THE PREVALENCE, DYNAMICS, AND FACTORS ASSOCIATED WITH SUBSTANCE ABUSE AND THEIR IMPLICATIONS FOR SUBSTANCE ABUSE TREATMENT AMONG IMMIGRANTS TO THE UNITED STATES FROM EASTERN EUROPE AND THE COMMONWEALTH OF INDEPENDENT STATES

by

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I would like to thank my parents for providing me with the skills to work towards my goals and to believe in myself. I would like to thank my wife for supporting me in all my endeavors.

Abstract Of The Dissertation

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This project analyzes the incidence of substance abuse among immigrants from Eastern Europe and The Commonwealth of Independent States (CIS) in the United States. In Eastern European and CIS cultures, alcohol is considered a necessary part of life: it is used for sealing contracts, marking life events, grieving, celebrating, and as a function of hospitality. Research shows that there are a number of stressors that trigger Eastern European and CIS immigrants to exhibit or continue exhibiting substance abuse behaviors following immigration to the United States. This study demonstrates that alcohol use by Eastern European and CIS immigrants not only affects the drinkers themselves, but also their families and communities. It is found that the majority of drinkers report their lives as highly stressful upon immigration to the United States. Given the stressors experienced during the resettlement process, alcohol use in newcomers, especially the women, is a challenging and hazardous problem. Immigrants with Eastern European and CIS backgrounds who are substance abusers receive treatment in facilities and substance abuse treatment programs that are based on United States based research. Immigrant-specific substance abuse treatment programs are outlined in this project.

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CHAPTER 1
PROBLEM FORMULATION

Introduction

This project analyzes the incidence of substance abuse among immigrants from Eastern Europe and The Commonwealth of Independent States (CIS) (the Republics of the former Soviet Union) in the United States. Substance abuse is a common problem in most societies and cultural groups in the countries of Eastern Europe and the CIS (Segal, 1990). CIS citizens have been found to use alcohol across different social activities as a means of demonstrating friendship, and of coping with different economic and political crises (Kagan, 1996). In Polish and other Eastern European and CIS cultures, alcohol is considered a necessary part of life: it is used for sealing contracts, marking life events, grieving, celebrating, and as a function of hospitality (Freund, 1985). One of the ways for men to demonstrate masculinity is to show their ability to consume a great deal of alcohol and not to get intoxicated, or not get intoxicated as fast as others. Despite the frequency of heavy drinking and a growing recognition of alcoholism as a serious problem, there is a strong cultural resistance to acknowledging alcoholism as a disease. Tryzno and his colleagues (1989) reported that alcoholism in Poland was a major cause of divorce, and that 21% of Polish children were raised in alcoholic homes.

Immigration to the United States has a significant effect on the cultural behaviors, including alcohol consumption, of Eastern European and CIS immigrants. In contrast, alcohol and substance abuse, as well as dependence, among immigrants from Eastern Europe in the United States is prevalent (Ratkowski, 2003). Increasingly, all socio-economic classes of Eastern European and CIS immigrant communities in the United States have been affected by problems related to substance abuse. This phenomenon has

been observed by a significant increase in substance abuse related crimes, such as driving under the influence, and a need for different short and long-term rehabilitation services (Marowitz, 1998). A few reports suggest that crack cocaine and heroin abuse is growing among younger Polish Americans (Marowitz, 1998). Drinking, even heavy drinking to the point severe alcohol intoxication, is accepted among Polish Americans. According to Folwarski and Marganoff (1996), bars and churches are two of the most common establishments in Polish-American communities in the major metropolitan cities in the United States. Of these, bars outnumber churches.

It has been demonstrated among different age groups that immigration to America causes a great deal of stress associated with assimilation and accommodation to the United States culture (Hertz, 1993). It appears that stress is one of the factors that make immigrants of various socio-economic classes and age groups start, continue, or increase exhibition of substance abuse behaviors. For instance, studies demonstrate that substance abuse is growing among younger and older Eastern European and CIS immigrants in response to various types of stressors (Pabis & Troczynska, 1998). Research demonstrates that this maladaptive stress coping strategy varies across immigrants of different age groups. These findings suggest that while crack and heroin abuse is growing among younger Polish Americans, alcohol is the principle substance of choice among older Polish Americans (Pabis & Troczynska, 1998).

Substance abuse and dependence have a significant effect on the lives of immigrants. Studies have demonstrated that substance abuse affects the ability of immigrants to adjust to United States society in the following ways:

1) It affects immigrants' ability to resolve pre-immigration and post-immigration problems successfully.
2) It prevents immigrants from crossing the cultural gap between country of origin and country of immigration in the timely manner (Hertz, 1993; Markowitz, 1993).
3) Substance abuse decreases the ability of migrants to deal with various emotional processes associated with immigration to American society. These emotional processes consist of dissociation from the values and norms of the society of origin and then resocialization, acquiring the values and norms of the new society (Bar-Yosef, 1968).

In summary, research shows that there are a number of stressors that trigger Eastern European and CIS immigrants to exhibit or continue exhibiting substance abuse behaviors following immigration to the United States. At the same time, once immigrants become involved in substance abuse behaviors, daily stressors are exacerbated which, in turn, increases their risk or need to abuse substances in order to cope. This becomes a vicious cycle that maintains substance abuse behaviors in the United States.

Based on the literature review, it can be concluded that there is a need for the application of specific rehabilitation services to assist Eastern European and CIS immigrants in their adjustment to United States culture. Unfortunately, there are a currently few rehabilitation and outpatient psychiatric centers that focus on the delivery of services for this demographic population in the major metropolitan areas of the United States. This research aims to provide more evidence on the necessity of establishing therapeutic policies and guidelines for culture-specific preventive and recovery methods

for Eastern European and CIS immigrants who suffer from substance abuse. Furthermore, this project delivers recommendations for the structure of substance abuse treatment intervention programs for Eastern European and CIS immigrants who reside in the United States. Moreover, this project delivers a structure and recommended objectives of the dynamic substance abuse treatment for this immigrant population.

Statement of the Problem

In summary, the research demonstrates that substance abuse among Eastern European immigrants is significantly higher than in the general population of the United States (Hong & Holmes, 1973). Those immigrants who tended to abuse substances in their home countries were found to continue abusing substances upon immigration to the United States (Knab, 1993). Alcohol abuse is the most serious substance abuse problem among Poles, both in Poland and in the United States (Folwarski & Marganoff, 1996; Knab, 1993; Morowski, 1992; Tryzno, et al., 1989).

Ratkowski (2003) and other researchers demonstrated certain risk factors (isolation, socio-economic difficulties, loss of family, lack of friends, etc.) that could predict the onset of alcohol and drug abuse among Eastern European and CIS immigrants in the United States. Every immigrant from Eastern Europe and CIS experiences those risks, at least for a short duration (Castex, 1996). Consequently, every Eastern European and CIS immigrant without history of substance abuse is at risk of developing some variety of substance abuse at some point during immigration to the United States and, especially, during early stages of adaptation as a way to cope with different routine daily difficulties.

It has been demonstrated in multiple studies that substance abuse has a significant effect on the quality of life of any individual (Marlatt & Witkiewitz, 2002). It is obvious that substance abuse presents a significant problem to Eastern European and CIS immigrants. However, this does not mean that research does not need to be conducted in this area. There has been little research on the nature and reduction of poly-substance abuse among Eastern European and CIS immigrants to date. The factors that predict poly-substance abuse among Eastern European and CIS immigrants have been under-researched, despite a significant growth of this immigrant population in the major metropolitan cities of the United States. This suggests that Eastern European and CIS immigrants are being underserved, and require further investigative attention.

This lack of research highlights the fact that treatment delivered to Eastern European and CIS immigrant population is lacking in scientific merit. Treatment to this immigrant population is, as a rule, not being delivered in various specialized centers (Rumbaut & Rumbaut, 1976). Rather, treatment is being delivered in different community psychiatric and recovery centers, treatment based on research into the non-immigrant population of the United States (Jacobs & Osfeld, 1977). Consequently, administered treatment does not contain strategies for intervention effective for Eastern European and CIS substance abuse population. Moreover, this "treatment as usual" fails to address various gender-related issues that are pertinent to Eastern European and CIS cultures.

More research is needed to develop specific intervention and community policy strategies to address the needs of Eastern European and CIS communities. Various treatment issues outlined by Kagan and Shafer (2001), such as the impact of immigration,

issues of trust, the importance of psycho-education, the need to understand spirituality, family dynamics, gender role and domestic violence, and treatment for substance abusing adolescents and women must be investigated in much more detail.

Purpose of the Study

The purpose of this project is to conduct a thorough analysis into substance abuse by the Eastern European and CIS immigrant population in the United States. This investigation aims to increase the understanding of different factors that trigger and maintain substance abuse among this demographic population and to develop the treatment interventions for this immigrant group. In particular, the project aims to examine the different economic, cultural, and social issues that the above immigrant population faces at different stages of immigration and how they can be effectively addressed in culture-specific treatment. This project also intends to analyze various factors associated with the onset and maintenance of substance use, abuse, and dependence, and the essential variables for successful substance abuse treatment. Furthermore, in this investigation various types of commonly abused substances among Eastern European and CIS immigrants are examined. Research demonstrates the differences in the types and amount of substances used is significant across different stages of adaptation to the United States culture and age groups of Eastern European and CIS immigrants. Consequently, this study intends to enable clinicians working with this immigrant population to better understand the types and nature of the stressors associated with their substance abuse, so it can be effectively focused on during substance abuse treatment. Finally, this project aims to present an example of a gender-specific alternate

substance abuse treatment program that can be used for treatment of Eastern European and CIS immigrants.

In summary, the goal of this project is to provide clinicians and researchers with more information about the struggles and stressors related to the risks of the onset, maintenance, and treatment of substance abuse behaviors among Eastern European and CIS immigrants. Understanding of these risks should assist in the design and facilitation of different clinical and community programs to reduce substance abuse behaviors among this immigrant population. At the same time, this study will assist policy researchers in the preparation and facilitation of policies that accommodate the needs of the Eastern European and CIS immigrant community, and consequently reduce their substance abuse behaviors. This investigation is a step toward the reduction of substance abuse behaviors among Eastern European and CIS immigrants who reside in the United States.

Importance of the Study

The study is important in that it summarizes exploratory data regarding alcohol and drug use, abuse, and dependence among immigrants from Eastern Europe and CIS living in the United States and presents gender specific substance abuse treatment suggestions for this immigrant population. Furthermore, this project presents data necessary to establish foundations for further research in this area, and implications for treatment policies of this immigrant population. Based on the literature review of this project, the recommendations for areas of treatment and levels of intervention, and a sample of the substance abuse treatment program for Eastern European and CIS immigrants are made.

To date, there are very few empirical treatments, especially gender-specific, and minimal research on substance abusers with Eastern European and CIS backgrounds, now residing in America. Immigrants with Eastern European and CIS backgrounds receive treatment in facilities and substance abuse treatment programs that are based on research findings conducted on individuals who were born and raised in the United States. Consequently, the treatment components offered by substance abuse recovery centers do not address the specific and varied cultural needs and unique characteristics of the Eastern European and CIS immigrant population. In other words, the Eastern European and CIS immigrant population does not receive state-of-the art treatment, which might explain the high prevalence of substance abuse and dependence in this minority. This project aims to make a step forward in creating an empirical substance abuse treatment methodology for Eastern European and CIS immigrants.

In summary, the importance of this project is based on its exploration of different under-researched issues that affect a large percentage of the three and a half million immigrants (U.S. Census Bureau, 2005) with Eastern European and CIS backgrounds who reside in major metropolitan areas of the United States. The findings of this study are intended to contribute to the improvement of the quality of life for a large percentage of this immigrant population that resides in the United States. Furthermore, the findings from this study can be generalized to address the needs of other under-served immigrant populations in the United States.

Scope of the Study

In this project immigrants from Eastern Europe and CIS are investigated. Eastern European immigrants are defined as individuals who were born in the countries of

Eastern Europe (e.g., Poland, Bulgaria, Slovania, etc.) and immigrated to the United States. CIS immigrants are defined as immigrants who were born in the countries of the former Soviet Union and immigrated to the United States.

For investigative purposes, both Eastern European and CIS immigrants are classified in the following ways: immigrants who were not substance abusers in their countries of origin, immigrants who were substance abusers in their countries of origin, immigrants who abuse substances in the United States, immigrants who do not abuse substances in the United States.

For analysis purposes, immigrants are divided into the following four groups: immigrants who did not abuse substances in their countries of origin but start abusing substances in the United States, immigrants who did not abuse substances in their countries of origin and do not abuse substances in the United States, immigrants who abuses substances in their countries of origin and continue abusing substances in the United States, immigrants who abused substances in the countries of origin and discontinued abusing substances in the United States.

In other words, Eastern European immigrant population is divided into the following subgroups for literature review and analysis: abusers in the countries of origin and non-abusers upon immigration, abusers in the countries of origin and abusers upon immigration, non-abusers in the countries of origin and non-abusers upon immigration, and non-abusers in their countries of origin and abusers upon immigration.

Further to this, Eastern European immigrants of different age groups are investigated to determine the types of substances they tend to abuse, the pattern of their substance abuse, and the elements of substance abuse interventions to which they will

respond the best. For investigative purposes *Adulthood* is classified as age of 35 years old and over; *Early Adulthood* is classified as between the ages of 18 and 35 years old; and *Adolescence* is classified as between the ages of 12 and 18 years old.

The variables examined in the study are: types of abused substances, frequency of substance use, amount of substance use, socio-economic status, mental health, family structure, education levels both before and after immigration, and levels of assimilation and accommodation to American culture.

The findings of studies on the patterns of substance abuse of Eastern European immigrant population can be generalized to CIS immigrants living in the United States and vice versa. It has been demonstrated that immigrants from Eastern European countries exhibit behavioral and cognitive patterns that are identical to CIS immigrants, including Russian immigrants, because of similar cultural backgrounds, processes of adaptation and assimilation to the Unites States' culture (Kagan, 1996; Kagan, 1997). For instance, it has been demonstrated that cultural, social, economic, and ideological aspects of Russian immigrants have important implications for various therapeutic interventions with substance-abusing immigrants. This is concurrent with findings on Polish immigrants.

Limitations of the Study

Although this project assumes that immigrants with Eastern European and CIS backgrounds have similar substance abuse patterns and characteristics, Eastern European and CIS countries tend to differ from each other in socio-economic climate and cultural dynamics. Since socio-economic background has an effect on adjustment to American

society, this could be a factor that confounds generalization of findings between Eastern European immigrants and CIS immigrants.

Furthermore, this project does not differentiate between immigrants from the former Soviet Union Republics, and puts them into one general group of immigrants from CIS. The countries of CIS vary from each other across their unique cultural values, which in turn may have an effect on adaptation and assimilation to the United States society.

The project uses self-report data for summary and analysis. Nemtsov (2000) emphasized that self-report data in Russia might not necessarily reflect true alcohol consumption patterns in that country. The criterion for substance abuse in the United States differs from the cultural norms of alcohol consumption in Eastern Europe and CIS. Consequently, collection of self-report data from Eastern European and CIS immigrants who reside in America might be characterized by profound minimization and inaccuracies because of subjects' attempts to minimize the reporting of drinking habits to avoid being ranked in the group of alcohol abusers and dependents.

In addition, it is expected that immigrants who suffer from substance abuse after immigration to the United States might not feel comfortable in disclosing their substance use patterns honestly. Fears associated with immigration status (e.g., misconception about being entitled to very few legal rights) and embarrassment associated with the stigma of substance abuse might prevent immigrants from disclosing their behavioral and emotional patterns truthfully. The collateral interviews might not provide a reliable source of data due to similar reasons.

The criteria for binge drinking in the United States is classified by the number of consumed units per occasion, while in Eastern European and CIS countries it is measured by the total number of grams of consumed alcohol (Nemtsov, 2000).

Furthermore, some Eastern European immigrants, especially at the early stages of immigration, do not speak English fluently. These immigrants are at the most risk of exhibiting a variety of substance abuse behaviors. The questionnaires used to assess the substance abuse behaviors are required to be translated to the subject's native language in order to collect reliable data. During translation, any assessment battery is at risk of losing its validity and reliability. To date, there are very few standardized questionnaires and limited substance abuse data collected using the native languages of Eastern European and CIS immigrants. Consequently, current data collected from immigrants might be confounded by poorly worded questionnaires and tests with very poor reliability and validity.

Definitions

Eastern European immigrant is defined as an individual who was born and raised in the country that belongs to the Eastern European block, and immigrated to the United States at some point after birth.

CIS immigrant is defined as an individual who was born and raised in any country that was once part of the former Soviet Union, and immigrated to the United States at some point after birth.

Substance abuse is defined as behavioral patterns that meet the Substance Abuse criteria of DSM-IV.

Substance dependence is defined as behavioral patterns that meet the Substance Dependence criteria of DSM-IV.

Binge drinking is defined as consumption by an individual of five or more drinks in one occasion.

CHAPTER 2
REVIEW OF LITERATURE

To date, there is little research on alcohol and drug abuse patterns of CIS and Eastern European immigrants in the United States (Ratkowski, 2003). The few studies that address the substance abuse problems of immigrants from the former CIS block and Eastern European countries demonstrate alarming data. The investigative studies show that there is an unusually large population of individuals with current alcohol and drug-related problems among this immigrant group. According to Isralowitz, etc. (2002), since the early 1990s, a growing drug abusing population from Eastern Europe and CIS has become visible. It has been observed that the rates of alcohol and drug problems among these immigrants appear to be disproportionately high, although reliable data is lacking (Isralowitz, etc., 2002). From this, Gilbert and Langrod (2001) argue that various cultural dynamics, including the roles of the family, women, and religion and different aspects of substance abuse itself can explain the nature of this widespread phenomenon.

Substance Abuse in CIS

In general, the countries of CIS have some of the highest incidences of alcoholism in the world (Segal, 1990). For hundreds of years, bingeing was characterized as a "Russian" style of drinking (Kagan, 1992). It is well known that throughout Russia's history, alcohol, primarily vodka, was used as an effective coping mechanism. Per capita alcohol consumption is difficult to establish, as current data is limited. It has been estimated that per capita consumption of alcoholic beverages in the former Soviet Union in 1985 was three times higher than the United States, and eight times higher than at the beginning of the century. The rate of violent alcohol-related crimes was 10.5 times as high as that in the United States. The reduction of work productivity in the Russian

economy due to consumption of alcoholic beverages is six times that of the United States (Segal, 1990).

More recent estimates indicate that 60% of the Russian workforce abuses alcohol (Anderson, 1992). Out of 148 million people, there are approximately 15 million "chronic alcoholics", and the number of "heavy drinkers" is three to four times that (Davis, 1994). In 1990, in the city of St. Petersburg (population 4,672,000), there were approximately 80,000 substance abusers (predominantly alcoholics), and 60,000 suicides, many of which were alcohol related. Moreover, there were 19,000 deaths from acute alcohol poisoning, and of the 22,000 murders, 80% were believed alcohol related (Yandow, 1992). In Moscow (population 10,446,000), about 145,000 patients were registered in the city's largest alcohol and drug abuse hospital during 1992. Of these, 95% were in the most severe stage of the disease, and about 10% were women (Nemstov, 2000).

Another study supports the above alarming data. According to Nemtsov (2003), alcohol consumption in Russia is significantly higher than in the United States. Furthermore, Nemtsov (2003) presented survey data that demonstrated that alcohol mortality in Russia is the highest in the world as compared to international figures. For instance, the rate of alcohol-induced psychotic disorders recorded in 1994 in Russia was 114 per 100,000 people, and fatal alcohol poisoning was 38 per 100,000 people. In contrast, the United States had a 1994 rate of fatal of alcohol poisoning of 0.06 per 100,000 people. This data demonstrates that individuals with Eastern European backgrounds acquire a culture of alcohol consumption behaviors that differ from the

United States, and are at risk to continue exhibiting these behavioral patterns upon immigration to the United States.

Parker, Levin, & Harford (1996) analyzed data from the *"Survey of Deviant Behavior Among Youth in the Moscow Region of Russia"*. In particular, they examined the effects of early drinking behaviors, and an antisocial orientation on the use of alcohol by young Russians. Additionally, using available data from the *"United States National Household Survey of Drug Abuse*", comparisons were made between the use of alcohol and the effects of early drinking among youth in the Moscow region and the United States. The analysis of the data from these two surveys indicated that a greater proportion of Russian youths began drinking by the age of 12, but that early drinking was associated with subsequent alcohol use among both Russian and American youth. Although there was no data on an antisocial orientation from the United States survey, such data is available from the Russian survey, and an analysis of that data indicated that the greatest alcohol use was found among young Russians who began drinking by the age of 12 and who had an antisocial orientation.

It is found in many studies since the collapse of the Soviet Union in 1991, that the abuse of different drugs has reached epidemic proportions (Davis, 1994). Currently, use of marijuana, cocaine, heroin, and prescription drugs is increasing in all CIS countries (Specter, 1997). Significant increases have occurred among adolescents in sniffing inhalants such as glue, paint, and homemade synthetic drugs (Davis, 1994; Specter, 1997).

Substance Abuse in Eastern Europe

It has been observed that since World War II there has been a substantial increase in the use and abuse of alcohol and other substances in Eastern European countries (Tryzno, et al., 1989). Alcohol abuse is the most serious substance abuse problem among Poles in Poland (Morowski, 1992). The use of and addiction to drugs in Eastern Europe began to emerge during the late 1960s, parallel with the experiences of the "hippie" generation in the United States. Hallucinogenic became the most popular drug among young people in Poland at that time (Sekiewicz, 1994).

During the mid-1970s, following a brief period during which sedative hypnotics and stimulants were popular, a massive increase in the use of narcotics took place after a pharmacy student developed what became known as Polish heroin, or "kompot." Kompot constitutes 70% to 80% of all illicit drugs used by Polish addicts (Curtis, 1994). Since 1991 Eastern European countries have become one of the largest world producers of the illicit amphetamine that was intravenously used with kompot (Stark, et al., 1995). Between 1991 and December 1992, law enforcement authorities confiscated more than 92 kilograms of illicit amphetamine that was exported from Poland alone (Holyst, 1994). As a result of this highly prevalent poly-substance abuse, many men in Eastern European countries become succumbed in alcohol and homelessness (Holyst, 1994).

Immigration issues faced by Eastern European and CIS immigrants

Immigration is experienced as a series of losses, including loss of homeland, loss of family and friends, loss of professional and social status, and loss of established personal identity (Castex, 1996). Shortly after immigration, people tend to suffer from profound feelings of confusion, inadequacy, insecurity, hopelessness, and worthlessness.

The need and pressure to rapidly accept new cultural values and societal belief systems leads to increased separation from the ethnic group of origin and, thus, weakens the needed support from that group (Castex, 1996).

The majority of CIS and Eastern European immigrants have an idealized image of America, which includes an ambiguous idea of financial freedom. Not only must CIS and Eastern European immigrants cope with their unrealistic expectations of American society, but they must also adapt to their new status within a very different social and economic system, with different notions of freedom, personal responsibilities, and openly individualistic and competitive attitudes (Goldstein, 1979). It was found that a large proportion of professionally and academically trained immigrants are confronted with the fact that they have to begin at the bottom and work their way up in American society. The loss of status is a threat to those whose profession, education, and position in the hierarchy of society became a large part of their personal identity (Goldstein, 1979). This sense of insecurity leads to increased levels of distress.

The differences in cultural and socio-economic status among CIS and Eastern European immigrants in the United States has a significant effect on their adaptation and assimilation to American culture (Goldstein, 1979). From World War II until the beginning of the 1980s, Eastern European and CIS immigration to the United States consisted mostly of educated professionals. These immigrants apparently had an easier time assimilating than their earlier counterparts (Folwarski & Marganoff, 1996). More recently, due to severe economic problems in Eastern Europe and CIS, there has been an influx of single, educated women, as well as working class men, who settled mainly in San Francisco, Chicago, New York City, Los Angeles, Boston, and other metropolitan

cities with existing CIS and Eastern European communities (Gilbert and Langrod, 2001). These newly arrived immigrants have to overcome an additional stressor. They tend to experience a great deal of difficulty relating with members of the existing immigrant communities, which makes it more difficult for them to adjust to American culture (Goldstein, 1979).

Literature demonstrates that although married couples and single people reported similar amounts of adjustment problems, the singles reported significantly lower family support, and significantly higher psychological levels of distress (Berkman, 1986). Although most Eastern European immigrants arrive with their families (including nuclear families), due to various immigration stressors they still tend to experience marital problems and discord (Malzberg, 1962). These marital problems might have a significant effect on levels of psychological distress.

Ticho (1971) defined the two most essential elements of immigration experienced by CIS and Eastern European immigrants: the sudden move from a familiar environment to one that is new and unpredictable, and second, grief for the loss of country of origin, and the threat to personal identity as new immigrants. These elements associated with immigration explain why a lack of social contact was found to be the strongest predictor of demoralization during the first year following immigration (Lerner and Zilber, 1991).

At the same time it was observed that the majority of Eastern European and CIS immigrants experience a great deal of isolation during the first year of immigration. For instance, Soviet Jews appear to suffer from a sense of alienation and identity confusion shortly after immigration (Markus & Schwartz, 1984). This might be another factor leading to increased levels of distress in this immigrant population.

Substance Abuse among Eastern European and CIS immigrants in the United States

Research shows that immigrants have a higher rate of psychiatric hospitalization than do native inhabitants (Malzberg, 1962). In a study of first admissions to a New York Hospital, the crude admission for immigrants was 65% higher than that for non-immigrants (Malzberg, 1962). Adjusted for age, this came to 27%. The highest differential was in the 10 to 19 year old age group, where immigrant hospitalizations exceeded the non-immigrant rate by 106%. It was demonstrated that the incidence of depression and psychosomatic illness (hypertension, peptic ulcers, pain disorders, rheumatoid arthritis, diabetes mellitus) are also increased in immigrant populations (Lin, Tazuma, & Masuda, 1979; Tyhurst, 1951; Rumbaut & Rumbaut, 1976). Aside from depression and psychosomatic illnesses, most existing studies have shown increased medical morbidity and mortality during the two years following major life stress, mediated by changes in immune functioning (Hong & Holmes, 1973; Holmes & Masuda, 1973; Jacobs & Osfeld, 1977). These findings suggest that immigrants are at risk of developing medical problems upon immigration to the United States, taxing their coping resources.

To date, according to the author's investigation, there is no documentation available on the prevalence of alcohol and drug problems among CIS immigrants in the United States. However, because approximately 20-25% of the population in the former Soviet Union have alcohol and drug problems (Davis, 1994), it can be assumed that thousands of the former Soviet Union citizens have problems related to alcohol and other drug use.

The following data demonstrates the significance of these statistics. According to the United States Immigration and Naturalization Service, almost one quarter of a million (247,764) former Soviets arrived in the United States between 1990 and 1994. During the 1996 fiscal year, 19,668 immigrants came to the United States from Russia, and another 21,079 from the Ukraine (United States Department of Justice, 1997). According to the United States Census Bureau (2005), there are approximately three and a half million Eastern European and former Soviet Union immigrants residing in the United States. Therefore, according to these statistics, at least 700,000 immigrants from the CIS who reside in the United States are at risk of exhibiting various forms of substance abuse.

In addition, the above data suggests that the roots of high prevalence of substance abuse among Eastern European and CIS immigrants in the United States is related, not only to the issues associated with immigration but also to substance abuse in the countries of origin. The investigation conducted by Parker, Levin, and Harford (1996) shows that substance abuse in home countries might be a significant predictor of the substance abuse behaviors of immigrants in the United States. Parker, Levin, and Hartford (1996) suggested that the strong tendency of Eastern European and CIS immigrants to deny the existence of psychological problems and blame external factors, rather than to face their own personal problems, exacerbates the severity of their substance abuse. Studies demonstrate that this immigrant population often presents with many physical complaints, which generally turn out to be psychosomatic expressions of unresolved psychological conflicts (Goldstein, 1979).

Hasin, etc. (2002) studied the prevalence of alcohol dependence criteria in a random sample of recent Russian immigrants. In that project, a structured interview

included highly reliable questions on alcohol dependence symptoms from the Diagnostics and Statistical Manual of Mental Disorders-IV (DSM-IV). Results of the study demonstrated that recent Russian immigrants had a number of past and lifetime DSM-IV substance dependence symptoms.

The few studies done suggest significant differences in the patterns of substance abuse between various groups of Eastern European and CIS immigrants. In 2003, Ratkowksi compared Polish immigrants who abuse alcohol and drugs in younger and older age groups. In that study, twenty mental health professionals with histories of working with Polish immigrants who suffered from substance abuse administered a semi-structured interview. The study found that Polish immigrants in younger age groups tend to abuse drugs more than alcohol, whereas immigrants in older age groups abuse alcohol more than drugs. The findings suggest that Polish immigrants who immigrated to the United States during the 1980s were more likely to abuse alcohol, whereas those who immigrated in the 1990s were more likely to abuse drugs.

In summary, behaviors acquired in the countries of origin, and different stressors associated with immigration are factors associated with substance abuse among Eastern European and CIS immigrants (Ratkowski, 2003). Surprisingly, Ratkowski (2003) did not find that Polish immigrants who were employed and proficient in the English language were less likely to abuse alcohol and drugs. In contrast, Ratkowski (2003) found partial support that Polish immigrants who were unemployed and separated from family were more likely to abuse alcohol and drugs. These findings suggest that economic and social problems associated with immigration are factors contributing to the high rates of alcohol and drug abuse behaviors in the United States.

CHAPTER 3
METHODOLOGY

My ultimate goal in taking on this study was to understand the substance abuse issues of Eastern European and CIS populations. The first year of my clinical training took place at the Acute Rehabilitation Center at the Veteran's Affairs Medical Center. At that time I observed primarily African-American polysubstance abusers who had a long history of addiction. During my first year of training I learned about the nature of substance dependence and how devastating it can be not only for individuals with this clinical issue but also for the entire families of these individuals.

Throughout the rest of my clinical training, I encountered different individuals and clinical cases associated with substance abuse. Many patients to whom I delivered care presented various psychosocial issues underneath which was addiction or abuse of various substances. I observed and learned how these psychosocial issues varied across different socio-economic characteristics and personal backgrounds of my patients.

At the Veteran's Affairs Center I worked with individuals with substance abuse disorders with primarily low socio-economic backgrounds. As I shifted my clinical training to private practice and hospital settings, I encountered individuals with higher socio-economic backgrounds. I observed that on average, substance abuse behaviors were much less prevalent and severe among individuals who had higher socio-economic backgrounds. My experience fit with the data on substance abuse and psychiatric illnesses that I encountered in many articles during my clinical training: substance abuse is more prevalent among individuals who experience financial, family, educational, and inter and intra personal stressors and difficulties.

After I completed my clinical training and opened a private practice for Eastern European and CIS immigrants, in addition to American clients, it became obvious to me that there were subtle differences in substance abuse characteristics among the above immigrant population and American clients. First, it was clear that substance abuse, in particular alcohol abuse and dependence, was very prevalent among clients who immigrated to the United States. Furthermore, substance abuse and dependence affected immigrants of all socio-economic backgrounds and classes, with and without financial, family, social, or emotional difficulties. For instance, I have encountered successful engineers, lawyers, businessmen, etc. with Eastern European or CIS backgrounds who came to my office for treatment of severe alcohol-related problems. At the same time I worked with individuals with similar ethnical backgrounds who were involved in blue color work and tended to exhibit similar to the "white color" group drinking patterns.

The more I was working with Eastern European and CIS immigrants, the more I realized how challenging this group of individuals was to treat. First, they experienced a profound bias against any form of psychotherapeutic intervention. Second, they were against changing their behavioral patterns and adapting to an American lifestyle when the issues surrounded substance abuse. Third, they refused to disclose personal problems to a professional like me "because they themselves knew the roots of their problems the best." Fourth, they did not believe that anyone could assist them in changing their alcohol consumption.

All of the above unique characteristics of my Eastern European and CIS clients created a great deal of obstacles in my therapeutic work with them. In particular, I had a great deal of difficulty initiating rapport with them to establish a foundation for treatment.

At my early stages of practice, most of the patients were not reaching even the third session of psychotherapy with me, even though they experienced a number of substance abuse related difficulties.

That lead me to investigate various cultural issues associated with substance abuse among individuals with Eastern European and CIS backgrounds to ensure that I would be able to deliver the best possible care to my immigrant clients. First, I learned more about various issues associated with immigration that they tend to encounter in the United States. Then I educated myself about various coping strategies that they apply to adapt and assimilate to the United States. As I was researching the literature, it became clear that that there are very few scientific studies on Eastern European and CIS immigrants who reside in the United States. In other words, empirical data about treatment components for these immigrants is almost absent. I could not find much clinical data that could have assisted me to deliver the improved treatment for this immigrant group. This lack of scientific data encouraged me to start working on this project to present the needed data and information for clinicians who work or tend to work with Eastern European and CIS immigrant populations in the United States.

CHAPTER 4
FINDINGS

The author's literature review demonstrates that alcohol use by Eastern European and CIS immigrants not only affects the drinkers themselves, but also their families and communities. Studies show that excessive alcohol use has been linked to preventable premature death, adverse health effects, and major social problems (Matuk, 1996). Further to this, Matuk (1995) states that heavy drinkers have twice the overall premature death rate compared to general population of the same age and gender.

Despite the harmful effects of alcohol, drinking practices continue to be a major problem for Eastern European and CIS immigrant populations. Alcohol abuse has been implicated in family discord, child abuse, job loss, decreased work productivity, suicide, crime, and violence (Witters, Venturelli, & Hanson, 1992).

In summary, the drinking pattern of immigrants has an impact on their well-being and families. The drinking patterns of Eastern European and CIS immigrants resemble the drinking patterns of African-American and Hispanic populations of the United States: their drinking patterns were more detrimental than the drinking patterns of White Americans (Sempos, et al., 2001). Sempos et al. (2001) argued that both African-American males and females (similar to Eastern European and CIS immigrants) consumed different volumes of alcoholic beverages per occasion than White-Americans. This supports survey data that reveals that the prevalence of drinking increases perceived stress levels among immigrants, and that one in five immigrants reported that drinking has been a source of tension in their family.

The literature review by the author shows that during the resettlement process, many immigrants are likely to experience personal, social, and economic hardships from occupational adjustments, social isolation, or racial discrimination (Matuk, 1995). They are vulnerable to depression, family tension, and emotional distress, all of which can be contributing factors to alcohol misuse or abuse (Witter, Venturelli, & Hanson, 1992). The above psychosocial factors were found as one of the variables that also predict higher substance-related problems among African-American and Hispanic population (Wallace and Muroff, 2002).

Studies demonstrate that among Eastern European and CIS immigrants the number of males who were "never-drinkers" or who drank "at least once a month" is generally higher than the corresponding number of females. The self-report data collected from a group of Eastern European and CIS immigrants (Witter, Venturelli, & Hanson, 1992) show that, on average, men consumed 3.9 drinks per week, and women consumed 1.5 drinks. Research demonstrates that about 9% of Eastern European and CIS immigrants have consumed 10 or more drinks on one occasion in the past 12 months. They were all males between the age of 20 and 64.

According to the author's literature review, the frequency of alcohol use among newcomers increases from 29% among those with low incomes (less than $30,000 annual family income) to 71% among those with high incomes. Thirty percent of "current drinkers" (32% of males and 26% of females) indicated that they have tried to reduce the amount they drink. Surprisingly, females expressed less concern about their own drinking behaviors and equal or less desire than males to reduce the amount they drink. The

discrepancy is most significant in the 20 to 44 age group, where only 26% of these reported were females and 36% were men.

According to the survey of Eastern European and CIS immigrants administered by Matuk (1996), 91% of Eastern European and CIS immigrants (89.3% of males and 93.3% of females) reported driving within an hour of consuming two or more drinks for less than five times in the year preceding the survey. The occurrence of drinking and driving more than five times is higher in men (10.7%) than in women (6.7%). The 20 to 44 age group was the most significant group. In contrast, data indicates that a much lower percentage of the general American population (about 11 percent) reports driving under the influence of alcohol (Bond & Cherpitel, 2004). This shows the significant difference in cultural values and beliefs associated with drinking and driving.

One in every four Eastern European and CIS immigrant (27% of males and 21% of females) aged 12 and over indicated that drinking has been a source of tension in their family. The 45+ age group experienced the most impact (31% of males and 38% of females), followed by the 12 to 19 age group (38% of males and 12% of females), and the 20 to 44 age group (23% of males and 21% of females).

Literature shows (Matuk, 1996) that Eastern European and CIS immigrants, in general, tend to express a high level of happiness and satisfaction with their liver. However the majority of drinkers reported their lives as highly stressful. Surprisingly more men than women among this immigrant population reported that they were happier and their lives were less stressful.

In summary, such variables as living conditions, education, income and wealth, psychological well-being, and family are the variables that predict substance abuse among Eastern European and CIS immigrants (Wallace, 1999).

Women Issue

Immigrant women tend to experience more stress in their lives and are less happy than immigrant men. During the immigration process, women often experience various degrees of distinct emotional stress and mental illness (Aroian, 1990). Although their husbands have a tendency to attend school and look for work, women remain in the home to care for their children and, sometimes their aging parents. They are usually isolated from American society and unable to establish important social networks. Their links to the outside world are often through television or friends, if any. This isolation makes Eastern European and CIS immigrant women struggle between the culturally oriented somewhat subservient role and the one endorsed by new cultural values.

It has been found that one in three alcoholics is a woman (Chatham-Carpenter & DeFrancisco, 1997). The incidence of women's alcohol use has been increasing across various socio-economic layers of society. Research has found that most women use alcohol as a result of: depression, loneliness, divorce, separation, infertility, absence of children at home, or husbands who are drinkers. Women with Eastern European and CIS cultural backgrounds, tend to drink alone or at home to avoid condemnation, and to conceal their alcohol dependency. The data show (Matuk, 1996) that women in the 20 to 44 age group are of a particular concern. They tend to consume a higher level of alcohol than women in other age groups. They tend to consume alcohol more regularly, and this could potentially lead to alcohol addiction.

Findings demonstrate that Eastern European and CIS women drink nearly as regularly, as many as "35 plus drinks" per week when compared to the men. They expressed the least concern toward the effect of alcohol on health, and had the least desire to reduce the amount they drink. Given the stressors experienced during the resettlement process, alcohol use in newcomers, especially the women, is a challenging and hazardous problem.

These findings highlight the importance of substance abuse treatment for Eastern European and CIS immigrants, both males and females. A number of scientific studies demonstrate that substance abuse treatment "works" (Weisner, Matzger, & Kaskutas, 2003). Several robust predictors of the effectiveness of alcohol treatment have been identified: demographic characteristics (e.g., gender, age, socio-economic class), problem severity (e.g., psychiatric problem severity), and social network (e.g., family, friends) (Jarvis, 1992). All of these robust factors have been associated with Eastern European and CSI immigrants to the United States. There is a great deal of need to design a specific treatment that addresses the above predictors during substance abuse treatment for these immigrants. Unfortunately, to date there are basically no treatments that specifically address these risk factors. Following, are examples developed by the author, of treatment processes for males and females that address all of the risk factors associated with substance among Eastern European and CIS immigrants.

CHAPTER 5

SUBSTANCE ABUSE TREATMENT PROGRAMS FOR EASTERN EUROPEAN AND CIS SUBSTANCE ABUSERS

The mission of any agency that is working with Eastern European and CIS immigrant substance abusers is to raise awareness and levels of education about the risks of alcohol and substance abuse, drinking and driving, and improve understanding of psychological problems and issues associated with substance abuse through individual, family and group counseling and education sessions. The goal is to contribute to the reduction of incidents of alcohol and drug use, abuse, or dependence among immigrant population through education, individual, family and group assistance.

Every individual who contacts the agency needs to be approached with cultural sensitivity. During the initial assessment, all clients need to be screened for current levels of substance abuse, and questioned to determine the risks for future substance abuse. Another goal of initial assessment is to provide a recommendation for an initial intervention to clients. Therefore, it is recommended that the following information be collected in the structured initial evaluation of every Eastern European and CIS immigrant who is presenting with the substance abuse problem:

- Chronological history of substance use from first use to present, including alcohol, prescription and non-prescription drugs, exposure to intoxicating compounds and illegal drugs that specifies the frequency and patterns of use, type and amount of substance used and any change in the use or abuse pattern and the reason for change.

- Extent to which the substance has caused marital, family, legal, social, emotional, vocational, physical, and/or economic impairment.
- Verbal description of legal history: alcohol and drug related legal history, driving history (all offenses), and any related substance use or chemical test results (blood alcohol concentration-BAC) and all substances used that resulted in all arrests, including the most recent DUI arrest.
- Past history of substance abuse evaluations, alcohol and drug treatment and/or self-help group involvement.
- Family history of substance abuse.
- Analysis of the Psychosocial Measures, including substance and drug abuse, depression, and anxiety questionnaires.
- Analysis of current driving records to ensure the presence of DUI offenses.
- After the determination of the severity of the problem, the evaluator should recommend the type and level of intervention. It is recommended that the recommendation be delivered in the follow up visit. For the follow up visit, the evaluator would design the Treatment Plan after consulting a Medical Director who is familiar with the unique cultural backgrounds of Eastern European immigrant clients. During in-person or phone consultation with a Medical Director, the evaluator should utilize all relevant information of the immigrant's substance use or arrest history. In particular, the evaluator should complete the medical screening to obtain the following information that should be relayed to a Medical Director.
- Primary complaint per patient.

- Date of last physical exam and the name of patient's primary care physician.
- History of substance use.
- History of past withdrawal symptoms and their severity.
- History of concurrent medical symptoms, complications or conditions, including sexual activity and risk for pregnancy.
- History of concurrent psychiatric symptoms, complications or conditions, including suicide/homicide potential.
- History of recent trauma (including physical/sexual abuse).
- Hospitalizations (including for detoxification and psychiatric reasons).
- Medications currently prescribed and any allergies to medications.
- Infectious or communicable diseases.

It is crucial that the evaluator considers all information pertinent to formulation of a recommendation for further services necessary, to reduce the immigrant's risk to self and others. The designed Treatment Plan must be signed and dated by the patient, indicating his or her willingness to participate in the development of the plan, and by the professional staff member assigned primary responsibility for services to the patient. It is absolutely necessary that the Treatment Plan be written gender and culture appropriate to each patient. The Treatment Plan must list problems, goals, objectives, methods, and a time table for achieving the goals and objectives of treatment that are within the time frame of the patient's expected participation. The Treatment Plan would need to include the description and frequency of all activities, referrals, and consultations planned for the patient and/or family members or significant others, and designate all professional staff members assigned to provide or coordinate referrals for such services. It is absolutely

necessary to establish on-going assessment of the patient's progress in treatment. This should occur in order to determine continuation of the level of care in which the patent is placed, or the need to move to another level of care, or to discharge.

In the follow up visit, all clients who need substance abuse treatment that cannot be delivered at the evaluator's agency will need to be referred for appropriate services at licensed agencies. These agencies must be able to accommodate clients with diverse cultural backgrounds. It is recommended that Eastern European and CIS immigrants be offered diverse multi-modal substance abuse treatment.

Therefore, the agency that specializes with this immigrant population would need to be able to deliver a multi-modal treatment that includes individual, group, and special education classes that can be offered in native languages to ensure full understanding of the delivered materials.

The primary goal of the education classes is to provide orientation to clients and their families regarding the impact of alcohol and other drug use on individual behavior and overall family functioning. The secondary goal of the education classes is to allow clients and their families to further explore the personal ramifications of their own substance use and abuse.

The Risk Education Curriculum for education classes is recommended to include the following topics:

- Information on alcohol as a drug.
- Physiological and Pharmacological Effects of alcohol and other drugs, including their residual impairment on normal levels of driving performance.

- Other drugs, legal and illegal, and their effects on driving when used separately and/or in combination with alcohol.
- Substance abuse/dependence and the effects on individuals and families.
- Blood Alcohol Concentration (BAC) levels and their effect on overall cognitive functioning, including judgment.
- Information about driving under the influence laws and associated penalties.
- Factors that influence the formation of patterns of alcohol and drug abuse.
- Information about referrals for services that can address any identified problem that may increase the risk for future alcohol/drug related difficulty.

It is recommended for the agency to design an assessment that enables evaluation of client and family member understanding of the delivered materials. It is crucial that the agency establishes sobriety and drug-free requirements during education classes.

In contrast to the educational groups, it is recommended that counseling groups for Eastern European and CIS immigrants have a specific focus and be more process oriented rather than didactic. The major purpose of the counseling groups should be to allow patients or significant others an opportunity to process issues related to their treatment in a group setting.

Both educational and counseling groups should be highly structured. It is recommended that the agency ensures appropriate documentation of necessary attendance of counseling and educational groups. Some clients might be undergoing treatment to satisfy court requirements. Therefore, the appropriate documentation is necessary to keep a record for each client. The appropriate agency representative needs to inform prospective clients regarding dates and hours the groups are held, and the therapeutic

orientation of the group. At the beginning of each group, all clients should be informed of the guidelines for group attendance and decide whether the group is opened or closed. The delivery of this information needs to be recorded in the client record. No counseling and educational groups should exceed 16 people.

Initial AIDS Risk Education is strongly recommended for all Eastern European and CIS immigrants entering the agency for treatment of substance abuse. To ensure awareness of the risks to infectious diseases, the following topics should be addressed in this session:

- Education relative to infectious disease control and HIV/AIDS with an emphasis on the etiology and transmission of HIV infection and associated risk behaviors, symptomology and clinical progression of HIV infection and AIDS and the relationship to substance abuse behavior, prevention of transmission, and risk education (including information about needle sharing, sexual transmission, transmission to infants, etc), the availability of counseling and testing services, the confidentiality rights of the patient regarding counseling, testing and HIV status and relapse prevention.
- -Education relative to infectious disease control of tuberculosis that includes information about its transmission and prevention, the importance of diagnosis, the requirement for skin testing and the interpretation of skin test results, the importance of X-rays for positive test results and HIV infected persons, the importance of treatment regimens and the basic symptoms associated with tuberculosis.

Upon admission and initial placement in Outpatient care, the clinical assessment of the patient needs to continue throughout a few sessions in order to confirm or make changes to the original Treatment Plan. Patient needs will be determined through the analysis of the six dimensions established in the American Society of Addiction Medicine (ASAM) Patient Placement Criteria and include the following:

- A review of the medical screening and subsequent physician referrals or changes in patient's health, including a determination of acute intoxication and/or withdrawal potential, the current substance or abuse pattern and medication use, and history of prior treatment for substance abuse or dependence and number of relapses.
- A review of any previous emotional or behavioral problems and treatment, and the patient's current emotional and behavioral functioning, including any history of previous or on-going psychological, physical, emotional or sexual abuse, in order to detect problems that may be life threatening or indicative of severe personality disorganization or that may seriously affect the patient's progress in treatment.
- An analysis of the patient's home and/or living environment including childcare needs, religion, childhood, military service history, education and vocational history, financial status, social or peer group, family constellation and history of substance abuse, a determination of the need for the participation of any family members or significant others in the patient's treatment, information on pending criminal or misdemeanor charges or any specific conditions of court supervision, probation or parole including any prior substance abuse evaluations.

- The agency should ensure that it keeps excellent progress notes to reflect patient's progress in treatment, and be consistent with the clinical assessment, level of care, and expectation of progress. Progress notes need to reflect summary of the services, and be delivered prior to each continued stay review, made upon each continued stay review for patient care. Progress notes include the following:
    - Chronological Documentation of the patient's progress in treatment.
    - Documentation of any changes in patient behavior.
    - Description of the patient's response to treatments, the outcome of treatment, and the response of significant others to events in the course of treatment.
- It is necessary for a session notes to include a subjective interpretation of the patient's progress. This can be accomplished by providing description of actual observed behaviors.

(See Appendix A).

CHAPTER 6
TREATMENT PROGRAM FOR EASTERN EUROPEAN AND CIS FEMALE SUBSTANCE ABUSERS

Considering the unique characteristics of female substance abusers with Eastern European and CIS cultural backgrounds, special substance abuse intervention is recommended for this unique population. The proposed Female Substance Abuse Treatment Program is being guided by the recommendations of the U.S. Department of Justice, National Institute of Corrections, Gender-Responsive Strategies, Research, Practice, and Guiding Principles for Women Offenders (July 2003).

Description of the Female Substance Abusers Program

The treatment of the Female Substance Abuser Program is based on **six** major therapeutic dimensions.

The primary goals of each of these dimensions are to:

- Establish women's competencies and strengths.
- Identify women's weaknesses.
- Deliver treatment intervention that ensures self-reliance by the reduction of various psychosocial effects caused by the identified weaknesses.

The above therapeutic objectives are met by applying the following:

- Acknowledge the subtle differences between female and male substance abusers.
- Create a safe, supportive, and respectful environment.
- Design policies and procedures that promote healthy connections between women, children, and family.
- Develop services to address women-specific mental health and substance abuse issues.

- Establish agreements with different vocational and medical centers that should be able to provide female substance abusers with the required medical and socioeconomic assistance.
- Establish ancillary recovery groups to ensure the necessary community supervision.
- Supervise the effectiveness of the program and staff.
- Establish protocols for reporting and investigating claims of misconduct.
- Develop assessment systems that are validated on the samples of women substance abusers.

Therapeutic Dimensions of the Female Substance Abusers Program

Below is the description of **six** therapeutic dimensions designed for Treatment of Female Substance Abusers:

1. Gender Issues.
2. Environment.
3. Interpersonal and Intra-personal Relationships.
4. Mental Health and Substance Abuse
5. Socio-Economic Intervention.
6. Post-Treatment Intervention and Community Supervision (Integration to the community).

Gender Issues

There are a number of major Gender Issues that need to be addressed throughout treatment of each individual female substance abuser: STD, AIDS/HIV, Osteoporosis, Cancer, Pregnancy, roles of families, domestic violence, career, etc.

Environment

In the Environmental part of the intervention, modification of women's current environment outside the therapeutic settings, prevention of violence against women and their children, and validation of the effects of women's growing up experiences on their present worldviews and overall functioning all need to be addressed.

Interpersonal and Intra-personal Relationships

This part of treatment is focused on the following: mother-child relationship (e.g., communication, child-boundaries, child-centered environment and context, etc.), boundaries in the relationships with peers and at home, domestic violence, promotion of the supportive relationships with others, and development of the community and peer-support networks.

Mental Health and Substance Abuse

This part of treatment addresses women's mental health and substance abuse issues. In particular, each woman's substance abuse and mental heath history is assessed, and the intervention created and provided, in both individual and group settings. Particularly, the focus is placed on the women specific issues: Eating Disorders, Depression, Anxiety, etc.

Socio-Economic Intervention

This part of treatment is focused on the social and economic needs of women. Female substance abusers receive vocational, employment, educational, and (among others) recreational interventions. The goal of this part of treatment is to integrate female substance abusers into society, and enable effective functioning in society.

Post-Treatment Intervention

This part of treatment is focused on prevention. Every risk for relapse is identified, and specific relapse prevention strategies are developed. Ancillary recovery groups are designed to assist female substance abusers in their daily functioning, by coaching them in various vocational, social, and communication skills.

Agency Structure

The agency should ensure that staff affiliated with the Female Substance Abusers Program reflect its population in terms of the characteristics of the female population. In particular, the agency needs to hire bilingual counselors in Russian, Polish, and other languages. The center needs to hire staff that reflect the demographic and cultural backgrounds of its clients.

It is recommended that the agency continue recruiting volunteer personnel that can work with different female substance abusers throughout their treatment. Furthermore, it is recommended that a female doctor, either medical or clinical be available to address medical and mental health concerns with the women.

In addition, the agency should consider hiring predominantly female professional clinical staff. The agency is advised that female staff should conduct all clinical interviews with female substance abusers entering into the. It is also recommended that the agency design initial assessment that collects data in the following areas:

- Demographic information.
- Mental health issues.
- Post Traumatic Stress Disorder (PTSD).
- Physical Abuse.

- Family Abuse.
- Sexually Transmitted Diseases.
- Parenting.
- Children.
- Childcare.

It is important that during the initial assessment, the necessity of administration of the treatment intervention in the clients' native language is determined.

To ensure that staff deliver state-of-the-art treatment to female substance dependent clients, Clinical and Medical Directors need to continuously assess and supervise the staff in the following areas:

- Demographics of female substance abusers.
- Roles of parenting and children in women's lives.
- Developmental and psychological characteristics of women, and the differences between males and females.
- Sexuality and alternative lifestyles (relations).
- Racial, ethnical, and cultural differences among women.
- Cross-gender issues.
- Use of appropriate language.
- Establishing and maintaining the professional boundaries.

Furthermore, to ensure excellence in service, the agency should establish referral lists and agreements with the different medical, vocational, employment, childcare, and social services agencies that assist in addressing the women's practical needs. The agency

needs to have the sufficient financial resources to accommodate the basic needs of female substance abusers, and provide them with access to a variety of community resources.

Throughout the course of treatment, the emphasis needs to be placed on parenting education, child development, and relationship/re-unification with children (See Appendix B).

It is strongly recommended that the agency include a component of female substance abusers discharge criteria from the "Helping Women Recover" ancillary recovery group. The group is coordinated by the Social Services Department of the State. These aftercare groups are being conducted by female staff and are designed for female substance abusers only.

In summary, any agency that delivers treatment for females who suffer from substance abuse needs to create a therapeutic environment based on the recovery guidelines issued by the U.S. Department of Justice, National Institute of Corrections, Gender-Responsive Strategies, Research, Practice, and Guiding Principles for Women Offenders (July 2003).

The agency needs to review all policies and procedures to ensure that they are congruent with the recommended policies of Female Substance Abuse Program and gender specific issues. The goal of the agency's clinical and medical director is to ensure that staff receive required training and supervision to deliver the outlined treatment dimensions.

The agency must accommodate sufficient human and financial resources to deliver the above services to female substance abusers. They would also need to establish and

adhere to the procedures to evaluate its resources on a regular basis to accommodate the needs of the Female Substance Abuse Treatment Program.

Further, the agency would need to ensure oversight of the staff of Female Substance Abuse Program is provided on a regular basis by administration and Medical and Clinical Directors. Finally, any agency would need to establish Utilization Review procedures to assess the effectiveness of treatment.

CHAPTER 7
CONCLUSION

To date there is very little research on substance abusers with Eastern European and CIS backgrounds now residing in the United States. Literature shows that immigration to the United States does have a significant effect on the cultural behaviors (e.g., alcohol consumption) of Eastern European and CIS immigrants. Increasingly, all socio-economic classes of Eastern European and CIS immigrant communities in the United States have been affected by a variety of substance abuse related problems. The studies demonstrate that during the resettlement process, many immigrants are likely to experience personal, social, and economic hardships from occupational adjustments, social isolation, or racial discrimination (Matuk, 1995). They tend to be vulnerable to depression, family tensions, and emotional distress, all of which can be contributing factors to alcohol misuse or abuse.

It has been shown that alcohol use by Eastern European and CIS immigrants not only affects the drinkers themselves, but also their families and communities. Despite the harmful effects of alcohol, drinking practices continue to be one of the major problems for the Eastern European and CIS immigrant population. Research summary demonstrates that substance abuse among Eastern European immigrants is significantly higher than among the general population of the United States.

It was demonstrated that immigrants who abused substances in their home countries tend to continue abusing substances during early stages of immigration to the United States (Knab, 1993). Alcohol abuse remains the most serious substance abuse problem among Eastern European and CIS immigrants residing in the United States.

Studies demonstrate that every Eastern European and CIS immigrant without history of substance abuse is at risk of developing a variety of substance abuse behaviors during immigration to the United States.

Presently there are very few empirical treatments designed specifically for substance abusers from these backgrounds. Immigrants with Eastern European and CIS backgrounds receive treatment in facilities and substance abuse treatment programs that are based on United States based research. Consequently, the treatment offered by substance abuse recovery centers does not address the cultural needs and unique characteristics of the Eastern European and CIS immigrant population. This demographic fails to receive state-of-the art treatment, which might explain the high prevalence of substance abuse and dependence in this population.

In general, research findings demonstrate the differences in drinking patterns between male and female substance abusers. Therefore, the two proposed substance abuse treatment programs have different components for male and female substance abusers. Furthermore, the proposed two programs tend to address the cultural backgrounds and issues that are essential for any substance abuse treatment for individuals with Eastern European or CIS backgrounds.

It is my hope that these two suggested programs be reviewed and commented on by the different substance abuse treatment agencies that provide services for Eastern European and CIS immigrants in the United States.

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APPENDIX A
SUBSTANCE ABUSE GROUP TREATMENT PROGRAM

SESSION I (3 hours)

1. Goals, structures, rules, and responsibilities during treatment sessions;
2. Clients' introduction;
3. Disease and harm-reduction models of alcohol and substance abuse;
4. Application of Disease and harm-reduction models of alcohol and substance abuse across different cultures;
5. The effects of alcohol on the physiological and psychological systems; how alcohol affects motor, cognitive, and information processing abilities;
6. "Uppers, Downers, All Arounders: Drugs & Effects" – Movie;
7. Discussion of the movie.

SESSION II (3 hours)

1. Overview of substance abuse and different illegal drugs and their combined effects on motor, cognitive, and information processing abilities;
2. The effects of illegal substances and their mixture with alcohol;
3. The effects of alcohol and substance abuse on occupational, recreational, and social activities;
4. The effects of substance abuse on family and loved ones;
5. Discussion of the effects of substance abuse on different activities and family prior to and post immigration;
6. "Alcohol-Brain Under the Influence" – Movie;
7. Discussion of the movie.

SESSION III (3 hours)

1. Review and discussion of the differences between substance abuse and substance dependence;
2. Blood Alcohol Concentration (BAC) and its effect on different cognitive functions;
3. Cross cultural discussion of the concepts of alcohol abuse and alcohol dependence;
4. "DUI - Dead in 5 Seconds" – Movie;
5. Discussion of the movie;
6. Discussion: Formation of Substance Dependency and the effect of culture on its formation.

SESSION IV (2 hours)

1. Review of the topics addressed in the previous treatment sessions;
2. Give a 5-minute speech on the topic "How I will Avoid Drinking in Hazardous Situations";

3. Introduction to various modalities and approaches of the substance abuse treatment agencies;
4. Discussion of different cross-cultural issues and their relationship with substance abuse treatment;
5. Sexually transmitted diseases: prevention and treatment.

SESSION V (3 hours)

1. Discussion of different inter and intra-personal issues faced by immigration;
2. Discussion of the relationship between inter and intra-personal issues and substance abuse;
3. "Elephant in the Living Room" – Movie; "Alcohol and the Mind" – Movie;
4. Discussion of the movies;
5. Biopsychosocial Model of Alcohol Dependency and Addiction;
6. Discussion of cross cultural aspects of the Biopsychosocial model;
7. Discussion of homework/How to write an essay "Personal history and my substance abuse";
8. HIV and AIDS: Prevention and Treatment.

SESSION VI (3 hours)

1. Review of the Biopsychosocial Model;
2. Clients' presentations of their essays/group feedback;
3. Psychological factors of alcohol abuse and addiction (focus on behaviors, cognitions, and emotions);
4. Behavioral analysis (Antecedents, Behaviors, and Consequences) in alcohol abuse and dependence;
5. Clients' presentations of own behaviors that are associated with one's substance use prior to and post immigration;
6. Group feedback;
7. The Process of Behavioral Change in alcohol abuse and dependence;
8. Cultural aspects associated with the process of change;
9. Clients' presentations of behavioral change;
10. Discussion of homework/How to write an Essay, "My substance abuse history and my past and present behaviors".

SESSION VII (3 hours)

1. Review of theBiopsychosocial Model;
2. Reviewing the roles of behaviors in addiction and substance abuse;
3. Essay presentations;
4. Discussion of the clients' essays with an emphasis on cross-cultural issues;
5. "Alcohol & You Part 2: All-American Killer" – Movie, "DWI Decision" – Movie;
6. Discussion of the movies;

7. The roles of cognitions in substance abuse and addiction; focus on the positive/negative expectations of the effects of alcohol;
8. Analysis of cognitions (Negative Automatic Thoughts, Cognitive Distortions, and Schemas);
9. Discussion of the effects of culture and individual experiences on cognitive formation;
10. Individual presentations of the Negative Cognitions and group analysis;
11. The process of changing Negative Belief System and identifying positive cognitions;
12. Discussion of homework and essay: "How my Negative Automatic Thoughts, Cognitive Distortions, and Schemas have an effect on my substance abuse".

SESSION VIII (3 hours)

1. Review of the Biopsychosocial Model;
2. Review of the concepts of Negative Cognitions and cognitive change;
3. Essay presentation;
4. Discussion of the clients' essays;
5. Introduction to the concept of emotions;
6. The relationship between emotions, culture, and substance abuse;
7. Clients' presentations of the roles of emotions in alcohol use and abuse;
8. Group discussion;
9. How to change negative emotions and monitor one's emotional state;
10. Homework discussion/Essay: "The effects of my emotions on my substance abuse".

SESSION IX (3 hours)

1. Review of the Biopsychosocial Model;
2. Review of the concepts of Negative Emotions and Changing Negative Emotions;
3. Essay presentations;
4. Discussion of clients' essays;
5. Cross-cultural relationship between behaviors, cognitions, and emotions;
6. Holistic approach to the formulation of substance abuse, including behaviors, cognitions, and emotions;
7. "Chalk Talk On Alcohol - Revised" – Movie;
8. Discussion of the movie;
9. Clients' presentations on personal relationships between substance abuse, behaviors, cognitions, emotions, and individual's cultural background;
10. Group feedback;
11. Homework discussion/Essay: "My substance use: why I use substances and what strategies I will use to stop."

SESSION X (3 hours)

1. Review of the relationship between behaviors, cognitions, emotions, and individual's cultural background;
2. Clients' essay presentation;
3. Group discussion and feedback;
4. Relapse – what is it?
5. Different strategies to prevent relapse;
6. Identification of the stressors associated with immigration and their relationships with the relapse triggers;
7. Group discussion;
8. "Addiction's Impact on Family and Friends" – Movie;
9. Group discussion;
10. Individual presentation of the relapse prevention strategies and group feedback;
11. Discussion of homework/Essay: "How I will prevent relapse in the future";

SESSION XI (3 hours)

1. Review of relapse prevention;
2. Presentation of clients' essays;
3. Group feedback;
4. Summary of the covered material;
5. Students' presentations of new substance abuse prevention strategies learned in the program;
6. "Relapse does not mean full lapse";
7. Group closure.

APPENDIX B
SUBSTANCE ABUSE GROUP TREATMENT PROGRAM FOR FEMALES

SESSION I (2 hours)

1. Initial Assessment;
2. Identification of the problematic areas, cultural issues, and individual therapeutic goals.

SESSION II (3 hours)

1. Goals, structures, rules, and responsibilities during sessions;
3. Clients introduction;
4. Disease and harm-reduction models of alcohol and substance abuse and their application across different cultures;
5. The effects of alcohol on the physiological (reproductive) and psychological systems (family dynamics);
6. Discussion of how alcohol affects motor, cognitive, and information processing abilities;
7. "Uppers, Downers, All Arounders: Drugs & Effects" – Movie;
8. Discussion of the movie.

SESSION III (3 hours)

1. Overview of substance abuse and different illegal drugs and their combined effects on motor, cognitive, and information processing abilities;
2. The effects of illegal substances and their mixture with alcohol on the reproductive system;
3. The effects of alcohol and substance abuse on occupational, recreational, and social activities pre and post immigration;
4. The effects of substance abuse on family, loved ones, and mother-child relationship;
5. "Alcohol-Brain Under the Influence" – Movie;
6. Discussion of the movie;
7. Discussion of the differences between substance abuse and substance dependence.

SESSION IV (3 hours)

1. Blood Alcohol Concentration (BAC) and its effect on cognitive functions;
2. Cross cultural discussion of the concepts of alcohol abuse and alcohol dependence;
3. "DUI - Dead in 5 Seconds" – Movie;
4. Discussion of the movie;
5. Review of the definition and formation of Alcohol Dependence;
6. Discussion: Formation of Substance Dependency across different cultures;
7. Give a 5-minute speech on the topic "How I will Avoid Binge Drinking";

SESSION V (3 hours)

1. "Elephant in the Living Room" – Movie; "Alcohol and the Mind" – Movie;
2. Discussion of the movies;
3. Biopsychosocial Model of Alcohol Dependency and Addiction;
4. Discussion of the cross cultural aspects of the model;
5. Discussion of homework/How to write an essay, "Personal history and my substance abuse";
6. Introduction to the effective communication strategies.

SESSION VI (3 hours)

1. Review of the Biopsychosocial Model;
2. Clients' presentations of the essays/group feedback;
3. Review of the effective communication strategies;
4. Assertive communication: cross-cultural aspects;
5. Psychological factors of alcohol abuse and addiction (focus on behaviors, cognitions, and emotions);
6. Behavioral analysis (Antecedents, Behaviors, and Consequences) in alcohol abuse and dependence;
7. Clients' presentations of behaviors that are associated with one's substance use pre and post-immigration;
8. Group feedback;
9. The Process of Behavioral Change in alcohol abuse and dependence;
10. Clients' presentations of behavioral change;
11. Discussion of homework/How to write an Essay, "My substance abuse history and my behaviors"
12. Relationships and its boundaries: family and friends.

SESSION VII (3 hours)

1. Review of the Biopsychosocial Model;
2. Review of the assertive communication strategies;
3. Review of the roles of behaviors in addiction and substance abuse;
4. Clients' essay presentations;
5. Discussion of the clients' essays;
6. "Alcohol & You Part 2: All-American Killer" – Movie, "DWI Decision" – Movie;
7. Discussion of the movies;
8. The roles of cognitions in substance abuse and addiction; focus on the positive/negative expectations of the effects of alcohol;
9. Discussion of the effects of culture and individual experiences on cognitive formation;

10. Analysis of cognitions (Negative Automatic Thoughts, Cognitive Distortions, and Schemas) and its associated with the cultural context and their relationship with cultural backgrounds;
11. Individual presentations of the Negative Cognitions and group analysis;
12. The process of changing a Negative Belief System and identifying positive cognitions;
13. Discussion of homework and essay: "How my Negative Automatic Thoughts, Cognitive Distortions, and Schemas have an effect on my substance abuse";
14. Child development: the basics that you need to know;
15. Effective parenting strategies.

SESSION VIII (3 hours)

1. Review of the Biopsychosocial Model;
2. Review of the child development stages;
3. Review of the concepts of Negative Cognitions and Cognitive Change;
4. Clients' essay presentation;
5. Discussion of the clients' essays;
6. The concept of emotion;
7. The relationship between emotions, substance abuse, and individuals' culture;
8. Clients' presentations of the roles of emotions and pre and post-immigration stressors on alcohol use and abuse;
9. Group discussion/feedback;
10. How to change negative emotions and monitor one's emotional state;
11. Homework discussion/Essay: "The effects of my emotions on my substance abuse";
12. Trauma: when the tragedy comes home.

SESSION IX (3 hours)

1. Review of the Biopsychosocial Model;
2. Review of the concepts of Negative Emotions and how to Change Negative Emotions;
3. Essay presentations;
4. Clients' discussion of essays;
5. The relationship between behaviors, cognitions, and emotions.
6. Holistic approach to the formulation of substance abuse, including behaviors, cognitions, and emotions;
7. "Chalk Talk On Alcohol - Revised" – Movie;
8. Discussion of the movie;
9. Individual presentations on personal relationships between substance abuse, behaviors, cognitions, emotions, and post-immigration issues;
10. Group feedback;
11. Homework discussion/Essay: "My substance use: why I use substances and what strategies I will use to stop using and abusing";
12. Female-specific medical issues: nurse's presentation.

SESSION X (3 hours)

1. Review of the relationship between behaviors, cognitions, and emotions;
2. Clients' essay presentation;
3. Group discussion;
4. Relapse – what is it?
5. Different strategies to prevent relapse;
6. Identification of the stressors associated with immigration and their relationship with the relapse triggers;
7. Group discussion;
8. "Addiction's Impact on Family and Friends" – Movie;
9. Group discussion;
10. Clients' presentation of the relapse prevention strategies and group feedback;
11. Discussion of homework/Essay: "How I will prevent my relapse in the future";
12. Vocational education and training: surviving immigration in the modern world.

SESSION XI (3 hours)

1. Review of relapse prevention;
2. Presentation of Clients' essays;
3. Group feedback;
4. Introduction to the Social Services agencies and assistance;
5. Summary of the covered material;
6. Clients' presentations of new substance abuse prevention strategies learned in the program;
7. "Relapse does not mean full lapse";
8. Group closure.

BIOGRAPHICAL SKETCH

Eugene V. Isyanov was born and raised in St. Petersburg, Russia and immigrated to the United States with his family shortly after graduating from high school in May of 1991. He pursued his education at the University of San Francisco and the University of Washington and earned his Bachelor of Science degree at the University of Washington in 1996. He went on to earn his Master of Science in Clinical Psychology at the Finch University of Health Sciences/The Chicago Medical School in 2000. With the completion of this dissertation, Eugene V. Isyanov graduated from International University of Professional Studies in May 2005 with a doctorate in Counseling Psychology.