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Drug Abuse Among Immigrants and the Role of Professionals in the Treatment Process

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Chemical dependency and alcohol abuse represent one of the most threatening public health hazards in Europe (and elsewhere), and has been shown to be related to inferior educational performance, delinquency, and self-injurious behavior. Providing effective forms of treatment modalities for people with substance abuse problems is perceived as a "central pillar" to the European nations' response to drugs, with estimates of over one million persons in the EU receiving treatment every year. This chapter focuses on one country, Greece, and its problems with drug abuse, albeit this could be seen as typical of many nations, and hopefully the findings, recommendations, and suggestions for social health policy makers and health professionals will be helpful for other countries.

Greece as a Plural Society

This chapter concentrates on immigration and drug abuse together with models for professionals treating refugee and immigrant drug abusers in a European country (Greece). It is guided by four key questions: (1) How do immigrants deal with immigration and acculturation? (2) What are the risk factors related to drug abuse among immigrants and refugees? (3) What are the differences in drug abuse among immigrants and natives in Greece? (4) How can professionals become more culturally sensitive in servicing immigrant and refugee drug abusers and their families?

We report some of the main findings on the prevalence of illicit drug use among immigrants in Greece aged 19 years or older in comparison to native Greeks. Estimates for immigrants and native drug abusers are based on data collected during 2005–2009 from adults on the Drug Dependence Unit-State Psychiatry Hospital of Attica. Sample sizes were: $N = 67$ (54.5%) immigrants (Countries: Albania, former Soviet Union, Arabic countries) and $N = 56$ (45.5%) native Greeks. The data collection method used in this study involved face-to-face structured interviews that examined personal and demographic

information (age, education in years, and country of birth), marital status, living conditions and housing, health status (HIV/AIDS), criminal and deviant behaviors, and information about the lifetime use of illicit substances. Immigrants are seen to differentiate their behavior in relation to drug abuse involvement and drug abuse treatment.

Starting in the mid 1980s, but especially during the 1990s, Greece turned from a country that was a source of immigrants into an immigration country. According to the Organization for Economic Cooperation and Development (OECD, 2000), the number of immigrants in the country was 1 million (10% of the Greek population). Major population inflows toward Greece include Albanian immigrants that constitute 56% of the total foreigners in the country. An estimated 13.3% of immigrants had come from the former Soviet Union and other countries of Eastern Europe, including Bulgaria and Romania (Baldwin-Edwards, 2004). Since 2003, the influx of Asian (Pakistani, Bangladeshi, and Indian) and Arab (Syrian and Egyptian) immigrants has sharply increased. It is estimated that the total number of Asian and Arab immigrants in Greece is no less than 130,000, representing roughly 10% of immigrants (Markoutsoglou, Kasou, Moshotos, & Ptohos, 2007). The same study also reported that immigrants from Sub-Sahara countries (Nigeria and Ethiopia) constituted approximately 2% of foreigners, although there were no entirely reliable data sources regarding their exact number. In addition, Germans, Britons, Italians, and other Europeans appeared as sizeable foreign communities, accounting for around 2% each of the total foreign population. A further group included ethnic Greek immigrants, including Pontics from the Black Sea region (152,204 Pontic Greeks) and Vorioepirotes (100,000), ethnic Greek-Albanian citizens (Gropas & Triandafyllidou, 2005) who had either been given Greek citizenship or awarded 5-year residency cards.

It is interesting to note that many of the immigrants entered the country irregularly, at least initially. Currently, about three quarters of the immigrant population have work and permit status (Gropas & Triandafyllidou, 2005). However, in 2008 there were between 200,000 and 250,000 undocumented immigrants in Greece (Lianos, Kanellopoulos, Gregou, Gemi, & Papakonstantinou, 2008). The pluralism of Greek society is reflected in the Greek National Health System. The percentage of hospitalized migrants in the General Hospital of Attica for the year 2003 was 6.2%, a percentage that approached the percentage of foreigners in comparison with the total population (Maratou-Alipranti & Gkazon, 2005).

Acculturation of Immigrants and Refugees

The process of migration can be understood as a transition life event (Suárez-Orozco, 2000) consisting of the pre-migration and departure phase and the transition and adaptation to a new country. The decision to migrate due to a perceived lack of prospects that a person has in his/her own country, related to economical or political conditions (Ward, Bochner, & Furnham, 2001), removes individuals from predictable contexts and creates a sense of loss (Suárez-Orozco & Suárez-Orozco, 2001). This sense of loss relates not only to one of belonging, but also the loss of family and social networks, customs, and language and even to the experience of homesickness (Stroebe, van Vliet, Hewstone,

& Willis, 2002). Following an initial period of hopes and expectations, many immigrants experience a sense of confusion in role, values, and identity, which can result in the experience of anxiety, disorientation, suspicion, and bewilderment (Oberg, 1960). Accordingly as the realities of the new situation are confronted, individuals may begin to experience a variety of psychological problems due to acculturation.

Acculturation implies cultural and psychological changes of persons in first-hand contact with persons representing another culture (Sam, 2006). Pressures on the individual to contend with the host society can lead to increased stress, or acculturative stress as a generalized physiological and psychological state brought about by the experience of stressors in the new environment (Berry, 2003). For example, stress is likely to be minimal and personal consequences are generally positive when the acculturation trajectory is bicultural as a result of a connection to both the country of origin and that of the mainstream culture. Alternatively, when an individual's adaptive resources are insufficient to support adjustment to a new cultural environment, or when individuals lack connection to both cultures, stress will be higher and its effects more negative (Berry, 2003). Acculturative stress is a common experience of first generation immigrants (Ward et al., 2001). Second generation and later generation immigrants may experience acculturative stress owing to the conflicts that arise out of their bicultural socialization (Roysircar-Sodowsky & Maestas, 2000). Longitudinal evidence suggests that acculturative stress has been frequently associated with the development of emotional and behavioral problems among immigrants (Organista, Organista, & Kurasaki, 2003), including substance abuse (Straussner, 2002).

Substance Abuse Among Immigrants

Drug dependence is characterized by a need for a markedly increased amount of abuse of legal drugs (e.g., alcohol and prescription drugs) as well as illegal drugs (e.g., cocaine, heroin, methamphetamines, and other substances), with the presence of physiological and behavioral symptoms associated with compulsive use, increased tolerance, and withdrawal symptoms (APA, 2000). Substance abuse and dependence is identified as a significant health problem for all European societies (Diamanduros, 2005). In addition, it is a serious social and public problem because it is widely associated with delinquent activities (Losoya et al., 2008), HIV, hepatitis B and C transmission through the sharing of needles, poverty, and social exclusion (WHO, 2008).

Research findings on substance use patterns among immigrant populations are mixed, with some studies indicating that substance use increased with increased time in the new country (Gfroerer & Tan, 2003). Acculturation processes with low educational aspirations for children of immigrants has been associated with high levels of substance abuse (Vega & Gil, 1999). Other studies have reported a decrease in substance use and mental health problems over time and with increased levels of acculturation (Caetano & Clark, 2003; National Institute on Drug Abuse [NIDA], 2001). Even within subgroups of immigrants, there is wide variability in substance use patterns. According to previous studies,

immigrants from the former Soviet Union faced with the highly complex challenge of acculturation often develop emotional and behavioral problems that include mental illness, delinquency, and alcohol and drug abuse (Isralowitz, Straussner, Vogt, & Chtenguelov, 2002). Their experiences in their new countries, where drugs and alcohol are readily available at low prices, may lead to some immigrants experiencing a tendency to turn to substance abuse as a way of coping. Early research shows that substance abusers from the former Soviet Union, especially those using drugs, are mainly bilingual males in their early twenties. Unlike other young people in the New York City area, this population does not start with "gateway" drugs, such as marijuana or ecstasy, but goes straight to injecting heroin (Isralowitz et al., 2002).

The mixed findings from research with immigrant and minority populations point to the need for considering a coexistence of stressors that can increase vulnerability of immigrants to use or experiment with illicit drugs. Most studies have relied on acculturation and acculturative stress effects on licit and illicit drug use by immigrant adolescents (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2003). Additional research addresses the culture itself, including the role of cultural values on the initial or continued substance abuse by minority youth (Robbins & Mikow, 2000), and on reactions to different substances (Straussner, 2002).

Risk Factors Related to Drug Abuse Among Immigrants

Acculturative stress, or the challenge of assimilating into the dominant culture, has been implicated as a mechanism for increased substance use among immigrants (NIDA, 2001). The process of acculturation implies role strains, cognitive manipulations, and affective states that are potentially stressful and responsible for the nonadaptive attitudes and behaviors of immigrants (Berry, 1997). An important premise of the acculturative stress process is that stressors are harmful and coping resources are inadequate for solving problems; demands must exceed resources to produce a negative outcome. Drug use is one possible negative outcome (Alaniz, 2002; Castillo & Henderson, 2002). Mental health professionals have described the common symptoms that most immigrants present and have labeled it "chronic and multiple stress syndrome" (Carta, Bernal, Hardoy, & Haro-Abad, 2005). Immigrants affected by this syndrome present depressive symptomatology with atypical characteristics. The development of this condition occurs progressively as the immigrants encounter difficulties that take place during the migration and acculturation process. This can manifest in difficulties in finding a job and housing, problems in obtaining documents, or experiences of racism encountered in a new country. According to specialists, chronic and multiple stress syndrome should constitute a category situated in between adjustment disorders and posttraumatic stress disorder.

Another hypothesis is that exposure to a new culture brings with it increasing familiarity with the social contexts of drug use, as well as opportunities for drug use in peer group situations, in which youth often construct spaces of competence in the underground (Suárez-Orosco, 2000). These peer groups function on the periphery of multiple

sociocultural worlds and include individuals who may feel confused, frustrated, and inferior. Consequently, the use of substances is adopted as a method of socialization into the new society. Thus, the addicts acquire friends or peers and are in this way grown-up, independent, and successful.

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

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

Moreover, a variety of problems exist when one parent, especially the man, migrates first, and, if married, leaves behind a wife and children, and the reunion occurs after he has become established in the new country (Suárez-Orozco & Suárez-Orozco, 2001).

The temporary loss of relationships and contact with the family, and the disruption of family support are related to the sense of loneliness and the lack of an accessible attachment figure (Peplau & Perlman, 1982). Drug addiction in this case, especially to heroin, does indeed appear to have many adaptive, functional qualities in terms of reducing negative emotional states of isolation, loneliness, and lack of family.

Contact with the new culture and conflicts that that are rooted in different rates of acculturation in the family (e.g., highly assimilated children and adherence of parents in the traditional values) lead to the disruption of the core family processes (perceived roles, hierarchy, exercise of power, and models of interaction), even in the case where the entire family immigrate. Weakness on the side of the parents in terms of supporting their children (perhaps because their economic needs force them to leave their children alone without observation for extended hours) can be highly problematic. Similarly, other problems, such as mental disturbance or divorce (Hjern, Angel, & Jeppson, 1998; Suárez-Orozco & Suárez-Orozco, 2001) can have a serious and negative impact. At the same time, the speedier acculturation of children due to their young age, together with their integration into the educational system, may result in parent-child conflicts concerning issues such as dress code, dating, and school performance, together with rights and obligations within the family (Booth, Crouter, & Landale, 1997). When the intensity of conflicts becomes unbearable and the youngster is unable to trust other people outside of the familial environment, drug abuse may present a means of making the negative emotions more tolerable. Using drugs may be considered to be a way of expressing frustration and anger, especially when young people are unable to deal with their parents directly. Young drug abusers may be bound up with a simultaneous need to defy their parents and to punish themselves for their own rebellion.

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

The path to acculturation is additionally problematic for undocumented immigrants who are illegal working citizens, persons with forged papers or who have assumed false

identities with real papers, or persons with pending immigration status (Karl-Trummer, Metzler, & Novak-Zezula, 2009). Undocumented alien status is a persistent psychoenvironmental stressor that increases vulnerability to the development of socioemotional problems that arise from exposure to stresses (Cavazos-Rehg, Zayas, & Spitznagel, 2007). Having no legal status, undocumented children grow up without the same opportunities as other children. Although these children are schooled, their transition to adulthood marks their entry into an undocumented life with legal limitations that is associated with fear of deportation and restriction to access employment and housing (Rumbaut & Komaie, 2010). In these situations, youth often develop their identity in alternative economies where drug-dealing and drug-taking is an important feature (Suárez-Orozco, 2001).

Drug addiction is often associated with homelessness among immigrants. People sleeping rough or relying upon overnight shelters constitute a population vulnerable to drug dependence (Anderson et al., 2006). For immigrants, and especially refugees, being homeless involves not only a loss of shelter, but moreover a loss of the social aspects of a home, which may translate into a state of emotional isolation and feelings of hopelessness (Hiebert, D'Addario, & Sherrell, 2005). To experience a good time, to forget problems, and the influence of street life culture are some of the reasons why people turn to drugs when they experience homelessness (Logothetis, 2003).

Additional factors that are connected with the pathology of usage are the loss of social resources, such as low economic and social level of the parents (Howard & Hodes, 2000), unemployment and economic poverty, low social status, the failure of the school as a basic institution of children's socialization (Hyman, Vu, & Beiser, 2000), and a lack of future opportunities (Caetano et al., 1998). The lack of economic resources may lead some individuals into selling and then using illegal substances to attain economic independence (Straussner, 2002).

Drug Dependence Among Immigrants and Refugees in Greece: The Experience of 18 ANO

Drug dependence may be an emerging problem among immigrants living in Greece (or elsewhere). The percentage of immigrant users in drug-specialized services in the years 1995 and 2003 was 2.1% (Kontogeorgiou, Pouloudi, Spyropoulou, & Terzidou, 2006). However, according to the Research Centre of 18 ANO Dependent Unit of Psychiatric Hospital of Attica there was a significant increase in the number of immigrant users admitted for treatment from 2005 to 2010. In 2009 alone, there were about 100 new immigrant users seeking treatment in the 18 ANO Dependent Unit Centre. In recent years, the 18 ANO Dependence Unit, which operates under the Ministry of Health and implements programs of internal residence and external supervision for general population, has been working to respond to the needs of addicted immigrants and refugees by developing and integrating a cultural, psychosocial model of substance abuse intervention. According to this model, the multi-stage therapeutic process consisting of sensitization (0–3 months),

psychological recovery (main treatment about 6–8 months), and social reintegration (8–12 months) is sensitive to cultural values and experiences of immigrant groups, while addressing the common etiological factors of substance abuse. The therapeutic team consists of specialized personnel such as psychologists, psychiatrists, social workers, nurses, etc., who through psychoanalytic and behavioral approaches, psychodrama, and educational activities support the rehabilitation and recovery process of people seeking admission to the 18 ANO Dependence Unit. An important aspect of the later phase of the treatment process is to provide bridges to social resources in the community and to provide information about supportive networks that facilitate the integration of individuals who have completed the program in the community.

We present information from a study on the prevalence of illicit drug use among male immigrants aged 19 years or older ($M = 30.96$, $SD = 7.26$) in Greece in comparison to native Greeks ($M = 31.30$, $SD = 7.06$). Estimates for immigrants and native drug abusers are based on data collected during 2005–2009 from adults on the Drug Dependence Unit at the State Psychiatry Hospital of Attica. Sample sizes were: $N = 67$ (54.5%) immigrants and $N = 56$ (45.5%) native Greeks. Of immigrants, 34.1% ($N = 42$) were from the former Soviet Union (Armenia, Georgia, Ukraine, and Moldova), 11.4% ($N = 14$) from Asiatic countries (India, Iraq, Iran, Afghanistan, and Bangladesh), and 8.9% ($N = 11$) from countries of Eastern Europe (Albania, Poland, and Bulgaria). In the above sample, 18 people (17.5%) were married, 72 (69.9%) single, and 12 (11.9%) divorced. Although some immigrants were married, their children and wife lived in their country of origin.

Materials

The data collection method used in this study involved structured interviews with the subjects, incorporating procedures that would be likely to increase respondents' cooperation and willingness to report honestly about their illicit drug use behavior. The interviews considered personal and demographic information (age, education in years, and country of birth), marital status (single, married, cohabiting, divorced, and widowed), living status (stable or unstable accommodation), employment status, health status (HIV/AIDS), criminal and deviant behaviors, as well as information relating to lifetime use of illicit substances. The interviews were conducted following the subject's decision to participate in the program of drug rehabilitation.

Results

Education level. Immigrant abusers displayed the same education level compared with Greek abusers. Most people were lyceum graduates (38.8%), followed by lower second education graduates (25.6%), university and college graduates accounted for 14%, and 19% of the sample had completed primary school.

Marital status. Out of the total of immigrants, 55.4% were single, 26.2% married, 12.3% divorced, 4.6% cohabiting, and 1.2% widowed. Over 78.2% of Greek people were single, 14.5% married, 5.5% divorced, and 1.8% widowed, $\chi^2(4, n = 120) = 9.62, p < .05$.

Living status. Unstable accommodation was reported by 29.7% of immigrants and 22.2% of native Greeks.

Employment status. With regard to employment status, immigrants displayed a considerably higher unemployment rate compared with Greek natives: 66.7% compared to approximately 48.2%, respectively; $\chi^2(1, n = 122) = 6.70, p = .01$.

Social security. The rate of immigrants without social security (50%) is remarkably higher than the rate of natives (21.4%); $\chi^2(1, n = 122) = 9.23, p < .01$.

Health status. The rate of immigrants that were not users of the health care system (44.4%) was significantly higher than the rate of native Greeks (28.6%), $\chi^2(1, n = 120) = 9.0, p = 0.05$. Furthermore, more immigrants (65.6%) than natives (28.6%) had no information about AIDS, $\chi^2(1, n = 120) = 16.79, p < .001$, and hepatitis infection (56.3% versus 25%), $\chi^2(1, n = 120) = 3.68, p < .05$.

Legal status. Prior arrest and imprisonment were reported by 32.5% of the sample. There were no significant differences between groups.

Total negative life experiences. We calculated the level of adversity of drug abusers including their marital status (divorced and widowed), living status (unstable accommodation), employment status (unemployment), social security (no social security), health status (hepatitis), and legal status (prior arrest and imprisonment) as a total adversity score. A score can then be calculated on a scale of 0–6 for negative life experiences. According to the results, 12.2% of the sample reported no sociodemographic adversity; one risk factor was reported by 30.9% of people, 33.3% reported two risk factors and 23.5% indicated three or more negative experiences. Most immigrants from Asiatic countries (57.1%) followed by immigrants from countries of Eastern Europe (36.4%) and the former Soviet Union (21.4%) reported three or more negative life experiences. Only 14.3% of Greek people reported three or more negative life experiences, $\chi^2(9, n = 123) = 21.96, p < .01$ (see Table 1).

Table 1. Distribution of participants according to origin and number of risk factors

	Former Soviet Union		Eastern Europe		Asiatic countries		Greece		Total	
Risk factors	*f*	%	*f*	%	*f*	%	*f*	%	*f*	%
0	4	9.5	–	–	–	–	11	19.6	15	12.2
1	11	26.2	2	18.2	3	21.4	22	39.3	38	30.9
2	18	42.9	5	45.5	3	21.4	15	26.8	41	33.3
3–6	9	21.4	4	36.4	8	57.1	8	14.3	29	23.6
Total	42	34.1	11	8.9	14	11.4	56	45.5	123	100

Substance abuse. With respect to primary drugs, heroin was the main illicit substance used by 82.6% of the sample. This compared to 9.1% who reported cocaine as their main substance, and the other 8.3% reported others drugs such as amphetamines, benzodiazepines, marijuana, and hashish. The vast majority of the sample immigrants from the Former Soviet Union reported heroin as their main substance of abuse, $\chi^2(1, n = 121) = 7.81$, $p < .01$. Furthermore, in comparison to other groups, the method of substance use among the most immigrants from Soviet Union occurs intramuscularly (65%) and through multiperson use of the needles and syringes (42.1%), $\chi^2(1, n = 115) = 13.68$, $p < .05$.

The path to drug addiction begins with the act of taking hashish or marijuana for about 75% of the Greek people, Asian immigrants, and immigrants Eastern Europe. Most people from Former Soviet Union (31.3%) began by using heroin, $\chi^2(1, n = 108) = 4.53$, $p < .05$. In regard to co-occurrence of different types of substance use, differences between groups were observed: Cocaine was associated with marijuana use in immigrants, whereas between natives multiple substance use was observed, $\chi^2(1, n = 108) = 26.58$, $p < .001$.

Age at first involvement with illicit substance use. The age at first involvement with elicit substances is older for Asian immigrants ($M = 23.14$ years) and younger for immigrants from Eastern Europe, $M = 15.55$; $F(3, 113) = 7.82$, $p < .01$. The mean age of first illicit substance use for immigrants from former Soviet Union is 21.5 years, whereas for Greek people it is 16.8. The age range for immigrants was between 10 and 48 years, whereas for natives it was between 12 and 30.

The mean length of use reported by natives was 8.3 years and by immigrants 5 years, $F(1, 116) = 11.04$, $p < .01$. There were no differences between immigrant groups.

Counseling and substance abuse treatment. The length of involvement of immigrants and natives in the treatment program was the same. However, immigrants, regardless of their origin, were two times less consistent than natives in attending their appointments, $F(1, 113) = 3.99$, $p < .05$ (see Table 2).

In addition, it emerged that many immigrant drug abusers tended to use treatment to reduce their level of drug abuse and not to eliminate the problem, $\chi^2(1, n = 116) = 4.96$, $p < .05$.

Conclusions

Immigrant status (i.e., being an immigrant) appears to be associated with accumulative negative life experiences across the family, the community, and the individual. About 40% of immigrants, mostly from Asian countries (about 60%), reported three or more negative experiences, such as unstable accommodation, unemployment, lack of social security, prior arrest or imprisonment, and health problems. Previous research confirms the association between sociodemographic characteristics of immigrants and refugees and mental health (Organista et al., 2003). Being of lower economic status was correlated with more isolation and limited opportunities, which, in turn, lead to lower acculturation and difficulties in seeking employment and social support. Homelessness or unstable accommodation is a common problem among many immigrants seeking services. This factor

Table 2. Means and standard deviation of involvement of immigrants and natives in treatment program

	Target group				
	Greeks		Immigrants		*F* value
Involvement in therapy	*M*	*SD*	*M*	*SD*	
Length of involvement – months	3.12	4.34	2.46	5.15	0.53
Appointments	9.41	11.3	5.5	9.58	3.99*

Note. *$p < .05$

comprises a significant barrier to engagement in the treatment program and becoming drug free. All of the above factors become exacerbated by the experience of being undocumented.

Many problems associated with drug abuse among immigrants and refugees are exacerbated by underutilization of mental health services. Immigrants accounted for 44.4% of the cases that do not use the health care system, compared with 28.8% of native Greeks. Of concern is the fact that many immigrants have no information concerning whether they are infected by AIDS or hepatitis. According to the above results, immigrants face a social and economic environment of inequality that includes unstable accommodation, unemployment, and a lack of social security. Other barriers that affect underutilization of mental health services may be differences in language and culture, stigmatization, and the failure of services to target immigrant groups (EMCDDA, 2003; Makimoto, 1998).

Drug abusers, natives, and immigrants, are more inclined to use heroin as a main illicit substance, and their use is mostly a combination of heroin with other substances. However, numerous factors tend to differentiate immigrants and native drug abusers including patterns of injection heroin use; intramuscular in combination with multi-person use of needles and syringes was present among most immigrants. Multi-person sharing of syringes is associated with rapid transition of HIV among illicit drug users, with HIV incidence rates as high as 20–50 per 100 persons. Moreover, most illicit drug users who continue to inject may be unable to obtain a sufficient number of syringes to effectively reduce their risk of acquiring and transmitting blood-borne viral infections (Batki & Nathan, 2004).

An extremely important outcome from this study concerned the speed at which immigrant substance users' progress from mild to severe involvement. The faster progression of immigrants compared to natives was in contrast to the later initiators of substance use among immigrants. The results also suggest that it is important to investigate whether immigration and acculturation may play a role in addictive liability, above and beyond what is accounted for by other factors. Although, heroin is the most common substance among immigrants and natives, the path to addiction is different between groups. For example, Russian immigrants had higher rates of excessive drinking relative to other groups; their path to substance abuse begins with using heroin. Rates of heavy drinking among Russians have been identified in previous studies (Bobak et al., 2004; Rahav,

Hasin, & Paykin, 1999). According to Tapilina (2007) Russians do not drink more frequently than others, but they consume very large quantities of alcohol. This is in part explained by cultural tradition that encourages excessive drinking among men.

In a similar fashion, immigrants are seen to differentiate their behavior in relation to drug abuse treatment. They are seen as having increased probability for missing appointments and in addition are seen to seek a medical fix for their addiction. Substance abuse staff found that many immigrants enter the program with misconceptions about addiction and unfamiliarity with the process of recovery. Their tendency to perceive more organic or somatic involvement in drug abuse has to do with the cultural meaning of somatic complaints (Tanaka-Matsumi & Draguns, 1997). Somatic complaints are less stigmatized among some cultures and somatization justifies an acceptable medical intervention. On the other hand, specialists must be cognizant of the immigration experience itself, on account of the stress and the lack of social and economic resources for coping that may deter immigrant people from using services and receiving appropriate care.

Multicultural Competent Treatment of Drug Abuse Among Immigrants and Refugees

It is important to begin substance abuse treatment among immigrants and refugees with a comprehensive assessment of drug abuse and its effect on the life of the people (Straussner, 2002). However, the pathway to recovery should take into account cultural and migration circumstances that serve as an agent in the rise of addiction problems. The therapist of an immigrant drug abuser must take into account cultural factors that include belief systems about drug abuse and concepts of health and disease (Lindert, Schouler-Ocak, Heinz, & Priebe, 2008). For example, seeking medical treatment for their addiction, immigrants express their problem in a psychosomatic form, which is consistent with low shame and stigma and the perceived legitimacy to seek help for bodily complaints (Kleinman, 1980). Recovery from drugs is a long process characterized not only by abstinence from illicit drugs (and alcohol). Recovery is about reclaiming physical and psychological health and having a vision of good quality of life (The Betty Ford Institute Consensus Panel, 2007). This perspective is quite different from the deficit approach or medical model that lead to partial recovery that includes two main features: (a) a reduced frequency, duration, and intensity of drug abuse and the reduction of problems related to drug dependence, (b) the sustained abstinence from illicit drugs, but the failure to achieve sociopsychological and occupational health (White, 2007). Thus, the focus of the mental health professionals is to support immigrants' motives for engaging in drug treatment programs by developing therapeutic alliance as a useful way for understanding issues when working with immigrants and refugees.

Many immigrants are vulnerable to barriers against following intervention programs, based on cultural beliefs combined with a low conception of drug abuse risk. Other drug abusers trying to maintain their recovery from heroin dependence may find it difficult

to deal with alcohol. Pre-immigration stressors may be important for drug addiction of immigrants and refugees. Refugees have several factors in common including exposure to violence, war, and torture, long separation from family and loved ones (van der Veer, 1998), and, in many cases, loved ones have been killed and possessions and homes are destroyed (Fazel & Stein, 2003). Some immigrants in our study report to us negative life events, which are culture general, such as divorce or losing one's parent, etc.

The process of migration in a globalized context includes new definitions of family life and different forms of family stress that begin in the pre-immigration stage (Falicov, 2007). Families with parents abroad and children with parents abroad as a result of segmented migration are characterized as distinct social groups. Research has noted that immigrant children experience separation from family members in which certain members of the family migrate first, and later, after their establishment, send for other family members (Suárez-Orozco, Todorova, & Louie, 2002). A long period of separation is particularly disruptive to adolescents who have to adapt to a new culture and to two sets of traumatic separations: First from their parents and later from the people who became their primary caretakers during the time that they were geographically separated from their parents. For example, S. from Bulgaria was 16 years old, when his mother moved to Greece. He lived with his grandmother, because his father had died. He was reunited with his mother after 6 years, when he became involved with drugs. Another respondent, from the former Soviet Union expressed extreme sadness at the loss of ties with his mother living in Greece and his alcoholic father in his country when he was about 10 years old. Although he referred to the economic benefits from his mother's migration and understood the reasons behind his mother's decision, he felt abandoned by her for a long time.

Sometimes we can talk about transnational families and virtual long-distance communication among parents and their children through new technologies (Falicov, 2007). Long distance parenthood using phone and internet has been referred to by many immigrants in our study, especially those coming from the former Soviet Union countries. The reunion after many years is seen more as a disorienting meeting of strangers than a true reunion. Young people have difficulty affirming parental authority after they have been independent or attached to another caregiver. In our clinical work, spousal separation, in particular, is another stressful situation for migrants.

The generational stress due to differing rates of acculturation between parents and teenagers makes family interactions stressful, leads to weakened quality of parent-child communication, and creates overreaction by parents to perceived loss of control over adolescent children (Szapocznik & Williams, 2000). According to clinical studies, immigrant teenagers must cope with different crises at the same time: The usual crisis of crossing from childhood to adulthood, the passing from one culture to another (Saucier et al., 2002), and generational stress due to acculturation that plays an important role in the disruptions of parent-child relationships. Immigrant parents often have to make dramatic sacrifices for a better future for their children. Within the new country, they set limits that are significantly more stringent than they would have if they had stayed in their country of origin. At the same time, they are often dependent upon their children. The children often

learn the new language more quickly than their parents and consequently they often take on new roles as translators and advocates for their families. Alternating between parentifying the children and at the same time severely constricting their activities may create significant tensions within the family, adolescent defiance, and loss of family cohesiveness (Brook et al., 2001).

Risk factors for mental health in the post-emigration stage are associated with living conditions and legal status in the country of settlement. In an attempt to deal with their conditions, it is important to build connections either with the co-ethnic community or with the community of a larger society. The creation of networks provides immigrants with social support (Ward et al., 2001) in terms of emotional support, social companionship, tangible assistance, and informational support (Ong & Ward, 2005). Emotional support is expressed by display of love, care, concern, and sympathy; social companionship is viewed as the sense of belonging to a social group that provides company for a variety of activities; tangible assistance is demonstrated in concrete material or financial forms of help. Finally, informational support comprises of communicating and advising with regard to current personal difficulties concerning new surroundings. Increased levels of social support reduces exhibited levels of psychological problems among immigrants. Specifically, immigrants are helped in dealing with various stressors in the environment and facilitated in a positive adjustment process by getting advice and encouragement from sources of support.

To meet the needs of addicted persons from culturally diverse groups, health care providers must engage in the process of becoming culturally competent. Multicultural competence refers to the process in which the therapist continuously strives to achieve the ability and availability to effectively work within the cultural context of an individual, family, or community. This concept includes generic and specific awareness, knowledge, skills, and emotions (Draguns, 2002; Lindert et al., 2008; Pedersen, 2002). In general, intervention by drug rehabilitation of immigrants needs to be more culturally sensitive by combining specific culture patterns, experience of immigration and acculturation with universal aspects of treatment approaches. Work teams that are helpful and open to cultural diversity will improve parameters for immigrants with addiction.

Summary

By way of summary, Figure 1 describes the main issues suggested for work with immigrant and refuges addicted to illicit drugs. In this article, we argue that a myriad of stresses often accompany drug treatment of immigrants and refugees. Pre-migration stress, negative life events, separation from family and friends, and loss of social resources have been identified as risk factors for substance abuse among immigrants. Cultural diversity plays an important role in addressing differences in symptom expression (see the chapter by Lindert in this book) and in understanding factors that affect the accessibility and acceptability of services by immigrants and refugees. The dual emphasis on the universal and

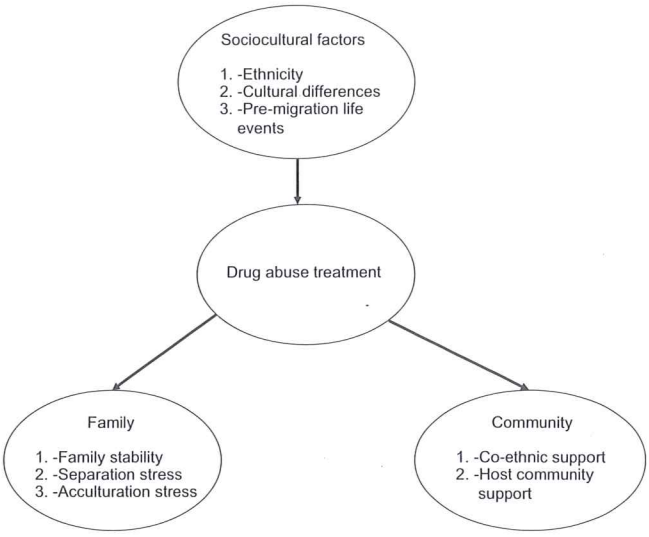

Figure 1. Context for drug abuse treatment among immigrants and refugees.

particular behavior of immigrants and refugees becomes a central professional issue in the development of multicultural competence for increasing success in counseling and treatment of different cultural groups.

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