



Reference and Resource Guide for Working With Hispanic/Latino Older Adults

**Based on TIP 26:
*Substance Abuse Among Older Adults***



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Executive Summary

This executive summary covers—

- > Why a Reference and Resource Guide?
- > Hispanic/Latino Older Adults
- > The Need For Cultural Competence

Introduction: Why a Reference and Resource Guide?

The impact of culture on substance abuse treatment and recovery cannot be overemphasized. Well-informed counselors and clinicians understand that a client's cultural background must be taken into account in the development of a treatment plan. This need can be even greater among older adult clients, as their attitudes and beliefs about health care are more likely to be those prevalent in their native countries.

Hispanic/Latino Older Adults

The Hispanic/Latino population in the United States is culturally complex, diverse, deeply rooted, and is also growing quickly. The proportion of the population that is above age 50 is growing even faster. Treatment providers increasingly need answers to challenging questions, such as:

- What are some substance abuse risk factors for Hispanic/Latino older adults?
- What are some ways that clinicians can make Hispanic/Latino older adults comfortable in a clinical setting?
- Where can a provider go for additional resources and information when treating Hispanic/Latino older adults?

This Reference and Resource Guide was developed to address these and other questions. Based on Treatment Improvement Protocol (TIP) 26: Substance Abuse Among Older Adults (Center for Substance Abuse Treatment, 1998), this Guide is intended for anyone who provides treatment for Hispanic/Latino older adults with alcohol and/or prescription drug use disorders. It is designed to help providers incorporate appropriate cultural elements into their treatment strategies for these clients. Because research suggests that illicit drug use is not a problem among Hispanic/Latino older adults, this topic is not covered in this Guide.

Unfortunately, there is little research available that is specific to Hispanics/Latinos over age 50 that investigates their patterns and risk factors for substance abuse or focuses on the efficacy of specific interventions. For that reason, this guide does not draw sharp boundaries between Hispanics/Latinos aged 50 and above, and Hispanic/Latino adults in general. Where information specific to older adults is available, it is presented as specific to that age group, although it may apply to younger adults as well.

Although further study is needed in the area of culturally sensitive substance abuse treatment, this publication reflects the research and practices of some of the leading treatment experts working with the Hispanic/Latino population. It is hoped that this Guide can be a starting point for providers who seek a better understanding of the unique treatment needs of Hispanic/Latino adults.

The Need For Cultural Competence

Studies show that disproportionate numbers of people within racial and ethnic groups in the United States do not have access to adequate health care (Office of the Surgeon General, 2001; U.S. Department of Health and Human Services [HHS], 2001). Factors such as a

“The 21st century can be expected to bring at least two treatment issues that must be addressed if the older Latino substance abuser is to be well served. The first is the development of placement criteria appropriate to this sub-population. The second issue is that of modifying existing treatment to be culturally sensitive. . .”

Kail and DeLaRosa, 1998, p.130.

person's economic status, race/ethnicity, or gender can be significant predictors of such access (HHS, 2001). For example, Hispanic/Latino older adults (especially elderly women) are more likely than non-Hispanic whites to live below the poverty level and less likely to have private insurance to supplement Medicare coverage (Administration on Aging [AoA], 2006). Older adults without private insurance to supplement Medicare coverage are more likely to delay seeking medical care or to go without care (AoA, 2006).

In a major effort to close the gap in health care access, HHS has adopted initiatives that require more culturally competent implementation strategies for health care (HHS, 2001). Similarly, the Office of the Surgeon General urged mental health providers in August 2001 to “embrace the Nation’s diversity” in research, training, education, and service delivery (Office of the Surgeon General, 2001, p. 1).

In a recent publication, *Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations*, HHS (2003) merged several existing definitions to conclude:

Cultural competence is a set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time (p. 12).

To become culturally competent, the counselor needs to understand his own culture and how it affects—or could affect—the counselor’s ability to interact with culturally diverse clients. Some researchers assert that cultural competence is a continuous process and propose a framework for understanding and increasing the “cultural capacity” of providers of health care and human services (Cross, Baznan, Dennis, and Isaacs, 1989; Kim, McLeod, and Shantzis, 1992). (See Figure 1.)

Figure 1: Stages of Cultural Capacity

Cultural Proficiency

Provider...

- > Understands in greater depth the qualities and issues involved in a culturally complex situation
- > Proposes and designs new approaches for interventions that aid in the delivery of services
- > Is committed to research and provides leadership in presenting new findings to better serve racial/ethnic groups

Cultural Competence

Provider...

- > Understands the client from the client's racial/cultural perspective
- > Examines, considers, weighs, and interprets culturally complex information
- > Conducts effective interventions for positive treatment outcomes

Cultural Sensitivity

Provider...

- > Demonstrates an openness to working with other ethnic/racial groups
- > Has only a limited knowledge of client's values, beliefs, traditions, etc.
- > Has difficulty interpreting culturally complex issues and contradictions

Cultural Blindness

Provider...

- > Believes all people are alike and should be treated equally
- > Avoids dealing with racial/ethnic issues, which are perceived as distracting

Cultural Incapacity

Provider...

- > Views racial/ethnic minorities as incapable of benefiting from conventional treatment
- > May administer alternative programs that are inferior in content and resources

Cultural Destructiveness

Provider...

- > Views ethnic/racial minority cultures as inferior to mainstream culture
- > Demonstrates discriminatory and insensitive behavior
- > May deny service to an ethnic/racial minority

Source: Cross et al., 1989; Kim et al., 1992.

Since every provider is responsible for the quality of the care he or she provides, comprehending a client's cultural beliefs and incorporating them into treatment and/or prevention planning is critical. A superficial knowledge of another's culture is not sufficient. According to the National Alliance for Hispanic Health, knowledge "must be integrated into the provider's world view and must penetrate his/her ethnocentrism and professional training" (National Alliance for Hispanic Health, 2000, p. 11).

References

- Administration on Aging. (2006). *A profile of older Americans: 2006*. Washington, DC: Author.
- Center for Substance Abuse Treatment. (1998). *Substance abuse among older adults. Treatment Improvement Protocol (TIP) Series 26* (HHS Publication No. (SMA) 98-3179). Rockville, MD: Author.
- Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Vol. I. Washington, DC: Georgetown University Child Development Center.
- Kail, B. L. & DeLaRosa, M. (1998). Challenges to treating the elderly Latino substance abuser: A not so hidden research agenda. *Journal of Gerontological Social Work*, 30 (1-2), 123-141.
- Kim, S., McLeod, J. H., & Shantzis, C. (1992). Cultural competence for evaluators working with Asian-American communities: Some practical considerations. In M. A. Orlandi, R. Weston, and L. G. Epstein (Eds.), *Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities*. OSAP Cultural Competence Series I (HHS Publication No. (ADM) 92-1884, pp. 203-260). Rockville, MD: Office for Substance Abuse Prevention.
- National Alliance for Hispanic Health. (2000). *Quality health services for Hispanics: The cultural competency component* (HHS Publication No. 99-21). Washington, DC: U.S. Department of Health and Human Services.
- Office of the Surgeon General. (2001). Press Release: *Culture counts in mental health services and research finds new Surgeon General Report*. Rockville, MD: Author.

U.S. Department of Health and Human Services. (2001). Press Release. *HHS reshaping the health of minority communities and underserved populations*. Washington, DC: Author.

U.S. Department of Health and Human Services. (2003). *Developing cultural competence in disaster mental health programs: Guiding principles and recommendations* (HHS Pub. No. SMA 3828). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

An Overview of the Hispanic/Latino Population In the United States

This chapter covers—

- > Who is Hispanic/Latino?
- > The U.S. Hispanic/Latino Population
- > Issues of Acculturation and Socioeconomic Status
- > The Health Status of Hispanics/Latinos
- > Traditional Health Practices of Concern to the Treatment Provider

“Hispanic/Latino” refers to people of Mexican, Puerto Rican, Cuban, Central American, South American, or some other Spanish origin living in the United States. This reference and resource guide will use either the term Hispanics/Latinos or names of specific subgroups as defined by the U.S. Census.

Who is Hispanic/Latino?

People of Spanish ancestry have been identified by a host of names, including *Mexican born*, *of Mexican parentage*, and *of Spanish origin*. In 1978, the U.S. Government adopted the term *Hispanic* to identify people of Mexican, Puerto Rican, Cuban, Central American, South American, or some other Spanish origin (Suarez and Ramirez, 1999). In the 1980s, two scholars introduced the term *Latinos* to identify people whose ancestries can be traced to Latin American countries in the Western Hemisphere (Suarez and Ramirez, 1999).

Currently, *Hispanic* and *Latino* are widely used throughout the U.S. (Suarez and Ramirez, 1999). However, neither term is universally accepted by subgroups of this population. Some groups prefer their ancestral identity (as in *Spanish American*) and identify as *Hispanics*. Others identify with Latin America, not with Spain,

Three of every five Hispanics/Latinos were born in the United States.

and prefer to be called *Latinos*. Still others prefer a specific native identity (as in *Puerto Rican*), or cultural and political identity (as in *Chicano* or *Chicana*). Even within specific groups, preferences may differ. For example, although *Chicano* represents racial consciousness and pride for some Mexican Americans, researchers have found that some older Hispanics/Latinos of Mexican origin regard *Chicano* as an offensive term and prefer to identify themselves as Mexican Americans (Sue and Sue, 2003).

Far from being a unitary ethnic group, Hispanics/Latinos include more than 30 national and cultural subgroups that vary by national origin, (see Figure 3) race, generational status in the United States, and socioeconomic factors (Castro, Proescholdbell, Abieta, and Rodriguez, 1999). The term “Hispanic/Latino” encompasses a tremendous diversity based on class, race, age, level of acculturation, education, income, and other variables. Aguirre-Molina, Molina, and Zambrana (2001) point out that this already diverse group has become increasingly diverse in at least two ways: (1) the number of different groups with significant numbers in the U.S. population, and (2) the growing diversity of social class among Hispanics/Latinos.

Clients have their own preferences regarding the terms Hispanic, Latino, Puerto Rican, Mexican American, etc. It is recommended that providers simply ask their clients what term they would prefer.

Further, people included within the broad category Hispanic/Latino vary from those who appear Caucasian to those who appear American Indian (especially those from South America) or African American.

In the 2000 Census, only about half of the respondents who identified themselves as “Hispanic” also identified themselves racially as “white” (Greico and Cassidy, 2001).

The U.S. Hispanic/Latino Population

Data from the 2000 U.S. Census showed that there were 35.3 million Hispanics/Latinos living in the United States, or about 13 percent of the U.S. population. This represents a 60 percent increase over the 1990 figure of 22.4 million (see Figure 1). Census experts predict that the Hispanic/Latino population will triple to 98.2 million by 2050, or 24 percent of the U.S. population.

Analysis of census data showed that 45 percent of Mexican Americans lived in a major metropolitan area, compared with 80 percent of Puerto Ricans and 21 percent of other Hispanics. Conversely, the survey showed no Puerto Ricans, only 8 percent of Mexican Americans, and 73 percent of other Hispanics living in rural areas. Of these 35.3 million people, the data revealed that 14.2 percent were age 50 and above, while 28.9 percent were age 30 to 50. Thus the number of older Hispanic/Latinos (those age 50 and older) is set to dramatically increase over the next several decades (see Figure 2).

Figure 1: Rate of Growth of the Hispanic/Latino Population (in millions)

Hispanic/Latino Population	Total U.S. Population
1990: 22.4	1990: 248.7
2000: 35.3	2000: 281.4
(up 57.6%)	(up 13.1%)

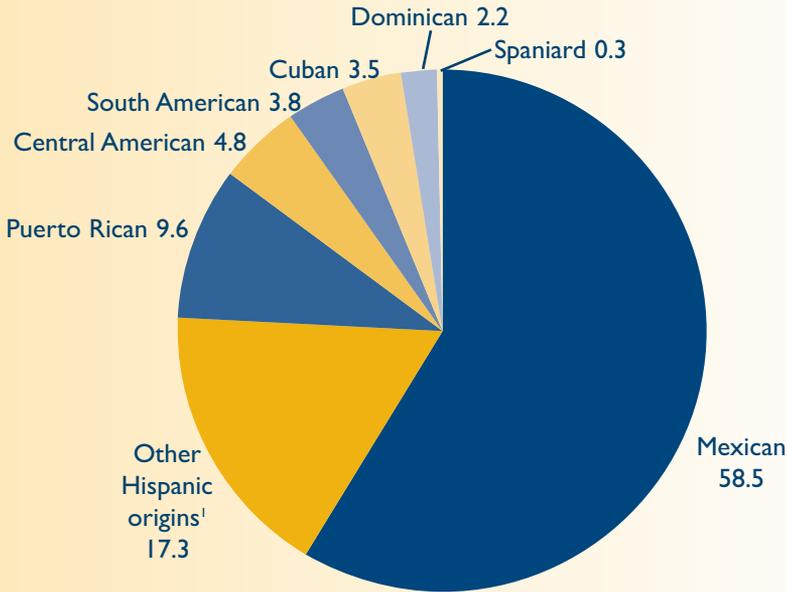
Source: Guzmán, 2001, pp. 2 and 4.

Figure 2: Projected Rates of Growth of Older Adult Populations between 2004 and 2030

Hispanics/Latinos	254%
Asian and Pacific Islanders	208%
American Indians, Eskimos, and Aleuts	143%
African Americans	147%
Whites	74%

Source: Administration on Aging, 2005, p. 3.

Figure 3: Ethnic Origins of Hispanics/Latinos of Any Race in the United States: 2000 (in percentages)



¹ “Other Hispanic origins” refers to respondents to the 2000 U.S. Census who identified themselves under the primary heading of “Hispanic/Latino/Spanish” without providing a more detailed explanation of ethnic origin.

Source: Guzmán, 2001, p. 2.

Issues of Acculturation and Socioeconomic Status

Assimilation can be defined as “the degree to which individuals integrate into U.S. society,” and acculturation is “the degree to which the dominant culture is adopted” (Suarez and Ramirez, 1999). The degree of assimilation and acculturation among Hispanics/Latinos affects their health-related behavior in both positive and negative ways (Suarez and Ramirez). For instance, immigrant Hispanics/Latinos show extremely low rates of drug abuse, but both substance use and abuse become more common with acculturation into the U.S. mainstream. However, the inability to speak English can be a hindrance to gaining employment that includes health benefits. At the same time, factors such as Spanish language, family loyalty, and respect for traditional values can be seen by the client and

clinician as positive factors that foster adequate health care for Hispanics/Latinos when they are recognized and appropriately integrated into treatment (Aguirre-Molina et al., 2001).

Researchers have found a strong correlation between English language use and socioeconomic status. A recent national study, the National Comorbidity Survey (NCS), reports distinct patterns of English language use in relation to immigrant status, age, and gender, which in turn relates to socioeconomic status. Data from the NCS showed 83 percent of Mexican Americans, 81 percent of Puerto Ricans, and 62 percent of other Hispanics spoke English as the primary language at home. However, the NCS did not use Spanish-speaking interviewers, so respondents comfortable in English are likely to be highly overrepresented (Ortega, Rosenheck, Alegria, and Desai, 2000). One study that did not rely entirely on English found that 75 to 90 percent of lower income Hispanic/Latina older adult women speak Spanish, rather than English, as a primary language (Suarez and Ramirez, 1999).

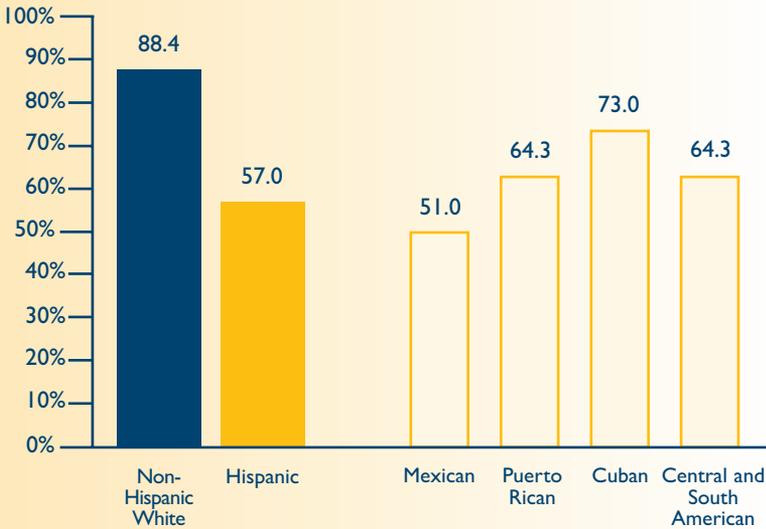
Age, economic status, and level of education affect the health of all Americans (National Center for Health Statistics [NCHS], 2006). All of these factors are likewise associated with health status among the various Hispanic/Latino groups (Suarez and Ramirez, 1999). Census data show that Hispanics/Latinos have fallen behind non-Hispanic whites in economic well-being and in level of educational attainment (Therrien and Ramirez, 2001). The degree to which this was the case varied among Hispanic/Latino subgroups.

In educational attainment, 57 percent of Hispanic/Latino adults aged 25 and over had at least a high school diploma, compared to 88.4 percent of non-Hispanic whites. Within Hispanic/Latino subgroups, Cubans had the highest percentage of adults with a high school diploma (73 percent). (See Figure 4.) Census

data also showed that 24 percent of Mexican Americans, 23 percent of Puerto Ricans, and 38 percent of other Hispanics had at least 16 years of education.

The ability to speak English is a typical measure of a person's ability to function in the American mainstream.

Figure 4: Population With at Least a High School Education by Hispanic Origin: 2000 (in percentages)



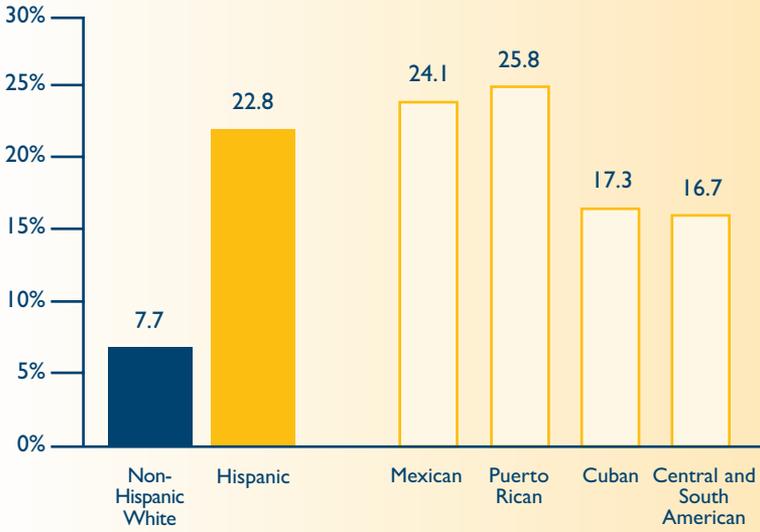
Source: Therrien & Ramirez, 2001, p. 5.

Economically, Hispanics/Latinos are less well off than non-Hispanic whites: 22.8 percent of Hispanics/Latinos lived in poverty in 1999 compared to 7.7 percent of non-Hispanic whites. Among Hispanic/Latino groups, persons of Puerto Rican origin constituted the highest proportion of persons living in poverty (25.8 percent). (See Figure 5.)

Among older adults, 21.8 percent of Hispanics/Latinos over age 65 were living in poverty in 2000. The most vulnerable among this population were the unmarried older adult women who lived alone or with non-relatives, of whom half lived in poverty (Proctor and Dalaker, 2002). Among those age 65 and over, 33 percent have no health insurance, while another third of this population rely entirely on Medicare.

However, the economic resources of the Hispanic/Latino population appear to be changing. The per capita income among Latinos grew 4.5 percent between 1997 and 1998, while per capita income among non-Hispanic whites grew 3.2 percent in the same period. Hispanics/Latinos continue to be underrepresented in government employment, business

Figure 5: People Living Below the Poverty Level by Detailed Hispanic Origin: 1999 (in percentages)



Source: Therrien & Ramirez, 2001, p. 6.

The Hispanic/Latino Population in the United States

ownership, and admissions into higher education; however, there is a small but growing Hispanic/Latino middle class that increasingly challenges the perception of this diverse group as primarily poor working-class immigrants (Aguirre-Molina et al., 2001).

The Health Status of Hispanics/Latinos

Despite their lower average income, Hispanics have an average life expectancy of 75.1 years for men and 82.6 years for women—slightly longer than Caucasians. In addition, Hispanics/Latinos, especially newcomers to the United States, experience lower rates of heart disease and, among women, lower rates of breast cancer. Thus Hispanic/Latino immigrants appear to benefit from a proposed “healthy migrant” effect. However, only two of five Hispanics/Latinos are immigrants, and with acculturation, the health problems faced by Hispanics/Latinos more closely resemble those of the rest of the U.S. population, in addition to other concerns (Aguirre-Molina et al., 2001).

The risk of contracting tuberculosis is six times higher among Hispanics/Latinos than among non-Hispanic whites. The prevalence of TB is highest among those age 25 to 44 and may be a particular problem among migrant workers (National Alliance for Hispanic Health, 2000).

In addition, diabetes and chronic liver disease are a greater concern among Hispanics/Latinos and their medical providers than for Caucasians. The incidence of non-insulin dependent diabetes is two to five times higher among Latinos than the general U.S. population, regardless of age or gender. Likewise, the death rate from cirrhosis of the liver among Hispanic/Latino men and women was nearly double the rate in the general U.S. population in 1997. Rates have been declining among African Americans and Whites over the past decade, but not among Hispanics/Latinos (National Institute on Alcohol Abuse and Alcoholism, 2006).

Traditional Health Practices of Concern to the Treatment Provider

The three primary healing/spiritual practices brought to the U.S. by Hispanics/Latinos are *espiritismo*, *santeria*, and *curanderismo*, of which *curanderismo* is the most widely known. Harmony and balance are common themes among all three. Failure to follow the prescribed rules can lead to suffering, sickness, and bad fortune (Gloria and Peregoy, 1996).

When immigrating to the U.S., Hispanics/Latinos bring their health customs with them.

Curanderismo is folk medicine for treating ordinary ill health and disease. The techniques of *curanderismo* evolved from several foundations: spiritualism, homeopathy, Aztec and Spanish cul-

tures, and other Western scientific foundations (Huff, 1999). It is practiced by a *curandero*, who is recognized by the local community as a healer. The identities of *curanderos* are closely guarded secrets, so it is impossible to determine how many are practicing in a local community (Applewhite, 1995; Lopez, 2005).

A variety of folk healers exists within *curanderismo* including herbalists (*herbalistas* or *yerberos*), midwives (*parteras*), and bone and muscle

therapists (*hueseros* and *sobadores*) (Huff, 1999). The extent to which *curanderismo* is used depends on the degree of acculturation, level of education, and other factors.

Hispanics/Latinos decide to visit the *curandero* and/or a Western treatment provider depending on the nature of the illness or problem, the cost associated with treatment, and the availability of treatment by either source (Huff, 1999). However, some researchers argue that those who use folk medicine are not likely to inform a Western practitioner of their use of these alternate medicines unless a high degree of trust has been established. In one large epidemiologic health study, 21.4 percent of foreign born Mexican Americans reported seeing a *curandero*, herbalist, or other folk medicine practitioner for health care within the past 5 years (Skaer, Robison, Sclar, and Harding, 1996).

A variety of folk remedies used by older Hispanics/Latinos contain hazards that providers should be aware of, including:

- **Mercury.** Sometimes used as a folk medicine or spiritual agent. Called *azogue* in Spanish, it is believed to possess spiritual power and is sometimes burned as incense or in a candle, or sprinkled about the house. Some of the symptoms include neurological disorders, personality changes, hypersensitivity of the hands and feet, fever, headache, and tremors (Aguirre-Molina et al., 2001).
- **Lead oxide.** An ingredient in several remedies, known as *greta*, *azarcon*, or *albayalde*. These traditional remedies are used to treat a disorder called *empacho*, which is believed to be an intestinal obstruction (Aguirre-Molina et al., 2001).
- **Metamizole.** Taken for pain, Metamizole (or dipyrrone) causes a deficiency in white blood cells, which can lead to severe infection and related problems. Many Metamizole preparations exist, under names such as Neo-melubrina or “Mexican aspirin.” Although Metamizole was banned by the FDA in 1979, it is still widely sold in the U.S. as well as in Asia, Africa, and Latin America. A survey at an

The curandero does not practice in opposition to Western medicine.

urban pediatric clinic found that 35 percent of Hispanic/Latino adults had taken Metamizole and 25 percent had given it to their children (Bonkowsky, Frazer, Buchi, and Byington, 2002).

The following is a list of idioms of distress, as listed by the American Psychiatric Association (2000), that treatment providers may encounter or inquire about in more traditional clients. Although these “cultural-bound syndromes” may occur in Hispanics/Latinos of any age, they may be more likely to appear in more traditional, older individuals:

- *Ataque de nervios*: (mostly among the Latino Caribbean population) A general feature of an *ataque de nervios* is of being out of control. It is an idiom to describe the reaction resulting from a very stressful event relating to the family and is characterized by uncontrollable shouting, crying attacks, trembling, heat in the chest rising into the head, and verbal or physical aggression. There may also be disassociative experiences, seizure-like or fainting spells, and even suicidal gestures.
- *Nervios*: Refers both to a general state of vulnerability to stressful life experiences and to a chronic syndrome brought on by difficult life circumstances. The symptoms include a wide range of emotional distress, somatic disturbances including headaches, “brain aches,” irritability, stomach disturbances, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like sensations).
- *Bilis* and *colera* (also referred to as *muina*): The underlying cause of these symptoms is considered to be strongly experienced anger or rage. Symptoms include acute nervous tension, headache, trembling, screaming, and stomach disturbances. Chronic fatigue may follow an acute episode.
- *Susto* (fright or soul loss): A folk illness among some in Mexico, Central America, and South America. It is also referred to as *espanto*, *pasmo*, *tripa ida*, *perdida del alma*, or *chibih*. It is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. These individuals experience strains in key social roles and have symptoms including appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feelings of sadness, lack of motivation to do anything, and feelings of low self-

worth or dirtiness. There may also be muscle aches or pains, headache, stomach ache, and diarrhea.

- *Locura*: A term used by Latinos in the U.S. and Latin America to refer to a form of chronic psychosis. It is considered to be a combination of inherited factors and multiple life difficulties. Symptoms include incoherence, agitation, auditory and visual hallucinations, inability to follow the rules of social interactions, unpredictability, and possible violence.

References

- Administration on Aging. (2005). *Profile of older Americans: 2000*. Washington, DC: Author.
- Aguirre-Molina, M., Molina, C.W., & Zambrana, R. E. (2001). *Health issues in the Latino community*. San Francisco: Jossey-Bass.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Applewhite, S. L. (1995). Curanderismo: Demystifying the health beliefs and practices of elderly Mexican Americans. *Health & Social Work, 20*, 247–253.
- Bonkowsky, J. L., Frazer, J. K., Buchi, K. F., & Byington, C. L. (2002). Metamizole use by Latino immigrants: A common and potentially harmful home remedy. *Pediatrics, 109*, e98.
- Castro, F. G., Proescholdbell, R. J., Abeita, L., & Rodriguez, D. (1999). Ethnic and cultural minority groups. In B. S. McCrady and E. E. Epstein (Eds.) *Addiction: A comprehensive guidebook for practitioners* (pp. 499–526). New York: Oxford University Press.
- Gloria, A. M., & Perego, J. J. (1996). Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment, 13*, 119–126.
- Grieco, E. M., & Cassidy, R. C. (2001). *Overview of race and Hispanic origin: Census 2000 Brief*. Washington, DC: U.S. Census Bureau.
- Guzmán, B. (2001). *The Hispanic population: Census 2000 Brief*. Washington, DC: U.S. Census Bureau, 2001.
- Huff, R. M. (1999). Cross-cultural concepts of health and disease. In R. M. Huff & M.V. Kline, (Eds.). *Promoting health in multicultural populations: A handbook for practitioners* (pp. 23–39). Thousand Oaks, CA: Sage Publications.

- Lopez, R. A. (2005). Use of alternative folk medicine by Mexican American women. *Journal of Immigrant Health, 7*, 23–31.
- National Alliance for Hispanic Health. (2000). *Quality health services for Hispanics: The cultural competency component* (DHHS Publication No. 99–21). Washington, DC: U.S. Department of Health and Human Services.
- National Center for Health Statistics. (2006). *Health, United States, 2006: With health and aging chartbook*. Hyattsville, MD: National Center for Health Statistics.
- National Institute on Alcohol Abuse and Alcoholism. (2006). *NIAAA analysis reveals increased risk for liver cirrhosis death among Hispanic Americans*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism.
- Ortega, A. N., Rosenheck, R., Alegria, M., & Desai, R. A. (2000). Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. *Journal of Nervous and Mental Diseases, 188*, 728–735.
- Proctor, B. D., & Dalaker, J. (2002). *U.S. Census Bureau, current population reports, poverty in the United States: 2001* (pp. 60–219). Washington, DC: U.S. Census Bureau.
- Skaer, T. L., Robison, L. M., Sclar, D. A., & Harding, G. H. (1996). Utilization of curanderos among foreign born Mexican-American women attending migrant health clinics. *Journal Cultural Diversity, 3*, 29–34.
- Suarez, L., & Ramirez, A. G. (1999). Hispanic/Latino health and disease: An overview. In R. M. Huff and M. V. Kline (Eds.) *Promoting health in multicultural populations: A handbook for practitioners* (pp. 115–136). Thousand Oaks, CA: Sage Publications.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally different: Theory and practice* (4th ed.). New York: John Wiley & Sons.
- Therrien, M., & Ramirez, R. R. (2001). The Hispanic population in the United States: Population characteristics. *Current Population Reports* (pp. 20–535). Washington, DC: U.S. Census Bureau.
- U.S. Census Bureau. (2000). *Census bureau project doubling of Nation's population by 2100*. Washington, DC: U.S. Census Bureau.
- U.S. Census Bureau. (2001). *Table 1: Population by age, sex, race, and origin: March 2000*. Washington, DC: U.S. Census Bureau.

Alcohol and Prescription Drug Attitudes and Use Among Adult Hispanics/Latinos

This chapter covers—

- > Patterns and Prevalence of Abuse
- > Uprooting and Acculturation in Hispanic/Latino Substance Use
- > Intergenerational Acculturation Stress
- > Screening and Assessment of Acculturation

Practitioners face several challenges when working with the Hispanic/Latino substance abuse treatment population. These challenges include understanding the impact of culture, economic status, age, and gender on alcohol consumption and other drug use. It also includes recognizing the symptoms of trauma and signs of psychological distress as a consequence of uprooting among those who are immigrants as well as intergenerational acculturation stress among those born in the U.S.

Patterns and Prevalence of Abuse

Certain elements of traditional Hispanic/Latino culture (e.g., *machismo*) dictate that men should be able to consume a great deal of alcohol. Conversely, these same traditional cultural variables also forbid excessive alcohol consumption among women (Cuadrado and Lieberman, 1998). Data from the 2004 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006) showed that in the previous year, among all Hispanics/Latinos above age 26, 42.5 percent had consumed alcohol, while 23.4 percent reported binge drinking (five or more drinks on one occasion), and 4.8 percent reported heavy drinking

Alcohol is by far the most common substance of abuse.

(four or more episodes of binge drinking in the past month). In addition, 25.3 percent of Hispanics/Latinos over age 26 had smoked cigarettes, and 8.9 percent had used illicit drugs. Similar data specific to those over age 50 is not available (SAMHSA, 2006).

These data show that alcohol is by far the most common substance of abuse, and that substance abuse patterns in Hispanics/Latinos are not dissimilar to patterns among non-Hispanic whites. However, the data conceal the fact that patterns of alcohol consumption differ between subgroups of Hispanics/Latinos, especially among the recent immigrant populations. For instance, Mexican-American men drink less often, but drink more per occasion, a pattern termed by researchers as *fiesta drinking*—the consumption of large amounts of alcohol primarily on special occasions (Kail and DeLaRosa, 1998).

Further, while the 20s are the peak drinking age among Caucasian men, Hispanic/Latino men drink most between the ages of 30 and 39. Single men and men who are not working are more likely to experience alcohol-related problems than married and employed men in the same age group (Nielson, 2000).

In most cultures, a gender difference in alcohol consumption exists in which men drink more than women. Overall, Hispanic/Latina women drink significantly less alcohol than Hispanic/Latino men, and a higher percentage abstain from alcohol completely, or consume it in smaller quantities (Randolph, Stroup-Benham, Black, and Markides, 1998).

Data suggest there is a small cohort of Hispanic/Latina women age 60 and older who begin use of alcohol and psychoactive drugs at this later point in their lives. Late onset of substance abuse appears to be a response to depression, bereavement, retirement, marital stress and/or illness.

Among Hispanic/Latina women, Puerto Ricans are the least likely to abstain, followed by Cuban Americans, Mexican Americans, and other Hispanic/Latino subgroups (Nielsen, 2000). However, younger and more acculturated Hispanic/Latina women drink more in quantity and more frequently than older women or younger women who are less acculturated (Randolph, et al.).

Although data on alcohol and prescription drug use among older Hispanic/Latino adults (those over age 50) are complex and somewhat limited in scope, studies have also shown evidence of heavy alcohol consumption and misuse of prescription drugs. Just as among the younger adults, alcohol use among Hispanic/Latino older adults demonstrates a pattern of infrequent but heavy consumption (Kail and DeLaRosa, 1998). One survey found that among older men of Mexican origin, the alcohol-related social problems typical of younger men do not markedly decline with age. Heavy drinking continues, which is particularly troublesome as these men age and begin to experience health problems while their financial and family responsibilities are heaviest (Vega, Sribney, and Achara-Abrahams, 2003).

Data also suggest a small cohort of Hispanic/Latina women age 60 and older begins use of alcohol and psychoactive drugs at this later point in their lives (Kail and DeLaRosa, 1998). These women reported higher rates and longer periods of use of benzodiazepines than non-Hispanic women in this age group (Kail and DeLaRosa). These include prescription sleeping pills as well as anti-anxiety medications.

However, there is evidence that even as the population of older Hispanics/Latinos doubles over the next decade or so, substance abuse may be diminishing. One survey found that among men over age 60, 24 percent reported frequent moderate or heavy drinking in 1984, compared with only 15 percent in 1995. Among women of the same age, only 6 percent reported frequent but modest consumption of alcohol in 1984, while 17 percent reported frequent light drinking in 1995. None of the women reported frequent heavy drinking (Aguirre-Molina et al., 2001).

A survey of 303 Puerto Ricans age 50 and older found that about 18 percent had up to three drinks in a day, while only 6 percent reported having more than 4 drinks on one day in the past year. However, 11 percent reported abusing drugs (primarily prescription drugs) in the past year (Weingartner, Robison, Fogel, and Gruman, 2002).

Additionally, researchers found that Hispanic/Latina women over age 60 reported higher rates and longer periods of use of benzodiazepines than non-Hispanic women in this age group (Kail and DeLaRosa, 1998). These include prescription sleeping pills as well as anti-anxiety

medications. These drugs may have been prescribed to the client by a physician, but they may also have been provided by a friend or family member, as sharing medicines to help relieve the distress of another is culturally sanctioned among Hispanics/Latinos (Alvarez and Ruiz, 2001). These medications are also widely available for sale outside the medical system.

Although differences in alcohol consumption patterns among the various Hispanic/Latino groups are not clearly understood, researchers have found a strong association between patterns of alcohol consumption and national origins, socioeconomic status, gender, age, and level of acculturation (Randolph et al., 1998). For example, Cubans who immigrated to the United States in the 1960s tend to have a higher socioeconomic status than people of Mexican and Puerto Rican origins. The alcohol consumption pattern among these Cubans is described as moderate. More recent Cuban immigrants are typically of lower socioeconomic status, and their consumption pattern is described as similar to those of Mexican Americans and Puerto Ricans—drinking less frequently but in larger quantities than the earlier generation of Cuban Americans (Randolph et al.).

An acceptance of alcohol or other drug use does not imply that abuse is condoned. One survey of Hispanic/Latino high school seniors showed that 79 percent disapproved of daily alcohol use (SAMHSA, 2006). Likewise, a survey of Mexican Americans living in Texas showed that 85.7 percent agreed that when used excessively, prescription drugs could have dangerous effects. Further, 81.4 percent agreed that a person who abused substances could make the whole

Sharing medicines to help relieve the distress of another is culturally sanctioned among Hispanics/Latinos.

family suffer, and 74.9 percent agreed that people who used drugs would participate in violent crimes. In addition, 71.8 percent believed that alcoholism is used as an excuse for vio-

lent behavior in the family. Only 8.5 percent agreed that women were not likely to abuse alcohol. Compared to spousal and child abuse, alcohol and other drug abuse were considered a more serious problem (Hadjicostandi and Chourprakobkit, 2002).

Recent research suggests that early onset of substance abuse among Latino youth is related not to cultural acceptance of fiesta drinking but to the stress associated with adjustment to U.S. society and values, while onset of substance abuse in older adults appears to be a response to depression, bereavement, retirement, marital stress, or illness (Kail and DeLaRosa, 1998).

Uprooting and Acculturation in Hispanic/Latino Substance Use

Surveys of newly arrived Hispanic/Latino immigrants show very low levels of both substance abuse and mental illness, a phenomenon that has been referred to as a “buffering” or “protective” effect of traditional culture (Escobar, 1998). However, as acculturation occurs, substance use among Hispanics/Latinos more and more resembles the patterns of use among non-Hispanic whites and African Americans in the United States.

Like other immigrants to the United States, many Hispanics/Latinos experience significant losses and psychological and physical trauma as a consequence of their migration. The enormous effort required to adjust to a new environment and the bombardments of a different way of life and language is called acculturation stress. Because alcohol and prescription drug abuse is often associated with high-risk stressors, substance use among Hispanics/Latinos must also be examined within the context of their immigration and traumatic experiences (Sue and Sue, 2003).

For instance, some older Latinos will have come from Cuba in the 1960s. These individuals left Cuba when Fidel Castro came to power and nationalized the country’s industries. Most immigrants from Cuba at that time were middle class, educated, and came to the U.S. with a profession and the economic resources with which to begin their new life. The alcohol consumption patterns of these early Cuban immigrants are described as moderate.

More recent arrivals from Cuba, however, have left a life of poverty, arrived in the U.S. under dangerous and extremely stressful circumstances, are mostly illegal immigrants, and have little in common with their older counterparts. Having arrived in the U.S. with few

resources, they are typically of lower socioeconomic status and level of acculturation than their older countrymen. These Cuban immigrants exhibit an alcohol consumption pattern that is similar to those of Mexican Americans and Puerto Ricans, drinking less frequently but in larger quantities (Rothe and Ruiz, 2001).

Immigrants who came from El Salvador between 1980 and 1992 during the 12-year civil war escaped political persecution and are likely to be well educated, but are unable to use their education in the U.S. However, those who came after the country's two earthquakes of 2001 experienced a much different migration stress. These later arrivals may not have experienced civil war and political persecution but may have lost their family, land, and everything else they owned in the devastation. Substance use among these El Salvadorians may be a response to post-traumatic stress disorder as well as acculturation stress.

The losses of immigration include not only the traumas suffered in their native country, but also separation from their homeland, family, friends, and other support networks as well as the loss of familiar foods, climate, sights, and sounds. Immigrants may feel resentment and a sense of alienation from members of the mainstream culture. For some immigrants, this experience may not be immediate. The initial benefit of relocating may outweigh the difficulties of adjusting to the new environment. Only after unsuccessful efforts at adapting or achieving upward mobility may intense feelings of stress emerge (Garcia-Preto, 1996; National Alliance for Hispanic Health, 2001).

Treatment providers should take the time to listen to their clients' stories not only as a way of establishing *personalismo* and *respeto* (see chapter 3), but in order to get a bigger picture of their trauma experiences and substance use histories and treatment needs. The treatment provider needs to consider each client as completely unique in his or her attachment to his or her cultural background, as even those from the same country may have little in common in terms of their immigration experiences or degree of family acculturation (National Alliance for Hispanic Health, 2001).

The psychological impact of immigration has specific relevance to substance abuse, because immigrants may use alcohol and other drugs to self-medicate for posttraumatic stress disorder or to cope with homesickness, loneliness, and the loss of support networks (Straussner, 2001). Some Hispanics/Latinos may tolerate substance abuse by undocumented immigrants in their families and communities to protect them from deportation. In addition, undocumented immigrants are ineligible for any treatment funded by Medicare/Medicaid or other programs that require a Social Security number. The distress of unemployment and/or losing economic status and the sense of powerlessness from role reversal are all factors contributing to substance abuse. Like others who are dependent on substances of abuse, Hispanics/Latinos use substances to medicate their discomfort and temporarily relieve their symptoms of stress.

Intergenerational Acculturation Stress

As mentioned in chapter 1, three of five Hispanics/Latinos were born in the U.S., and thus acculturation stress in many U.S.-born clients will present as intergenerational acculturation stress. (The ratio of foreign-to U.S.-born among Hispanics/Latinos age 50 and older is not known.) Data from the Administration on Aging (2005) show that 16 to 20 percent of Hispanic/Latinos over age 60 live in a household with grandchildren under age 18. About four percent of these elder adults are responsible for the care of these grandchildren.

Surveys show that much intergenerational acculturation stress is a function of the relentless, daily chronic hassles of meager living rather than discrete major stressful life events. These hassles include a lack of English-speaking ability by various members of the family, which not only severely limits their employment opportunities but also means that other members of the family (sometimes very young children) are constantly required to intervene on their behalf for even small everyday needs. Thus the children, in the context of U.S. society, have to “parent” their traditional elders. Another stress is living in a poor neighborhood with a high crime rate and encountering the liberal beliefs of the larger Anglo society (Cervantes and Pena, 1998).

Often there are one or more elders expressing strict adherence to conventions that are out of context with current cultural demands, even as they must rely on their children to function on a day-to-day basis.

Ortega and colleagues (2000) speculate that it is this long-term upheaval of the traditional family structure that causes the acculturation stress resulting in an elevated risk of substance use and mental disorders among second- and third-generation Hispanics/Latinos. In addition, children and younger members of the family acculturate much

faster than their elders. Often there are one or more elders expressing strict adherence to conventions that are out of context with current cultural demands, even as they must rely on their children to function on a day-to-day basis. This breakdown in the traditional family structure produces family conflict and familial disorganization that results from the clash between U.S. and traditional Hispanic/Latino customs.

This clash creates stress and disruption to all family members. The hallmark scenario of intergenerational acculturation stress is the U.S.-born son who rejects his parents' native culture, with an over-involved and under-acculturated mother who shows neurotic patterns of behavior and a father who is distant and provides inconsistent discipline or is absent (Cervantes and Pena, 1998).

In families suffering from intergenerational acculturation stress, the U.S.-born children are at risk of substance abuse from the familial disorganization alone. However, where there is substance abuse among one or both parents, the risk is higher. Several studies have shown that

parental substance abuse, whether prescription drugs, alcohol, or another substance, is the biggest predictor of substance use by their children (Vega and Sribney, 2003; Cervantes and Pena, 1998).

Acculturation stress in many U.S.-born clients will present as intergenerational stress.

Ortega and colleagues (2000) found in their analysis that among those of Mexican, Puerto Rican, and other Hispanic/Latino backgrounds, those with at least one parent born in the U.S. and whose current language spoken at home was English were significantly more likely to have a substance use or mental disorder than those who were foreign-born. Among a group of Mexican Americans diagnosed as having an alcohol abuse disorder, only a third of those who were immigrants reported that their parents also had the disorder. However, two thirds of the U.S.-born Mexican Americans reported parental alcohol abuse disorder (Vega and Sribney, 2003).

Screening and Assessment of Acculturation

A number of assessments are available for determining the degree of acculturation present in a client if that information is needed for treatment planning. These include the 12-question Marin Short Scale (Marin, Sabogal, Marin, Otero-Sabogal, and Perez-Sable, 1987) and the longer Acculturation Rating Scale for Mexican-Americans – Revised (ARSMA-II) (Cuellar, Arnold, and Maldonado, 1995). See the chart on the following page.

Most clients want some assurance that their counselor at least understands their worldview, even if they do not share it. Sue, Fujino, Hu, Takeuchi, and Zane's study (1991) of thousands of outpatients in the Los Angeles County mental health system found that, especially among people who did not speak English as a primary language, counselor–client matching for ethnicity and language predicted longer time in treatment (more sessions) with better outcomes. However, in some cases, gender has been found to be even more important than ethnicity in matching clients with counselors, particularly for female clients (Sue and Sue, 2003).

The chart on the next page describes some instruments available for use in assessing a client's degree of acculturation. A clearer, more objective measure of acculturation may help the provider better plan treatment appropriate for the Hispanic/Latino client. Additional information regarding these instruments and other resources is found in chapter 5.

Acculturation Scales		
Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents (Felix-Ortiz et al., 1994)	Multidimensional construct places adolescents in one of four categories based on language, behavior/familiarity, and values/attitudes: (1) bicultural, (2) Latino-identified, (3) American-identified, and (4) low-level bicultural.	Latinos/ Latinas
Acculturation Rating Scale for Mexican Americans-I (ARSMA-I) (Cuellar et al., 1980)	Differentiates between 5 levels of acculturation: (1) Very Mexican, (2) Mexican-Oriented Bicultural, (3) True Bicultural, (4) Anglo-Oriented Bicultural, and (5) Very Anglicized. Established validity.	Mexican Americans
Acculturation Rating Scale for Mexican Americans-II (Cuellar et al., 1995)	Like ARSMA-I, except that it includes separate subscales to measure multidimensional aspects of cultural orientation toward Mexican and Anglo cultures independently.	Mexican Americans
Bidimensional Acculturation Scale for Hispanics (Marín & Gamba, 1996)	Measures acculturation for Hispanic and non-Hispanic domains based on 12 items measuring 3 language-related areas. High consistency and validity.	Mexican Americans and Central Americans

References

- Administration on Aging. (2005). *A profile of older Americans: 2005*. U.S. Department of Health and Human Services, Aging Information Center. Bethesda, MD: Author.
- Aguirre-Molina, M., Molina, C.W., & Zambrana, R. E. (2001). *Health issues in the Latino community*. San Francisco: Jossey-Bass.
- Alvarez, R. A., & Ruiz, P. (2001). Substance abuse in the Mexican American population. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 111–136). New York: Guilford Press.
- Cervantes, R. C., & Pena, C. (1998). Evaluating Hispanic/Latino programs: Ensuring cultural competence. *Alcoholism Treatment Quarterly*, 16, 109–132.
- Cuadrado, M., & Lieberman, L. (1998). Traditionalism in the prevention of substance misuse among Puerto Ricans. *Substance Use and Misuse*, 33, 2737–2755.
- Cuellar, I., Arnold, B., & Maldonado, R. (1995). Acculturation rating scale for Mexican Americans-II: A revision of the original ARSMA Scale. *Hispanic Journal of Behavioral Sciences*, 17, 275–304.
- Cuellar, I., Harris, L. C., & Jasso, R., (1980). An acculturation scale for Mexican American normal and clinical populations. *Hispanic Journal of Behavioral Sciences*, 2, 199–217.
- Escobar, J. I. (1998). Immigration and mental health: Why are immigrants better off? *Archives of General Psychiatry*, 55, 781–782.
- Felix-Ortiz, M., Newcomb, M. D., & Meyers, H., (1994). A multicultural measure of cultural identity for Latino and Latina adolescents. *Hispanic Journal of Behavioral Sciences*, 16, 99–115.
- Garcia-Preto, N. (1996). Latino families: An overview. In M. McGoldrick, J. Giordano, & J. K. Pearce (Eds.) *Ethnicity and family therapy* (2^d ed., pp. 141–154). New York: Guilford Press.
- Hadjicostandi, J., & Cheurprakobkit, S. (2002). Drugs and substances: Views from a Latino community. *American Journal of Drug and Alcohol Abuse*, 28, 693–710.
- Kail, B. L., & DeLaRosa, M. (1998). Challenges to treating the elderly Latino substance abuser: A not so hidden research agenda. *Journal of Gerontological Social Work*, 30, 123–141.

- Marin, G., & Gamba, R. J. (1996). A new measurement of acculturation for Hispanics: The bidimensional acculturation scale for Hispanics (BAS). *Hispanic Journal of Behavioral Sciences, 18*, 297–316.
- Marin, G., Sabogal, F., Marin, B., Otero-Sabogal, R., & Perez-Sable, E. J. (1987). Development of a short acculturation scale for Hispanics. *Hispanic Journal of Behavioral Sciences, 9*, 183–205.
- National Alliance for Hispanic Health. (2001). *A primer for cultural proficiency: Towards quality health services for Hispanics*. National Alliance for Hispanic Health. Washington, DC: Estrella Press.
- Nielsen, A. L. (2000). Examining drinking patterns and problems among Hispanic groups: Results from a national survey. *Journal of Studies on Alcohol, 61*, 301–310.
- Ortega, A. N., Rosenheck, R., Alegria, M., & Desai, R. A. (2000). Acculturation and the lifetime risk of psychiatric and substance use disorders among Hispanics. *Journal of Nervous and Mental Disease, 188*, 728–735.
- Randolph, W. M., Stroup-Benham, C., Black, S. A., & Markides, K. S. (1998). Alcohol use among Cuban-Americans, Mexican-Americans, and Puerto Ricans. *Alcohol Health & Research World, 22*, 265–269.
- Rothe, E. M., & Ruiz, P. (2001). Substance abuse among Cuban Americans. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 97–110). New York: Guilford Press.
- Straussner, S. L. A. Ethnocultural issues in substance abuse treatment: An overview. (2001). In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment*. (pp. 3–28). New York: Guilford Press.
- Substance Abuse and Mental Health Services Administration. (2006). *Results from the 2005 National Survey on drug use and health: National findings*. Rockville, MD: Office of Applied Studies.
- Sue, D. W., & Sue D. *Counseling the culturally different: Theory and practice* (4th ed.). New York: John Wiley & Sons, Inc.
- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991) Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*, 533–540.

- Vega, W. A., Sribney W. M., & Achara-Abrahams, I. (2003). Co-occurring alcohol drug, and other psychiatric disorders among Mexican-origin people in the United States. *American Journal of Public Health, 93*, 1057–1064.
- Vega, W. A., & Sribney, W. (2003). Parental risk factors and social assimilation in alcohol dependence of Mexican Americans. *Journal of Studies on Alcohol, 64*, 167–175.
- Weingartner, K., Robison, J., Fogel, D., & Gruman, C. (2002). Depression and substance use in a middle aged and older Puerto Rican population. *Journal of Cross-Cultural Gerontology, 17*, 173–193.

Hispanic/Latino Culture and the Substance Abuse Treatment Provider

This chapter covers—

- > The Treatment Setting and Hispanic/Latino Culture
- > Religion and Fatalism
- > A Note About Confidentiality

As with all people, the core cultural values of Hispanics/Latinos exert a strong influence on their approach to health care. Research has shown that Hispanics/Latinos seek participation in drug and alcohol treatment programs at about the same rate as the mainstream U.S. population.

The degree to which a client is acculturated will moderate the impact his or her traditional cultural elements have on his or her participation in treatment. Even so, even a modest degree of cultural competence in treatment staff will help Hispanic/Latino clients feel comfortable in approaching a facility and improve their engagement and retention in treatment. Even among the most acculturated clients, an acknowledgment of these traditional values by the treatment provider will help establish the therapeutic connection (Sue and Sue, 2003).

The traditional elements of Hispanic/Latino culture discussed in this chapter will provide a framework for interacting with all Hispanic/Latino clients, regardless of whether you are a substance abuse counselor or a medical practitioner. This chapter provides tools for showing cultural competence beginning with the first contact, whether through a phone call, a referral

There is an expectation that the family is the first and often only place one turns in times of distress. To go outside the family is embarrassing. One does not wash dirty laundry in public.

from another agency, or an unannounced visit, and continuing through the client's intake interview, assessment, and treatment.

Acculturation plays a significant role in how the Hispanic/Latino client responds to individual staff members as well as a specific facility. Assessing a client's degree of acculturation may be an important first step. This can be done very informally at an initial meeting ("Are you comfortable talking about yourself in English? Do you prefer being called Hispanic or Mexican American?") and more precisely with an assessment tool during treatment planning. See chapter 2 for instruments for determining acculturation.

The Treatment Setting and Hispanic/Latino Culture

The traditional Hispanic/Latino cultural values described below may be more important to older adults, especially if they are less acculturated.

Familismo

Accommodating family is critical to culturally competent treatment among Hispanics/Latinos. The stronger the traditional identification with and attachment to the family, the more likely that decisions about treatment will involve the entire family, or be deferred to the family member with the most authority (Suarez and Ramirez, 1999). Some studies suggest that the degree to which family members are attached to the family (*familismo* or *familia unida*) can positively influence health behavior. However, the power of the family to unintentionally disrupt treatment out of a concern for protecting the family or the family member in treatment must also be taken into account. *Familismo* dictates that decisions are based on what is best for the family, not what is best for an individual member. Level of acculturation typically varies across the generations and one member's positive attitude toward treatment may conflict with a more authoritative family member's concerns. In working with more traditional Hispanics/Latinos, the more the health care provider recognizes these forms of family attachments, the more culturally competent the provider will be (Sue and Sue, 2003).

Traditional Hispanic/Latino families are hierarchical, granting the men, especially the elder men of the family, the greatest importance. Gender roles are clearly defined, and children are expected to obey their parents.

Women's roles in general are

very restricted, and adolescent females are given much less freedom than their brothers. Children are sometimes expected to contribute financially to the family, and members often rely on each other financially throughout their lifetimes (Headden, 1997). Acculturation, however, frequently plays havoc with this structure. For instance, elders often expect compliance with customs that are out of context with current demands. Or instead of being the heads of the family, older parents must rely on their grown children to function on a day-to-day basis. This breakdown in the traditional family structure produces conflict, as discussed previously in chapter 2.

Familismo dictates that decisions are based on what is best for the family, not what is best for an individual member.

One aspect of *familismo* is a tremendous cultural pressure to keep all problems and issues within the family. One does not talk to others about anything that could embarrass the family, and loyalty to the family is paramount. For a Hispanic/Latino, discussion of his or her personal, family, and substance use issues in treatment may be considered disloyal. A client's family and social circle often includes individuals who have a vested interest in keeping them away from treatment. This could be a vested interest in their shared drug use, but is also often because of a vested interest in protecting the relationship. As one Latina, when she stated that she was going to treatment, described the response: "Why do you want to go there? I don't want you to go there. Who's going to be there, and I won't be there to be able to watch you" (Kail and Elberth, 2002, p. 7). Thus, the family may not initially support treatment until the provider has established a level of trust and proven to the larger family that he or she truly has the best interests of the client, and ultimately the family, at heart.

This priority of the family may also mean that it often takes several appointments for the client to get to the clinic, and missed appointments may become routine. For instance, going to work and providing

It is very important for Hispanic/Latino clients...that family is involved in treatment. However, they need flexibility...concerning which family members are included, and when this inclusion is initiated.

for the family is a Hispanic/Latino man's first priority as long as he is deemed able, while a Hispanic/Latina woman's first priority is child care—including her grandchildren—and she may miss appointments not because of lack of motivation, but because she was needed to help with child care.

Familismo also means that those surrounding the person abusing substances may react in a number of unexpected ways. Families and friends can close their eyes to the appearance of substance abuse to avoid confrontation and preserve family unity and thus enable the person with a substance use problem to continue using (Kail and Elberth, 2002). Many family members will break off contact or give a substance using family member money in order to avoid confrontation over the drug use situation. A family may send a substance abusing member of the family back to their home country or, in the case of elders, send the grandmother or grandfather from the household of one offspring to another to avoid embarrassment. Hispanic/Latino clients may simply disappear from the community because it became known that they were in treatment. The more acculturated the family, the less this option is used (Kail and Elberth, 2003).

On the other hand, it was very important for the clients who responded to Kail and Elberth's (2003) survey that family was involved in treatment. However, they needed flexibility on the part of program policies where involving families was concerned. This flexibility primarily meant allowing discretion concerning which family members were involved, and when this involvement was initiated.

Personalismo

To substance abuse treatment providers, *personalismo* is perhaps the feature of cultural competence that should be, figuratively speaking, hung on the front door. In Hispanic/Latino cultures, personal connec-

tions are paramount, and *personalismo* refers to the importance given to personal rather than institutional relationships (Mancini, 2001). Because the person with whom one does business or makes contact takes on greater importance than the institution, a Hispanic/Latino will not think of the clinic as the provider, but rather the individual staff member with whom he or she meets for treatment, and the person who greets him or her at the front desk or who answers the phone.

The Hispanic/Latino client will prefer to first establish a personal connection with a member of the intake staff before going through the routines to establish eligibility. Being immediately placed in contact with a Hispanic/Latino or Latina staff member is a tremendous motivator for a client to proceed with treatment. Regardless of the ethnic background of the staff, he or she should spend time being friendly and getting to know the client a little as a person before beginning the more formal task-oriented procedures of the clinic. Efficiency will have to take a lower priority than the personal connection if a Hispanic/Latino client is to be engaged in treatment. If possible, a single staff person should handle this initial visit, rather than handing the client off to another staff member to fulfill administrative requirements. This means taking several sessions to gather the needed information to allow for the development of a personal connection, and to reassure the client that the staff's relationship with him or her is important (Kail and Elberth, 2003).

The first criterion mentioned in Kail and Elberth's (2003) survey of how to improve culturally competent treatment was the presence of Hispanic/Latino staff so that they communicate in whichever language they are most comfortable. Even if staff do not speak any Spanish, being able to greet new as well as current clients with *Buenos dias* (good morning) or *Buenos tardes* (good afternoon) suggests a welcome attitude. Regardless of language, staff should not forget a handshake. "We are a touching people. If you are more than a handshake distance from your client, you're too far" (National Alliance for Hispanic Health, 2001, p. 23).

Personalismo also extends into group dynamics. For example, in the Hispanic/Latino community, meetings and gatherings that extend beyond the family are normally held in homes and time is allowed for

food and socializing on a personal level before business is conducted. In a group treatment setting, scheduling extra time for a little socializing and even providing chips, cookies, or some other snack before the therapy session begins could help make Hispanic/Latino clients feel more at home, and less at the mercy of an impersonal institution (Marsiglia and Daley, 2002).

Respeto

Once the Hispanic/Latino client is inside the door and has established a personal connection with intake staff, it is attention to *respeto* that will engage the client and encourage him or her to continue treatment.

“We are a touching people. If you are more than a handshake distance from your client, you’re too far.”

Respeto refers to the rule that persons in positions of authority (most often determined by age, gender, and social role) are to be respected. In a health care setting, Hispanic/Latino clients tend to view providers as authority

figures. However, among Hispanics/Latinos, even though one may be of lower social status, he or she expects to be treated with respect.

Among those surveyed by Kail and Elberth, (2002), the clients who completed treatment stated that being addressed with respect was very important. One of their difficulties with entering treatment occurred with routine checks for drugs and verification of information. These routine searches were considered embarrassing, a violation of their dignity, and showed lack of respect. Policies involving checking for contraband should be explained carefully, and conducted without violating the respect and dignity important to the Hispanic/Latino client. Staff should reassure clients that these activities are performed for security reasons.

Respect for authority may make a Hispanic/Latino client reluctant to ask questions (Mancini, 2001). Also out of respect, Hispanic/Latino clients may be hesitant to express doubts about their treatment, make suggestions, or to admit they are confused. This stems from a cultural taboo against expressing negative feelings directly (National Alliance for Hispanic Health, 2001). Because *respeto* governs interpersonal relationships, it also dictates behavior with authority figures, and the substance

abuse treatment provider will be seen as an authority figure. Thus out of *respeto*, a client may not disagree with a treatment plan, and appear to be compliant, but express his or her disapproval or dissatisfaction with *pelea monga*, a “relaxed fight” a passive non-cooperation reflecting the clients’ feeling of being misunderstood, rather than unmotivated (Medina, 2001).

Simpatía

Simpatía refers to the tendency to avoid conflict in social situations, and is characterized as politeness and pleasantness even in times of distress. In a treat-

ment setting, a client may tend to hide pain or discomfort (Mancini, 2001). Some studies suggest that *simpatía* may lead to overreporting of socially desirable responses (Suarez and Ramirez, 1999).

Hispanic/Latinos who abuse substances are viewed rather harshly in their own culture.

Hispanics/Latinos place a high value on achieving harmony in interpersonal relationships. However, it is noted by Kail and Elberth (2002) that Hispanics/Latinos who abuse substances are viewed rather harshly in their own culture. The men may be viewed negatively for being economically irresponsible or abusive while intoxicated, while women with a substance abuse disorder are treated especially badly for so radically violating gender role expectations. Thus, Hispanic/Latino clients are particularly sensitive to the sense of being judged by staff in their contact with a treatment facility. It was particularly important to them that they felt accepted, even while making initial inquiries about the program over the telephone. Active assistance and warmth were very important in their decision to further pursue contact and move forward with treatment.

Likewise, after entering therapy, confrontational techniques by staff or other members of the group in therapy caused Hispanics/Latinos great discomfort. This included questions that were embarrassing (Did your father abuse you?), overt pressure to change, and tones of voice that implied lack of respect. Another factor mentioned by Kail and Elberth’s (2002) survey respondents is the availability of single-sex groups. Hispanic/Latino men do not want to talk about their issues in front of women, and vice versa.

Confianza

Once the Hispanic/Latino client is in treatment, *confianza*, or trust, will grow over time if the treatment provider shows respect for the client and his or her culture and takes a personal interest in him or her. The Hispanic/Latino client grants this trust when he or she comes to believe that the provider has his or her best interests at heart.

Especially with women, the counselor who develops the skill to engage in a therapeutic conversation that resembles a relaxed, informal chat (*platica*) will be more successful. The informal chat must allow for diversions into other areas of the client's life, as a business-like focus on the client's substance abuse for the sake of efficiency will interfere with *confianza*.

One technique that can be used with diverse clients is known as ethnographic interviewing, and tools used in this interviewing technique may be useful to build *confianza*. In ethnographic interviewing, the clients are the teachers, and the counselors are the learners. The counselors want to learn about the clients' experiences. One tool of this technique is to ask clients to draw a map of a particular experience, whether drug related or other. They draw circles or other shapes to represent people/feelings/events and draw lines to interconnect them to show relationships. This encourages them to think of their substance-use decisions and issues in the context of their culture and their relationships. It is especially useful among Hispanics/Latinos, as in general, they tend to view the sources of their problems as existing outside themselves, and in their environment. The exercise of the map and the ethnographic interview encourages them to see the role of their own decisions in their experiences.

Such a visual tool also helps transcend language barriers. The interviewer listens to the particular vocabulary and terms the client uses to describe his or her life and experiences and then adopts these terms and phrases to develop rapport with the client. Extra time is allowed for diversions into other areas of the client's life and conversations that may not be specifically focused on the client's substance use (Spradley, 1979).

Treatment providers who take the time to develop this trust with Hispanic/Latino clients will find that with *confianza* there is compliance (National Alliance for Hispanic Health, 2001).

Hispanic/Latino Cultural Values and Their Influence on Health Care	
<i>Familismo/familia unida</i> (familism) Attachment to the family	Client is likely to defer the requirements of treatment to the needs of family
<i>Personalismo</i> (personalized relations) Importance of personalized and empathic communication	Client will prefer—even expect—to deal with an individual, not an institution, and its policies and procedures
<i>Simpatía</i> (politeness and pleasantness) Harmony in interpersonal relations	Client will expect to be treated with dignity and sympathy and will not react well to confrontational techniques
<i>Respeto</i> (respect) Respect for elders and other persons in positions of authority	Client may be reluctant to ask questions of the provider Even though the provider may have greater social status, the client expects to be treated with respect and to not feel judged
<i>Confianza</i> (trust) Interpersonal relationships that build mutual trust	A provider needs to prove trustworthiness before his or her advice or treatment instructions are followed Clients want to establish a friendly and comfortable rapport with a provider before being asked to reveal sensitive information
<small>Source: Castro et al., 1999, p. 510; Mancini, 2001, p. 3; National Cancer Institute, 1996, p.2; Suarez and Ramirez, 1999, p. 120.</small>	

Religion and Fatalism

Religion and spirituality play an important role in Hispanic/Latino cultures. Most Hispanics/Latinos are Roman Catholics, and therefore acknowledge religion as a powerful moral and social influence on their

day-to-day living. However, in addition to Catholicism, Hispanic/Latino cultures are grounded to varying degrees in a belief in spirits and divine intervention (Gloria and Peregoy, 1996). Among less educated and more traditional Hispanics/Latinos, ill health and disease may be attributed to either God's will or witchcraft and treated through traditional folk methods.

However, levels of religious belief and commitment vary a great deal among individuals (Gloria & Peregoy, 1996). This should be considered before bringing pastoral counselors into the treatment process.

A common belief in Hispanic/Latino culture, and one that will vary with acculturation, is *fatalismo*, the belief that persons have little or no control over their personal health. This may be expressed in the phrase *así es la vida* (such is life). That is, behaviors, diseases, and illnesses cannot be controlled because they are believed to be inherited or produced by factors beyond one's control. A similar attitude is defined by the term *resignacion*, the belief that one should accept fate without question or complaints, which is closely associated with religion. For instance, one study found that a majority of Hispanics/Latinos believed that cancer was a death sentence and God's punishment, and therefore very little could be done to prevent it (Suarez and Ramirez, 1999). This belief is not entirely unfounded, because the high prevalence of late-stage screening and diagnosis of cancer among low income Hispanics/Latinos is associated with higher death rates. The attitude of *resignacion* is more commonly expressed by women and older men (National Cancer Institute, 1996).

Among less educated and more traditional Hispanics/Latinos, ill health and disease may be attributed to either God's will or witchcraft and treated through traditional folk methods.

A religious corollary to traditional cultural beliefs is the conviction that alcohol or drug use may be the result of moral failings or connected to a mental disorder, which carries a stigma in many Hispanic/Latino communities (Kail and DeLaRosa, 1998). This idea may be revealed through an initially high degree of resistance to treatment.

However, the treatment provider who shows acceptance and a non-judgmental attitude, and shows a reasonable degree of cultural competence, can overcome a client's own fatalism and resignation. The client can begin to understand that the treatment provider is an ally in his or her struggle with substance use. With a strong commitment to treatment, and the help of the treatment provider, these clients can overcome not only their substance use but also gain skills for the rest of their lives.

A Note About Confidentiality

Many Hispanics/Latinos have been exposed to anti-immigrant legislation, or have entered the country illegally. Among these clients, you may be regarded with great suspicion and must put extra effort into building trust. Do not assume a client has a general idea of the legal and other informational barriers between agencies and other professionals involved in social services. This will help establish a therapeutic alliance and provide a starting point to talk of the client's immigrant-, family-, or trauma-related experiences as appropriate (Alvarez and Ruiz, 2001).

References

- Alvarez, R. A., & Ruiz, P. (2001). Substance abuse in the Mexican American population. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 111–136). New York: Guilford Press.
- Castro, F. G., Proescholdbell, R. J., Abeita, L., & Rodriguez, D. (1999). Ethnic and cultural minority groups. In B. S. McCrady, & E. E. Epstein (Eds.) *Addiction: A comprehensive guidebook for practitioners* (pp. 499–526). New York: Oxford University Press.
- Gloria, A. M., & Peregoy, J. J. (1996). Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment, 13*, 119–126.
- Headden, S. (1997). The Hispanic dropout mystery. *U.S. News & World Report, 123*, 64–65.

- Kail, B. L., & DeLaRosa, M. (1998). Challenges to treating the elderly Latino substance abuser: A not so hidden research agenda. *Journal of Gerontological Social Work*, 30, 123–141.
- Kail, B., & Elberth, M. (2003). Engaging and treating the substance-abusing Latina. *Journal of Ethnicity in Substance Abuse*, 2, 19–30.
- Kail, B., & Elberth, M. (2002). Moving the Latina substance abuser toward treatment: The role of gender and culture. *Journal of Ethnicity in Substance Abuse*, 1, 3–16.
- Mancini, P. (2001). *Cultural sensitivity*. Clinic for Education, Treatment and Prevention of Addiction, Inc. Retrieved April 11, 2007, from http://www.lasculturas.com/aa/vs_ManciniCulture.htm.
- Marsiglia, F. F., & Daley, J. M. (2002). Latinos participating in multiethnic coalitions to prevent substance abuse: A case study. In J. B. Torres & F. G. Rivera (Eds.) *Latino/Hispanic liaisons and visions for human behavior* (pp. 97–121). Haworth Press.
- Medina, C. (2001). Toward an understanding of Puerto Rican ethnicity and substance abuse. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 137–164). New York: Guilford Press.
- National Alliance for Hispanic Health. (2001). *A primer for cultural proficiency: Towards quality health services for Hispanics*. Washington, DC: Author.
- National Cancer Institute. (1996). *Communicating with Hispanic consumer[s]: A focus group study*. Bethesda, MD: Author.
- Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rhinehart and Winston.
- Suarez, L., & Ramirez, A. G. (1999). Hispanic/Latino health and disease: An overview. In R. M. Huff & M. V. Kline (Eds.) *Promoting health in multicultural populations: A handbook for practitioners* (pp. 115–136). Thousand Oaks, CA: Sage Publications.
- Sue, D. W., & Sue D. (2003). *Counseling the culturally different: theory and practice* (4th ed.). New York: John Wiley & Sons.

Treating Hispanic/Latino Older Adults

This chapter covers—

- > A Hidden Population
- > The Older Immigrant
- > Counseling the Older Hispanic/Latino
- > Addressing Family and Social Issues

Both the graying and the growth of the Hispanic/Latino population will present challenges for the treatment provider, whether medical, substance abuse, or mental health counselors. Older Hispanic/Latinos are less likely to be fully comfortable talking about personal matters in English, and clients who speak English as a second language are most likely to discontinue treatment in settings where bilingual and bicultural therapists are underrepresented (Gloria and Peregoy, 1996).

The biggest barrier to treatment among older Hispanics/Latinos is not language. It is lack of insurance coverage.

Given the strong cultural tradition that dictates that older family members are cared for at home, aging Hispanics/Latinos present a challenge for their families as well. For instance, in 1995, there were 9.5 persons over age 65 for every 100 people of working age in the Hispanic/Latino population. By the year 2030 it is estimated that there will be 21.1 people over age 65 for every 100 of working age (Aguirre-Molina et al., 2001).

A Hidden Population

Some researchers regard Hispanic/Latino older adults who abuse alcohol and prescription drugs as a “hidden population” because they are difficult to identify in their communities. Women who abuse alcohol

are even more difficult to identify. The daily activities of these older women are centered in the home, where alcohol consumption and prescription drug use are most likely to occur. The widely shared value of *familismo* may translate into an approach that enables or hides grand-ma's alcohol or drug use. Out of respect for the elderly, younger family members are not likely to confront a Hispanic/Latina with an alcohol or drug use problem. The older family member may be able to hide his or her substance abuse from the family or disguise the signs of abuse as a medical issue. Furthermore, alcohol or drug use problems by older adults of both genders are not likely to be discussed outside the family. Problems are to be kept within the family, which is expected to deal with them as best as possible (Kail and DeLaRosa, 1998).

To better identify the “hidden population,” awareness of potential risks for abuse must be raised within the external support systems for

The older family member may be able to hide his or her substance abuse from the family or disguise the signs of abuse as a medical issue.

Hispanic/Latino older adults (Kail and DeLaRosa, 1998). These mainly consist of medical and social service providers, as well as the informal network of friends who have the most contact with older adults outside of the family.

Older Hispanics/Latinos normally live with family members. It is a part of Hispanic/Latino culture that families accept the responsibility and have a preference for providing care for their older members in the home. Among Hispanics/Latinos age 65 and older, only 22 percent lived independently, compared with 42 percent of non-Hispanic whites and African Americans. Most older Hispanic/Latino men lived with their spouse (67 percent) or other family members (16 percent) while among older Hispanic/Latina women, 37 percent lived with their spouse and 36 percent lived with other relatives (Federal Interagency Forum on Aging Related Statistics, 2006). Few can afford nursing homes or assisted living facilities.

The Older Immigrant

This preference for living with family can result in complex migration patterns, which add to the stresses that place the older members at

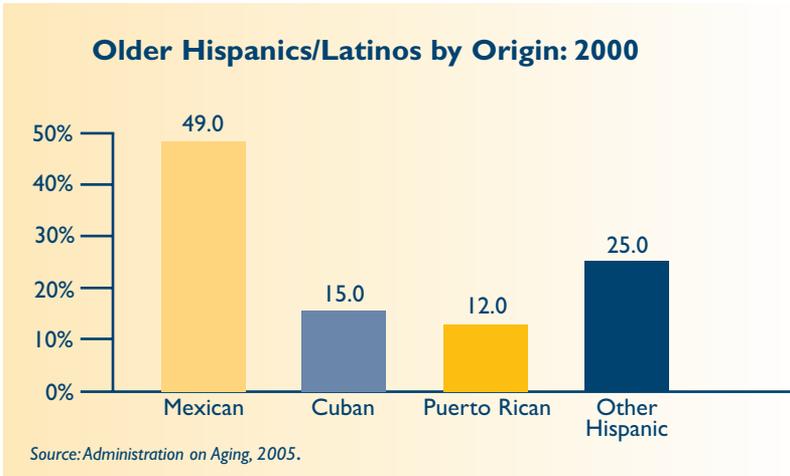
risk of substance abuse. For instance, Hispanic/Latino older adults who have retired from working in their native country may migrate as retirees to the U.S. to join their children's households. This may occur early in their retirement in order to help care for grandchildren, or later when they themselves need to be cared for by their offspring. They find themselves, after a lifetime in their home country, suddenly in a place where they do not know the language, without the skills necessary for living competently in a foreign land, living with offspring whose family norms they may not approve of, living with grandchildren who do not show them respect, and possibly newly widowed or ill (Falicov, 1998).

Among older immigrants, an older woman may become reasonably integrated into her familiar tasks of cooking, housekeeping, and babysitting, but the older man may be limited to small errands and watching Spanish TV for long hours at a time. These stresses can escalate moderate drinking habits to alcohol abuse (Falicov, 1998).

However, the opposite may also be true: older Hispanics/Latinos who are estranged from their families in the U.S. or whose families cannot care for them will migrate back to their native country where they have other relatives and the cost of living is far lower. Some go back and forth to avoid the cold northern winters. Thus older Hispanics/Latinos will sometimes abruptly leave and re-enter a provider's care (Falicov, 1998).

Older Hispanic/Latino immigrants have an especially difficult time adjusting to a new environment, because they leave a significant degree of their life experiences behind to adapt to a new situation. In addition, the reality of retirement, death of a spouse, physical and mental decline, and the fear of dependency may cause additional distress for older immigrants (Hernandez & McGoldrick, 1999).

Older immigrants who do not speak English often depend on their adult children as spokespersons in an English-speaking environment. For traditional families, this dependency represents at least a partial role reversal, because the older adults would be forced to relinquish their position as the source of authority. Studies show that this role reversal can lead to intergenerational conflict and a loss of respect by the adult children for their parents (Straussner, 2001). As a bridge to traditional



cultural values, an older immigrant may experience conflict with children (and grandchildren) who prefer to adopt the new cultural values.

Among older Hispanics/Latinos who have spent decades or even their entire lives in the U.S., research indicates that depression, bereavement, retirement, marital stress, and illness play a significant role in the onset of substance abuse. Further, a group of Puerto Ricans surveyed by Weingartner and colleagues (2002) showed that those in their 50s were significantly more likely to be depressed than those age 60 and older and that depression and substance use were strongly associated. Thus substance abuse may begin as a result of the stresses and depression that are unique to midlife. However, older adults may also enter treatment for substance use that is decades old, but becomes of concern when responsibilities change with middle age, such as when they are now called upon to care for grandchildren or a very elderly family member.

*There is ... a strong association between having experienced an *ataque de nervios* and depression and substance use.*

The prevalence of trauma or abuse among the older Latinas and Latinos is not known, but treatment providers should be aware that a history of trauma is always a highly significant possibility. One survey of young substance-abusing Hispanic/Latinas

showed that depression was the most common co-occurring disorder, and that 80 percent of this population had suffered abuse and trauma (Amaro, Nieves, Johannes, and Cabeza, 1999).

Among some Hispanics/Latinos, depression may not be the presenting illness: the more culturally recognized syndrome is called an *ataque de nervios* (see chapter 1). Weingartner, Robison, Fogel, and Gruman's 2002 survey revealed a strong association between having experienced an *ataque de nervios* and depression and substance use. In their survey, 31 percent of the women and 15 percent of the men had had an *ataque de nervios*. However, it was the *ataque de nervios* that caused the individuals to seek treatment, indicating that an *ataque de nervios* is a culturally recognized and acceptable reason for seeking help, while substance use and depression are not.

Screening and Assessment of the Older Hispanic/Latino

Screening and assessment instruments appropriate to the Hispanic/Latino population are listed in chapter 5, including Spanish-language assessment instruments. However, in assessing the older members of this population, additional matters must be considered. For instance, physiological symptoms of alcohol abuse such as confusion or dementia, difficulty sleeping, and gastrointestinal distress mimic some of the normal processes of aging, making it difficult to determine the extent of the problem among elderly Hispanics/Latinos.

Medical treatment providers may want to consult the National Hispanic Medical Association (NHMA) Web site [<http://www.nhmamd.org>]. The NHMA Web site features a “kit” of tools for screening and intervention of alcohol abuse among Hispanic/Latino clients. For additional information, see chapter 5, Resources.

Measures of social impairment used to assess substance abuse in older non-Hispanic whites are often inappropriate to the older Hispanic/Latino and need to be reconsidered. For instance, older members of this group are unlikely to have employment obligations and may not own or drive a car. However, in some families they are often expected to provide assistance with child care and discipline, to

provide emotional support and advice, especially in times of crisis, and to socialize across the generations, imparting cultural values of the family. Impairment should be assessed based on these and similar measures.

Measures of social impairment used to assess substance abuse in older non-Hispanic whites are often inappropriate to the older Hispanic/Latino and need to be reconsidered.

It may be helpful to ask the client about his or her ability to use the telephone, travel some distance, do the grocery shopping, prepare meals, do laundry, take medicine, and manage money (Aguirre-Molina et al., 2001).

A study comparing two screening instruments showed that the Fuld Object Memory Test, which tests for Alzheimer's-type memory impairment, was not influenced by ethnic origin or educational level. However, the Mini-Mental State Exam overdiagnosed cognitive impairment in Hispanics with less than an eighth grade education (Ortiz, LaRue, Romero, Sassaman, and Lindeman, 1997).

Counseling the Older Hispanic/Latino

In counseling Hispanic/Latino older adults who abuse alcohol and prescription drugs, it is important that providers acknowledge those cultural factors that can inhibit therapy. For instance, Hispanic/Latino older adults may exhibit a higher level of resistance to treatment because of the belief that alcohol or drug abuse represents a moral failure, or is connected to mental illness. However, these same cultural values can also facilitate recovery (Kail and DeLaRosa, 1998).

Especially with the older members of the culture, providers need to be warm, friendly, respectful, and take an active interest in the client's life. Always use a client's last name, and address them as *Señor* (Mr.), *Don* (sir), *Señora* (Mrs.), or *Doña* (madam). Handshakes are expected. Staff should always maintain eye contact as a gesture of respect. If conversations are conducted in Spanish, staff should remember to use the formal and respectful *usted* instead of the casual *tu* to address clients, especially older clients (National Alliance for Hispanic Health, 2001).

Counselors should not hurry to begin treatment. Allow time at the beginning of sessions to establish and renew social ties. In traditional communities, this would involve developing some form of kinship tie: “Where are you from?” “I have a cousin who lives there.” “Where do your children work?” “I have a neighbor who also works there.” The connection may be small, but this step is important to Hispanic/Latino elders. In addition, a small compliment is expected before therapy begins: “Those are lovely earrings.” “What a handsome watch.” Allowing time for these interactions will actively promote a therapeutic alliance.

Therapeutic sessions should be conducted in a friendly, informal conversation (*la platica*). This enables the counselor to build a sense of respect and trust before moving to task-oriented elements of counseling. Surveys of older Hispanic/Latinos have shown they are intolerant of impersonal, disrespectful, efficiency-oriented treatment settings (Applewhite, 1995).

The use of confrontation, often associated with therapeutic communities and Alcoholics Anonymous, may be even less tolerated by the elderly Hispanic/Latino, who carries expectations that social interactions be conducted in a manner characterized by *respeto*, *dignidad*, and *simpatia*. The value of *simpatia* places a premium on graciousness, harmony, and the avoidance of conflict. The values of *respeto* and *dignidad* imply that power differentials between individuals are understood, but that individuals are to feel that their own personal power, whatever it may be, is acknowledged. They should be able to retain some “face.” Confrontational techniques appear to be almost diametrically opposed to these culturally-based expectations (Kail and DeLaRosa, 1998).

Clients may be resistant initially because previous encounters with institutions in the U.S. resulted in experiences that were impersonal, dehumanizing, or humiliating. Older adults in particular may not be open to group therapy, especially those composed mostly of younger people or non-Hispanics, or groups of both men and women. One-on-one or family sessions of about 75 minutes that focus on emotional states such as depression, loneliness, and feelings of loss as well as the

The elderly Latino carries expectations that social interactions, including counseling sessions, be conducted in a manner characterized by respeto, dignidad, and simpatia.

stress of their current familial roles are likely the best mix of approaches.

Family therapy is easily accepted by Hispanics/Latinos because it fits with their view that emotional problems are largely a result of family conflicts and

financial difficulties (Falicov, 1998). It may even be advisable to not use the term “substance abuse” as the concept of a “substance” and its “abuse” may be culturally very foreign. Narrowing the issue to the client’s specific perspective—the number of pills swallowed, or drinks consumed—and the family problems associated with the pill or alcohol consumption, is less likely to evoke a negative reaction.

At the end of an appointment, the treatment provider should be aware that, especially with the older Hispanic/Latino, taking the time to say a warm and leisurely goodbye is also necessary. An abrupt handshake as they are ushered out the door is contrary to *personalismo* and may offend.

Addressing Family and Social Issues

Clinicians have noted the difficulty of getting older women who abuse benzodiazepines to reduce their dosages. Among Cuban women, success has been found to result from a combination of supportive and cognitive-behavioral therapy that addresses unresolved grief and pathological mourning. The client’s self-esteem, dignity, and self-respect are restored when the client’s accomplishments, such as having overcome the challenges of migration, building a new life from nothing, and having raised children under very difficult and hostile circumstances, are acknowledged, and they can then enter the necessary mourning process that will eventually reduce their need to medicate their pain (Rothe and Ruiz, 2001).

An older man who abuses alcohol may be resistant to the idea that he uses alcohol to cope with his difficulties because it implies weakness. Affirming that his use is not a sign of weakness, but something that may interfere with his ability to function as head of the family and leader of

those who look to him for wisdom and authority will allow him to maintain his dignity and remain engaged in treatment (Alvarez and Ruiz, 2001).

Researchers recommend that providers examine the extended family network, especially the role the Hispanic/Latino older adult plays in this network. For instance, unlike mainstream U.S. culture that emphasizes autonomy and the independence of adult children, among Hispanic/Latino families it is normal for unmarried adult children to remain in their parents' home. It is also the custom for a son to continue to live at his parents' home after he has married, and thus older Hispanics/Latinos often have to renegotiate their household arrangements with a new daughter-in-law. At the same time, these older adults, who have perhaps been raised with the idea of being married for life, are exposed to mainstream expectations of self-fulfillment and marital happiness and may be experiencing inner as well as external conflicts (Alvarez and Ruiz, 2001).

The counselor must be careful to not impose mainstream values on such a situation and assume separate households will resolve a problem. Substance abuse in the context of the family conflict means the treatment provider, in helping a client become free of his or her substance abuse, will have to help the client renegotiate the family relationships within the context of Hispanic/Latino culture and generational acculturation stress.

Researchers recommend to counselors that the best survival strategy for these families is to, firstly, diagnose and treat substance use disorders among the elders, and secondly, help the elders adjust as much as possible to the prevailing environment. This usually means negotiating practical matters, such as helping elders understand that when a daughter wants to go away to college, it does not mean she is abandoning the family (Cervantes and Pena, 1998; Straussner, 2001).

For older Hispanics/Latinos who are recent immigrants, the hard reality of social isolation often leads to the substance abuse that eventually brings them to treatment. Whereas those from Puerto Rico or Colombia can simply complain about the high price of airfare that prevents them from visiting loved ones, those from Cuba and other places cannot go back. These people are cut off from their past, and

may have never mourned their loss. Helping them grieve and develop new social contacts may be the most critical form of treatment. In Florida, older Cuban immigrants have established organizations called Cuban Municipalities in Exile, where people reconnect and socialize with acquaintances from childhood and their families (Rothe and Ruiz, 2001). In communities where there are fewer Hispanics/Latinos, the local Senior Citizens Center may provide resources. Although they are public institutions, nearly every Senior Citizens Center has a circle of Hispanic/Latino men and women who meet weekly or even daily to socialize and enjoy the Center's activities. Many Senior Citizen Centers even provide limited transportation.

Older Hispanics/Latinos are less likely to consider alcohol or other drug abuse a disease and are more likely to consider it a sin and

offense against family and faith (Gomberg, 2003). Thus, as providers evaluate the recovery environment, they may find value in considering the role of the client's priest or other spiritual leader within the community.

The counselor must be careful to not impose mainstream values on a situation.

Given its strong influence in the lives of many Hispanics/Latinos, Catholicism can be a major source for comfort in times of stress. Strong religious coping, that is, deriving strength from God in times of adversity, can play a protective role against substance use (Weingartner et al., 2002). Further, researchers have shown that a priest can have a positive impact in counseling sessions (Sue and Sue, 2003). However, it is important to note that growing numbers of Hispanics/Latinos are Protestants, particularly Evangelical Christians (Barna Research Group, 2001). Here also, treatment practitioners should be aware that the degree of religious belief or practice varies among Hispanic/Latino males and females.

Whether Catholic or Protestant, many Hispanics/Latinos believe in prayer and most attend religious services (Sue and Sue, 2003). Because of their strong religious beliefs, many traditional Hispanics/Latinos value the virtues of self-sacrifice, charity, and enduring adversity. Some researchers contend that as a consequence of having these values, many Hispanics/Latinos have difficulty behaving assertively. Problems or

adverse events are “meant to be” and cannot be changed (Sue and Sue, 2003, p. 290). With this background in mind, treatment practitioners should also be aware that individual Hispanics/Latinos differ in their degree of acceptance and observation of these traditional religious values and behaviors.

Language Issues

Although lack of insurance coverage is the biggest barrier to substance abuse treatment in the Hispanic/Latino population, language is a significant secondary barrier. Among the older members of this group, language may be just as important a barrier as economics, and treatment providers need to have a means of communicating with these clients (Aguirre-Molina, et al., 2001).

It is essential that providers be bilingual. The elderly are not likely to participate, especially those less acculturated, unless they are comfortable in the language. The availability of bilingual/bicultural therapists is an important influence on the utilization of social services.

Older Hispanics/Latinos who are comfortable in English may come to an appointment alone, but it is more likely that they will come with a friend or family member. When ill or injured, Hispanics/Latinos frequently consult with other family members and close friends and often ask them along to medical visits. Thus the older Hispanic/Latino will nearly always come to a care provider’s office accompanied by a friend or family member, and may or may not speak English. The presence of this family member or friend, especially if the client has brought them to serve as interpreter, must be handled delicately. The friend/family member may be acceptable translators for intake purposes, and intake procedures may proceed with the perspective that information should be confirmed at a later appointment. However, if a bilingual provider is not available for continuing treatment, alternative translation services according to agency policy should be arranged.

However, given the emphasis on family (that family be involved in treatment and that issues are not discussed outside the family) in Hispanic/Latino culture, clients may prefer or even insist that the friend/family member serve as translator in negotiating the language issue. Extreme care and caution must be exercised in this case, espe-

cially if the person is of a younger generation. The individual's fitness to serve as translator should be clarified (National Alliance for Hispanic Health, 2001). For instance, the provider should ask:

Was the individual born in the U.S. And is Spanish a secondary language? Among Hispanics/Latinos born in the U.S., even though Spanish may have been spoken in the home daily as they were growing up, their vocabulary is probably limited to day-to-day domestic concerns. Their vocabulary and cultural understanding of a native-born Hispanic/Latino may be inadequate for health and substance use discussions. A second generation Hispanic/Latino could mistakenly confuse “heart pain,” “heartache,” and “heart-broken” or not have a vocabulary at all sufficient to discuss matters such as symptoms of trauma or acculturation stress or the side effects of medications. This problem may be compounded by the fact that the older immigrant may also lack a Spanish vocabulary for substance abuse treatment concepts.

Is the individual—especially offspring—willing to talk to his elders about sensitive topics such as drinking habits or prescription drug use? Some children may be too concerned about upsetting their elders to tell them everything a counselor reports. The client may resent being asked personal and embarrassing questions by children or friends.

Will the individual be willing to “cross check” the information given by the client? Elder Hispanics/Latinos may, out of respect for a counselor, tell him or her what he or she may want to hear—such as that they are taking their medicine or following a prescribed regimen, when in fact they did not fill a prescription because of the cost, or they may be abusing the prescription medicine, or are sharing medicines with friends, or they decided to go to a *herbalista* instead. The individual who is translating may be completely unaware of the elder's actual behavior, or unwilling to challenge their statements on behalf of the provider if the information seems questionable (National Alliance for Hispanic Health, 2001).

The best scenario is for some staff members to be both fluent in Spanish and also trained in delivery of the relevant services. However, this is often not the case and understanding the limitations of the available translation possibilities is necessary in order to provide the best treatment possible. For providers who lack the appropriate staff trans-

lation possibilities, and who are faced with the language limitations of clients and their self-selected translators, there are many technology-based tools that can be used to enhance communications. Counselors with limited Spanish proficiency can consider using computer programs or hand-held electronic devices to help translate entire sentences, such as instructions for taking medicines. Also available are telephone-based full translation services and Internet-based translation options. However, some of these tools can be expensive, and automated translations can be imprecise.

Other Treatment Issues

Hispanics/Latinos tend to be present-oriented and look for concrete, practical solutions to their problems. Long-term (or even short-term) counseling or psychotherapy for insight and growth is not part of their native cultural background. They expect treatment providers to work from a position of authority, to provide clear and concise instructions for improving their situation, and appreciation and pats on the back for following those instructions (Rothe and Ruiz, 2001).

As with any client, referral to medical care may be needed. Physical problems should be investigated when symptoms suggest that substance abuse is not a client's only problem. However, it could be a valuable savings in time and resources to question a client about his traditional medicine use, as well as his use of prescription medicines. When treating an older Hispanic/Latino, providers are advised to remember the cultural syndromes and traditional medicines covered in chapter 1.

Further, in addition to substance use, Weingartner's 2002 survey of Hispanics/Latinos above age 50 found a significant degree of confusion regarding the correct use of prescription medications. Many did not know what their medications were for and did not take them as prescribed, either taking a higher dose or taking them only when they "felt bad."

Hispanics/Latinos are also far more likely to live in areas where they are exposed to excessive levels of lead and second-hand cigarette smoke. Older men who have worked as migrant/seasonal laborers or in agricultural work have been exposed to high levels of pesticides and herbicides and may show long-term health consequences.

Conclusion

These four short chapters are only a beginning to achieving cultural competence among older Hispanics/Latinos. Treatment providers are encouraged to continue to expand their understanding of this population and to strive to include Hispanic/Latino professionals on their staff. Only when all staff members are reasonably versed in Hispanic/Latino culture, and a clinic has sufficient numbers of Spanish-fluent treatment providers on its staff, can this population be adequately served.

References

- Aguirre-Molina, M., Molina, C., & Zambrana, R. E. (2001). *Health issues in the Latino community* (p. 158). San Francisco: Jossey-Bass.
- Alvarez, R. A., & Ruiz, P. (2001). Substance abuse in the Mexican American population. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 111–136). New York: Guilford Press.
- Amaro, H., Nieves, R., Johannes, S., & Cabeza, N. M. (1999). Substance abuse treatment: Critical issues and challenges in the treatment of Latina women. *Hispanic Journal of Behavioral Sciences, 21*, 266–282.
- Applewhite, S. L. (1995). Curanderismo: Demystifying the health beliefs and practices of elderly Mexican Americans. *Health & Social Work, 20*, 247–253.
- Barna Research Group. (2001). *The faith of Hispanics is shifting*. Ventura, CA: Barna Research Group. Retrieved April 11, 2007, from <http://www.barna.org/FlexPage.aspx?Page=BarnaUpdate&BarnaUpdateID=78>
- Cervantes, R. C., & Pena, C. (1998). Evaluating Hispanic/Latino programs: Ensuring cultural competence. *Alcoholism Treatment Quarterly, 16*, 109–132.
- Falicov, C.J. (1998). Mexicans, Puerto Ricans, and Cubans: An overview. In C. J. Falicov (Ed.), *Latino families in therapy: A guide to multicultural practice* (pp. 33–45). New York: Guilford Press.
- Federal Interagency Forum on Aging-Related Statistics. (2006). *Older Americans 2006: Key indicators of well-being*. Federal Interagency Forum on Aging-Related Statistics, Washington, DC: U.S. Government Printing Office.

- Gloria, A. M., & Peregoy, J. J. (1996). Counseling Latino alcohol and other substance users/abusers: Cultural considerations for counselors. *Journal of Substance Abuse Treatment, 13*, 119–126.
- Gomberg, E. S. (2003). Treatment for alcohol-related problems. Special populations: research, recent developments. *Alcohol, 16*, 313–333.
- Hernandez, M., & McGoldrick, M. (1999). Migration and the life cycle. In B. Carter (Ed.) *The expanded family life cycle: Individual, family, and social perspectives* (3d ed., pp. 169–184). Boston: Allyn and Bacon.
- Kail, B. L., & DeLaRosa, M. (1998). Challenges to treating the elderly Latino substance abuser: A not so hidden research agenda. *Journal of Gerontological Social Work, 30*, 123–141.
- National Alliance for Hispanic Health. (2001). *A primer for cultural proficiency: Towards quality health services for Hispanics*. National Alliance for Hispanic Health. Washington, DC: Estrella Press.
- Ortiz, I. E., LaRue, A., Romero, L., Sassaman, F., & Lindeman, R. D. (1997). Comparison of cultural bias in two cognitive screening instruments in elderly Hispanic patients in New Mexico. *American Journal of Geriatric Psychiatry, 5*, 333–338.
- Rothe, E. M., & Ruiz P. (2001). Substance abuse among Cuban Americans. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 97–110). New York: Guilford Press.
- Straussner, S. L. A. (2001). Ethnocultural issues in substance abuse treatment: An overview. In S. L. A. Straussner (Ed.) *Ethnocultural factors in substance abuse treatment* (pp. 3–28). New York: Guilford Press.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally different: Theory and practice* (4th ed.). New York: John Wiley & Sons.
- Weingartner, K., Robison, J., Fogel, D., & Gruman, C. (2002). Depression and substance use in a middle aged and older Puerto Rican population. *Journal of Cross-Cultural Gerontology, 17*, 173–193.

Resources

This chapter covers—

- > Federal Resources
- > Advocacy Groups and Organizations
- > Publications
- > Training and Interventions
- > Assessment Instruments
- > Other Resources

Federal Resources

Administration on Aging (AoA)

330 Independence Avenue, SW
Washington, DC 20201
Tel: 202.619.7501

The agency within the U.S. Department of Health and Human Services (HHS) that provides services and covers all concerns having to do with the elderly. The AoA maintains statistics, health information, an eldercare locator, and other information of interest to anyone involved with elders. A Spanish version of the site is also available from the home page.

* The opinions expressed herein are the views of the organizations presented in this section. No official support or endorsement by CSAT, SAMHSA, or HHS of these resources is intended or should be inferred.

Centers for Medicare and Medicaid Services (CMS)

7500 Security Boulevard

Baltimore, MD 21244-1850

Toll-Free: 877.267.2323

Local: 410.786.3000

TTY Toll-Free: 866.226.1819

TTY Local: 410.786.0727

The Centers for Medicare and Medicaid Services main Web page can be accessed at <http://cms.hhs.gov>, or Medicaid and Medicare information can be accessed directly by using the Web addresses listed above. This Federal-level Web site explains the purposes of and differences between the Medicare and Medicaid programs and supplies every possible element of technical information to those working inside and outside CMS.

For the substance abuse counselor and others working with low income clients who may be immigrants, the Web site may be most useful as a place to link to specific State Medicaid and Medicare programs. From either the Medicare or Medicaid main page, users can select their State or territory and go directly to that State's Medicare or Medicaid Web site for the needed information. Most State Medicaid/Medicare Web sites list the State's eligibility criteria and also allow the user to download brochures and selected forms to print and fax or mail to the appropriate local office. Local contact information and local news about regulatory changes and other matters is also available on these links.

Centros Para el Control y la Prevención de Enfermedades/ Centers for Disease Control and Prevention

1600 Clifton Road

Atlanta, GA 30333

Tel: 800.311.3435

Spanish language Web site for the Centers for Disease Control and Prevention (CDC). CDC is the lead Federal agency providing credible health information in areas such as disease prevention and control, health promotion, and education designed to improve the health of Americans.

National Institute on Aging

National Institutes of Health
Building 31, Room 5C27
31 Center Drive, MSC 2292
Bethesda, MD 20892
Tel: 301.496.1752

Leads a broad scientific effort to understand the nature of aging and to extend the healthy, active years of life. Provides leadership in aging research, training, health information dissemination, and other programs related to aging and older people. Primary Federal agency performing Alzheimer's disease research.

National Institute on Drug Abuse (NIDA)

National Institutes of Health
6001 Executive Boulevard, Room 5213
Bethesda, MD 20892
Tel: 301.443.1124

Leads the Nation in scientific research on drug abuse and addiction. Provides strategic research support and conducts research across a broad range of disciplines. Ensures rapid and effective dissemination and use of the results of the research to improve drug abuse and addiction prevention, treatment, and policy. Provides Spanish language publications.

Substance Abuse and Mental Health Services Administration (SAMHSA)

1 Choke Cherry Road
Rockville, MD 20857

Federal agency tasked with reducing the impact of substance abuse and mental illness by targeting substance abuse and mental health services to the people who need them most and by translating relevant research effectively and rapidly into the health care system. Comprises three Centers that carry out the agency's mission: the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment.

Substance Abuse Treatment Facility Locator

Web: <http://findtreatment.samhsa.gov>

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides an on-line resource for locating drug and alcohol abuse treatment programs. The Locator lists private and public facilities that are licensed, certified, or otherwise approved for inclusion by their State substance abuse agency, as well as those administered by the Department of Veterans Affairs, the Indian Health Service, and the Department of Defense. All information in the Locator is completely updated each year, based on facility responses to SAMHSA's National Survey of Substance Abuse Treatment Services. New facilities are added monthly. For additional advice, you may call one of the Referral Helplines operated by SAMHSA's Center for Substance Abuse Treatment:

1.800.662.HELP

1.800.662.9832 (Español)

1.800.228.0427 (TDD)

Advocacy Groups and Organizations

American Public Health Association (APHA)

800 I Street, NW

Washington, DC 20001-3710

Tel: 202.777.2742

Oldest and largest organization of public health professionals in the world. Actively serves the public, its members, and the public health profession through its scientific and practice programs, publications, annual meeting, awards programs, educational services, and advocacy efforts. Established the Latino Caucus in 1973.

Ethnic Elders Care Network

Department of Psychiatry
University of California
Davis, CA
Tel: 925.372.2105
Email: Ecarenet@yahoo.com

An online resource for treatment professionals and caregivers of the elderly, focusing on dementia and ethnic minorities. Contains practical culturally competent information on treating Hispanic/Latino elders as well as their caregivers.

Hands Across Cultures

P.O. Box 2215
Española, NM 87532
Tel: 505.747.1889

Dedicated to improving the health, education, and well-being of the people of northern New Mexico by creating community programs that demonstrate intercultural cooperation. Believes that an understanding of intercultural perspectives is vital to solving health and social problems.

The Hispanic Federation

130 William Street, 9th Floor

New York, NY 10038

Tel: 212.233.8955

Established in 1990 by a group of Hispanic leaders, the Hispanic Federation (HF), is a membership organization of 81 Latino health and human services agencies in New York, New Jersey, and Connecticut. The Hispanic Federation's member agencies work in the areas of education, health, elderly services, child care, HIV/AIDS, housing, and economic development. Each year, these agencies serve more than 800,000 of the tri-State area's most underprivileged and vulnerable Latinos. Since its inception, the Hispanic Federation's mission has remained the same: to better meet the growing needs of the Hispanic community, to obtain a fair share of resources, and to help its member agencies to secure new resources.

The Hispanic Federation Web site grants access to a list of member agencies, which includes Hispanic/Latino mental health agencies and professionals.

Hispanic Health Council, Inc.

175 Main Street, Floor 1-1

Hartford, CT 06106

Tel: 860.527.0856

Provides a comprehensive community-based approach to serving people through research, service, training, and advocacy. Committed to improving the health and social well-being of Puerto Ricans/Latinos and underserved communities in Connecticut.

Latino Gerontological Center

120 Wall Street, 23rd Floor
New York, NY 10005
Tel: 212.344.9636

Established to improve the lives of Latino seniors through advocacy and education. Seeks to advocate for improved services for Latino seniors and educate them about various available options. Services include various forms of education through the media, testimony at public hearings, and conferences addressing issues affecting the elderly.

MANA: A National Latina Organization

1725 K Street, NW, Suite 501
Washington, DC 20006
Tel: 202.833.0060

National Latina organization working to create a better quality of life for Hispanics. Empowers Latinas through leadership development, community service, and advocacy.

National Alliance for Hispanic Health

*Formerly the National Coalition of
Hispanic Health and Human Services (COSSMHO)*
1501 16th Street, NW
Washington, DC 20036-1401
Tel: 202.387.5000

Oldest and largest network of health and human service providers serving more than 10 million Hispanic consumers throughout the United States since 1973. Promotes education and initiatives in health-related areas such as tobacco and HIV/AIDS awareness. Provides services in English and Spanish.

National Council on the Aging

300 D Street, SW
Suite 801
Washington, DC 20024
Tel: 202.479.1200

First association of organizations and professionals dedicated to promoting the dignity, self-determination, well-being, and contributions of older persons. Provides assistance to community organizations and develops programs and services. Serves as a national voice and powerful advocate for public policies and public attitudes, and business practices that promote vital aging.

National Council of La Raza

1111 19th Street, NW, Suite 1000
Washington, DC 20036
Tel: 202.785.1670

Largest constituency-based national organization serving all Hispanic nationality groups in all regions of the United States. Involved in organizational development, research, policy analysis, and advocacy. Houses one of the leading think tanks on Hispanics in the United States and a clearinghouse of census data on Hispanics.

The National Hispanic Council on Aging

2713 Ontario Road, NW
Washington, DC 20009
Tel: 202.265.1288

National membership-based organization dedicated to improving the quality of life for the Latino elderly, families, and communities. Keeps members informed about issues critical to Latino seniors, which include health, income, education, employment, housing, families, and communities. Services include advocacy, capacity and institution building, educational materials, technical assistance, demonstration projects, policy analysis, and research.

National Hispanic Medical Association

1411 K Street, NW, Suite 200
Washington, DC 20005
Tel: 202.628.5895
Web: <http://www.nhmamd.org>

National organization that provides policymakers and health care providers with expert information and support in strengthening health service delivery to Hispanic communities throughout the Nation. Also provides a physician database and links to Hispanic medical sites.

The NHMA Web site offers tools for screening and intervention of Hispanic/Latino clients. This toolkit, which can be downloaded or printed from the Web site, contains the CAGE questionnaire and other questions for screening and assessment of alcohol abuse, and scoring that is adapted for the Hispanic/Latino population, including both males and females and for different age groups. The NHMA toolkit also contains a version of the ED-Direct Brief Intervention for medical personnel to use in referring Hispanic/Latino clients for substance abuse treatment. Also included are resources for developing a list of local referrals for substance abuse treatment and recommendations for appropriate medical assessments for Hispanics/Latinos at risk of alcohol-related medical problems, such as macrocytic anemia. To access this feature, type “toolkit” into the Web site’s search field and follow the links.

National Latina Health Network

1680 Wisconsin Avenue, NW 2nd floor
Washington, DC 20007
Tel: 202.965.9633

Nonprofit organization dedicated to strengthening and developing networks of Latina leaders in public health and building local and national community health partnerships that enhance the quality of life for Latinas and their families throughout the Nation. Through culturally appropriate value-based programs, NLHN empowers Latinas to make informed decisions about their lives.

Publications

A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics.

Author: National Alliance for Hispanic Health

Publisher: Estrella Press

1501 16th Street, NW

Washington, DC 20036-1401

Tel: 202.387.5000

Publication Date: 2001

The primer consists of eight chapters discussing culture, working in diverse cultures, language, history of Hispanics and Hispanic data, role of community based organizations, and implementation. This and other publications of the National Alliance for Hispanic Health are available online.

Achieving Cultural Competence: A Guidebook for Providers of Services to Older Americans and Their Families

Author: Administration on Aging

Publisher: U.S. Department of Health and Human Services

Publication Date: January 2001

Guide to treatment approaches and interventions that respect cultural values and beliefs of culturally diverse older populations. Includes hand-outs and overheads for presentations on cultural competence.

Counseling the Culturally Diverse: Theory and Practice, 5th edition (528 pp.)

Authors: D.W. Sue and D. Sue

Publisher: John Wiley & Sons, Inc.

Publication Date: 2007

Most widely used and critically acclaimed reference on cross-cultural counseling. Covers general issues in cross-cultural counseling and issues involving racial/ethnic populations and special populations such as the elderly. Includes detailed clinical case examples. Completely revised and updated from the 2003 edition.

CSAP Implementation Guide: Hispanic/Latino Natural Support Systems (44 pp.)

Publisher: Center for Substance Abuse Prevention (CSAP)

Available from: SAMHSA's Health Information Network,
1-877-SAMHSA-7 (1-877-726-4727) (English and Español)

Guide to implementing a culturally sensitive program that involves formal and informal systems of support. Represents an integrated approach that takes advantage of the strengths and resources of the community.

Cultural Competence for Evaluators: A Guide for Alcohol and Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities. CSAP Cultural Competence Series I (307 pp.)

Author: M. A. Orlandi, et al.

Publisher: Center for Substance Abuse Prevention

Available from: SAMHSA's Health Information Network,
1-877-SAMHSA-7 (1-877-726-4727) (English and Español)

A guide to integrating two types of competence in prevention programs: program evaluation competence and cultural competence. Provides conceptual frameworks and practical suggestions for evaluators working with ethnic/racial groups.

Handbook of Multicultural Mental Health: Assessment and Treatment of Diverse Populations

Authors: I. Cuellar and F. A. Paniagua

Publisher: Academic Press

Publication Date: 2000

Handbook aims to lay the foundation for a more balanced therapeutic view after a half-century of emphasis on brain-behavior relations that has largely overlooked the cultural forces that shape perceptions, attitudes, and actions. Chapters stress the need for an ecological perspective that examines behavior within the “web of life” surrounding each person, including the cultural factors that are a significant component of family, community values, meaning, purpose, motivations, and spiritual life.

National Standards for Culturally and Linguistically Appropriate Services in Health Care

Final Report (139 pp.)

Author: IQ Solutions, Inc.

Publisher: Office of Minority Health, U.S. Department of Health and Human Services

Publication Date: March 2001

Tel: 1.800.444.6472

Web: <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

Sets forth what service providers should do to achieve competency and how it should be done. Provides a basis for evaluation, comparison, and quality assurance by policymakers, consumers, and researchers. Also provides guidelines for accreditation and credentialing agencies, advocates, educators, and the health care community in general.

Promoting Health in Multicultural Populations: A Handbook for Practitioners (554 pp.)

Authors: R.M. Huff and M.V. Kline

Publisher: Sage Publications

Publication Date: 1999

Handbook of the most current theoretical models and strategies for promoting health and preventing disease in multicultural settings. Devotes a four-chapter section to Hispanics/Latinos, which includes tips for working with this population. Written in simple, practical, and understandable terms.

Quality Health Services for Hispanics: The Cultural Competency Component (116 pp.)

Author: National Alliance for Hispanic Health

Publisher: U.S. Department of Health and Human Services

Publication Date: 2000 (DHHS Publication No. 99-21)

Tel: 888.ASK.HRSA (275.4772)

Special educational guide representing a collaboration between the Health Resources and Services Administration, the Bureau of Primary Health Care, the Substance Abuse and Mental Health Services Administration, the Office of Minority Health, and the National Coalition for Hispanic Health and Human Services Organizations. Reflects the cumulative experience of community programs addressing the “art and science of cultural competence.” Designed to help health care professionals better understand and more effectively respond to the growing needs of Hispanics/Latinos in a variety of clinical, prevention, and social service settings.

Treatment Improvement Protocol (TIP) 26: Substance Abuse Among Older Adults (173pp.)

Available from: SAMHSA’s Health Information Network,
1-877-SAMHSA-7 (1-877-726-4727) (English and Español)
(inventory number BKD250)

Presents treatment providers and other health care professionals with practical advice for identifying, screening, assessing, and treating substance abuse among people 60 and older. Details how disorders typical in an aging person, such as dementia and delirium, can mask or mimic the effects of alcohol and prescription drug abuse. Elderly-specific screening and assessment instruments are included, along with adjustments to the DSM-IV criteria for substance abuse and dependence.

Training and Interventions

Addiction Technology Transfer Center (ATTC)

Tel: 816.235.6888

The ATTC is funded by SAMHSA and maintains a distance education center for substance abuse treatment professionals, including online classes and interventions tailored to Hispanic/Latino populations.

Bishop's Council on Alcohol and Other Drugs (BCOAOB)

Diocese of Lansing

300 W. Ottawa Street

Lansing, MI 48933

Tel: 877.342.2513

The BCOAOB provides an intervention for use by families, friends, and treatment professionals to confront and treat a person with a substance abuse problem, called "Take Charge!" While not specifically targeted to Hispanics/Latinos, it is culturally compatible with Hispanic/Latino and Catholic perspectives. Go to the website and type "take charge" into the search field.

Counseling the Family and Multicultural Issues

Publisher: Texas Addiction Technology Transfer Center

Tel: 512.349.6600

Course discusses the family as a dynamic system and the effects of alcohol and drug abuse on the family. Also covers treatment of the family, roles in the family, adult children of alcoholics, and codependency issues. Family issues comprise 40 hours. Multicultural counseling issues and special populations comprise 23 hours.

Distance Learning Center for Addiction Studies

(toll free) 866.471.1742

Web: <http://www.dlcas.com>

The Distance Learning Center for Addiction Studies (DLCAS) is an Internet based educational service that provides comprehensive training and information in the field of addiction studies. DCLAS currently offers courses focusing on Hispanics/Latinos.

Project ADEPT Volume V – Race, Culture, and Ethnicity in Primary Care: Addressing Alcohol and Other Drug Problems

Publisher: New England Addiction Technology Transfer Center

Tel: 401.444.1808

Designed to train health care professionals to effectively and compassionately respond to the needs of patients with diverse cultural backgrounds. Ideal for groups of 12 to 20 students. Easily adaptable for larger group settings. Includes teaching aids such as a videotape, slides or overhead transparencies, instructor's outline, and handouts.

Assessment Instruments

Acculturation Rating Scale for Mexican-Americans (ARSMA)

An acculturation scale for Mexican-American normal and clinical populations.

Cuellar, I., Harris, C., and Jasso, R.

Hispanic Journal of Behavioral Sciences 2, 199–217, 1980.

Acculturation Rating Scale for Mexican-Americans-II (ARSMA-II)

The acculturation rating scale for Mexican-Americans-II

A revision of the original ARSMA scale.

Cuellar, I., Arnold, B., and Maldonado, R.

Hispanic Journal of Behavioral Sciences 17, 275–304, 1995.

Bidimensional Acculturation Scale for Hispanics (BAS)

A new measurement of acculturation for Hispanics

Marin, G., and Gamba, R. J.

Hispanic Journal of Behavioral Sciences, 18, 297–316, 1996.

Familism Scale for Use with Latino Populations

Steidel, A.G.L., and Contreras, J.M.

Hispanic Journal of Behavioral Sciences 25, 312–330, 2003.

Fuld Object Memory Test

Stoelting Company

620 Wheat Lane

Wood Dale, IL 60191

The Fuld Object Memory Test was developed to assess memory and other cognitive impairment in those age 70 and above, for which norms are available. The test can be used among those with visual as well as hearing impairments and is “culturally fair.”

Geriatric Depression Scale

Web: <http://www.stanford.edu/~yesavage/GDS.html>

A screening test for measuring depressive symptoms experienced by the elderly. Ideal for evaluating the clinical severity of depression and for monitoring treatment. Easy to administer and well validated in home and clinical environments. Available in several translations of Spanish and in several electronic formats through the Web address above.

M.I.N.I.

Medical Outcome Systems, Inc.

Web: <http://www.medical-outcomes.com>

Spanish version available from the Web address listed above.

Multidimensional Measure of Cultural Identity for Latino and Latina Adolescents

Feliz-Ortiz, M., Newcomb, M.D., and Meyers, H.

Hispanic Journal of Behavioral Sciences 16, 99–115, 1994.

Short Acculturation Scale for Hispanics (SASH)

Marin, G., Sabogal, F., Van Oss Marin, B., Otero-Sabogal, R.,
Perez-Sable, E.

Hispanic Journal of Behavioral Sciences 9, 183–205, 1987.

Other Resources

American Translators Association (ATA)

225 Reinekers Lane, Suite 590

Alexandria, VA 22314

Tel: 703.683.6100

Fax: 703.683.6122

An association of interpreters (for spoken translation) and translators (for written translation). The association certifies those who perform written translation, but not spoken translation. Translators can be found on-line through searches by zip code, language, State, and/or distance from the ATA Web site.

The following individuals were involved in the production of this Reference and Resource Guide: Rose Urban, M.S.W., J.D., LCSW, CCAC, CSAC, CDM KAP Executive Project Director; Susan Kimner, KAP Managing Project Co-Director; Elizabeth Marsh, former KAP Managing Project Co-Director; Jennifer Frey, Ph.D., former KAP Managing Project Co-Director; Jessica Culotta, M.A., KAP Managing Editor; Jason Merritt, former Collateral Products Manager; Virgie Paul, M.L.S., KAP Librarian; Darlene Colbert, Senior Writer; Leslie Kelley, Senior Writer; Lee Ann Knapp, Quality Assurance Editor; Amy Conklin, former Quality Assurance Editor; and Cecil Gross, Graphic Artist.

Ordering Information

TIP 26 *Substance Abuse Among Older Adults*

TIP 26-Related Products

Consumer Brochure on Substance Abuse, Aging, Medicines, and Alcohol

Consumer Brochure on Mental Health, *Good Mental Health is Ageless*

KAP Keys for Clinicians based on TIP 26

Quick Guide for Clinicians based on TIP 26

Other Treatment Improvement Protocols (TIPs) that are relevant to this Reference and Resource Guide:

TIP 19, *Detoxification From Alcohol and Other Drugs (1995)* **SMA 06-4131**

TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians (1997)* **SMA 97-3139**

TIP 27, *Comprehensive Case Management for Substance Abuse Treatment (1998)* **SMA 98-3222**

TIP 34, *Brief Interventions and Brief Therapies for Substance Abuse (1999)* **SMA 99-3353**

TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment (1999)* **SMA 99-3354**

Easy Ways to Obtain Free Copies of All TIP Products

1. Call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español)
2. Visit <http://www.store.samhsa.gov> or <http://www.kap.samhsa.gov>

This Reference and Resource Guide provides:

- > The historical background of the Hispanic/Latino population in the United States
- > The size and expected growth patterns for this population
- > The general health patterns among Hispanic/Latino older adults
- > The possible effects of culture on Hispanic/Latino health status
- > The prevalence of substance abuse among Hispanic/Latino older adults
- > The relevance of immigration to substance abuse
- > Guidelines for effective identification, assessment, and treatment
- > Additional organizational, online, and published assistance in offering English-language and Spanish-language services to Hispanics/Latinos

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