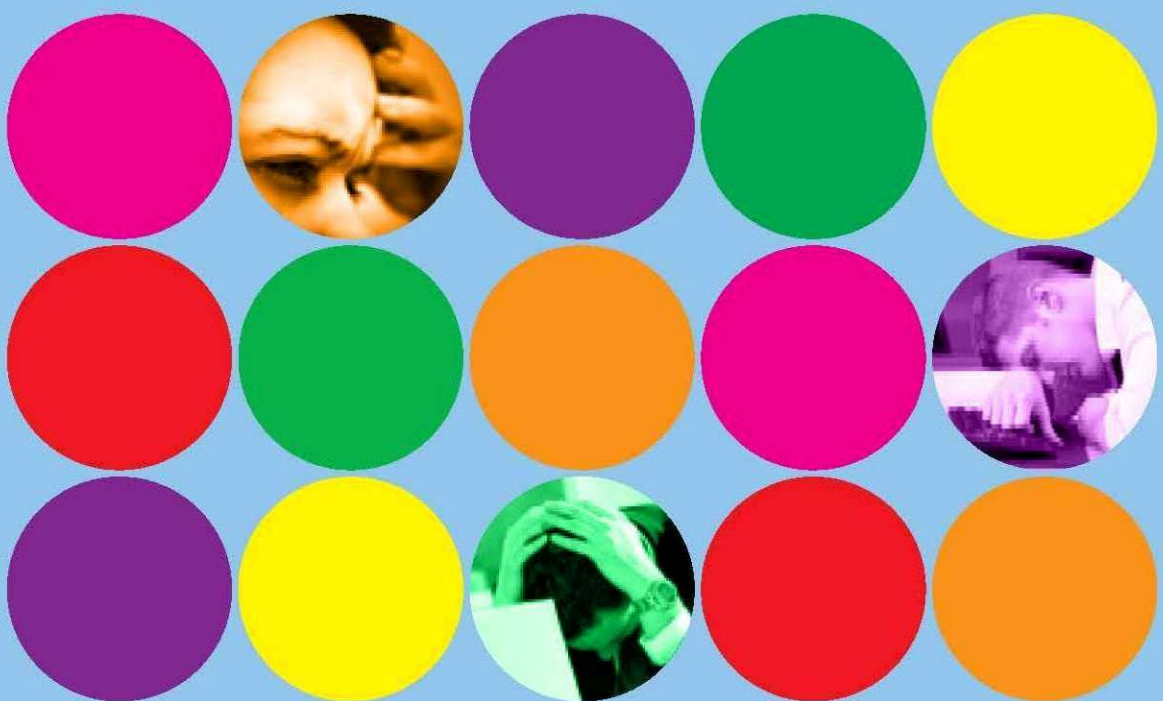
Handbook of Managerial Behavior and Occupational Health



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NEW HORIZONS IN MANAGEMENT

25 Immigration, acculturation and drug abuse: multicultural aspects of treatment

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Introduction

Migration in Europe

Immigrants and refugees are an increasingly substantial subset of the European societies. During the year 2000, more than 22 million foreign nationals resided in Western Europe, comprising over 5.5% of the total population (Salt, 2003). This number includes legal immigrants, asylum seekers, and undocumented immigrants arriving each year. Projections suggest that the numbers of first- and second-generation residents will continue to expand rapidly. The future of Europe is ultimately related to the adaptation of immigrants and their children, even with possible future efforts to reduce immigration.

Immigrants arrived in two waves to Greece. The first was during the early 1990s, in which Albanians dominated. The second arrived after 1995, and involved much greater participation of immigrants from other Balkan states, the former Soviet Union, Pakistan, India, Iraq and Iran. According to the 2001 Census, the largest group of immigrants draws its origins from the Balkan countries of Albania, Bulgaria, and Romania. People from these countries make up almost two-thirds of the total 'foreign population'. Migrants from the former Soviet Union (Georgia, Russia, Ukraine, Moldavia, etc.) comprise 10% of the total and are mainly of Greek origin; the EU countries approximately 6%. A heterogeneous group of people from places such as the United States, Canada, and Australia (mostly first- or second-generation Greek emigrants returning home), also account for around 6%. Finally, a residual group from a wide variety of countries makes up 13% (Labrianidis & Lyberaki, 2001).

Drug abuse is a significant health problem for all European societies. There are an estimated 2 million drug abusers in Europe alone and the numbers are growing steadily, particularly among young people (Diamanduros, 2005). In Greece the number of problem drug users appeared to increase in 2004, compared to 2003. Among the users, non-Greek nationals accounted for 2.5%. In addition, from 1993 up to 2001 a sharp increase in drug-related deaths was observed. Non-Greek nationals accounted for 5.8% (Terzidou, 2005). A 1996 World Health Organization (WHO) report noted that the consumption of tranquillizers and antidepressants by young immigrants across Europe is growing. Most of the research and literature that examines drug abuse problems identify risk factors for the general population, but, more specifically find immigrant youth to be particularly at risk of beginning the use of drugs because of their minority status (Robbins & Mikow, 2000). In order to design effective intervention programs and services for minority people, it is important to understand the process of immigration as a transition, and also the differences in culture that may affect the decision of an immigrant to use different substances.

This chapter provides an overview of the relationship between immigration, acculturation and drug abuse in immigrants. In this section, immigration and acculturation factors which play a role in immigrants' adaptation are presented. The focus then moves to the relationship between acculturation and drug abuse with greater emphasis on risk factors that are related to immigrants' drug addiction. The subsequent section deals with the accessibility of substance abuse and mental health services by immigrants, followed by a section that is more focused on comparative research regarding differences and similarities in drug abuse among native Greeks and immigrants**.** The penultimate section pays attention to the integration of culture concepts into intervention programmes for the rehabilitation of addicted immigrants, and the final section concludes.

Immigration and acculturation

The process of migration can be understood as a profound non-normative life transition (Suárez-Orozco, 2000) consisting of the pre-migration and departure phase, and the transition and adaptation to a new country. Even under the best of conditions, migration involves a series of events that can be highly traumatizing and that can place migrants at risk. The decision to migrate as a perceived lack of prospects that people have in their own country due to economic or political conditions (Ward et al., 2001) removes them from predictable contexts (family, friends, customs, language) and leads to a keen sense of loss (Suárez-Orozco & Suárez-Orozco, 2001). During the initial period following arrival, many immigrants experience a sense of confusion, including anxiety, disorientation, suspicion and bewilderment (Oberg, 1960), but as the realities of the new situation are confronted, they begin to experience a variety of psychological problems due to acculturation.

Acculturation implies changes over time in beliefs, emotions, attitudes, values, behaviors and identification pattern of persons in first-hand contact with persons representing another culture (Sam, 2006). Pressures on the individual to contend with the host society can lead to increased stress, or acculturative stress (Berry, 2003) as a generalized physiological and psychological state brought about by the experience of stressors in the environment, and which requires some reduction through a process of coping until some satisfactory adaptation to the new situation is achieved. When behavioral shifts have taken place without difficulty, stress is likely to be minimal and personal consequences are generally positive. When acculturative problems do arise, but have been successfully coped with, stress will be low and the immediate effects positive. But when an individual's adaptive resources are insufficient to support adjustment to a new cultural environment, stress will be higher and the effects more negative (ibid.). Acculturative stress is a common experience of first-generation immigrants (Ward et al., 2001). Second- and later-generation immigrants experience acculturative stress owing to the conflicts that arise out of their bicultural socialization (Roysircar-Sodowsky & Maestas, 2000). Accumulative evidence suggests that acculturative stress may have important implications for the mental health of immigrants, including psychosocial, somatic and social aspects (Organista et al., 2003).

Substance abuse among immigrants

Important considerations in studying the relationship between immigration and drug abuse are differences on substance use patterns between the general population and immigrants. A body of research that we have found useful assesses whether foreign-born

individuals demonstrate higher or lower rates of substance use than their native-born counterparts, and the variety of variables (the nature of migration, culture differences, lack of support) that mediate the relationship between acculturation and mental health and make people vulnerable to substance abuse (Gfroerer & Tan, 2003). Comparison across groups often includes the role of psychosocial characteristics across two or more culture groups, or in the medical context the treatment in which the specialist and the patient belong to different cultures (Westermeyer, 2004).

Research findings on substance use patterns among immigrant populations are mixed, with some studies indicating that substance use increases with increased time in the new country (Gfroerer & Tan, 2003). Other studies showed decreased substance use and mental health problems over time and with increased levels of acculturation (NIDA, 2001; Caetano, & Clark, 2003). Even within subgroups of immigrants, there is wide variability in substance use patterns. According to Isralowitz et al. (2002), immigrants from the former Soviet Union (FSU) faced with the highly complex challenge of acculturation often develop emotional and behavioral problems that include mental illness, delinquency, and alcohol and drug abuse. Their experiences in their new countries, where drugs and alcohol are readily available at low prices, lead immigrants who are experiencing difficulty to turn to substance abuse as a way of coping. Early research shows that FSU substance abusers, especially those using drugs, are mainly bilingual males in their early twenties. Unlike other young people in the New York City area, this population does not start with 'gateway' drugs, such as marijuana or ecstasy, but goes straight to injecting heroin.

The mixed findings from research with immigrant and minority populations have pointed to the need for considering coexistence of stressors that increase vulnerability to personal problems of immigrants such as drug use. Most studies have relied on acculturation and acculturative stress effects on licit and illicit drug use by immigrant adolescents (EMCDDA, 2002). Additional research addresses the culture itself, including the norms for the abuse of alcohol, tobacco and other drugs within the specific culture and their meaning and effect on the initial or continued abuse of drugs by minority youth (Robbins & Mikow, 2000).

Risk factors that are related to drug abuse among immigrants: a review of the literature

Acculturative stress, or the challenge of assimilating into the dominant culture, has been implicated as a mechanism for increased substance use among immigrants (NIDA, 2001). The process of acculturation implies role strains, cognitive manipulations, and affective states that are potentially stressful and responsible for the non-adaptive attitudes and behaviors of immigrants (Berry, 1997). An important premise of the acculturative stress process is that stressors are harmful only when coping resources are inadequate for solving problems; demands must exceed resources to produce a negative outcome. Drug use is one possible negative outcome (Alaniz, 2002; Castillo & Henderson, 2002). Mental health professionals have described the common symptoms that most immigrants present and have called it 'chronic and multiple stress syndrome' in immigrants (Carta et al., 2005). Immigrants affected by this syndrome present depressive symptomatology with atypical characteristics, where depressive symptoms are anxiety, somatoform and dissociative symptoms. The development of this condition occurs progressively as the immigrants encounter difficulties that take place during the migration and acculturation process, difficulties in finding a job and housing, in obtaining documents, or with

the racism encountered in a new country. According to specialists, chronic and multiple stress syndrome should constitute a category situated in between adjustment disorders and post-traumatic stress disorder.

Another hypothesis is that exposure to a new culture brings with it increasing familiarity with the social contexts of drug use, as well as opportunities for drug use in peer group situations, in which youth often construct spaces of competence in the underground (Suárez-Orozco, 2000). These peer groups function on the periphery of multiple sociocultural worlds and include individuals who may feel confused, frustrated, and inferior. Therefore, the use of substances is adapted as a method of socialization into the new society. Thus, the addicts have friends or peers and are in this way grown up, independent, and 'successful'.

Despite the plausibility of both explanations, they are neither satisfactory nor comprehensive. Becoming a drug user is a complex, multipath process that has no unitary explanation. While it is evident that immigrant youth who have greater exposure to a new culture may be more delinquent or use more illicit drugs, this fact alone cannot explain which youth are susceptible among all youth so exposed. Similarly, the argument that acculturative stress increases drug use among immigrants fails to identify the factors or conditions that differentiate users from non-users. Added stressors from the process of immigration itself can lead to increased risk for emotional disturbance and drug abuse in newer immigrants. These include previous traumatic exposure in their homelands (war, torture), many of which prompt the decision to emigrate in the first place. These are often compounded by the loss of extended family and kinship networks (and even separation from nuclear family members, such as children from their parents) as well as the lack of social support and assimilation or marginalization (Caetano et al., 1998; Makimoto, 1998; Elder et al., 2000). Such experiences create vulnerability in children and adolescents due to their incomplete biopsychosocial development, dependency, inability to understand certain life events and underdevelopment of coping skills. These risk factors for drug use operate through increasing the probability of incorporation of deviant norms generally, by increasing the chances of involvement with deviant peers (Beauvais & Oetting, 1999).

Accumulating data indicate that unaccompanied children and adolescents and those separated from family members are consistently at greater risk of having psychiatric and mental health problems than their accompanied peers (Sourander, 1998). By definition, an unaccompanied immigrant child is an individual under 18 years of age who has been separated from both parents and is not being cared for by a responsible adult (Servan-Schreiber et al., 1998; Sourander, 1998). Unaccompanied adolescents and youths are particularly vulnerable as their increasing autonomy causes them to relive past separations, creating difficulties in adjustment. Separation of children from their parents (for whatever reason) can directly affect the parent–child relationship and may result in increased vulnerability and risk for children. On reunification, parents and children have to adjust to living together again. The parental viewpoint of separation–reunion is often very different from that of their children. Parents have expectations that their children will be happy, affectionate and obedient. In the absence of such behaviors, parents may perceive the child as ungrateful and experience hurt and anger when faced with a hostile or unappreciative child (Suárez-Orozco, 2000). The symptom of addiction in these cases provides a form of 'pseudo-individuation' at several levels, containing elements of the

fear of being separated or abandoned and presenting an attempt to punish the parents by engaging in acting-out behavior.

Moreover, a variety of problems exist when one parent, especially the father, migrates first and, if married, leaves behind a wife and children, and the reunion occurs after he had become established in the new country (Suárez-Orozco & Suárez-Orozco, 2001). The temporary loss of relationships and contact with the family, and the disruption of family support, are related to the sense of loneliness and the lack of an attachment figure (Peplau & Perlman, 1982). Drug addiction in this case, especially to heroin, does indeed appear to have many adaptive, functional qualities that fuel negative emotional states of isolation and loneliness in addition to the 'pleasurable' features that serve to fulfill the unconscious need to entertain and to enact various kinds of homosexual and perverse fantasies, and at the same time to avoid taking responsibility for this.

Contact with the new culture and conflicts that are rooted in different rates of acculturation in the family (e.g., highly assimilated children, adherence of parents to the traditional values) lead to the disruption of the core family processes (perceived roles, hierarchy, exercise of power, models of interaction), even in cases where the entire family immigrate. The weakness of the parents in supporting their children, either because their economic needs force them to leave their children alone without supervision for long periods, or because of mental disturbance or divorce (Hjern et al., 1998; Suárez-Orozco & Suárez-Orozco, 2001), and the faster acculturation of the children due to their young age together with their integration into the educational system, together result in parent–child conflicts that concern issues such as dress code, dating, and school performance, and also rights and obligations within the family (Booth et al., 1997). When the intensity of conflicts becomes unbearable and the youngster is unable to trust other people outside of the familial environment, then drug abuse is a way of making the negative emotions more tolerable. Using drugs is considered to be a way of expressing frustration and anger, especially when the young people are unable to deal with their parents directly. Young drug abusers are bound in a simultaneous need to defy their parents and to punish themselves for their own rebellion.

Acculturation strategies, regarding the way in which immigrants regulate the proximity and the distance in the transformation of identity and in their relationships with the country of origin and the country of reception (Akhtar, 1999) are considered to have different effects on mental health (Sam, 2006). The issue of substance abuse. If young people feel isolated because they are unable to integrate, or feel rejected by the mainstream culture, or if their ethnic group is viewed by the majority culture as devalued and denigrated, they may identify and internalize these negative perceptions, which may lead to negative self-emotions, which in turn may lead to substance abuse. At the other end of the continuum, they may develop an adversarial identity, standing in defiance of the majority culture, which is seen as depriving them of social and financial aspirations and marginalizing them. In these situations, some young people who are not able to embrace their own culture and who develop an adversarial identity against the mainstream culture, construct spaces of competence in the underground and may join gangs. For them, gangs offer a sense of belonging, solidarity, protection, discipline, and warmth. These groups structure the anger many feel towards the society that violently rejected their parents and themselves (Suárez-Orozco, 2000).

Additional factors that are connected with the pathology of usage are the low economic and social level of the parents (Howard & Hodes, 2000), economic poverty, low

social status connected with the national group, failure at school as the basic institution of children's socialization (Hyman et al, 2000), and also the lack of future opportunities (Caetano et al., 1998; Elder et al., 2000).

Healthcare services and drug dependence in immigrants: the experience in Greece

Studies in drug abuse document that immigrant groups have less access to, and availability of, mental health services and they are less likely to receive needed mental health care. They often receive a poorer quality of mental health care in terms of treatment and are underrepresented in mental health research (EMCDDA, 2002). A constellation of barriers deters minorities from obtaining treatment. Many of these barriers operate for all people: cost, fragmentation of services, lack of availability of services, and societal stigma toward dependence from illicit substances. But additional barriers deter racial and ethnic minorities: personal beliefs, mistrust and fear of treatment, racism and discrimination, and differences in language and communication (Israelowitz, 2004).

Personal cultural beliefs have a great impact on the perception of substance use. Culture determines how people understand and deal with substance use and abuse. For example, people from traditional cultures may avoid substance abuse services due to the fear of stigmatization. For them, substance abuse is a moral problem and a source of family shame (Sue, 2002). Cultural factors influence the type of symptoms displayed and conceptions of mental health and disturbance. People from collectivistic cultures tend to have more organic or somatic involvement in emotional disturbance. They also believe that the exercise of willpower, and the avoidance of morbid thoughts, are means of enhancing psychological well-being. As a consequence they may avoid Western forms of mental health treatment and seek medical treatment for emotional problems (Tanaka-Matsumi & Draguns, 1997)

Experiences of discrimination and stereotyping, alienation, healthcare providers' biases, as well as communication problems can prevent immigrants from utilizing health services. Discrimination and stereotyping play a role in mistrust and subsequent service utilization in immigrants and in greater use of informal services and help seeking from friends or relatives, but not in the use of formal services (Spencer & Chen, 2004). The ability to communicate with one another is essential for all aspects of healthcare, yet it carries special significance in the area of mental health because drug abuse and substance abuse treatment is based on encompassing thoughts, moods, and the highest integrative aspects of behavior. People often respond to the language barrier by remaining silent, appearing withdrawn, moody, and fearful. Thus, the treatment of substance abuse dependence greatly depends on verbal communication and trust between patient and specialist. The lack of culturally and linguistically appropriate services and mistrust of mental health providers constitute significant elements of social exclusion.

Although in Greece the officially recognized drug treatment programs operating in the country add up to 51 in total and deliver different types of treatment services (Terzidou, 2005), little attention has been paid to the examination of utilization of drug abuse treatment services by immigrants. There are different sources of information, but up to the present there has not been any attempt to design comprehensive surveys regarding the handling of immigrant populations and mental health. The interest in different treatment services has focused on the characteristics of immigrant groups, recording changes in patterns of use and trying to better understand their needs.

In terms of the treatment services available, integrated culture-specific treatment is provided by two programs for immigrant drug users. More specifically, the Drug Dependence Unit 18 (ANO) (Psychiatric Hospital of Attica), which comes under the Ministry of Health, has been working in recent years to respond to the needs of addict immigrants and refugees by developing and integrating a culturally sensitive plan of substance abuse intervention. According to this plan, the multistage therapeutic process consisting of sensitization, psychological recovery (main treatment) and social reintegration is sensitive to cultural values and experiences of immigrant groups, while addressing the common etiological factors of substance abuse. The main treatment services offered integrate different needs of immigrants. The therapeutic team provides bridges to social resources in the community to provide information about supportive networks that facilitate the reintegration of immigrants and refugees (document and housing aid, language learning).

The Therapy Center for Dependent Individuals (KETHEA) has established the MOSAIC Transitional Centre in Athens in order to provide psychosocial support to dependent individuals from vulnerable social groups, such as repatriated Greeks, refugees and immigrants. The program delivers healthcare services, motivation, empowerment, dependence treatment and social activation, adapting a cross-cultural approach (Terzidou, 2005).

Drug abuse among native and immigrant adults: a comparative study in Greece

This study presents information on the prevalence of illicit drug use among immigrants aged 18 or older in Greece, in comparison to native Greeks. Estimates for immigrants and native drug abusers are based on data collected during 2005–06 from adults in the Drug Dependence Unit at the State Psychiatry Hospital of Attica. Sample sizes were: $N = 53$ (51%) immigrants and $N = 51$ (49%) native Greeks. Some 60% (31) of immigrants were from the FSU, 17% (8) from Arabic countries (Iraq, Iran), 15% (7) from countries of Eastern Europe (Albania, Poland, Bulgaria) and 8% (5) were repatriated Greek immigrants from the FSU, Australia and Germany. In the above sample, 18 people (17.5%) were married, 72 (69.9%) were single and 12 (11.9%) were divorced. Although the immigrants were married, their children and wives lived in their country of origin.

Materials

The data collection method used in this study involved in-person structured interviews with the sample population, incorporating procedures that would be likely to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. The interview included personal and demographic information (age, education in years, and country of birth), marital status, living conditions and housing, health status (HIV/AIDS), criminal and deviant behaviors, and information regarding lifetime use of illicit substances. The interview was conducted after the person had decided to participate in the drug rehabilitation program.

Results

Education level Immigrant abusers displayed a considerably higher education level compared with Greek abusers. Some 49% of immigrants compared to approximately 24% of native Greeks held a university degree: $\chi^2(1, n = 104) = 3.16$, $p = 0.05$.

Employment status In terms of the kind of jobs that people did there were no differences between immigrants and natives. The main occupations for all drug abusers were paid employment in construction (54.5%), in manufacturing sectors (27.7%) and in the scientific sector (5.9%), with a small percentage in self-employment (2%). With regard to employment participation, immigrants also displayed a considerably higher unemployment rate compared with Greek natives (63% compared to approximately 47.1%, respectively: $\chi^2(1, n = 104) = 6.36$, $p = 0.01$. Moreover the rate of immigrants without social security (50%) is considerably higher than that of natives: $\chi^2(1, n = 104) = 5.06$, $p < 0.05$.

Health status The rate of immigrants that were users of the healthcare system (53.8%) was considerably lower than the rate of native Greeks (29.4%): $\chi^2(1, n = 104) = 9.0$, $p < 0.01$. In terms of acquired immuno-deficiency syndrome (AIDS) more immigrants (26.4%) than natives (13.7%) have no information about AIDS infection: $\chi^2(1, n = 104) = 6.8$, $p < 0.01$.

Substance abuse With respect to the main illicit substance there were no differences among groups. Specifically, heroin is the main illicit substance that the majority of the group 86.5% (90) use, 6.7% reported that they use cocaine as a main substance, and the remaining 6.7% reported using other drugs such as amphetamines, benzodiazepines, marijuana and hashish. However, differences were found with regard to methods of substance use: $\chi^2(1, n = 104) = 3.5$, $p = 0.05$. Compared with natives (36.7%), substance use among most immigrants occurs intramuscularly, through multiperson use of needles and syringes (51%). More natives than immigrants use illicit substances orally, or inhaled. With respect to the multiperson use of a common syringe there were no differences between the groups. Some 32% of people reported multiperson use of syringes.

The path to drug addiction begins with the act of taking hashish or marijuana for 72.6%, 9.9% use narcotics such as heroin and opium, and the remainder (7.7%) begin with using depressants, cocaine and amphetamines. With regard to concurrent use of different types of substances, differences between groups were observed: heroin was associated with marijuana use in immigrants, whereas among natives multiple substance use was observed: $\chi^2(1, n = 104) = 23.9$, $p = 0.001$.

Age of first involvement with illicit substance use The age of first involvement with elicit substances is older for immigrants ($M = 18$) than for natives ($M = 15.6$): $F(1, 96) = 8.5$, $p < 0.01$. The mean age of first illicit substance use for immigrants is 18 years, with the youngest aged 10 and the oldest aged 40. Natives appeared to have a mean initiation age of 15.6 years, with the youngest aged 12 and the oldest aged 30.

Although immigrants appeared to have been initiated into illicit substance use at an older age, their developmental sequence of substance use involvement increases faster compared to natives. Immigrants advance to intramuscular substance use more rapidly than Greeks. The average time of dependency does not differ among groups. The mean length of use reported by natives was 7 years and by immigrants 5.2 years. The longest time of use for natives is 25 years and for natives 36.6 years.

Legal status According to statistics, there are differences in drug-related offences between groups: $\chi^2(1, n = 103) = 23.9$, $p < 0.05$. Immigrants reported fewer offences

than natives. However, more immigrants than natives do not give information about their legal status. Differences were found with regard to trial or court decisions: $\chi^2(1, n = 100) = 6.7$, $p < 0.01$ and to awaiting such trial or court decision: $\chi^2(1, n = 100) = 3.0$, $p < 0.05$. More specifically, a lower proportion of drug users among immigrants than among natives reported that they are a waiting a hearing and a decision concerning a past offense. But a higher proportion of immigrants than Greeks provide no information about their previous history of trial or court decisions. Regarding prior punishment and imprisonment there were no differences between the groups. A total of 45.6% reported the outcome of their case: prior arrest and prison was reported by 23.8%; self-report data indicated that 29.7% had committed a serious violent offense; suspension of judgment was reported by 18%; and trial by jury by 33.3%.

Counseling and substance abuse treatment The length of involvement of immigrants and natives in a treatment program was the same. However, immigrants are twice as poor as natives at keeping their appointments: $F(1, 95) = 5.5$, $p < 0.05$. In addition, immigrant drug abusers tend to seek a medical solution for their addiction. It appears that many of them use treatment to reduce their level of drug abuse, not to eliminate the problem: $\chi^2(1, n = 96) = 4.3$, $p < 0.05$.

Conclusions Immigrant status (i.e., being an immigrant) does appear to influence the attitudes and behavior of drug abusers. Drug abusers, natives and immigrants, are more inclined to use heroin as a main illicit substance and their behavior is mostly related to a combination of heroin with other substances. But numerous factors tend to differentiate immigrants and native drug abusers, including patterns of injected heroin use: intramuscular in combination with multiperson use of needles and syringes was present among most immigrants. Multiperson sharing of syringes is associated with rapid transition of HIV among illicit drug users, with HIV incidence rates as high as 20–50 per 100 person years at risk. Moreover, most illicit drug users who continue to inject may be unable to obtain a sufficient number of syringes to effectively reduce their risk of acquiring and transmitting blood-born viral infections (Batki & Nathan, 2004).

The second important result refers to the speed at which immigrant substance users progress from mild to more severe involvement. Faster progression of immigrants compared to natives is in contrast to the later initiators of substance use among immigrants. The results also suggest that it is important to investigate whether immigration and acculturation may play a role in addictive liability, above and beyond what is accounted for by other factors.

Descriptive findings confirm that immigrants have less access to mental health services than natives; and they are less likely to receive needed care because immigrants are unlikely to use formal mental health and primary healthcare services. To understand ethnic disparities in specialty care, the effects of ethnicity should be analyzed in combination with other factors including the financial costs involved. According to the results, a higher rate of immigrant drug users face a social and economic environment of inequality that includes greater poverty, unemployment and lack of social security. Other barriers that affect utilization of mental health options may be categorized as follows: differences in language and culture, stigmatization and the failure of services to target immigrant groups (Makimoto, 1998; Elder et al., 2000; EMCDDA, 2002).

Similarly, immigrants are seen to differentiate their behavior in relation to drug abuse treatment. Immigrants are seen as having an increased probability of missing appointments and also of seeking a medical solution for their addiction. Culturally based factors such as shame and stigma, conceptions of mental health, and alternative options are important factors that affect utilization and appropriateness of mainstream services (Sue, 2002). The tendency to have more organic or somatic involvement in drug abuse disturbance has to do with the cultural meaning of somatic complaints (Tanaka-Matsumi & Draguns, 1997). Somatic complaints are less stigmatized among some cultures and somatization justifies an acceptable medical intervention. On the other hand, specialists must be cognizant of the immigration experience itself because of stress and the lack of social and economic resources for coping, which may deter immigrants from using services and receiving appropriate care.

Importance of adapting an integrated multicultural approach to drug dependence problems of immigrants

Recently, there has been a demand for cultural sensitivity and competence in treating refugees and immigrants. It is a common task of mental health professionals to understand the role of culture in order to help people from different contexts to optimize their functioning and well-being. Culture is usually defined as a way of life or the totality of the individual artifacts, behaviors, and mental concepts transmitted from one generation to the next in a society. It is visible and invisible, cognitive and affective, conscious and unconscious, internal and external, rational and irrational at the same time (Draguns, 2002). Comparisons across cultures in a treatment context are often termed 'etic', whereas noncomparable, culture-specific elements or patterns are termed 'emic' (Westermeyer, 2004).

The influence of culture in the treatment process can be understood in terms of two dimensions: (i) the specific sets of environments that influence the individual's experience such as family, school and community, and (ii) the specific meanings of social phenomena including patterns of social behavior, self-concept, interpersonal interaction, beliefs about social gender roles and sexuality (Draguns, 2002). Many studies have shown that people differ in their experience of pain, in what they label as a symptom, how they communicate their pain or symptoms, in their beliefs about its cause, the attitudes toward therapists and the treatment they desire or expect (McGoldrick & Giordano, 1996). Furthermore, a careful, well-documented treatment plan necessitates an addicted individual detailing the nature of stressful events and acculturative stress, information about the cultural context that influences the behavior of the individual, and the therapists' awareness and self reflection about their own possible prejudice and cultural biases (Azima, 2002). It is important to be aware of the challenges that face addicted immigrants and refugees: acculturation and acculturative stress, parental acculturation and related stress, disruption in the family structure and 'parentification' of the child, a new identity based on certain features of the culture of origin and the host culture.

Diversity within cultural groupings

It is also important that mental health professionals are sensitive to variations within a culture. For example, Middle Eastern ethnic groups share many similarities in culture and traditions which include the importance of family, spirituality, and a collectivistic

set of societal expectations. But they also have many differences including language (e.g., Arabic, Farsi, Armenian, and Lebanese) as well as differences in religion. The family attitudes and traditions in smaller cultural groups are also likely to be different and need to be understood in order for an addicted individual to become more trusting of the therapist (ibid.).

Legal status

Immigrants' legal status is a key factor for their well-being. Undocumented immigrants constantly appear to do worse in many health and social indicators than their legal counterparts. Legal status directly affects immigrants' wages and work conditions. Many health problems of this group often remain undiagnosed and without treatment due to undocumented underutilization of health services. More than half of undocumented immigrants are uninsured compared to legal immigrants (Passel, 2005). The lack of access to drug services contributes to the hidden nature of drug abuse among immigrants and to the employment of alternative strategies to keep the drug abuse within the family or community.

Acculturation modes

Knowing how addicted individuals feel about their culture allows for an understanding of their adaptation process. Some individuals will be ashamed of their culture and will feel rejected in a new environment. The conflicting values put an extra burden upon the individual's ego, rendering identity consolidation difficult. Such individuals have to create a 'third reality', not of their homeland or of the adopted land, but something uniquely different (Akhtar, 1999). Other individuals remain comfortable in their homoethnic group, but find it difficult to mingle with the culture at large (Suárez-Orozco, 2000). Youths clustering around the assimilation, leave their ethnic group behind, and feel embarrassed by their parents' attachment to traditional culture. The frequent difficulties facing young immigrants arise from the struggles to balance the demands of the new culture with those of traditionally minded parents.

Acculturative stress

There are also significant sources of acculturative stress that immigrants must respond to (Chope & Fang, 1999), for example:

- physical stress in adjusting to a new, unfamiliar physical environment with different housing standards and climate;
- psychological stress when values, beliefs, attitudes, and sense of belonging change;
- family stress when generational differences are magnified by disparate contact with the host culture;
- social stress effected by vast changes in employment opportunities, educational instruction, and ethnic and social status, history of discrimination; and
- cultural stress in the encounter with a new language, religion, and purchasing power.

Migration history

Adaptation is affected by whether one family member migrated alone or whether many members of the family came together. Family migration can take different forms, for

example: (i) parents will migrate with their family (family migration); (ii) parents will migrate either singly or together with the intention of sending for the rest of their family at a later date (serial migration); (iii) parents will migrate either singly or together for a defined period or indefinitely but have no intention of having their children live in the overseas country (parental migration) (Crawford-Brown & Rattray, 2002); (iv) parents (or a single parent) who migrate for up to six months at a time to work in the host/receiving country (seasonal migration); and (v) unaccompanied children and adolescents when placed with adults of similar or dissimilar cultural backgrounds (Sourander, 1998). When working with immigrant families, the theme of migration, which in turn includes issues of acculturation, acculturation stress, changes in socioeconomic status, minority status, and ethnic identity, is very powerful. Therapists are advised to explore the circumstances surrounding the family's migration including the decision making around the migration, and immigration-related attachment disruptions.

Acculturation processes in the family

There may be conflicts in the family over just assimilating in the new culture. The intergenerational conflict due to differing rates of acculturation between parents and children makes family interactions stressful and leads to a weakened quality of parent–child communication and creates overreaction by parents to perceived loss of control over adolescent children (Szapocznik & Williams, 2000). The end point of this process is adolescent resistance to parental expectations, personal distress and possibly acting out through delinquency and drug use.

Migration often creates changes within the structure of the family. Former family leaders may be demoted and the nature of the gender relationships may shift (Suárez-Orozco, 2000). For example, when employment conditions are such that a woman from a traditional couple can obtain a job more easily than a man, her new role as the breadwinner may create tensions and stress in the family structure. Furthermore, in maladaptive relationships, the reconfiguration of the power structure and the redefinition of family roles result in rules and consequences that are unclear and unpredictable. The children become part of a triangle in the parental system conflict. They may become entangled in destructive coalitions with a parent, act out in response to ineffective control, or disengage from the family to avoid distressing interactions (Chun & Akutsu, 2003).

Acculturation plays a role in the disruptions of parent–children relationships. Immigrant parents often have to make considerable sacrifices for a better future for their children. Within the new country, they set limits that are significantly more stringent than if they had stayed in their country of origin. At the same time they are often dependent upon their children. The children often learn the new language more quickly than their parents and consequently they often take on new roles as translators and advocates for their families. Alternating between 'parentifying' the children and at the same time severely constricting their activities may create significant tensions within the family, adolescent defiance and loss of family cohesiveness (Brook et al., 2001).

Emotional and physical closeness is another dimension in which it is important to be sensitive to culture-specific differences (Santisteban & Mitrani, 2003). Immigrant families place a relatively higher value on collectivism and give precedence to the needs of the family rather than to the needs of the individual. If those who are assimilated are rebelling because they are not allowed to be individuals, then the tendency for greater emotional

and psychological closeness in the family is related to the emergence of symptomatic behavior. A strategy of working with such families is to recognize the strengths of self-autonomy while trying to make some small changes in the willingness of family members to band together in a time of need or crisis.

Multicultural competence

To meet the needs of addicted persons from culturally diverse groups, healthcare providers must engage in the process of becoming culturally competent. 'Multicultural competence' refers to the process by which the therapist continuously strives to achieve the ability and availability to effectively work within the cultural context of an individual, family or community. This process includes addressing the importance of awareness, knowledge and skills. Cultural awareness may be equated with the ability of therapists to judge the situation from both their own viewpoint and from the viewpoint of members of other cultures. If multicultural competence helps the therapist to ask the right questions, cultural knowledge is the process of understanding the worldview of members of other cultures to explain how they interpret their illness and how it guides their thinking, doing, and being. Multicultural skill is the ability to collect relevant cultural data regarding the presenting problem as well as accurately performing a culturally based assessment that helps to determine explicit needs and intervention practices within the context of the people being served (Draguns, 2002; Pedersen, 2002).

In general, intervention in drug rehabilitation of immigrants needs to be more culturally sensitive by combining specific culture patterns, experience of immigration and acculturation with universal aspects of treatment approaches. Therapists should also assess the socioeconomic and educational levels of the addicted immigrant and his/her family, as well as their level of acculturation into the new culture, because these variables are responsible for variations in belief systems and value orientations and contribute, to an important extent, to the way in which the intervention and intervention goals are structured. Failure to take these variables into account may lead to erroneous cultural oversimplifications and stereotyping that will damage the intervention process.

Conclusion

This chapter has focused on drug abuse issues among immigrants: acculturation and acculturative stress as risk factors contributing to drug abuse in these groups, as well as treatment and services approaches for addressing their unique needs. There is general agreement in the published literature that a myriad of stresses that often accompany immigration (breaking with family, friends, and established social networks, departing from traditional routines, value systems, and accepted ways of behaving and having to adapt to new social and psychosocial environments) are related to mental health problems among immigrants. Although substance abuse has increased in recent years among general populations, insufficient attention has been paid to illicit substance use among immigrant populations.

It is important to understand that the presentation of substance abuse among immigrants may be different from that of non-immigrants. Furthermore, there is a need to understand what symptoms of substance abuse mean to the individual and the immigrant family (adaptation to the host environment, different rates of acculturation in the family, 'parentification' of the child, disruption in the family structure, marginalization)

and what their expectations are of the treatment they seek. The principles of culturally competent mental health services are most applicable to the development and delivery of mental health services for immigrants and refugees. This includes addressing differences in symptom expression and factors that affect the accessibility and acceptability of services such as stigmatization, linguistic barriers, documentation and legal status, and cultural competence of professionals.

Much more research is needed for a better understanding of the prevalence of drug addiction in immigrants, and for developing protective programs and interventions that may be required to help these groups. Research needs to be more sensitive by combining an integrative approach that recognizes how people from all populations are both similar and different at the same time. The dual emphasis on the universal and particular becomes a central professional issue in counseling and treatment of different cultural groups.

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