A model of the interplay of culture and immigration stress in the development and maintenance of alcohol-related disorders in Hispanic/Latino immigrants

Marilyn J Strada

University of Nevada, Las Vegas

Follow this and additional works at: https://digitalscholarship.unlv.edu/rtds

Repository Citation
Strada, Marilyn J, "A model of the interplay of culture and immigration stress in the development and maintenance of alcohol-related disorders in Hispanic/Latino immigrants" (2007). UNLV Retrospective Theses & Dissertations. 2778.
https://digitalscholarship.unlv.edu/rtds/2778
A MODEL OF THE INTERPLAY OF CULTURE AND IMMIGRATION STRESS IN THE DEVELOPMENT AND MAINTENANCE OF ALCOHOL-RELATED DISORDERS IN HISPANIC/LATINO IMMIGRANTS

by

Marilyn J. Strada
Bachelor of Arts
Chapman University
2002

Master of Arts
University of Nevada, Las Vegas
2004

A dissertation submitted in partial fulfillment of the requirements for the

Doctor of Philosophy Degree in Psychology
Department of Psychology
College of Liberal Arts

Graduate College
University of Nevada, Las Vegas
December 2007
INFORMATION TO USERS

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleed-through, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.
Dissertation Approval
The Graduate College
University of Nevada, Las Vegas

November 5, 2007

The Dissertation prepared by

Marilyn J. Strada

Entitled

A Model of the Interplay of Culture and Immigration Stress in the Development and Maintenance of Alcohol-Related Disorders in Hispanic/Latino Immigrants

is approved in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in Psychology

Examination Committee Chair

Dean of the Graduate College

Examination Committee Member

Examination Committee Member

Graduate College Faculty Representative

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
ABSTRACT

A Model of The Interplay of Culture and Immigration Stress in the Development and Maintenance of Alcohol-Related Disorders in Hispanic/Latino Immigrants

by

Marilyn J. Strada

Dr. Marta Meana, Dissertation Committee Chair
Associate Professor of Psychology
University of Nevada, Las Vegas

The Hispanic/Latino population represents the largest ethnic minority group in the United States, with immigrants comprising a substantial portion of this population. For both U.S.-born and immigrant Hispanic/Latinos, alcohol abuse and dependence is of particular concern given their reported high prevalence rates, the severe alcohol-related consequences that they experience, and the various barriers to obtain treatment that they encounter. In comparison to members of other ethnic groups, Hispanics/Latinos have the lowest rates of perceived need for treatment, the lowest past and current rates of participation in treatment, and the highest dropout rates after attending just one counseling session. Although there is limited information about barriers to treatment specific to immigrants, it is likely that they face similar, and likely worse, treatment-related barriers given their limited resources.
The purpose of this study was to apply the Common Sense Representations of Illness framework in an examination of meanings of alcohol-related disorders within the Hispanic/Latino cultural perspective. We aimed at identifying beliefs and values that Hispanics/Latinos associate with these disorders, which, in turn, might contribute to guiding the development of culturally sensitive prevention and treatment initiatives. We used Grounded Theory methodology to develop a theory/model about the interplay of culture and alcohol-use, grounded in the experiences of 56 Hispanic/Latino immigrant males who were mandated to treatment for alcohol-abuse.

We found that the participants’ cognitive representations about alcohol-related disorders were shaped amidst a clash of divergent cultural perspectives and immigration stressors. In essence, our participants held two separate, and often competing, sets of cognitive schemas about alcohol-related disorders. One schema was rooted in the participants’ culture of origin, and the other one was shaped by their perceived views about the substance in their host culture. These clashing cognitive representations, in concert with significant stress associated with their immigration experiences, seemed to increase their risk for developing and maintaining alcohol-related disorders. We also identified the Hispanic/Latino values of Familismo, Machismo, Simpatia, and Conviviencia to be highly relevant for incorporation in public health, prevention, and treatment interventions.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER I INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER II REVIEW OF THE LITERATURE</td>
<td>5</td>
</tr>
<tr>
<td>Alcohol Use Among Hispanics/Latinos</td>
<td>5</td>
</tr>
<tr>
<td>Population Demographic Profile</td>
<td>5</td>
</tr>
<tr>
<td>Epidemiology of Alcohol Use in the U.S. Hispanic/Latino Population</td>
<td>6</td>
</tr>
<tr>
<td>Drinking Patterns and Emigration</td>
<td>10</td>
</tr>
<tr>
<td>Drinking Patterns by Hispanic/Latino Subgroup, Age, Gender, and Socioeconomic Characteristics</td>
<td>13</td>
</tr>
<tr>
<td>Acculturation</td>
<td>16</td>
</tr>
<tr>
<td>Alcohol-Related Consequences</td>
<td>19</td>
</tr>
<tr>
<td>Summary</td>
<td>21</td>
</tr>
<tr>
<td>Treatment of Alcohol Abuse in Hispanic/Latino Populations</td>
<td>22</td>
</tr>
<tr>
<td>Client Characteristics</td>
<td>22</td>
</tr>
<tr>
<td>Treatment Utilization Patterns and Barriers</td>
<td>25</td>
</tr>
<tr>
<td>Differential Response to Treatment</td>
<td>30</td>
</tr>
<tr>
<td>Summary</td>
<td>37</td>
</tr>
<tr>
<td>Cultural Considerations in the Development and Implementation of Treatment</td>
<td>40</td>
</tr>
<tr>
<td>Theoretical and Empirical Support for Culturally Sensitive Treatments</td>
<td>41</td>
</tr>
<tr>
<td>Hispanic/Latino Cultural Values Potentially Relevant to Treatment Development and Implementation</td>
<td>47</td>
</tr>
<tr>
<td>Summary and Recommendations</td>
<td>56</td>
</tr>
<tr>
<td>Cognitive Representations of Illness and Alcohol Abuse in a Cultural Context</td>
<td>59</td>
</tr>
<tr>
<td>Common Sense Representations of Illness Model</td>
<td>59</td>
</tr>
<tr>
<td>Cognitive Representations of Alcohol Abuse</td>
<td>67</td>
</tr>
<tr>
<td>Summary</td>
<td>70</td>
</tr>
<tr>
<td>Aims of the Study</td>
<td>72</td>
</tr>
<tr>
<td>CHAPTER III METHODOLOGY</td>
<td>75</td>
</tr>
<tr>
<td>Participants</td>
<td>75</td>
</tr>
<tr>
<td>Research Approach</td>
<td>75</td>
</tr>
<tr>
<td>Measures</td>
<td>77</td>
</tr>
<tr>
<td>Procedure</td>
<td>78</td>
</tr>
<tr>
<td>Data Collection</td>
<td>79</td>
</tr>
<tr>
<td>Protocol Adherence</td>
<td>79</td>
</tr>
</tbody>
</table>
CHAPTER IV RESULTS...............................................................................................................85
Alcohol Use Characteristics of Participants ................................................................. 85
Reliability Analysis........................................................................................................... 86
The Emerging Theory -Model of Alcohol Abuse Risk in Hispanic/Latino Immigrants:
A Clash of Cultures and Immigration Stress ................................................................. 87
Figure 1 ................................................................................................................................. 88
Table 1 Model of Alcohol Abuse Risk in Hispanic/Latino Immigrants.......................... 90
Representations of Alcohol Use and Abuse in Culture of Origin ................................... 94
Meanings ............................................................................................................................... 94
Barriers to Abuse .............................................................................................................. 100
Consequences of Abuse ................................................................................................. 101
Treatment ............................................................................................................................ 102
Representations of Alcohol Use and Abuse in Host Culture ........................................ 103
Meanings ............................................................................................................................... 103
Barriers to Abuse .............................................................................................................. 108
Consequences of Abuse ................................................................................................. 108
Treatment ............................................................................................................................ 109
Immigration Stressors ........................................................................................................ 110
Lack of Social Support ..................................................................................................... 110
Emotional Distress .......................................................................................................... 112
Societal Marginalization ................................................................................................. 113
Occupational/Economic Stress ....................................................................................... 114
CHAPTER V DISCUSSION................................................................................................. 115
Cognitive Representations of Alcohol Use Within the Context of CSM ....................... 115
Identity ................................................................................................................................. 116
Consequences ..................................................................................................................... 118
Time Line ............................................................................................................................ 120
Causal Attributions .......................................................................................................... 121
Cure/Control ....................................................................................................................... 123
The Role of Cultural Beliefs and Values in the Development and Maintenance of
Alcohol-Related Disorders............................................................................................... 125
Familismo ............................................................................................................................ 126
Machismo ............................................................................................................................ 128
Simpatia ............................................................................................................................... 129
Conviviencia ........................................................................................................................ 130
The Role of Immigration Stress in the Development and Maintenance of
Alcohol-Related Disorders............................................................................................... 133
Implications for Prevention and Treatment ..................................................................... 134
Public Health Outreach Initiatives.................................................................................. 135
Prevention ............................................................................................................................ 138
Treatment ............................................................................................................................ 139
Directions for Future Research ......................................................................................... 149
ACKNOWLEDGEMENTS

I would like to especially thank my committee chair and mentor, Dr. Marta Meana, for all her efforts to help me reach my professional goals. While completing this dissertation, she provided me with the greatest gifts a student can ask for, including her time, wisdom, patience, guidance, and enthusiasm about our project. All of which contributed to reviving my excitement about conducting research. She inspired me to reconnect with my cultural roots and introduced me to a new and exciting research methodology that will serve as a foundation to my future work. Gracias Dr. Meana!

I would like to express gratitude to my committee members, Drs. Brad Donohue, Daniel Allen, and Larry Ashley, for their support, time, and valuable feedback.

I am also thankful to Antioco Carrillo from Community Mental Health for his support and collaboration in facilitating and expediting the process of data collection for this study.

It would have been nearly impossible to reach this long awaited accomplishment without the inspiration, support, encouragement, influence, and unconditional love of three very special people in my life, my pillars, Paul Lessick, Marie Stouwie, and Francisca Estrada. Thank you for believing that I could reach this goal, and pushing me to get there!
CHAPTER I

INTRODUCTION

The Hispanic/Latino population represents the largest ethnic minority group in the United States, with immigration being "the largest source of population growth since the 1970's" (Pew Hispanic Center, 2004, pg.1). The rapid growth of this population and the complex dynamic of its heterogeneity (e.g., cultural backgrounds, immigration circumstances, acculturation levels) warrant special attention to this population's needs for health care services. In particular, Hispanic/Latino immigrants have unique characteristics and needs associated with several challenges they are likely to encounter before and after their arrival to the United States. These include the effects of the sociopolitical environment in the native country, immigration and acculturation-related experiences, limited access to healthcare, language barriers, cultural differences, and limited employment opportunities (Sherryll, et al., 2005). Unfortunately, there is limited research focused specifically on this population, with very few studies specifying whether the data refer to U.S.-born Hispanics, immigrants, or both. Therefore, this literature review focuses largely on Hispanics/Latinos in general, with a special emphasis on immigrants when the data is available.

Alcohol abuse and dependence is of particular concern for both U.S.-born and immigrant Hispanics/Latinos in the United States (Caetano, 2003). Indeed, the latest National Survey on Drug Use and Health [Substance Abuse and Mental Health Services
Administration (SAMHSA), 2003] estimated that 24% of Hispanics/Latinos, aged 12 or older, participate in alcohol binge-drinking (i.e., 5 or more drinks on one occasion over a 30-day period), and over 5% of them engage in heavy drinking of alcohol (i.e., 5 or more drinks on one occasion on at least 5 different days over a 30-day period). Furthermore, nearly 10% of individuals in this ethnic group meet diagnostic criteria (i.e., based on DSM-IV) for Alcohol Dependence or Abuse (SAMHSA, 2003).

The high prevalence of Alcohol Dependence or Abuse in the Hispanic/Latino population underscores an increasing demand for treatment services. There is a paucity of research, however, on the efficacy of existing alcohol abuse treatments in adult members of this population. To date, examinations of differential response to alcohol abuse treatment as a function of ethnicity have been limited to analyses of a single data set (i.e., Project MATCH) comprised of 141 U.S.-born and immigrant Hispanic/Latino clients (e.g., Arroyo, Miller, & Tonigan, 2003; Tonigan, Connors, & Miller, 1998). There is also a dearth of research on culturally differentiated responses to treatment in relation to other psychological disorders [U.S. Department of Health and Human Services (USDHHS), 2001]. Understandably, there is growing concern about the efficacy of extant treatments delivered to individuals of ethnic minority groups (e.g., Hispanics/Latinos), as well as an increasing emphasis on the need to develop culturally sensitive treatments (e.g., Bernal & Scharron-del-Rio, 2001; Clay, Mordhorst, & Lehn, 2002; Hall, 2001; Sue, 1998). The importance of cultural factors in treatment has been supported by rapidly accumulating evidence suggesting that individuals’ cultural beliefs, values, and experiences play a pivotal role in both psychological health and illness (USDHHS, 2001). Furthermore, consideration of these cultural factors might be particularly relevant given the large
percentage of this population who immigrated to the United States fairly recently [i.e.,
over half of immigrants arrived in the United States between 1990 and 2002 (Ramirez &
De La Cruz, 2002)]. The tendency is for members of this population to retain a strong
connection to their cultural roots independent of generational status [e.g., three-quarters
speak Spanish or are bilingual (Pew Hispanic Center, 2004)].

Relevant to the Hispanic/Latino population, several unique culture-related
characteristics and values (e.g., language, *simpatia*, interdependence, immigration and/or
acculturative stress) have been identified as essential elements to consider in the
development of culturally sensitive interventions (Hall, 2001; Marin, 1993). Although
some models of, and guidelines for, culturally sensitive treatments have been proposed
for this population (Hall, 2001; Marin, 1993), their development is still at a nascent stage.
Central to these models is the necessary identification of the beliefs and values that
Hispanics/Latinos associate with a targeted behavior, such as alcohol abuse (e.g., Marin.
1993).

In an attempt to begin the process of developing a culturally sensitive alcohol
abuse treatment for Hispanics/Latinos, an examination of the meaning of alcohol use,
abuse, and dependence within the context of their cultural worldview seems warranted.
Indeed, the literature on lay theories of illness suggests that individuals’ common sense
representations of their illnesses tend to influence health-related behaviors, such as
treatment-seeking and treatment-compliance (Kleinman, 1988; Leventhal, Meyer, &
Nerenz, 1980). The aim of this study was thus to apply the common sense representations
of illness approach to an examination of the meaning of alcohol-related disorders in the
context of the Hispanic/Latino cultural perspective, to propose a theory/model of how
these representations might interact, and to discuss ways in which these findings may be integrated in treatment.
CHAPTER II

REVIEW OF THE LITERATURE

Alcohol Use Among Hispanics/Latinos

Population Demographic Profile

The term Hispanic is often used to refer to individuals who are of Spanish or Latin American ancestry and/or who speak Spanish (Center for Substance Abuse Treatment, 1999). The term Latino, however, has been viewed as more suitable when referring to individuals who identify primarily with their Latin American origin and/or do not speak Spanish, such as Brazilians (Comas-Diaz, 2001). In an attempt to be culturally sensitive to the different ethnic identification preferences among members of this population, the term Hispanics/Latinos will be used throughout this document. All of the data reviewed here is on Hispanics/Latinos living in the United States whether or not the term “American” is appended to their ethnicity. When the word “American” is hyphenated and joined to a cultural group (e.g., Mexican-American) we are not asserting that they are either citizens of the US or even documented immigrants. In most of the datasets, their status remains unknown.

Hispanics/Latinos represent the largest ethnic minority group in the United States (i.e., 37.4 million or 13.3% of the total U.S. population; Ramirez & De La Cruz, 2002). A large proportion of this population is comprised of immigrants (i.e., 40%), and over half of immigrants entered the U.S. between 1990 and 2002 (Ramirez & De La Cruz, 2002).
The latest U.S. Census Bureau estimates suggest that individuals of Mexican origin constitute the largest Hispanic/Latino subgroup (67%), followed by individuals of Central and South American (14%), Puerto Rican (9%), and Cuban descent (5%; Ramirez & De La Cruz, 2002). The same report indicates that a large proportion of the Hispanic/Latino population tends to be young, with approximately 33% in age group 25 to 44 and 34% in age group 18 years old and under, and they tend to have large families (i.e., 27% of households comprised five or more family members). It is estimated that more than half of adult Hispanics/Latinos speak Spanish at home (i.e., 63%), but English language dominance tends to increase in subsequent generations (i.e., 78% of third generation individuals; Pew Hispanic Center, 2004).

Epidemiology of Alcohol Use in the U.S. Hispanic/Latino Population

The National Survey on Drug Use and Health [Substance Abuse and Mental Health Services Administration (SAMHSA), 2003] provided the latest estimates of alcohol use among Hispanics/Latinos. This survey included data from over 9,000 U.S.-born and immigrant Hispanics/Latinos, ages 12 and older, with approximately equal number of male and female respondents. Based on these data, lifetime alcohol use in the Hispanic/Latino population was estimated at 76%, and those individuals in age group 26 to 34 reported the highest lifetime rate at 82%. Current use of alcohol, defined as any use of alcohol reported within the past 30 days prior to responding to the survey, was estimated at 42%. Rate of current alcohol use, however, was higher among individuals ages 18 to 25 (i.e., 52%). The rate of binge use of alcohol (i.e., drinking five or more drinks on the same occasion on at least 1 day during a 30-day period) was also higher.
among 18 to 25 year olds (i.e., 37%) than among Hispanics/Latinos in all other age
groups (i.e., 24%). Heavy use of alcohol (i.e., drinking five or more drinks on the same
occasion on 5 or more days during a 30-day period) was estimated at 5% for the overall
Hispanic/Latino population, and at 11% for individuals in age group 18 to 25.

Relevant to the diagnosis of alcohol use as a disorder among members of this
population, SAMHSA (2003) estimated the past year rate of alcohol abuse and
dependence, based on criteria from the Diagnostic and Statistical Manual of Mental
Disorders [DSM-IV: American Psychiatric Association (APA). 2004], at approximately
8%. Also, it was estimated that nearly 10% of Hispanics/Latinos meet criteria for
Substance Abuse and Dependence Disorder, which may include the use of alcohol and/or
illicit drugs.

Estimates based on data from a comparable survey, the National Institute on
Alcohol Abuse and Alcoholism's 2001-2002 National Epidemiologic Survey on Alcohol
and Related Conditions (NESARC: Grant, et al., 2004), suggested that the 12-month
prevalence of alcohol use disorders among the general Hispanic/Latino population was
much lower. The NESARC sample included responses from over 8,000
Hispanics/Latinos in the U.S., ages 18 and older, with approximately equal gender
representation (i.e., 55% female). In this survey, the rates of both alcohol abuse and
dependence were estimated at approximately 4% in the overall Hispanic/Latino
population, 6% among men, and almost 2% among women. Prevalence rates of alcohol
use disorders, however, were much higher among Hispanics/Latinos in age group 18 to
29. 6% of who were assessed to have these problems with prevalence rates of 9% for men
and 3% for women (Grant, et al., 2004). Noteworthy was the finding that, consistent with
national trends, the overall prevalence of alcohol dependence has significantly decreased over the past decade among male Hispanics/Latinos, but the rates of alcohol abuse have nearly doubled among Hispanic/Latina women in most age groups (Grant et al., 2004).

Prevalence estimates of withdrawal symptoms (e.g., drinking in the morning to get over prior night’s drinking, becoming sick after drinking, depressed, irritable mood) may also be useful in determining the magnitude of alcohol dependence in the population (Caetano, Clark, & Greenfield, 1998). Data from a subset of over 1,600 Hispanics/Latinos participating in a national alcohol survey suggested that approximately 9% of the general Hispanic/Latino male population, and 3% of women, experience one or more withdrawal symptoms (Caetano, et al., 1998). The same researchers (Caetano, et al., 1998) reported that the prevalence of withdrawal symptoms tended to be much higher in clinical populations, with 60% of a sample of 221 Mexican-American men in detoxification and residential alcohol treatment programs reporting symptoms such as anxiety or depression, insomnia, sweating, weakness, and engaging in drinking to reduce withdrawal symptoms.

Comorbidity of Alcohol Abuse and/or Dependence and other non-alcohol-related disorders, such as Depression, Anxiety, and Antisocial Personality Disorder (APD), has been widely reported in the literature as a common occurrence in substance abusing populations (e.g., Vega, Sribney, & Achara-Abrahams, 2003; Zayas, Rojas, & Malgady, 1998). Although few studies have examined the comorbidity of alcohol-related disorders among Hispanics/Latinos, these have consistently suggested that rates of the aforementioned disorders tend to be higher in populations with substance abuse and/or dependence. For instance, Hesselbrock, Hesselbrock, Segal, Schuckit, and Bucholz.
(2003) reported on the comorbidity of Substance Dependence and several other psychological disorders among 67 Hispanic/Latino males and 16 females seeking treatment at inpatient and outpatient facilities. They estimated lifetime prevalence of depression at approximately 34% for males and almost 70% for females among individuals with substance dependence. The same researchers reported females’ lifetime comorbidity rates for substance dependence and other disorders at 31% for APD, 13% for Mania and Panic Disorder, and 6% for Social Phobia and Obsessive-Compulsive Disorder. Lifetime comorbidity rates were much lower for males than for females (i.e., ranging from 1.5% to 4.5%), with the exception of APD, estimated at 36%. Hesselbrock and colleagues’ (2003) findings, however, may be limited by the small size of their sample.

In contrast, Vega and colleagues (2003) conducted a study with a large, non-clinical sample of U.S.-born Mexican Americans (N = 1178) and Mexican immigrants (N = 1834). Overall, they estimated the lifetime comorbidity of Substance Abuse and/or Dependence and Mood Disorders at 24% for females and 49% for males and for Anxiety Disorders at 19% for females and 43% for males. Although both Hesselbrock et al (2003) and Vega et al (2003) documented the comorbidity of substance abuse/dependence and other psychological disorders among some Hispanic/Latino populations, they did not report their findings separately by type of substance (i.e., alcohol versus drug use).

Nevertheless, Zayas and colleagues (1998) found low rates of comorbidity for depression and drug use in their study with 100 Puerto Rican, 88 Dominican, and 100 Colombian adult males from the community. Conversely, heavy alcohol drinkers seemed to be twice
as likely to suffer from depression, as compared to their abstainer counterparts (Zayas et al., 1998).

In an attempt to further understand the comorbidity of alcohol use and depression, Johnson and Gurin (1994) examined the effects of alcohol expectancies among 568 adult Puerto Rican men and women in a non-clinical setting. Their findings suggested that individuals’ beliefs about the potential for alcohol to ameliorate negative feelings moderated the comorbidity of alcohol-related problems and their experience of depression.

**Drinking Patterns and Emigration**

Alcohol consumption has also been found to vary among Hispanics/Latinos depending on their place of emigration and length of residency in the U.S. These findings, however, have been mixed and are difficult to interpret partly due to the extensive heterogeneity in nationality and emigration circumstances (e.g., potential added stressors associated with leaving their country). For instance, Gordon (1985) reported on the drinking patterns of 7,700 Dominican, 3,300 Puerto Rican, and 1,000 recently immigrated Guatemalan males. He found that Dominican men tended to report lower levels of alcohol consumption prior to their migration, and their overall alcohol drinking frequency was lower and more restrictive than individuals from the other nationalities. In contrast to their Puerto Rican and Guatemalan counterparts, Dominican men counted with greater support from family members, reported placing greater value on harmony, and expressed greater desire for upward social mobility. Guatemalan men, on the other hand, reported higher levels of alcohol consumption prior to their arrival to the region, and reported drinking alcohol in higher frequency and quantities than men of other
nationalities. Furthermore, single men who had little family support were over represented among Guatemalan immigrants compared to immigrants from the other two nationalities. In contrast, alcohol consumption among Puerto Rican men was unaffected by their relocation to a new region and their degree of family support. Conceivably, this lack of change in Puerto Rican men’s drinking patterns might be related to the differences in their immigration experience, as compared to their Dominican and Guatemalan counterparts. That is, given Puerto Ricans’ closer geographic proximity and unrestricted access to the U.S., they might experience a lesser degree of disconnect from familial support and immigration-related stress, which in Dominicans’ and Guatemalans’ case might have impacted their drinking patterns.

Zayas and colleagues (1998) found similar results regarding alcohol drinking among Dominicans. Their study focused on mostly Dominican and Colombian immigrant men and mostly U.S.-born Puerto Rican men. Their findings suggested that Dominican men, who had lower unemployment rates and higher income and education levels than their counterparts, tended to report fewer alcohol-related problems than Puerto Rican and Colombian men. In contrast, Puerto Rican men, who reported higher rates of divorce and unemployment and lower income and education levels, tended to report the highest number of alcohol-related problems. Nevertheless, these researchers found no significant differences in rates of abstinence from alcohol drinking across the three groups. The findings of this study are of particular relevance given that a large proportion of the Hispanic/Latino population is comprised of immigrants. Immigrants likely come to the United States primarily in search of opportunities for employment and financial growth and thus might be more likely to be of low socioeconomic status, at least initially.
Another example of differences in alcohol drinking patterns among immigrants is illustrated in Zayas, et al. (1998) review of this literature. They found higher rates of abstention among immigrant men from El Salvador and Nicaragua (i.e., approximately 52%) than among Mexican American men (38%). Zayas and colleagues’ (1998) review suggested that those U.S.-born Mexican Americans exhibited higher rates of alcohol abuse and dependence (24%) than Mexican immigrants (14.4%). This latter finding is supported by results from Caetano and Raspberry’s (2000) study of alcohol drinking patterns with a sample of 126 U.S.-born Mexican Americans and 124 Mexican immigrants. In Caetano and Raspberry’s (2000) study, 27% of U.S.-born Mexican Americans versus 9% of Mexican immigrants met DSM-IV criteria for alcohol dependence. The percentage of individuals who met DSM-IV criteria for alcohol abuse, however, was similar between the two groups (i.e., 41% for U.S.-born and 43% for Mexican immigrants). Their study also suggested that the drinking patterns of U.S.-born Mexican Americans mirrored those of Caucasian/White individuals. Namely, they tended to drink small, but frequent, amounts of alcohol, whereas Mexican immigrants tended to report larger amounts of alcohol consumed less frequently. Although acculturation levels and/or length of residency were not considered in this study, it appears that the nature and extent of the problem of alcohol abuse and dependence, as well as drinking patterns, are different for U.S.-born and for Mexican immigrants and might have important implications for the development of prevention and treatment interventions for both segments of the population.

Rates of comorbidity for substance abuse/dependence and other psychological disorders also have been found to vary according to place of emigration. Vega and
colleagues (2003), for example, reported that U.S.-born Mexican Americans tend to exhibit comorbid rates of Substance Abuse/Dependence and Mood Disorders that are nearly twice as high (i.e., 42%) as their immigrant counterparts (i.e., 23%). Similarly, they found that comorbid rates for Anxiety Disorders tend to be much lower among Mexican immigrants (i.e., 16%) than they are among U.S.-born Mexican Americans (i.e., 39%).

Drinking Patterns by Hispanic/Latino Subgroup,

Age, Gender, and Socioeconomic Characteristics

The Hispanic Health and Nutrition Examination Survey (HHANES; National Center for Health Statistics, 1985) is the largest study conducted on Hispanic/Latino health thus far. This data set included responses from approximately 16,000 Mexican Americans, Puerto Ricans, and Cuban Americans. Although this survey gathered data only from regions in the U.S. with high concentrations of individuals from these subgroups (i.e., Southwestern states, Miami, and New York City), and is much less recent (i.e., 1982-1984) than the SAMHSA (2003) survey, it represents the most comprehensive health survey to date conducted among Hispanics/Latinos (Delgado, Johnson, Roy, & Trevino, 1990). Relevant to alcohol use, analyses have centered on a subset of these data comprised of mostly males (i.e., 65%) ages 20 to 74 (e.g., Lee, Markides, & Ray, 1997; Marks, Garcia, & Solis, 1990). Lifetime prevalence of alcohol drinking was defined in the HHANES (1985) as ever having 12 or more drinks. Current alcohol drinking was categorized as light/occasional (i.e., .01 to .21 oz. of ethanol per day), moderate/regular (.22 to .99 oz. of ethanol per day), and heavy alcohol drinking (1 or more oz. of ethanol per day).
per day). Because of differences in the samples’ demographic characteristics and definitions of drinking patterns, comparisons of data between the SAMHSA (2003) and the HHANES (1985) surveys may not be feasible.

Based on HHANES (1985) data, Marks and colleagues (1990) estimated alcohol use prevalence rates by Hispanic/Latino ethnic subgroup and gender. Their estimates suggested that current alcohol use rates differed somewhat by ethnic subgroup, with Mexican American men exhibiting the highest rate at 77% (i.e., 71% for Puerto Rican men, 69% for Cuban American men). In contrast, a greater portion of Puerto Rican women tended to report current alcohol use (33%) than Mexican American and Cuban American women (i.e., 24% and 23% respectively). Relevant to heavy drinking, no difference surfaced between Mexican American and Puerto Rican men (i.e., both at 17%), but their rates of heavy drinking were almost twice as high as the rate reported by Cuban American men (9%). Prevalence of heavy alcohol drinking was also highest among Puerto Rican women (3%), as compared to their Mexican (1%) and Cuban (1.4%) counterparts.

Lee and colleagues’ (1997) analyses of the HHANES data by age group also found variations in patterns of heavy drinking across subgroups. For instance, the highest incidence of male past heavy alcohol drinking was reported in age group 35 to 54, with 40% of Mexican Americans, 37% of Puerto Ricans, and 23% of Cuban American men in this age group reporting a past history of heavy drinking. History of past heavy drinking also differed by age among Puerto Rican and Mexican American women. In contrast to their male counterparts, the highest rate of past history of heavy alcohol drinking among women was in age group 55 to 74, with 34% of Puerto Rican and 20% of Mexican
American women in this age group reporting this drinking pattern. No notable differences across age groups in the rate of past heavy drinking surfaced among Cuban American women.

Caetano and Clark (1998) analyzed data from a national random sampling alcohol survey of almost 1,600 U.S.-born and immigrant Hispanic/Latino households and, like Lee and colleagues (1997), estimated rates of heavy drinking (i.e., drinking at least five drinks on one or more times per week) by age group. They found that, overall, 18% of Hispanic/Latino men and 3% of women admitted to engaging in heavy drinking. Rates were highest among men between ages 30 and 49 (i.e., approximately 22%) and women in age group 18-29 (6%). Caetano and Clark (1998) also estimated abstinence rates. Their findings suggested overall rates of abstinence at 35% among men and 57% among women. Men 60 years and older reported the highest abstinence rates at 60%, while more than half of women in all age groups indicated they abstained from drinking alcohol.

Data on alcohol consumption obtained from the HHANES survey (1985) was also examined in relation to various socioeconomic factors, including education and income levels, employment status, and religiosity (Marks et al., 1990). A positive relationship surfaced in these data between education level and alcohol consumption, with stronger effects found among women. A similar relationship surfaced among a sample of 1,861 Mexican American women (Black & Markides, 1993), with more educated women reporting higher frequency of alcohol drinking and being more likely to be drinkers than their less educated counterparts. No clear pattern emerged in Marks and colleagues’ (1990) data regarding the relationship between income level and alcohol consumption across subgroups, except for Cuban American women, for whom there was a positive
relationship between these variables. In contrast, Caetano and Clark (1998) found that lower income levels were related to lower alcohol consumption among Hispanic/Latina women, and education level was negatively related to alcohol consumption among men. Black and Markides' (1993) findings regarding income level and alcohol consumption also contradicted those of Marks et al. (1990) who suggested that Mexican American women with incomes at the poverty level were less likely to be drinkers than those with higher incomes.

Regarding the relationship between alcohol consumption and unemployment, Caetano and Clark (1998) found a positive relation between this variable and alcohol consumption for both men and women. This finding was also supported in Black and Markides' (1993) study with Puerto Rican, Cuban and Mexican women. Moreover, in Caetano and Clark's (1998) sample, men for whom religion was not important tended to have higher alcohol consumption. Religion served as a protective factor against alcohol drinking among women. Finally, non-married Mexican American women appeared to have higher levels of alcohol drinking than their married counterparts (Black & Markides, 1993).

Acculturation

Acculturation has been defined as "the process whereby immigrants change their behavior and attitudes toward those of the host society" (Rogler, Cortes, & Malgady, 1991, pg. 585). Because of the extensive mixed findings and lack of integration in this literature, Rogler and colleagues (1991) have suggested there is a lack of clear understanding about the relationship between acculturation and mental health, especially alcohol abuse and dependence. Contributing to this lack of understanding is the limited
focus in this line of research on factors that likely affect the acculturation process, such as immigration-related stress or individuals' immigration experiences. Relevant to research on alcohol use and acculturation, a similar pattern of inconsistent findings has surfaced. Indeed, studies in this area have found positive and negative relationships, as well as variations of these relationships among Hispanics/Latinos as a function of gender and age (Rogler et al., 1991). For instance, some researchers (Black & Markides, 1993; Caetano, 1987; Hines & Caetano, 1998) have reported differences between men and women regarding the nature of the relationship between alcohol consumption and acculturation level. Irrespective of acculturation levels, however, Hispanic/Latino males have been found to be heavier drinkers than females (Hines & Caetano, 1998).

Some findings among males have suggested a positive relationship in which more acculturated males tend to report higher levels of alcohol drinking than less acculturated ones (Caetano, 1987). The pattern of this relationship, however, varied by age group, with younger (i.e., ages 18 to 39) Hispanic/Latino males who were more acculturated reporting increases in abstention rates, and older (i.e., 40 years and older), more acculturated men reporting lower rates of abstention (Caetano, 1987). In contrast, Markides, Krause, and Mendes de Leon (1988) found acculturation to be unrelated to alcohol consumption among a group of men with a mean age of 74, but among a group of men with a mean age of 49, acculturation was negatively related to alcohol drinking. The relationship between alcohol use and acculturation also varied among males in relation to their birthplace in Caetano's (1987) study. A positive relationship between abstention rates and acculturation surfaced among male immigrants, whereas findings for U.S.-born.
first generation males suggested a positive relationship between alcohol drinking and acculturation (Caetano, 1987).

Acculturation-related changes in alcohol drinking patterns among males of some Hispanic/Latino subgroups, such as Mexican immigrant males, are of special concern because of their possible contribution to rapid increases in the prevalence rates of Alcohol Abuse/Dependence and of alcohol-related problems (Vega et al., 2003). Vega and colleagues (2003) highlighted the finding that less acculturated Mexican immigrants tend to report drinking high volumes of alcohol with less frequency than their more acculturated counterparts. As they acculturate and mirror the drinking patterns of the host culture, however, they tend to increase their frequency of alcohol drinking while retaining the high volume of alcohol consumption.

Research findings of alcohol and acculturation among females have been more consistent than those found among males (Caetano, 1987; Marks et al., 1990; Vega et al., 2003). Indeed, several researchers have found a positive relationship between acculturation and alcohol drinking among women (e.g., Black & Markides, 1993; Caetano, 1987), with a high percentage of them (i.e., 78%) reporting higher acculturation levels (Hines & Caetano, 1998). Furthermore, this relationship did not vary as a function of age (Caetano, 1987). Regarding place of birth, a positive relationship emerged between acculturation and alcohol drinking among first generation, U.S.-born Hispanic/Latina females, but no relation was observed among their immigrant counterparts (Caetano, 1987). As was the case with men, Caetano (1987) found that, with increased levels of acculturation, the alcohol drinking patterns of women tended to mirror those of the general U.S. female population.
Alcohol-Related Consequences

Alcohol abuse has been associated with several negative consequences, including social, health, and legal problems (Caetano, 1997; I.ex, 1987). Relevant to Hispanics/Latinos, Caetano (1997) reported drastic increases between 1984 and 1990 (i.e., from approximately 9% to over 16%) in the number of social problems experienced among alcohol drinkers in this population. Furthermore, Caetano (1997) reported that, over a one-year period, 7% of Mexican American males experienced job problems associated with alcohol, and 6% reported marital problems related to alcohol consumption over the same period of time. Along these lines, Caetano (1997) reported 12-month prevalence rates for other problems related to alcohol among members of the same population, including 6% for impairments in ability to control behavior, 5% for experience of withdrawal symptoms, and 6% for experience of health problems. Indeed, among Mexican American males, past heavy drinkers have been found to assign lower ratings to the state of their health than individuals who have not been heavy drinkers (Lee, et al., 1997). Caetano (1997) found a higher risk for alcohol-related problems among Hispanic/Latino males who were younger than 50 years old, had an education level lower than high school, and incomes greater than $20,000 (Caetano, 1997).

Furthermore, variations by Hispanic/Latino subgroup in the reporting of alcohol-related problems have been documented. For instance, Caetano and Clark (1998) reported lower problem incidences related to alcohol-intake control, health, and marriage among Cuban males, as compared to their Mexican American and Puerto Rican male counterparts.

One of the indicators that have been thought to reflect the negative effects of alcohol abuse on health is death rate related to cirrhosis of the liver (Mann, Smart, &
Researchers and health agencies (e.g., Caetano, 2003; Lex, 1987; National Institute on Alcohol Abuse and Alcoholism, 1994) have highlighted that death rates related to cirrhosis are currently highest among Hispanic/Latino males, as compared to males of other ethnic groups (i.e., 20 per 100,000 population; Caetano, 2003).

Another common indicator of the negative impact of alcohol abuse is degree and nature of legal problems experienced. Hispanics/Latinos appear to experience severe legal consequences related to alcohol, as evidenced by data on driving under the influence of alcohol (e.g., Braver, 2003; Caetano & Clark, 1998). In one study (Caetano & Clark, 1998), it was reported that, over a one-year period, approximately 21% of Hispanic/Latino males drove a vehicle after consuming alcohol at levels that exceeded the limits stipulated by the law, with U.S.-born Hispanic/Latino males reporting a higher incidence of drunk-driving than their immigrant counterparts. Accordingly, Hispanic/Latino males tend to be arrested for driving under the influence (DUI) of alcohol, and to report a much higher incidence of DUI arrest than males of other ethnic groups (Caetano & Clark, 1998). Another study (Braver, 2003) found that both Hispanic/Latino males and females who were involved in fatal injury vehicle accidents tended to exhibit higher levels of Blood Alcohol Concentrations (BAC) than individuals of other ethnic groups. When socioeconomic variables were controlled for, however, levels of BAC found in Hispanic/Latino drivers were no different than those of males of other ethnicities. Nevertheless, adding to the severity of the problem is Braver’s (2003) finding that driving without wearing a seatbelt while intoxicated with alcohol tends to be more common among Hispanic/Latino males than among males in other ethnic groups, although low socioeconomic status was found to be a stronger predictor of driving.
without a seatbelt and having high BACs. Immigrants might be at especially high risk for experiencing these consequences, given their likely limited knowledge about and familiarity with laws and safety rules in the United States.

Summary

Hispanics/Latinos are a highly heterogeneous, relatively young population, with a large proportion of immigrants and individuals who retain ties to their cultural traditions. Alcohol use and related problems among Hispanics/Latinos are of concern as lifetime and current prevalence rates of alcohol consumption, as well as diagnosed cases of alcohol abuse/dependence and rates of comorbidity with other psychological disorders, are high, particularly among young males and acculturated females.

Alcohol-drinking patterns among Hispanics/Latinos have been found to vary as a function of nationality (e.g., Mexican descent) and place of emigration. Although more severe alcohol-drinking patterns have been observed among Mexican American males than among their Puerto Rican and Cuban counterparts, most findings across studies in this area have been mixed. Furthermore, possible factors that may contribute to these differences are not yet well understood. Frequency and quantity of alcohol consumption have been also found to vary among members of this population according to age, gender, and socioeconomic characteristics, but no clear patterns have surfaced. Similarly inconclusive results have been found regarding the effects of acculturation on alcohol-drinking patterns. One consistent finding that has emerged, however, is that more acculturated U.S.-born individuals tend to exhibit patterns of alcohol drinking that mirror those patterns of the general population. Also consistent is the finding that the pattern of
drinking heavily on few occasions, a common practice among immigrants, tends to develop into a more severe and chronic pattern of heavy drinking.

In sum, although research on alcohol use and related disorders among Hispanics/Latinos now spans a few decades, it still lags behind studies conducted with the general population. Thus, much work remains to be done in order to gain understanding about the complex nature of this condition, particularly with regard to variations in alcohol-drinking patterns across different subgroups, acculturation levels, and immigration-related stressors. Expanding this literature is especially important given the negative consequences that Hispanics/Latinos experience in association with alcohol, such as high death rates from cirrhosis, arrests due to driving under the influence of alcohol, occupational problems, and marital conflict.

Treatment of Alcohol Abuse in Hispanic/Latino Populations

The treatment research literature on alcohol use disorders (AUD) has been accumulating now for several decades, and numerous models of treatment have been developed and evaluated empirically for efficacy (Read, Kahler, & Stevenson, 2001). Despite the large number of modalities found efficacious in the treatment of AUDs, evidence supporting the superiority of a particular treatment over another is still lacking (Miller, et al., 1995). Furthermore, when McCrady (2000) evaluated AUD treatment outcome studies based on the stringent criteria delineated by the American Psychological Association Division 12 Task Force on Promotion and Dissemination of Psychological Procedures for the identification of empirically validated treatments, only a couple of
modalities were identified as efficacious and one as possibly efficacious. Under these guidelines, a treatment modality is considered efficacious when studies demonstrate, for example, their superiority to medical placebo, psychological placebo, and/or an established treatment in a sample of at least 30 participants per group. Furthermore, studies must implement treatments with the use of manualized protocols, be conducted by at least two independent teams of investigators, and describe study participant characteristics with specificity sufficient to clearly determine the generalizability of the findings (Chambless, et al., 1996). Therefore, despite the extensive literature on AUD treatment outcome, it remains unclear what the optimum treatment is, and which treatment is more suitable for a specific population (Miller, et al., 1995).

There is even less clarity regarding which treatments are effective for the treatment of AUD among ethnic minority populations. In a review of AUD treatment outcome studies published over nearly a 30-year period, Swearingen, Moyer, and Finney (2003) found that approximately 74% of participants in a sample of 357 studies were middle-aged white males and approximately 22% were African American, with no mention of the extent to which other ethnic minority groups were represented. Swearingen and colleagues (2003) also highlighted the difficulty in assessing the generalizability of treatment outcome findings due to the small number of studies that provide descriptions of participant characteristics, including ethnicity (i.e., less than a third of studies). Although outcome studies generally include some ethnic minority participants, few studies have directly examined issues related to the AUD treatment of ethnic minority groups, including Hispanics/Latinos. The research initiatives that have been conducted have focused mostly on the examination of client characteristics.
treatment utilization patterns, and identification of treatment barriers, with fewer studies examining differential response to treatment in relation to ethnicity.

Client Characteristics

National survey data regarding characteristics of individuals who are in treatment have not been specific to alcohol use. These data have not typically specified whether these individuals in treatment are U.S.-born or immigrant Hispanics/Latinos. However, given the large proportion of this population who are immigrants, it is likely that this segment of the population is represented within the samples. Thus, the focus of this survey was on individuals receiving treatment for substance abuse in general. Findings in this area suggest that most Hispanic/Latino individuals who receive substance abuse treatment are males (i.e., 77%; Alvarez, Olson, Jason, Davis, & Ferrari, 2004). Additionally, Hispanics/Latinos receiving substance abuse treatment are less likely to have health insurance or be covered by Medicaid (Wells, Klap, Koike, & Sherbourne, 2001), and they tend to be younger, less educated, and drink with less frequency, but higher intensity, than their Caucasian counterparts (Arroyo, et al., 2003). A similar gender ratio was found in a substance abuse clinical sample of Puerto Ricans, Mexican Americans, and Cuban Americans (i.e., 76% males; Alvarez, et al., 2004). Alvarez and colleagues (2004) noted, however, that although women represent less than 30% of Hispanics/Latinos receiving treatment, they enter treatment reporting more severe medical, psychological, and societal problems than their male counterparts. The same investigators theorized that, although Hispanic/Latina women in the general population tend to have high rates of abstention, those who enter substance abuse treatment might encounter financial and/or cultural barriers that may delay their help seeking until their
problem has escalated in severity. Nevertheless, a greater proportion of Hispanics/Latinos had delays in seeking care for alcohol abuse than their Caucasian counterparts (23% versus 11%, respectively; Wells, et al., 2001). Delays in seeking care are of particular concern, as they have been linked to poorer treatment outcomes possibly due to premature termination of treatment (Alvarez, et al., 2004). Namely, delaying care may lead to presentation with more severe symptoms which, in turn, may impede progress resulting in high dropout rates (Alvarez, et al., 2004).

Data from national surveys also suggest that Hispanics/Latinos receiving substance abuse treatment differ in terms of their nationality and the types of substances for which they seek treatment (Alvarez, et al., 2004). A large proportion of Hispanic/Latino treatment seekers tend to be of Mexican and Puerto Rican descent. Alcohol is typically the most common substance for which Mexican Americans and Cuban Americans seek treatment, whereas for Puerto Ricans, alcohol is the second most common substance that leads to initiate treatment (i.e., Opiates is the primary substance: Alvarez, et al., 2004). The same data suggested that alcohol abuse is generally the most common reason males enter treatment, whereas opiates and alcohol are most often reported as the primary substances for which females enter treatment.

Treatment Utilization Patterns and Barriers

The manner in which treatment is utilized is another aspect of treatment seekers’ characteristics that has been examined in Hispanic/Latino populations. Overall, differences in rates of participation in substance abuse treatment by ethnicity have been found across various settings (e.g., community, forensic: Lopez, 2003). For instance, Lopez (2003) reported that Hispanics/Latinos, when compared to individuals of other
ethnic groups, report some of the lowest past and current rates of participation in
treatment, despite evidencing high prevalence rates of substance use (Arroyo, et al.,
2003). Similarly, in samples of former inmates, Hispanics/Latinos tend to have the lowest
rates of participation in substance abuse aftercare programs (Burdon, Messina, &
Prendergast, 2004). Utilization of treatment services has also been investigated by
examining dropout rates of individuals who request counseling services. Schwarzbaum
(2004) reported high dropout rates (i.e., nearly 50%) after first counseling session among
low-income Hispanics/Latinos seeking general counseling services. Hispanic/Latina
women, in particular, tend to initiate treatment services the least, and have higher dropout
rates than individuals in other ethnic groups (Mora, 1998).

Among the factors that are thought to influence utilization of treatment services
are socioeconomic and cultural variables (Schwarzbaum, 2004). Indeed, individuals of
low socioeconomic status have been found to experience higher dropout rates, possibly
due to their low degree of familiarity with accessing, and participating in, counseling
services (Schwarzbaum, 2004). Lack of familiarity with how to access health care service
might be a concern particularly with individuals who have not been in the United States
long enough to know the types of services available to them, such as in the case of
immigrants. This finding, however, refers to counseling services in general, not alcohol
abuse treatment exclusively. Some of the culture-related factors thought to influence
utilization of treatment services include fear of stigma, fear of consequences resulting
from admitting need for treatment (e.g., loss of child custody; Mora, 1998), language
barriers, and shortage of ethnically matched service providers (Delgado, 1998).
Another factor that has been found to impact treatment utilization is perceived need for treatment (Burdon, et al., 2004; Lopez, 2003). Research suggests that, in general, individuals who perceive a strong need for treatment tend to enter and remain in treatment longer than those who do not perceive this need (Lopez, 2003). Relevant to substance abuse treatment among Hispanics/Latinos, the literature suggests that they tend to express more negative views about treatment, and their perceived need for treatment tends to be lower than that of members of other ethnic groups (Lopez, 2003). This finding was supported also in Lopez’ (2003) study with Hispanic/Latino adolescents, in which this group of adolescents reported less perceived need for treatment than their Caucasian counterparts. Moreover, past history of substance abuse treatment (Lopez, 2003) and length of stay in prior treatment programs (Burdon, et al., 2004) tend to predict perceived need for treatment and utilization of services among Hispanics/Latinos, as well as individuals of other ethnic groups. That is, individuals who have undergone treatment for substance abuse in the past tend to perceive a stronger need for treatment.

As reflected in Burdon and colleagues’ (2004) study, social and family support also plays a pivotal role in the utilization of services by Hispanics/Latinos. They reported that Hispanic/Latino former inmates had the lowest rates of participation in aftercare programs, but the lowest rates of recidivism in comparison to members of other ethnic groups. Consistent with the finding in the general inmate population that strong family support (e.g., being married or living with relatives prior to incarceration) predicts aftercare participation (i.e., less participation among those with strong family support). Burdon et al (2004) found that Hispanics/Latinos in this sample reported greater reliance on family support than individuals of other ethnic backgrounds. Nevertheless, the
common finding among members of the general population has been that high rates of recidivism tend to be associated with low participation in aftercare programs, yet this relationship was not found among Hispanics/Latinos (Burdon, et al., 2004). The impact of the family disconnect that might be experienced among immigrants who leave their families behind when they come to the United States has not been explored.

Views about the nature of substance use disorders that may not be amenable to participation in treatment have also been found among members of some segments of the Hispanic/Latino population. For instance, Lopez (2003) reported that Hispanic/Latino arrestees tend to view dependence on substances as being due to spiritual weakness, rather than mental illness, whereas their Caucasian counterparts are less likely to hold this view.

Given the Hispanic/Latino susceptibility to the numerous factors that influence mental health service utilization, it is not surprising that members of this population experience disproportionate rates of unmet needs for alcohol abuse treatment (Wells, et al., 2001). Indeed, in their examination of ethnic differences in access to care for alcoholism, Wells and colleagues (2001) found that Hispanics/Latinos were almost twice as likely as their Caucasian counterparts to have unmet needs for treatment (i.e., 22.6% and 12.5%, respectively). The rate of unmet need for treatment was estimated by first assessing for the presence of an alcohol use disorder, next evaluating individuals’ perceived need for treatment, and then measuring use of treatment services (Wells, et al., 2001).

Several researchers have proposed culture-related explanations for the wide underutilization of mental health services and the high rates of unmet need for treatment.
reported in studies with Hispanics/Latinos (e.g., Alvarez et al., 2004; Arroyo, Westerberg, Tonigan, 1998; Delgado, 1998; Lopez, 2003; Schwarzbaum, 2004). Lopez (2003), for example, has theorized that approaches commonly implemented in counseling services agencies may be incompatible with the values and beliefs of Hispanic/Latino culture, whereas Alvarez and colleagues (2004) pointed to cultural differences between treatment providers and clients as possibly contributing to premature termination of treatment. Schwarzbaum (2004) indicated that rates of service utilization tend to be lower in communities where there is a greater gap in cultural values between treatment providers and clients, and Delgado (1998) identified lack of consideration of clients’ socio-cultural values on the part of treatment agencies as a barrier to treatment utilization among ethnic minorities. Arroyo and colleagues (1998) emphasized the paucity of research to evaluate the efficacy of established treatments in comparison to treatments that incorporate cultural components, as well as evaluations of established treatments in ethnic minority populations.

Some of these possible culture-related explanations have been proposed in light of findings indicating that Hispanics/Latinos differ from their Caucasian counterparts in various treatment-related variables. For instance, findings from national surveys have consistently revealed a greater degree of dissatisfaction with mental health services and interventions among Hispanic/Latino clients than among clients in the general population (Alvarez et al., 2004; Wells et al., 2001). Furthermore, Hispanics/Latinos evidence preferences for treatment format that differ from their Caucasian counterparts. This was the case, for example, in Arroyo et al.’s (1998) examination of ethnic differences in utilization of formal (e.g., structured individual counseling) and informal (e.g., Alcoholic
Anonymous (AA) meetings] treatment modalities. They concluded that Hispanic/Latino clients preferred outpatient, formal therapy, as suggested by their higher utilization of these types of services (e.g., higher attendance). Findings from other studies regarding ethnic differences in rates of attendance to 12-step model treatments, however, have been mixed (e.g., Fiorentine, 1999; Humphreys & Moos, 1996), with percentage of Hispanic/Latino membership to AA programs ranging from 4% to 48% of individuals in treatment programs (Roland & Kaskutas, 2002). Notwithstanding the aforementioned findings regarding differences in treatment-related variables among Hispanic/Latino clients, it has yet to be examined empirically whether these findings may be attributed to culture-related factors.

Differential Response to Treatment

Relevant to treatment outcome research for AUD among Hispanics/Latinos, a search of the literature for the present paper identified one study that conducted a group-specific comparison of primary interventions efficacy in the treatment of AUD (i.e., Burge et al., 1997) and four studies that examined possible differential response to treatment as a function of ethnicity (i.e., Arroyo, et al., 1998; Arroyo et al., 2003; Babor et al., 1996; Ronald & Kaskutas, 2002).

The group-specific investigation was a double-blind outcome study in which Burge and colleagues (1997) compared the effects of primary care interventions (i.e., brief individual versus psychoeducational group interventions) aimed at the reduction of alcohol consumption among early stage problem alcohol drinkers. Their sample consisted of 175 Mexican American individuals who met DSM-III diagnostic criteria for Alcohol
Abuse and Dependence. Participants in the study were randomly assigned to one of four conditions and remained in the study for a period of 18 months.

In one of the conditions, a physician administered a brief intervention (i.e., 10 to 15 minutes), which followed a confrontation/discussion format regarding the patient’s current alcohol drinking patterns. In this form of intervention the physician expresses concern about the patient’s drinking, presents evidence regarding the negative effects and consequences of alcohol drinking to the patient’s health, develops a plan with the patient to reduce drinking, offers treatment recommendations and educational materials, and follows up with the patient at a later time. Participants in a psychoeducational group attended six 90-minute classes designed to be culturally sensitive to individuals of Mexican American cultural orientation. Accordingly, a bilingual, Mexican American facilitator conducted the session in English or Spanish. The session facilitator utilized a combination of bilingual didactic lectures, audiovisual materials, and group discussions to educate attendees on the effects of alcohol in various dimensions of life (e.g., impact on family, chemical effects of alcohol). Additionally, participants in this condition were encouraged to involve family members to support the participants’ sobriety. Another condition involved a combination of both the brief intervention and attendance to the psychoeducational group. The fourth condition was intended to serve as a control or inactive treatment. In addition to medical care-as-usual provided by a physician, participants in the control condition completed three 45-minute assessment sessions (i.e., at 6, 12, and 18 months after initiating participation in the study), in which research assistants evaluated and discussed patients’ alcohol drinking patterns and the consequences of their drinking. The care-as-usual condition sometimes included
treatment for a problem related to alcohol use. Some of the outcome measures included screening instruments, such as the Diagnostic Interview Schedule, questions regarding frequency and quantity of alcohol consumption, and assessments of psychosocial problems related to alcohol use with the use of the Addiction Severity Index (ASI).

The findings of the study indicated that participants in all four conditions evidenced improvements at all measuring points, with no significant treatment effect differences across conditions. The researchers emphasized that this pattern of treatment effects is inconsistent with most outcome studies in which participants in the active treatment conditions show greater improvements than participants in the inactive condition. This pattern of results, however, is similar to the pattern found in studies with treatment populations in Mexico. That is, Mexican citizens, like the Mexican American participants in this study, tend to respond to control conditions as well as experimental conditions, unlike European-origin samples (Babor & Grant, 1994). Alternatively, Burge and colleagues (1997) proposed the possibility that their control condition was not sufficiently inactive, as compared to the experimental conditions.

The efforts devoted in this study to recruit participants of Hispanic/Latino origins are noteworthy. The under representation, and challenges in the recruitment, of members of ethnic minority populations has been underscored in various lines of research (Harris, et al., 2003), as well as in substance abuse treatment outcome studies (e.g., studies in adolescent populations; Strada, Donohue, & Lefforge, in press). Not surprisingly, the identification of 175 participants who met criteria for this study required conducting over 4,000 interviews in a medical hospital setting over a period of one year.
Of the four studies identified examining differential effects of treatments within the context of ethnicity, two followed quasi-experimental designs (i.e., Arroyo, et al., 1998; Ronald & Kaskutas, 2002) and two were randomized controlled studies (i.e., Arroyo et al., 2003; Babor et al., 1996). In the first nonexperimental study, the sample consisted of 62 Caucasian and 46 English-speaking Hispanic/Latino individuals (i.e., New Mexican, Puerto Rican, Cuban, Mexican) who were diagnosed with Alcohol Abuse and/or Dependence and received treatment during the 6-month course of the study. Participants received therapeutic services, which included either one treatment modality or a combination of detoxification, group and/or individual therapy, or intensive outpatient services. Participants’ progress was assessed at two, four, and six months after treatment. The outcome measures included abstinence rates, number of drinks consumed, and frequency, intensity, and quantity of alcohol drinking, as reflected in self-reports of the total standard units of alcohol consumed. Despite differences in the types of treatments that participants of each ethnic group received (i.e., Hispanics/Latinos participated in more formal therapy sessions; Caucasians participated in more informal services), the results of this study did not reveal any significant ethnicity by time interactions on any of the outcome measures. The researchers concluded that prior to developing culture-specific treatments, the extant models of treatment should be evaluated for efficacy in ethnic minority populations. They cautioned, however, on the generalizability of their findings given that this particular sample of Hispanics/Latinos consisted of English-speaking, highly acculturated individuals, who may have different treatment needs than individuals with low levels of acculturation. Additionally, the investigators acknowledged the possibility that the staff members at the clinic, who had
been providing services to members of diverse populations for nearly 20 years, may have inadvertently behaved in a culturally sensitive manner.

The second study that followed a nonexperimental design (Ronald & Kaskutas, 2002) focused on examining the efficacy of an AA approach. Ronald and Kaskutas (2002) analyzed epidemiological data collected at an alcohol research facility for individuals who had received treatment at various sites (e.g., health maintenance organizations, private and public agencies, outpatient and inpatient settings, detoxification centers). Participants in this sample were of various ethnicities, including 60 Hispanics/Latinos. The researchers examined ethnic differences in treatment outcome (i.e., rate of sobriety) 30 days after treatment conclusion and found no significant differences. Instead, they found that religiosity or spirituality, for Hispanic/Latino clients, and degree of involvement with AA treatment components (e.g., attending over 30 meetings in a year period, reading AA literature), for participants of all ethnic groups in the sample, were predictive of sobriety by the 30-day posttreatment assessment.

One of the studies that examined differential response to treatment in relation to ethnicity following a randomized design was organized by the World Health Organization (Babor et al., 1996). This study examined the cross-cultural generalizability of brief interventions among heavy drinkers and/or individuals in hospitals, emergency rooms, primary care settings, and health agencies who were at risk for chronic conditions related to alcohol consumption. The sample consisted of 1,169 patients in various countries, including Australia, Kenya, Mexico, Norway, Wales, Russia, United States, and Zimbabwe. The participants were randomly assigned to one of three conditions. The control condition involved a 20-minute interview about health in general, including
substance use. The simple advice condition included the same health interview and a 5-minute advice session regarding the importance of abstinence and suggested limits for alcohol drinking. The third condition was a brief counseling session that included the health interview and a 15-minute psychoeducational oriented session about alcohol drinking and coping strategies. Albeit the results of the study were not reported separately by country of origin, the researchers found no significant differences in treatment effects across the various sites. They reported that men evidenced equal outcomes in both experimental conditions, with reductions reported in the overall average quantity of alcohol consumed and the number of drinks consumed per occasion. Furthermore, male participants in the experimental conditions were significantly more improved than their counterparts in the control condition. In contrast, there were no significant differences in the improvements evidenced by women across all three conditions in terms of their overall alcohol consumption.

The second study to examine ethnic differences in treatment outcome in a randomized design was conducted by Arroyo and colleagues (2003). They analyzed data from a subset sample of 100 Hispanics/Latinos and 105 Caucasians, predominately male clients (i.e., 80% males), who were part of a larger study, Project MATCH (Project MATCH research group, 1993). Project MATCH was a controlled, randomized treatment outcome study that evaluated the efficacy of three widely utilized manual-based treatment modalities, Cognitive Behavior Therapy (CBT), Motivational Enhancement Therapy (MET), and Twelve-Step Facilitation Model (TSF). Arroyo and colleagues' (1998) study, however, focused mostly on the effects of TSF. Some of the outcome measures utilized included session attendance, degree of involvement in treatment.
frequency of alcohol use, and experience of alcohol-related problems. Overall, the findings indicated that Hispanic/Latino clients showed pre- to post-treatment improvements across all treatment modalities. When compared to the outcomes evidenced by their Caucasian counterparts, however, Hispanics/Latinos showed some differences in their response to treatment. Whereas there were no significant outcome differences among participants in the CBT and MET conditions, some variations in the effects of TSF emerged in relation to ethnicity. Namely, Caucasian clients in the TSF condition had significantly better outcomes (i.e., lower levels of frequency and intensity of alcohol drinking) than Hispanic/Latino clients in the same condition. Moreover, Hispanics/Latinos attended fewer number of TSF sessions, as compared to Caucasian clients, but showed greater degree of involvement when they attended the sessions. No significantly different treatment effects were found across conditions among Hispanic/Latino clients, but their Caucasian counterparts fared significantly better in the TSF than the CBT and MET conditions.

Unlike other studies, Project MATCH incorporated a well-established acculturation measure for Hispanics/Latinos (i.e., Acculturation Rating Scale for Mexican Americans) instead of simply using the variable ethnicity as an indicator of cultural orientation. Relevant to this variable, however, no variations in treatment outcome emerged in association with level of acculturation. Nevertheless, the investigators cautioned that a large percentage of this particular sample of Hispanics/Latinos were highly acculturated to the dominant culture, 20% of the sample failed to complete the acculturation measure, and the instrument was not adapted to reflect the cultural orientation of their heterogeneous sample of various Hispanic/Latino subgroups (i.e., the
scale was presented in its original form, designed for use with individuals of Mexican origin).

Summary

Despite the profusion of outcome research for the treatment of AUDs among members of the general population, evidence supporting the superiority of a particular treatment is still lacking (Miller, et al., 1995). For members of Hispanic/Latino populations in general, and specifically for immigrants, the optimal AUD treatment may be even less clear, particularly given the paucity of outcome research that has been conducted in this population (Arroyo, et al., 1998). Most studies on AUD treatment do not provide sufficient descriptions about the participants to adequately establish generalizability. Of the few studies that have provided this information, some have concluded that Hispanics/Latinos have been underrepresented (e.g., Swearingen, et al., 2003). Aside from small samples of Hispanics/Latinos in outcome studies precluding the examination of treatment effects as a function of ethnicity, many researchers subscribe to the philosophy that empirically derived interventions are likely to be universally efficacious across populations (i.e., etic view; Hall, 2001). Others, however, have proposed that individuals' cultural orientation may influence health related variables, such as presentation of symptoms, help-seeking behaviors, views about mental illness, and treatment outcome [e.g., U.S. Department of Health and Human Services (DHHS). 2001]. Additionally, other culture-related factors not yet explored with relevance to treatment include acculturation and immigration experiences. These views question the universal efficacy of treatments for AUD developed without considering cultural factors (Hall, 2001). Although several differences between Hispanics/Latinos and members of
other groups have emerged regarding, for example, treatment utilization patterns (Lopez, 2003), degree of satisfaction with services (e.g., Alvarez, et al., 2004), treatment dropout rates (Schwarzbaum, 2004), perceived need for treatment (Lopez, 2003), and rates of unmet need for treatment (Wells, et al., 2001), much work remains to be done to identify any specific, potentially contributing culture-related factors.

Along these lines, mixed findings have surfaced in the few studies that have examined differential response to treatment within the context of ethnicity. Mostly, in these studies Hispanics/Latinos have evidenced no significant differences in improvements when compared to their Caucasian counterparts, with the exception of Twelve-Step Facilitation treatment in which Hispanics/Latinos showed fewer improvements than Caucasian individuals (Arroyo, et al., 2003). When outcomes were compared across treatment modalities, Hispanic/Latino participants tended to respond indiscriminately with positive results to all therapy models examined (i.e., standard brief intervention approach, culture-specific treatment, Cognitive Behavior Therapy, Motivational Enhancement Therapy, Twelve-Step Facilitation (TSF) or Alcoholic Anonymous model), including inactive treatments or control conditions. Therefore, despite the overall improvements observed, it seems difficult to ascertain whether improvements have been directly associated with the treatment components implemented in most studies given this pattern of responding. Indeed, some of the investigators have cautioned about several factors that may have confounded the studies' findings. For instance, Burge and colleagues (1997) pointed to the possibility that their procedures in the control condition may not have been sufficiently inactive to permit detection of treatment effect differences. Additionally, the main features of their culture-specific
intervention consisted of bilingual presentation and availability of information and delivery of information by a Mexican American individual. Although conveying cultural sensitivity by incorporating these two features has been found to be significant predictors of attrition in treatment settings (Sue, Fujino, Hu, Takeuchi, & Zane, 1991), cultural competence encompasses more than language and ethnic-match (Marin, 1993; Sue, 1998). Arroyo and colleagues (1998; 2003) noted that their findings were based on samples of Hispanics/Latinos who were predominantly English speaking and highly acculturated, and, thus, may not generalize to other Hispanics/Latinos. Additionally, Arroyo et al (2003) described challenges encountered in the assessment of their participants’ level of acculturation (e.g., instrument not adapted accordingly to non-Mexican American participants).

Overall, there is a dearth of outcome research focusing specifically on Hispanic/Latino populations, particularly studies with randomized, controlled methodology. Furthermore, most studies in the treatment-related literature on Hispanics/Latinos have focused on substance abuse in general and not on alcohol abuse. Moreover, the treatment outcome studies that have focused on Hispanics/Latinos have examined ethnicity in relation to differential response to treatment. Although essential aspects of the self, such as ethnic identity, cultural values, and attitudes and behaviors are subsumed within the construct of ethnicity (Phinney, 1996), mere self-identification or labeling by others as a member of a particular ethnic group provides limited information about other culture-related factors, such as sociopolitical histories and immigration-related experiences. All of these may have relevance in treatment (Hansen, Zomboanga, & Sedlar, 2000). Therefore, investigations, such as those of Arroyo and colleagues’
(2003) that attempt to consider factors such as acculturation level, may help elucidate whether cultural differences may indeed result in differential treatment response. Although there is an immediate need for these types of research initiatives for Hispanics/Latinos given their increased need for treatment services (Arroyo, et al., 2003), an initial step may be to identify cultural variables that may be central to this particular ethnic group. Accordingly, the next section reviews the literature on cultural values and beliefs that have been identified as important components of Hispanic/Latino culture.

Cultural Considerations in the Development and Implementation of Treatment

Several definitions of culture have been proposed in the literature (Castro & Hernandez-Alarcon, 2002; Frisby, 1999), but generally culture has been thought to encompass shared values, beliefs, heritage, and societal rules that characterize members of a particular group of people (DHHS, 2001). After conducting an extensive review of the literature regarding the role of culture on mental health, the Surgeon General (DHHS, 2001) called attention to the reciprocal impact that culture may likely have on the views of both clients and clinicians about symptoms, diagnosis, and treatment. Cultural background may influence clients’ symptom presentations, help-seeking behaviors, coping styles and utilization of social support systems, as well as views about mental illness. Clinicians’ culture may, in turn, influence their views and decisions about the clients’ illness and care. While acknowledging that existing treatment modalities have not been found to lack efficacy in ethnic minority populations, the Surgeon General (DHHS, 2001) underscored the need to improve the quality of care provided to members of ethnic
minorities by considering and developing culturally sensitive treatments that may be more palatable to these populations. Gaining a sound understanding of the cultural values and beliefs central to a particular ethnic group is, therefore, a fundamental initial step in the development of culturally sensitive treatments (DHHS, 2001; Marin, 1993). This integration of culture into treatment is particularly relevant given that the Western model of medicine continues to prevail, despite the growing heterogeneity of American culture (DHHS, 2001).

Theoretical and Empirical Support for Culturally Sensitive Treatments

Although cultural differences between members of ethnic minorities and non-minorities have been increasingly recognized, the consideration of these differences in treatment conceptualization, development, and implementation has been limited (Bernal, Bonillo, & Bellido, 1995). Nevertheless, in light of the impact that cultural values and beliefs may likely have on individuals' health-related behaviors, several professional agencies [e.g., APA, Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (CNPAAEMI), National Latino/a Psychological Association (NLPA)], government funded agencies [e.g., DHHS, National Institute on Alcohol Abuse (NIAA)], and researchers (e.g., Bernal & Scharron-Del-Rio, 2001; Hall, 2001) have advocated for the integration of cultural variables and cultural sensitivity in various aspects of mental health services, including treatment development and implementation. For instance, the efforts of professional organizations such as APA's Task Force from Divisions 17 and 45 have included the development of the Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for
Psychologists (APA, 2003). These guidelines emphasize the importance of practicing culturally competent psychology when serving culturally diverse populations.

Cultural competence has been generally defined as having “cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture” (Sue, 1998, p. 441). Furthermore, Sue (1998) has proposed the following three main characteristics to further describe the concept of cultural competence: (1) scientific mindedness, (2) dynamic sizing, and (3) expertise with specific elements of a culture. Hypothesis testing of the therapists’ stereotypical views about members of ethnic cultures is subsumed within the first characteristic. Dynamic sizing involves the ability to determine when and how to apply cultural information relevant to an individual’s ethnic group, without neglecting the individual’s uniqueness. It also entails examining one’s own stereotypical views and evaluating their potential to interfere with the establishment of a therapeutic relationship. Knowledge about one’s worldview, as well as the worldviews of individuals from differing ethnic cultures, is encompassed within Sue’s (1998) third characteristic of cultural competence. Others have formulated similar definitions of cultural competence (e.g., Arredondo & Toporek, 1996; CNPAAEMI, 2003; Lo & Fung, 2003) suggesting that it involves acquiring knowledge of the client’s culture and the impact of culture-related variables at all phases of the psychotherapy process (i.e., pre-engagement, engagement, assessment, treatment, and termination). Additionally, the ethnic matching of clients and therapists has been proposed as another component of culturally competent care, with the idea that increased understanding of clients’ cultural background and language may be a natural consequence of this practice.
(Sue, et al., 1991). It has been theorized that ethnic-match, in turn, may lead to better
treatment outcomes (Maramba & Hall, 2002; Sue, et al., 1991).

Despite the paucity of research in this area, the potential positive effects of
therapists’ cultural competence and sensitivity have been supported in some studies.
Focusing on individuals receiving treatment at a university’s counseling center,
Constantine (2002) evaluated the degree to which individuals’ ratings about their
counselors’ multicultural competence accounted for their level of satisfaction with the
counseling services received. Among ethnic minority participants, perceived counselors’
multicultural competence accounted for a significant portion of the variance in the
participants’ ratings of satisfaction with their counselors.

In terms of ethnic-match, Maramba and Hall (2002) conducted a meta-analysis on
the effects of this practice on treatment dropout, utilization, and outcome. Accordingly,
they identified seven studies published over a period of approximately 20 years. Their
findings suggested that ethnic-match had a more positive effect for ethnic minority
participants than for non-minority participants with regard to dropout rates and session
attendance, but not with regard to overall treatment outcome [i.e., as measured by Global
Assessment Scores (GAS)]. Due to the small combined effect sizes yielded in the studies
reviewed, however, Maramba and Hall (2002) concluded that ethnic-match was not a
clinically significant predictor of treatment outcome.

Similarly, findings from more recent ethnic-match studies have been mixed. For
instance, results of studies conducted by Sue and colleagues (Sue, 1998) suggested that
the provision of ethnic-specific services (e.g., bicultural/bilingual staff, location within
ethnic communities) was related to lower dropout rates among ethnic minority clients.
but not to overall treatment outcome (i.e., as measured by GAS). Specific to Hispanics/Latinos, Sue (1998) reported that Mexican Americans attended more therapy sessions and had lower dropout rates after their initial session when their therapists were of the same ethnicity and/or spoke their language. In contrast, Erdur, Rude, and Baron’s (2003) analyses of data from 42 university counseling centers found number of sessions attended and treatment outcome (i.e., as measured by scores on the Outcome Questionnaire 45) to be unrelated to client-therapist ethnic-match. Furthermore, they reported that a noteworthy, though non-significant, trend emerged among ethnically dissimilar dyads. Specifically, Hispanics/Latinos matched with Caucasian therapists had higher session attendance.

The methodological limitations of these studies (i.e., retrospective, non-controlled designs), as well as the mixed findings that have emerged about the effects of ethnic-match, make it difficult to draw any conclusions thus far. Furthermore, even in the cases in which ethnic-match had positive effects on treatment factors, the mechanisms regulating these effects remain unknown (Sue, 1998). Nevertheless, in light of the findings that do underscore the potential benefits of integrating culture into treatment, numerous researchers have proposed various elements to be considered, as well as guidelines and models for developing culturally sensitive treatments (e.g., Bernal, et al., 1995; Constantino & Rivera, 1994; Delgado, 1998; Marin, 1993; Terrell, 1993).

In addition to the integration of cultural values into treatment, a consideration of language and acculturation has also been hypothesized to be important by researchers focusing on Hispanics/Latinos (Delgado, 1998; Terrell, 1993). Recommendations consist of assessing clients’ language preferences in therapy (Delgado, 1998) and incorporating
treatment components that address stressors related to cultural adaptation (Terrell, 1993). Additionally, NLPA (CNPAAEMI, 2003) has suggested that culturally sensitive treatment developers should address demographic and socioeconomic factors that may act as structural barriers (e.g., transportation availability, cost of care) to treatment accessibility among some segments of the Hispanic/Latino population. Furthermore, they have proposed that culturally competent care should involve modifying clinicians’ expectations of clients away from those associated with the traditional medical model framework. Hence, caution should be exercised against pathologizing culture appropriate behaviors, such as behaviors related, for example, to Espiritismo (e.g., belief in folk-medicine) and Familismo (e.g., involvement of extended family members in treatment decision-making). As an initial step, however, the need to identify cultural variables (e.g., Familismo) relevant to a particular group has been acknowledged (Marin, 1993). Constantine and Rivera (1994) and Marin (1993) have posited that treatment components should be evaluated for their degree of congruency with these cultural factors, and existent treatments should be modified accordingly.

Although this literature review did not identify any studies that evaluated the efficacy of culturally sensitive treatments with regard to alcohol abuse among Hispanic/Latino adults, some researchers have made significant efforts to integrate cultural factors into treatment outcome research in other populations and/or for other disorders (e.g., children, adolescent substance abuse). For instance, having identified the use of folktales as an integral aspect of Puerto Rican culture, Constantino and Rivera (1994) developed interventions that utilized storytelling as an element of modeling therapy, for children and adolescents. In a controlled outcome study design, they
evaluated the effects of using stories based on Puerto Rican culture, as compared to stories based on mainstream culture and to a no-treatment condition. Their sample consisted of children (i.e., grades kindergarten through 3rd) and adolescents (i.e., grades 8 and 9) who were at risk for mental disorders and/or behavior problems. Their findings suggested that the children in the culturally adapted story group evidenced less posttreatment symptomatology related to conduct problems and anxiety than the children in the other two conditions. Similarly, adolescents in the adapted story group experienced decreases in anxiety levels and increases in self-esteem and ethnic identity compared to adolescents in the other two groups.

Szapocznik and colleagues’ line of research has focused extensively on addressing the unique needs of Hispanic/Latino substance abusing youth and their families (e.g., Szapocznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983; 1986). They identified factors valued by Hispanics/Latinos and integrated them in systematic controlled outcome studies to develop and evaluate interventions and treatment engagement strategies. Some of the cultural factors they incorporated included family involvement, interpersonal style preferences, and stressors related to cultural differences between parents and adolescents. In particular, Szapocznik and colleagues’ (1983; 1983; 2000) One-Person Family Therapy, Conjoint Family Therapy, and Brief Strategic Family Therapy have been found effective in the treatment of Hispanic/Latino youth.

Notwithstanding the promising findings from studies on culturally sensitive treatment development and adaptation, Terrell (1993) submits that much work remains to be done to demonstrate their superiority to standard treatments. Specifically, data is lacking regarding the identification and understanding of specific elements of culturally
sensitive interventions that are efficacious, particularly in the treatment of substance abuse. In the following section, we review some of the components of Hispanic/Latino culture that might reasonably have an impact on the identification and treatment of substance abuse disorders.

Hispanic/Latino Cultural Values Potentially Relevant to Treatment Development and Implementation

The rapid growth of the Hispanic/Latino population in the United States has been paralleled by an increased interest in its cultural underpinnings. Consequently, several researchers have sought to identify some of the cultural values and beliefs that may be shared across Hispanic/Latino subgroups, notwithstanding the acknowledged extensive heterogeneity across subgroups (e.g., Alvarez, et al., 2004; Antshel, 2002; Castro & Hernandez-Alarcon, 2002; Coma-Diaz, 1990; Fernandez-Pol, Bluestone, Morales, & Mizruchi, 1985; Hall, 2001; Laureano & Poliandro, 1991; Marin, 1993; Terrell, 1993; Zimmerman & Sodowsky, 1993). Some of the Hispanic/Latino values and culture-related variables that have been most commonly discussed in the literature include *Familismo*, *Machismo*, * Marianismo*, * Simpatia*, *Personalismo*, *Respeto*, *Spiritualismo*, and *Fatalismo*.

*Familismo*. The Hispanic/Latino cultural value of *Familismo* refers to the inclination to have strong ties and loyalty to both nuclear and extended family members (Castro & Hernandez-Alarcon, 2002; Coma-Diaz, 1990). Members of Latino/Hispanic families often take an active role as part of the social support systems and decision-making processes of the identified client (Antshel, 2002). Hispanics/Latinos with a strong
family orientation may express it, for example, by showing respect and obedience to
authority figures and making sacrifices for the benefit of the family (Antshel, 2002), as
well as by being cooperative and non-confrontational with family members (Coma-Diaz,
1990).

Within the context of substance abuse, Familismo has been thought to serve as
both protective and risk factors in substance abuse related issues. For instance, strong
reliance on, and involvement of, family support has been associated with improvements
in treatment adherence (Antshel, 2002). Alternatively, disruptions in family systems, such
as those that might occur with immigration, and reliance on substance abusing family
members to learn about the use of substances pose a risk for developing a substance
abuse disorder (Gloria & Peregoy, 1996). Furthermore, having to consult with family
members prior to making treatment decisions may lead to delays in receiving the needed
care (Flores, Abreu, Schwartz, & Hill, 2000). Therefore, it has been suggested that
considering and integrating certain elements of Familismo in treatment settings may be
beneficial (Antshel, 2002). For example, Antshel (2002) highlighted the importance of
utilizing Hispanics/Latinos’ family support to improve treatment adherence. For some
immigrants, however, implementing this approach might be challenging or not applicable
at all due to the disruption in the family system that often takes place due to immigration
to the United States, with many individuals leaving their families behind. Although the
impact of considering Familismo in treatment development has not been examined
empirically within the context of alcohol use, studies in other areas have yielded positive
results. For instance, Marin, Marin, Perez-Stable, Sabogal, and Otero-Sabogal (1990)
increased the palatability of a smoking cessation treatment by enlisting the support of a
nonsmoking family member as part of the intervention. Additionally, their successful media campaign to encourage Hispanics/Latinos to quit smoking centered on the negative effects of smoking on the family.

For many traditional Hispanics/Latinos, the expectation of adhering to prescribed gender roles is subsumed within the value of *Familismo* (Antshel, 2002). For instance, in the traditional, patriarchal family, the father is viewed as an authority figure (Gloria & Peregoy, 1996), and men are expected to be autonomous, courageous, and strict (Antshel, 2002; Coma-Diaz, 1990). This Hispanic/Latino cultural script for maleness is often referred to as *Machismo* (Zimmerman & Sodowsky, 1993). Men are also expected to have pride, ability to self-control, and self-respect (Zimmerman & Sodowsky, 1993), as well as be responsible for the financial support of the family (Antshel, 2002; Gloria & Peregoy, 1996). Accordingly, Antshel (2002) suggests that Hispanic/Latino men may become uncomfortable when asked to act in ways inconsistent with their prescribed gender role (e.g., admitting they have a problem, acknowledging the need for help, accessing support systems, interacting with medical staff).

Several theories have been formulated about the role and treatment implications of *Machismo* in alcohol abuse (Gloria & Peregoy, 1996). A common assumption has been that traditional Hispanic/Latino men who adhere to *Machismo* may equate masculinity with the ability to manage the consumption of large amounts of alcohol, which may be related to the heavy drinking patterns evidenced in this population (Gloria & Peregoy, 1996). Empirical investigations of this hypothesis, however, have not yielded definitive support (Caetano, Clark, & Tam, 1998). Indeed, in their review of this literature, Caetano and colleagues (1998) found no indication that Hispanic/Latino men
differ from their Caucasian counterparts in their views about masculinity and ability to
drink alcohol. In contrast, Fernandez-Pol and colleagues (1985) found that Puerto Rican
males with alcohol abuse disorder were more likely to endorse traditional family values,
including *Machismo*, than males without alcohol abuse disorder. Characteristics of
*Machismo*, such as pride and dignity, were associated with managing to drink heavily,
denial of having a problem with alcohol, and viewing alcoholism as a moral weakness as
opposed to a medical problem.

Another theory has been that heavy alcohol drinking patterns may emerge as
Hispanic/Latino men experience stress related to inability to fulfill prescribed male role
expectations (e.g., provide financially for the family; Gloria & Peregoy, 1996). Not
unique to Hispanic/Latino men, the experience of stress (i.e., in the form of anxiety and
anger) has been generally found among men in situations in which they may be unable to
behave according to the gender role characteristics prescribed by societal scripts (Eisler
& Skidmore, 1987). The male script for Hispanic/Latino men, however, may be
particularly restrictive and place them at greater gender role discrepancy risk than their
non-Hispanic/Latino counterparts. This remains, of course, an empirical question.

Relevant to treatment implications, it has also been speculated that emphasizing
positive aspects of *Machismo* may be beneficial. For example, Zimmerman and
Sodowsky (1993) suggest that bringing attention to the incompatibility of heavy drinking
and some of the characteristics of *Machismo*, such as pride and self-control, may elicit
desire to reduce high-risk behaviors. Similarly, Castro and Hernandez-Alarcon (2002)
advise on the importance of underscoring Hispanic/Latino men's views about their social
and familial responsibilities (e.g., protecting family from harm) to increase motivation to
enter treatment. Along these lines, Gloria and Perego (1996) recommend the use of non-confrontational treatment approaches, which may reduce the perceived threat to masculinity in traditional Hispanic/Latino men.

In contrast to the gender role prescribed for men, women in traditional Hispanic/Latino culture may be expected to take a passive, submissive role in the family (Coma-Diaz, 1990). Accordingly, self-sacrifice, decency, and modesty characterize the expected traditional female behavior, also known as Marianismo (Castro & Hernandez-Alarcon, 2002). The term Marianismo has been derived from the idea that Hispanic/Latina women should aspire to emulate the qualities of the Virgin Mary (Bracero, 1998). Thus, women are expected to be strong and flexible as they meet the multiple demands associated with their roles within the family (e.g., wives, mothers, workers; Gloria & Perego, 1996). Notwithstanding the expectation that Hispanic/Latina women defer decision-making to men, closer observations of interactions among family members in this population reveal that, even in traditional Hispanic/Latino families, men and women generally share equal responsibility and power in the family’s decision-making processes (Coma-Diaz, 1990). Furthermore, Coma-Diaz (1990) suggests that gender roles within these families may be increasingly fluid, particularly among low-income immigrants as they adopt American values and as women join the job market more easily than do men.

With regard to substance use, some theories (e.g., Castro & Hernandez-Alarcon, 2002; Fernandez-Pol, et al., 1985) have proposed that adherence to traditional gender roles should serve as a protective factor against substance use among Hispanic/Latina women. Contrary to this view, however, Fernandez-Pol and colleagues (1985) found that
Puerto Rican women with alcohol abuse disorder held more traditional views than their counterparts who did not have this disorder. Interestingly, this finding counters the results from studies that have found positive relationships between acculturation to mainstream culture and alcohol drinking among Hispanic/Latina women (e.g., Black & Markides, 1993; Caetano, 1987). Nevertheless, consistent with traditional gender role expectations, Fernandez-Pol et al. (1985) reported that Puerto Rican women with alcohol disorder tended to conceal their alcohol consumption by drinking at home rather than publicly. This may be reflective of the stigma perceived in association with this behavior.

Unfortunately, the possible role and treatment implications of Marianismo among Hispanic/Latina women have received little attention in the literature both theoretically and empirically.

Simpatia. Another value central to Hispanic/Latino culture is Simpatia. This value refers to a strong predilection for positive, cooperative, and harmonious interactions with others (Castro & Hernandez-Alarcon, 2002; Marin, 1993). Accordingly, it may be difficult for Hispanics/Latinos who value Simpatia to be confrontational, express anger, and/or convey disagreement (Antshel, 2002). Instead, agreeableness, compliance, politeness, and courtesy may be displayed (Castro & Hernandez-Alarcon, 2002), even when they do not accurately reflect inner experience. Griffith, Joe, Chatham, and Simpson’s (1998) findings in a population of substance abusers suggested that Simpatia was more salient for Hispanics/Latinos than for individuals of other ethnic groups. Furthermore, they found positive correlations among Hispanics/Latinos between Simpatia and both social support and social conformity. Conversely, Simpatia was negatively correlated with hostility (Griffith, et al., 1998).
Some researchers have theorized that *Simpatia* may have important implications within the context of mental health services (e.g., Antshel, 2002; Flores et al., 2000; Gloria & Peregoy, 1996). For example, Antshel (2002) proposed that it might be difficult for Hispanics/Latinos to report negative side effects, acknowledge lack of understanding about prescribed treatments, and/or admit failure to comply with treatment. Relevant to substance abuse, Gloria and Peregoy (1996) suggest that *Simpatia* may be related to reductions in the impact of social and family support systems, in that family members may avoid confronting the substance abuser. Along these lines, incorporating *Simpatia* as a component in treatment interventions, for example by increasing the client’s awareness about the importance of keeping harmony within the family, has been theorized to be beneficial (Flores et al., 2000; Gloria & Peregoy, 1996). Furthermore, Flores and colleagues (2000) suggest that failure to convey *Simpatia* may result in Hispanics/Latinos’ dissatisfaction with the services received. *Simpatia* may also be a factor in the development of substance abuse disorders, as well as in post-treatment relapse. It may be particularly difficult for individuals who value *Simpatia* to take a stand against a behavior in light of social pressure, lest it seem disagreeable. Although these theories about the possible effects of *Simpatia* on mental health related variables make intuitive sense, no empirical investigations have been conducted to date.

**Personalismo.** Similar to *Simpatia*, *Personalismo* is a value in Hispanic/Latino culture related to prescribed conduct in interpersonal relationships (Gloria & Peregoy, 1996). According to *Personalismo*, courtesy, character strengths (as opposed to external traits or material possessions), loyalty, and personalized interactions are highly appreciated and respected (Antshel, 2002; Castro & Hernandez-Alarcon, 2002; Gloria &

53
Elements of communication, such as physical contact and proxemics are also important in Personalismo (Antshel, 2002). Thus, in treatment settings, traditional Hispanics/Latinos may expect clinicians to convey concern (Galanti, 2003), devote time to build rapport and trust prior to addressing the presenting problem (Gloria & Peregoy, 1996), display socially appropriate physical contact, and interact within close physical proximity (Antshel, 2002). Although Personalismo has not been directly examined empirically in association with alcohol abuse, Antshel (2002) reported on studies that support the theory that Personalismo has important general implications in treatment. Findings from these studies included Hispanics/Latinos’ loyalty to their health care providers, their inclination to refer to their health care provider by name rather than by the institution to which the provider is affiliated, and failure to comply with treatment when there is distrust associated with the service provider.

respeto. The Hispanic/Latino value Respeto serves as a script for proper conduct within the context of public and private interpersonal relationships (Castro & Hernandez-Alarcon, 2002; Laureano & Poliandro, 1991). Respeto calls for traditional Hispanics/Latinos to express reverence according to age (e.g., elderly), gender (e.g., women), and social position (e.g., health care providers, teachers; Antshel, 2002; Coma-Diaz, 1990). In their daily interactions, they may express Respeto by addressing others formally (e.g., use of last name instead of first name, use of person’s title) and using formal salutations (e.g., good morning; Antshel, 2002). Failure to express Respeto may be construed as a character flaw (Laureano & Poliandro, 1991). Failure to receive appropriate Respeto may also be judged as an insult. Many of the problem-identification, help-seeking behaviors and other components required of substance abuse treatments

54

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
(e.g., confrontation, short-visits, impersonal interactions) may be experienced as lacking in *Respeto* by individuals who place a high premium on this cultural value.

*Espiritualismo*. Many Hispanics/Latinos hold strong beliefs in a higher power, often referred to as *Espiritualismo* (Castro & Hernandez-Alarcon, 2002). *Espiritualismo* encompasses several dimensions. One of them centers on religious beliefs, frequently associated with Catholicism, and trust in God's will (Coma-Diaz, 1990; Gloria & Peregy, 1996). Thus, church members and/or priests are commonly relied upon for support in times of need (Baez & Hernandez, 2001). Another dimension of *Espiritualismo* involves beliefs in supernatural forces. Somewhat conflicting with the beliefs of organized religion, a large proportion of the Hispanic/Latino population believe that supernatural forces may be responsible for negative and positive events in their lives (e.g., good and bad luck, illness; Gloria & Peregy, 1996). Belief in supernatural forces takes different names across Hispanic/Latino cultural subgroups, such as Curanderismo in Mexican culture, Espiritismo in Puerto Rican culture, and Santeria in Cuban or Caribbean culture (Gloria & Peregy, 1996). Both dimensions of *Espiritualismo* (affiliation with organized religion and a belief in the supernatural) are closely related to the Hispanic/Latino value of *Fatalismo*, which refers to the belief that individuals have little control over their destinies and may be powerless to intervene or seek help (Coma-Diaz, 1990).

Reliance on folk healers, herbal medicine, and spiritual rituals are aspects of *Espiritualismo* that are common particularly among individuals who adhere to traditional Hispanic/Latino culture (Antshel, 2002). Hence, their integration in treatment development and implementation has been theorized to be important (Antshel, 2002: 55).
Coma-Diaz, 1990). For instance, Gloria and Peregoy (1996) have suggested that certain beliefs about illnesses, such as alcohol abuse being God’s intended punishment for an individual or divine intervention being needed to stop alcohol consumption, may interfere with seeking help from mental health professionals. Similarly, Baez and Hernandez (2001) have proposed that Hispanics/Latinos who value Espiritualismo may seek to restore balance and harmony both spiritually and physically, as opposed to obtaining simple relief from physical symptoms. Therefore, understanding and integrating spiritual belief systems into mental health care may be particularly important given their enduring permanence within the culture. Indeed, Castro, Furth, and Karlow (1984) assessed the variability of health and illness beliefs as a function of acculturation among urban Mexican-origin, Mexican American, and Anglo women and found that beliefs about Latino folk-medicine did not disappear with increased adaptation to mainstream culture. Specifically, although these types of beliefs were significantly stronger among Mexican-origin and Mexican American women with low and bicultural acculturation levels, highly acculturated Mexican American women accepted Latino folk-medicine beliefs to a greater degree than their Anglo women counterparts. Overall, mild to moderate levels of acceptance for these beliefs were found in Mexican-origin and Mexican American women, independent of acculturation level.

Summary and Recommendations

As stressed in the Surgeon General’s report on mental health (DHHS, 2001), there is a growing body of literature supporting the crucial role of culture in clients’ health-related behaviors. In support of the theories about the positive effects of culturally sensitive approaches, findings from most of the aforementioned studies suggest that
integration of some cultural factors into treatment was beneficial, despite mixed findings from ethnic-match studies. Therefore, it is not surprising that many researchers have proposed guidelines to facilitate both the process of modifying extant treatments and developing new treatments that convey cultural sensitivity. Central to these proposed guidelines and procedures is the need to identify culture-related variables relevant to the presenting concern and the target population.

Bernal and colleagues (1995) have argued that the development of culturally congruent treatments would necessitate the application of methodologies that are environmentally reflective of the conditions in which the treatment will be utilized, a concept known as ecological validity (Shadish, Cook, & Campbell, 2002). Accordingly, Bernal et al (1995) posit that ecologically valid treatments would integrate unique and shared characteristics of both treatment developers and clients, which inarguably includes an understanding of client’s cultural values and beliefs, as well as about the presenting problem from a cultural perspective. Therefore, culturally sensitive empirically derived interventions should ideally be developed through the following process: (a) formulation of a hypothesis as to how the symptom or problem is related to a cultural phenomena; (b) formulation of an alternative hypothesis; (c) developing a specific intervention based on the cultural hypothesis; (d) testing of the intervention in a clinical situation; (e) evaluating the hypothesis vis-à-vis the clinical data; and (f) confirming, disconfirming, or revising the original hypothesis (Bernal, et al., 1995, p.10). In their evaluation of Cognitive Behavior Therapy and Interpersonal Psychotherapy with depressed Puerto Rican adolescents, Rossello and Bernal (1999) found support for the efficacy of culturally adapting treatments in the aforementioned manner.
Similarly, Castro and Hernandez-Alarcon (2002) have underscored the importance of ecological validity in treatment modalities for ethnic minority populations. In their view, methodologies that integrate both quantitative and qualitative approaches are needed to fully understand cultural variables in relation to treatment. That is, these expanded methodological approaches may contribute to ecological validity because they may help extract “inductively-generated thematic content and generate thematic categories that capture the salient features of a racial ethnic minority person’s life” (Castro & Hernandez-Alarcon, 2002, p.792). Utilizing structured quantitative designs may otherwise overlook these themes. Indeed, the use of qualitative methods has been deemed appropriate and advisable in health-related research. Qualitative methodologies may be particularly fruitful at the exploratory or preliminary stages of studies centering on the identification of elements essential to an understanding of the phenomena from the targeted populations’ perspective (National Institute of Health, 1999). In turn, a fundamental initial step in this process is the understanding of the presenting concern within the client’s cultural worldview. To this end, the use of methodologies that incorporate both qualitative and quantitative approaches have been proposed, as these methods may facilitate a greater understanding of the treatment needs of understudied populations.

The cultural variables that may have an impact on the identification and treatment of alcohol abuse in Hispanics/Latinos include Familismo, Machismo, Marianismo, Simpatia, Personalismo, Respeto, Espiritualismo, and Fatalismo. Although few empirical investigations have been conducted in this area, several researchers have theorized that some of these cultural values may serve as protective and risk factors for the development
of psychological disorders, as well as play a key role in various aspects of treatment, including help-seeking behaviors, treatment adherence, palatability, dropout, and outcome. Findings from the handful of empirical studies that have examined the effects of some of these variables have suggested that they may play a role in the development and treatment of substance disorders (e.g., Marin, et al., 1990), although research is scarce and results are mixed. In light of the current paucity of research and the various recommendations for an ecologically valid approach to these questions (Bernal et al., 1995; Castro & Hernandez-Alarcon, 2002), it may be fruitful to address Hispanics/Latinos directly about the meanings of alcohol use in their lives. What are their lay conceptualizations of alcohol abuse and its treatment? The investigation of lay theories of illness and treatment has proven very productive in increasing our understanding of the way different individuals and cultural groups approach illness.

Cognitive Representations of Illness and Alcohol Abuse in a Cultural Context

Common Sense Representations of Illness Model

One of the early, seminal studies that elucidated the important role of lay theories of illness within the context of treatment development and delivery was Friedl’s (1982) research on explanatory models of black lung in a sample of Appalachian migrant coal miners. Despite efforts to provide easily accessible treatment services for Appalachian miners with black lung, members of this population evidenced tremendous reluctance to seek treatment and high rates of treatment noncompliance. Based on Kleinman’s explanatory model of illness (cited in Friedl, 1982), Friedl conducted interviews focusing
on the understanding of Appalachians' beliefs about their condition within a social and cultural context. He found a high degree of divergence between health care providers' and miners' explanatory models of black lung, making it evident why accessibility to medical services was not sufficient to ensure their use.

From the perspective of a biomedical model of treatment for this incurable condition, the focus of treatment is symptom management. In contrast, from a traditional Appalachian cultural perspective, acute, not chronic, illnesses are suitable for medical treatment, and treatment is usually sought from folk healers, as hospital visits are typically unaffordable. Furthermore, the value of fatalism, which is central to Appalachian traditional culture, involves accepting the consequences of the aging process, including incurable conditions, and letting them run their course. Therefore, to be offered services for an incurable condition raised suspicion and distrust among members of this population and influenced their decision to decline treatment. Friedl's (1982) findings regarding Appalachians' explanatory model of black lung were fundamental to the identification of treatment components, such as psychoeducation, that could help to modify help-seeking and treatment noncompliance behaviors among members of this population.

Indeed, there is a large body of literature suggesting that people form theories or cognitive representations about health and illness, and that these representations have a direct impact on their health-related behaviors (e.g., help-seeking, treatment adherence and outcome; see Hagger & Orbell, 2003; Lau & Hartman, 1983). Furthermore, it has been posited that discrepancies between clinicians and clients in their respective theories of medical conditions may lead to miscommunication, discrepancies in treatment
expectations and goals, poor adherence, and negative perceptions of the care provider’s competence (Insel, Meek & Leventhal, 2005; Martin, Rothrock, Leventhal, & Leventhal, 2003). Understanding individuals’ theories about their conditions is, therefore, of particular importance given their implications in various dimensions of problem identification and treatment.

One explanatory framework, emanating from medical anthropological research that has been applied extensively to understand people’s cognitive representations about their conditions is Leventhal and colleagues’ (1980) Common Sense Representations of Illness Model (CSM). This model was initially developed by exploring lay beliefs about the meaning of health and illness among individuals in healthy and clinical populations (Lau, 1997). Five elements surfaced in the structure of individuals’ common sense theories of their illnesses, consistently across populations. These elements were (1) identity, (2) consequences, (3) time line, (4) cause, and (5) cure or control (Lau, 1997).

The first component, identity, refers to the recognition of symptoms in relation to a particular condition and to the labeling of that condition (Lau, 1997). Thus, as individuals experience bodily sensations, they interpret them within the context of similar past experiences, the communicated experience of their social support network, or may be even collective, cultural conceptions of what those sensations signify. It is within this larger context that the individual assigns a label to their symptoms (Martin, et al., 2003). Identification and labeling of symptoms has several important implications. For example, it facilitates communication about the individual’s perceived condition (Martin, et al., 2003), and it may prompt an individual to seek help and/or stay in treatment (Lau & Hartman, 1983).
The next component in CSM is consequences. This element involves individuals' cognitive representations of their condition's severity and its impact on their lives across various dimensions of functioning (e.g., long and short-term social, psychological, and physical effects; Jessop & Rutter, 2003; Lau & Hartman, 1983). People's beliefs about the potential consequences resulting from their conditions are likely to have an impact on health behaviors, such as help-seeking and treatment compliance (Martin, et al., 2003). Thus, consequences that are perceived as sufficiently negative may have a stronger influence in the individual's decision to take some form of action to address the condition. On the other hand, consequences that are perceived as grave may also have the paradoxical effect of making the individual avoid help-seeking for fear of finding his or her worst fears confirmed or be subjected to stigma associated with the illness.

Within the CSM framework, time line refers to cognitive representations about the duration of a condition and of its treatment. Namely, this element includes individuals' perceptions about the amount of time involved in symptom development, the course of the condition (Martin, et al., 2003), whether the condition is acute or chronic, and the probability of relapse (Lau & Hartman, 1983). Relevant to treatment, time line involves representations about the duration of the intervention and the amount of time it may take for the treatment to exert its effects (Martin, et al., 2003). As was the case with the aforementioned CSM elements, time line also has important treatment implications. For instance, representations about how long a particular symptom should last prior to interpreting it as a condition that requires medical attention is likely to impact self-referral to treatment (Martin, et al., 2003). Similarly, individuals' perceptions about treatment effectiveness may have an impact on their motivation to enter and/or stay in
treatment. Furthermore, people’s views about the timeline of their condition have been shown to have an impact on treatment dropout (Meyers, Leventhal, & Gutmann, 1985). For instance, in Meyers and colleagues’ (1985) study with a sample of patients receiving treatment for high blood pressure, newly treated patients who viewed their condition as acute (i.e., lasting a life-time) evidenced the highest dropout rates (i.e., 58%), whereas patients who viewed their illnesses as chronic had the lowest dropout rates (i.e., 17%).

The fourth component in CSM involves individuals’ attributions about the causes of the condition experienced. This element comprises subjective ideas and explanations about the potential factors that contribute to the development and maintenance of the condition (Jessop & Rutter, 2003; Lau, 1997; Lau & Hartman, 1983). Whether individuals form causal attribution theories that point to external, internal, controllable, or uncontrollable factors is likely to have significant impact on their health-related behaviors (Lau & Hartman, 1983). Indeed, several studies have documented the effects of attributing the causes of illness to a variety of treatment related variables, such as predicted recovery, treatment engagement, and experience of psychological symptoms (see Meana, Binik, Khalife, & Cohen, 1999). Causal attributions for a condition have also been shown to be related to psychological adjustment, regardless of the accuracy of the attribution (Meana, et al., 1999). This is particularly relevant in the case of disorders of unknown etiology, in which individuals cannot anchor their beliefs in any medical knowledge.

Lau and Hartman (1983) proposed a fifth element of CSM, the representation of the recovery process or cure, which they believed was particularly relevant in the experience of less severe medical conditions. They indeed found support for the idea that
people form theories about the factors that they believe contribute to their recovery from illnesses or to symptom reduction. Findings from Lau and Hartman's (1983) factor analyses suggested that individuals' theories about recovering from an illness could be conceptualized within the same categories evidenced in their theories about getting sick (i.e., external/internal locus of control, controllability, stability). This component of CSM also includes control, which refers to individuals' cognitive representations about the possible course of actions available to them in order to ameliorate their symptoms (Lau, 1997). Control also has been proposed to involve ideas about the degree to which the condition may be treatable (Jessop & Rutter, 2003).

CSM, therefore, provides a theoretical foundation to guide the exploration and identification of cognitive factors that may have an impact on health-related behaviors. The elements embedded within this model center on the processing and integration of information to understand the pathways through which cognitive representations of illnesses become part of individuals' schema for health and illness (Hagger & Orbell, 2003). Two of the several studies that have been conducted in the medical anthropological field utilizing CSM are presented below as examples to elucidate the considerable clinical utility of this model.

Meyer and colleagues (1985) identified treatment noncompliance as a problem among patients suffering from hypertension. They applied the CSM model in an attempt to understand patients' perceptions about their condition after their review of this literature suggested that noncompliance was not fully accounted for by the variables researchers have characteristically proposed (e.g., patient characteristics, such as social class and personality, cost and accessibility to treatment). Accordingly, Meyer and
colleagues (1985) conducted interviews with patients who (1) had recently entered treatment for the first time, (2) had remained in treatment for a period between 3 months and 15 years, and (3) had returned to treatment after a period of noncompliance. A fourth group of patients who had never been diagnosed with hypertension and were receiving care for other conditions served as controls. During the interviews, the components of the CSM framework were applied to elicit patients' perceptions about their condition (e.g., meaning of the condition, causes).

The findings from this study suggested that patients indeed had formed cognitive representations about hypertension, and certain aspects of these theories had an impact on treatment adherence. For instance, they found significant differences among patients regarding the degree to which they identified and labeled their symptoms as a function of their diagnoses and treatment stage. That is, less symptom identification occurred among patients who had not been diagnosed with hypertension. Conversely, symptom identification increased progressively with increased exposure to the condition (i.e., patients in the treatment re-entry category identified the most symptoms). Differences in patients' conceptualization of hypertension with regard to time line were also noted. Namely, patients with longstanding diagnoses of hypertension were more likely to view the condition as chronic, as opposed to acute. A large proportion of the patients (i.e., 75% to 80%) had formed ideas about the causes of hypertension, independent of diagnosis or treatment stage.

Regarding the impact of patients' theories about hypertension on noncompliance (i.e., measured as adherence to prescribed medication regimen for patients who were continuing treatment and as dropout rates for newly treated patients), Meyer and
colleagues (1985) found that perceived treatment efficacy influenced treatment adherence, with more patients who believed treatment would be effective being more likely to comply. Regarding treatment dropout among the group of newly treated patients, greater degree of symptoms reported during the interview was associated with higher dropout rates. Interestingly, patients who dropped out reported viewing their persisting symptoms as indicative of treatment failure, and they equated symptom remission to being cured. Additionally, newly treated patients’ dropout rates changed as a function of time line, with patients who viewed their condition as acute experiencing greater dropout rates than those who viewed hypertension as a chronic condition. No relationship was found, however, between representations about the causes of hypertension and treatment compliance (Meyer, et al., 1985). Overall, the application of CSM in this study was fundamental to an understanding of patients’ common sense representations about hypertension. This understanding in turn led to the identification of elements that may help reduce noncompliance, such as the need for educational components, assessment and monitoring of patients’ views about their illnesses, and importance of early identification of factors that may contribute to treatment dropout.

Another study that applied the theoretical foundation embedded within CSM focused on a sample of breast cancer patients. As in the aforementioned study, this group of researchers (Rabin, Leventhal, & Goodin, 2004) turned to CSM after finding that objective measures, such as time since diagnosis, type of cancer, and/or stage of disease, failed to yield consistent predictions about the degree of posttreatment emotional distress. Following a longitudinal design, they assessed patients three weeks prior to treatment, one-month post-treatment, and three months post-treatment. Next, they classified
patients' representations of their condition in one of three categories: acute, chronic, and cyclic. Within the context of CSM, they theorized that patients' perceived time line (i.e., chronic, cyclic, acute) would impact their experience of distress. Their hypothesis was supported with the finding that patients who viewed their condition as acute tended to report less emotional distress than those who viewed their condition as chronic or cyclic. Furthermore, patients' time line representations had a greater impact on their experience of emotional distress than did objective data, such as stage of disease. Thus, the crucial role of understanding patients' representations about their illnesses was again highlighted in this study. Indeed, these findings have several valuable clinical and treatment implications, such as the importance of educational components in aftercare and the assessment of patients' beliefs about the various stages of their condition.

In both of the aforementioned studies, researchers identified phenomena that were poorly explained and/or predicted by variables characteristically proposed within a traditional scientific perspective, such as patient characteristics and cost and accessibility to treatment. In both cases, examination of these phenomena within the context of a CSM framework facilitated the expansion of knowledge and understanding about which variables impact health-related behaviors, how they do so, and what their potential clinical and treatment implications may be.

**Cognitive Representations of Alcohol Abuse**

Research on the examination of alcohol abuse within the context of a formal CSM framework is nonexistent. A few studies, however, have explored lay theories or beliefs about alcohol abuse outside of this theoretical orientation (e.g., Beckman, 1979; Cunningham, Sobell, Freedman, & Sobell, 1994; Furnham & Lowick, 1984), but their
focus has been limited to examining the causal attributions of this condition. In an extensive review of studies in this area published over a period of nearly two decades, Furnham and Lowick (1984) suggested that lay theories about the causes of alcoholism generally agreed with academic explanations (e.g., medical, moralistic, psychoanalytic, sociocultural models). Nevertheless, they noted extensive variability, overlap, and inconsistency across studies' findings. For instance, when participants in one study were asked to endorse either a medical or moralistic model, there was about equal support for each one (Mulford & Miller, 1961 cited in Furnham & Lowick, 1984). When participants in another study were allowed to endorse one or both models, approximately 50% of participants endorsed both the medical and moralistic model (Orcutt, 1976 cited in Furnham & Lowick, 1984). In yet another study, participants who were given a listing of various models from which to choose yielded in a more complex pattern of findings (Beckman, 1979). In this latter study, Beckman (1979) focused on a sample of women in both clinical and non-clinical settings (i.e., alcohol-abusing and dependent individuals, problem drinkers, non-problematic drinkers). A questionnaire asking participants to rate several potential causes of alcoholism in order of importance was administered (i.e., on a 4-point scale). Some of the causal factors queried included external variables (e.g., job-related stress), distressful events (e.g., divorce), individual's fault, environmental/circumstantial factors (e.g., job), heredity, illness, and destiny. The results indicated that a moralistic model of alcohol abuse predominated among participants in both the clinical and non-clinical samples. The view that individuals' were responsible for their condition was rated as most important, although external factors, such as environmental factors and stressful events, were also rated high in importance.
Furnham and Lowick (1984) also reported a pattern of inconsistent findings across studies that utilized open-ended questions instead of structured questionnaires. Again, lay theories about the causal attributions of alcoholism reflected those views proposed in the aforementioned traditional models, but a different set of findings emerged in each study (i.e., some endorsed moralistic or medical views, while others endorsed psychological causes such as depression, anxiety, or personality factors).

Furnham and Lowick's (1984) own study on causal attributions of alcoholism in a sample of participants in England revealed similar findings. They developed a questionnaire containing 30 possible causal explanations for alcoholism derived from the literature on academic and lay theories of causal factors and from interviews with 10 individuals. Causal factors related to social anxiety (e.g., anxiety, depression, boredom) and psychological stress (e.g., work-related stress) were rated as more influential than biological or sociocultural factors. Furthermore, women tended to endorse social anxiety and social and cultural norms as more important causal factors than men, and older participants viewed inadequate socialization or education, social and cultural pressures, and biological and genetic factors as more influential to the development of alcoholism than did younger people.

In a more recent study, Cunningham and colleagues (1994) examined the beliefs about the causes of alcohol, nicotine, and cocaine addiction held by young, educated participants at a science center. The participants were asked to indicate the degree (i.e., on a 5-point scale) to which they believed that the causes of addiction for each substance was due to (a) disease or illness, (b) wrongdoing, (c) habit, not disease, or (d) drug addiction. Relevant to alcohol use, the findings of this study suggested that the majority
of participants endorsed the belief that alcohol abusers were ill and/or addicted to the substance.

In sum, research on lay theories of causal attributions of alcohol abuse has revealed some degree of congruency between academic or traditional models and lay people’s beliefs, but there has been a lack of consistency in the findings across studies. Moreover, the focus of these studies has been largely limited to examining beliefs about causal factors, and data have been collected mainly through the use of questionnaires in which individuals have been asked to endorse predetermined concepts about alcohol abuse, which may not permit individuals’ own cognitive representations to surface unfettered by researchers’ assumptions. With the exception of Furnham and Lowick’s (1984) study, the effects of demographic variables, such as age and gender, have been largely understudied, and the possible effects of culture have been overlooked. Therefore, much work remains to be done to understand individuals’ common sense theories about alcohol abuse (i.e., in terms of identity, consequences, time line, cause, cure or control), as well as their implications for treatment development and implementation.

Summary

Alcohol abuse and treatment seems ideally positioned to an examination of cognitive representations of the disorder. First, there is long-standing controversy in the empirical and theoretical literature as to whether alcoholism is a high-risk paradigm disease or primarily a behavioral problem (Furnham & Lowick, 1984; Miller & Hester, 1995). There is also debate as to treatment approaches, from the total abstinence model to the moderated drinking model (Miller & Hester, 1995). Finally it is a disorder that is essentially an extension of accepted and even encouraged social behavior in many
cultures (Heath, 1999). All of these conditions provide fertile ground for the development of lay theories about its labeling, causes, course, and treatment. Even when disorders are anchored in relatively certain medical knowledge and societal prohibitions, individuals have a way of devising their own idiosyncratic theories. When no such certainty exists, the ground is fertile for the proliferation of individual theories.

The mixed findings regarding views and beliefs about this condition also points to the need for further investigation. The findings that emerged from medical anthropological studies about the impact of cognitive representations of illnesses on health-related behaviors are likely to be analogous in the case of alcohol abuse. For instance, individuals' theories about which symptoms must be present in order to label alcohol abuse as a condition that requires professional attention might influence help-seeking behaviors. Similarly, perceptions about the efficacy of alcohol abuse treatment might impact individuals' decisions to stay in treatment. Therefore, the examination of alcohol abuse within the context of the CSM framework seems warranted.

The CSM framework is also ideally suited for the examination of cultural factors relevant to health behaviors related to substance abuse. Kleinman (2004) asserts that individuals' cultural worldviews are likely to have an impact on their experiences with health and illness and, in turn, on their health-related behaviors. He and his colleagues (Kleinman, Eisenberg, & Good, 1978) have proposed that cultures provide scripts for the representations of health and illness, including individuals' perceptions about their illnesses, symptom labeling, causal explanations, and coping mechanisms. Thus, they have proposed that "illness is culturally shaped" (Kleinman, et al., 1978, p.252). Research on examinations of the meanings of illnesses within a cultural perspective, however, has
received little attention. Consequently, it is not surprising that no such studies have been conducted among Hispanic/Latino populations. A study on cognitive representations of alcohol abuse utilizing CSM may be particularly suitable for this population because of the 1) unique cultural factors that have been theorized to impact patterns of alcohol abuse and 2) unexplained treatment underutilization/dropout rates and reported dissatisfaction with mental health services that have been found among members of this population.

Aims of the Study

The rapid growth of the Hispanic/Latino population over the last few decades, particularly immigrants, presents challenges and opportunities to identify and address their needs for mental health care. In specific reference to immigrant members of this population, factors such as emigration circumstances, country of origin’s sociopolitical environment, limitations with access to health care, language barriers, and lack of familiarity and information on how to access services may have significant implications for prevention and treatment initiatives. This may also be particularly germane in the case of alcohol-related disorders, as they have been documented to be a serious problem with severe consequences among Hispanics/Latinos. The high prevalence of these disorders underscores an increasing demand for treatment, but the elements that comprise an optimal form of treatment remains poorly understood. Although rapidly accumulating evidence supports the idea that individuals’ cultural beliefs, values, and experiences influence the manifestation of psychological health, illness, and health-related behaviors, the effects of integrating cultural factors into treatment continues to be largely understudied. Conceivably, Hispanic/Latino cultural values might be theorized to be
related to attitudes and beliefs that are likely to influence patterns of alcohol drinking, views and expectations about treatment, and treatment outcome, especially for individuals who adhere strongly to their cultural roots, which might likely be the case of immigrants. The examination of this possible association is warranted in light of the central role that culture plays in Hispanics/Latinos’ lives, the influence of general societal and cultural views about alcohol drinking, and the documented efficacy of culturally sensitive treatments for other disorders.

The aim of this study was to gain an in-depth understanding about the meaning of alcohol-related disorders within the context of the Hispanic/Latino cultural perspective, particularly as it pertains to immigrants. Rather than make assumptions about the manner in which alcohol-related disorders are viewed and understood from this cultural perspective, Leventhal and colleagues’ (1980) model of Common Sense Representations of Illness was applied to investigate Hispanic/Latino lay theories about this condition. Accordingly, the meaning of alcohol-related disorders were examined in relation to the several dimensions encompassed within this model, including (1) identity, (2) consequences, (3) time line, (4) cause, and (5) cure or control. To this end, in-depth individual and group interviews were conducted with Hispanics/Latinos to elicit their cognitive representations of alcohol-related disorders and their treatment. In turn, these interviews facilitated the emergence of a theory/model from this grounded data about the manner in which cultural views and alcohol use interplays with Hispanic/Latino immigrants’ experiences.

The ultimate aim of this investigation was to provide researchers and clinicians with valuable information about alcohol-related disorders and Hispanic/Latino
immigrants that could then be integrated into treatment outcome research and evaluated quantitatively.
CHAPTER III

METHODOLOGY

Participants

The participants were 56 adult Hispanic/Latino male immigrants (mean age = 33.71, SD = 8.37) who were in mandated treatment for alcohol-related disorders in community mental-health clinics. The majority of participants emigrated from Mexico (89%). Five participants were from Central and South America (i.e., Guatemala, El Salvador, Honduras, Colombia) and two were from Caribbean Islands (i.e., Cuba, Puerto Rico). Their reported average length of residence in the United States was 11.5 years (SD = 7.23), and their average number of years of formal schooling was 8 years (SD = 3.75). Fifty-six percent of the participants were employed in construction, over 35% of them worked in various service industries (e.g., restaurant, retail, plumbing, landscaping), 5% held supervisory positions, and 4% were unemployed. There was a wide range in their reported annual household income, ranging from $6,000 to $45,000 per year ($M = $19,704, SD = $8972).

Research Approach

Our research approach for this investigation was a qualitative procedure called Grounded Theory (GT; Strauss & Corbin, 1998), which has been used extensively in health research to interpret qualitative information (Charmaz, 1995; Fassinger, 2005) and for theory development (Chamberlain, 1999). GT methodology is considered by some researchers to
be a rapidly growing, highly influential qualitative framework in the social sciences (Fassinger, 2005).

When Glaser and Strauss developed GT in 1967 (cited in Fassinger, 2005), they incorporated elements from several philosophies, but some argue that constructionist ideas and positivists procedures are predominant in this methodology (Fassinger, 2005). The influence of constructionist ideas is apparent in GT’s assumption that individuals’ realities are shaped by their social interactions through the sharing of symbols that facilitate communication and give meaning to their experiences (Fassinger, 2005). Consistent with these principles, Strauss, in particular, emphasized the idea that individuals actively respond to challenges, and their responses are dependent on the meanings associated with these challenges (Strauss & Corbin, 1998). Additionally, he posited that meanings are fluid and change continuously as a result of people’s interactions with others. Glaser, on the other hand, emphasized the importance of making comparisons between data to create a theory. Fassinger (2005) argues that some of the procedures followed in GT, such as the use of structured interviews, detailed coding, and categorization, are rooted in positivist principles (e.g., based on observation).

GT methodology is used ultimately to construct a theory that is grounded in the data collected (Strauss & Corbin, 1998). Both inductive and deductive principles are applied in the process of building a theory (Fassinger, 2005). Data is systematically obtained by asking open-ended and semi-structured questions without preconceived hypotheses to members of the target population, thus allowing for the emergence of categories and relationships between these categories that form the theory (Chamberlain, 1999). The theory is tested deductively through simultaneous and continuous comparison.
of, and gathering of additional data (Chamberlain, 1999). The process of building a theory through GT methodology begins with data collection through the initial interview, but data analysis occurs simultaneously thereafter, guiding modifications to subsequent interviews until saturation (i.e., new elements cease to emerge) is reached (Strauss & Corbin, 1998). A grounded theory, therefore, emerges as a result of the interplay between the data and its analysis and through the application of several components, which are not necessarily implemented in a linear manner (Chamberlain, 1999; Fassinger, 2005).

The National Institutes of Health (1999) has suggested that qualitative methods are appropriate for the study of health-related issues, particularly at the exploratory stages of studies aiming to expand understanding about a phenomenon from a particular population's perspective. Additionally, Maxwell (1996) specified several types of studies for which qualitative methods of research may be especially suitable. These types of studies include those in which the researchers' goals are to understand individuals' meanings about their subjective experiences, generate new, grounded theories about these experiences, and/or develop causal explanations, all of which are reflective of the aims in the present study.

**Measures**

*Background Questionnaire.* Participants were asked to provide the following demographic information: cultural affiliation, age, education level, income, language preference, and years of residence in the United States. They were also asked about their age of onset for alcohol drinking, their alcohol-related problems, their past histories of alcohol abuse/dependence treatment, and their experiences with their current treatment (See Appendix A).
Semi-Structured Interview. A semi-structured interview designed specifically for this study was used (see Appendix B). The interview was designed to cover all elements of Leventhal and colleagues' (1980) Common Sense Representations of Illness model.

Procedure

Hispanic/Latino immigrant males receiving services at community clinics for alcohol-related disorders were recruited to participate in the study through posted announcements at the clinics. The announcements were in both English and Spanish and contained a brief description of the study and the interviewer's contact information. An additional recruitment strategy involved the interviewer making in-person visits to the clinics at times when potential participants were attending group therapy meetings, at which point they were extended invitations to be part of the study. Potential participants were provided with an overview of the study and invited to participate in in-depth individual or group interviews to take place on the same day of the invitation or at a later time, depending on participants' time availability. All of our participants were recruited through the in-person invitation approach, as no participants responded to the posted announcements. Individuals who agreed to participate were provided with informed consent forms, which emphasized the confidential nature of the data solicited and their right to withdraw from the study at any time. Consents to audiotape the interviews were also obtained from the participants. To ensure the confidentiality of the participants' data, their informed consents were obtained without the involvement of the clinics' treatment staff. Information obtained from the participants was not made available to the treatment staff.
staff, and the interviews were conducted on-site for participants’ convenience but in a private room.

The group interviews consisted of 10 to 13 participants in each group. The duration of the group interviews was approximately two to three hours. Individual interviews were approximately 90 minutes long. The number of interviews conducted was based on the estimated number of interviewees needed to reach the point of saturation, the point at which no new themes emerged during the interviews. Although saturation was reached early in the study, additional interviews were conducted to ensure that all relevant themes had emerged.

Data Collection

All interviews were audio taped, and the investigator transcribed their contents word-for-word in Spanish, which was the language in which they were conducted. Each interview was then examined for emerging themes prior to the next individual or group interview, as prescribed in grounded theory methodology. Accordingly, new themes were incorporated in the ensuing interviews.

Protocol Adherence

To ensure that participants in all group and individual interviews were administered all items contained in the semi-structured interview questionnaire in a uniform manner, the interviewer maintained a checklist next to each item of the questionnaire, and each item was checked off as it was administered. Prior to ending each interview, the investigator reviewed the items listed to ensure that all items had been administered.
administered accordingly. Due to the open-ended format of the interview questionnaire items, responses to some items emerged prior to their administration. If the topic of an item emerged prior to the investigator’s administration in a manner that addressed the item, then the particular item was checked off. As new themes emerged, the questionnaire and checklist were updated prior to their administration to the next participant or group. A second verification of adherence to protocol was performed at the time that the interviews were transcribed. As the investigator listened to the audio taped interviews to transcribe them word-by-word, items administered were checked off. Again, if the subject of an item was addressed prior to its administration, the item was checked off as administered. This process ensured the integrity of protocol adherence across interviews.

**Data Analysis**

_Coding_. Elements in each interview were identified, developed, and related to other elements, all of which constituted the foundation of the emerging theory. Continuous data comparisons across participants and across emerging categories or themes were made, and three types of coding were applied to the data: open, axial, and selective.

_Open Coding_. In open coding, transcripts of interviews were examined line-by-line to identify their smallest unit of meaning. The size of a unit of meaning ranged from a single word to several sentences. Through this process, concepts were identified, conceptualized, and labeled to form independent categories. The data obtained from each interview was compared to other concepts identified in prior interviews to identify similarities and differences, thus determining whether (1) these new data fit within
previously determined categories, (2) it was necessary to develop new categories, and/or
(3) existing categories required modification.

**Axial Coding.** Axial coding is conceptualized as a process of integration in which
the smallest units of meaning found in the open coding are reassembled into broader
categories. It is at this stage that we identified subcategories that fell within broader or
umbrella categories, as well as relationships between categories, the properties or
attributes and dimensions of these categories, and the formulation of possible explanatory
hypotheses. We continued this interplay of comparisons between new data and existing
concepts and categories until saturation was reached.

**Selective Coding.** The third level of coding in GT focuses on the refinement and
further development of the theory (Strauss & Corbin, 1998). In this phase, we integrated
any categories discovered in the prior coding phases and represented them with one core
or central category. Additionally, selective coding involved further comparisons between
the central category and the data to ensure that the theory was grounded in the
experiences reflected in the participants’ interviews. We followed Strauss and Corbin’s
(1998) steps to determine a core category, including (1) establishing relationships
between other categories and the core category, (2) the core category must have surfaced
in all, or almost all, individual cases within the data, and (3) the core category should
explain variations and alternative explanations within the data.

In summary, the aforementioned coding procedures were followed and the
transcribed interviews obtained in this study were carefully examined to interpret the
meanings of each statement made by the participants within the context of
Hispanic/Latino culture and their immigrant experiences. First, each transcript was
examined line-by-line prior to conducting the ensuing interview. The data obtained from each interview was compared to the concepts, themes, and categories that emerged in prior interviews and incorporated into the subsequent interview. Next, the data was grouped into emerging themes and relations to other subcategories. In the next phase, the subcategories were integrated into a broader, central category that captured the essence of the theory.

Reliability and Validity

Reliability and validity are two standards customarily applied to determine the scientific soundness of methodology in quantitative studies (Fassinger, 2005; Henwood & Pidgeon, 1992). In qualitative research, these standards are subsumed within the concept of trustworthiness (Fassinger, 2005). Given the absence of numeric data, the reliability and validity or trustworthiness of qualitative studies is often evaluated, for example, in terms of the validity of the data, the objectivity of the researcher, the methodical application of study procedures, and the reliability of coding procedures (Morrow, 2005). Accordingly, several researchers have defined sets of criteria to evaluate these types of studies and the theories that emerge from them (e.g., Henwood & Pidgeon, 1992; Morrow, 2005; Strauss & Corbin, 1998). For the purposes of this study, we integrated the methodological recommendations from the aforementioned researchers to establish a set of 4 criteria to which this study adhered in an attempt to maximize the reliability and validity of results.

Criterion #1 – Reflexivity. In light of the difficulty in removing subjectivity from the process of analyzing and interpreting data, the researcher documented her own biases
both a) as a way to raise awareness of biases in the hopes that this awareness and
disclosure made it less likely that the bias would interfere with the coding of data, and b)
as a public disclosure so that evaluators of the ultimate theory can be fully informed of
the possible effects of these biases on the research process. This disclosure is called
*bracketing* in qualitative research and was conducted prior to data collection. The
primary investigator’s biases about the interface of culture and alcohol abuse in
Hispanic/Latino populations are provided in Appendix C.

*Criterion #2 – Detailed documentation of the research process.* Another way of
remaining as transparent as possible about the process that led to the evaluation of the
theory is to provide as much detail as possible in regard to the research process. To that
end, the primary investigator provided a list of all open-coding themes, detailing which of
these were subsumed under which axial codes, and finally which axial codes were further
subsumed into selective codes. Then a narrative explanation of how the selective codes
were further elaborated into a theory was provided. In this fashion, the process of theory
building is open to evaluation.

*Criterion #3 – Keeping close to the data.* It is essential to ensure that the data and
the theory are a good fit. This criterion, thus, centers on verifying that the categories that
form the theory are reflective of the data gathered. To this end, a second researcher (the
research supervisor) also engaged in the coding of data at the open and axial stages,
independently of the primary investigator. When both completed their open and axial
stage coding, the two researchers met to evaluate agreement on codes and emerging
themes. Disagreements were discussed until a code/theme that both researchers felt was
faithful to the data was agreed upon.
Criterion #4 – Theory evaluation. Further testing of the theory’s validity and usefulness was conducted by evaluating 1) its clinical significance in contributing to knowledge of Hispanic/Latino culture and alcohol abuse and 2) the extent to which it provides guidelines for action in terms of the development of culturally sensitive clinical interventions. This evaluation was of a qualitative nature and is presented in the discussion of the final dissertation document.
CHAPTER IV

RESULTS

Alcohol Use Characteristics of Participants

Participants’ responses to the background questionnaire revealed that approximately 41% of them had their first drink between ages 15 and 18 ($M = 17.48$, $SD = 4.95$). More than half of them (57%) reported having immediate family members who had a tendency to drink alcohol excessively. Nearly a third reported having members of their immediate family who had experienced legal or medical problems due to alcohol drinking (29% and 27% respectively). Endorsements of symptoms experienced and problems associated with the alcohol drinking indicated that 100% of participants met DSM-IV-TR criteria for alcohol abuse (i.e., all participants were mandated to treatment for driving under the influence of alcohol) and 39% met DSM-IV-TR criteria for alcohol dependence. Among the most commonly reported symptoms and problems were having a strong desire, and/or making constant efforts, to stop drinking but being unable to do so (64%), drinking for longer periods or in larger amounts than initially intended to (41%), and decreasing the amount of time devoted to important activities due to drinking alcohol (27%). Sixty-six percent reported entering treatment after their first referral, 20% had been referred to treatment twice, and 11% had been referred to seek treatment three times, before entering. The majority of the participants were in treatment for the first time
(80%), with a smaller group entering treatment for second (12%) and third (5%) times. Among those who had been in treatment in the past, dropout rates from treatment were low, with 4% reporting they had dropped out of treatment once in the past, and only 2% reporting having dropped out twice in the past.

**Reliability Analysis**

After interviews were transcribed both the primary investigator and an independent rater (the research supervisor) coded the data at the open and axial stages and identified emerging themes. The two independent coders then met to compare their findings. When both the rater and the investigator identified the same theme in the data, this was considered an agreement. When the investigator identified a theme that the rater did not, or vice versa, this was construed as a disagreement. An inter-rater reliability percentage was obtained by dividing the total number of agreements by the combined total number of disagreements and agreements and multiplying by 100. The inter-rater agreement was 90%, suggesting that the process was reliable. Disagreements were addressed by referring back to the data from which the theme was supposedly identified. If, in this process, both raters agreed that the theme was in fact supported by the data, that theme was kept. If one rater remained unconvinced that the data supported a particular theme, then that theme was discarded. Therefore, only themes on which there was a consensus were included to construct the theory.
The Emerging Theory -Model of Alcohol Abuse
Risk in Hispanic/Latino Immigrants: A Clash
of Cultures and Immigration Stress

What emerged was a complex interplay between two separate, and at times competing, cognitive representations of alcohol use (one derived from the culture of origin and one derived from the host culture) experienced within the stressful context of difficult immigration circumstances. Decisions about using and abusing alcohol appeared to be made at the crossroads of these three cognitive and emotional mediators: indigenous beliefs about alcohol, perceptions of American beliefs about alcohol, and a significant amount of stress associated with their foreigner status in this country. This meeting point was theorized by us to constitute a high-risk situation for alcohol abuse (Figure 1 illustrates this proposed model/theory).
Model of Alcohol Abuse Risk in Hispanic Immigrants: A Clash of Cultures and Immigration Stress

<table>
<thead>
<tr>
<th>Immigrants’ Representations of Alcohol Use/Abuse in Culture of Origin</th>
<th>Immigrants’ Representations of Alcohol Use/Abuse in Host Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meanings</strong></td>
<td><strong>Meanings</strong></td>
</tr>
<tr>
<td>• Traditional part of community and familial celebrations</td>
<td>• Ambiguous media and other messages — drink/don’t drink</td>
</tr>
<tr>
<td>• Rite of passage into manhood</td>
<td>• Not exclusively social-often solitary</td>
</tr>
<tr>
<td>• Integral part of <em>simpatía</em></td>
<td>• Gender non-differentiated</td>
</tr>
<tr>
<td>• Abuse a function of interpersonal problems</td>
<td>• Abuse as function of addiction/illness</td>
</tr>
<tr>
<td>• Abuse not recognized as major, chronic problem</td>
<td>• Abuse recognized as major, chronic problem</td>
</tr>
<tr>
<td><strong>Barriers to Abuse</strong></td>
<td><strong>Barriers to Abuse</strong></td>
</tr>
<tr>
<td>• Family and community support</td>
<td>• Initial lack of familiarity w/new environment</td>
</tr>
<tr>
<td>• Responsibility to family</td>
<td>• Initial lack of social connection</td>
</tr>
<tr>
<td>• Economic constraints</td>
<td><strong>Consequences of Abuse</strong></td>
</tr>
<tr>
<td></td>
<td>• Loss of driver’s license</td>
</tr>
<tr>
<td><strong>Consequences of Abuse</strong></td>
<td>• Potential loss of job</td>
</tr>
<tr>
<td>• Minimal - Slap on the wrist</td>
<td>• Criminalization</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td><strong>Treatment</strong></td>
</tr>
<tr>
<td>• Rare</td>
<td>• Organized</td>
</tr>
<tr>
<td>• Minimally organized</td>
<td>• Mandated</td>
</tr>
</tbody>
</table>

- Lack of Social Support
- Emotional Distress
- Societal Marginalization
- Occupational/Economic Stress

**Figure 1**
Both the culture of origin and the host culture representations of alcohol use and abuse appeared to be composed of four categories: meanings attributed to alcohol use, barriers to alcohol abuse, consequences of that abuse, and attitudes about treatment. Privy to both culture of origin and perceived host culture views about alcohol, participants described feeling stranded between these often divergent cognitive schema for alcohol use and abuse. They expressed confusion about the mixed messages and the appropriate way to navigate the cultural divide. Although we did not start out with the specific aim of investigating immigration circumstances, it became very clear from our interviews that our participants were experiencing a significant number and intensity of stressors directly associated with their immigration experiences. The participants themselves connected these stressors to their alcohol use. Overall, the fundamental dynamic reflected in the participants' data was a confusing clash between Hispanic/Latino cultural beliefs and attitudes about alcohol use and perceived Anglo-American cultural beliefs and attitudes about this substance, with a substantial amount of immigration stress thrown to complicate matters further. Both at the cognitive and affective levels, our participants were confronted with confusion and difficulty. These cognitive incongruencies and emotional distress appeared to us and to them to constitute a high-risk situation for alcohol abuse and dependence and to constitute significant interference in treatment-seeking and adherence. For a detailed account of how we arrived at this theory/model from participant data see Table 1.
## Table 1  Model of Alcohol Abuse Risk in Hispanic/Latino Immigrants

<table>
<thead>
<tr>
<th>Categories</th>
<th>Conceptual Subcategories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meanings</td>
<td>Traditional part of community and familial celebrations</td>
<td>• Widely used in family gatherings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• It’s been done for generations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Customary to commemorate significant events (parties, “despedidas”)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mainly a social activity</td>
</tr>
<tr>
<td>Rite of passage into manhood</td>
<td>Common for close family member to introduce to alcohol in mid adolescence</td>
<td>• Facilitates social bonding/fitting in</td>
</tr>
<tr>
<td></td>
<td>Men expected to drink, manly activity</td>
<td>• Important to be polite, agreeable (rude to decline a drink)</td>
</tr>
<tr>
<td></td>
<td>Men expected to drink, manly activity</td>
<td>• Vulnerable to peer pressure</td>
</tr>
<tr>
<td>Integral part of <em>Simpatia</em></td>
<td>• Due to emotional problems (loneliness, love failures, stress, social anxiety) and family problems (divorce)</td>
<td></td>
</tr>
<tr>
<td>Abuse as a function of</td>
<td>• Abuse not recognized as major chronic problem</td>
<td>• Normal, every day life activity</td>
</tr>
<tr>
<td>interpersonal problems</td>
<td></td>
<td>• Not a physical illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Little/no knowledge of negative effects of alcohol drinking</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Only a problem if causes severe consequences (rare in native country)</td>
</tr>
<tr>
<td>Barriers to Abuse</td>
<td>Family and Community Support</td>
<td>• Live in small, contained communities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No anonymity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Limited mobility, no need to travel far to obtain alcohol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Govt./public agencies not structured to monitor or set limits for drinking</td>
</tr>
<tr>
<td></td>
<td>Responsibility to family</td>
<td>• Close family ties keep drinking in check</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shame to family in being a drunkard, respect to family</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Resources allocated to support</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
| Economic constraints          | Limited job opportunities, have to work hard and long hours just to feed family  
|                              | Most cannot afford to own a car  
|                              | Many cannot afford to buy alcohol |
| Consequences of Abuse        | No broader/societal consequences  
|                              | Limited personal consequences  
|                              | Police involvement is rare; laws rarely enforced, if so get a scolding by cops or a small fine but not legal repercussions or treatment |
| Treatment                    | Treatment conceptualized as only for extreme cases  
|                              | Family members take initiative to lead into treatment  
|                              | Treatment is voluntary  
|                              | Need will power to stop, not treatment |

**Immigrants’ Representations of Alcohol Use/Abuse in Host Culture**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Conceptual Subcategories</th>
<th>Themes</th>
</tr>
</thead>
</table>
| Meanings                    | Ambiguous media and other messages     | Media promotes alcohol use, portrays as positive, acceptable behavior  
|                              |                                        | Society restricts and monitors use  
|                              |                                        | Increased awareness about negative effects of alcohol use  
|                              |                                        | Lack information about laws and their strict enforcement |
|                              | Little shame in open inebriation       | Perceive host culture as liberal, carefree, and permissive about alcohol  
|                              |                                        | Less concerned about being judged |
| Not exclusively social –    |                                        | Drinking does not occur exclusively in context of familial or social settings like in culture of origin  
| often solitary              |                                        | Anglo-American culture perceived as more individualistic  
|                              |                                        | Celebration not as tied to alcohol use |
| Gender non-differentiated   |                                        | Acceptable for both men and women to drink  
|                              |                                        | Women in US are more educated and able to work, drink more |
| Abuse as a function of addiction/illness | Increased awareness of negative effects  
Increased recognition of role of biological and hereditary factors |
| Abuse recognized as a major, chronic problem | Seen as serious problem in host culture, with major consequences  
Concerns about damaged health, serious medical conditions |
| Barriers to Abuse | Lack of familiarity with new culture/environment  
Drinking contained initially due to limited knowledge about environment  
Initial lack of social connection  
People are more comfortable drinking in their native country |
| Consequences of Abuse | Significant loss of privileges  
Loss of driver's license  
Freedom  
Possible deportation |
| Potential loss of job | Limited ability to provide for family  
Lost work time due to legal problems  
Difficulty finding new job |
| Criminalization | Strict laws  
Restrictions on drinking behaviors, age limits, heavily enforced  
Seen as criminal offender |
| Treatment | Organized  
Mandated when in trouble w/law  
Mandated treatment seen as positive lesson, turning point  
Needed to overcome problem |

### Immigration Stressors

<table>
<thead>
<tr>
<th>Categories</th>
<th>Conceptual Subcategories</th>
<th>Themes</th>
</tr>
</thead>
</table>
| Lacking of Social Support   | Disconnect from family   | Leave family behind  
Don’t have social support in US  
Often unable to return for home visits |
|                             | Reliance on co-workers for support/company/assistance | Peer pressure to drink  
Drink while working  
Only source of social support  
Social connective |
| Emotional Distress          | Loneliness/Homesickness  | Away from significant others  
Loss of spouses due to relocation |
| Psychological Distress      |                          | Anxiety, Stress  
Sadness |
<table>
<thead>
<tr>
<th>Societal Marginalization</th>
<th>Stigma about immigrant status/Discrimination</th>
<th>Occupational and Economic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Concerns with limited rights as immigrant</td>
<td>▪ Limited job opportunities</td>
</tr>
<tr>
<td></td>
<td>▪ Concerns with image of Hispanics as drunkards</td>
<td>▪ Frequent exploitation</td>
</tr>
<tr>
<td></td>
<td>▪ Discriminated against for not speaking the language</td>
<td>▪ Work long hours, with limited options for recreation or relaxation</td>
</tr>
</tbody>
</table>

To summarize, following the open and axial coding procedures, concepts were identified and coded according to their developing themes to form conceptual subcategories. Through selective coding procedures, the conceptual subcategories were linked to broader theoretical constructs that were then incorporated as core elements of the emerging theory. The following sections will provide an elaborated narrative account of each of the elements that constitute the proposed theory/model, including samples of the participant quotes in which the categories and theory are grounded.
Representations of Alcohol Use and Abuse in Culture of Origin

Although the participants reported varied lengths of stay/residency in the US, they seemed to be highly enculturated to their native culture and reported a strong adherence to values rooted in their culture of origin. These values seemed to underlie the early formation of their cognitive representations of alcohol use.

Meanings

The meanings that they ascribed to alcohol use spanned functions relating to social traditions, developmental rituals, and self-soothing/self-medication as follows:

*Traditional Part of Community and Family Celebrations.* Participants particularly valued their strong ties to immediate and extended family members, and alcohol was a strong part of these ties. Alcohol was a significant component of memories related to people who were close to them and whom they loved. They commonly reported exposure to heavy alcohol use in the family. The use of the substance was seen as central to their traditions. Hence, it had been taking place for generations and was widely practiced by participants’ male role models and/or parental figures (e.g., grandfathers, fathers, godfathers, older brothers, cousins, family friends).

*En mi persona fue que casi en toda mi familia siempre han habido personas que toman. Desde que tengo uso de razón he estado en el ambiente. Mis tíos, mis padrinos, mi papa, siempre han tomado. Uno desde chico siempre ha crecido viendo que ellos toman.*

*As for myself, it was that in almost all of my family there have always been people who drink. Ever since I can recall I have been in that environment. My uncles, my godparents, my father all have always drank. Ever since one is a little child one grows up seeing that everyone drinks.*
The use of alcohol as a social connective was central and prominent in the participants' experiences. In gatherings with family and friends, alcohol use facilitated and enhanced social interaction, for example, by bringing people together (conviviencia), lifting people's moods, promoting lively conversations, and alleviating social anxiety and shyness. Thus, alcohol use was strongly associated with having a good time with friends and family.

...la cultura de uno tiene mucho que ver...siempre casi hay un motivo, una boda, una quinceanera, una pelea de box, el cumpleanos...(alcohol) es lo primero que va a ver allí. Llega uno a ir a una quinceanera, aunque uno llegue con la familia, va a pasar que uno no lleva el deseo de tomar, pero bueno ya para...esta alla en la fiesta...allí viene quieres una soda o una cerveza...(dicen) tomate una cerveza...ya es costumbre.

...culture has a lot to do with it...there's almost always a reason, a wedding, a sweet fifteen party, a boxing match, a birthday...(alcohol) it's the first thing there's going to be. One goes to a sweet fifteen party, and even if you go there with your family, it happens that you get there with no desire to drink, but once you are at the party...there comes the offer to drink a soda or a beer...(they say) drink a beer...it's the custom.

Its use was in essence seen as requisite in celebrations and commemoration of special events. Indeed, participants' recollections of their early experiences with alcohol often involved memories of family gatherings in which alcohol use was an integral element. Others recalled alcohol use in association with significant and meaningful events in their life, such as at family members' send-offs (despedidas). It was a marker of important emotional milestones.

...hicieron una fiesta antes que se fuera mi hermano a Angola...en Cuba reclutan a partir de los 16 años, cuando aquello era la Guerra de Angola...y cuando lo mandaron a mi hermano por dos anos hicieron una fiesta. Mi hermano me dijo toma un poquito (de alcohol) antes que me vaya porque no sabes si me vas a ver otra vez.

...They organized a party before my brother left to Angola...in Cuba they recruit starting at age 16, when the Angola War was taking place...and when my brother
was leaving for two years they held a party for him. My brother said to me drink a little bit (of alcohol) before I leave because you don’t know if you will see me again.

Participants’ interaction with alcohol started early on as children, even before they had their first drink. For example, given the lack of enforcement of age restriction laws for purchasing alcohol, participants reported that inebriated adults often sent them as children to purchase alcohol at nearby stores. Thus, alcohol use was perceived as a relatively harmless substance, widely consumed in the context of social and familial interactions and celebrations, central to normal, everyday life. So innocuous, in fact, that it was perfectly normal and acceptable to send children off to buy the substance. Thus, many of our participants had little history of considering the danger inherent in alcohol. If anything, alcohol was about connection, community, friendship, and family.

*Rite of passage into manhood.* Generally, participants identified that the onset of their alcohol use was in adolescence. Typically a member of the family or close friend allowed and/or encouraged them to try their first drink at this time. It was commonly reported that drinking alcohol was seen as a manly activity, with that first drink signifying their transition into manhood.

...desafortunadamente nuestra sociedad nos sirve de machismo como dicen los compañeros...nos obligan nuestros papas, nuestra propia familia (nos dicen)...tomate esto para que seas hombre, para que seas macho...

...unfortunately our society facilitates machismo in us like my buddies here said...we are obligated by our parents, by our own family (they say)... drink this so you can be a man...so you can be macho...

The notion that this rite of passage was specific to men was highly salient in the participants’ narratives. Most of them expressed little cultural tolerance and/or acceptance for alcohol drinking among women. Consistent with the Hispanic/Latino
culture value of *machismo*, participants perceived the amount of alcohol they were able to
drink as a direct measure of their degree of manliness, with high tolerance and
consumption indicating a high degree of manliness. Participants who disliked alcohol,
became inebriated after a few drinks, and/or expressed desire to cut down were often
ridiculed or harshly criticized by their peers. The pressure to drink and to have a high
tolerance was thus experienced early on.

*Integral part of simpatia.* Participants’ adherence to the cultural value of *simpatia*
also seemed to play a significant role in their cognitive representations of alcohol use,
which in turn seemed to guide their behaviors. As mentioned earlier, *simpatia* refers to
the high value placed by Hispanics/Latinos in maintaining harmonious relationships
through compliance, conformity, and agreeableness, as well as withholding expression of
negative emotions and avoidance of conflict. Accordingly, participants viewed declining
an offer to drink alcohol as socially unacceptable, impolite behavior. In some cases,
participants indicated that they often drank to please others, to promote social bonding,
and to avoid offending others.

...todos me rogaban pues tomate una cerveza...me sentia forzado...me sentia
obligado...que si no tomaba no los iba a tener contentos. Y con el amigo que
vivia, pensaba pues si no me la tomo hasta me va a correr de su casa.

...everyone would beg me to drink a beer...I felt forced...I felt obligated...such
that if I didn’t drink then I wasn’t going to make them happy. And the friend with
whom I was living, I thought he might kick me out of his house if I didn’t drink.

Declining to drink alcohol was perceived as a rejection of the person offering it,
as a rejection of friendship. Thus, our participants reported being afraid that refusals to
drink might likely result in social disconnect and isolation. In turn, this dynamic seemed
to impede any efforts to cut down on, or stop, the drinking of alcohol, as the participants
were very susceptible to the rejection of their peers. In a related vein, alcohol use appeared to relieve social anxiety, which in turn facilitated their social interactions and created a more harmonious environment.

*Otra cosa que me preocupa es el aislarte de los amigos. Que va ser de tu vida sin tus amigos si te influencian pero si te aislas voy a estar peor porque me voy a deprimir mas y me voy a estresar mas...Pero cuando voy con los amigos me ofrecen (una bebida) y les digo no, pero si me tengo que tomar una porque me dicen, no que te pega (tu esposa)?...*

*Another thing that worries me is isolating myself from my friends. What’s going to happen to your life if your friends influence you, but if you isolate yourself then it’s going to be worse because I will get more depressed and more stressed...But when my friends offer me (a drink) I say no, but I still have to drink one because (otherwise) they say, what, are you afraid your wife will hit you?...*

It is interesting that in this quote we again see the cultural value of *machismo* raise its head. Not only is drinking a social requirement, if you don’t drink, you might give the impression that you are “hen-pecked” – that you are not the dominant figure in the family. The pressure to drink was thus very significant.

*Abuse as a function of interpersonal problems.* The majority of participants reported receiving little to no education in their native countries about the potential causes of alcohol abuse or dependence. Their own causal attributions for alcohol abuse centered largely on the self-medication of interpersonal problems and emotional distress. Thus, they reported observing that individuals tended to abuse alcohol, for example, when they experienced divorce or other losses of significant others, when they were stressed due to hard labor or financial hardship, or when they felt lonely due to separation from their families.

*Por causas sentimentales, por problems del amor...la separacion de las parejas...o a veces los divorcios.*
It's due to emotional problems, problems with love...when couples separate...or sometimes due to divorces.

Abuse not recognized as major chronic problem. The participants also reported limited knowledge about the negative effects of alcohol abuse on their health. Some participants indicated having difficulty considering alcohol abuse and dependence a physical illness, given the absence of physical symptoms and their lack of awareness about its potential bodily harm. Instead, they viewed excessive use as a mental vice, which they described as a habit of lesser severity than an addiction.

...no porque entonces quería decir que hay mucho enfermo, que en los casinos hay mucho enfermo, y todos los lugares donde venden cerveza hay enfermedad. Se envicia uno...por decir...Yo cuando me metí a jugar en las máquinas, no me metí en la enfermedad, me metí en el vicio del juego. Y mi vicio era grande pero no era enfermedad. Ese es vicio...

...it's not (an illness) because then it would mean that there's lots of people who are ill, that at the casinos there are lots of people who are ill, and that everywhere beer is sold illness is present. One gets into a vice...for example...when I got into gambling, I did not get into an illness. I got into a vice of playing (machines). And my vice was big but it was not an illness. That's a vice...

In their culture of origin representations of alcohol use, they rarely identified problems associated with alcohol use, except in severe cases and when it was used in a context outside of their early familial experiences. For example, they viewed the use of alcohol as problematic when individuals made it a habit to drink outside of a social or familial context (e.g., frequently drinking alone at a bar), when it caused major financial problems (e.g., spend most money on alcohol instead of providing for family), or when individuals were seen drunk, sleeping on the streets. In other words, unless the alcohol abuse resulted in dramatically evident negative outcomes, it was downplayed as bad behavior that could easily be re-directed.

99
Barriers to Abuse

Some of the sociocultural and environmental characteristics of the participants’ upbringings in their countries of origin appeared to protect against the risk for alcohol abuse. The majority of the participants described their hometowns as small, contained communities in which family members and friends lived in close proximity and often kept their drinking in check. Especially given the high value placed on *respeto* (i.e., cultural script for conduct in which reverence is expressed to the elderly, parents, and authority figures), participants typically avoided drinking alcohol in excess when in the presence of esteemed family members. Being inebriated in front of their parents or in public was seen as shameful to their families. Although numerous participants abused alcohol, they had to go to greater lengths in order to do so while they were in their native country.

_También esta la familia... uno no lo hace alla por los papas, lo haces a escondidas para que no vean tus papas... pero hay más respeto a la familia._

_There’s also the family... one doesn’t do it (get drunk) over there because of the parents, you do it hiding so that your parents don’t see you... but there is more respect for the family._

Access to alcohol seemed contained also by the participants’ limited financial resources. Particularly with the high emphasis in their culture that men should provide food and resources for their families, the resources available to purchase alcohol were limited. They had to work long hours, earning low wages that were barely sufficient to provide for the basic necessities of their families’ lives.

..._alla para comprar un veinte tienes que trabajar todo un día..._ y aqui solo tienes que trabajar una hora o menos... _alla si tomaba no comía o si comía no tomaba._

100
...over there (back home) to buy a twelve-pack you have to work all day...and here you only have to work one hour or less...over there if you drank you couldn’t eat or if you ate then you couldn’t drink.

It is clear that back home, one often had to choose between eating and drinking alcohol. These impoverished circumstances constituted a clear protective factor against alcohol abuse.

Consequences of Abuse

Participants reported they experienced limited consequences from alcohol abuse in their native countries. For instance, in the small town environment in which they lived, participants had access to alcohol within close geographic proximity. Thus, they rarely drove while intoxicated, as they could easily purchase alcohol at stores located within walking distance, or they could send children to the local store to buy it for them.

Alla hay tiendas en los pueblos en cada esquina...los ninos son los que hacen los mandados. Dice el papa que manda al nino que apenas puede cargar la bolsa...dile que te de dos, tres caguam as y traeme cigarras tambien...

Back in the villages there are stores in every corner...the children are sent to do errands. The father says to send the child who can barely carry a bag...tell them to give you two, three beers and bring me cigarettes too...

Additionally, only a handful of participants owned motor vehicles in their native countries also due to their limited financial resources. Hence, they had little familiarity with the consequences of driving under the influence of alcohol, which further limited the consequences they experienced from alcohol abuse.

... hay personas que llegan de alla...y tu sabes venimos porque somos de escasos recursos...y alla no tuviste la oportunidad de tener tu propio carro...y sentiste un poquito, no tanto libre si no un poco mas dueño de lo que haces o el dinero que recibes...luego ya estas aqui y al rato traes tu carro pero traes las mismas ideas de alla...todavia no te adaptas al sistema de aqui y entonces te llevas tu carro, te vas de parranda, y te vuelves a salir y tienes la mentalidad todavía como si estuviéren en el rancho...y te agarra un policia y te dice no mijo aqui es Estados Unidos
there are many people that come here...and you know that we come from backgrounds of limited resources...and over there you didn't have the opportunity to have your own car...and to feel a little, not so much free but a little more responsible for your own actions and the money that you receive...then you get here and next you have your own car but you have the same ideas that you had over there...you still haven't adapted to the system here and then you take your car, and you party, and you go out again and your mind set is still like if you were in your ranch...and the police stop you and tell you no, my son, this is the US.

Participants’ narratives suggested that public agencies in their small communities (e.g., law enforcement) were not structured to sanction alcohol drinking. Thus, it was common for participants who were caught driving while intoxicated to simply pay a fine or pay off a corrupted police officer, without facing any major consequences. No participants recounted anything more serious than a slap on the wrist from the authorities back home. Hence, the participants’ perceived the consequences for abuse as minimal and experienced at a personal level. There appeared to be no significant societal consequences or public shaming as a consequence of alcohol abuse.

Treatment

Participants reported having little to no familiarity with treatment for alcohol abuse and dependence in their countries of origin. This is hardly surprising considering that it was generally not considered to be a major problem in their communities. Prior to their experience of severe consequences in the US, few participants believed that treatment was necessary to stop drinking, and many expressed their belief that will power was the primary intervention needed to overcome this problem. In their native countries, treatment for alcohol abuse and dependence was not mandated by law. Instead, it was the family members’ responsibility to take a person in for treatment when the individual’s alcohol problems became severe (e.g., falling down drunk in the streets). The majority of
the participants reported this was a rare occurrence in their native countries. Treatment resources were scarce and minimally organized.

_Pues en Mexico no hay lugares asi. Cuando te paran no te mandan a tratamiento. Si hay alcoholicos anonimos pero uno va cuando uno quiere no porque te manden_  

_Well, in Mexico there are no places like this. When you get stopped they don’t send you to treatment. Alcoholics Anonymous exists but one goes when one wants to and not because they send you._

Representations of Alcohol Use and Abuse in Host Culture

Upon their arrival to the US, the participants encountered dramatic differences between their old and new environments. Contrasts between their culture of origin beliefs and the beliefs they perceived to be commonplace in the host culture in some cases created confusion and in others worked to change their early cognitive representations of alcohol use.

**Meanings**

The meanings they perceived as ascribed to alcohol use in their new, American environment shared little with the messages they had grown up with. It all felt very ambiguous, with a multitude of ads encouraging the practice coupled with the message that alcoholism was a bona fide illness. Their old connections between alcohol and both community and manhood also seemed to be quite foreign in this new land.

_Ambiguous media and other messages._ Participants noticed that alcohol use was heavily promoted and portrayed as bringing about positive outcomes (e.g., billboards advertising drinking establishments at every corner and advertisements for beer on every channel promising popularity and fun).
...esto es como un negocio muy grande porque a cada rato te bombardean por todos lados con esos mensajes de tomate una y te vas a sentir bien chido... O sea que te ponen mensajes subliminales allí... y si tu estas tratando de dejar de hacer cosas, pero por todos lados ves lo mismo y lo mismo...pues como quiere que yo le haga entonces (para dejar de tomar).

...This is like a big business because at every moment they bombard you from everywhere with those messages saying to drink one and you will feel great... That is they put subliminal messages there...and if you are trying to stop doing it, but everywhere you see these same messages...then how do you want me to stop (drinking).

On the other hand, they also took notice of advertising campaigns alerting them to the negative effects of alcohol use and to the laws against driving while intoxicated. They had not been exposed in this manner to these messages in their countries of origin. It was not just the threat of getting caught, it was the instilling of guilt about drinking and driving.

Le hacen pensar los comerciales que a lo mejor en la borrachera yo hubiera podido hacer algo y no me acuerdo. Y cuando dicen que si uno toma y maneja es un criminal entonces uno se siente emocionalmente mal como que uno es criminal. Aun sin que te pare la policia si estas tomando borracho tambien es lo mismo aunque no te paren.

The announcements make you think that maybe I could have done something bad when I was drunk without remembering it. And when they say that if you drink and drive you are a criminal then one feels bad emotionally like if you are a criminal. Even if the police didn’t stop you when you were drunk it feels the same as if they had stopped you.

These contradictory messages were confusing to many of our participants. Which was it? Was alcohol the key to interpersonal success or was it the keys to the county jail? Lacking information and understanding about the strict enforcement of these laws, some of the participants resolved their confusion by continuing to engage in the same drinking behaviors in which they had engaged back home.
Little shame in open inebriation. Whereas in their native countries the participants’ drinking was contained by their adherence to cultural values such as respeto and familismo (e.g., shameful to be drunk in public or in front of family), in their new surroundings they perceived a more liberal and carefree atmosphere. Many of them sensed a more permissive attitude toward drinking alcohol in the Anglo-American culture. Additionally, this large city environment in which they had few to no acquaintances or family members, seemed to help them be less concerned about the judgment of others when drinking.

Es que la cultura de aqui es diferente de la de nosotros. La cuhira de aqui es mas liberal...los padres no les pueden decir nada a los hijos porque si lo hacen que ya se pone agresivo...ya vienen controversias...y en Mexico, o en la cultura de nosotros, no, porque uno le tenia mas respeto (a los padres)...le tenia mas respeto, le tiene miedo...porque si me ve tomado me va a pegar. si me ve que estoy fumando tambien me va a pegar o me van a reganar. o tiene uno miedo que lo vean a uno...uno respeta mas a la familia...Y aqui yo veo como que no respetan...al contrario mas lo hacen...

The culture here is different than our culture. The culture here is more liberal...parents can’t say anything to their children because if they do then they (the children) get aggressive...and they become confrontational...and in Mexico, or in our culture, you don’t do that, because you have more respect for your parents...I had respect for them...I was afraid of them...because if they saw me drinking they would hit me, or if they saw me smoking they would also hit me, or one is afraid that others see you...one respects family more...And here I see that there is a lack of respect...on the contrary they do it more...

Not exclusively used in social or familial context. The participants’ accounts of alcohol use within the context of Anglo-American culture suggested that they perceived alcohol drinking to play a lesser role in the process of familial and social bonding. In contrast to the beliefs that they held in their native countries, drinking alcohol alone and/or outside of the social context did not appear to be viewed as problematic in Anglo-American culture.
...en los países Latinos, casi...la mayoría de las personas que toman se agrupan...La cultura Americana es más regada que la cultura Hispánica...(es diferente) en relacionarse con las amistades, en los bailes, es diferente.

...In Latin countries, almost...the majority of the people who drink are in groups...in the American culture (their drinking) is more spread out than in the Hispanic culture...(it’s different) in their way of relating to their friends, in the dances, it’s different.

This introduced a new concept of drinking to our participants – solo drinking. Suddenly alcohol lost its social adhesive function and was considered for the first time as potentially a solitary activity.

*Gender non-differentiated.* Another area in which their early representations of alcohol use clashed with the representations they perceived in their new environment was the social acceptance of alcohol drinking among women. They perceived women in the US to be more educated and active in the workplace, which, in their minds, partly explained the equality in their right to drink.

*Aqui lo veo diferente en que ...la mujer aquí toma igual que uno...y lo que dicen pues es que trabaja igual, gana igual o mejor...esta más liberalista...*

*Here I see it different in that...women here drink equally like one does...and what they say is that they work equally, they earn money equally or better...they are more liberal...*

The lack of gender-differentiation in drinking customs in their new environment served to divorce alcohol from its function as a marker of manliness. In some ways this could be argued to have had the effect of making alcohol use seem less serious. Within a machismo framework, the ability of women to drink de-emphasized the potency of the substance.

*Abuse as a function of addiction/illness.* Despite the confusion about alcohol use that emanated from the mixed messages they perceived in the media, participants’
awareness and knowledge about the potential negative effects of alcohol abuse and its causes had increased since their arrival in this country. Accordingly, they acknowledged having learned about the biological and hereditary factors that likely contribute to alcohol abuse and dependence. For many of them, this represented a shift in their views about the causes of alcohol abuse, from it being a mental vice to it being an addiction/physical illness as viewed in the Anglo-American culture.

_Yo pienso que es una enfermedad porque cuando uno es alcoholico si no esta tomando empieza a sentir la desperacion y ansias..._

_I think it is an illness because when one is an alcoholic if one is not drinking then one starts to feel desperate and anxious..._

This constituted a major paradigm shift from alcohol as a minor substance that made you a little happy to a serious illness. Not all of them had completely bought into this view but all had become aware of it.

_Abuse recognized as a major, chronic problem_. Participants’ perceived that, in the Anglo-American culture, alcohol abuse is seen as a problem that brings about severe consequences and is associated with serious medical conditions. Their awareness and knowledge about the severity of the problem of alcohol abuse seemed to increase with their experience of these serious, negative consequences.

..._falta de informacion...yo creo que yo no supe hasta que llegue acá...si sabia que era malo, pero no sabia que era asi de serio o lo que ocacionaba...Es por falta de educacion. Nosotros no estamos educados a lo que te va a pasar si pisteas...eso es falta de educacion...en nuestro pais nadie nos dijo hey la cerveza es mala...o te va a pasar algo...es falta de informacion y educacion._

..._information is lacking...I think that I never knew until I got here...I knew that it was bad, but I did not know that it was this serious or the problems that it causes...It’s due to lack of education...in our countries nobody tells us that beer is bad...or that something is going to happen to you...it’s the lack of information and education._
Barriers to Abuse

Whereas there were several elements in the participants’ cultures of origin that served as risk-minimizing, protective factors, similarly acting elements were rare in their new environment. Upon arrival to the US, participants’ drinking was contained initially by their limited knowledge about how to get by in their new environment. For instance, they reported not knowing many people, having little familiarity with the big city environment, and having to travel longer distances to purchase alcohol. These barriers disappeared quickly and the risk was further compounded by the perceived lack of protective factors. There was no family to respond to, economic hardship had lessened thus making alcohol purchases more feasible, drinking alone was acceptable, and availability and accessibility were high. Prior to their arrests, our participants had lost the barriers to alcohol abuse that had been organic to their cultures of origin.

Consequences of Abuse

Participants reported that the drinking behaviors in which they had engaged in their native countries with little to no consequences had, to their surprise, resulted in severe consequences in the US. Without the preceding protective factors, the law had been their final and sometimes only barrier. With their new economic upturn, they had increased access to alcohol and motor vehicles, but they had limited knowledge about the strict laws on alcohol use. Thus, the men in this study experienced severe consequences, including arrests for driving under the influence of alcohol and loss of driving privileges, sometimes resulting in employment loss.

Yo me emborrache varias veces alla en Mexico y no era borracho yo y aqui si...aqui que menos me emborrachado...estoy mas fichado aqui por borracho por los DUI por una descuidada que me di con una cerveza en el carro. Y aqui si se me hizo problema por andar en el carro
I got drunk various times in Mexico but I was not a drunk there and here I am...here where I don’t even get drunk...I have a record here for being a drunk for the DUI for one time that I wasn’t careful and I drove with a beer in the car. Here it became a problem to drive a car.

They also faced more severe consequences regarding their job security due to drinking at work and/or missing work due to drinking alcohol. In turn, jeopardizing their source of income also had potential negative consequences in their ability to provide for their families back home. Some of them were even concerned about deportation.

**Treatment**

Participants’ experiences with treatment in their new environment largely transpired as part of the legal consequences they faced for abusing alcohol while driving. They learned that alcohol abuse was not only criminalized, but also seen as a serious condition that warrants treatment. Most of them viewed their mandated treatment in a positive light and as a turning point for their harmful behavior.

_Pues aquí se pone más estricto en la forma de para que uno entienda y le dan más capacitación. Allá nomas pagas o te encierran pero aquí les importa más que agarres terapia y pues es mejor aquí._

_Well here it’s stricter in the way that they make you understand and they give you more knowledge. Back home you pay or they lock you up but here they care for you to get therapy and it’s better here._

This concept of treatment for alcohol abuse was novel to most of them, but there was a surprising level of acceptance of the concept of treatment. We witnessed very little resistance to the interventions they were engaged in and to our investigation of their alcohol problems.
Immigration Stressors

In addition to the cultural clash participants experienced in regards to their representations of alcohol use and abuse, numerous stressors associated with their experiences as immigrants further complicated the situation and most likely added to the participants’ increased risk for alcohol abuse.

Lack of Social Support

Most participants reported leaving their families behind when they emigrated from their countries of origin. Thus, the strong social support on which they counted in their native countries was lost. Furthermore, many of them were unable to return for regular home visits because of economic hardship. Several of them expressed deep sadness about not having seen their children or spouses for years, in some cases. For members of a culture in which familismo is a core value, this disconnect from their families was particularly distressing.

...cuando yo me vine de je ...tengo un nino de 17 anos que es nacido alla. Cuando yo me vine tenia dos meses de nacido. Entonces todas esas cosas van afectando... y me sentia mal. Me acostaba a dormir bueno y sano y me ponia a llorar. Y me daba una nostalgia. Yo sonaba que me regresaba, que iba de regreso a mi rancho. Y asi los primeros tres, cuatro meses. Entonces empeze a tomar y a tomar.

...when I came here I left...I have a 17-year-old child who was born there. When I left he was 2 months old. Those things affect you...and I felt bad. I would fall asleep fine and I would start crying. I was homesick. I used to dream that I would return to my ranch. And that’s how it was for the first three, four months. Then I started to drink and drink.

With the loss of their primary social support, they sought to establish new connections with other individuals who shared their cultural roots. They often turned for support and company to co-workers, who became their primary, and in most cases, only source of support. Their reliance on this single source of support frequently turned
problematic, as co-workers often abused alcohol both in and outside of the workplace. Thus, some of the participants expressed feeling obligated to drink in order to maintain their social interaction.

...lo que pasa es que yo trabajaba con una compañía con mucha gente y hacían fiesta cada ocho días...y allí empecé y como yo no tenía otro trabajo y tenía que trabajar allí y allí tomaban mucho...y los que no tomaban se iban...y como mi trabajo me quedaba lejos donde yo vivía me quedaba allí...hay veces que no quería tomar yo...yo me apartaba...en veces como que me sentía muy solo...y decía pues allí están ellos de fiesta y yo aquí estoy aburrido...y al ultimo me iba para allá y como no quería tomar decía me voy a tomar solo una para no aburrirme...

...what happened is that I used to work in a company where there were a lot of people and they used to have parties every week...and that's when I started (drinking) and since I did not have any other job and I had to work there and there was a lot of drinking there...the ones who did not want to drink used to leave...and since my job was far from where I used to live I would stay there...sometimes I did not want to drink...so I would isolate...sometimes I would feel very lonely...and I would think that since they are there in the party and I'm here bored...in the end I would go and since I didn't want to drink I would say I will drink only one to avoid being bored...

Some participants found alcohol drinking facilitated their social connection and ability to relate to others. As newcomers to this environment, social anxiety was far more rampant than it had been at home where they knew everybody. Here, many get-togethers involved meeting strangers and thus the opportunities for squelching this social anxiety with alcohol were far more numerous than they had been back home.

...se va a una fiesta y empieza a tomar y le salen 4 o 5 amigos que no conocían...Va uno a la tienda como a comprar cerveza y allí se encuentra pues a los paisas y se saludan y pues ya una cerveza y allí se van con uno...así me ha tocado a mí ver eso...le dicen vengase pues a la casa a tomar.

...when you go to a party and you start drinking then you have 4 or 5 friends who you did not know before...you go to a store to buy beer and you find there comrades and you greet each other and to drink the beer they end up going with you...I've seen that happen...they say come over to our house to drink.

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
Emotional Distress

It was common among the participants to report that they had turned to alcohol to cope with emotional problems associated with their emigration. The majority of them experienced loneliness and melancholy, and expressed immense longing to see their families and friends back home. These feelings were especially pronounced among participants who reported that they emigrated in search of better job opportunities to earn money and send it back home to support their families. They felt a responsibility to stay in the US to continue working and support their families from afar. Many of the participants, who did not know when or if they would return to their native countries, lost their spouses in the long-term as well as their connection to their children.

*Yo si en Mexico tuve una separacion al venirme para acá para estados unidos, hace doce anos...y esa separacion causo que me pusiera a tomar como por tres meses...tomando diario. No me banaba, no me rasuraba, no me cambiaba.*

*In Mexico I had a separation (from significant other) to come here to the US, 12 years ago, and that separation caused me to drink for three months...drinking daily. I did not want to shower, or shave, or change clothes.*

Another major source of emotional distress for the participants was the process of learning to function in a new and very different environment. Moving from a small town to a large city, difficulty communicating due to language differences, lack of social support, and the urgent responsibility to promptly secure employment to provide for families back home, all contributed to the participants’ reported high degree of anxiety and stress. Many of them reported feeling a sense of isolation and lack of belonging in their new environment. For many participants, drinking alcohol was a way to pass the time that helped them forget their problems, relieve emotional distress, and retain a
connection to their cultural roots and traditions. For instance, one of the participants who was living with his sister and his brother-in-law reported that:

_Cuando mi hermana y mi cuñado...se iban a trabajar y me quedaba yo solito encerrado... me compraban un seis o un doce de cervezas para que no me estuviera aburrido._

_When my sister and my brother-in-law...would leave to go to work and I would stay home alone, locked up... they would buy me a six or a twelve-pack of beers so that I wouldn’t be bored._

**Societal Marginalization**

A salient theme in the participants’ narratives was the stress associated with being an immigrant in the US. Some of them reported experiencing discrimination associated with both their Hispanic/Latino origin and their status as immigrants. Most of the participants reported uncertainty about their rights in the US, but viewed them as being limited due to their immigrant status. Even when they knew their rights, some participants found it difficult to exercise them due to their lacking of proficiency in the English language.

...supongamos...que yo voy tomado y no hablo inglés...y me toca un policía Americano...luego, luego me va hacer mas cargos...pero si fuera una persona Americana le puede explicar y se puede defender mas que uno...a uno no le hacen caso...

...let’s suppose...that I am drinking and I don’t speak English...and if the police that stops me is American...he will quickly press charges...but if he stopped an American person then that person could explain what happened and can defend him/herself more than one can...they don’t pay attention to us.

Adding to their immigration-related stress was the participants’ concerns that others view Hispanics/Latinos in the US as drunkards. This collection of alienating experiences and concerns made our participants feel marginalized and many of them felt like strangers in their current home, the host culture. This imbued them with a feeling of
insecurity and fear that at any time they could be sent home, lose jobs, or have their rights trampled on, whatever these rights were.

**Occupational/Economic Stress**

Participants reported several economic factors that caused significant immigration-related stress for them. For instance, many of them reported that their primary reason for emigrating was to improve financial conditions for their families back home. Thus, they felt tremendous pressure to fulfill these financial responsibilities, but they had limited occupational, educational, and language skills, which limited their employment opportunities. Consequently, they typically worked jobs that involved long hours of hard manual labor. Furthermore, they sometimes experienced exploitation from employers who were aware of their immigrant status and their need for work. A large group of the participants engaged in alcohol drinking to relieve this stress.

...*muchas veces trabajamos en lugares donde esta pesado el trabajo...cuando se siente cansado, como tiene que terminar el trabajo, dice...no pues sabes que vamos a beber unas cervezas y ahorita le seguimos...yo por mi...yo si he necesitado tomarme unas cervezas para controlarme un poco y seguir trabajando. De lo contrario no termina.*

...*many times we work in places where the job is hard...and when you feel tired, since you have to finish the job, one says...let’s drink a few beers and then we continue...I have needed to drink beer to control myself and keep working. Otherwise I wouldn’t finish the job.*
CHAPTER V

DISCUSSION

The aim of this study was to apply the Common Sense Representations of Illness framework (CSM) in an examination of meanings of alcohol-related disorders within the Hispanic/Latino cultural perspective. Our hope was that this exploration would lead us to identify beliefs and values that Hispanics/Latinos associate with this disorder, which, in turn, might contribute to guiding the development of culturally sensitive prevention and treatment initiatives. Accordingly, the findings of this study are discussed in the following section first within the context of CSM. Second, the findings are discussed within the Hispanic/Latino cultural framework, including beliefs, values, and immigration stressors. The latter is included because our participants highlighted that these stressors played a central role in their use of alcohol. Next, the findings' implications for prevention and treatment are discussed. Lastly, we offer caveats regarding the limitations of this study and suggestions for future research.

Cognitive Representations of Alcohol Use

Within the Context of CSM

CSM proposes that individuals develop theories about their illnesses, and that these theories have a significant impact on their health-related behaviors (Lau & Hartman, 1983). In applying this model to our investigation, we found that
Hispanic/Latino immigrants had two separate, and often competing, sets of cognitive schemas about alcohol-related disorders. One schema was rooted in the participants' culture of origin, and the other one was shaped by their perceived views about the substance in their host culture. These clashing cognitive representations, in concert with significant stress associated with their immigration experiences, quite probably increased their risk for alcohol abuse. In the absence of past research on the meaning of alcohol-related disorders, it is difficult to know the extent to which these findings are unique to Hispanic/Latino immigrants. Research on other medical conditions suggests that theories of illnesses vary across individuals as a function of the stage of the illness in which they are interviewed (e.g., recently diagnosed individuals versus individuals who have been in treatment for a period of time [Meyer et al., 1985]), but generally they are represented within a single cognitive schema. In the case of our participants, the two sets of cognitive representations that emerged were held concurrently, despite their high degree of divergence. This duality in their cognitive representations appeared to be the result of their experiences navigating through two different cultural worldviews. Their dual cognitive schemas had significant impact on their health-related behaviors, which can be further understood in the context of CSM's five dimensions (i.e., identity, consequences, timeline, cause, and cure/control).

Identity

The first dimension of CSM, identity, refers to the recognition and labeling of symptoms, as well as individuals' beliefs about whether those symptoms correspond to an illness or a condition that requires attention (Lau, 1997). The participants in this study recognized some short-term physical symptoms that resulted typically after heavy alcohol
drinking episodes (e.g., nausea, headaches), but they generally did not view them as indicative of an illness or a condition that required medical attention. This was partly because they associated physical illnesses with physical symptoms, and alcohol use did not appear to them to manifest according to these criteria. A similar dynamic has been evidenced in the cognitive representations of other conditions largely perceived to be asymptomatic, such as hypertension (Meyer, et al., 1985). Given that the serious, negative effects of alcohol are usually cumulative and not seen immediately, absence of physical discomfort for our participants meant they were free from disease. Moreover, they believed that symptoms of serious illnesses should last longer than the one to two days that their symptoms lasted. Thus, they were not vigilant of negative bodily sensations experienced as a result of drinking.

Their lack of attentiveness to physical symptoms is not surprising given that in their early cognitive representations, the consumption of alcohol was perceived as relatively harmless and an integral part of normal life and social interaction. Therefore, they had no reason to consider their physical symptoms in the context of an illness. It is important to consider, however, that the participants in this study were recruited at an early stage in their treatment. It is not uncommon for individuals who have recently become aware that they have a disease, or who have little exposure to treatment, to have poor recognition of their symptoms in association with their illness (Meyer, et al., 1985). This lack of recognition is, however, a different concept from denial, which refers to the unwillingness to admit that alcohol use is problematic (Ward & Rothaus, 1991).

After a period of sobriety, the participants retrospectively associated several symptoms they had experienced in the past with their alcohol abuse. It was only after
they had stopped drinking that they were able to recognize these symptoms as potentially signaling a serious health problem. Some of these included chronic lack of energy and clarity of thought, as well as depressed mood. Although they somewhat increased their awareness about alcohol abuse-related symptoms upon their arrival to the US, the mixed messages about alcohol use that abounded in their host culture representations did not significantly facilitate their ability to link these symptoms to the presence of an illness. It was highly concerning that the participants had little to no recognition of their symptoms, and that the few symptoms they recognized were not associated with their alcohol abuse. For instance, they perceived no need to stop drinking or seek treatment. Furthermore, they engaged in problem solving approaches that did not directly address the core of their problem (e.g., using herbal teas to ameliorate physical symptoms, selling their vehicles to avoid getting in trouble for driving while intoxicated).

**Consequences**

In CSM, the dimension of consequences refers to individuals’ perceptions about the severity of their condition and its impact on various areas of functioning (Lau & Hartman, 1983). The participants’ early representations about the consequences of their drinking were not sufficiently negative for them to perceive alcohol use as problematic. Thus, they did not perceive their drinking as having a negative impact on their functioning in any area or in any major fashion. In turn, this view did not promote changes in their health-related behaviors (e.g., help-seeking).

Their perceptions about the consequences of alcohol abuse changed after they arrived to the US, and they viewed them as much more severe than they had in their countries. Unfortunately, they had this realization late, only after they had already
experienced the consequences (e.g., arrested for DUI). Subsequent to this experience, they were able to recognize the negative impact of alcohol abuse on various dimensions of their life, including long- and short-term consequences (e.g., loss of job, loss of freedom, potential deportation, getting criminal record), psychological (e.g., low self-esteem, depression), physical (e.g., potential to develop cirrhosis of the liver), and financial (e.g., fines, treatment fees). These different perceptions about their consequences had the effect of increasing some participants’ motivation to stop drinking. Most, however, admitted to being in treatment because it was legally mandated. Most did not think they would continue with treatment once it was no longer required. They seemed reluctant to stop drinking partly due to their inability to link alcohol with the negative consequence they received. Instead, some believed their problems were due to the combination of drinking and driving. For these individuals, their perceptions about the consequences meant that they should simply stop driving while intoxicated. This was especially the case for participants who estimated the consequences of not drinking, such as loss of social support and bonding, as even more severe.

Furthermore, for a large number of participants drinking alcohol was a way of coping with numerous immigration-related stressors. Without having an alternative method of coping, it seemed extremely difficult to stop despite the severe consequences. Accordingly, several participants expressed a desire to learn to navigate the system better instead. Some of them wanted to apply some of the strategies they had observed among their counterparts in the host culture, whom they perceived to be more experienced in the system (e.g., using taxi services when inebriated). Others wanted to revert back to some of the barriers that kept them out of trouble in their countries (e.g., not owning a vehicle.
letting others drive, staying close to home). Overall, the changes in their perceptions about their consequences and their impact from mild to severe did not seem to impact their health-related behaviors. In other words, the growing realization of severe consequences motivated them to accommodate to the new rules but not necessarily to stop drinking.

Time Line

This dimension of CSM refers to the cognitive representations about the duration of an illness, as well as its symptoms and treatment. As aforementioned, our participants believed that the duration of symptoms for a serious illness should be longer than one to two days. Thus, their general perceptions about the time line of illnesses obstructed their recognition of alcohol abuse as an illness and the need for treatment. Even among the few who recognized it as an illness, there was a high degree of ambiguity about whether this was an acute or chronic condition. It was difficult for them to transition from their life-long view of alcohol abuse as more or less normal to viewing it as an illness. Other participants viewed this condition as lasting a lifetime, which in turn contributed to a greater degree of acceptance that they would never be able to drink alcohol again. Many disagreed with the chronic view and were convinced that their current problems with alcohol were temporary. They openly expressed hoping they would be able to drink again once they learned how to navigate their new environment. Clearly, the latter group of participants would not be good candidates for treatments in which complete abstinence is the goal, but they might be most receptive to harm reduction approaches.

There was also a high degree of uncertainty about how long their treatment should last, but their perceptions generally ranged from three months to one year. with a few
participants indicating treatment should be ongoing. It makes intuitive sense that
perceiving treatment as effective should increase motivation to stay in treatment. This
was not, however, the case with our participants. They expressed a high degree of
satisfaction with, and liking for, their current treatment. They also held positive outlooks
about their treatment outcomes. Yet, most of them admitted their continued attendance
was due specifically to law requirements. The majority of them did not perceive a need
for aftercare services, despite their concerns for relapse. Conceivably, they may have
been turned off to the concept of attending treatment because their treatment was
mandated, which brought shame to their self-concepts for having committed a crime.
Having associated treatment with criminalization, they might attempt to separate
themselves from that experience to minimize the stigma. Overall, their perceptions about
time line had little impact on their help-seeking behaviors.

Causal Attributions

CSM proposes that individuals form representations about what causes their
illnesses, how their illnesses develop, and the factors that contribute to their maintenance
(Lau, 1997). Although research on causal attributions of alcohol abuse has been
conducted (e.g., Furnham & Lowick, 1984), it is difficult to examine our findings in light
of past research because of the differences in methodologies that have been applied (i.e.,
questionnaires versus qualitative data), the mixed findings that have emerged (i.e.,
inconsistent endorsement of medical model, moralistic view, psychological causes), and
the different populations in which research has been conducted (clinical, non-clinical,
focused on Caucasians).
Contrary to the high variability in beliefs about the causes of alcohol use that has emerged in past research, our participants’ early representations on the subject revealed a very consistent explanation for alcohol abuse that centered on personal and interpersonal problems. Although their causal attributions shifted somewhat to incorporate their host culture set of representations (e.g., increased awareness about medical model), their behaviors were highly influenced by their earlier cognitive schemas. Thus, when they experienced personal and interpersonal problems, they used alcohol as a coping mechanism. The course and development of their condition also differed drastically from the progression that has been documented in some studies with the general population. Jellinek’s (1991) seminal study analyzing over 2,000 histories of alcohol-dependent males, for example, suggested that onset of drinking commonly occurs within the context of social interactions. He proposed, however, that social isolation becomes progressively a central characteristic in the developmental course of alcohol-related disorders. Increased tolerance leads to increased consumption of alcohol, which after several years of use results in inability to control the drinking, as well as other behaviors (e.g., driving inebriated). In turn, Jellinek (1991) suggested, the individual becomes chronically dependent on alcohol and drinks nonstop throughout the day. In contrast, drinking alcohol never lost its social context and function for most of our participants, even after tolerance had increased to worrisome levels. Interestingly, our participants viewed drinking alone, like in Jellinek’s (1991) model, as signaling problematic drinking. Furthermore, the progression of their drinking did not escalate as Jellinek (1991) described while the participants were in their native countries. But once they arrived to the US, they quickly skipped to Jellinek’s (1991) stage in which they lost control of their
drinking. Our participants’ drinking patterns, nevertheless, remained, as they were initially, as weekly episodes of binge drinking in social settings (as opposed to daily solitary drinking). This pattern of drinking may have been largely determined by economic factors. The pattern we witnessed appeared to be one of post-paycheck, weekend binge-drinking episodes followed by periods of abstinence until the next pay period when they would have access to additional funds.

Cure/Control

The cure/control component of CSM refers to individuals’ perceptions about the treatment for their condition, the options available to them for help, their ability to control their illness, and the actions they consider taking to ameliorate their symptoms (Lau & Hartman, 1983). Our participants did not initially view their alcohol drinking as requiring medical treatment. When they experienced physical symptoms in consequence to intoxication, they resorted to herbal remedies or to drinking alcohol again the following day for relief. Their culture-of-origin-grounded cognitive representations for cure and control were supported and reinforced by their past experience of only minimal consequences and by the lack of organized treatment in their native countries. Accordingly, they perceived their drinking behavior to be controllable, requiring only will power to stop. The severe consequences they experienced once in the host culture, however, altered these views, but did not seem to have an impact on their health-related behaviors. As aforementioned, some of their problem-solving strategies included selling their vehicles to avoid driving while intoxicated, letting others drive, and staying away from drinking buddies. While these actions may have the effect of minimizing their external negative consequences, they illustrate the participants’ reluctance to view the
drinking of alcohol itself as the problem. Moreover, the few incidents in which they made attempts to stop drinking were hindered by the widespread peer pressure to drink. Furthermore, given the often intense loneliness associated with their immigrant status, these men found it difficult to detach from their drinking friends.

Of particular concern regarding the participants’ views about treatment was their newly formed association between treatment and criminalization. They came to the US with nearly no past experience with organized treatment for alcohol abuse, and their first experience was mandated treatment as a consequence of committing a crime. Conceivably, this experience may have set a negative precedent in the participants’ mind about being in treatment. The criminalizing alcohol abuse may have paradoxically resulted in the “criminalization” of treatment. This might in part explain our participants’ reluctance with continuing treatment once their required number of sessions was met. Unfortunately, it might also engender resistance to seek treatment in the future. On the other hand, participants reported generally positive experiences while in treatment. One of the greatest benefits reported was that group session settings allowed them to meet their needs for social bonding without the use of alcohol.

In sum, our results supported the findings in CSM research that people form cognitive representations of their illnesses, and that these schemas have an impact on their health-related behaviors (Lau & Hartman, 1983). For our participants, these representations were more complex, however, as they were rooted in two distinct belief systems that were often in conflict with each other. Their early cognitive representations, rooted in their cultural traditions, were essentially unambiguous and steadfast and seemed to have the most influence on guiding their health-related behaviors. Their most recently
acquired set of cognitive representations, based on their host culture, was perceived as confusing and largely incongruent with their early beliefs. Consequently, it was less influential on their health-related behaviors, which placed them at higher risk for alcohol abuse. To complicate matters further, alcohol use also played a significant role as a coping mechanism for the considerable stress they experienced in association with their status as immigrants. The dynamic of these three elements in their cognitive representations seemed to interfere with their perceived needs for treatment. This increased risk for alcohol abuse is particularly alarming given that Hispanic/Latino males in the US, including immigrants, have the highest death rates related to cirrhosis of the liver (Mann, et al., 2003), the highest number of arrests for DUls (Caetano & Clark, 1998), and, when involved in fatal motor accidents, evidence the highest levels of blood alcohol concentrations (Braver, 2003), as compared to males of other ethnicities.

The Role of Cultural Beliefs and Values in the Development and Maintenance of Alcohol-Related Disorders

Consistent with the Surgeon General’s conclusions (DHHS, 2001), we found that cultural background seemed to influence the participants’ representations of alcohol use, which, in turn, had an effect on their coping strategies and their help-seeking behaviors. The following cultural beliefs and values seemed to play a particularly significant role in the participants’ theories about alcohol abuse, as well as the development and maintenance of the disorder: *Familismo*, *Machismo*, and *Simpatía*. Additionally, *Conviviencia*, a value not mentioned in prior research, emerged. *Conviviencia* referred to
the strong need among our participants to form and maintain social bonds, as well as interact in social settings within and outside of the family context. Furthermore, we found that, despite the variance in the length of residency in the US among the participants, they retained close ties to their cultural roots. Thus, as has been reported in the literature (Pew Hispanic Center, 2004), degree of exposure to their host culture, or level of acculturation, did not seem to lead to significant changes in their cultural values and beliefs to adopt the host culture values. This tendency had both positive and negative effects in their development of alcohol abuse.

On one hand, they perceived attitudes about alcohol use in the host culture to be more liberal and permissive, which might lead to increases in their alcohol consumption. Indeed, Vega and colleagues (2003) found that as Mexican immigrants in their sample acculturated to the host culture they continued their heavy consumption of alcohol and, in addition, their frequency of drinking increasingly mirrored the host culture pattern. Thus, our participants' retention of their cultural values and beliefs in this case may have the effect of deterring the increase of their frequency of drinking. On the other hand, holding on to their early cognitive representations of alcohol use made it more challenging to recognize the negative aspects of its use and seek help.

**Familismo**

The strong ties to immediate and extended family members that has been found among Hispanics/Latinos (Coma-Diaz, 1990) was evidently reflected in our participants' narratives. This strong connection acted as both a risk and a protective factor for alcohol abuse in various aspects and significantly influenced their cognitive representations. One way in which Familismo was a risk factor was the participants' exposure at an early age...
to widespread use of alcohol among their parental and role model figures. Growing up in an environment in which alcohol use was perceived as harmless seemed to contribute to their difficulty recognizing alcohol-related symptoms in association with an illness. As Gloria and Peregoy (1996) found in their research, this value also increased their risk for alcohol abuse because of the tendency within the Hispanic/Latino family system to introduce the participants to alcohol drinking. Whereas in their native countries participants’ reliance on their families for social support minimized their risk for alcohol abuse, separating from them during emigration placed them at higher risk for this condition. This was particularly detrimental for the participants because most of them emigrated alone, and even when they found some form of support in their host culture, it was not comparable to the support they were accustomed to receiving from their families.

Another significant area in which *Familismo* contributed to the development and maintenance of alcohol abuse was the emotional distress that being separated from their families caused for the participants after they emigrated. The loneliness and homesickness they experienced highly contributed to the exacerbation of their drinking.

Close ties to their families minimized their excessive use of alcohol while in their native countries, as relatives in small geographic proximity kept their drinking in check. If alcohol drinking became severe and problematic, it was the family’s responsibility to link participants to treatment. Indeed, the role of family support and involvement in treatment has been associated with increased adherence to treatment (Antshel, 2002). Once the participants emigrated, however, they lost these protective factors associated with *Familismo*. It may not be feasible for clinicians to involve family members of
Hispanic/Latino immigrants who most likely tend to leave their families behind, but it may be helpful to invoke the family back home in motivational strategies.

**Machismo**

Past research on whether Hispanic/Latino men associate masculinity with drinking to a greater extent than men of other ethnicities has yielded mixed findings (Caetano, et al., 1998; Gloria & Peregoy, 1996). Our findings were consistent with research suggesting that traditional Hispanic/Latino men who abuse alcohol perceived their ability to drink heavily as a direct measure of their masculinity (Fernandez-Pol, et al., 1985; Gloria & Peregoy, 1996). Indeed, most of our participants adhered firmly to gender scripts prescribed in their culture. Consequently, the highly esteemed value of *Machismo* seemed to present a significant risk factor in their alcohol abuse. Drinking heavily was consistent with their internalized self-concept of being a man. Moreover, they faced tremendous peer-pressure and ridicule when they made attempts to decrease or stop drinking alcohol.

Embedded in the value of *Machismo* was a sense of responsibility among the participants to provide financially for their families. In accordance with this cultural gender script, the majority of them had discontinued their education in their native countries early on and begun working to help support the family. Alcohol drinking was often seen as a reward for their hard work. When they emigrated, they brought this value with them. Hence, they worked long hours in hard labor jobs, with little room for recreational activities other than drinking alcohol, which further increased their risk for alcohol abuse.
Also because *Machismo* prescribes that men should be self-reliant, admitting to having a problem with alcohol seemed to be particularly difficult for many participants. This attitude may have the negative consequence of limiting self-referral to treatment and reluctance to disclose to family members that they need help. Whereas for treatment with other Hispanic/Latino populations (e.g., adolescents) family involvement has been effective (Szapocznik, et al., 1983), for traditional males this practice may be counter to their cultural values.

**Simpatia**

Our findings supported that *Simpatia* was a salient and esteemed value in Hispanic/Latino culture (Griffith, et al., 1998). Until now, hypotheses about the effects of *Simpatia* on health-related behaviors have been theoretical, with no empirical investigations conducted thus far. The results of this study suggest that adherence to *Simpatia* functioned largely as a risk factor that facilitated alcohol drinking and obstructed the participants’ efforts to stop this behavior. For instance, when participants were in the company of others who were drinking alcohol, they found it difficult to not join in the drinking or to leave, as doing so would likely be considered rude or impolite. Similarly, declining offers to drink could be perceived as unappreciative. Particularly given that the majority of the participants were from backgrounds where resources were limited, being offered food or alcohol was perceived as a gesture of reverence, and declining the offer expressed disrespect to the host. Thus, most participants often felt obligated to comply so as to avoid being perceived as discordant with their cultural scripts for interpersonal relationships.
Relevant to treatment, it has been theorized that Hispanics/Latinos may be reluctant to express dissatisfaction with their health services, report negative side effects from medications, or admit to lack of improvement from treatment because of their high value of Simpatia (Antshel, 2002). In our study we did not assess the effectiveness of the participants’ treatment with objective measures. Our interviews and observations, however, provided useful insight into the effects of this value. Participants at all levels of treatment indicated high degree of satisfaction with their current treatment. When asked to list any areas of their treatment that would benefit from improvement, they were not able to identify any. It is highly likely that these responses were due to the fact that they were receiving treatment at clinics that catered to the needs of Hispanic/Latino clients. Accordingly, the clinics were staffed with bilingual front desk clerks and therapists, administrative forms were available in Spanish, and they offered a personable environment in which participants felt comfortable. It is conceivable, however, that the high value placed on Simpatia may have influenced the participants inability to list clinics’ shortcomings. This tendency may partly account for the high dropout rates after the first session of counseling (Schwarbaum, 2004) and the disproportionate rates of unmet needs for treatment (Wells, et al., 2001) that have been reported for Hispanics/Latinos. Influenced by their value of Simpatia, they may simply stop attending treatment to avoid being perceived as rude or impolite for expressing disagreements or dislikes.

**Conviviencia**

The participants’ strong need for, and high value placed on, social bonding was a salient component of their culture of origin. Embedded in this value was the tradition of
getting together for celebrations and commemoration of meaningful events. Significant life events, such as send-offs, as well as day-to-day events, such as acknowledging the end of a work-week, constituted reasons for celebration. *Conviviencia* was at the root of the onset of alcohol use for most of the participants, who first started drinking during social gatherings. Moreover, their early cognitive representations of alcohol use evidenced a strong association between the drinking of this substance and the act of celebrating (i.e., associated with positive feelings, happiness of sharing time with others). Drinking outside of social settings was often perceived as indicative of problematic drinking. In their native countries *Conviviencia* did not seem to increase the participants’ risk of alcohol abuse because most gatherings involved family members. Given the participants’ high degree of *respeto* for the family, they were less likely to drink excessively or with high frequency. After they emigrated, however, their social bonding typically occurred with other individuals who, like the participants, were away from home and had limited or no family support. Thus, drinking with this new circle of friends offered them a sense of belonging and the opportunity to meet their needs for *Conviviencia*. Consequently, this made it very difficult to detach from friends who drank alcohol when the participants attempted to stop drinking.

On the other hand, *Conviviencia* was an element of the participants’ current treatment that facilitated their continued engagement and adherence. Because their treatment was administered in a group format, they obtained a high degree of gratification from the social interaction with fellow clients. They seemed to benefit from a treatment environment in which they were able to share their experiences, as well as learn from others’ experiences, in a small group setting. The effectiveness of a group therapy
modality, like the one in which the participants received treatment (i.e., combination of psychoeducation and insight oriented therapy), has yet to be examined empirically among Hispanic/Latino immigrants, but it warrants investigation given that our findings diverged from past research with Hispanics/Latinos in general. Notwithstanding mixed findings, past research suggests that Hispanics/Latinos respond indiscriminately to all treatment conditions in outcome studies (e.g., Burge, et al., 1997), but they generally seem to prefer formal, structured, individual therapy formats (Arroyo, et al., 1998). Conceivably, the treatment needs of traditional Hispanic/Latino immigrants may differ from the needs of their second-generation counterparts, as they were very responsive to this more insight oriented and social bonding based treatment format.

To summarize, of the several cultural values and beliefs that have been proposed in the literature to likely be of relevance in the treatment of Hispanics/Latinos (e.g., Antshel, 2002; Marin, 1993), the values of Familismo, Machismo, and Simpatía emerged as central to the participants’ alcohol-related disorder. Additionally, Conviviencia, a value that had not yet surfaced in past research, was also found to play a significant role in this condition. As aforementioned, adherence to these values functioned as both risk and protective factors, as well as facilitated and impeded the participants’ perceived need for, and participation in, treatment. These cultural values and beliefs played a fundamental role in the participants’ cognitive representations of alcohol use and guided their health-related behaviors.
The Role of Immigration Stress in the Development and Maintenance of Alcohol-Related Disorders

Acculturative stress has been identified as an inherent part of the immigration experience as individuals come in contact with their host culture (Smart & Smart, 1995a). This form of stress is thought to result in part from the environmental, social, and cultural demands that immigrants encounter in the process of adapting to their new environment (Smart & Smart, 1995b). As Smart and Smart (1995a) highlighted, Hispanic/Latino immigrants appear to be affected more severely by acculturative stress than immigrants from other ethnicities because their resources to deal with these stressors often tend to be minimal (e.g., limited educational, occupational, and linguistic skills, limited financial resources). Our findings suggest that immigration factors were indeed an additional and significant source of stress for the participants in this study. Similar to the major contributors to acculturative stress that Smart and Smart (1995b) identified in their review of the literature, our participants experienced a deep sense of loss as a result of disconnecting from their families and lacking social support. Additionally, some of the participants experienced a pending threat of loss given their status as illegal immigrants.

Acculturative stress has been associated with the development and exacerbation of psychological distress, such as anxiety (Hovey & Magana, 2002), as well as detriments to physical health (Smart & Smart, 1995a). Although we did not assess our participants for the presence of psychological problems, it was apparent in their narratives that they experienced emotional distress in connection with their immigration circumstances. Their reported distress due to societal marginalization was also of concern given the findings in the literature that being the subject of discrimination has been associated with negative
effects on psychological and, in some cases, physical health (Finch, Hummer, Kolody, & Vega, 2001). Their limited occupational skills and financial resources were another significant source of immigration-related stress for the participants. Smart and Smart (1995a) have suggested that acculturative stress further limits Hispanics/Latinos opportunities for economic upward mobility. They propose that dealing with this type of stress exhausts the energy that would otherwise be spent on improving their occupational and educational conditions, thus perpetuating their experience of acculturative stress.

Overall, immigration-related stressors in many cases were a catalyst for the onset of alcohol abuse among some of our participants. In other cases, the experience of these stressors led to further increases in alcohol consumption. A large number of the participants used alcohol as a coping mechanism for emotional distress. Thus, immigration stressors constitute an important area to consider in the treatment of this population. Implications for treatment are presented in the following section, but some obvious implications specific to immigrants include the need to establish social support systems, address issues related to co-occurring disorders, stress management, and linkage to community organizations (e.g., immigrants’ rights organizations).

**Implications for Prevention and Treatment**

Several barriers to obtain treatment and a high degree of service underutilization have been identified in the literature across various mental health settings in association with Hispanic/Latino populations. Indeed, in comparison to other ethnic groups, Hispanics/Latinos have the lowest rates of perceived need for treatment (Lopez, 2003), the lowest past and current rates of participation in treatment, including aftercare.
programs (Arroyo, et al., 2003; Burdon, et al., 2004), and a nearly 50% dropout rate after attending just one counseling session (Schwarzbaum, 2004). Furthermore, they tend to endorse effectiveness for all treatment conditions in outcome studies, including control or placebo conditions (Burdon, et al., 2004). Yet, they continue to be twice as likely as their Caucasian counterparts to have unmet needs for treatment (Wells, et al., 2001). Moreover, they experience to a greater degree the severe consequences that result from alcohol abuse (Burdon, et al., 2004).

Little is known about barriers to treatment and utilization patterns among immigrants because they are a largely understudied segment of the population. But it makes intuitive sense, especially given their limited resources (Smart and Smart, 1995a), that they face similar, and likely worse, treatment-related barriers. In light of these challenges in treatment, it is clear that public agencies, researchers, and clinicians need to reassess the manner in which outreach, prevention, and treatment initiatives for this population are developed and delivered. In this section, we discuss the implications of our findings within the context of each of these three areas. Overall, our suggestions are specifically relevant to Hispanic/Latino, immigrant males and eclectically borrow from various theoretical models. Some of our suggestions already have empirical support in the literature, others are theoretically grounded, while yet others warrant empirical evaluation given the importance of incorporating cultural elements into treatment.

Public Health Outreach Initiatives

In developing alcohol-related outreach messages for Hispanic/Latino immigrants, it is not sufficient to present factual information about the negative effects of the substance. The consideration that Hispanic/Latino immigrants hold dual cognitive
schemas about alcohol use, as evidenced in this study, seems important to the crafting of preventive message that will make sense to this audience. Although our participants were not consciously aware of how their competing representations and unique stressors increased their risk for alcohol abuse, it was apparent that they experienced confusion and emotional distress in association with their conflicting views. Therefore, public campaigns should first focus on helping increase their understanding of the differences that exist between their cultures of origin and their host culture in regards to the meanings of alcohol use. Only then should these initiatives follow up with the dissemination of information about alcohol use.

Second, emphasis should be placed on addressing the barriers to treatment rooted in their dual cognitive schemas. For instance, their early representations obstructed their ability to recognize alcohol abuse as an illness. Their recognition of alcohol abuse as an illness was also hindered by their belief that physical illnesses manifest themselves only in immediately grave physical symptoms. The mixed messages they received about alcohol use in their host culture led to confusion and further impaired their ability to treat alcohol abuse as an illness. Therefore, public health efforts should concentrate on clarifying and rectifying the messages about alcohol abuse with factual information. In doing so, they should take into account Hispanic/Latino cultural values and beliefs and have them reflected in public campaign messages. As has been suggested in the literature (Zimmerman and Sodowsky, 1993), for example, the positive aspects of Machismo could be highlighted to increase motivation to act responsibly vis-à-vis one’s family and community by not drinking and driving. Similarly, campaigns illustrating how Conviviencia can take place with limited or no use of alcohol might help reduce the
strong association that exists in their cognitive schema between sharing a good time with friends and drinking alcohol.

Third, there is a considerable need to focus public health efforts on addressing stressors unique to immigrant populations, such as the losses in social support they endure when they emigrate. Establishing community resources that are easily accessible for members of this population and that fill their social void might be particularly germane.

One example of how these resources might contribute to establish support systems can be found in the notable efforts of some local Spanish-speaking radio stations. Having identified obesity and lack of information about healthy-eating as a critical problem in the Hispanic/Latino community, one radio station developed an informational segment for its audience as part of their regular programming. Because resistance to changes in eating habits among family members was identified as a barrier, the producers complemented the informational program with linkage to Madrinas (Godmothers). Accordingly, female long-term listeners who have greater experience with eating healthy and overcoming resistance to change in the family call in to the program to volunteer as mentors for new female listeners. In this manner, the radio program helps establish a source of support for women who might otherwise fail in their efforts to change their eating habits due to lack of support at home. Although these initiatives are likely not developed within research settings, and it is doubtful that they are evaluated in a systematic, empirical manner, they illustrate the manner in which important social support systems could be established. The overwhelming response to this form of outreach also attests to the apparent high degree of palatability for this form of outreach.
The suggestions included in this section represent a snapshot of the variety of ways in which public health could utilize our findings to reach this population in a more effective manner. Indisputably, public health efforts are extremely important given that, as discussed in the following section, the opportunities to intervene with this population at early stages seem to be very limited.

**Prevention**

Development and implementation of prevention strategies may be particularly challenging with Hispanic/Latino immigrants because of the limited opportunities to reach them. Indeed, our participants seemed to have limited interaction in environments outside their workplace and their small circle of friends. Furthermore, they had limited insight and knowledge about factors that might have helped them prevent their alcohol use from escalating to the point of facing legal consequences. Adding to the challenges in prevention is that the family system in their native country typically played an important role in creating awareness in the individual about their needs for medical care. Given their reluctance to view alcohol as an illness and their lack of family support in their host culture, they are not likely to seek preventive medical attention on their own. Thus, early detection of potential alcohol-related problems might be limited to doctors’ visits in which Hispanic/Latino immigrants seek medical services for conditions unrelated to alcohol. Medical staff could, thus, make alcohol abuse screening be a standard part of their intake questionnaires. Similarly, clinicians who treat this population for other psychological disorders should assess for alcohol-related disorders as well.
Treatment

The importance of cultural competence in the delivery of mental health services is now well established in the literature. We encourage the application of the various cultural competence guidelines suggested in the literature (e.g., clinicians’ consideration of their own biases, dynamic sizing, consideration of language needs and acculturation level [Arredondo & Toporek, 1996; Delgado, 1998; Sue, 1998]) for the treatment of Hispanic/Latino immigrants. Indeed, these practices have been associated with greater degree of satisfaction with treatment among ethnic minority clients (Constantine, 2002).

In accordance with cultural competence guidelines we caution that our treatment recommendations listed below may not be applicable to all immigrants or to all individuals of Hispanic/Latino cultures. They are, nevertheless, grounded in our participants’ experiences with alcohol use, whose interviews offered valuable insight into how cultural sensitivity can be infused into their treatment. We grouped these interventions in the following categories: pre-engagement, engagement, assessment, treatment, and aftercare.

**Pre-Engagement.** Some of the findings that emerged with relevance to this stage of treatment included the participants’ negligible history of interaction with mental health clinics. They lacked knowledge about basic clinic procedures such as how to reschedule appointments, what documents to bring to their initial session, and/or what to expect at their first session. Thus, it would seem important to forgo assumptions that these procedures are simple and basic to all service seekers. Similarly, support staff should consider the values of *Respeto* and *Simpatia* when interacting with Hispanic/Latino immigrants to avoid being perceived as rude or impolite, which might discourage the

---

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
clients from attending their first session. Similarly, it would be a good practice to ensure that these clients fully understand items presented on intake forms even if they are translated into Spanish. This is particularly important given that a large number of Hispanic/Latino immigrants come from low educational backgrounds and small villages, where speaking slang-Spanish is typical. Some of our participants, for example, reported that they had difficulty understanding some forms at their initial intake session. As predicted by the high value placed on Simpatia, they felt embarrassed to ask for clarification. Instead, they left out information that was potentially highly relevant to their initial assessment. Although the interviewer in this study was fully bilingual and bicultural, interview questions often had to be re-phrased to facilitate participants’ understanding of them (e.g., they often interpreted the word “culture” to mean “sophistication” in the high-class, worldly sense rather than in the ethnic, country of origin sense we intended.) Therefore, the pre-engagement process presents several opportunities to set a tone that conveys to Hispanic/Latino immigrants that they are welcomed, valued, and understood.

Engagement. Building rapport is clearly crucial in the process of establishing any therapeutic relationship. Its centrality, however, is even more accentuated when attempting to engage members of a culture that places an extremely high value on interpersonal relationships (e.g., values of Simpatia, Familismo, Personalismo, Respeto, Conviviencia). Thus, it is recommended that clinicians working with the Hispanic/Latino immigrant population devote considerable efforts to establishing rapport prior to inquiring about the reason that the client is seeking therapy. Therefore, information relevant to their background, their families, and their culture may be gathered during this
process, without placing emphasis at this time on the issue of alcohol use. Additionally, it may be appropriate for the clinician to attempt to establish a common ground with the client (e.g., sharing information about clinicians’ cultural background or general experiences in working with Hispanics/Latinos). Our participants expressed high degree of receptivity for clinicians who were able to balance between being warm and personal, and professional.

Next, given that immigrants are likely not familiar with organized treatment in their native countries, it is especially important to allocate time during the first session to provide psychoeducation and clarification about the treatment process. Assessing client perceptions and expectations about their treatment would also be important. For instance, the word counseling translates to Spanish as consejeria, which also means a place where advice is given. Thus, despite their lack of knowledge about treatment, many of our participants had the expectation that their treatment should involve receiving advice about how to stop drinking alcohol.

Incorporation of cultural values, such as Simpatia, in the engagement process should also include early discussions with clients about their perceived potential barriers to engaging in treatment. Clinicians should not, however, expect for Hispanics/Latinos to know if asked directly how Simpatia is likely to interfere with their treatment. Instead, clinicians may need to raise awareness in their clients about how some cultural scripts for conduct may interfere with their communication by avoiding the expression of negative feelings or opinions, as well as dislikes of treatment components. Hence, clinicians should encourage the client early on to express these feelings, and reassure them that doing so would not be considered as inappropriate in this setting. Clinicians should then
establish a protocol with the client for how she/he might communicate these feelings to the therapist, should they arise, in a manner that is comfortable for the client (e.g., treatment satisfaction survey at the end of each session, end-of-session check-up). Addressing this content in the first session would be ideal, given the high rate of dropout after the first counseling session that has been reported for Hispanics/Latinos (Schwarbaum, 2004). Additionally, clinicians should monitor the client’s degree of engagement at various points in their treatment.

Administrative staff and clinicians should engage in collaborative efforts to create a treatment atmosphere that reflects the values esteemed in Hispanic/Latino culture. For instance, our participants evidenced a high need for social interaction and commemoration of special events (i.e., Conviviencia). Therefore, incorporating opportunities to meet this need, such as through group therapy sessions or group recreational activities/club houses, seemed highly palatable for our participants. Not only did they report high degree of satisfaction with a group therapy format, but they also expressed feeling relaxed after sessions and enjoying learning from their peers. Furthermore, recognition of their accomplishments in therapy at various points seems congruent with their cultural scripts.

Assessment. In addition to assessing domains relevant to alcohol-related disorders, several other areas seemed important to consider in the assessment of Hispanic/Latino immigrants. First, many of our participants reported coming from low socioeconomic backgrounds. Given that some assessment instruments require a certain level of reading proficiency, clinicians should ensure that the test is appropriate for the client’s level of understanding. Second, substantial information should be obtained regarding the client’s
immigration experience. Screening for potential traumatic experiences and co-morbidity, as well as stressors that might increase the client’s risk for alcohol abuse, is highly relevant. Because of the important role that social support plays as a protective factor for alcohol abuse, clinicians should assess the forms of support available to the client. Linkage to organizations who advocate for immigrant rights should be available if applicable.

Third, the assessment needs to account for acculturation level. Length of residency in the US and/or language preference should not be considered indicative of degree of acculturation. As we found among our participants, some of them preferred to speak Spanish even though they could speak English. Although some of them had resided in the US for as long as 18 years, they continued to adhere primarily to traditional Hispanic/Latino cultural values.

Relevant to the assessment of alcohol-related disorders, we suggest that clinicians evaluate the degree to which their Hispanic/Latino immigrant clients are similar to our participants in the duality of their cognitive schemas about alcohol-abuse. Assessing the extent to which their cognitive representations are rooted in their culture of origin or their host culture is likely to help guide treatment.

*Treatment Interventions.* Psychoeducation should be a central element of treatment for Hispanic/Latino immigrants. As aforementioned in the engagement section, they are highly unfamiliar with the treatment process. Additionally, they hold clashing views about alcohol use because of their dual cognitive schemas, which might interfere with their interpretation and learning of alcohol-related information. Therefore, a goal with psychoeducation should be to help them gain awareness about the effects of these
factors on their alcohol use (e.g., their view that alcohol use is a normal part of life interferes with recognition of it as an illness). Having a clearer understanding about this dynamic may facilitate their new learning of information about alcohol within the context of an illness model. The participants in our study admitted to having been deprived of information about the negative effects of alcohol while in their native countries. They seemed highly receptive of the opportunity to gain knowledge about their condition through the information videos, handouts, and pamphlets that were available at their clinic.

As was reflected in our model, there were several natural barriers imbedded in our participants’ culture of origin that had kept their drinking contained in their native countries. In contrast, we had a difficulty identifying a corresponding protective system in their host culture. Therefore, another major component of treatment for this population should be the identification and/or development of protective factors or barriers against alcohol abuse within the context of the host culture. Some of these could include increasing their awareness about the negative consequences resulting from alcohol abuse, such as legal trouble, deportation, and financial hardship. Similarly, helping them rebuild their social support, which in their country served as a protective factor, should be a priority in treatment. Regarding this treatment component, clinicians can help Hispanic/Latino clients identify recreational activities that do not involve alcohol drinking. Clinicians should expect for this to be a challenging task. Hispanic/Latino immigrants are likely to struggle replacing their current friends who drink alcohol for non-drinking friends because of the high value they place on Simpatia and Machismo. Their reliance for social support on co-workers who drink and their need to increase their
competence in navigating their new environments are two areas that would be fruitful treatment targets. Assertiveness training might be helpful in this regard. Nevertheless, it is important to keep in mind that an assertive communication style is counter to Hispanic/Latino values (Simpatia). Therefore, it should not be seen as a skill deficit, nor should clients be expected to acquire this skill without being provided first with extensive rationale to help them understand the necessity of its application.

In view of the significant role that immigration-related stressors play on the development and maintenance of alcohol-related disorders, stress management should be a major component of treatment. In addition to the traditional behavioral strategies that are typically used in relaxation training, Hispanic/Latino immigrants would benefit from developing and/or increasing their repertoire of problem-solving skills as applied to their host culture. Although they may already possess good problem-solving abilities, the chronic experience of multiple, serious stressors has been found to negatively affect individuals’ decision-making abilities (Smart & Smart, 1995a). Along these lines, there is a tremendous need for clinicians to help members of this population develop coping strategies to deal with emotional distress, as the current coping mechanism of our participants was largely limited to drinking alcohol.

Generally, it has been suggested in the research that traditional Hispanics/Latinos may not respond well to treatment approaches that use direct confrontation or contest cultural beliefs (Gloria & Peregoy, 1996). In our study, the values of Simpatia and Machismo certainly seem to support the notion that confrontation may not be a culturally sensitive practice. Nevertheless, many of our participants expressed the desire that their male therapist “call them on things.” Conceivably, confrontation from male authority
figures, or in certain settings, may be acceptable. Of course, this remains an empirical question. Alternatively, other approaches that do not use confrontation as part of their treatment elements, such as Motivation Enhancement Therapy, have been found effective in the treatment of alcohol-related disorders (Arroyo, et al., 2003).

Finally, clinicians should consider presenting various treatment options to clients, so that treatment goals can be derived collaboratively. Considering the central role alcohol plays in Hispanic/Latino culture and their resistance to complete abstinence, harm reduction models of treatment should also be considered.

Aftercare. Engaging Hispanic/Latino clients in aftercare programs has been found to be challenging (Burdon, et al., 2004). This may be even more difficult in immigrant populations. Indeed, effective aftercare programs tend to rely heavily on the mobilization of family members to support the recovery of the alcohol abuser (O’Farrell, 1995). Unfortunately, most of our participants had emigrated alone and had little to no social support. Accordingly, efforts should be devoted to minimize their risk for relapse. Indeed, Hispanic/Latino immigrants may be at particularly high risk for relapse because so much emphasis is needed during treatment on changing their views about alcohol.

Ways in which clinicians may be able to help increase the likelihood that clients return for follow up visits include establishing a sound therapeutic relationship and ensuring that the clinic’s atmosphere is perceived as welcoming to clients. Indeed, Antshel (2002) found that Hispanics/Latinos tend to be highly loyal to health care providers who embrace their value of Personalismo (i.e., treat them with courtesy and personalized interactions).
Limitations

There were several limitations in this study. First, it focused on Hispanic/Latino immigrants the majority of whom were of Mexican origin. Our findings should thus not be generalized to second, or later, generation Mexican-Americans nor should they be generalized to Hispanics/Latinos from other countries of origin. Cognitive representations about alcohol use in our sample were shaped by the immigrant experience, indicating that U.S.-born Hispanic/Latinos may have different representations. In addition, although several values and beliefs are held collectively among individuals of various Hispanic/Latin American cultures, these cultural values may vary from country to country as a function of sociopolitical differences and pre-Columbian influences. Thus, generalizations about our findings should be made with caution when applied to immigrants of origins other than Mexican. Nevertheless, individuals of Mexican origin constitute the largest subgroup of Hispanics/Latinos in the US (67%; Ramirez & De La Cruz. 2002). Similarly, immigrants represent a considerable proportion of the Hispanic/Latino population (40%; Ramirez & De La Cruz. 2002), and they are largely understudied, despite their greater risk for alcohol abuse.

Second, the participants in our sample were all male. Although we would have liked to include women in our study, they were simply not represented at the clinics where recruitment took place. The absence of women in treatment for alcohol abuse is not surprising given the stigma held within this cultural perspective about female alcohol drinking. Our all-male sample, however, mirrored the characteristics described for participants in past alcohol research with Hispanics in terms of gender (Alvarez, et al., 2004), age, and education level (Arroyo, et al., 2003).
The fact that our sample consisted of Spanish-speakers who had low degrees of acculturation to the host culture also limits the generalizability of our findings. Conceivably, the impact of their native and/or host culture on their cognitive schemas may have been different as a function of their degree of acculturation to the host culture. Nevertheless, there is a high tendency among Hispanics/Latinos to retain use of their language and cultural roots, independent of generational status (Pew Hispanic Center, 2004). Furthermore, our findings offered a window into this understudied group, as well as into their salient cultural beliefs and value systems.

Finally, the men in our sample were in mandated treatment for alcohol-related disorders due to legal problems. It is unknown to us what biases may have been introduced into our participants’ responses as a function of this factor. Since cognitive representations have been found to vary as a function of treatment stage (Meyers, et al., 1985), it is possible that their stage of treatment and the circumstances of their treatment engagement (e.g., mandated) had an impact on their cognitive schemas. Men who are self-referred to treatment, rather than mandated, may have a greater ability to identify their alcohol abuse symptoms, and they may be more likely to label alcohol-abuse as an illness. We also did not assess our participants’ degree of readiness for treatment [e.g., as per Prochaska & DiClemente’s (1982) stages of change model], and therefore cannot comment on the ways in which the readiness factor may have influenced their views about alcohol.

We must also keep in mind that while qualitative research can provide a very rich account of participants’ experiences, it does not seek to make grand generalizations. It is strongest in its ability to generate hypotheses. On the other hand, the consistency of
reports from our participants and the extremely quick attainment of saturation (the point at which no new themes are being discovered) with this sample give us confidence in the potential generalizability of results.

Directions for Future Research

In light of the aforementioned limitations, future research should expand the study of cognitive representations of alcohol use to samples of US-born Hispanic/Latinos. It would be especially relevant to determine how, for example, variations in immigration-related stressors (e.g., exposure in US-born individuals to the immigration experiences of family members) and higher degree of acculturation to the host culture, might shape their cognitive representations differently than for relatively recent immigrants. There continues to be, however, a high need to focus on immigrant populations, particularly given that they are a high-risk group for alcohol abuse. Additionally, interventions delivered at periods of time when their degree of acculturation to the host culture is low might be highly effective (i.e., before they adopt the high frequency of drinking prevalent in the host culture) and may continue to have intergenerational impact as immigrants adapt to their host culture.

Similarly, there is a high need to devote efforts in research to the study of alcohol-related disorders among Hispanic/Latina women. This is likely to be a challenging task that may first require the development of innovative recruitment approaches to reach this population, given this culture’s stigmatizing views about women who drink. Nevertheless, their rapidly escalating rates of alcohol use in the last decade (Grant, et al.,
as well as their under representation in treatment for alcohol-related disorders suggest that Hispanic/Latino women warrant attention in research.

Relevant to outcome research, there is a dearth of assessment instruments designed to measure stress associated with immigration. These measures would be of high importance given that the immigration experiences of our sample were theorized to play a significant role in the development and maintenance of our participants' alcohol-related disorders, as well as in their attitudes to treatment. The development of such a measure could be useful in the assessment and treatment of a variety of problems, in addition to alcohol-related disorders.

A primary purpose in our study was to identify cultural values and beliefs with relevance to the development of prevention and treatment interventions. Having identified these factors in our sample of Hispanic/Latino immigrants, the next step would be to incorporate them into treatment and empirically evaluate their palatability and effectiveness in treatment outcome studies. Accordingly, we hope that the treatment recommendations drawn from our qualitative study have provided a foundation from which quantitative studies can be developed.

Finally, the application of qualitative research is fundamental to gain in-depth understanding about individuals’ meanings and causal explanations about their illness, which likely impact their health behaviors. The approach used in our study is ideally suited to identify cognitive representations within a cultural framework and can be expanded to the study of other disorders. Indeed, it may be a fruitful approach in generating culturally relevant elements for the development of future prevention and treatment initiatives in other cultures or ethnic groups.
APPENDIX A

QUESTIONNAIRE

Background Questionnaire
(English Version)

Please answer the following questions:

1. How old are you? ____________________________

2. Circle your gender: Male Female

3. What is your highest level of education? _________________

4. What is your present occupation? _________________

5. What is your approximate yearly household income? _________________

6. Which of the following Hispanic/Latino cultures best represents your cultural identity?
   a. Mexican Native
   b. Mexican American
   c. Central American (Please specify as many countries as applicable)
   d. South American (Please specify as many countries as applicable)
   e. Caribbean Islands (Please specify as many countries as applicable)
f. Other (Please specify as many countries as applicable

__________________________________________________________________________

7. What is your country of birth? ________________________________

8. What is your native language? ________________________________

9. Where were your parents born? ________________________________

10. If you immigrated to the United States, in what year did you arrive? _____

11. How old were you when you had your first drink of alcohol? ________________

12. Has any member of your family ever had a tendency to drink Alcohol excessively?  Yes ___ No ___

13. Has any member of your family ever experienced legal problems because of their alcohol consumption?  Yes ___ No ___

14. Has any member of your family ever experienced serious medical problems because of their alcohol consumption?  Yes ___ No ___

15. Do you recurrently fail to fulfill your major responsibilities at work, school, or home because of your alcohol-drinking?  Yes ___ No ___

16. Do you recurrently perform physically hazardous tasks, such as driving or operating machines while intoxicated with alcohol?  Yes ___ No ___

17. Do you recurrently experience legal problems because of your alcohol-drinking?  Yes ___ No ___

18. Do you continue to drink alcohol despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol?  Yes ___ No ___

19. Do you feel like you need markedly increasing amounts of alcohol consumption in order to achieve the desired effect or become intoxicated?  Yes ___ No ___

20. Do you experience markedly diminished effect with continued use of the same amount of alcohol?  Yes ___ No ___

21. Please if you experience any of the following symptoms when you stop drinking alcohol:

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
a. Sweating
b. Increased pulse rate
c. Hand tremors
d. Insomnia
e. Nausea
f. Vomiting
g. Problems with vision or hearing
h. Hallucinations or illusions
i. Agitation
j. Anxiety
k. Seizures?

22. Do you drink alcohol for longer periods of times or in larger amounts than you initially intended? Yes ___ No __

23. Have you persistently desired or made unsuccessful attempts to cut down or control your alcohol intake? Yes ___ No __

24. Do you spend a great deal of time in activities necessary to obtain or drink alcohol or to recover from drinking alcohol? Yes ___ No __

25. Have you given up or reduced your involvement with important activities at work, with friends and family, or hobbies because of your consumption of alcohol? Yes ___ No __

26. Do you continue to drink alcohol despite knowing that you have a persistent physical or psychological problem that is likely to have been caused or exacerbated by your alcohol-drinking? Yes ___ No __

27. How many times in the past have you been referred to treatment for alcohol abuse or dependence, including your present treatment? ______________________

28. How many times in the past have you entered treatment for alcohol abuse or dependence, including your present treatment? ______________________

29. How many times in the past have you entered treatment for alcohol abuse and dependence and then stopped before completing your treatment? ____________

30. Please indicate your level of satisfaction with the treatment you are receiving at the present time:

1 ___________ 2 ___________ 3 ___________ 4 ___________ 5 ___________
Not Satisfied_____________ Very Satisfied
Historial
(Background Questionnaire - Spanish Version)

Por favor responda a las siguientes preguntas:

1. Cual es su edad? ____________________

2. Circule su género: Masculino Femenino

3. Cual es el grado máximo que complete en su educación? ________________

4. Cual es su ocupación actualmente? ________________

5. Indique aproximadamente cuanto dinero gana su familia en total anualmente? ________________

6. Cual de las siguientes culturas Hispanas/Latinas representa mejor su identidad cultural?
   a. Nativo(a) de Mexico
   b. Mexico-Americano(a)
   c. Centro-Americano(a) (Por favor indique todos los países que apliquen ________________) 
   d. Sur-Americano(a) (Por favor indique todos los países que apliquen ________________)
   e. Islas Caribeñas (Por favor indique todos los países que apliquen ________________) 
   f. Otro (Por favor indique todos los países que apliquen ________________)

7. En que país nació? ____________________

8. Cual es su lenguaje nativo? ____________________

9. En que país nacieron sus padres? ____________________
10. Si emigró a los Estados Unidos, en que año llegó? 

11. Cuantos años tenía cuando tomo su primera bebida de alcohol? 

12. Ha habido algún miembro de su familia inmediata que haya tenido alguna vez tendencia a tomar alcohol execivamente?  

13. Ha habido algún miembro de su familia inmediata que haya tenido alguna vez problemas con la ley debido a que toma alcohol?  

14. Ha habido algún miembro de su familia inmediata que haya tenido alguna vez problemas medicos debido a que toma alcohol?  

15. Tiende usted regularmente a dejar de cumplir con sus responsabilidades mayores en el trabajo, la escuela, or su hogar por culpa de la cantidad de alcohol que consume or la manera en que toma?  

16. Performa usted regularmente activitidades fisicas peligrosas, como manejar su auto u operar maquinas, mientras que esta intoxicado con alcohol? 

17. Tiene usted regularmente problemas legales o con la ley debido a la cantidad de alcohol que consume o la forma en que toma? 

18. Continua usted tomando alcohol a pesar de tener persistentemente o constantemente problemas sociales o personales causados o empeorados por los efectos del alcohol? 

19. Siente que cada vez necesita tomar alcohol en cantidades mucho mas grandes para poder obtener los efectos de intoxicacion que desea o para emborracharse? 

20. Piensa que se siente menos intocicado o emborrachado cuando continua tomando al mismo nivel o la misma cantidad de alcohol? 

21. Por favor indique cuales de los siguientes sintomas siente cuando deja de tomar alcohol:
   a. Sudor  
   b. Aumento en su latido del corazon o de sus pulsos

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
c. Manos temblorosas
   Si ___ No ___
d. Insomnio (dificultad para dormir)
   Si ___ No ___
e. Náusea
   Si ___ No ___
f. Vómitos
   Si ___ No ___
g. Problemas con sus oídos o su vista
   Si ___ No ___
h. Alucinaciones o ilusiones
   Si ___ No ___
i. Agitación
   Si ___ No ___
j. Ansiedad
   Si ___ No ___
k. Ataques
   Si ___ No ___

22. Hay veces que toma alcohol por periodos de tiempo más largos
   o en cantidades más grandes de lo que usted inicialmente planea? Si ___ No ___

23. Ha tenido constantemente deseos de dejar de tomar o ha hecho
   constantemente esfuerzos para dejar de tomar o de reducir o controlar
   la cantidad de alcohol que toma sin haberlo logrado? Si ___ No ___

24. Pasa usted una gran parte de su tiempo dedicado a actividades que
   son necesarias para poder obtener alcohol o tomar alcohol o
   recuperándose después de haber tomado alcohol? Si ___ No ___

25. Ha reducido el tiempo que dedica a actividades importantes
   en su trabajo, con sus amistades y familia, o en pasatiempos por
   culpa de su consumo del alcohol? Si ___ No ___

26. Continúa bebiendo alcohol a pesar de saber que tiene un problema
   serio físico o psicológico el cual es muy probable que haya sido
   causado o empeorado por su consumo del alcohol? Si ___ No ___

27. Cuántas veces en el pasado le han referido a que vaya a recibir
   tratamiento para el abuso o la dependencia del alcohol,
   incluyendo esta vez que está en tratamiento ahora? __________

28. Cuántas veces en el pasado ha entrado en tratamiento para el abuso o la
   dependencia del alcohol, incluyendo esta vez que está en tratamiento ahora? ____

29. Cuántas veces en el pasado ha entrado en tratamiento para el abuso o la
   dependencia del alcohol y después ha dejado de asistir al tratamiento antes de
   completarlo? __________

30. Por favor indique cuál es su nivel de satisfacción con el tratamiento que está
    recibiendo actualmente:
    1 ----------- 2 ----------- 3 ----------- 4 ----------- 5
    No estoy nada Satisfecho
    completamente
    Satisfecho

156
APPENDIX B

INTERVIEW

Semi-Structured Interview

1. When you were young, before you ever drank, what was your impression of alcohol and the effect that it had on the adults around you? Was it a positive impression or a negative one and why? What messages do you think you had received about alcohol use? Do you think those messages are different in Hispanic/Latino culture than in mainstream American culture? If so, how?

Cuando usted era joven, antes que hubiese tomado por primera vez, cuales eran sus impresiones acerca del alcohol y los efectos que tenia en los adultos? Eran positivas o negativas sus impresiones y porque? Que mensajes cree usted que ha recibido acerca del uso del alcohol? Cree que esos mensajes son diferentes en la cultura Hispana/Latina en comparacion a la cultural American? Si es asi, porque?

2. When and in what circumstances did you start drinking? What role do you think alcohol played in your life before it became a problem? What did alcohol make easier or harder for you before it became a problem?

Cuando y en que circunstancias empezo usted a beber? Que papel piensa que tenia el alcohol en su vida antes de que se le convirtiera en problem? Que hacia el alcohol mas facil o mas dificil para usted antes de que se combiertiera en problema?
3. What do you think your culture expects of men in terms of drinking? What do you think your culture expects of women in terms of drinking? Do you think there is a difference between what mainstream American culture expects of men and women in regard to alcohol use is different than what is expected in Hispanic/Latino culture?

Que piensa usted que su cultura espera de los hombres en términos del alcohol? Que piensa que su cultura espera de las mujeres en términos del alcohol? Cree que hay una diferencia entre lo que la cultura Americana espera de los hombres y las mujeres con relación al uso del alcohol y lo que se espera en la cultura Hispana/Latina?

4. When do you think alcohol use became a problem in your life (if you think it is a problem) and how did you know it had become a problem? What are other ways do you think one would know that alcohol has become a problem?

Cuando cree que el uso del alcohol se convirtió en un problema en su vida (si cree que es un problema) y cómo se dio cuenta que se había convertido en un problema? De que otra forma cree que se daria cuenta que el tomar alcohol se ha vuelto problemático?

5. What do you think causes alcohol abuse or alcoholism in general? Which of those causes have you been told about in treatment and which did you believe before you entered treatment? What do you think caused you specifically to abuse alcohol? What are the reasons that caused you to start drinking?

Cuales piensa usted que son las causas del abuso del alcohol o el alcoholismo en general? Cuales de esas causas piensa que le fueron dadas a usted en su
6. How serious a problem do you think alcohol abuse is and why?
Que tan serio cree que es el abuso del alcohol y porque?

7. Tell me about the consequences, good and bad, that you have experienced as a result of drinking alcohol? Has alcohol impacted your life in any other way? If you are an immigrant, do you think your life would have been impacted in similar ways if this had happened back home? If you are not an immigrant, do you think there are any aspects of being Hispanic/Latino(a) that make this problem better or worse for you?

Cuenteme acerca de las consecuencias, buenas y malas, que usted ha tenido como resultado de tomar alcohol? Ha tenido el alcohol alguno otro impacto en su vida? Si es usted un imigrante, cree que su vida se hubiese visto impactada de la misma forma si esto le hubiese pasado en su pais de origin? Si usted no es un imigrante, cree que hay algunos aspectos de ser Hispano(a)/Latino(a) que ha contribuido a que este problema sea peor para usted?

8. How has your alcohol problem affected your self-concept? How has your perception of yourself changed by having this problem? If you are an immigrant, do you think the same would have happened back home? If you are not an immigrant, do you think the fact that you are Hispanic/Latino(a) has played any role in the way alcohol abuse has changed the way you feel about yourself?
Como ha impactado el alcohol su concepto de sí mismo? Como han cambiado sus percepciones acerca de su persona por haber tenido este problema? Si usted es un inmigrante, cree que le hubiera afectado de la misma forma en su país de origen? Si no es un inmigrante, cree que el hecho de ser Hispano(a)/Latino(a) ha contribuido en alguna manera a la forma en que el abuso del alcohol le ha cambiado como se siente acerca de sí mismo?

9. Describe specifically the ways in which alcohol drinking may have affected your relationships with family members and/or significant others. Do you think it has affected the role you play in their lives? Do you feel they perceive you differently?

Describa específicamente la manera en la cual el tomar alcohol le pueda haber afectado sus relaciones con su familia o personas importantes en su vida. Cree que ha afectado el rol que usted desarrolla en sus vidas? Se siente que ellos lo(a) perciben de manera diferente?

10. Describe the ways in which alcohol drinking may have affected your relationships with friends, coworkers, bosses or acquaintances? Do you think they know? Do you think they perceive you differently?

Describa la manera en la que el tomar alcohol le pueda haber afectado sus relaciones con sus amistades, compañeros de trabajo, jefes, or conocidos? Piensa que saben lo que le paso? Piensa que lo(a) perciben de manera diferente?

11. What do you think happens once a person starts abusing alcohol? Do you think they (you) can stop? Do you think they (you) need to get help or do you think
they (you) can do it on their own? How long do you think it would take to
overcome the problem?
Que cree que le pasa a una persona cuando empieza a abusar del alcohol? Cree
que puede o pueden parar de tomar? Cree que necesitaria(n) ayuda o piensa que
puede(n) parar por si solo(s)? Cuanto tiempo cree que tomaria para sobrepasar el
problema?

12. What are some of the things that can be done to prevent alcohol abuse?
Que cosas piensa que se pueden hacer para prevenir el abuso del alcohol?

13. What are some of the things that you think can be done to treat alcohol abuse?
Que cosas piensa que se pueden hacer para tratar el problema del abuso del
alcohol?

14. Tell me about your opinions regarding the treatment for alcohol abuse that you
are receiving? Do you feel understood? Do you think it’s effective? If not, how not?
Cuenteme sus opiniones acerca del tratamiento para el abuso del alcohol que usted
esta recibiendo? Se siente comprendido? Piensa que es eficiente? Si no lo es, en
que manera piensa que es ineficiente?

15. What parts of the treatment you are receiving helpful and what parts do you not
find helpful?
Cuales aspectos del tratamiento que esta recibiendo piensa que le han ayudado y
cuales aspectos piensa que no le han ayudado?

16. How long do you think you need to be in treatment to overcome your problem?
Do you think it is something you will struggle with all of your life or do you think
you can get over it after a specified period of time? How optimistic or pessimistic do you feel about your chances of getting over your alcohol problem?

Cuanto tiempo piensa que necesita estar bajo tratamiento para poder sobrepasar su problema? Cree que es algo con lo que va a batallar toda su vida o cree que puede sobrepasarlo después de un cierto tiempo? Que tan optimista o pesimista se siente acerca de la posibilidad de sobrepasar su problema con el alcohol?

17. How confident are you that treatment will be able to help you with this problem?
   If not very confident, why?

   Que tanta confianza siente en que el tratamiento que recibe podra ayudarle con este problema? Si no se siente seguro, porque?

18. Are there any aspects of the treatment you are getting that you think misunderstand where you come from culturally? If so, which and how?

   Hay algunos aspectos del tratamiento que recibe que le hacen pensar que no comprenden sus raíces culturales? Si es así, porque y en que manera no le comprended?

19. How do you think your life will be different if you stop drinking? Or How has your life changed by stopping to drink alcohol? What are the positive things that have come out of that (or that you think will come out of that)? What are the negative things that have come out of that (or you think will come of that)?

   De que manera cree que su vida seria diferente si usted dejara de tomar alcohol? O Como ha cambiado su vida desde que dejo de tomar alcohol? Que cosas positivas le han pasado o piensa que le van a pasar al dejar de tomar? Que cosas negativas le han pasado o piensa que le van a pasar al dejar de tomar?
20. What differences do you perceive in the way mainstream American culture views problem drinking and the way in which Hispanic/Latino culture views problem drinking?

Que diferencias percibe usted entre la manera que la cultural American ve el problema del abuso del alcohol y la manera que se ve ese problema en la cultural Hispana/Latina?

21. Do you think the fact that you are Hispanic/Latino(a) and thus part of a minority group in this country makes your experience of having an alcohol problem different than if you were part of the majority? If so, how?

Piensa que el hecho que usted es Hispano(a)/Latino(a) y parte de un grupo minoritario en este país hace que sus experiencias con el problema de tomar alcohol diferente de como serían si usted fuera parte del grupo mayoritario? Si es así, de que manera?
Examining my biases with regard to alcohol use and Hispanic/Latino culture is an essential component within grounded theory methodology, as it contributes to the promotion of objectivity in the implementation of the study. My views of this topic have been influenced by, and reflect, my own experiences with both Hispanic/Latino and mainstream culture. Being a Hispanic woman, I have directly experienced the effects of some of the values central to this culture on many behaviors, including alcohol use, on myself, as well as on other members of my cultural group. Based on my bicultural experiences, I have become aware of cultural differences that I believe are likely to shape the conceptualization of alcohol abuse from a cultural perspective and to have treatment implications. Thus, despite the extensive cultural heterogeneity and fluidity that has been noted within Hispanic/Latino subgroups, I believe that the shared beliefs, norms, and values comprised within this culture are likely to influence individuals' behaviors and perceptions, including their cognitive representations of phenomena such as alcohol-related disorders. Alcohol drinking also, I believe, is a behavior highly influenced by societal views and cultural scripts and is perceived in many ways to be a socially acceptable behavior. Thus, I would expect that some Hispanic/Latino cultural values (e.g., familismo, gender roles, and simpatia) would have an effect on views and attitudes
toward alcohol use (e.g., who should drink, when and how much is appropriate to drink), as well as views about alcohol abuse and dependence (e.g., when does drinking become a problem, how to address the problem, where to go for help). Consequently, it is my belief that although some treatments developed without the consideration of individuals' cultural worldviews are effective, I am not convinced that they are optimal. This belief is a catalyst to increase my understanding about the interplay between culture and alcohol use in members of the Hispanic/Latino population.
REFERENCES


Medicine, 88, 251-258.


267-276.


179


VITA

Graduate College
University of Nevada, Las Vegas

Marilyn J. Strada

Home Address:
125 Ximeno Avenue, Unit 17,
Long Beach, CA 90803

Degrees:
Bachelor of Arts, Psychology, 2002
Chapman University

Master of Arts, Psychology, 2004
University of Nevada, Las Vegas

Special Honors and Awards:

Summa Cum Laude, Chapman University

Minority Fellowship Program Award, American Psychological Association

Graduate College Presidential Award, University of Nevada, Las Vegas

Barnes & Noble Book Scholar Award, Las Vegas, Nevada

Graduate Student Research Award (Spring, 2005), Department of Psychology,
University of Nevada, Las Vegas

Graduate Student Research Award (Spring, 2004), Department of Psychology,
University of Nevada, Las Vegas

Graduate Student Research Award (Spring, 2003), Department of Psychology,
University of Nevada, Las Vegas

Outstanding Research Award (Spring, 2004), Achievement Center, Department of
Psychology, University of Nevada, Las Vegas

Graduate Student of the Year Award (Fall, 2002), Achievement Center, Department of
Psychology, University of Nevada, Las Vegas

Outstanding Research and Service Award (Fall, 2002), Achievement Center,
Department of Psychology, University of Nevada, Las Vegas

183
Third Place for Outstanding Student Research Poster Presentation *(Spring, 2005)*, Graduate and Professional Student Association Research Forum, University of Nevada, Las Vegas


Gray Key Academic Honor Award *(2002)*, Chapman University

Cheverton Trophy Nominee *(2002)*, Chapman University

Psychology Department Honor Academic Award *(2002)*, Chapman University

Publications:


184


Dissertation Title: A Model of The Interplay of Culture and Immigration Stress in the Development and Maintenance of Alcohol-Related Disorders in Hispanic/Latino Immigrants

Dissertation Examination Committee:
   Chairperson, Marta Meana, Ph.D.
   Committee Member, Brad Donohue, Ph.D.
   Committee Member, Dan Allan, Ph.D.
   Graduate Faculty Representative, Larry Ashley, Ed.S.