Harm Reduction

Pragmatic Strategies for Managing High-Risk Behaviors

SECOND EDITION

Edited by
G. Alan Marlatt
Mary E. Larimer
Katie Witkiewitz

THE GUILFORD PRESS
NEW YORK LONDON

A Division of Guilford Publications, Inc.
72 Spring Street, New York, NY 10012
www.guilford.com

Printed in the United States of America

This book is printed on acid-free paper.

Last digit is print number: 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data

Harm reduction : pragmatic strategies for managing high-risk behaviors / edited by G. Alan Marlatt, Mary E. Larimer, Katie Witkiewitz. — 2nd ed.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-4625-0256-1 (hardcover)
1. Substance abuse—Complications—Prevention. 2. Substance abuse—Treatment. 3. Health behavior—Social aspects. 4. Harm reduction. I. Marlatt, G. Alan. II. Larimer, Mary E. III. Witkiewitz, Katie.
RC564.H364 2012
362.29—dc23

2011026409

CHAPTER 11

Harm Reduction for Asian American and Pacific Islander Populations

KAREN CHAN OSILLA
EUNICE C. WONG
NOLAN ZANE

The Asian American and Pacific Islander (AAPI) population is anticipated to grow from 15.5 million to 40.6 million by the year 2042, representing one of the fastest-growing groups in the United States (U.S. Census Bureau, 2008). With this anticipated growth comes increasing concern that our understanding of how addictive behaviors affect AAPIs is limited and more research in this area is needed. Due to "model minority" stereotypes and the aggregation of AAPIs in research studies, AAPIs are often presumed to be relatively unaffected by addictive behavior problems (Caetano, Clark, & Tam, 1998; Lin & Cheung, 1999; Wong, Faith Lai, Nagasawa, & Lin, 1998). However, emerging evidence suggests that AAPIs may experience certain addictive behaviors at similar or higher rates than other ethnic groups (Harachi, Catalano, Kim, & Choi, 2001; Lee, Fong, & Solowoniuk, 2007; Zane & Kim, 1994). Moreover, many have posited that AAPIs may be reluctant to seek needed mental health and addiction services because of various structural and cultural barriers (Kung, 2004; Leong & Lau, 2001; Wong et al., 2007). Yet few studies have examined the applicability of existing addiction treatment approaches with AAPIs.

Harm reduction is an approach to addiction that is gaining increasing recognition (Marlatt & Witkiewitz, 2002). In contrast to traditional approaches that focus on a single goal of abstinence or the complete cessation of addictive behaviors, harm reduction approaches emphasize the reduction of negative consequences associated with addiction (Denning, 2000; Marlatt, 1998; Tatarsky, 2003). Thus, harm reduction supports multiple client-driven goals, recognizing any gains in individual and community quality of life as treatment successes. As with most other treatment approaches, there has been little empirical investigation on the effectiveness of harm reduction with AAPIs. The purpose of this chapter is to discuss the use of harm reduction with AAPIs. We begin by reviewing the research on addictive behaviors and addiction treatment among AAPIs. We then discuss areas in which cultural mismatches can arise within addiction treatment in general and the applicability of harm reduction principles to the AAPI population. Finally, relapse management techniques are often used in conjunction with a harm reduction philosophy. Based on available research, we describe clinical strategies for adapting relapse management for AAPIs.

ADDICTIVE BEHAVIORS AMONG AAPIs

AAPIs are commonly reported to experience relatively low addiction problems. For example, recent reports state that AAPIs have the lowest overall rates of past-year alcohol use (Grant, Dawson, et al., 2004; Hasin & Grant, 2004; National Survey on Drug Use and Health, 2002), past-month cigarette use (Giovino, 2002; Grant, Stinson, et al., 2004; National Survey on Drug Use and Health, 2006), and illegal drug use (Compton, Thomas, Stinson, & Grant, 2007). However, these reports tend to be based on small samples of AAPIs or samples where AAPIs are aggregated as one group (Caetano et al. 1998; Wong, Klingle, & Price, 2004). More than 35 subgroups encompass the category of AAPIs, and addictive behaviors may vary widely by each group based on history, cultural norms, living environments, region, biology, and availability and access to substances (Caetano et al., 1998; Gomez, Kelsey, Glaser, Lee, & Sidney, 2004; Hendershot, Dillworth, Neighbors, & George, 2008; Kim, Ziedonis, & Chen, 2007; Sue, 1999; Varma & Siris, 1996; Wong et al., 2004). For example, Chinese, Japanese, and Korean subgroups have exhibited deficiencies in aldehyde dehydrogenase (ALDH2), which is responsible for metabolizing alcohol. These groups might experience different physiological responses to alcohol because the deficiency is associated with slower alcohol metabolism and slower elimination of alcohol from the blood (Goedde et al., 1992). It has been suggested that this ALDH2 deficiency might also be associated with variations in progression to other substance use among Asian Americans

(Hendershot et al., 2009; Wall, Shea, Chan, & Carr, 2001). Accounting for subgroup differences within the AAPI population is important for addressing the specific needs of these groups. Furthermore, important within-group differences may significantly influence addictive behaviors. For instance, greater levels of acculturation have been associated with increased drinking (Hahm, Lahiff, & Guterman, 2003; Nakashima & Wong, 2000), whereas parental respect and school factors have been associated with lower rates of drinking among AAPI youth (Shih, Miles, Tucker, Zhou, & D'Amico, 2011). In a study with a nationally representative sample of AAPIs, generational status was positively associated with increased risk for substance abuse disorders (Takeuchi et al., 2007). Finally, there is growing evidence that discrimination and low ethnic identity impact the odds of developing an alcohol use disorder (Chae et al., 2008).

Although studies have generally found lower rates of addictive behaviors among AAPIs relative to other ethnic groups, there is some evidence that addictive disorders may be on the rise for AAPIs. For example, between 1991 and 2001, rates of alcohol dependence more than doubled among AAPIs, going from 4% to 10% (Grant, Dawson, et al., 2004). Epidemiological data also show that some drug use disorders may be higher than whites (Xu et al., 2011). Moreover, when rates are examined by AAPI subgroups or across different addictive behaviors, a very different portrait is revealed (Price, Risk, Wong, & Klingle). Research on adolescent and adult alcohol, tobacco, and other drug use show that Native Hawaiians and other Pacific Islanders report lifetime and past-month rates similar to, if not higher than, whites and are among the highest-using subgroup within the AAPIs (National Survey on Drug Use and Health, 2006; Wong et al., 2004). Adolescent and adult Japanese also report rates similar to whites for marijuana, cocaine, and other illicit drugs (Price et al., 2002). Among ninth- and 11th-grade students in California, lifetime use of any substance varied from 11% among Southeast Asians to 50% among Pacific Islanders, compared to 45% among non-Asians. Lifetime alcohol use varied from 47.5% among Southeast Asians to 77% among Pacific Islanders, compared to 80% among non-Asians (Harachi et al., 2001). Among AAPI adults in California, Japanese Americans have the highest prevalence of lifetime drinking (69%), while Chinese Americans again have the lowest (25%) (Zane & Kim, 1994).

Some evidence indicates that gambling may be a growing problem among AAPIs. For instance, although AAPIs make up about 10% of California's population, they comprise approximately 70% of the gamblers in California's casinos, due in part to aggressive marketing aimed specifically at AAPIs (California Department of Alcohol and Drug Programs, 2005; Commission on Asian & Pacific Islander American Affairs [CAPIA], 2005; Toy & Wong, 1999). The existing studies suggest that AAPIs are at higher risk for gambling problems than individuals of

other ethnicities. One study by Lesieur and his colleagues (1991) found that Asian Americans had the highest rate of gambling relative to African Americans, whites, and American Indians. Other investigators have found higher rates of gambling and more problem gamblers among Asian Americans than white Americans (Chan, Zane, & Saw, 2007; Saw, Zane, & Chan, 2007). For example, Chan, Zane, and colleagues (2007) found that among young adult gamblers in college, the proportion of potential problem gamblers among Asian Americans was substantial (47.7%) and almost twice that of whites (27.5%). Other small-scale, California-based sample studies suggest that ethnic differences in gambling rates are mediated by psychological distress (i.e., social phobia) (Chan, Zane, et al., 2007), motives to socialize with others (Saw et al., 2007), and coping styles to deal with negative affect and tension (Saw et al., 2007). History and trends in the AAPI culture may also influence and increase rates of gambling among AAPIs (Raylu & Oei, 2004). Collectively, these studies provide initial empirical support that ethnic differences in gambling exist between Asian American and white American young adults. Overall, findings suggest that monitoring addictive behaviors among AAPIs will continue to be important, especially as the AAPI population increases in the coming years. Monitoring will be especially important among the AAPI groups with the highest risk factors (i.e., Southeast Asian refugees, Koreans, and Filipinos) that represent some of the fastest-growing groups in the AAPI population.

TREATMENT UTILIZATION AND OUTCOMES AMONG AAPIs

Based on evidence primarily from the mental health literature, AAPIs experience significant levels of unmet need. AAPIs have been depicted as having less access to services and poorer quality of mental health care (U.S. Department of Health and Human Services, 2001). AAPIs often experience worse outcomes in mental health treatment (Lee & Mixson, 1995; Zane, Hall, Sue, Young, & Nunez, 2004; Zane, Enomoto, & Chun, 1994; Zane & Kim, 1994). Among the available literature on addictions treatment utilization, research suggests that AAPIs with past-year substance dependence are less likely to report past-year treatment compared to substance-dependent whites and are six times less likely to perceive a treatment need (Sakai, Ho, Shore, Risk, & Price, 2005). Among AAPIs who utilize drug treatment, they report more negative attitudes toward treatment and fewer total services than non-AAPIs (Niv, Wong, & Hser, 2007). However, unlike mental health treatment, some studies show that AAPIs in substance use treatment show no ethnic group differences in treatment duration and retention (Niv et al., 2007; Zane et al., 2004). More research is needed to examine issues of addictions treatment among AAPIs.

BARRIERS TO ADDICTION TREATMENT

A variety of cultural and practical barriers have been attributed to the low rates of treatment utilization by AAPIs (Leong & Lau, 2001; U.S. Department of Health and Human Services, 2001). Practical barriers include lack of transportation, high cost of services, lack of insurance, and unavailability of treatment (U.S. Department of Health and Human Services, 2001). Cultural barriers such as problem recognition, stigma, and lack of credibility of available treatments may also serve as significant obstacles to accessing services (Sue, 1999). Although much of the literature on treatment barriers has been derived from mental health services research with AAPIs, many of the same barriers are likely to apply to substance abuse treatment. A more detailed discussion of areas where cultural disconnects may occur between AAPIs and standard addiction treatment is provided below.

Problem Recognition

Some have posited that AAPIs may not seek substance abuse treatment because of the lack of recognition of problematic substance use (Sakai et al., 2005). Failure to recognize and self-monitor problematic substance use has been attributed to cultural influences on how addiction is defined, cultural attitudes toward alcohol and substance use, and stigma associated with addiction. According to the DSM-IV, substance dependence is defined by symptoms of physiological dependence (i.e., tolerance or withdrawal); loss of control over use; substantial time spent on supporting addiction; interference in social, occupational, or recreational activities; and failure to discontinue use even in light of harmful physical or psychological effects. AAPIs may place greater emphasis on the degree to which substance use impairs one's functioning when defining addiction (James, Kim, & Moore, 1997). For instance, even if physiological signs of substance dependence may be present, AAPIs may not consider such use problematic as long as family obligations such as maintaining employment are met. There is also some evidence that AAPIs may associate alcoholism more with the negative physiological consequences of chronic alcohol use (e.g., liver damage) than with the inability to control one's drinking (Cho & Faulkner, 1993).

Certain cultural normative attitudes about alcohol and substance use may also inhibit recognition of problematic use (Matsuyoshi, 2001). Alcohol is often associated with social gatherings and events within AAPI communities. Offering alcoholic beverages to guests may be considered a gesture of hospitality (Kwon-Ahn, 2001). Among Asian Indians, drinking may be considered a status symbol of one's standing in the community (Sandhu & Malik, 2001). In upper socioeconomic classes of Asian Indians, alcohol is often central to personal and professional interactions. Among Korean males, after-work social gatherings are commonplace where

coworkers may offer one another drinks and refusal of drinks may be seen as impolite (Kwon-Ahn, 2001). Similarly, heavy drinking is often associated with social gatherings among Chinese and Japanese American men (Chi, Kitano, & Lubben, 1988). In such contexts, drunken behavior may be tolerated to a greater extent and recognition of problematic use may be more difficult to identify (Kwon-Ahn, 2001). Among some AAPI groups, alcohol use may be used for medicinal purposes. For instance, Southeast Asians have been reported to view alcohol as possessing healing properties (Makimoto, 1998). Thus, alcohol may not be viewed as a potentially harmful drug, which may obscure recognition of problematic use. Finally, some have posited that the stigma associated with substance abuse in AAPI communities may be so great that individuals may not recognize problematic use out of sheer denial. Denial of substance abuse has been identified as the primary barrier to substance abuse treatment for AAPIs (Ja & Aoki, 1993; Yen, 1992). Many AAPIs may enter treatment involuntarily through the legal system, child protective agencies, physicians, or employer mandates (Amodeo, Robb, Peou, & Tran, 1996).

Stigma

Even on recognition of problematic substance use, AAPIs may still be reluctant to seek treatment because of the stigma associated with addiction and the use of professional mental health services (James et al., 1997). AAPIs may view addiction as a lapse in willpower, moral weakness, or a medical problem (Fong & Tsuang, 2007; Lee, 2000; Lee, Law, & Eo, 2004), which can compromise not only the reputation of the individual involved in problematic use but also incur "loss of face" to the immediate and extended family for subsequent generations (Gong-Guy et al., 1991). Individuals with addictive problems are often seen as overly self-indulgent, nonproductive, and lack "good moral character." Consequently, AAPIs often make extended efforts to manage the addiction within the family and avoid outside professional help unless absolutely necessary (Ja & Aoki, 1993).

Lack of Credibility of Treatment

Standard treatments, which have been typically developed within a Western cultural framework, may not be viewed as a credible approach to addiction by many AAPIs (Sue, 1999; Sue & Zane, 1989). Lack of familiarity and cultural mismatches with the treatment process and interventions have been cited as factors that may lessen the credibility of existing treatments among AAPIs (Kwon-Ahn, 2001; Sue, 1999). One aspect of treatment that may be unfamiliar and a cause for discomfort for AAPIs is talking about one's problems particularly with an outside professional (Nguyen, 1982; Yamamoto & Acosta, 1982). Essentially, to many AAPIs, it is unclear how

"talk therapy" can alleviate one's problem with addiction. Compared to European Americans, AAPIs have been found to be significantly less likely to discuss mental health problems with friends, relatives, physicians, or mental health specialists (Zhang, Snowden, & Sue, 1998). AAPIs may be less likely to talk about personal problems to professionals or even family members because of cultural values that encourage self-reliance or because of stigma. Yet a core feature of most addiction treatments involves discussing problematic substance use and related risk factors. Given the lack of familiarity with addiction treatment, many AAPIs may not understand why talking about one's problems is an important part of the treatment process. Moreover, treatment often focuses on examining negative thoughts or emotions, which may be directly opposed to culturally normative ways of coping. For instance, when faced with mental health problems, AAPIs have been described as relying on the avoidance of morbid thoughts and the suppression of negative emotions as an appropriate coping method (Bui & Takeuchi, 1992; Butler, Lee, & Gross, 2007; Lam & Zane, 2004; Leong & Lau, 2001; Root, 1985; Sue, 1994).

AAPI perceptions of mental health and addiction problems as a lapse in willpower or self-discipline can also lessen the credibility of existing treatments (Uba, 2003). For instance, AAPIs may believe that increased willpower or determination is all that is needed to overcome addictive behaviors and may not see the relevance of professional treatment. In addition, the perceived credibility of treatments may vary depending on the extent to which treatments align with beliefs about the role of willpower and addictive behaviors. For example, a core principle of Alcoholics Anonymous is acknowledging one's powerlessness over addiction, which may run counter to AAPI conceptualizations of coping with addiction.

Although many AAPIs may lack familiarity with standard treatments, this does not mean that AAPIs enter treatment devoid of expectations. Studies suggest that AAPIs may expect and be most responsive to treatment that is brief, structured, and directive (Hwang, 2006; Lin & Cheung, 1999). Many AAPIs may enter treatment only as a last resort after their addictions have caused significant impairment (Bui & Takeuchi, 1992; Durvasula & Sue, 1996; Ja & Aoki, 1993; Sakai et. al., 2005). The main focus for many AAPIs may be on how to quickly return to previous functioning and on the restoration of roles and responsibilities (Murase & Johnson, 1974). However, the connection between core components of treatment and the resumption of responsibilities may not be readily apparent. For example, the 12 steps in Alcoholics Anonymous have no explicit mention of functional outcomes that may be particularly salient for AAPIs. Similarly, treatment programs that focus on thoughts or emotions associated with addictive behaviors without making explicit the connection to the restoration of roles and responsibilities may fail to garner credibility in the eyes of AAPIs. So a key task at the beginning of treatment involves strate-

gies that provide compelling arguments or evidence that therapy will lead to enhanced functioning in work, education, career, and so forth. Failure to establish the credibility of treatments has been attributed to AAPIs' premature termination of therapy and poor treatment outcomes (Kung, 2004; Zhang et al., 1998). In fact, perceptions of provider credibility has been shown to be the single most important factor associated with intent to utilize mental health services among Chinese students (Akutsu, Lin, & Zane, 1990).

HARM REDUCTION PRINCIPLES WITH AAPIs

Harm reduction possesses certain principles that may offer a useful and compatible approach to addressing addictive behaviors among many AAPIs. The core elements of harm reduction include: (1) a shift from the moral, criminal, and disease models of drug use and addiction to a public health perspective; (2) acceptance of alternative treatment goals other than abstinence; (3) promotion of low-threshold access to services; and (4) adoption of a compassionate pragmatic versus a moralistic idealism stance. A general framework for how harm reduction may fit with the AAPI population is described below followed by a section that discusses specific clinical strategies that can be used with AAPI clients.

The core tenets of harm reduction may provide a viable approach to addressing some of the common barriers to treatment experienced by AAPIs. Given that problem recognition is a barrier to treatment for many AAPIs, a harm reduction approach may be useful for increasing access to treatment. AAPIs who may not readily admit to an addiction problem because of stigma, denial, or cultural conceptualizations of addiction may be amenable to accessing treatment to reduce associated consequences of their addictive behavior. For example, AAPIs may be much more willing to admit to the need to cut down on drinking because of adverse effects on work performance or family life, but may be more reluctant to acknowledge being an alcoholic and feeling powerless (Bui & Takeuchi, 1992; Durvasula & Sue, 1996; Kung, 2004). Similarly, they may be more willing to focus their treatment on occupational functioning rather than on achieving abstinence. Treatments that are based in abstinence-only outcomes may carry the risk of intense shame with any lapses in one's ability to maintain abstinence. In contrast to many abstinence-based addiction programs where entry is conditional upon individuals admitting to an addiction and being abstinent, harm reduction sidesteps the conversation of whether drug use is morally wrong, a disease, or criminal in nature and instead examines how individuals' behaviors have been harmful or helpful. Many AAPIs, who adhere to collectivist cultural heritages, often feel an obligation and responsibility to their family and might therefore find that treatment goals

related to functioning and work are more salient to them. Harm reduction focuses on the consequences of addictive behaviors (e.g., impact on family or work), which may be compatible with the importance placed by AAPIs on functioning, fulfillment of roles and responsibilities, and "saving face" (Bui & Takeuchi, 1992; Durvasula & Sue, 1996; Hwang, 2006; Kung, 2004; Yang, 2007).

A harm reduction approach may also be effective in reducing the stigma and shame some AAPIs face entering and utilizing treatment. Programs that create a low threshold for AAPIs to get "in the door" of an organization may enhance access to treatment for this population. Neighborhood programs that offer multiple services such as translation, immigration, and other social service supports in addition to addiction services may help reduce stigma and shame associated with clinics that only offer mental health or substance use services (Chow, 1999, 2002; Lee, 2000). For example, a client may initially go to a multiservice agency for immigration support and may eventually inquire about addictions treatment after building rapport and credibility for their services. Access to treatment may be easier at these multiservice agencies compared to stand-alone treatment facilities. Often, these multiservice programs are long-standing in communities, offer a variety of services, outreach widely to communities, and are governed by a board of directors (Chow, 2002). Partnering with these types of organizations to offer addiction treatment is consistent with a harm reduction approach because clients are able to utilize services for a continuum of behaviors and treatment goals.

Finally, because the harm reduction approach is pragmatic and focuses on everyday functioning, the chronicity of relapse is viewed compassionately and differently than traditional forms of addiction treatment. Nearly 90% of clients with addictive behaviors do not achieve behavior change with their first attempt (Polivy & Herman, 2002) and about two-thirds of all relapses occur within the first 90 days following treatment (Hunt, Barnett, & Branch, 1971). This reality of addictive disorders can be very discouraging to anyone, but because addictive problems can be especially shameful for many AAPIs (Ho, 1989; Sue & Morishima, 1982), they may be at higher risk of ending treatment prematurely (Lee, 2000). The harm reduction approach may help retain these clients in treatment because it does not confront the client when he or she drinks or uses, but instead focuses on pragmatically reducing the consequences associated with addictive behaviors.

While certain aspects of the harm reduction approach may be culturally congruent with AAPIs, other features of harm reduction may be problematic for these clients. For example, harm reduction may be more acceptable for treating alcohol and gambling than for illegal drugs. Alcohol and gambling are more publicly accepted behaviors compared to more sanctioned illegal drug use. In addition, harm reduction may be perceived

as "encouraging" individuals to engage in addictive behaviors. Moderation can be seen as unwillingness to adopt abstinence, which may be interpreted as a weakness in character or selfishness. In collectivist cultures such as AAPIs and Native Americans, regaining the respect and trust of family and community members is important and may be difficult to achieve without complete abstinence (Daisy, Thomas, & Worley, 1998). Common across all ethnic groups, certain individuals may disagree with the harm reduction approach, while others may find it as a helpful alternative to styles of traditional addiction treatment. Harm reduction could offer a promising approach for AAPIs and more research is needed to evaluate this.

HARM REDUCTION AND RELAPSE MANAGEMENT TECHNIQUES

As discussed above, core features of harm reduction may provide a culturally congruent approach to addictive behaviors with many AAPI clients. The following section offers more specific clinical strategies when conducting harm reduction and addiction treatment in general with these clients. However, as stressed earlier in this chapter, there is great heterogeneity among AAPIs, and clinical strategies should be matched to the needs of the client. While the below domains may be appropriate for many AAPI clients, they are not all-encompassing, and an individualized needs assessment is important before applying the subsequent clinical strategies.

Orienting Clients to Harm Reduction

As reviewed earlier, many AAPIs in substance use treatment are less likely to utilize services, perceive a treatment need, recognize substance-related problems, and are more likely to have more negative attitudes toward treatment (Fong & Tsuang, 2007; Hwang, 2006; Lee, 2000; Lee et al., 2004; Niv et al., 2007; Sakai et al., 2005). As a result, orienting clients to treatment, harm reduction, and relapse management techniques (described below) is important for preventing premature treatment termination. As part of orienting, counselors can educate clients about the importance of open communication with the counselor and how such communication is integral to developing an effective treatment plan. It may be important to acknowledge, anticipate, and normalize any discomfort that clients might feel when asked to provide open feedback to the counselor about the treatment experience. Individuals from collectivistic cultural backgrounds that highly value harmony with others may view open expressions of dissatisfaction or disagreement as disrespectful. The below section describes additional methods for orienting clients to harm reduction aimed to effectively educate and engage the client in treatment.

Assessing Treatment Expectations

Clients often enter treatment with preconceived notions influenced by myriad factors including previous experiences, cultural upbringing, the media, and word of mouth. Some research suggests that AAPI clients respond better to more hierarchical, directive, and structured therapies (Hwang, 2006; Lin & Cheung, 1999). In fact, as described earlier, a common barrier to seeking treatment is the lack of credibility for traditional talk therapy programs. During the first session, the counselor should refrain from asking too many personal questions because of the stigma associated with seeking treatment and the discomfort of discussing personal issues with "outsiders" (Hwang, 2006; Sue, 1999).

To build credibility, counselors may first talk about their own credentials, the degree of experience they have had with treatment success, and then provide a rationale for assessing the client's expectations. AAPI clients commonly enter treatment expecting to receive more "answers" than "questions" (Hwang, 2006). For example, the counselor might state that in order to work together successfully and productively, he or she might ask some questions in the same way a doctor would ask questions about a patient's medical symptoms. The counselor might also state that the origin of questions is based on collecting more information, that he or she asks the same questions of all clients in order to understand what treatment recommendations to make, and that the origin of the questioning is not to judge or devalue the client. Normalizing the process by providing a rationale may help these clients feel less shame and stigma, especially with clients new to the treatment process (Lee, 2000).

After building a rationale for assessing the client, the counselor may then ask a few questions related to what they know about treatment, what types of topics would be most useful to discuss, and how they foresee treatment sessions to be like. The counselor can then educate the client in areas where there are discrepant treatment beliefs. For example, if clients perceive that treatment will not be useful to them because it will not help them get back to work, the counselor may discuss treatment options that incorporate occupational functioning. Finally, during this assessment, it is important that the client has the opportunity to ask the counselor questions about the treatment process. Through the client's questions, the counselor should continue to be attentive to prevalent treatment expectations (e.g., How will I get back to work?). Setting realistic treatment expectations with the client is important in preventing premature treatment dropout (Sue, 1999). Counselors should follow up this assessment with questions about the client's understanding (e.g., How does what we discussed fit with your understanding of treatment?). As stated earlier, some AAPI clients may be reluctant to express disagreement, and part of the orienting process should normalize open communication with the counselor. Cognitive match, or

the degree to which the client's worldview and the counselor's conceptual model match, has been linked to greater therapeutic alliance (Sue, 1999; Sue & Zane, 1989) and influence of initial treatment responses (Zane et al., 2005). Therefore, assessing the extent of congruence between the client's and the counselor's understanding of treatment in the early stages of treatment is helpful.

Establishing Treatment Goals

An important aspect toward orienting clients to therapy is to understand the client's treatment goals. Assessing how the client defines treatment "success" is very important. Identifying incremental and achievable goals with AAPI clients, in particular, is important. "Gift giving," or helping the client achieve success early in treatment, has been underscored as important (Hwang, 2006; Sue & Zane, 1989). While the counselor may view reduced substance use or abstinence as the ultimate goal, AAPI clients may associate treatment effectiveness with improved roles/functioning. As an example, one of the authors referred an Asian American student to the student counseling center for drinking problems, and when asked how counseling was going, he replied that he had dropped out because counseling was not helping his academic grades improve. Connecting improved functioning to the treatment of substance use is very important in orienting AAPI clients.

AAPIs may be more responsive to treatment if they see how treatment will help them achieve goals that are important to them. Consistent with harm reduction, establishing the client's goals in treatment means to identify the consequences their substance use behaviors are having on their family, job, relationships, social functioning, and health (Sue, 1999). Clients may not readily state abstinence as a goal, for example, but may be more likely to state that obtaining a job or financial assistance is important to them. Once the functional goals are identified, the impairment resulting from substance use can be integrated into their treatment plan. The counselor and client may work on small, incremental goals that the client finds valuable to structure the client's treatment plan and problem-solve how substances may interfere with achieving each goal. As stated earlier, allowing AAPI clients to experience treatment gains early in treatment may enhance credibility of the treatment and prevent premature termination. Using the college student's example, incremental goals might be to carve out 2 hours in the evening twice a week to read a chapter in his textbook. After establishing that goal, the counselor and client might problem-solve barriers that might get in the way of achieving that goal, and may discover that drinking in the evening often impairs the student's concentration. As a result, the client may include another goal of not drinking until after his reading time or not drinking on the 2 days when he wants to accomplish his goals. Concordant with a harm reduction philosophy, the counselor

and client work to reduce the substance-related consequences that interfere with the client's functioning.

A common barrier AAPI clients experience when establishing treatment goals is the conflict between their personal goals and the goals of their family. Because in many AAPI cultures a greater emphasis is often placed on the welfare of the family than the individual, it is also important to assess whether the client's treatment goals stem from the client or his/her family, and what impact that might have on the client's treatment motivation. Family members may play a supportive role in treatment, while others may act as a barrier toward the individual improving. Assessing parental support, rejection, and the family's role in the individual's addictive behaviors may provide insights to forming the client's treatment goals (Rastogi & Wadhwa, 2006). AAPIs have been shown to be motivated by more collectivistic than individualistic influences (Lee, 2000; Markus, Kitayama, & VandenBos, 1996; Uba, 2003). Proper assessment of familial pressures and the effects of these pressures on the client's treatment motivation are important to understand. In some situations, the pressure to regain face in their family may motivate the client to reduce addiction consequences, while in other situations this pressure may perpetuate the client's addiction.

Providing a Treatment Rationale

For any intervention, providing a treatment rationale by giving clients information about the process and requirements of treatment is important for enhancing therapeutic alliance and engagement (Acosta, Yamamoto, Evans, & Skilbeck, 1983). For AAPI clients in particular, providing a treatment rationale is important because therapy and treatment may be more stigmatizing and less familiar to them (Hwang, 2006). Among immigrant populations, seeking therapy may be seen as a sign of weakness and a lack of resiliency to solve their own problems, and providing a treatment rationale may help save face and reduce stigma early in treatment (Hwang, 2006).

The treatment rationale involves providing information on why harm reduction works, how it works, and what steps are required in order for it to work. The counselor may take an expert stance in describing the rationale to build credibility for the counselor and the therapeutic process. For example, a counselor might describe why harm reduction works (Marlatt, 1998) and the research supporting the approach (Marlatt & Witkiewitz, 2002). The counselor may then provide an example of how harm reduction can specifically help the client's presenting concerns (e.g., "You state that returning to work is very important to you. We can use harm reduction to reduce the consequences that get in the way of you finding work and being productive"). The counselor may then summarize the research on harm reduction by saying that the approach has been widely used for about the past 30 years and has been shown to be as effective as abstinence-oriented

approaches (Marlatt & Witkiewitz, 2002; Larimer et al., Chapter 3, this volume). Harm reduction is commonly used with adolescent and college student populations because moderation in drinking and a reduction in drinking consequences are more realistic goals than abstinence (Baer, Kivlahan, Blume, McKnight, & Marlatt, 2001; Dimeff, Baer, Kivlahan, & Marlatt, 1999; Marlatt et al., 1998). Describing how and why harm reduction works involves describing the principles and research supporting the approach, which can increase its perceived credibility.

The most efficient way to concretely describe how harm reduction works in substance use treatment might be to use the relapse prevention framework (see Figure 11.1). Relapse prevention therapy consists of cognitive-behavioral self-management and lifestyle balance techniques to prevent initial lapses and full-blown relapses from occurring (Marlatt & Gordon, 1985). However, as described below, relapse prevention therapy is abstinence focused and therefore differs from the consequence focus of harm reduction. Counselors might describe the relapse prevention framework in the context of the client's example and may find it helpful to illustrate Figure 11.1 during the conversation. For example, the counselor might restate the last time the client had an argument with his wife (high-risk situation), how he withdrew, isolated, and blamed himself for the fight (ineffective coping responses), felt he was a bad husband and wanted to drink to take the shame/guilt away (decreased self-efficacy and positive outcome expectancies), had one drink to numb the shame, felt he failed as a husband by drinking and that he should continue to drink to erase the pain (abstinence violation effect and perceived effects of substance), and continued drinking heavily for a week (increased probability of relapse). Referring back to the diagram, the counselor might describe that therapy will teach the client how to intervene in each stage of the diagram (e.g., what to do when in an argument or when he feels that he is a bad husband). By describing the process of relapse and drinking in the context of roles/responsibilities (e.g., being a good husband), the AAPI client begins to conceptualize how treatment might help him.

Finally, the counselor describes what is required for the harm reduction approach to work. This is an opportunity to get specific with the AAPI client so that he or she understands his or her role in therapy. The counselor might describe the logistics of counseling (e.g., frequency, cost, length, and duration). Some have stated that a strength of the AAPIs' culture is the willingness to persevere, tolerate, and be patient during challenging situations (Lee, 2000). In Japanese, this concept is called *gaman*, or the endurance of pain in uncomfortable situations. Counselors may capitalize on this tendency by indicating that treatment can be hard work but that, as they know, hard work often leads to great benefits. Moreover, part of this hard work may involve doing things that they find unfamiliar and uncomfortable such as discussing their feelings and focusing on negative

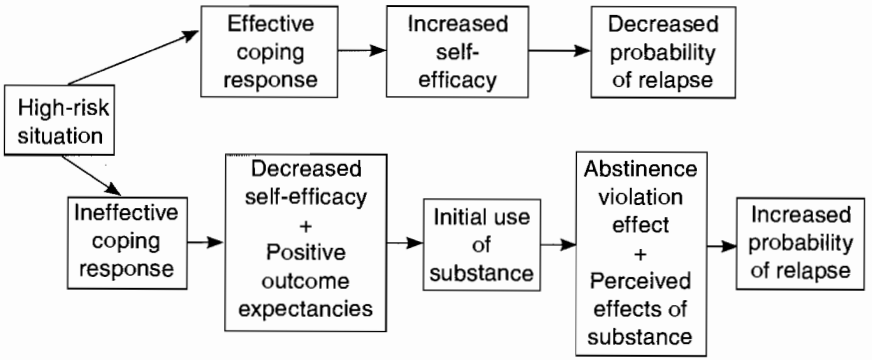

FIGURE 11.1. A cognitive-behavioral model of the relapse process. From Witkiewitz and Marlatt (2004). Copyright 2004 by the American Psychological Association. Reprinted by permission. This figure illustrates a linear version of the relapse process and is included here to facilitate discussion with clients more easily. A more recent and dynamic model incorporating proximal and distal factors has been recently suggested (see Witkiewitz & Marlatt, 2004).

emotions and thoughts. However, analyzing the client's thoughts and feelings is essential to learning how they are connected with the consequences related to their client's presenting problem (e.g., cognitive-behavioral therapy; Beck, Wright, Newman, & Liese, 1993). The counselor can normalize the experience of discomfort by stating that AAPIs often feel nervous and anxious about the therapeutic process, but that this feeling decreases over time. The counselor may also discuss client or counselor behaviors that may interfere with therapy and compromise treatment success (e.g., missing appointments, early dropout, counselor pushing too hard) (Linehan 1993a). Finally, the counselor can provide hope for the client to persevere even when treatment and life situations are challenging, offer hope that together they can work toward reducing the consequences that are challenging the client's life, and that treatment can be useful in helping them reassume important roles in their lives.

Relapse Management Techniques

Relapse prevention techniques are tailored to specific stages of development in the relapse process (e.g., high-risk situation, no coping response, decreased self-efficacy). Elements of relapse prevention may be culturally adapted to AAPI clients (Blume & García de la Cruz, 2005). Because of the abstinence focus of relapse prevention, relapse management is used to describe relapse prevention techniques used under a harm reduction framework (Laws, 1996; Stoner & George, 2000). In this case, relapse management provides techniques to manage the harm caused by relapse instead of

preventing specific stages of relapse, which may be more culturally compatible compared to other mainstream therapies (Blume, Anderson, Fader, & Marlatt, 2001). This distinction may be particularly important for AAPI clients who use the role of functioning to measure whether their behaviors are problematic (e.g., arriving late to work or not fulfilling family obligations because of drinking) (James et al., 1997). In this next section, several relapse management techniques are proposed that may be used with AAPI clients. We use the same stages of relapse categories described in relapse prevention (see Figure 11.1), but adapt them to a harm reduction framework and for AAPIs.

Identifying High-Risk Consequences

High-risk consequences from addictive behaviors could be described as situations that perpetuate harmful problems and impairment. For example, a high-risk consequence from drinking might be to arrive late to work, which may cause decreased productivity, coworker conflict, or injury. In harm reduction, techniques could include drinking earlier the previous day so that the individual could fall asleep earlier, drinking less a few hours before bed, scheduling a carpool to work for more accountability, or establishing stronger behavioral cues in order to wake up more punctually. For AAPI individuals, common high-risk consequences may involve relationship (family, social, intergenerational, romantic), occupation (academic, employment, unemployment), reputation (loss of face and shame), financial, discrimination, and legal situations.

The importance of a thorough and accurate assessment of high-risk situations has been emphasized throughout several therapies as the cornerstone to good treatment (Linehan, 1993a). Detailed assessment is especially important with AAPIs. Some research suggests that AAPIs tend to suppress strong negative emotions because morbid thinking is seen as maladaptive (James et al., 1997), are less likely to self-monitor, and have less emotional expression compared to whites (Uba, 2003), which may hinder psychological help-seeking (Komiya, Good, & Sherrod, 2000). Furthermore, talking about their consequences may perpetuate shame and guilt, and should be conducted collaboratively and delicately.

To begin increasing the client's ability to self-monitor, exercises building biological awareness and emotion labeling may be helpful. In these biofeedback exercises, counselors teach clients to notice their bodily sensations (e.g., the aches in their neck or shoulders) throughout the day and especially during times of stress, and to use these signals to improve their health (e.g., University of Pittsburgh Medical Center, 2008). Clients learn to notice when they are tense or anxious and intervene if they are linked with high-risk consequences. For addiction treatment, targeting somatic symptoms or the negative physical symptoms of substance abuse (e.g., headaches, sleep-

ing problems, memory problems) may provide AAPIs with a sense of the usefulness of treatment while lessening some of the stigma associated with addiction (Kwon-Ahn, 2001; Sandhu & Malik, 2001). Other exercises can focus on emotion labeling, where clients learn to name and identify their emotions. These exercises can be conducted after clients learn biofeedback. For example, clients can learn to label bodily sensations with emotions such as stressed, angry, tense, uncomfortable, or disappointed. Counselors teach clients to become more aware and less judgmental of self-monitoring.

To do a thorough assessment with a client, a counselor might need to assess a client's high-risk consequences using a downward arrow or chaining technique. For example, a client may state that he isolates after drinking and with further query the client may disclose that he isolates because he gets moody and the highest risk consequences for him are the verbal fights he has with his wife. It is really important to him to be a good husband for his wife, but he finds a way to argue with her after he drinks. By asking questions such as "What happens after you isolate? How does that affect you?" the client becomes more specific about the more meaningful harm the behaviors cause. The counselor needs to be attentive to levels of shame the client may be experiencing when recounting the details of high-risk situations and associated consequences. It may be important to check in with and to continue to orient the client to the purpose of the exercise and how it relates to accomplishing treatment goals. After assessing, the counselor could orient the client to form treatment goals to reduce these consequences. For this client, the treatment goal of fighting less with his wife may be paired with learning to communicate with his wife when he is not drinking, drinking less or none at all when she is home, or working with the couple to explore issues that they fight about. These techniques, which are very role specific, tailor the consequences the client identifies to specific treatment goals.

Developing Effective Coping

Coping refers to methods an individual uses to respond to a stressful situation, and effective coping implies techniques the individual uses successfully to obtain stress relief. AAPI individuals exhibit heterogeneity in their coping skills and what is considered effective coping. It is important to be knowledgeable of coping patterns that may be more salient among AAPI clients. For example, there is some tendency among AAPI clients to avoid negative thoughts or emotions (Bui & Takeuchi, 1992; Lam & Zane, 2004; Leong & Lau, 2001; Root, 1985), and restraining these emotions is seen as a sign of maturity (Sue, 1999). There have been some studies showing that AAPI individuals tend to habituate much more quickly after being startled compared to whites (Moy Shum, 1996), which suggests that they may not linger as long with emotional upsets than others would. AAPI individu-

als also tend to change their attitudes about a situation when coping with interpersonal stress, as compared to whites, who in general change their environments first (Markus & Kitayama, 1991). Therefore, AAPI clients can cope effectively by avoiding or habituating to emotions within a short period. The counselor should assess how effective the client's coping skills are for resolving consequences related to addictive behaviors and supplement their repertoire with additional skills as needed.

Techniques that might be helpful in coping effectively may include structured exercises such as emotion regulation, problem solving, and interpersonal skills training. Counselors may need to orient and teach clients how to identify and monitor their emotions if useful to the client's presenting problem, explaining that being mindful of emotions may be counterintuitive to them, but has been shown to help prevent future upsets (e.g., recognizing and intervening early signs of anger to prevent arguments with his wife). Clients may also need to problem-solve difficult situations. For example, the client mentioned above may need to problem-solve how not to isolate after arguments with his wife. Strategies may include listening or communication skills (Daley & Marlatt, 2006; Linehan, 1993b). Similar to AAPI clients, interpersonal conflict is widespread among all ethnic groups, and more coping in relationships may be important.

Increasing Self-Efficacy

Self-efficacy theory states that individuals vary in their level of confidence to resist drinking in risky situations, and those individuals with higher levels of self-efficacy are at reduced risk of engaging in harmful behaviors (Bandura, 1997). Counselors can highlight the client's positive coping strategies in high-risk situations and help identify the client's helpful tools for coping with difficult life circumstances to increase self-efficacy. Increased self-efficacy can often be misconstrued as high self-esteem, and the difference is important to distinguish with AAPI clients. In some collectivistic/Asian cultures, humility is highly valued, and highlighting one's own accomplishments may be less culturally compatible. Having higher self-esteem can therefore be counterintuitive. Therefore, self-efficacy could be reframed as enhancing the client's ability for self-control or increasing personal will power. For example, with the aforementioned client, the language of self-efficacy might be framed as having the skills to fight less with his wife instead of doing a good job of fighting less with her.

AAPI clients that are collectivists may place more weight on interdependence or collective efficacy (Bandura, 2000; Earley, Gibson, & Chen, 1999), where focus is placed on the "family" self instead of the "I" self (James et al., 1997; Sue, 1999). Thus, the consequences of an individual's addictive problems may affect not only the individual but also the family.

The counselor can phrase self-efficacy in the context of the client's role in the family and community (e.g., being a role model in their family and to local Chinese Americans).

Understanding Outcome Expectancies

Similar to how expectancies are addressed in relapse prevention, understanding the client's expectations for addictive behavior may help address barriers that may perpetuate harm. AAPI individuals tend to suppress negative emotions (Butler et al., 2007), so that they may be more likely to use substances to self-medicate their emotions (Amodeo et al., 1996; Nagoshi, Nakata, Sasano, & Wood, 1994). Individuals, for example, may self-medicate to minimize the aversive symptoms associated with depression, social anxiety, or posttraumatic stress disorder (Bromley & Sip, 2001). This tendency to use substances for self-medication may be especially problematic and can be a focal point of relapse management for clients. For example, if the client discussed above has positive expectations that drinking when his wife is around helps him feel less depressed or more social when she is present, a helpful strategy may be to educate the client about the depressive effects of alcohol or the placebo effects often experienced when drinking (e.g., biphasic response of alcohol or the balanced placebo experiments) (Dimeff et al., 1999). Clients may also feel social pressures to use and may overestimate their peers' use of substances. In this case, normative feedback or providing statistics about how their use compares to others in the United States may also be an effective technique. For example, a counselor might say to the client that "compared to men your age, your percentile ranking is 87%, which suggests you drink more than 87% of men your age" (Chan, Neighbors, Gilson, Larimer, & Marlatt, 2007). Providing pragmatic education around how the client's use compares to norms found in research may help increase the credibility of the counselor's feedback and create dissonance between the client's current behaviors and values.

The Abstinence Violation Effect

Similar to the abstinence violation effect (AVE) used in relapse prevention, the AVE in harm reduction could be conceptualized as maladaptive thoughts and negative emotions associated with relapse-related consequences. Our client may experience the AVE after having a drink and a subsequent argument with his wife. Experiencing the AVE for him as a result of drinking may involve thoughts such as "I am a failure to my family, my relationship with my wife is never going to improve, and all this work I gained from not drinking was for nothing." The negative emotions he might feel are shame, guilt, and disappointment. The danger of the AVE occurring is early treatment dropout, decreased motivation, and increase in harmful behaviors

(Marlatt & Gordon, 1985). In AAPI communities, shame and loss of face are prevalent emotions that may perpetuate risky behaviors. Loss of face refers to losing one's social integrity. Individuals tend to blame themselves for any "failures" (James et al., 1997; Nguyen, 1982) and conceptualize failures as a loss of face to themselves and their social networks (Hwang, 2006; Lee, 2000; Lee et al., 2007; Uba, 2003). In this context, the experience of shame and face loss should be extensively explored with the client so the emotional distress associated with these states can be used as important cues that the client may be vulnerable to AVE in that situation. In this way, many AAPI clients can develop skills to anticipate the AVE and thus avoid early treatment termination. When clients experience the AVE, counselors might reiterate the therapy rationale, normalize the relapse process, and instill hope that the client can continue to persevere through challenging situations. Interventions may include cognitive restructuring (Beck et al., 1993) or correcting dysfunctional thoughts that foster maladaptive coping, shame, and guilt. Clients often can relate to experiencing the AVE in the past and may problem-solve with counselors how to cope effectively if the client slips in treatment, and may additionally troubleshoot incremental behavioral goals the client can make more in the short term to regain self-efficacy and treatment success.

CONCLUSION

In this chapter, we highlighted the increasing rates of addictive behaviors among subgroups of AAPIs, discussed the barriers and cultural factors that may contribute to lower treatment utilization among AAPIs, and provided a framework for how harm reduction and corresponding relapse management techniques may be used among this clientele. Emerging evidence suggests that addictive behaviors may be a growing problem among AAPIs, and there is currently little research known about the effectiveness of existing addiction treatment approaches. Harm reduction is gaining increasing recognition as a promising approach, and certain aspects of this approach may be culturally compatible with the values, coping orientations, and treatment expectations of AAPI clients. Specifically, the focus on consequences and psychosocial functioning, the shift from shame-based to acceptance models of addiction and the low-threshold access into care may be especially helpful to AAPI individuals with addiction problems. By framing treatment as a method of improving clients' roles and responsibilities, treatment may be perceived as more useful and pragmatic. Harm reduction may provide a more acceptable alternative to traditional abstinence-based treatments for AAPIs, given its focus on reducing the negative consequences associated with addictive behaviors. Harm reduction is a promising approach that warrants further study with AAPI populations.

REFERENCES

Acosta, F., Yamamoto, J., Evans, L., & Skilbeck, W. (1983). Preparing low-income Hispanic, black, and white patients for psychotherapy: Evaluation of a new orientation program. *Journal of Clinical Psychology, 39*(6), 872–877.

Akutsu, P., Lin, C., & Zane, N. (1990). Predictors of utilization intent among Chinese and white students: A test of the proximal–distal model. *Journal of Counseling Psychology, 37*(4), 445–452.

Amodeo, M., Robb, N., Peou, S., & Tran, H. (1996). Adapting mainstream substance-abuse interventions for Southeast Asian clients. *Families in Society, 77*(7), 403–413.

Baer, J., Kivlahan, D., Blume, A., McKnight, P., & Marlatt, G. (2001). Brief intervention for heavy-drinking college students: 4-year follow-up and natural history. *American Journal of Public Health, 91*(8), 1310–1316.

Bandura, A. (1997). *Self-efficacy: The exercise of control.* New York: Freeman.

Bandura, A. (2000). Exercise of human agency through collective efficacy. *Current Directions in Psychological Science, 9*(3), 75–78.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York: Guilford Press.

Blume, A., Anderson, B., Fader, J., & Marlatt, G. (2001). Harm reduction programs: Progress rather than perfection. In R. Coombs (Ed.), *Addiction recovery tools: A practical handbook* (pp. 367–382). Thousand Oaks, CA: Sage.

Blume, A. W., & García de la Cruz, B. (2005). Relapse prevention among diverse populations. In G. A. Marlatt & D. M. Donovan (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed., pp. 45–64). New York: Guilford Press.

Bromley, M., & Sip, S. (2001). Substance abuse treatment issues with Cambodian Americans. In S. L. A. Straussner (Ed.), *Ethnocultural factors in substance abuse treatment* (pp. 321–344). New York: Guilford Press.

Bui, K., & Takeuchi, D. (1992). Ethnic minority adolescents and the use of community mental health care services. *American Journal of Community Psychology, 20*(4), 403–417.

Butler, E. A., Lee, T. L., & Gross, J. J. (2007). Emotion regulation and culture: Are the social consequences of emotion suppression culture-specific? *Emotion, 7,* 30–48.

Caetano, R., Clark, C., & Tam, T. (1998). Alcohol consumption among racial/ethnic minorities. *Alcohol Health and Research World, 224*(4), 233–241.

California Department of Alcohol and Drug Programs. (2005, March). Situational assessment of problem gambling in California. Retrieved from *www.adp.ca.gov/opg/pdf/reportpgassessment.pdf.*

Chae, D. H., Takeuchi, D. T., Barbeau, E. M., Bennett, G. G., Lindsey, J. C., Stoddard, A. M., et al. (2008). Alcohol disorders among Asian Americans: associations with unfair treatment, racial/ethnic discrimination, and ethnic identification (the national Latino and Asian Americans study, 2002–2003). *Journal of Epidemiology and Community Health, 62*(11), 973–979.

Chan, A. K. K., Zane, N., & Saw, A. (2007, November). *Common and differential risk factors for problem gambling and problem drinking for young adults.*

Poster presented at the annual meeting of the National Center for Responsible Gambling, Las Vegas, NV.

Chan, K., Neighbors, C., Gilson, M., Larimer, M., & Marlatt, G. (2007). Epidemiological trends in drinking by age and gender: Providing normative feedback to adults. *Addictive Behaviors, 32,* 967–976.

Chi, I., Kitano, H., & Lubben, J. (1988). Male Chinese drinking behavior in Los Angeles. *Journal of Studies on Alcohol and Drugs, 49*(1), 21–25.

Cho, Y., & Faulkner, W. (1993). Conceptions of alcoholism among Koreans and Americans. *International Journal of Addiction, 28*(8), 681–694.

Chow, J. (1999). Multiservice centers in Chinese American immigrant communities: Practice principals and challenges. *Social Work, 44,* 70–81.

Chow, J. (2002). Asian American and Pacific Island mental health and substance abuse agencies: Organizational characteristics and service gaps. *Administration and Policy in Mental Health, 30*(1), 79–86.

Commission on Asian & Pacific Islander American Affairs (CAPIA). (2005). Rising to the task: Facing new challenges in California's APIA Communities. Retrieved from *democrats.assembly.ca.gov/apilegcaucus/pdf/AnnualReport.pdf.*

Compton, W., Thomas, Y., Stinson, F., & Grant, B. (2007). Prevalence, correlates, disability, and comorbidity of DSM-IV drug abuse and dependence in the United States: Results from the national epidemiologic survey on alcohol and related conditions. *Archives of General Psychiatry, 64*(5), 566–576.

Daisy, F., Thomas, L. R., & Worley, C. (1998). Alcohol use and harm reduction within the Native community. In G. A. Marlatt (Ed.), *Harm reduction: Pragmatic strategies for managing high-risk behaviors* (pp. 327–350). New York: Guilford Press.

Daley, D., & Marlatt, G. (2006). *Overcoming your alcohol or drug problem: Effective recovery strategies.* Oxford, UK: Oxford University Press.

Denning, P. (2000). *Practicing harm reduction psychotherapy: An alternative approach to addictions.* New York: Guilford Press.

Dimeff, L. A., Baer, J. S., Kivlahan, D. R., & Marlatt, G. A. (1999). *Brief alcohol screening and intervention for college students (BASICS): A harm reduction approach.* New York: Guilford Press.

Durvasula, R., & Sue, S. (1996). Severity of disturbance among Asian American outpatients. *Cultural Diversity and Mental Health, 2*(1), 43–51.

Earley, P., Gibson, C., & Chen, C. (1999). "How did I do?" versus "how did we do?": Cultural contrasts of performance feedback use and self-efficacy. *Journal of Cross-Cultural Psychology, 30,* 594–619.

Fong, T., & Tsuang, J. (2007). Asian-Americans, addictions, and barriers to treatment. *Psychiatry, 4,* 51–59.

Giovino, G. (2002). Epidemiology of tobacco use in the United States. *Oncogene, 21*(48), 7326–7340.

Goedde, H. W., Agarwal, D. P., Fritze, G., Meier-Tackmann, D., Singh, S., Beckmann, G., et al. (1992) Distribution of ADH2 and ALDH2 genotypes in different populations. *Human Genetics, 88,* 344–346.

Gomez, S., Kelsey, J., Glaser, S., Lee, M., & Sidney, S. (2004). Immigration and acculturation in relation to health and health-related risk factors among specific Asian subgroups in a health maintenance organization. *American Journal of Public Health, 94*(11), 1977–1984.

Gong-Guy, E., Cravens, R. B., & Patterson, T. E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist, 46*(6), 642–648.

Grant, B., Dawson, D., Stinson, F., Chou, S., Dufour, M., & Pickering, R. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991–1992 and 2001–2002. *Drug and Alcohol Dependence, 74*(3), 223–234.

Grant, B., Stinson, F., Dawson, D., Chou, S., Dufour, M., Compton, W., et al. (2004). Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 61*(8), 807–816.

Hahm, H., Lahiff, M., & Guterman, N. (2003). Acculturation and parental attachment in Asian-American adolescents' alcohol use. *Journal of Adolescent Health, 33*(2), 119–129.

Harachi, T., Catalano, R., Kim, S., & Choi, Y. (2001). Etiology and prevention of substance use among Asian American youth. *Prevention Science, 2*(1), 57–65.

Hasin, D., & Grant, B. (2004). The co-occurrence of DSM-IV alcohol abuse in DSM-IV alcohol dependence: Results of the National Epidemiologic Survey on Alcohol and Related Conditions on heterogeneity that differ by population subgroup. *Archives of General Psychiatry, 61*(9), 891–896.

Hendershot, C. S., Collins, S. E., George, W. H., Wall, T. L., McCarthy, D. M., Liang, T., et al. (2009). Associations of ALDH2 and ADH1B genotypes with alcohol-related phenotypes in Asian young adults. *Alcoholism: Clinical and Experimental Research, 33*(5), 839–847.

Hendershot, C. S., Dillworth, T. M., Neighbors, C., & George, W. H. (2008). Differential effects of acculturation on drinking behavior in Chinese- and Korean-American college students. *Journal of Studies on Alcohol and Drugs, 69*(1), 121–128.

Ho, M. (1989). Applying family therapy theories to Asian-Pacific Americans. *Contemporary Family Therapy: An International Journal, 11,* 61–70.

Hunt, W., Barnett, L., & Branch, L. (1971). Relapse rate in addiction programs. *Journal of Clinical Psychology, 27,* 455–456.

Hwang, W. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *Amereican Psychologist, 61*(7), 702–715.

Ja, D., & Aoki, B. (1993). Substance abuse treatment: Cultural barriers in the Asian-American community. *Journal of Psychoactive Drugs, 25*(1), 61–71.

James, W. H., Kim, G. K., & Moore, D. D. (1997). Examining racial and ethnic differences in Asian adolescent drug use: The contributions of culture, background, and lifestyle. *Drugs: Education, Prevention, and Policy, 4*(1), 39–51.

Kim, S., Ziedonis, D., & Chen, K. (2007). Tobacco use and dependence in Asian Americans: A review of the literature. *Nicotine and Tobacco Research, 9*(2), 169–184.

Komiya, N., Good, G., & Sherrod, N. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of Counseling Psychology, 47*(1), 138–143.

Kung, W. (2004). Cultural and practical barriers to seeking mental health treatment for Chinese Americans. *Journal of Community Psychology, 32*(1), 27–43.

Kwon-Ahn, Y. H. (2001). Substance abuse among Korean Americans: A sociocultural perspective and framework for intervention. In S. L. A. Straussner (Ed.), *Ethnocultural factors in substance abuse treatment* (pp. 418–436). New York: Guilford Press.

Lam, A., & Zane, N. (2004). Ethnic differences in coping with interpersonal stressors: A test of self-construals as cultural mediators. *Journal of Cross-Cultural Psychology, 35*(4), 446–449.

Laws, D. (1996). Relapse prevention or harm reduction? *Sexual Abuse: A Journal of Research and Treatment, 8*(3), 243–247.

Lee, B. K., Fong, M., & Solowoniuk, J. (2007, November). *Transplanted lives: Immigration challenges and pathological gambling among four Canadian Chinese immigrants.* Paper presented at the Problem Gambling Conference 2005: Advances in Problem Gambling: Theory, Service and Research in the Asia-Pacific Region, Hong Kong.

Lee, E. (2000). *Working with Asian Americans: A guide for clinicians.* New York: Guilford Press.

Lee, M.-Y., Law, P. F., & Eo, E. (2004). Perception of substance use problems in Asian American communities by Chinese, Indian, Korean, and Vietnamese populations. *Journal of Ethnicity in Substance Abuse, 2*(3), 1–29.

Lee, W., & Mixson, R. (1995). Asian and Caucasian client perceptions of the effectivness of counseling. *Journal of Multicultural Counseling and Development, 23,* 48–56.

Leong, F., & Lau, A. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental Health Services Research, 3*(4), 201–214.

Lesieur, H. R., Cross, J., Frank, M., Welch, M., White, C. M., Rubenstein, G., et al. (1991) Gambling and pathological gambling among university students. *Addictive Behaviors, 16,* 517–527.

Lin, K., & Cheung, F. (1999). Mental health issues for Asian Americans. *Psychiatric Services, 50*(6), 774–780.

Linehan, M. M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Linehan, M. M (1993b). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Makimoto, K. (1998). Drinking patterns and drinking problems among Asian-Americans and Pacific Islanders. *Alcohol Health and Research, 22*(4), 270–275.

Markus, H., Kitayama, S., & VandenBos, G. R. (1996). The mutual interactions of culture and emotion. *Psychiatric Services, 47*(3), 225–226.

Marlatt, G. A., (1998). Basic principles and strategies of harm reduction. In G. A. Marlatt (Ed.), *Harm reduction: Pragmatic strategies for managing high-risk behaviors* (pp. 49–66). New York: Guilford Press.

Marlatt, G. A., Baer, J., Kivlahan, D., Dimeff, L., Larimer, M., Quigley, L., et al. (1998). Screening and brief intervention for high-risk college student drinkers: Results from a 2-year follow-up assessment. *Journal of Consulting and Clinical Psychology, 66,* 604–615.

Marlatt, G. A., & Gordon, J. R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors.* New York: Guilford Press.

Marlatt, G., & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behavior, 27*(6), 867–886.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98,* 224–253.

Matsuyoshi, J. (2001). Substance abuse interventions for Japanese and Japanese American clients. In S. L. A. Straussner (Ed.), *Ethnocultural factors in substance abuse treatment* (pp. 393–417). New York: Guilford Press.

Moy Shum, L. (1996). Asian-American women: Cultural and mental health issues. *Annals of the New York Academy of Sciences, 789*(1), 181.

Murase, T., & Johnson, F. (1974). Naikan, Morita, and Western psychotherapy. *Archives of General Psychiatry, 31*(1), 121–128.

Nagoshi, C., Nakata, T., Sasano, K., & Wood, M. (1994). Alcohol norms, expectancies, and reasons for drinking and alcohol use in a U.S. versus a Japanese college sample. *Alcoholism: Clinical and Experimental Research 18*(3), 671–678.

Nakashima, J., & Wong, M. M. (2000). Characteristics of alcohol consumption, correlates of alcohol misuse among Korean American adolescents. *Journal of Drug Education, 30*(3), 343–359.

National Survey on Drug Use and Health. (2002). Low rates of alcohol use among Asian youths. *The NSDUH Report.* Available at *oas.samhsa.gov/2k2/AsianYouthAlc/AsianYouthAlc.cfm.*

National Survey on Drug Use and Health. (2006). Past-month cigarette use among racial and ethnic groups. *The NSDUH Report.* Available at *oas.samhsa.gov/2k6/raceCigs/raceCigs.htm.*

Nguyen, S. (1982). Psychiatric and psychosomatic problems among South East Asian refugees. *Psychiatric Journal of Ottawa, 7,* 163–172.

Niv, N., Wong, E. C., & Hser, Y. I. (2007). Asian Americans in community-based substance abuse treatment: Service needs, utilization, and outcomes. *Journal of Substance Abuse and Treatment, 33*(3), 313–319.

Polivy, J., & Herman, C. (2002). If at first you don't succeed. False hopes of self-change. *American Psychologist, 57*(9), 677–689.

Price, R., Risk, N., Wong, M., & Klingle, R. (2002). Substance use and abuse by Asian Americans and Pacific Islanders: preliminary results from four national epidemiologic studies. *Public Health Report, 117*(Suppl. 1), S39–S50.

Rastogi, M., & Wadhwa, S. (2006). Substance abuse among Asian Indians in the United States: A consideration of cultural factors in etiology and treatment. *Substance Use and Misuse, 41*(9), 1239–1249.

Raylu, N., & Oei, T. (2004). Role of culture in gambling and problem gambling. *Clinical Psychology Review, 23*(8), 1087–1114.

Root, M. (1985). Guidelines for facilitating therapy with Asian American clients. *Psychotherapy, 22,* 349–356.

Sakai, J. T., Ho, P. M., Shore, J. H., Risk, N. K., & Price, R. K. (2005). Asians in the United States: substance dependence and use of substance-dependence treatment. *Journal of Substance Abuse and Treatment, 29*(2), 75–84.

Sandhu, D. S., & Malik, R. (2001). Ethnocultural background and substance abuse treatment of Asian Indian Americans. In S. L. A. Straussner (Ed.), *Eth-*

nocultural factors in substance abuse treatment (pp. 368–392). New York: Guilford Press.

Saw, A., Zane, N., & Chan, A. K. K. (2007, November). *Ethnic differences in motives for gambling among Asian American and white American university students.* Poster presented at the annual meeting of the National Center for Responsible Gambling, Las Vegas, NV.

Shih, R. A., Miles, J. N. V., Tucker, J. S., Zhou, A. J., & D'Amico, E. J. (2011). Racial/ethnic differences in adolescent substance use: Mediation by individual, family, and school factors. *Journal of Studies on Alcohol and Drugs, 71*(5), 640–651.

Stoner, S. A., & George, W. (2000). Relapse prevention and harm reduction. In D. Laws, S. Hudson, & T. Ward (Eds.), *Remaking relapse prevention with sex offenders: A sourcebook* (pp. 56–78). Thousand Oaks, CA: Sage.

Sue, S. (1994). Mental health. In N. Zane, D. Takeuchi, & K. Young (Eds.), *Confronting critical health issues of Asian and Pacific Islander Americans* (pp. 266–268). Thousand Oaks, CA: Sage.

Sue, S. (1999). Science, ethnicity, and bias: Where have we gone wrong? *American Psychologist, 54*(12), 1070–1077.

Sue, S., & Morishima, J. (1982). *The mental health of Asian Americans.* San Francisco: Jossey-Bass.

Sue, S., & Zane, N. (1989). The role of culture and cultural techniques in psychotherapy. *American Psychologist, 42,* 37–45.

Takeuchi, D. T., Zane, N., Hong, S., Chae, D. H., Gong, F., Gee, G. C., et al. (2007). Immigration-related factors and mental disorders among Asian Americans. *American Journal of Public Health, 97,* 64–90.

Tatarsky, A. (2003). Harm reduction psychotherapy: Extending the reach of traditional substance use treatment. *Journal of Substance Abuse Treatment, 25*(4), 249–256.

Toy, S., & Wong, A. (1999). *Gambling among Chinese adults in San Francisco.* Paper presented at the Chinese Community Problem Gambling Project.

U.S. Census Bureau. (2008). An older and more diverse nation by midcentury [Press release]. Retrieved from *http://www.census.gov/newsroom/releases/archives/population/cb08-123.html.*

U.S. Department of Health and Human Services. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Uba, L. (2003). *Asian Americans: Personality patterns, identity, and mental health.* New York: Guilford Press.

University of Pittsburgh Medical Center. (2008). Stress coping: Body awareness exercise. Retrieved from *healthylifestyle.upmc.com/StressBodyAwareness.htm.*

Varma, S., & Siris, S. (1996). Alcohol abuse in Asian Americans: Epidemiological and treatment issues. *American Journal on Addictions, 5*(2), 136–143.

Wall, T., Shea, S., Chan, K., & Carr, L. (2001). A genetic association with the development of alcohol and other substance use behavior in Asian Americans. *Journal of Abnormal Psychology, 110*(1), 173–178.

Witkiewitz, K., & Marlatt, G. A. (2004). Relapse prevention for alcohol and drug problems: That was Zen, this is Tao. *American Psychologist, 59*(4), 224–235.

Wong, E., Marshall, G., Shetty, V., Zhou, A., Belzberg, H., & Yamashita, D. (2007). Survivors of violence-related facial injury: Psychiatric needs and barriers to mental health care. *General Hospital Psychiatry, 29*(2), 117–122.

Wong, M., Klingle, R., & Price, R. (2004). Alcohol, tobacco, and other drug use among Asian American and Pacific Islander Adolescents in California and Hawaii. *Addictive Behaviors, 29*(1), 127–141.

Wong, P., Faith Lai, C., Nagasawa, R., & Lin, T. (1998). Asian Americans as a model minority: Self-perceptions and perceptions by other racial groups. *Sociological Perspectives, 41*(1), 95–118.

Xu, Y., Okuda, M., Hser, Y. I., Hasin, D., Liu, S. M., Grant, B. F., et al. (2011). Twelve-month prevalence of psychiatric disorders and treatment-seeking among Asian Americans/Pacific Islanders in the United States: Results from the National Epidemiological Survey on Alcohol and Related Conditions. *Journal of Psychiatric Research, 45*(7), 910–918.

Yamamoto, J., & Acosta, F. X. (1982). Treatment of Asian Americans and Hispanic Americans: Similarities and differences. *Journal of the American Academy of Psychoanalysis, 10*(4), 585–607.

Yang, L. (2007). Application of mental illness stigma theory to Chinese societies: Synthesis and new directions. *Singapore Medical Journal, 48*(11), 977–985.

Yen, S. (1992). Cultural competence for evaluators working with Asian/Pacific Island-American communities: Some common themes and important implications. In M. Orlandi, R. Weston, & L. Epstein (Eds.), *Cultural competence for evaluators* (pp. 236–291). Rockville, MD: U.S. Department of Health and Human Services.

Zane, N., Enomoto, K., & Chun, C. (1994). Treatment outcomes of Asian and white American clients in outpatient therapy. *Journal of Community Psychology, 22*, 177–191.

Zane, N., Hall, G., Sue, S., Young, K., & Nunez, J. (2004). Research on psychotherapy with culturally diverse populations. In M. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 767–804). New York: Wiley.

Zane, N., & Kim, J. (1994). Substance use and abuse. In N. Zane, D. Takeuchi, & K. Young (Eds.), *Confronting critical health issues of Asian and Pacific Islander Americans* (pp. 316–346). Thousand Oaks, CA: Sage.

Zane, N., Sue, S., Chang, J., Huang, L., Huang, J., Lowe, S., et al. (2005). Beyond ethnic match: Effects of client–therapist cognitive match in problem perception, coping orientation, and therapy goals on treatment outcomes. *Journal of Community Psychology, 33*(5), 569–585.

Zhang, A., Snowden, L., & Sue, S. (1998). Differences between Asian and white Americans' help seeking and utilization patterns in the Los Angeles area. *Journal of Community Psychology, 26*(4), 317–326.