounded healers: II. The era of professionaliza­ tion and *specialization.Alcoholism Treatment Quarterly* 18(2):1-25, 2000.

White Bison, Inc. *The Red Road to Wellbriety: In the Native American U0y.* Colorado Springs, CO: White Bison, Inc., 2002.

Whitebread, C.H. *The History of the Non-Medical Use of Drugs in the United States.* Los Angeles: University of Southern California Law School, 1995.

Whitesell, N.R., Beals,]., Mitchell, C.M., Novins, D.K., Spicer, P., and Manson, S.M. Latent class analysis of substance use: Comparison of two American Indian reservation populations

and a national *sample.journal of Studies on Alcohol* 67(1):32-43, 2006.

Whitley, R. Religious competence as cultural competence. *Transcultural Psychiatry* 49(2):245-260, 2012.

Wiebe,J.S. and Penley,J.A. A psychometric comparison of the Beck Depression Inventory-II in English and Spanish. *Psychological Assessment* 17:481-485, 2005.

Wiechelt, S.A., Gryczynski,J.,Johnson,J.L., and Caldwell, D. Historical trauma among urban American Indians: Impact on substance abuse and family *cohesion.journal of Loss and Trau­ ma* 17:319-336 2012.

Wijeyesinghe, C., and Jackson, E.W. *New Perspectives on Racial Identity Development: Integrating Emerging Frameworks,.2nd* ed. New York: New York University Press, 2012.

Wilcox, D.M. *Alcoholic Thinking: Language, Culture, and Belief in Alcoholics Anonymous.* Westport, CT: Praeger Publishers/Greenwood Publishing Group, 1998.

Williams, D.R., and Williams-Morris, R. Racism and Mental Health: The African American experience. *Ethnicity* & *Health* 5(3-4):243-268, 2000.

Williams, E.E., and Ellison, F. Culturally informed social work practice with American Indian clients: Guidelines for non-Indian social workers. *Social Work* 41(2):147-151, 1996.

Williams, M.T., Domanico,J., Marques, L., Leblanc, N.J., and Turkheimer, E. Barriers to treat­ ment among African Americans with obsessive-compulsive *disorder.journal of Anxiety Disor­ ders* 26(4):555-563, 2012.

250

Appendix A-Bibliography

Williams, T.M. *Crackhouse: Notes From the End of the Line.New* York: Penguin Books, 1992. Winawer, H., and Wetzel, N.A. German families. In: McGoldrick, M., Giordano,]., and Garcia­

Preto, N., eds. *Ethnicity and Family Therapy.* 3rd ed. (pp. 555-572). New York: Guilford Press, 2005.

Wing,J.K., Sartorius, N., and Usti.in, T.B., eds. *Diagnosis and Clinical Measurement in Psychiatry: A Reference Manual far SCAN* Geneva: World Health Organization, 1998.

Wong, E.C., Beutler, L.E., and Zane, N.W. Using mediators and moderators to test assumptions underlying culturally sensitive therapies: An exploratory example. *Cultural Diversity and Eth­ nic Minority Psychology* 13(2):169-177, 2007*a.*

Wong, F.Y., Huang, Z.J., Thompson, E.E., De Leon,J.M., Shah, M.S., Park, R.J., and Do, T.D. Substance use among a sample of foreign- and U.S.-born Southeast Asians in an urban set­

*ting.journal of Ethnicity in Substance Abuse* 6(1):45-66, 2007*b.*

Woody, G.E., McLellan, A.T., Luborsky, L., and O'Brien, C.P.Twelve-month follow-up of psycho­ therapy for opiate dependence [published erratum appears in *The American journal of Psychiatry,* 1989. Dec;146(12):1651]. *TheAmericanjournalof Psychiatry* 144(5):590-596,1987.

Woody, G.E., McLellan, A.T., Luborsky, L., and O'Brien, C.P. Psychotherapy in community methadone programs: A validation study. *TheAmericanjournal of Psychiatry* 152(9):1302- 1308, 1995.

Worby, P.A., and Organista, K.C. Alcohol use and problem drinking among male Mexican and Central American immigrant laborers: A review of the literature. *Hispanic journal of Behav­ ioral Sciences* 29(4):413-455, 2007.

World Health Organization. *Management of Substance Abuse: Facts and Figures.* Geneva: World Health Organization, 2009.

Worrell, F.C., Cross, W.E.,Jr., and Vandiver, B.J. Nigrescence theory: Current status and chal­ lenges for the *future.journal of Multicultural Counseling and Development* 29:201-213, 2001.

Wright, E.M. Substance abuse in African American communities. In: Straussner, S.L.A., ed. *Eth­ nocultural Factors in Substance Abuse Treatment* (pp. 31-51). New York: Guilford Press, 2001.

Xie, Y., and Greenman, E. *Segmented Assimilation Theory:A Reformulation and Empirical Test.* Re­ search Report 05-581, Ann Arbor, MI: University of Michigan Population Studies Center, 2005.

Yamada, A.M., Marsella, *A.].,* and Yamada, S.Y. The development of the Ethnocultural Identity

Behavioral Index: Psychometric properties and validation with Asian Americans and Pacific Islanders.Asian *American and Pacific Islander journal of Health* 6:35-45, 1998.

Yamamoto,]., and Acosta, F.X. Treatment of Asian-Americans and Hispanic Americans: Simi­ larities and *differences.journal of the Academy of Psychoanalysis* 10:585-607, 1982.

Yang, M.J. The Chinese drinking problem: A review of the literature and its implication in a cross-cultural study. *Kaohsiung journal of Medical Sciences* 18(11):543-550, 2002.

Yang, *P.QEthnic Studies: Issues and Approaches.* Albany, NY: State University of New York Press, 2000.

251

Improving Cultural Competence

Yeung, A., Neault, N., Sonawalla, S., Howarth, S., Fava, M., and Nierenberg, A. A. Screening for major depression in Asian-Americans: A comparison of the Beck and the Chinese Depres­ sion *Inventory.Acta Psychiatrica Scandinavica* 105:252-257, 2002.

Yu,J., and Warner, L.A. Substance abuse treatment readmission patterns of Asian Americans: comparisons with other ethnic groups. *The American journal of Drug and Alcohol Abuse* 39(1):23-27, 2013.

Yudko, E., Lozhkina, 0., and Fouts, A. A comprehensive review of the psychometric properties of the Drug Abuse Screening *Test.journal of Substance Abuse Treatment* 32:189-198, 2007.

Zane, N., and Mak, W. Major approaches to the measurement of acculturation among ethnic minority populations: A content analysis and an alternative empirical strategy. In: Chun, K.M., Balls-Organista, P., and Marin, G., *eds.Acculturation:Advances in Theory, Measurement, and Applied Research* (pp. 39-60). Washington, DC: American Psychological Association, 2003.

Zea, M.C., Asner-Self, K.K., Birman, D., and Buki, L.P. The Abbreviated Multidimensional Acculturation Scale: Empirical validation with two Latino/Latina samples. *Cultural Diversity and Ethnic Minority Psychology* 9(2):107-126, 2003.

Zemore, S.E. Re-examining whether and why acculturation relates to drinking outcomes in a rigorous, national survey of Latinos. *Alcoholism: Clinical* & *Experimental Research* 29(12):2144-2153, 2005.

Zemore, S.E., and Kaskutas, L.A. Helping, spirituality and Alcoholics Anonymous in recovery.

*journal of Studies onAlcohol* 65(3):383-391, 2004.

Zhang, A.Y., Snowden, L.R., and Sue, S. Differences between Asian and White Americans' help seeking and utilization patterns in the Los Angeles *area.journal of Community Psychology* 26(4):317-326, 1998.

Zhang, W. American counseling in the mind of a Chinese *counselor.journal of Multicultural Counseling and Development* 22:79-85, 1994.

Zhang, Y., Young, D., Lee, S., Li, L., Zhang, H., Xiao, Z., Hao, W., Feng, Y., Zhou, H., and Chang, D.F. Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry* 39(1):115-129, 2002.

Zheng, Y. and Lin, K.-M. Comparison of the Chinese Depression Inventory and the Chinese version of the Beck Depression Inventory. *Acta Psychiatrica Scandinavica* 84:531-536, 1991.

Zuckerman, M. Some dubious premises in research and theory on racial differences. In: Balls­ Organista, P., Chun, K.M., and Marin, G., eds. *Readings in Ethnic Psychology* (pp. 59-69). New York: Routledge, 1998.

252